Semiologia del dolore vulvare e diagnosi clinica nelle mutilazioni genitali femminili

Semiology of vulvar pain and clinical diagnosis in women with female genital mutilation/cutting

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Introduction

Female genital mutilation/cutting (FGM/C) involves the partial or total removal of the female genital organs for **non-therapeutic reasons**. It can involve the cutting of the clitoris and can cause psychological, sexual, and physical complications (WHO 2008).

Complications of FGM/C

According to the World Health Organization (WHO), FGM/C is classified into four types as showed in table 1 (Abdulcadir et al, 2016; web: https://www.youtube.com/watch?v=XRid7jIUzMY; WHO 2008). Depending on the ethnic group, it can happen in unsterile or medicalized conditions; during childhood (more frequently) or adulthood. The removal of sensitive genital tissue can result in complications possibly responsible for **acute or chronic vulvar pain** (WHO 2008). Neurogenic shock for acute pain and chronic conditions such as dyspareunia, painful vulvar cysts, and clitoral neuromas have been reported as specific consequences of FGM/C (Ezebialu et al, 2017).

Table 1 - Classification of FGM/C (WHO 2008)

Type I : Partial or total removal of the clitoris* and/or the prepuce (clitoridectomy) - **Type Ia:** Removal of the clitoral hood or prepuce only - **Type Ib:** Removal of the clitoris* with the prepuce
Type II : Partial or total removal of the clitoris* and the labia minora, with or without excision of the labia majora (excision) - **Type IIa:** Removal of the labia minora only - **Type IIb:** Partial or total removal of the clitoris* and the labia minora - **Type IIc:** Partial or total removal of the clitoris*, the labia minora and the labia majora
Type III : Narrowing of the vaginal orifice with creation of a covering seal by cutting and apposition the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation) - **Type IIIa:** Removal and apposition of the labia minora - **Type IIIb:** Removal and apposition of the labia majora
Type IV : Unclassified - All other harmful procedures to the female genitalia for **non-medical purposes**, for example, pricking, piercing, incising, scraping and cauterisation

* Note: When total removal of the clitoris is reported, it refers to the total removal of the glans of the clitoris.

Short and long term psychophysical consequences vary depending on the anatomical damage, eventual immediate and long term complications, memories and experiences associated to the rite of passage and other co-existing physical, mental and social factors. In addition, current studies have shown that women having undergone FGM/C have been found at increased risk of **co-existent traumas**, especially sexual such as **rape and forced marriage** (Antonetti et al, 2015) that can also be a co-factor contributing to vulvar pain.

Pain from FGM/C can originate from **scarring complications** such as **bridles, vulvar cysts** possibly inflamed or infected (abscesses) and **clitoral neuroma** (Ezebialu et al, 2017). The latter is due to the proliferation of nervous fibers after the traumatic cutting of the dorsal nerve of the clitoris (Abdulcadir et al, 2017a). Clitoral neuroma is probably an under-reported and under diagnosed condition and the evidence on its prevalence, symptoms, management, and recurrence rate is limited. Few case reports and a small retrospective case series have been published in the literature. A clitoral neuroma can be asymptomatic or, less frequently, painful. When painful, it is associated to **allodynia** and **hyperalgesia**, functional impairment and psychological distress with a severe impact on the quality of life and relationship (Abdulcadir et al, 2015a; Abdulcadir et al, 2017a; Abdulcadir et al, 2017b).

Women with FGM/C are at increased risk of episiotomy, perineal tears, third degree tears and prolonged labour because of vulvar scarring (Berg and Underland 2013). Such **obstetric complications** can also lead to long term perineal pain.

FGM/C type III or **infibulation** is the **narrowing of the vaginal orifice** with apposition of the labia minora or majora, with or without excision of the clitoris (WHO 2008). Infibulation is one of the most severe type of FGM/C and is **responsible for obstructed micturition and dysuria, dysmenorrhea, recurrent uro-gynecological infections, superficial dyspareunia and difficult or impossible penetration** (WHO 2008).

Primary or secondary vaginismus related to psychophysical factors can also be responsible for painful or impossible penetration (Ezebialu et al, 2017).

Therapeutic options

A recent systematic review on surgical and non surgical treatments for vulvar and clitoral pain after FGM/C found no study on the subject and concluded that very limited information exists (Ezebialu et al, 2017). However, in spite of the lack of evidence, there are a number of possible interventions that can reduce or eliminate vulvar and clitoral pain in women who underwent FGM/C. Among non surgical interventions there are in particular **counselling** and **psychological support** such as **cognitive behavioural therapy**, which has been showed effective for vaginismus for

instance. Topic anaesthetics and lubricants have not been studied in this population of women. Among **surgical interventions** there is defibulation, clitoral reconstruction and surgical excision of scar tissue/neuromas/bridles and symptomatic cysts.

Defibulation is a surgery that opens the cutaneous bridge of infibulation, exposing the urethral meatus, the vaginal opening and the clitoris when this was not excised. It allows vaginal penetration, treats uro-gynecological, obstetric and sexual complications and allows gynaecological exams and urinary catheterization. Pre and post-operative briefing, counselling and information are crucial to explain the changes in micturition, vaginal discharges, period flow, sexuality and genital appearance that could frighten or surprise the patient (Nour et al, 2006).

Clitoral reconstruction, also called clitoral transposition, is a surgery that resects the cutaneous and sub-cutaneous peri-clitoral fibrous tissue and re-exposes a healthy clitoral neo-glans in a more accessible position, avoiding lesions to the neurovascular bundle of the clitoris (Foldès et al, 2012). It is a recent surgery, which is becoming increasingly popular.

