Module 3: Management of FGM-related complications

Session 2

Management of FGM-related gynaecological and urogynaecological complications

Overview of the Session

This session focuses on assessment and management of **gynecological and urogynecological complications and conditions arising from FGM**:

- ✓ Chronic vulvar pain
- ✓ Clitoral neuroma
- ✓ Reproductive tract infections
- ✓ Menstrual problems such as dysmenorrhea (painful menstruation) and difficulty in passing menstrual blood
- ✓ Urinary tract infections (often recurrent)
- ✓ Painful or difficult urination
- ✓ Epidermal inclusions cysts (lumps in the surface tissue)
- ✓ Keloids in the genital area (overgrowth of scar tissue)

Learning Objectives

By the end of this session, participants will:

- ✓ Identify long-term gynecological and urogynecological health complications and conditions arising from FGM
- ✓ Manage female patients who have suffered such health complications & conditions

Management of Chronic Vulvar Pain *(1)*

- The clitoral glans and surrounding genital tissues (e.g., **clitoral prepuce and labia minora)** are injured through cutting, pricking, nicking or stitching

    - Formation of **inelastic scar tissue or, in some women, to the formation of keloids, cysts and neuromas**.

- Pain in the vulvar area often manifests **during sexual intercourse**; however, it may also arise during daily activities

Management of Chronic Vulvar Pain *(2)*

- The management of chronic vulvar pain is as follows:
  - ✓ **Establish** the cause of the pain by taking medical history & performing a genital examination
  - ✓ **Obtain woman's permission and inspect** the vulvar area carefully
  - ✓ If the physical examination does **not reveal any specific or detectable cause**, potential **psychosocial factors** associated with the symptoms should be considered
  - ✓ If the pain is **severe or persists**, refer the woman to a gynaecologist for further investigation & management

Management of Clitoral Neuroma *(1)*

- A neuroma is a **benign tumor** that arises after the section or injury of a nerve. In the case of a **clitoral neuroma**, the dorsal clitoral nerve is injured during the cutting of the **clitoral glans**

- When the nerve fibers regenerate, they do so in disorganized manner, which leads to the appearance of a **clitoral neuroma**

- A clitoral neuroma can be **asymptomatic,** or it may cause **allodynia (pain resulting from a stimulus – such as a light touch of the skin** – which would not normally cause pain), **sensations of electric discharge, or chronic pain** in the surrounding area

Management of Clitoral Neuroma *(2)*

- With this condition, sitting, sexual intercourse, or even the friction of underpants, can cause pain

▪ If the neuroma is **symptomatic, it should be managed as follows:**

✓ Collect a detailed **medical history probing for typical symptoms such as chronic pain, allodynia and sensations of electric discharge** in the genital area

✓ Before touching the genital area, **explain** carefully what you will do. Perform a **genital examination.**

Management of Clitoral Neuroma *(3)*

Be very gentle when examining your patient. A clitoral neuroma can be very painful!

- ✓ **Inspect** the vulvar area carefully; a neuroma is not always immediately visible
- ✓ You can check for the presence of a neuroma by carefully touching the area around the clitoral scar with **a delicate object such as a cotton bud/swab**, searching for allodynic areas
- ✓ You can offer **lidocaine cream**, which the woman can apply to the painful area and advise the woman **to wear loose underpants** to avoid friction
- ✓ If the symptoms are **severe**, refer the woman for **surgical excision of the neuroma**

Management of Reproductive Tract Infections *(1)*

- ✓ Women who have undergone FGM have an increased risk of reproductive tract infections (RTIs), including **bacterial vaginosis**

- ✓ Partial occlusion of the vaginal opening – due to the presence of **scar tissue or infibulation**, among women living with **type III FGM** – is a contributing factor for the development of these conditions

Management of Reproductive Tract Infections *(2)*

- ✓ **RTIs** can be painful and may be accompanied by abnormal vaginal discharge:
  - ➢ They can be **recurrent** and, if left untreated, may become persistent and lead to **pelvic inflammatory disease (PID)**

- ✓ The consequences of RTIs for reproductive health can be severe and life threatening: They include:
  - ➢ **PID, infertility, ectopic pregnancy**
  - ➢ Adverse pregnancy outcomes, such as **miscarriage, stillbirth, preterm birth and congenital infection**

Management of Reproductive Tract Infections *(3)*

- The management of RTIs is as follows:
  - ✓ Take a **medical history** and perform a **genital examination.** Assess the woman to identify the type of FGM she has and the likely cause of the problem (i.e., RTI)
  - ✓ If **rapid diagnostic tests (RDTs)** lab facilities are available, take a vaginal swab/ cervical swab and then provide treatment based on **etiology**
  - ✓ If lab facilities are not available, treat the woman based on **symptoms and signs (syndromic treatment)**

