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Female Circumcision

Female genital mutilation

WORLD HEALTH ORGANIZATION

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO)

Female circumcision in any of its three forms, is a painful fact of life for about 80 million girls and women in over 30 countries of Africa, the Middle East and South East Asia where its practice is widespread.

Although a traditional practice, female circumcision is also a health issue because it potentially affects the physical and mental well being of every woman and girl who undergoes the surgical procedure.

In its mildest form, female circumcision involves only the removal of the foreskin of the clitoris. But in the majority of cases the clitoris itself is removed, together with all or part of the labia minora and in the most severe form the labia majora.

Initial circumcision is carried out before a girl reaches puberty sometime between 1 week and 14 years, and in some societies where infibulation is practiced, women are commonly re-infibulated after each delivery, after divorce and on the death of their husband.

Because the operation is usually preformed by traditional midwives, with unsterilized knives, razors or pieces of glass and without any anesthesia, it carries many health risks.

The immediate physical effects — acute infection, tetanus, bleeding of adjacent organs, shock resulting from violent pain, and hemorrhage — can even cause death. In fact, many such deaths have occurred and continue to occur as a result of this tradional practice.

The lifelong physical and psychological debilities resulting from female genital mutilations, are manifold: chronic pelvic infections, keloids (scar tissue), vulval abscesses, sterility, incontinence, depression, anxiety and even psychosis, sexual dysfunction and marital disharmony, and obstetric complications, with risk to both the infant or fetus and the mother. Female circumcision also carries with it the possibility of AIDS infection. Finally, there is profound impairment of women's potential for development as a result of trauma and chronic suffering.

Female circumcision is significantly associated with proverty, illiteracy and low status of women, with communities in which people face hunger, ill health overwork and lack of clean water. In these settings, the woman who is not circumcised is stigmatized, ostracized and not sought in marriage. Regardless of her personal feelings, a woman who wants to remain with her own community cannot afford to rebel against or even question this tradition which remains profoundly entrenched in powerful taboos and is protected by secrecy and moral codes. If she loses her community social acceptance and support, it may mean the difference between life and death. Hence the paradox — the victims of the practice are also its strongest proponents.

Because of the difficulty and delicacy of eradicating a practice based on cultural and traditional patterns that have been traced back for over 2000 years, the issue can only be addressed effectively by promoting awareness through education of the public, of health workers and of trained practitioners. It requires the active involvement of local communities, their leaders, women groups and organizations rather than emotional statements by outsiders, however well intentioned they may be. Experience shows that when the practice of female circumcision has been condemned by outsiders or outlawed by governments in isolation from the complex psychosocial, cultural process of which it is but one part, it has led to the exacerbation of the problem. The practice has simply been done with greater secrecy and those suffering from complications have been inhibited from seeking help.

In any effort to change prevailing attitudes towards this custom, the education of men is as critical as the wider efforts to improve the status of women including that of their reproductive health as a whole. In settings where female circumcision represents one among many other serious problems facing women, it is these women themselves who must set their priorities and initiate the steps towards the abolition of this practice in line with the religious and cultural sensitivities surrounding this subject. National and local women's organizations, governmental or not, have been distinctly identified as the most appropriate mechanism for influencing the process of change in attitudes and practice of this age old custom. Such national and local initiatives can be greatly helped by outside support to accelerate this pace of change.

Together with UNICEF, UNFPA, WHO and FIGO continue to support national efforts against female circumcision and to collaborate in research and in the dissemination of information. WHO also collaborates with the Inter-African Committee, a regional NGO which works through its affiliates in 22 African countries.

WHO believes that integrating information on female circumcision in programs of primary health care and safe motherhood will have a far reaching effect.

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Dr. Adi E.Dastur

Secretary & Manager

haematoma.

Here it is very difficult to locate bleeding vessels. In such type of cases one has to choose between total hysterectomy or bilateral ligations of internal iliac arteries, with extensive repair operation, depending upon the prevailing circumstances during operative procedure.

III. Atonic Postpartum haemorrhage : Sometimes atonic postpartum haemorrhage occurs in patients with incoordinate uterine action etc., after vaginal delivery or during or after Caesarean section. Inspite of administration of Oxytocics and Prostaglandins, if the postpartum haemorrhage is not controlled, one has to choose between hysterectomy and bilateral ligation of internal iliac arteries.

