

Deinfibulation Timing and Technique

1. Purpose

This document outlines the timing and technique for performing deinfibulation at the Women's.

2. Definitions

Infibulation is a narrowing or partial closure of the vaginal introitus resulting from the traditional practice of female genital mutilation or cutting.

Deinfibulation is a surgical procedure dividing scar tissue (resulting from infibulation) which partly obstructs the vaginal introitus and/or urethra.

"Reversal" of FGM/C is a misnomer which should not be used.

Reinfibulation refers to suture following deinfibulation and usually birth, intended to restore the previous infibulation state. It is a traditional practice which is harmful and illegal.

3. Responsibilities

Nursing, midwifery, obstetric and gynaecological medical staff.

4. Guideline

4.1 Referrals and resources

FARREP team: accept direct referrals of women and provide advice and support to clinicians regarding FGM/C. Where possible they will see women on the day of their clinic appointment. FARREP staff will assist women to understand and negotiate care options. Contact 8345 3058

African Women's Clinic: nurse/midwife-led service with medical support; will see women with any health problems or concerns relating to a history of FGM/C. Deinfibulation when needed can usually be undertaken in the AWC for pregnant women not > 34/40 gestation and non-pregnant women using local anaesthetic. Referrals; via the Internal Referral form OP/20, via external referral from treating clinician or via self-referral by contacting the Women's Welcome Centre on 8345 3037

4.2 Indications for deinfibulation

Planned:

- to restore normal anatomy and function to the extent possible, at a woman's request; may be in conjunction with a planned gynaecological procedure or prior to embarking on a sexual relationship
- in accordance with birth plan to facilitate birth and/or intra-partum assessment and minimise risk of tearing
- may be required on an urgent basis for instance due to impending marriage

Unplanned:

- when undiagnosed infibulation is found at the time of a procedure or birth and prevents safe conduct of same

4.3 Timing of deinfibulation

There is a lack of evidence about optimal timing, which may be influenced by clinical, cultural and psychological factors, including the woman's preference.

In addition to affecting urinary and menstrual flow, the degree of introital narrowing may determine whether sexual intercourse, cervical screening and other examinations, gynaecological procedures and vaginal birth are possible without division.

- **Elective non-pregnant** deinfibulation should be offered, so that it may be undertaken in a planned setting by experienced practitioners.
- **Urgent** referral for deinfibulation can be arranged if necessary for instance following Emergency Department presentation; prompt care should be facilitated and can usually be offered in the African Women's Clinic.
- **At gynaecological procedure:** deinfibulation may sometimes be required for safe conduct of curettage for miscarriage or abortion, or other gynaecological procedure, in which case it should be undertaken with consent.

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- **Antenatal deinfibulation:**
 - is preferred if adequate vaginal examination (VE) and/or catheterisation in labour likely to be difficult or impossible
 - may be preferred if experienced clinicians are more likely to be available electively
 - may be preferred due to more straightforward aftercare
 - is usually done any time antenatally up to 34/40
- First stage of labour
 - Deinfibulation may be performed if required to allow adequate assessment and intrapartum management
 - Local or epidural anaesthesia may be used depending on the circumstances
- At delivery
 - If needed to allow birth, deinfibulation should be performed prior to assessing the need for episiotomy
- Perioperatively
 - If caesarean section is undertaken when intrapartum deinfibulation has been planned, deinfibulation may be undertaken following delivery with consent.

4.4 Information and consent

Must include information about bodily changes such as faster noisier urinary flow and potentially heavier, shorter duration of revealed menstrual loss following removal of obstruction.

4.5 Location and anaesthesia

Deinfibulation is a minor surgical procedure which can usually be safely undertaken in a clinical room equipped for minor procedures or a birth suite room.

For straightforward cases, if it is the woman's preference, it can generally be done with local anaesthesia. Consideration should be given to the possibility that it may provoke recall of the original FGM/C procedure, which could be distressing.

