

A large mons pubis mass, what could it be? A case report of an epidermal cyst as a late complication of prior circumcision.



Kamdar T, Zinkhan S

Te Whatu Ora, Health New Zealand

Te Whatu Ora
Health New Zealand

Case study

A 59 year old refugee from the African continent was referred to the gynaecology department with a one year history of a mons pubis lump which had been increasing in size and caused her pain with walking and bending for her prayers.

She had a previous childhood circumcision, however she subsequently had several uncomplicated vaginal births. She had no other gynaecological history of note.

On examination, there was a fluctuant lump in the area of the mons pubis. Evidence of previous type 1 FGM (female genital mutilation) was noted with absence of the clitoral hood.

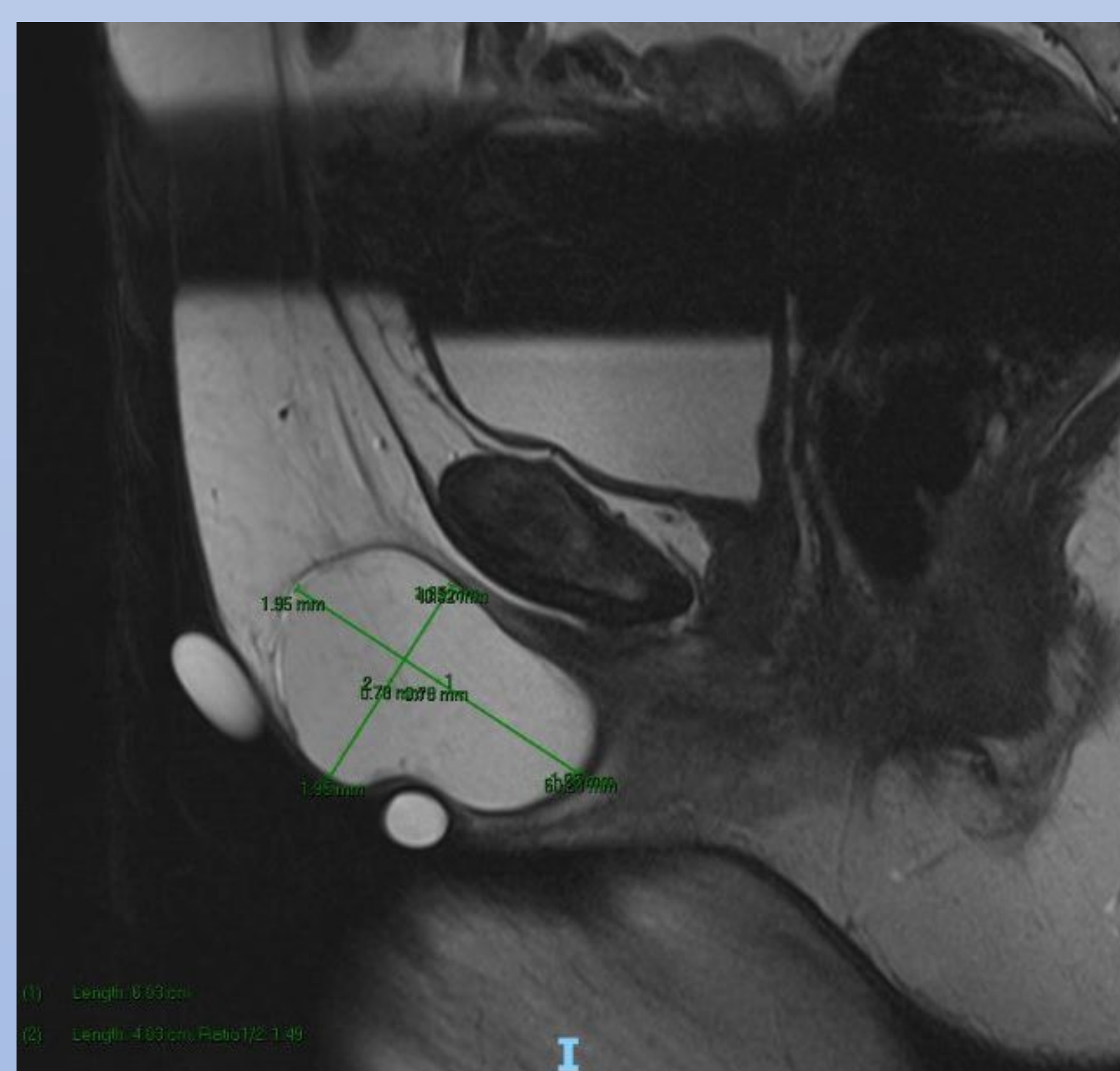
MRI imaging showed a well-defined 60mm x 40mm x 40mm cystic structure lying within the subcutaneous fat layer, anterior to the pubic bone. There was no extension or involvement of the urethra, however the mass appeared connected to the anterior introitus, and was thought to be related to the prior circumcision.

