World Journal of Advanced Research and Reviews
eISSN: 2581-9615 CODEN (USA): WJARAI
Cross Ref DOI: 10.30574/wjarr
Journal homepage: https://wjarr.com/

(CASE REPORT)

Check for updates

Delayed presentation of a giant clitoridal cyst following female genital mutilation: A case report

Awopola Ibiebelem Jumbo * and Rose Sitonma Iwo-Amah

Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria.

World Journal of Advanced Research and Reviews, 2022, 15(01), 075–078

Publication history: Received on 03 May 2022; revised on 01 July 2022; accepted on 03 July 2022

Article DOI: https://doi.org/10.30574/wjarr.2022.15.1.0532

Abstract

Background: Clitoridal cyst is an epidermal inclusion cyst occurring in the region of the clitoris. It is a complication of female genital mutilation. It is usually underreported and thus a rare clinical diagnosis. This may be because the cyst is usually asymptomatic and in a concealed location, as well as the proscribed status of female genital mutilation (FGM) in society. This is a case of a 36-year-old multipara with a giant clitoridal cyst following FGM in childhood.

Case report: Mrs B.E was a 36-year-old P4+0(all alive) who presented on 18/4/22 with a 10year history of anterior vulval swelling which was progressive and painless. She had female genital mutilation in childhood. Treatment with cyst excision under anaesthesia was done and the postoperative period was satisfactory.

Conclusion: The clitoridal cyst is a long term complication of FGM. Women with clitoridal cysts often present late when they can no longer cope with the size of the cyst or when complications have occurred. At this stage treatment may be complicated, hence there is a need to increase public awareness of this condition through reporting, female education and sensitization.

Keywords: Clitoridal Cyst; Female Genital Mutilation; Cyst Excision; Inclusion Cyst

1. Introduction

The clitoridal cyst is an epidermal inclusion cyst occurring in the region of the clitoris [1]. They usually occur following implantation of the epidermis of the clitoridal skin into the dermis [1, 2]. As the entrapped epidermis proliferates, there is an accumulation of desquamations and secretions that could not find an exit to the exterior forming a cystic mass [2, 3].

The clitoridal cyst is often a complication of female genital mutilation (FGM) [2, 4]. Many women with this condition hardly present to the hospital except when complications develop, as the cyst is often painless and concealed and FGM is a proscribed practice [3, 5]. Therefore, the clitoridal cyst is an uncommon clinical diagnosis [3, 4]. This is a case report of a giant clitoridal cyst occurring in a 36year old multiparous woman following female genital mutilation in childhood.

2. Case report

Mrs B.E was a 36year old P4+0(all alive) who presented to the gynaecology clinic of the Rivers State University Teaching Hospital (RSUTH) Port Harcourt on 18/4/22 with a 10year history of swelling in the vulva. The swelling was initially small but has increased over time. It has become a source of worry and caused coital difficulties which warranted her

* Corresponding author: Awopola Ibiebelem Jumbo
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria..

presentation to the clinic. The swelling was painless and there was no itching, ulceration, discharge, difficulty in urination, dyspareunia, fever or weight loss. She had female genital mutilation in childhood. She attained menarche at the age of 13 years and there were no menstrual complaints. She has had four spontaneous vaginal deliveries over the past 10years.

Examination of the perineum revealed a 10cm x 6 cm well-circumscribed mass in the peri-clitoral area. The mass was cystic, not tender and there was no differential warmth. The clitoris and labia minora were absent. The urethral orifice was patent and the vagina was normal, there was no inguinal lymphadenopathy.

A diagnosis of the clitoridal cyst was made. Her packed cell was 34%, retroviral screening was negative and urinalysis was normal. She was counselled for cyst excision and consent was obtained. Cyst excision was done under regional anaesthesia the following day, and the urethral catheter was removed 24 hours after the procedure. She was discharged on the 2nd postoperative day on a sitz bath, analgesics, and antibiotics. She was seen in the gynaecology clinic two weeks later and her clinical condition was satisfactory. Her histology report was reviewed and she was discharged from the clinic. Results of histology showed a 10cm x6cm x 6cm unilocular cyst containing sebaceous materials and lined by keratinized stratified squamous epithelium. This confirms the diagnosis of epidermal inclusion cyst of the clitoris.