Epidural, spinal or general anaesthesia may be used if indicated by the clinical circumstances, eg labour, complex scarring with cysts, concomitant procedure/s to be undertaken, woman's preference.

4.6 Technique

Elective, non-pregnant or pregnant women no later than 34/40 gestation (but preferably as early as possibly antenatally) refer to African Women's Clinic (AWC) discussing urgency with Family and Reproductive Rights Education Program (FARREP) and/or Clinic team.

In the setting of a surgical procedure or birth suite, deinfibulation is ideally undertaken or supervised by clinician (doctor or nurse/midwife) experienced in the technique.

De-infibulation before the second stage of labour (including non-pregnant and antenatal):

Refer to the diagrams below:

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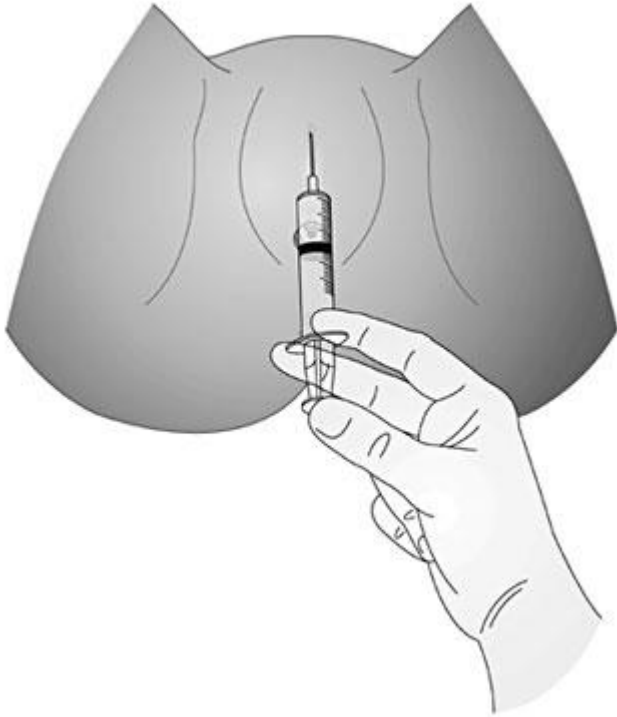


Figure 1: preparation

Preparation for de-infibulation should be as for a minor surgical procedure.

Adequate anaesthesia is essential: Infiltrate the midline area along the original scar line with local anaesthesia (LA) prior to the incision (LA may also decrease post-operative discomfort).

Epidural or spinal anaesthesia may be used depending on the circumstances and the woman's preferences.

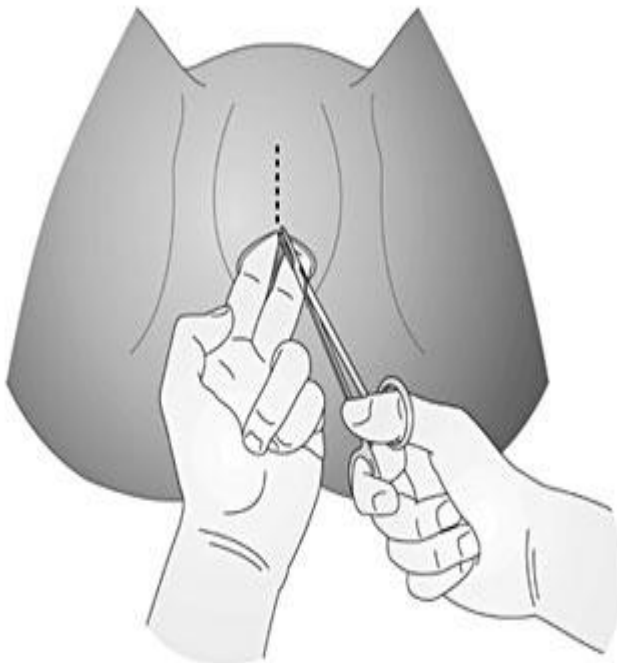


Figure 2: Dividing the infibulation

Insert a pair of artery forceps or alternatively 1-2 fingers under the anterior scar tissue to protect and avoid damage to underlying tissue, including the urethral meatus.