IV. Hydatidiform Mole : In elderly patients over the age of 35 years, prophylactic abdominal total hysterectomy in cases of hydatidiform mole would save the patient from future possible development of chorionepithelioma.

Sometimes one comes across cases of perforating hydatidiform mole, which leads to severe intraperitoneal haemorrhage and shock. The correct diagnosis is made on laparotomy. In such patients abdominal total hysterectomy may be necessary as a life saving measure. Such invasive moles leading to perforation are diagnosed much earlier these days, by repeated radioimmune assay of ßHCG and ultrasonography. Timely treatment with chemotherapy with Methotrexate can be administered. This will retain the fertility potential of the patient in the younger age group.

V. Septic Abortion : In some cases of illegal abortions done especially by quacks/unqualified persons, uterus gets severely infected. Such cases sometimes are prone to get bacteraemic shock, which proves fatal within few days.

I had some occasions to do timely total abdominal hysterectomy on such patients, who have survived subsequently.

VI. Cornual rupture of ectopic gestation : Sometimes in such patients severe intraperitoneal haemorrhage occurs alongwith shock. Nowadays on laparoscopy one can diagnose such a condition. In such cases abdominal total hysterectomy may be necessary.

VII. Carcinoma of Cervix with pregnancy : If carcinoma of cervix is detected in the first and second trimester of pregnancy, in cases of stage O, I, and II a, Radical Wertheim's Hysterectomy of such gravid uterus could be carried out. If patients come during the third trimester of pregnancy, then patients with stage O, I and IIa, particularly between 26th and 28th week of gestation, treatment may be delayed until 34th and 36th week, so that the fetus may have a good chance for survival. At about 34th and 36th week of gestation, a classical caesarean section is carried out followed by Radical Wertheim's Hysterectomy. Radical Wertheim's hysterectomy during pregnancy is much easier, because of the plane of cleavage is much easier and better while dissecting the tissues.

Conclusion : In the developing countries there is necessity of doing Hysterectomy in gravid uterus. If the socioeconomic conditions, literacy rate and antenatal, intranatal, and postnatal care facilities improve, and if offered are availed off by patients, the incidence of obstructed labour will come down considerably, thereby reducing the necessity of doing hysterectomy.

If investigation facilities like radioimmune assays of ßHCG, ultrasonography are made available, an early diagnosis can be obtained in case of placenta praevia Ac-

cidental Haemorrhage, hydatidiform mole, perforating hydatidiform mole etc. which can further reduce the necessity of doing hysterectomy.

I would advocate doing the total abdominal hysterectomy whenever feasible instead of subtotal hysterectomy.

In some cases one has to choose between bilateral internal iliac arteries (or anterior division of internal iliac arteries) ligation and hysterectomy, depending upon the underlying indication and whether one wants to retain the menstrual and reproductive function in the patient. However there are some patients who do not respond favourably even after bilateral ligation of internal iliac arteries, in whom one might have to do total abdominal hysterectomy as a last resort.

Elective caesarean hysterectomy for prevention of future gynaecological disease and as one of the method of sterilisation according to me is too radical a procedure, when the same could be achieved by a good follow up and by simple procedures of tubal ligation for sterilisation.

Dr. R.D. Pandit

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EDITORIAL

HYSTERECTOMY IN A GRAVID PATIENT

Hysterectomy in a gravid patient, either during pregnancy, labour, or puerperium, usually is an emergency procedure, and hardly has any place as an elective one. There are some indications where caesarean section is done, followed immediately by hysterectomy, or when there are extensive tears in uterus, hysterectomy is carried out, or in some cases the gravid uterus is removed entirely at different terms of pregnancy depending upon the underlying conditions.

The main indications for Hysterectomy in gravid patients are as follows :

I. Some cases of Rupture of uterus.

II. Some cases of uncontrollable haemorrhage in following :

A) During Caesarean section for :

1. Placenta Praevia - III or IV Degree.

2. Concealed Accidental Haemorrhage (Couvelaire uterus)

3. Occasionally embedded intrauterine device.

4. Placenta Accreta especially partially separated.

5. Extension of incision involving uterine vessels during extraction of baby.

6. Repeat caesarean sections.

7. Broad ligament haematoma.

III. Atonic Postpartum haemorrhage.

IV. Hydatidiform Mole after the age of 35 years and some cases of perforating mole.

V. Some cases of septic abortion.

VI. Occassional case of cornual rupture of

ectopic gestation.

