



CLITORIDAL CYST FOLLOWING FEMALE CIRCUMCISION: A CASE REPORT

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ABSTRACT

Introduction: *Clitoridal cyst is usually a long-term complication of female circumcision. Female genital mutilation or cutting may lead to one of the common types of cutaneous cyst which is an epithelial inclusion cyst resulting from implantation of epidermal elements in the dermis and can be found in any part of the body including the perineum. These epidermal elements desquamate and produce secretions to form a cyst. It may also occur in very few cases result from minor trauma to the clitoris, such as vulval dermatitis.*

Case presentation: *She was a 35-year primiparous woman who presented to us at a private facility with a history of progressive swelling on her circumcision site. She could not remember how long, but she was circumcised in infancy. She had a surgical excision under anaesthesia and was discharged home in a stable clinical state.*

Conclusion: *Clitoridal cysts can occur as a complication of female genital cutting. Satisfactory treatment outcome can be achieved by surgical excision.*

Keywords: *Clitoridal cyst, female circumcision, surgical excision*

INTRODUCTION

A clitoridal cyst is usually a long-term complication of female genital mutilation or cutting. It is a gynaecological tropical issue of public health importance. It may also occur in very few cases from minor trauma to the clitoris, such as vulval dermatitis.^{1,2} Female genital mutilation involves all procedures that include partial or complete removal of the external genitalia or other non-therapeutic injuries to the female genital organs (such as stitching of the labia majora or pricking of the clitoris).^{1,2} It is classified into four major types: type I (clitoridectomy) involves partial or total removal of the clitoris and, rarely, the prepuce as well; type II (excision) is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; type III (infibulation) is the most severe form and involves partial or total removal of the labia minora and majora with or without clitoridectomy. In type III FGM, the remaining labial tissues are then re-approximated, i.e., infibulated, leaving a small anterior opening for the passage of urine and a similar posterior opening for the passage of blood. This bridge of scar tissue results in a narrowed neo-introitus. Type IV FGM refers to all other harmful procedures to the female genitalia for non-medical purposes, e.g.,

pricking, piercing, incising, scraping, and cauterizing the genital area. Type I and II constitute about 80% of female genital mutilation. Despite the non-health usefulness of female genital mutilation; it has been observed to alter the normal female sexual bodily functions with numerous negative effects on a woman's life, including her physical, mental, and sexual health. It also affects her relationship with her husband or partner and other close family members. It is often considered as a variance of gender violence.¹⁻⁴

Clitoridal cyst resulting from female genital mutilation can be a source of worry to the woman's sexual health. Its treatment is known to improve the perceived quality of sexual life of the women living with it.

CASE REPORT

She was a 35-year-old Para₁⁺² woman, who presented to a private clinic with a history of progressive swelling in her perineum. She could not remember when the swelling started. It was located on the anterior aspect of the vulva and there was a history of circumcision in infancy. The swelling was not present before the circumcision. This swelling was initially small but gradually and progressively increased in size. The swelling

had not bothered her until about a year before the presentation when her suitor noticed and complained about it. There was no associated pain, bleeding, discharge, itching, or ulceration but she started avoiding her suitor. There was no swelling in any other part of the body, no acne, deepening of the voice, or abnormal hair distribution. She attained menarche at the age of 13 years and menstruated for 4 days in a regular cycle of 28-day cycle. There was no history of dysmenorrhea or menorrhagia. Her coitarche was at the age of 21 years.

Physical examination revealed a healthy-looking young woman, not pale, afebrile, anicteric, not dehydrated, with no pedal oedema and no peripheral lymphadenopathy. Her pulse rate was 80 beats/min, and her blood pressure was 120/70mmHg. Her liver and spleen were not palpably enlarged and her kidneys were not ballotable. Perineal examination revealed a 14cm by 12cm cystic, mobile, non-tender, rounded, well-circumscribed mass in the peri-clitoral area (**Figure 1**). The labia minora and majora on the right were also affected, the urethral orifice, vaginal orifice, and the labia minora and majora on the left were normal. There was no bleeding or discharge. Digital vaginal examination revealed a normal vagina, the uterus was normal, the adnexa was free and

the Pouch of Douglas was empty, the examining fingers were clean. A pelvic ultrasound scan reported a normal-sized uterus. Her clitoris was enlarged with thickened wall and cystic space within it suggestive of fluid collection. Other tissues were normal.

