

Female Genital Cutting: Addressing the Issues of Culture and Ethics

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Understanding female genital cutting will help the clinician gain insight into providing culturally competent care.

Female genital cutting (FGC) is an ancient cultural practice gaining increased attention due to immigration from FGC-affected regions of the world. FGC is defined as any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs, whether for cultural or nontherapeutic reasons.¹

Widely known as female circumcision or female genital mutilation, these terms may be offensive when working with affected communities. Consequently, “female genital cutting” has been widely adopted as a more neutral term.^{2,3}

In order to provide culturally competent care, clinicians need to understand the range of procedures performed, the potential complications in obstetrics, and effective strategies for averting and addressing the clinical, ethical, and legal challenges.

CLASSIFICATION

FGC is divided into 4 categories (Figure 1). Type I is the partial or total removal of the prepuce or clitoris (clitoridectomy). Type II is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III involves cutting and appositioning the labia minora and/or majora to create a covering that restricts the vaginal introitus (infibulation). This is the most extreme category, but it only comprises 10% of cases of FGC.² Type IV includes other alterations to the genitals that do not remove tissue, such as piercing, pricking, or cauterization.¹

EPIDEMIOLOGY

FGC affects up to 140 million women worldwide. Each year 3 million girls are at risk of undergoing this practice.¹ FGC is documented in 28 countries throughout sub-Saharan Africa and in regions of Southeast Asia and the Middle East. Prevalence rates vary between and within nations, with some regions possessing rates higher than 90%.¹ Based on estimates from the 2000 US Census, 228,000 women and girls in the United States are either living with or at risk for FGC.⁴

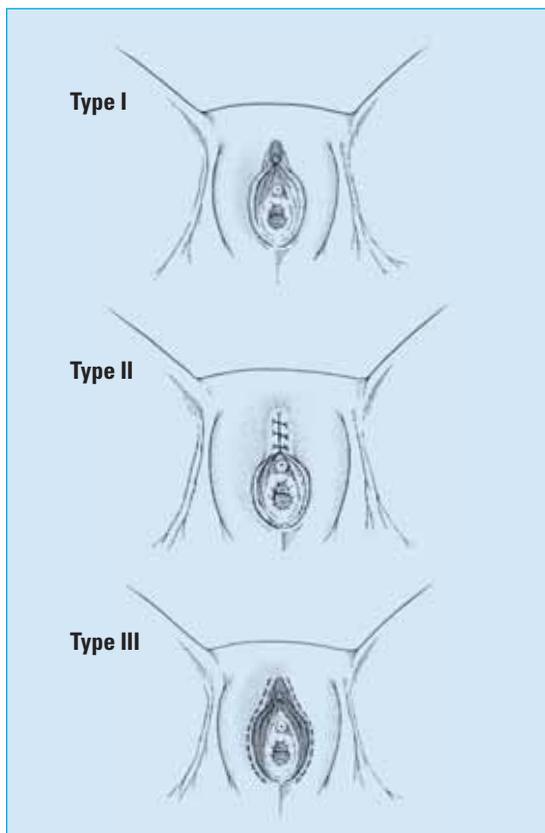


FIGURE 1. Classification of female genital cutting.

Source: Toubia N. Female circumcision as a public health issue. *N Engl J Med.* 1994;331(11):712-716. Copyright © 1994 Massachusetts Medical Society. Used with permission; all rights reserved.

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CULTURAL PRACTICE

FGC is often performed as a ritual initiation into womanhood: ensuring one's chastity and eligibility for marriage and instilling pride, honor, value, and aesthetics. The ritual of FGC varies among societies. Girls usually undergo FGC between the ages of 5 and 12; however, some communities practice FGC on newborn infants or on young women prior to marriage. It is usually performed by professional circumcisers, traditional healers, or birth attendants.

ASSOCIATED MORBIDITY

FGC is typically performed under nonsterile conditions with limited or no anesthesia. Both immediate and long-term complications can arise from FGC, and they vary with the type and severity of tissue excised. Morbidity has been shown to increase with the severity of cutting, with type III FGC having the highest rate of complications. It is important to keep in mind that not all women will experience morbidity. Immediate complications may include pain, infection, laceration of adjacent structures (eg, the bladder, urethra, vagina, or rectum), and uncontrolled hemorrhage.

Long-term complications, seen mostly in women with type III FGC, include chronic urinary tract infections, severe dysmenorrhea, and dyspareunia, which in severe cases may lead to infertility.¹ Evidence is mixed as to the extent to which sexual function is affected by FGC.³ More research is needed to further elucidate the impact of varying types of FGC on a woman and her partner's sexual health.

