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A relationship between female genital piercings and genital mutilation?

Sir,

Kelly and Foster[1] offer up an astounding discussion of the Female Genital Mutilation (FGM) Act in England and Wales, and we certainly laud the efforts of this Act to 'protect girls and women from the medical dangers and societal pressures that produce FGM'. The authors' realistic debate (Case 3) about any relationship between FGM and females with genital piercings (FGP) was good, especially their conclusion that 'few, if any of the significant ethical or medical objections to female genital cosmetic surgery (FGCS), apply to FGP'.[1]

We believe that our published research supports Kelly and Foster's[1] beliefs, even for FGM, from evidence obtained in three different cross-sectional studies performed over the past 10 years that included more than 800 national and international FGPs.[2] These studies document the motivations for genital piercing as 'helped improve and express myself sexually' and 'helped me feel unique', rather than being mutilating actions of self-harm or body alteration. Men more frequently obtained genital piercing in the early years of modern body piercing, but now there are more FGPs. Interestingly, over half the FGPs report abuse, and a third describe forced sexual activity against their will, with many illustrating how their genital piercing 'helped them to take control of (or reclaim) their body after these violations'.[2,3] Infibulations for abstinence on women (locked labial rings) and men (passing a fastening device along the foreskin) remain rare.

Of women wearing general body piercings, 1–3% choose genital sites, are older (≥30 years of age), and exhibit more deliberate decision making; they demonstrate effective genital piercing care and suffer few complications.[2,3] A recent genital piercing review found numerous uncited, but published, assumptions about genital piercing complications, yet only 17 actual peer-reviewed cases over 35 years were found.[2] Certainly we favour regulations to reduce medical risks, such as infectious disease transmission: there should be a requirement for the specific education of genital piercing piercers, and compliance issues regarding piercing jewellery and equipment should also be monitored.

From our perspective, the only commonalities between FGP and the FGM Act seem to be the terms 'females' and 'genitals'. Our evidence reported by consenting adult FGPs is not the same as the permanent mutilating outcome of FGM to young girls or women, nor does it encompass the permanent surgical alternation of FGCS. Not only are there striking intentional differences for FGM but also immediate and major complications, including specific psychological concerns, as well as urinary incontinence, dysmenorrhoea, dyspareunia, infertility, haematocolpos, haematometra, vesicovaginal and rectovaginal fistulas, and increased female/neonatal mortality.[4] In contrast, when genital piercing wearers no longer value their piercings as a 'meaningful part of their lives that enhances sexual satisfaction and self-expression',[2,3] they have the control/ability to remove the genital piercing swiftly, and without anyone's permission or assistance, with little or no residual scarring. ■

Disclosure of interests

The authors of the original article were invited to respond to this letter, but did not feel that a response was necessary. ■

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Intra-operative frozen section analysis for suspected early-stage ovarian cancer

Sir,

We read with interest the article by Cross et al.[1] on the use of intra-operative frozen section for suspected early ovarian cancer. We would like to commend the authors for their work in providing these data and we recognise the need for mechanisms that can be used to address the National Institute for Health and Clinical Excellence (NICE) Guidelines CG122, which recommend assessment of the para-aortic lymph nodes in women with early ovarian cancer.[2]

However, there are a number of areas of practice that we feel need to be examined further before frozen section procedures can be used to alter the management of women with suspected early-stage ovarian cancer.

First, we are perplexed that the authors deemed it necessary to undertake para-aortic lymphadenectomy for women with borderline ovarian tumours. These are by nature an unpredictable class of tumour with mostly good outcomes and little in the way of nonsurgical treatment options when there is disseminated disease. Further, they are usually early-stage tumours and so the utility of a para-aortic lymph node dissection is questionable. If the authors had described the rate of disease in lymph nodes and the difference in outcome this provided for the woman with positive nodes their data would lend stronger support for more widespread implementation.

Accepting this and examining the authors data for 'all comers' (Table 1) we calculate that 28.8% (415) of women had an appropriate para-aortic lymph node dissection on the basis of the frozen section prediction, which represents the real-world scenario for the gynaecological oncology surgeon waiting in theatre for a frozen section analysis to be phoned back.

If the authors changed their protocol to only using dissection in women with malignancy on frozen section, 63.8% (918) of women would appropriately not undergo a para-aortic dissection. The total number of women correctly triaged by frozen section analysis would be 92.6%. Of the remainder, 7% would not undergo a para-aortic dissection that should and 0.35% would have a dissection they do not need. Such a protocol change compares with the authors' figures who, when including a policy of para-aortic dissection for borderline tumours on frozen section, overtreated 8% of the women and undertreated 1.3%.

The answer to deciding which strategy one would wish to take up must come down to the differences in outcome for these women, defined by morbidity and mortality comparisons from overtreatment or undertreatment by surgery or chemotherapy, respectively, and any subsequent influence this has on overall survival. Unfortunately the authors do not provide this information, and only allude to data in preparation that indicate their ability to increase the stage of a woman's disease. However, this figure can be calculated from their data in Table 1 to equate to 82 women (5.7%) who had a frozen section showing borderline disease but whose final paraffin section report showed a malignancy. Until other centres can validate their techniques and such practice can be shown to translate into a survival benefit for women, it is unlikely that their data will change surgical practice in women with early ovarian cancer. ■

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Intra-operative frozen section analysis for suspected early-stage ovarian cancer

Authors' reply

Sir,

We are grateful for the interest and comments from Twigg and Cruickshank[1] on our recent publication describing our experience of offering a frozen section (FS) service for intra-operative diagnosis in apparent early-stage ovarian cancer.[2] However, it is unclear from their letter[1] whether they are arguing against the use of an FS service for all women within this clinical context or are supportive of an FS service but critical of the protocol of which women

