CLINICAL MANAGEMENT OF FEMALE GENITAL MUTILATION MUST BE HANDLED WITH UNDERSTANDING, COMPASSION

André Lalonde, MD, MSc, FSOGC

In Brief • En bref

Canadian obstetricians, gynecologists and family practitioners are not allowed to perform female genital mutilation (FGM), but because of immigration patterns it is still a reality for them. Dr. André Lalonde, an Ottawa obstetrician-gynecologist who serves as executive vice-president of the Society of Obstetricians and Gynaecologists of Canada, offers some practical suggestions from his own experience for physicians unaccustomed to seeing patients who have experienced FGM.

Les obstétriciens, les gynécologues et les médecins de famille du Canada n'ont pas le droit de pratiquer de mutilations génitales chez les femmes, mais à cause des tendances de l'immigration, le problème demeure une réalité pour eux. Le Dr André Lalonde, obstétricien-gynécologue d'Ottawa, qui est aussi vice-président exécutif de la Société des obstétriciens et gynécologues du Canada, présente quelques suggestions pratiques tirées de son expérience personnelle aux médecins qui ne sont pas habitués à accueillir des patientes qui ont subi des mutilations génitales.

Canada's physicians are not allowed to perform female genital mutilation (FGM), but because of immigration patterns it is still a reality for the country's obstetricians, gynecologists and family practitioners. The practice is common in 26 African countries as well as the Middle East, Indonesia, Malaysia, India and Pakistan, and with increased immigration to Canada, particularly from north African countries, more women who visit gynecologists' offices have undergone clitoridectomy and/or closure of the vagina. Data from the Canadian Advisory Council on the Status of Women indicate that between 1986 and 1991 nearly 40 000 women who arrived in Canada from northern and eastern Africa had experienced some form of FGM.

Such patients are usually referred to a gynecologist because the woman, now an adult, wishes to marry, have intercourse and/or begin a family. I have managed the care of a number of patients who became pregnant even though the vagina was closed save for a small opening of a half-centimetre or less at the posterior fourchette of the vagina.

The repair can be done effectively and easily through outpatient surgery that is performed under general anesthesia. The surgeon introduces an obstetrical dilator into the narrow opening at the posterior fourchette to elevate the skin and then, with sharp scissors, makes an incision up to the clitoral hood or the periurethral area. This effects an immediate opening of the vagina. The vulva is then repaired using fine absorbable sutures in an interrupted manner. There is very little blood loss.

Inspection of the hymenal area is undertaken. In the 10 cases I have managed, we have never seen a complete closure of the hymen once the vulva-vaginal skin coverage has been opened. Usually the clitoris is absent. In two cases, however, the clitoris was present underneath this skin closure.

Fine absorbable sutures are indicated for lessening scarring around the vulva. This procedure can be done on an outpatient basis and the patient has to be advised not to have intercourse for 2 to 3 weeks, after which healing should be complete.

This may seem like obvious advice, but several of my patients felt that they could begin or resume intercourse immediately after the surgery. This procedure obviously cannot be done the day before a wedding; when possible, patients should be made aware of this. Careful counselling of the man who accompanies the patient is extremely important in these cases.

If a pregnant patient presents but vaginal penetration has not occurred, it may be best to wait until the patient is in labour and fully dilated before acting. The physician then uses a metal catheter and makes an incision to release the opening of

André Lalonde is executive vice-president of the Society of Obstetricians and Gynaecologists of Canada.

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the vagina. Following the delivery, physicians can proceed with the repair as described above. I have dealt with two of these patients in the last 2 years with no difficulty and no need of extensive episiotomy.

Language is often a barrier to communication with these patients, but my impression is that they do not appear to be overly stressed by their experience; this may not be the case for girls. It is very difficult to establish whether this procedure has caused any permanent psychosexual damage. My patients have not wanted to discuss the very difficult experience of FGM, but indicated that they wanted to get on with their lives.

Most of my patients seemed to want to adapt to Western culture, however, and have never indicated to me or my nursing assistants any desire to have the vagina reclosed. At no time have I been requested, either by a patient or her husband, to repeat the procedure.

When it passed a policy statement in September 1992 that condemned the practice of female genital mutilation, the Society of Obstetricians and Gynaecologists of Canada (SOCG) said women who have been subjected to such procedures should be treated with understanding and compassion. Clinical management is only part of the physician's challenge; health promotion and counselling is also important, but doctors must be sensitive to the patient's culture, customs and tradition. We may condemn the practice of FGM, but we must never condemn the women who as children were its innocent victims.

[The practice of female genital mutilation has been widely condemned by the World Medical Association, as well as Canadian medical organizations such as the SOGC, the CMA, the Federation of Medical Women of Canada, and the colleges of physicians and surgeons of British Columbia, Alberta and Ontario. Dr. May Cohen, chair of the CMA's Gender Issues Committee, says that in addition to condemning the practice of FGM, the medical profession has an important role to play in teaching physicians how to give supportive, culturally sensitive and understanding care to patients who present with FGM-related conditions and needs. — Ed.] ■