Obstetric and neonatal outcomes may also be adversely affected. A prospective study across 6 African nations has demonstrated a trend toward adverse obstetric and neonatal outcomes with increasing severity of FGC when compared to those without FGC. Adverse outcomes include cesarean delivery, postpartum hemorrhage, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death.⁵

DEFIBULATION

Long-term complications of type III FGC (infibulation) can be alleviated by a defibulation procedure performed as a same-day outpatient procedure in women suffering

from FGC-related morbidity, prior to coitus or pregnancy, or during the antepartum or intrapartum period.

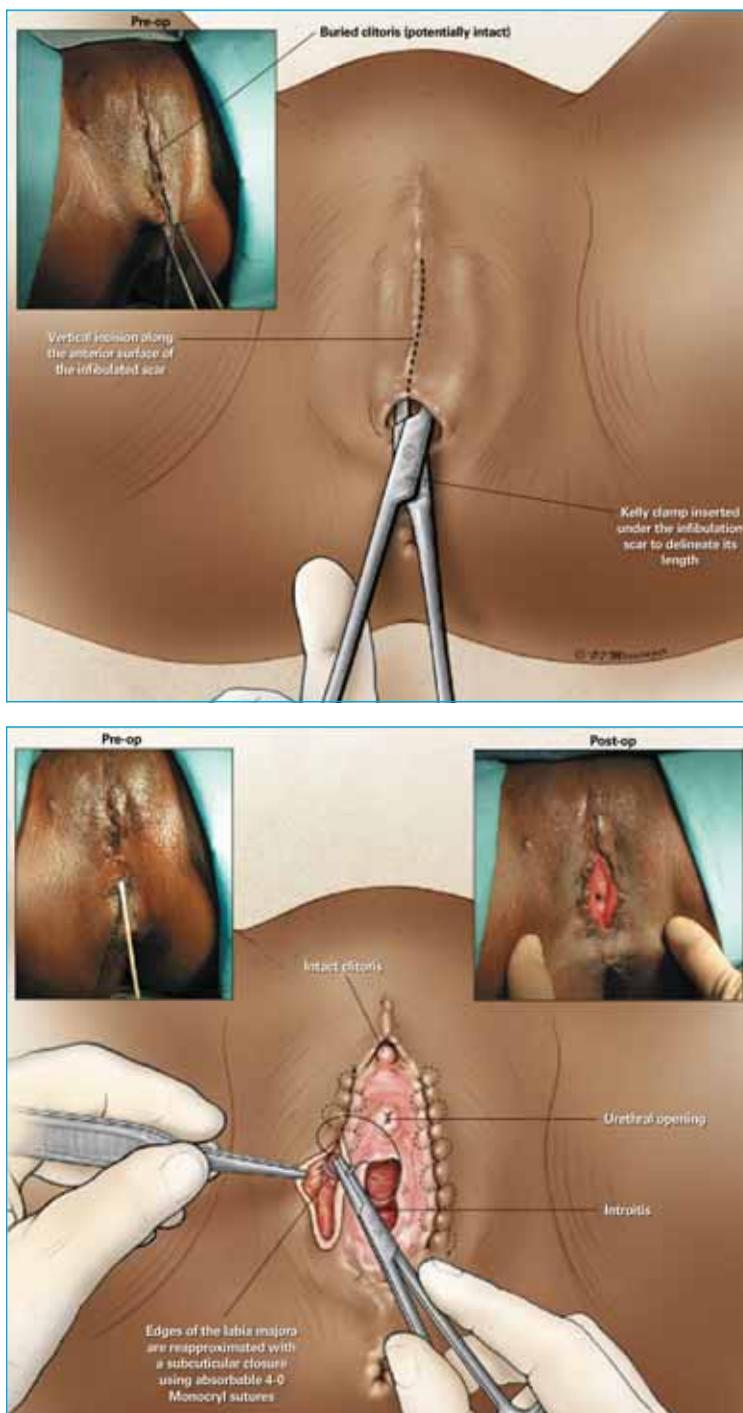


FIGURE 2. Defibulation.

Source: Johnson C, Nour NM. Surgical techniques: defibulation of type III female genital cutting. *J Sex Med.* 2007;4(6):1544-1547. Used with permission from John Wiley and Sons, Inc.

Defibulation entails the surgical release of the vulvar scar tissue by making a vertical incision along the infibulation to expose the urethral meatus and introitus, followed by reapproximation of the raw edges on each labia majora (Figure 2). Care must be taken to avoid injuring any buried clitoral tissue. This procedure can usually be done under regional or general anesthesia. Local anesthesia should be avoided, as patients may experience posttraumatic stress disorder.⁶ Patients should be counseled to expect a change in their urinary stream postoperatively.

