Clitoridal inclusion cyst as a complication of female genital mutilation in a 7-year-old Nigerian girl

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Abstract

Clitoridal inclusion cyst is a common complication of childhood female genital mutilation (FGM) wrong referred to as female circumcision which is still a predominant practice in Sub-Saharan Africa and Asia. Inclusion cyst of the clitoris can present as infants; during childhood or later in life as a complication of FGM. We present a case of a 7-year-old girl with Clitoridal inclusion cyst. She had FGM during infancy in a nursing home in Nigeria. She had enucleation of the cyst with re-fashioning of the external genitalia.

Keywords: Clitoridal inclusion cyst; Female Genital Mutilation; Circumcision

1. Introduction

Clitoridal cyst formation is one of the complications of female genital mutilation (FGM) and usually presents in early childhood [1]. It may rarely present late in adulthood [2]. Post-menopausal Clitoridal cyst long after childhood FGM has been documented [2]. Vulval surgeries or trauma are the risk factors [1, 2]. Clitoridal cyst or Clitoridal inclusion cyst represents 5.7% gynaecological cases in a Nigerian southern state occurring as an inclusion cyst due to FGM or cutting, trauma or infections [3, 4, 5].

The complications associated with FGM including the occurrence of clitoridal inclusion cyst depend on the extent of the initial genital cutting or mutilation and can occur early following the procedure or it may occur several years later. Inclusion cyst of the clitoris accounts for nearly half of female genital mutilation-related complications [6, 7]. This is related to the high prevalence of female genital mutilation in Sub-Saharan Africa and Asia. [2, 6, 8]. The reasons behind FGM are purely religio-cultural and superstitious beliefs with no therapeutic basis [2, 5, 7]. These reasons vary from one ethno-religious group to another. It can be present without causing any symptoms because it is a slow-growing tumor.

2. Case

Patient was a 7-year-old girl who had progressive midline vulval swelling in the clitoridal region without any other history of trauma besides a female genital cutting perfumed in infancy. Swelling had been asymptomatic and slow growing. However, her parents decided to bring her for repair on account of cosmetic concern. Details of events surrounding the circumcision was not mentioned besides that it was done by an elderly woman in a nursing home without anaesthesia. Examination showed a painless, midline, mobile and cystic mass extending around the entire clitoridal region.

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She had a clitoridal cyst excision using combined conscious sedation and local anaesthetic infiltration. A single midline vertical incision was made on the mass after urethral catheterization to protect the urethra and the cyst dissected and enucleated with haemostasis secured with polyglactin 2/0 suture at the base of cyst. Excess skin was excised, and skin closed with subcuticular polyglactin 2/0 suture. Procedure was well tolerated, and catheter removed after 24 hours and discharged on oral antibiotic and analgesics. Histology was confirmatory of inclusion cyst with presence of cyst wall lined by stratified squamous keratinized epithelial cells.

3. Discussion

Clitoridal inclusion cyst presents mostly as infantile or early childhood complication of FGM or circumcision [5] or infrequently as late complication of female circumcision [4, 9, 10] where it may present many years after and complications varying with severity of the mutilation [4]. Clitoridal inclusion cyst is rare in the absence of a prior circumcision [4, 11]. However, spontaneous occurrences with non-admittance of FGM have been reported [11, 12].

Pathophysiology of clitoridal inclusion cyst is the invagination of active sebaceous-secreting epithelial cells during healing from trauma [4]. Infections from application of native herbal concoctions and mixtures, coupled with use of recycled unsterilized instruments are contributory [7].

It is usually an asymptomatic mass. If large may cause difficulty in urination, walking and sexual discomfort in the sexually active adult. It is usually located in clitoridal region, midline in location, painless, mobile, and cystic in texture and well circumscribed. Other parts of the vulva are usually normal except for any persisting distortion from the predisposing trauma or surgery [1]. Pain may signify complication such as inflammation, secondarily infection and ulceration of a large mass. Malignant transformation and fungal development within the cyst may occur but rare.

Diagnosis is usually clinical. A painless central mass at the clitoridal site which was absent prior to history of circumcision is usual [4]. Histological confirmation is that of a cyst wall lined by stratified squamous keratinized epithelium [4].
Additional investigations such as pelvic ultrasound scan, hormonal assay, karyotype etc will depend on history in order to exclude differentials.

Differential diagnosis of clitoridal inclusion cyst include cysts from nearby glands and ducts such as Gartner's duct cyst, cyst of Skene's glands and cyst of the canal of Nuck. True hermaphroditism, aberrant hormone secretion from adrenal hyperplasia, ovarian and adrenal neoplasms, stromal hyperthecosis, polycystic ovarian syndrome, and exogenous androgen exposure may cause clitoromegally. Clitoral neoplasm is also not impossible [4,13,14].

Indications for treatment are mainly for cosmetic purpose and coital difficulties caused by large cyst [4, 14].

The standard treatment is the surgical enucleation of the cyst and its capsule [4, 13] with excision of redundant skin flap to improve appearance. Complications of treatment include haemorrhage [4], urinary infection, urethral injury and obliteration which can be prevented by operative caution and pre-operative catheterization.

To summarize therefore, it is worth noting that FGM is an oppressive and ancient practice used to control the sexual identities and bodies of women and girls. It is even much surprising that all effort and awareness geared towards stopping the practice of FGM is primarily directed towards traditional genital cutters or elderly community women with little or no effort made towards discouraging the medicalization of this procedure by some health workers.

4. Conclusion
FGM is a predominant practice in Africa and Asia despite new legislations in some countries to the contrary. Women empowerment, education of the girl child and more awareness is required to stop this age long practice thereby preventing the occurrence of these consequences.

Compliance with ethical standards

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Disclosure of conflict of interest
No conflict of interest to be disclosed.

Statement of ethical approval
This study was approved by the research committee of the Kingswill advanced fertility center Lagos, where this patient was managed.

Statement of informed consent
The authors certify that they have obtained all appropriate patient consent forms for the data to be published.

Guarantor
The corresponding author will act as the guarantor for this manuscript.

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