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Evaluation and Management of FGC/FGM:

1. Definition or Key Clinical Information*: This type of procedure is where the vagina/clitoris/vulva is altered in a way that removes and/or restructures the preexisting anatomy.*

2. Assessment

i. Risk Factors: *Did the patient come from a culture or country where this practice is prevalent or ever lived in one of these places? Female circumcision can cause physical, mental, and psychosocial health problems, including both short-term complications of the procedure and long-term complications. The short-term effects range from urinary to sexual issues and problems related to childbirth. The effects of circumcision on maternal and neonatal outcomes have been investigated in several studies, including postpartum hemorrhages, perineal tears, rectovaginal fistula, increased risk of cesarean section, prolonged labor, and prenatal resuscitation and premature neonatal death, stillbirth, and hospitalization (Rabiepour & Ahmadi, 2023).*

ii. Subjective Symptoms *Depending on the patient's comfort level, they may be open to verbally discussing their level of FGM/C with their care team. On the other hand, they may not know they are different than intact females if it is so culturally present for them. The patient may not feel comfortable discussing the matter, and in that situation, keep in mind the risk factors associated with FGC/M. If the patient complains of any of these symptoms, further assessment such as visual assessment may be necessary with consent.*

iii. Objective Signs *If they consent to a vaginal exam/ visual examination these are the classifications for FGM/C.*

Type I – Clitoridectomy*: Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and/or the prepuce (the clitoral hood or fold of skin surrounding the clitoris).* ***Type II – Excision:*** *Partial or total removal of the clitoris and the inner labia, with or without excision of the outer labia (the labia are the 'lips' that surround the vagina.* ***Type III – Infibulation****: Narrowing of the vaginal opening by creating a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without the removal of the clitoris.* ***Type IV – Other****: All other harmful procedures to the female genitalia for non-medical purposes, eg, pricking, piercing, incising, scraping, and cauterizing (burning) the genital area (World Health Organization, 2022).*

iv. Clinical Impressions *The patient may be uncomfortable discussing this matter, and judging their emotions around this can be crucial. They may also not know they are circumcised/mutilated and think they are "Normal". They may know and consider it an honor or a sanitary aspect. We may be the first to inform them of this and then need to assess the*

emotional impact this may have. Anxiety, pain and fear may be experienced in all births subsequent to FGM but may be heightened during the first birth.

v. Clinical Test Considerations *A vaginal exam may be indicated to address the level of FGM/C. Depending on results, further research may be needed for the specific effects of their FGM/C on birth. If they develop symptoms of infection we could also offer urine complete testing and vaginal swabs for STI or BV.*

iv. Differential Diagnosis *Not Applicable*

3. Management plan

i. Therapeutic measures to consider within the CPM scope *Assess the patient's psychological well-being. If the patient has trauma associated to FGC/M, incorporate TIC and make referrals as necessary for advanced psychological treatment. The use of TIC during the childbearing year will aid in the acceptance and usefulness of care for the patient. The use of a doula in labor may aid in a successful, trauma-free vaginal birth. We can also recommend pelvic floor therapy and possibly vaginal dilators as needed to help naturally stretch the tissues depending on the level of FGC/M (Royal College of Physicians Ireland, n.d.).*

ii. Therapeutic measures commonly used by other practitioners *Type III will require deinfibulation in order to attempt vaginal childbirth. This type of procedure can be performed either antenatally or intrapartum. If the patient decides to perform antenatally, the procedure will need to be scheduled during 20-28 weeks gestation. Anesthesia options consist of spinal or general (Royal College of Physicians Ireland, n.d.).*

iii. Ongoing Care *If it is identified that a patient has a FGC/M, routinely check in at antenatal appointments and assess if it is necessary to implement any therapeutic/complementary therapies. F/U with routine emotional check-in's and inquire about their thoughts and feelings of the upcoming birth. If they get a deinfibulation, F/U through healing on patient comfort and support needs. F/U after the birth with emotional needs and healing tissue needs, watch for PPMD.*

iv. Indications for Consult, Collaboration, or Referral *If deinfibulation is necessary, a urologist or other PCP will need to be referred to for the procedure to take place. A referral for Allied Health Services is available for all patients with FGC/M. A therapy referral may be needed to aid emotional healing, and a referral for pelvic floor therapy may be needed as well (Royal College of Physicians Ireland, n.d.).*

v. Client and family education *Educate clients on the anatomy and physiology of delivery and how their FGC/M will play a role in the process. Education around the potential morbidities associated with this type of FGC/M will need to be provided to assist in the both the short and long-term health of the patient. Educate on their specific type of FGM/C as needed, especially if they were unaware. Discuss with the family that we are mandated reporters and that in this country FGM/C is considered child abuse and a violation of human rights. If we suspect this is occurring we must report it (Department of Homeland Security, 2017).*

References

Female genital mutilation or cutting (FGM/C) outreach strategy. (2017). Department of Homeland Security. *https://www.uscis.gov/sites/default/files/document/guides/DHS_FGM_Outreach_Plan_-_Final_-_1-17-17.pdf*

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