For pregnant patients with type III FGC, cesarean delivery should be performed only for the usual obstetric indications, and precautions should be taken to ensure a safe vaginal delivery. Counseling is needed during the antepartum period to discuss what to expect during labor, as well as to determine the most appropriate timing of defibulation (antepartum during the 2nd trimester vs intrapartum). Antepartum defibulation avoids excessive blood loss at the time of delivery, facilitates the assessment of cervical dilation, and allows for urethral catheterization and the placement of intrauterine devices, while minimizing patient discomfort. There should be appropriate documentation in the medical records of the agreed upon plan for and timing of defibulation, as well as effective communication between antepartum and intrapartum care providers.

CULTURALLY COMPETENT CARE

Women suspected of being at risk for or who have undergone FGC should be asked about their history in a culturally sensitive manner, with careful use of the patient's own terminology.⁷ Certain challenges may arise in the care of women with FGC. During the physical exam, it is important to gain the trust of women who may feel uncomfortable with gynecologic exams.⁷ Pelvic exams may pose a challenge in women with a narrowed opening, and a pediatric speculum may be needed. Likewise, performing a bimanual exam may be difficult, and a rectovaginal exam may be required.

ETHICAL AND LEGAL CONTROVERSIES

FGC has created controversy in the United States. An ethical conflict may arise where-

in some women may feel more comfortable with their fused labia and may request to have their scar reapproximated (reinfibulated) to varying degrees after delivery to restore their sense of beauty, normalcy, and genital self-image.⁷ There may also be sociocultural pressures within a woman's family and/or community that drive her decision making.^{2,3}

Although FGC on minors is banned in the United States, reinfibulation is legal in certain states, with exceptions provided for intrapartum women.⁸ However, practitioners may feel ethically conflicted due to their own views on primary infibulation.⁷

In special circumstances and after extensive patient counseling, discussion, and education, providers may consider partial reinfibulation of the most cephalad portion of the old scar tissue for those patients who place value in their sense of normalcy of their original infibulation. The American Congress of Obstetricians and Gynecologists does not currently have policy recommendations in place to guide clinicians in their decision making and patient counseling. Regardless of clinician beliefs, a discussion with the patient should ensue during the antepartum period to elicit the patient's desires and prepare her for management of the infibulated scar postpartum.

Controversy surrounds the criminalization of FGC. In an attempt to prevent girls from being transported by their families back to their native country to undergo FGC, the American Academy of Pediatrics (AAP) revised its policy statement endorsing the option of ritual nicking of the clitoris as an alternative to the more severe forms of FGC.⁹ This was met with swift and strong global outrage and criticism, which led the AAP to withdraw the revision to its statement.^{10,11}

A bill was introduced before Congress (Girls Protection Act of 2010 H.R. 5137) to amend the federal criminal code imposing penalties for anyone who knowingly transports female minors outside of the United States for the purposes of undergoing FGC.¹²

Controversy also surrounds the comparison of FGC to female genital cosmetic surgery, as it is argued to be a double standard to forbid elective genital modifications of consenting adult women with FGC while

FOCUSPOINT

Based on the 2000 census, 228,000 women and girls in the United States are either living with or at risk for FGC.

accepting elective female genital cosmetic surgeries or male circumcision.³

SUMMARY

Regardless of personal beliefs, it is important to keep a nonjudgmental and open mind when caring for women with FGC. Until further guidance is provided by regulatory bodies, clinicians must evaluate their own views in professional ethics while providing counseling, education, and clinical care, as well as respecting their patients' culture and autonomy.

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Coding for Female Genital Cutting

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There are specific ICD-9 codes that describe the classification categories:

- 629.20** Female genital mutilation status, unspecified
Female genital cutting status, unspecified
Female genital mutilation status, NOS
- 629.21** Female genital mutilation Type I status
Clitorectomy status
Female genital cutting Type I status
- 629.22** Female genital mutilation Type II status
Clitorectomy with excision
of labia minora status
Female genital cutting Type II status
- 629.23** Female genital mutilation Type III status
Female genital cutting Type III status
Infibulation status

- 629.29** Other female genital mutilation status
Female genital cutting Type IV status
Female genital mutilation Type IV status
Other female genital cutting status

The defibulation procedure does not have a CPT code, so the physician must use those codes that most closely describe the procedure performed. You can use one of two CPT codes from the Vulva, Perineum, and Introitus Section.

- 56441** Lysis of labial adhesions

- 56800** Plastic repair of introitus

If the physician feels that this was a more complicated operation and required more physician work than that described in the CPT code, add the -22 modifier and document the additional physician work.

Philip N. Eskew Jr, MD, is past member, *Current Procedural Terminology (CPT)* Editorial Panel; past member, *CPT* Advisory Committee; past chair, ACOG Coding and Nomenclature Committee; and instructor, *CPT* coding and documentation courses and seminars.