Clitoral reconstruction is performed for improving pain symptoms, sexual function, body image and female identity. Some published data show interesting and promising results. However, **conclusive evidence** on its safety and effectiveness **is lacking** (Abdulcadir et al, 2015a; Abdulcadir et al, 2015b) and the technique is not recommended by the Guidelines of WHO (WHO 2016). It seems able to reduce or treat clitoral pain, and increase sexual pleasure, sexual function (lubrication, arousal, orgasm, satisfaction) and body image. We recently hypothesised that in women suffering from clitoral pain chronically or during sexual intercourse, the removal of the fibrous tissue containing eventual neuromas could improve or treat painful symptoms (Abdulcadir et al, 2017a; Abdulcadir et al, 2017b).

Psychological support and adequate analgesia must be prescribed as both operating on the ancient site of trauma and post-operative pain can make a woman feel like she was cut again and even cause **a relapse an ancient post traumatic stress disorder associated to the past FGM/C** (Abdulcadir 2016).

Conclusions

In my presentation, the different conditions responsible for vulvar and clitoral pain after FGM/C will be discussed, together with their multidisciplinary management.

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Web

- Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals https://www.youtube.com/watch?v=XRid7jIUzMY; WHO 2008

Alessandra Graziottin e Filippo Murina
(a cura di)

ATTI E APPROFONDIMENTI DI FARMACOLOGIA

Il dolore vulvare dall'A alla Z: dall'infanzia alla post-menopausa

Milano - 7 APRILE 2017

Fondazione Alessandra Graziottin onlus
PER LA CURA DEL DOLORE NELLA DONNA

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PROGRAMMA

8.15 - 8.45 **Registrazione**

8.45 - 9.00 **Introduzione e saluti**

9.00 - 9.30 **Opening lecture**
Il dolore vulvare dall'infanzia alla post-menopausa
Alessandra Graziottin (Milano)
Introduce: Filippo Murina (Milano)

9.30 11.50

Mastociti, infiammazione e comorbilita' nel dolore vulvare. Specialisti a confronto

Moderatori: Maria Adele Giamberardino (Chieti), Filippo Murina (Milano)

9.30 - 9.50 **Mastociti, infiammazione e comorbilità nel dolore viscerale**
Maria Adele Giamberardino (Chieti)

9.50 -10.10 **Dolore vulvare e dolore gastrointestinale**
Vincenzo Stanghellini (Bologna)

10.10 -10.30 **Dolore vulvare e dolore vescicale**
Daniele Grassi (Modena)

10.30 -10.50 **Dolore vulvare e dolore pelvico cronico**
Alessandra Graziottin (Milano)

10.50 -11.10 **Il progetto VU-NET: indagine epidemiologica multicentrica sul dolore vulvare in Italia**
Dania Gambini (Milano)
Coordinatori Nazionali: Alessandra Graziottin (Milano), Filippo Murina (Milano)

11.10 -11.30 **Discussione**

11.30 -11.50 **Coffee Break**

11.50 14.00

Semeiologia del dolore vulvare e diagnosi clinica - Parte 1

Moderatori: Metella Dei (Firenze), Vincenzo Stanghellini (Bologna)

11.50 -12.10 **Nell'infanzia e nell'adolescenza**
Metella Dei (Firenze)

12.10 -12.30 **Nelle mutilazioni genitali**
Jasmine Abdulcadir (Svizzera)

12.30 -12.50 **Nelle comorbilità dermatologiche**
Filippo Murina (Milano)

12.50 -13.00 **Discussione**

13.00 -14.00 **Lunch**

14.00 15.30

Semeiologia del dolore vulvare e diagnosi clinica - Parte 2

Moderatori: Claudio Crescini (Treviglio), Emmanuele Jannini (Roma)

14.00 - 14.20 **Nel dolore sessuale: dispareunia e vaginismo**
Alessandra Graziottin (Milano)

14.20 - 14.40 **Nel post parto e in puerperio**
Raffaele Felice (Milano)

14.40 - 15.00 **In post-menopausa, dopo tumori e cause iatrogene**
Filippo Murina (Milano)

15.00 - 15.20 **Impatto del dolore vulvare e della dispareunia sulla sessualità maschile**
Emmanuele Jannini (Roma)

15.20 - 15.30 **Discussione**

15.30 18.15

Principi e protocolli di terapia del dolore vulvare nell'arco della vita

Moderatori: Alessandra Graziottin (Milano), Ezio Vincenti (Padova)

15.30 - 15.50 **Dolore vulvare e dolore pelvico cronico: contraccezione e strategie terapeutiche**
Alessandra Graziottin (Milano)

15.50 - 16.10 **Fisioterapia nel dolore vulvare**
Arianna Bortolami (Padova)

16.10 - 16.30 **Laser e chirurgia nella terapia del dolore vulvare**
Filippo Murina (Milano)

16.30 - 16.50 **Psicoterapia nel dolore vulvare**
Chiara Micheletti (Milano)

16.50 - 17.10 **Terapia antalgica nel dolore vulvare**
Ezio Vincenti (Padova)

17.10 - 17.30 **Stili di vita e terapia farmacologica del dolore vulvare - Linee Guida**
Alessandra Graziottin (Milano), Filippo Murina (Milano)

17.30 - 17.45 **Discussione**

17.45 - 18.00 **Conclusioni e take home message**

18.00 - 18.15 **Test ECM e chiusura dei lavori**

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