Use your fingers to feel how far up to cut as you divide the old scar tissue.

Aim for the division to extend just beyond the urethral meatus to allow for unobstructed voiding.

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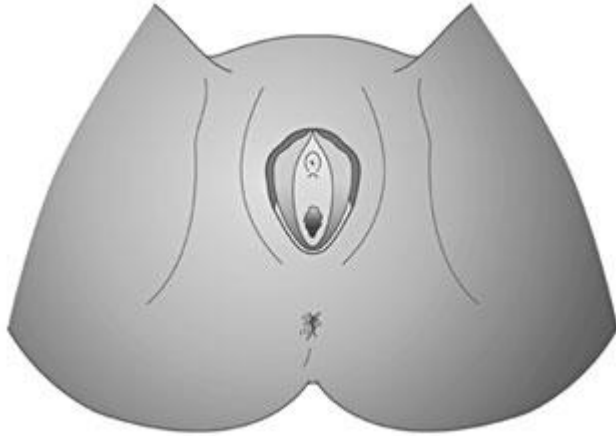


Figure 3: Inspection and assessment

Once deinfibulation is complete it is possible to identify the extent of the remaining genital tissue.

A partial or intact clitoris may be palpable within the scar tissue.

Labia minora may also be left intact/be visible

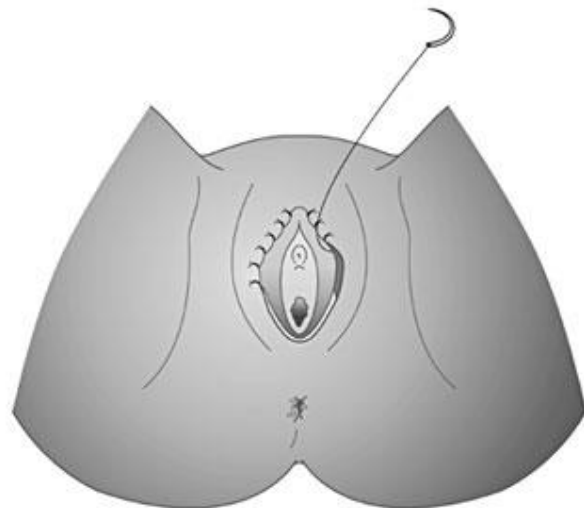


Figure 4: Repair

Suture the retracted tissue to promote haemostasis and prevent re-anastomosis of the raw wound edges.

Use a fine, rapidly absorbed suture such as a 2/0 or 3/0 Vicryl Rapide on a small suture needle.

A small number of interrupted sutures or a continuous suture will be adequate.

Ensure that adequate analgesia is prescribed and provided and appropriate advice on wound management and body changes given to the woman.

De-infibulation at birth:

Refer to the diagrams below

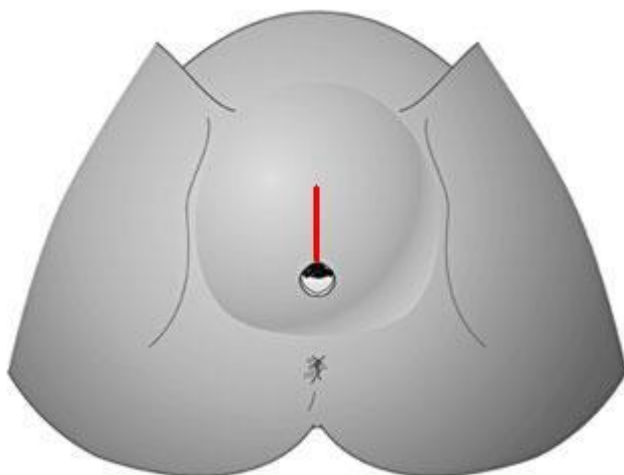


Figure 5: Approach

When undertaking deinfibulation in the second stage of labour, the steps are the same as for the elective procedure but some adjustment is required to compensate for the distension of the perineum as the baby's head descends.