VII. Carcinoma cervix diagnosed during pregnancy.

1. Rupture of Uterus : In the developing countries due to ignorance, illiteracy, low socioeconomic conditions, lack of antenatal, intranatal, and postnatal care, or even if these are available, not utilised by patients, ultimately results in obstructed labour, leading to rupture of uterus at varying sites, giving rise to profuse haemorrhage and tremendous shock. The actual line of treatment can only be decided after doing a laparotomy.

In my experience, I have found resuturing of the tears, sometimes after freshening the edges with or without sterilisation procedure as the case may be, is always preferable, being less traumatic in such moribund cases, as they can withstand this simple procedure much better. I would advocate hysterectomy only if tears in the uterus are very large, extensive, irregular, friable, involving big vessels and extending extensively into the broad ligament. It is always preferable to do a total abdominal hysterectomy whenever feasible compared to subtotal hysterectomy.

In intractable haemorrhage, in some patients in younger age group, bilateral ligation of internal iliac arteries or their anterior division could be carried out, and tears of the uterus resutured. This could give chance of retaining the menstrual and reproductive function.

II. Uncontrollable haemorrhage :

A) During Caesarean Section for :

1. Sometimes one comes across persistent oozing from the placental bed while doing caesarean section for III or IV degree of placenta praevia. If Oxytocics and Prostaglandins fail to efficiently control the haemorrhage, one has to choose between bilateral internal iliac ligation or total hysterectomy. I had some occasions to do total hysterectomy in such cases.

2. In the early fiftys and sixtys, I had come across some cases of concealed Accidental haemorrhage (Couvelaire uterus), where after doing the caesarean section, the uterine walls were so thin, papery, soft & flabby, that the uterus would not contract at all, and hence I had to do hysterectomy in such circumstances.

3. I came across a multiparous patient, about twenty five years back, when I was doing caesarean section, I found lippe's loop embedded in the musculature of the lower segment on the posterior wall. After removing the said embedded loop there was severe bleeding from the raw area. After adopting all possible measures, the bleeding continued, and hence I had to do a quick total hysterectomy. In a younger age group patient who wanted to preserve the childbearing function, I would have tried bilateral internal iliac arteries ligation.

4. Sometimes I had encountered patients with placenta Accreta especially those which are partially separated, which gave rise to profuse postpartum haemorrhage either after vaginal delivery or while doing caesarean section. In some of the cases I had to resort to total abdominal hysterectomy.

5.6, & 7 While doing caesarean section for indications like repeat caesarean section where there are plenty of adhesions and hardly any lower segment available, and hence one has to take inverted T shaped incision. Many times there is extension of uterine incision involving the uterine blood vessels, and extensive involvement of the broad ligament, especially during extraction of baby in some cases, resulting in profuse haemorrhage and broad ligament

ECTOPIC PREGNANCY UNUSUAL CLINICAL PRESENTATIONS

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SUMMARY

An Ectopic pregnancy is one in which the fertilised ovum implants at a site other than the endometrial cavity. Ectopic gestation should always be foremost in mind when assessing a patient in childbearing age who presents herself with an "acute abdomen". Unfortunately, however, there is no other disorder in obstetrics & gynaecology which presents so many diagnostic pitfalls and alleys. The purpose of this study is to present critical analysis of the unusual clinical presentations of ectopic pregnancies from our hospital. A total of 46 cases with unusual presentation out of 135 cases of diagnosed ectopic pregnancies from January 1987 to December 1990 are described briefly in our compact review.