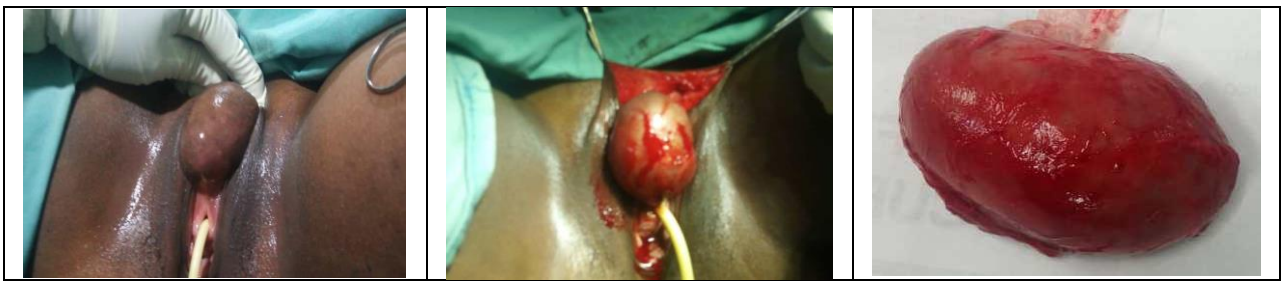

Figure 1 Excision of giant clitoridal cyst

3. Discussion

Epidermal inclusion cysts are tumours of the epidermal cells [6, 7]. They are the most common cutaneous cyst and can occur anywhere on the body, they are most commonly seen on the face, neck, scalp, and trunk [4, 7].

Epidermal inclusion cyst occurs due to implantation of the epidermis into the dermis [7, 8]. As the epidermis proliferates within the circumscribed space of the dermis there is an accumulation of desquamations and secretions forming a cystic mass [4, 7]. Epidermal inclusion cyst usually follows trauma, but may also occur spontaneously [4, 7].

The clitoridal cyst is an epidermal inclusion cyst occurring in the region of the clitoris [3, 9]. It usually follows trauma to the clitoris, although it can occur spontaneously [1, 9]. The exact incidence of clitoridal cyst is unknown but is believed to be a rare clinical condition [9].

The clitoridal cyst is often a long term complication of female genital mutilation [4, 10]. FGM is a traditional practice and consists of all procedures that involve partial or complete removal of the female external genitalia for non-medical reasons [10.11]. It is classified into four major types depending on the extent of tissues removed: Type 1 involves partial or total removal of the clitoris (clitoridectomy), Type II involves partial or total removal of the clitoris and the labia minora with or without excision of the labia majora (excision), Type III involves excision of part or all of the external genitalia and stitching of the vaginal opening(infibulation), while Type IV refers to all other harmful procedures to the female genitalia eg piercing, pricking, scraping, incising or cauterizing of the genital area (unclassified)[4,11]. Mrs B.E had a type II FGM in childhood.

FGM has no medical benefits and is often associated with lots of complications [11, 12]. The United Nations regards the practice as a human rights violation and is considered for elimination [13]. FGM is proscribed by the law in many countries, but it is still practised underground by quacks with associated serious complications [1, 14].

The clitoridal cyst is one of the long term complications of FGM and is often underreported [4]. This may be because the cyst is asymptomatic and in concealed location as well as the proscribed status of female genital mutilation in the society [3]. It was reported to occur in 5% after Type 2 FGM, but less than 1% with other types [4].

The time interval between FGM and the development of clitoridal cyst is highly variable, and it is believed to be influenced by the level of circulating oestrogen [5]. Increased level of oestrogen stimulates proliferation and secretions in the entrapped epidermal cells of the clitoris [5, 15]. Mrs B.E had FGM in childhood but developed the clitoridal cyst in her late twenties. This may have been precipitated by the higher level of circulating ovarian hormones in pregnancy/reproductive years and by repeated small perineal tears (which may have gone unnoticed) on the mutilated site during deliveries.

The clitoridal cyst usually presents as painless anterior vulval swelling which is often small to medium in size. The cyst may remain small or enlarge progressively over time [1-3]. The growth tends to increase in reproductive age due to the influence of ovarian hormones [3]. At times, the swelling may become inflamed and painful, and there may be associated psycho-sexual problems, and coital or urinary difficulties [1, 3, 5].

The diagnosis is made clinically and confirmed with histology [1, 2]. The finding of a cyst in the region of the clitoris following a history of FGM or trauma is highly suggestive, and histologic finding of a cyst lined by keratinized stratified squamous epithelium is confirmatory [1-3]. Differential diagnoses include cyst of the canal of Nuck, skene,s gland cyst, Gartner's cyst and dermoid cyst[1]. Complications of clitoridal cysts include abscess formation, stone formation, ulceration, or malignancy [3].