Following a review of the images, the mass was completely excised under general anaesthesia. The histology confirmed an epidermal cyst. The patient made an excellent post-operative recovery with no signs of recurrence at her 3 month follow up.

Images



Image of clinical findings of a mons pubis mass



Selected MRI images :
Mass is well circumscribed
It does not communicate with the urethra.
It is not connected to the Pubic bone.

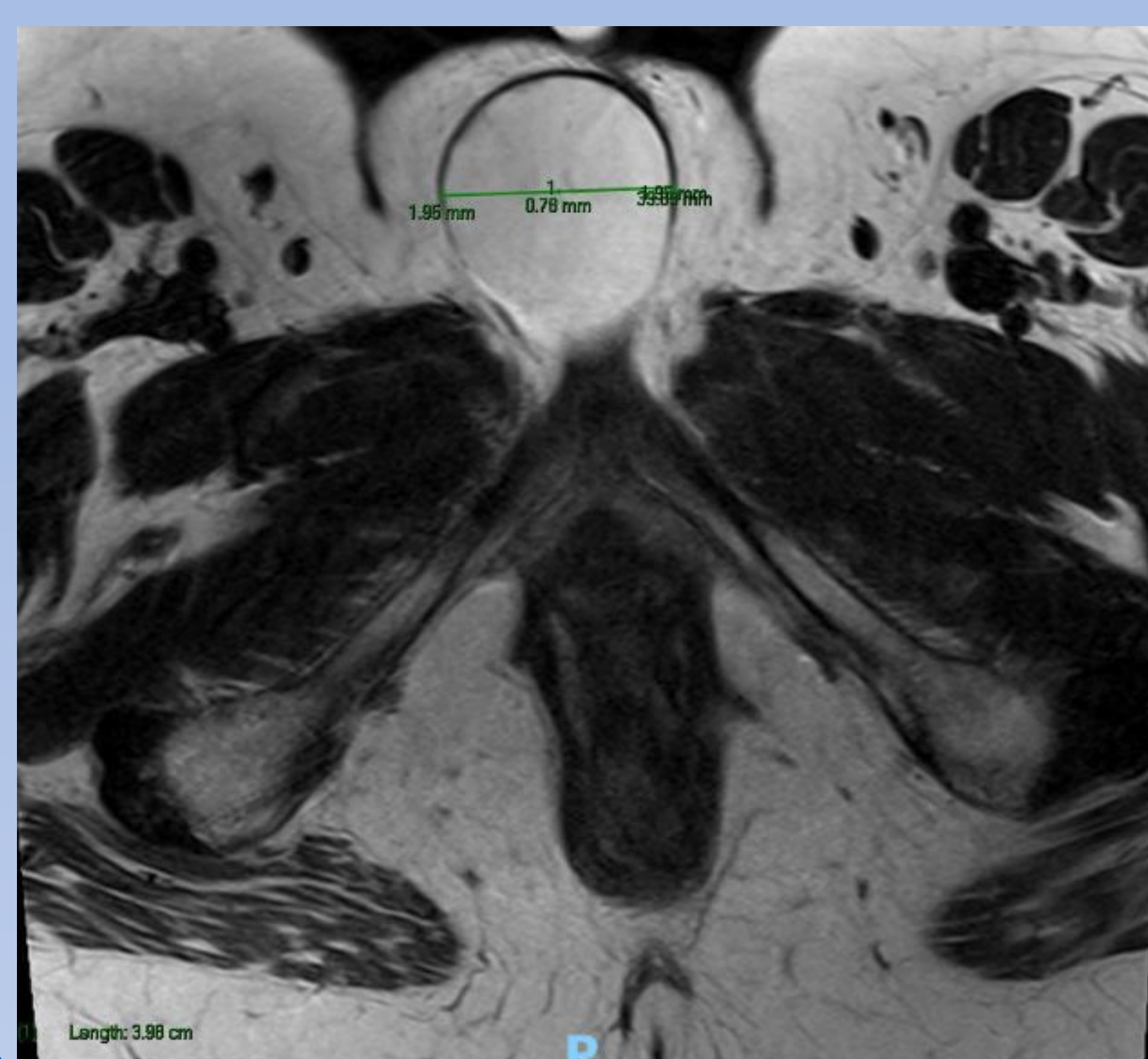
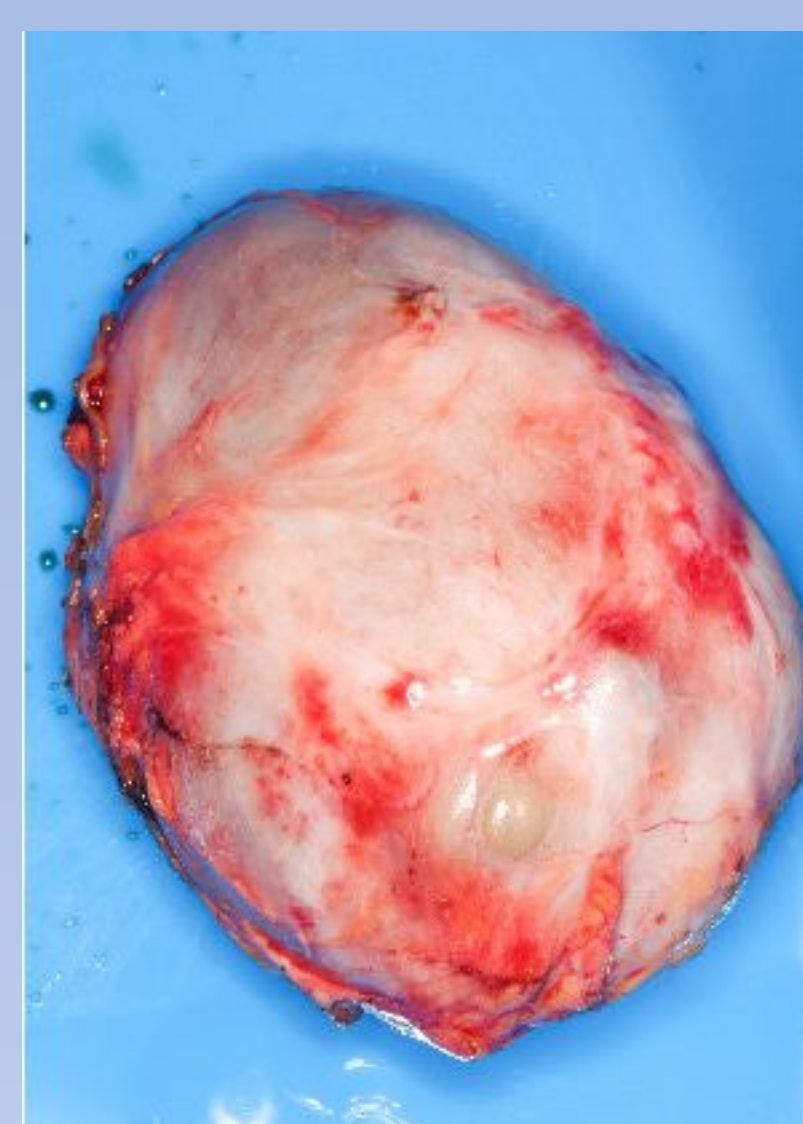