INTRODUCTION

The diagnosis of ectopic pregnancy is not always easy to make. Alsuleiman Grims (1982) & Brenner et al (1980) reported that 36-50% of patients admitted with ectopic pregnancy had previously been examined by a physician and received an incorrect diagnosis. The fallopian tube is the most common site, accounting for more than 95% of ectopic pregnancies, but other implantation sites include the cervix, the abdominal cavity and the ovary. The incidence of ectopic pregnancy in the United States nearly tripled during the 1970's; currently 1 of every 100 reported pregnancies is ectopic (Center for Disease control 1984). One of the highest local rates reported is from the West Indies, where 1 ectopic pregnancy is noted for every 28 pregnancies (Novak 1981). The woman with an ectopic pregnancy may present as an abdominal pain and minimal vaginal bleeding. The key to the diagnosis of ectopic pregnancy is always to maintain a high index of suspicion in evaluating any woman in the reproductive age group who presents with lower abdominal pain. Agressive diagnostic evaluation of the patient with suspected ectopic pregnancy is essential . A ruptured ectopic pregnancy represents a major surgical emergency

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since this disease accounts for approximately 10% of maternal deaths even in a developed country like USA (Dorfman 1983). Early diagnosis may allow the possibility of performing conservative surgery to maintain the patients fertility. The catastrophic presentation does not require much diagnositic acumen since the patient is in shock. She has a "surgical abdomen" - that is, rigidity, tenderness and signs of peritoneal irritation, but without fever or other signs of infection. Pelvic examination may reveal a fullness or doughy mass in the cul-de-sac caused by intraperitoneal blood. Haemoperitoneum can be confirmed by culdocentesis. Almost all the unusual clinical presentations of ectopic pregnancy are from the group of "subtly presenting ectopic pregnancy".

MATERIAL & METHODS

A total of 46 cases with unusual clinical presentation of ectopic pregnancy from January 1987 to December 1990 are included in our review. The classic triad of signs and symptoms of ectopic pregnancy includes :

1) history of missed menstrual period followed by abnormal vaginal bleeding.
2) abdominal or pelvic pain.
3) an adnexal mass.

Cervical motion tenderness is an additional finding of substantial importance. Most of the patients have this classic triad and presented to our hospital with shock, marked tachycardia and pallor. All the patients not fitting in the classic triad of signs and symptoms have been included in our review. Every patient is studied in detail including any unusual presenting symptom complex and examination findings.

OBSERVATIONS AND ANALYSIS

The incidence of Ectopic Pregnancy in our series is 0.5%. The frequency of ectopic pregnancy increases with increasing age but reduces with increasing parity. The majority of our patients were between the age group 26-30 yrs. and almost 60%were nulliparas. Significant past history was available only from 20 patients out of 46 cases (Table I). Almost 9% of patients gave previous history of Pulmonary Tuberculosis and

TABLE I

Incidence of significant past history

Past History	No. of cases	Percentage
History of Tuberculosis	4	8.6%
Chronic pelvic infection	4	8.6%
History of D & C	3	6.6%
History of tubal ligation	5	10.9%
History of contraception	4	8.6%
No significant past history	26	56.7%
Total	46	100.0%

the same number of patients gave a past history suggestive of chronic pelvic infection. In a 20 year Swedish study, a sevenfold increase in the risk of ectopic pregnancy was demonstrated following acute salpingitis (Westrom et al 1981). Five patients in our study gave history of tubal ligation and 4 patients were previous users of intrauterine contraceptive devices (Table I).

A period of amenorrhoea is reported in 74-98% of patients (Gonzalez and Waxman 1981). Though amenorrhoea is an important symptom, absence of amenorrhoea does not rule out the possibility of ectopic pregnancy. Out of 46 cases, only 12 patients came with amenorrhoea while the most common symptom was pain in abdomen with pallor, vomiting or rectal symptoms. In our study, 38 patients presented with pain in abdomen. Out of the 8 patients who did not have pain in abdomen 4 complained of distension of abdomen and the other 4 of lump in abdomen. The

TABLE II

Provisional Clinical Diagnosis

Diagnosis	No. of cases
Ectopic Pregnancy	89
Pelvic peritonitis	4
Pelvic inflammatory disease	14
Ectopic (suspected)	8
Gastroenteritis	4
Appendicitis	7
Delayed period	4
Paralytic ileus	1
Acute abdomen	1
Threatened abortion	2
Chronic ectopic	1
Total	135