Treatment is surgical, and cyst excision is the treatment of choice [1, 16]. Marsupialization or incision and drainage can also be done [1]. Complications of treatment include trauma to the urethra/vagina, haemorrhage, damage to the arterial/ nerve supply to the clitoris, infection, scarring, wound dehiscence, or recurrence [1, 2, 16]. Mrs B.E had FGM in childhood and presented with a 10year history of painless huge anterior vulva swelling associated with coital difficulties. She had a cyst excision, and histology confirmed a clitoridal cyst. There were no complications.

4. Conclusion

The clitoridal cyst is a long term complication of FGM, and it is often under-reported. The prevention of clitoridal cysts will involve the elimination of female genital mutilation, prevention of perineal tears during deliveries and encouraging women to seek help early. This could be achieved through education, public enlightenment, health awareness programmes, and legislation. Also, health insurance, availability of skilled attendants in labour and delivery and the provision of alternative sources of livelihood for FGM practitioners and traditional birth attendants will reduce the incidence.

Compliance with ethical standards

Acknowledgments

We wish to express our profound gratitude to all those who participated in the management of this patient.

Disclosure of conflict of interest

The authors declare that there was no conflict of interest.

Statement of ethical approval

As per the university standard guideline, patient consent and ethical approval have been collected and preserved by the authors.

Statement of informed consent

Informed consent was obtained from the patient in the study.

References

[1] Orisabinone IB, Oriji PC. Large Clitoridal Inclusion Cyst Following Female Genital Mutilation/Cutting-A Case Report. Gynecol Obstet Case Rep. 2020; 6: 1-3.

[2] Oriji PC, Allagoa D, Omietimi J, Tekenah E, Njoku C. Clitoral Retention Cyst Following Female Genital Mutilation/cutting: A Case Report. Yenagoa Medical Journal. 2020; 2(1): 183-5.

[3] Osifo OD. Post genital mutilation giant clitoral epidermoid inclusion cyst in Benin City, Nigeria. Journal of Pediatric and Adolescent Gynecology. 2010; 23(6): 336-40.

[4] Rouzi AA. Epidermal clitoral inclusion cysts: not a rare complication of female genital mutilation. Human reproduction. 2010; 25(7): 1672-4.

[5] Asante A, Omurtag K, Roberts C. Epidermal inclusion cyst of the clitoris 30 years after female genital mutilation. Fertility and sterility. 2010; 94(3): 1097-e1.

[6] Weir CB, St.Hilaire NJ. Epidermal Inclusion Cyst. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; Jan 2022. Available from: Available from: https://www.ncbi.nlm.nih.gov/ books / NBK532310.

[7] Trinh CT, Nguyen CH, Chansomphou V, Chansomphou V, Tran TT. Overview of epidermoid cyst. European journal of radiology open. 2019; 6: 291-301.

[8] Pandya KA, Radke F. Benign skin lesions: lipomas, epidermal inclusion cysts, muscle and nerve biopsies. Surgical Clinics. 2009; 89(3): 677-87.

[9] Ibrahimi A, Kallat A. Epidermoid cyst of the clitoris. The Pan African Medical Journal. 2021; 38: 59.

[10] Birge O, Erkan MM, Serin AN. Case report: epidermoid inclusion cyst of the clitoris as a long-term complication of female genital mutilation. Journal of Medical Case Reports. 2019; 13(1): 1-4.

[11] Abdulcadir J, Catania L, Hindin MJ, Say L, Petignat P, Abdulcadir O. Female genital mutilation. Obstetrics & Gynecology. 2016; 128(5): 958-63.

[12] Klein E, Helzner E, Shayowitz M, Kohlhoff S, Smith-Norowitz TA. Female Genital Mutilation: Health Consequences and Complications - A Short Literature Review. Obstet Gynecol Int. 2018;2018:1-8.

[13] Williams-Breault BD. Eradicating Female Genital Mutilation/Cutting: Human Rights-Based Approaches of Legislation, Education, and Community Empowerment. Health Hum Rights. 2018; 20(2): 223-233.

[14] Nour NM. Female genital cutting: a persisting practice. Rev Obstet Gynecol. 2008; 1(3): 135-9.

[15] Rizk DE, Mohammed KH, Joshi SU, Al-Shabani AY, Bossmar TR. A large clitoral epidermoid inclusion cyst first presenting in adulthood following childhood circumcision. Journal of obstetrics and gynaecology. 2007; 27(4): 446-8.

[16] Diouf AA, Mbaye M, Gueye M, Coly AN, Moreira P, Moreau JC, Diouf A. Surgical treatment of clitoral cysts complicating female genital mutilation. J Gynecol Obstet Biol Reprod (Paris). 2014; 43(4): 328-31.