She was counseled on her condition, the possible cause, and the management option. Written informed consent was obtained for surgical excision under anaesthesia in theatre. Anaesthesia (saddle block) was administered and the patient was placed in the lithotomy position. After routine cleaning and draping, and insertion of size 16 Foley's urethral catheter, the surrounding skin of the clitoral cyst was infiltrated with adrenaline to reduce blood loss. A circumferential incision was made around the base of the cyst and deepened to the fascial plane of the cyst wall. **Figures 2 and 3** show the procedure in progress. Bleeding points were secured using mosquito artery forceps and ligated with vicryl 2/0 suture. By blunt and sharp dissections, the cyst was freed from the surrounding skin and subcutaneous tissue. It was also freed from its attachment at the base, and bleeding vessels were ligated with vicryl 2/0 suture. The dead space was obliterated using vicryl 2/0 suture. The redundant skin was then

excised and the skin closed with interrupted stitches of vicryl 2/0 suture. The operation was well tolerated. Blood loss was minimal. The cyst (**Figure 4**) 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 in situ for 24 hours to prevent urinary retention from pain. There was no dysuria, urinary retention, and

frequency. She was discharged home 24 hours after surgery and was given a two-week follow-up appointment.

The histopathologic evaluation reported a cyst lined by stratified squamous epithelium. The cavity contained keratinous debris. The wall showed numerous congested vascular channels. These corresponded to epidermal inclusion cysts. There was no evidence of malignancy.



Figure 1: A well-circumscribed mass in the peri-clitoral area



Figure 2: Surgical excision of the cyst



Figure 3: Outlook after excision of the cyst



Figure 4: The excised cystic mass

DISCUSSION

Female genital mutilation has been reported in 30 countries in Africa and a few countries in Asia and the Middle East. It is estimated that about 200 million and more girls and women alive today have had female genital mutilation and often carried out in females between infancy and age 15.²⁻⁵ The most common reason for female genital mutilation is respect for tradition, a rite of passage, ensuring virginity, femininity, social convention, enhance convention, religion, cleanliness, and beauty amongst others.²⁻⁵

The formation of clitoridal cysts or epithelial inclusion cysts in the genital area following

female genital mutilation occurs mainly on the line of the scar. This occurs due to the embedment of the epithelial cells and sebaceous glands in the dermis, leading to epidermal inclusion cyst that can gradually increase in size over a long period and may become inflamed or even infected leading to pain.⁴ Clitoridal cysts are often painless and may occur with some other gynaecological problems such as dyspareunia, urinary symptoms, discharge from the vagina and pain in the vulva. Grossly, the cysts vary in size, they are unilocular and usually contain sebaceous material. Confirmation of the diagnosis is made by histopathologist findings of a cyst lined by keratinized stratified

squamous epithelium. Three types of vulval cysts based on histological characteristics are; epithelial inclusion cysts, mucin-secreting cysts, and non-mucin-secreting cysts. An example of an epithelial inclusion cyst is one which arises from trauma or represents a residuum of chronically obstructed sebaceous ducts as the clitoridal cyst that complicates circumcision.⁵⁻⁸

Differential diagnoses of clitoral cysts include inclusion cysts arising from the Wolfian duct system, urethral diverticulum, urethral caruncle, urethral prolapse, keloid, vulval varices, leiomyoma, and adrenogenital syndrome.¹⁻⁶

Surgical excision of the cysts is often the treatment of choice, however, for those with small size and without symptoms; watchful waiting can be done. Recurrence of the cyst is not common; however, it may re-occur when drainage rather than enucleating of the cysts or incomplete enucleation of the cyst is done. Post-clitoridal cyst excision complications are haemorrhage, infection of the wound site, trauma to the urethral, labial adhesions, and formation of hypertrophic scars or keloid.^{4,9}

CONCLUSION

Clitoridal cysts can arise following female genital cutting. Management by surgical

excision is associated with satisfactory outcome. Female genital mutilation should be holistically discouraged globally to prevent immediate and long term complications associated with its practice.

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