Image of the completely excised mass



Case discussion

There is an increasing migrant population in Australia and New Zealand. Clinicians should be aware of both immediate as well as late complications of prior FGM. This case highlights a rare, but known late complication of prior FGM.

FGM involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and is a violation of human rights for girls and women.¹

FGM is classified into 4 types

Type 1: this is the partial or total removal of the clitoral glans and/or the prepuce/clitoral hood .

Type 2: this is the partial or total removal of the clitoral glans and the labia minora, with or without removal of the labia majora.

Type 3: Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Early complications of FGM include haemorrhage, shock, infection and death.^{1,2}

Long term complications can include difficulty passing urine, recurrent pelvic infection, dysmenorrhoea, dyspareunia, obstetric complications and psychosocial sequelae.^{1,2}

There have been several case studies that have reported the development of epidermal cysts as a late complication of FGM.²⁻⁷

Timing from circumcision and development of the cyst is variable, although there were few case reports in the literature of women presenting when post-menopausal.

The literature suggests that these cysts form as a result of the invagination and embedding of the squamous epithelium and sebaceous gland in the line of the scar which then desquamates and produces a cystic mass. The size of the mass can then increase in puberty in response to oestrogen, or during the perimenopausal state when there may be unopposed oestrogen due to anovulatory cycles.^{5,7}

Women who have had repeated deinfibulation and reinfibulation during childbirth may carry further risk of tissue damage, scarring and risk of formation of inclusion cysts.³

Excision of these masses is recommended due to the risk of discomfort, inflammation, secondary infection and malignant transformation.³

Surgical techniques have also been described which involve excision with preservation of remaining clitoral hood.²

We hope that with increased awareness of this complication, clinician diagnosis and management may improve with more judicious use of imaging.

References

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