

CLITORAL RETENTION CYST FOLLOWING FEMALE GENITAL MUTILATION/CUTTING: A CASE REPORT.

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Abstract

Background: Clitoral retention cyst results from the invagination of squamous epithelium and sebaceous glands along the scar following female genital mutilation/cutting. This desquamates and produces secretions to form a cystic mass. It is usually a complication of type I female genital mutilation.

Case presentation: She is a 10-year-old female child, who presented to the gynaecological clinic with her mother, with a 6-year history of progressive swelling in her perineum. She was circumcised at the age of 2 years. She had surgical excision under anaesthesia, and was discharged home in good health condition.

Conclusion: Female genital mutilation is still being practised, especially in the developing world. More work needs to be done by every stake holder to help stop this harmful practice in order to prevent the complications associated with it.

Keywords: Clitoral retention cyst, Female genital mutilation/cutting, Surgical excision, Harmful practice.

Cite this article: Orij PC, Allagoa DO, Omietimi JE, Tekenah ES, Njoku C. Clitoral retention cyst following female genital mutilation/cutting: A case report. *Yen Med J.* 2020;2(1):183–185.

INTRODUCTION

Female circumcision also known as female genital mutilation and more recently, female genital cutting is defined by the World Health Organisation as all procedures involving partial or total removal of the female external genitalia or other injuries to the female genital organs whether for cultural or other non-therapeutic reasons. It is practiced in many countries in Africa, South-East Asia and Middle East.¹

Associated complications depend on the severity of the mutilation. Some of these complications are immediate while others may manifest years after the mutilation. Some of the immediate complications are haemorrhage, shock, pain, urinary incontinence, urinary retention, dysuria, genital oedema, and acute infections. The

long-term complications are keloid formation, fibrosis, labial adhesions, tissue rotation, psychosexual problems, dyspareunia, recurrent urinary tract infections, infertility, childbirth complications and clitoral retention cyst.^{3,4}

Female genital mutilation/cutting is classified into four types. They are; type 1 which is also referred to as clitoridectomy, involves partial or total removal of the clitoris and on rare occasions only the removal of the prepuce.² In type 2, there is partial or total removal of the clitoris and the labia minora with or without excision of the labia majora.^{2,5} In type 3 (infibulation), there is narrowing of the vaginal opening through the creation of a covering seal.^{2,5} This seal is formed by cutting and repositioning the labia minora or majora through stitching, with or

without clitoridectomy.^{2,5} Type 4 involves all other harmful procedures for non-medical purposes to the female genitalia that do not fall within the types 1 – 3 such as incision, pricking piercing, scraping of the genital area and cauterisation.^{2,5}

CASE PRESENTATION

She was a 10-year-old female child, who presented to the gynaecological clinic with her mother, with a 6-year history of progressive swelling in her perineum. Six years prior to presentation, a swelling was noticed on her clitoris. This swelling was initially small but had gradually and progressively enlarged in size. There was no associated, pain, ulceration, discharge, bleeding or itching. She was circumcised at the age of 2 years. There was no swelling in any other part of the body, acne, deepening of voice or abnormal hair distribution. She was premenarchial. She was the third female child in a family of five children (3 females and 2 males), and there was no similar complaint from any of her siblings.

Physical examination revealed a healthy-looking girl, not pale, afebrile, anicteric, not dehydrated and no pedal oedema. The pulse rate was 88 beats/min, and the blood pressure was 110/70 mmHg. The liver and spleen were not palpably enlarged and her kidneys were not ballotable. Perineal examination revealed a 6 cm x 4 cm cystic, mobile, non-tender, rounded, well-circumscribed mass in the periclitoral area [Figure 1]. The labia minora, majora, urethral orifice, vaginal orifice, and hymen were normal. There was no bleeding or discharge.

Pelvic ultrasound scan reported a normal-sized uterus measuring about 18 mm in its antero-posterior diameter. Both adnexae were free and the pouch of Douglas was empty. The clitoris was enlarged with thickened wall and cystic space within it suggestive of an abscess collection measuring 15 mm x 26 mm x 9 mm. Other tissues were normal.

The mother was counselled about her daughter's condition, the possible cause and management of the condition. A written informed consent was obtained for surgical excision under anaesthesia. Theatre was

booked for the procedure. After routine cleaning and draping, and insertion of size 8 Foley's urethral catheter, the surrounding skin of the clitoral cyst was infiltrated with adrenaline to reduce blood loss. An inverted V-shaped incision was made on the skin covering the cyst. The skin was held with two Allis forceps and dissected off the cyst. The cyst was removed completely intact by blunt dissection. Some figure-of-eight stitches with No. 3/0 vicryl were used to achieve haemostasis in the cyst bed. The redundant skin was trimmed and the edges brought together for re-approximation. The skin was repaired with vicryl 4/0 in a subcuticular fashion. Blood loss was minimal. The cyst was sent for histological examination. She had analgesics and prophylactic antibiotics. She recovered from anaesthesia, and her immediate postoperative condition was satisfactory. Foley's urethral catheter was left insitu for 24 hours to prevent urinary retention from pain. There was no dysuria, urinary retention and frequency. She was discharged home on the second post-operative day, and was given a two-week follow-up visit to the gynaecological clinic.

Histopathologic evaluation reported a 6 cm x 4 cm x 3 cm unilocular cyst that was filled with thick sebaceous materials. Microscopy reported a cyst wall, lined by keratinizing stratified squamous epithelium which corresponded to epidermal inclusion cyst.



Figure 1: Clitoral retention cyst 10-year-old female child.

DISCUSSION

Clitoral retention cyst is as a result of the invagination of squamous epithelium and sebaceous glands along the scar following female genital mutilation.⁶ This desquamates and produces secretions to form a cystic mass.⁶ It is usually a complication of type I female genital mutilation.^{3,6} The patient presented had female genital mutilation/cutting at the age of 2 years. The incidence of clitoral retention cyst among females that had genital mutilation is 48.72%.³

Many countries of the world had practised female genital mutilation at one time or the other.⁷ Presently, the practice is limited to the developing countries where it is performed for various traditional and cultural reasons, by traditional practitioners and non-medical personnel that use non-sterile instruments.⁷ Their actions predispose females to immediate and long-term complications.⁷

Clinical features depend on the age of the patient at presentation, extent of the procedure, associated complication, and the size of the cyst.⁶ Clitoral retention cysts are usually painless and may be associated with other urogenital symptoms, such as difficulty in wearing underwear, vaginal discharge, urinary symptoms, vulval pain and dyspareunia.⁸ The swelling is usually discovered incidentally by the parents⁹ as it happened in this patient.

Physical examination usually reveals a cystic, mobile, non-tender, rounded, well-circumscribed mass in the peri-clitoral area¹⁰ as observed in this patient.

Management of clitoral retention cyst is surgical with excision of the cyst and prognosis is good. Surgical excision was done for this patient, and was discharged home in good health condition.

CONCLUSION

Female genital mutilation/cutting is still being practised, especially in the developing world. More work needs to be done by every stake holder to help stop this harmful practice in order to prevent the complications associated with it.

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