Explain the procedure to the woman and elicit her cooperation as you work between and during contractions.

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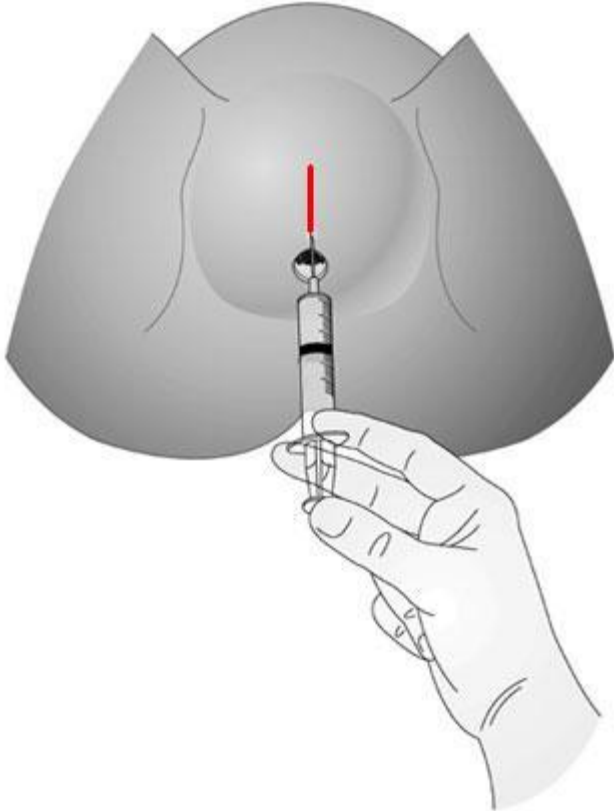


Figure 6: preparation

If possible, undertake vulval skin cleansing and administer local anaesthetic along the anterior scar tissue.

Place 1 or 2 fingers underneath and to one side of the anterior scar tissue.

Infiltrate the scar using a very superficial angle on the needle to protect both the baby's head and yourself

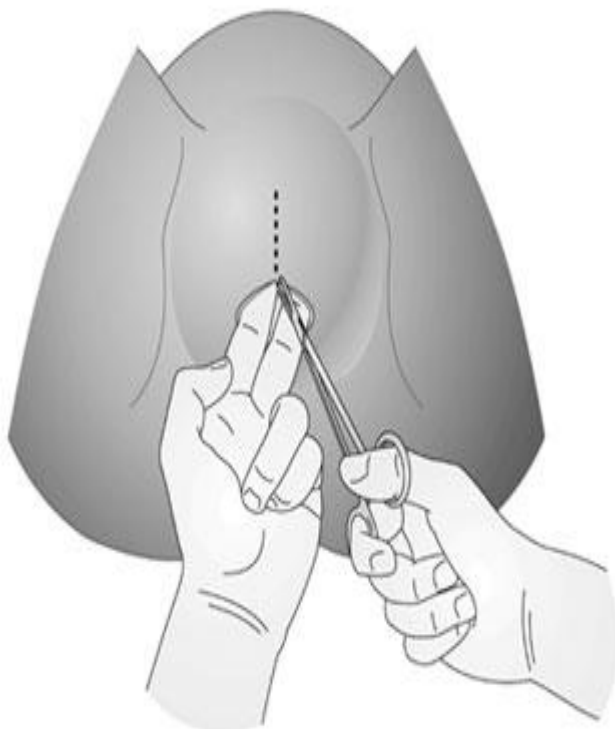
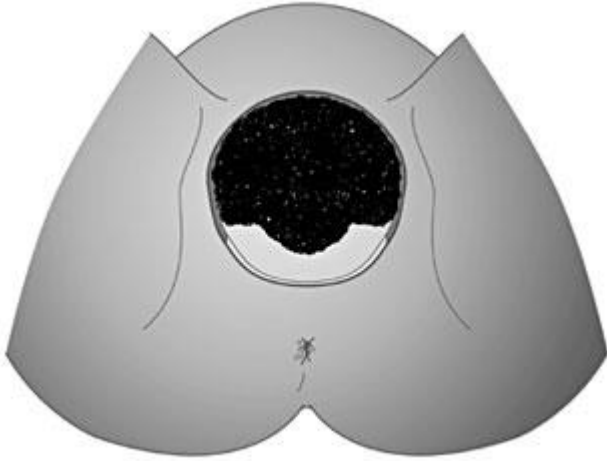