Management of Reproductive Tract Infections *(4)*

- ✓ If an **STI** is diagnosed or suspected, **provide partner management**. If **bacterial vaginosis or candidiasis** are suspected, there is no need to treat the husband/partner
- ✓ Explain that if the **symptoms continue,** she should return for care
- ✓ **NOTE OF REFERRAL:** refer patient to a higher-level health facility if:
  - ➢ The symptoms persist
  - ➢ The cause of the infection is obstruction due to injury of the genital tissue
  - ➢ The woman has type III FGM (inform and counsel her about the need for deinfibulation)

Management of Menstrual Difficulties *(1)*

- ✓ Menstrual difficulties include **dysmenorrhea** (painful menstruation), **difficulty in passing menstrual blood**, and **haematocolpos** and **hematometra** (accumulation of blood within the vagina and uterus, respectively)

- ✓ Girls and women who have undergone FGM often report **dysmenorrhea with or without menstrual irregularity**:
  - ➢ Possible causes include **tight infibulation or severe scarring** leading to narrowing of the vaginal opening

Management of Menstrual Difficulties *(2)*

- The management of menstrual difficulties is as follows:
  - ✓ **Establish the cause** of the menstrual disorder by taking a **medical history** and performing a **clinical examination**
  - ✓ If available, perform a **pelvic ultrasound** to confirm the cause
  - ✓ A palpable suprapubic mass may indicate **haematocolpos**

Management of Menstrual Difficulties *(3)*

- ✓ **NOTE OF REFERRAL:** refer patient to a higher-level health facilities
  - ➢ **If the condition is severe**, refer to a gynecologist for further investigation and management
  - ➢ If the woman has **type III FGM (infibulation)** or a **tight vaginal opening**:
    - ✓ **Inform and counsel** her in detail about the need for **deinfibulation or surgical removal of the scar tissue** that will allow for normal menstrual flow
    - ✓ Seek her **informed consent** and, if she agrees, make a **referral or appointment** for the procedure

IMPORTANT! ***Dysmenorrhea may be associated with conditions other than FGM; this should be investigated, and these conditions should be treated according to local protocol or national guidelines (e.g., endometriosis, adenomyosis)***

Management of Urinary Tract Infections *(1)*

- ✓ Girls and women who have undergone FGM, especially those with **type III FGM**, have an increased risk of developing urinary tract infections (UTIs), including **recurrent UTIs**

- ✓ UTIs in women living with FGM usually occur due to **obstruction** and **stasis of the urine:**
  - ➢ This may happen among **infibulated women** or due to **injury to the urethral opening**
  - ➢ The obstruction affects the normal flow of urine, which is **only able to slowly drip out when the woman urinates**
  - ➢ This causes the urine to **stagnate**, making it **susceptible to bacterial growth that can lead to a UTI**, that can become **recurrent**

Management of Urinary Tract Infections *(2)*

- The management of UTIs is as follows:
  - ✓ **Establish the cause** of the UTI by taking a **medical history and** performing a **genital examination**
    - ➢ **Ask** the woman if she has had **similar symptoms or a confirmed UTI** in the past year
    - ➢ **Inspect** the vulvar area carefully to **establish the cause of infection**
    - ➢ **If laboratory facilities are available**, send a **urine sample for urinalysis** before providing treatment. If not, give **antibiotic treatment** according to local protocol or national guidelines
  - ✓ **Advise** the woman to drink **plenty of water**
  - ✓ **Advise** her to return for care if the **symptoms do not improve**, **get worse** or **return** after treatment

Management of Urinary Tract Infections *(3)*

Recurrent UTI: a symptomatic infection of the urinary tract (bladder and kidneys) that **follows the resolution of a previous UTI**, generally **after treatment.**

- ✓ Definitions of recurrent UTI vary and include **two UTIs within the previous six months**, or a **history of one or more UTIs before or during pregnancy**

Management of Urinary Tract Infections *(4)*

✓ **NOTE ON REFERRAL:**

- If the woman experiences **recurrent UTIs**, refer her to a secondary health care facility
- If you identify **damage to the urethral opening**, you must refer the woman for surgical correction **after providing treatment for the UTI**
- If **infibulation (type III FGM) is the cause**, inform and counsel the woman in detail about the need for **deinfibulation:**
  - ✓ Explain to her that unless she is **deinfibulated**, the UTI is likely to recur and may eventually **affect the bladder and kidneys**

WHO RECOMMENDATION:
Deinfibulation is recommended for preventing and treating **urologic complications** – specifically **recurrent UTIs** and **urinary retention** – in girls and women living with **Type III FGM**

Management of Painful or Difficult Urination *(1)*

- ✓ Painful (difficult urination) may be caused by a **UTI**, or **by difficulty passing urine due to damage to or partial obstruction of the urethral opening:**
  - ➢ In women living with FGM, **scar tissue/type III FGM** are usually the cause of the obstruction

- The management of painful or difficult urination is as follows:
  - ➢ **Establish the cause** of painful or difficult urination by first taking a **medical history** and a **genital examination.** Ask these questions to determine if your patient has a partial obstruction:
    - How long does it take you to **empty your bladder**?
    - Do you pass urine **drop by drop**? Do you **feel you cannot empty your bladder completely**?
    - Do you **lose drops of urine regularly during daily activities**?