early pain from ectopic pregnancy is usually described as colicky in nature and is believed to be a result of tubular distension. 36 patients complained of pain in the lower abdominal quadrants while 2 complained of epigastric pain. With a large collection of blood and clots in the cul de sac, there is pressure on the rectum, causing rectal tenesmus and passage of small quantities of mucus. These symptoms were seen in almost 24% of cases of present series (Table II). According to DeCherney and Maheux (1982) from 50-94% of patients with ectopic pregnancy report some abnormal vaginal bleeding. Various types of bleeding occur, with mild to moderate bleeding usually being associated with ectopic pregnancy and heavy vaginal, bleeding usually more indicative of threatened or incomplete abortion. 15 out of 46 patients came with bleeding per vaginum and different provisional clinical diagnoses were made (Table II). 16 patients had a marked degree of pallor and 36 patients had a pulse rate of above 100/min. Temperature may fall in acute haemorrhage but in chronic cases there may be slight pyrexia due to absorption of blood clots. This pyrexia may be intermittent upto 101° F as different from acute salpingitis where temperature is more that 101° F. Subnormal temperature may be encountered because of pallor and shock. 28 patients had a subnormal temperature, 10 had a normal temperature while 8 patients had a temperature more than 101° F on admission. Out of 46 patients 6 showed no abdominal signs while the remaining 40 had distension, tenderness, guarding or free fluid. On per vaginum examination, the uterus was normal in size in 20 patients, bulky in 14 and the size could not be made out in the remaining cases. Cervical motion tenderness was present in 19 cases (41.3%). According to Alsuleiman (1982), an adnexal or cul de sac mass is reported in approximately 40% of cases. The absence of a palpable mass even during examination under anaesthesia does not rule out an ectopic pregnancy. Table III gives us the findings on per vaginum examination. As most of our patients do not come imme-

diately after missing a period but come only when further symptoms like pain, bleeding etc. develop unruptured ectopics are hardly seen in general hospitals. Colpopuncture was the diagnostic method in 7 cases, abdominal tap in 10, laparotomy in 13 and laparoscopy in 16. In 44 patients, salpingectomy was carried out; in one milking of the tube was done and in one a salpingostomy was carried out. Routine blood tests done at the time of admission were of little help in the differential diagnosis. Low hemoglobin levels under 10 gm% was the most common finding. Urine pregnancy tests were asked for in 31 patients and came positive in 17 only. Serum beta HCG levels and emergency laparoscopy were not possible in our set up. USG was done on 18 patients & the procedure gave a differential diagnosis in all cases.

TABLE III

Findings in fornices on per vaginum examination

Findings	No. of cases
Mass in right fornix	6
Mass in left fornix	10
Mass in both fornices	6
Bogginess	12
No mass	12
Total	46

DISCUSSION

The dilemma of early diagnosis in Ectopic Pregnancy is illustrated by the various diagnoses made by the referring physicians (Table II). Few cases were conserved for more than a day and a few opened by surgeons. The main problems are the frequent absence of amenorrhoea. Amenorrhoea was present in only 12 (26%) of the cases. Pain in abdomen was the constant feature in 38 (82%) cases. The uterine size was bulky in only 14 (30%) cases and colpopuncture positive in only 7(15%) cases. High degree of suspicion was very important because of the atypicality of ectopic pregnancy.

In attempting to diagnose ectopic pregnancy in a patient in stable cardiovascular condition, one must consider the following other possibilities :

Salpingitis, Threatened Abortion, Appendicitis, Intra Uterine Device related Symptoms.

Regular menses with severe dysmenorrhoea; Dysfunctional Uterine Bleeding; Persistent or ruptured corpus luteum or cyst; Gastroenteritis; Urinary calculus or infection; Torsion of an ovarian cyst; Endometriosis or ruptured endometrioma are other rare possibilities.

Patients with ectopic pregnancy generally have low titres of HCG. Thus, only approximately 50% patients have a routine urine pregnancy test positive. Limitations to the Beta-HCG radioimmunoassay include the expense and the prolonged turn around time for results. Pelvic ultrasonography is a useful diagnostic tool to evaluate patients suspected of having an ectopic pregnancy. Kadar et al (1981) have reported a discriminatory HCG zone (6000 - 6500 mIU/ml) in which an intrauterine sac should be identified by USG. An HCG level in excess of this and no finding of an intrauterine gestational sac on USG usually identifies an ectopic pregnancy. Laparoscopy is an extremely improtant diagnostic tool especially in unruptured ectopics. In one study, the procedure confirmed ectopic pregnancy in 21 of 36 patients with that clinical diagnosis and identified 6 of 26 ectopic pregnancies that had been unsuspected clinically (Murphy and Fliegher 1981).

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