Figure 7: Dividing the infibulation

Use 1 or 2 fingers to create clearance from the emerging head prior to inserting the scissors.

Make the anterior incision up the midline scar to just above the urethral meatus.

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**Figure 8: Completing the delivery 1**

The raw edges will retract as the head begins to crown.

**Figure 9: Completing the delivery 2**

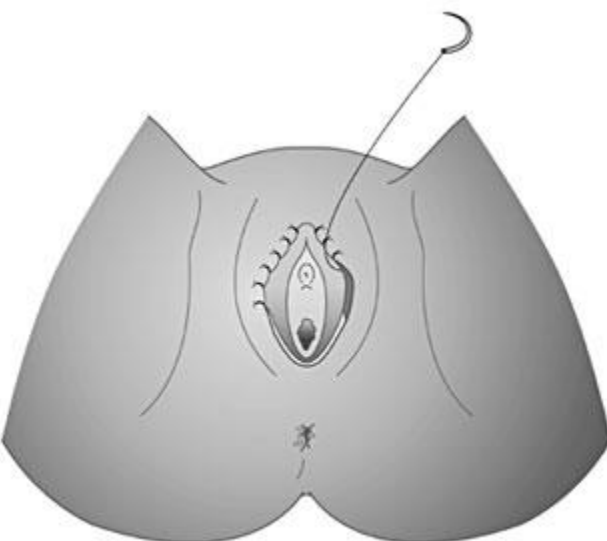
Control the birth of the emerging head with light downward pressure as usual, carefully monitoring perineal stretching throughout because:

- Scarring from the infibulation may not stretch well
- There may be vaginal scarring which is not evident externally

Be prepared to perform an early medio-lateral episiotomy if there is any degree of tightness or evidence of severe scarring.

A bilateral episiotomy is rarely needed nor recommended.

Avoid downward midline incisions as these have the potential to extend to a 3rd or 4th degree tear

**Figure 10: Repair after birth:**

Suture the retracted tissue to promote haemostasis and prevent re-anastomosis of the raw wound edges.

Use a fine, rapidly absorbed suture such as a 2/0 or 3/0 Vicryl Rapide on a small suture needle.

A small number of interrupted sutures or a continuous suture will be adequate.

Any extension of the anterior incision above the urethra may also be repaired at this time.

Repair of the episiotomy or other genital tract trauma follows the procedures outlined in the guideline: [Perineal Trauma Assessment, Repair and Safe Practice](#).

Ensure that adequate analgesia is prescribed and provided and appropriate advice on wound management

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and body changes given to the woman.

4.7 Post deinfibulation care

Analgesia.

Advice on wound management.

Advice on bodily changes including micturition.

5. Evaluation, monitoring and reporting of compliance to this guideline

Compliance to this guideline will be monitored by review of incidents reported through VHIMS.

6. References

- Royal College of Obstetricians and Gynaecologists (RCOG). (2015). *Female Genital Mutilation and its Management (Green-top Guideline No. 53)*. Retrieved from <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/>
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). (2010). *Female Genital Mutilation (FGM)*. Retrieved from http://www.ranzcog.edu.au/component/docman/doc_view/1078-female-genital-mutilation-c-gyn-01.html

7. Legislation/Regulations related to this guideline

Crimes Act 1958.

8. Appendices

Not applicable.

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