Management of Painful or Difficult Urination *(2)*

- The management of painful or difficult urination cont'd:
  - If the pain is caused by a UTI, manage as indicated in previous section

✓ **NOTE OF REFERRAL:** If you identify **damage to the urethral opening and type III FGM**, you must refer the woman for surgical correction

Management of Epidermal Inclusion Cysts in Genital Area *(1)*

- ✓ The cutting of the genital area leads to **a wound**. When a wound heals, it leaves a scar. Sometimes, external **layers of the skin (epidermis)** become “trapped” in deeper layers (dermis). This can lead to **epidermal inclusion cysts** that can gradually increase in size

- ✓ If located in the genital area, epidermal inclusion cysts can cause **discomfort during sexual intercourse** & **possible obstruction of the vaginal opening during childbirth**

Management of Epidermal Inclusion Cysts in Genital Area *(2)*

- The management of epidermal inclusion cysts is as follows:
  - ✓ Take a medical history and perform a genital examination
  - ✓ If you suspect a **vulvar abscess**, manage as indicated
  - ✓ If the cyst does not represent a potential obstruction or cause other difficulties, **explain to your patient that it can be left undisturbed**
  - ✓ If there is a cyst that is large, recurrently inflamed or located in an area that may cause obstruction during childbirth, the woman should be **referred to have it removed under anaesthesia**

Management of Keloids in the Genital Area *(1)*

- ✓ **Keloids** are raised scars that grow excessively and can become larger than the original area of skin damage. Once it appears, **a keloid can enlarge slowly for months or years and it may feel painful or itchy**:
  - ➢ Keloids can be difficult to treat. Even after surgical removal, a keloid scar may grow back

Management of Keloids in the Genital Area *(2)*

- The management of keloids is as follows:
  - ✓ Take a **medical history** and perform **a genital examination** and assess the **size and location of the keloid**
  - ✓ If the keloid does not represent a potential obstruction or cause other difficulties, explain to your patient that it can be left undisturbed
  - ✓ If there is a keloid that may **cause obstruction or which causes other difficulties**, the woman should be **referred to a specialist experienced in removing keloid scars**

Family Planning for Women Living with FGM *(1)*

- ✓ Family planning (FP) is as appropriate for women living with FGM as it is for any other woman:
  - ➢ **Medical Eligibility Criteria** set by WHO can be used to determine the most suitable contraceptive methods for these women

Family Planning for Women Living with FGM *(2)*

✓ **CONSIDERATIONS** when helping FGM woman choose suitable contraception:

- **Genital examination** should be carried out to identify the **type of FGM** and to check that there are no problems that need attention, especially **infections**

- **Infibulated women**: may have difficulties in using a method which has to be **inserted vaginally,** such as **female condoms, diaphragm, cervical cap, intrauterine device (IUD) and** sometimes **male condoms**

- Since women with FGM of any type are prone to **RTIs**, **IUDs** should be used only after careful consideration

Cervical Screening for Women Living with FGM *(1)*

✓ Women with FGM may have been exposed to the **human papillomavirus (HPV)** and they are also at risk of developing **cervical cancer:**

- Therefore, they should undergo **cervical screening at regular intervals**

Human papillomavirus (HPV) is the **most common viral infection of the reproductive tract** – most people get it at some time in their life. **Cervical cancer** is caused by certain types of HPV that are passed through **sexual contact**

IMPORTANT! ***All women should be screened for cervical cancer at least once between the ages of 30 and 49 years, or in accordance with national guidelines***

Cervical Screening for Women Living with FGM *(2)*

- ✓ Taking a cervical sample for screening can sometimes be difficult if the woman has undergone **type III FGM or has extensive genital scarring**

- **RECOMMENDATIONS** for health-care professionals performing cervical screening for woman with FGM:
  - ➢ Explain to her that you will need to perform a **genital examination** to decide if you can do the test, and obtain **her permission** to perform this examination
  - ➢ Assess the **vaginal opening and the level of difficulty** for performing cervical screening
  - ➢ Conduct the cervical screening, **if possible**, but reassure her that the **procedure can be stopped if it becomes too painful**

Cervical Screening for Women Living with FGM *(3)*

- **RECOMMENDATIONS** for health-care professionals performing cervical screening for woman with FGM cont'd:

  - ➢ If speculum insertion is possible, use the **smallest available size** with application of **lubrication** on the speculum edge

  - ➢ Instruct the woman to use **relaxation techniques**, such as **deep breathing**

  - ➢ Difficulties performing the screening may highlight the need for **deinfibulation**:
    - ✓ **If cervical screening is not possible, do not insist**
    - ✓ Discuss **deinfibulation** with the woman, and her husband/partner where appropriate

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