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H AREA
Scientific Session of Communications of the Romanian Society of Clinical Sexology and Human Procreation - June 9, 2018

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Abstract:
An event of special scientific significance was organized on June 9, 2018, at the Romanian Academy, where sexology papers were presented, and also the first “Treaty of Clinical Sexology” in English.

In the opening session of the working session, the President of the Romanian Society of Clinical Sexology and Human Procreation – Associate Professor Nițescu Vasile, Ph.D (fig.1.a,b), welcomed the presence of over 200 participants from all over the country and thanked for the support given to the organization committee of the scientific event, in particular to the Academician Leon Dănăilă, Academician Mircea Beuran and Academician Bogdan Marinescu, to Doina Ramba, and to the RSCSHP Department of Research and Youth led by Nițescu Valentin and to the secretary of the RSCSHP, Ms. Violeta Niculae-Porumbescu, together with her team.

Key words:
Treaty of Clinical Sexology, oncogenic genotypes, STDs, viral oncoproteins, microbiome, intranuclear receptors, Research Department, RSCSHP

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Main text:

An event of special scientific significance took place on June 9, 2018, in the Aula of the Romanian Academy, where papers of sexology were presented, and also the first “Treaty of Clinical Sexology” in English was launched, namely the “Treaty of clinical sexology”.

Academician Leon Dănăilă, Academician Bogdan Marinescu, Academician Mircea Beuran, Prof. Gl. Constantin Dulcan, Ph.D, Prof. Tudorel Butoi, Ph.D, and Assistant Professor Nițescu Vasile, Ph.D delivered speeches before the presentation of the papers.

Academician Leon Dănăilă (fig.2.a,b): “Sexology must explain the many specific problems that arise in society, the central nervous system controlling both the normality and the abnormality of the facts integrated into this particular area of science. I have a deep conviction that the Romanian Society of Clinical Sexology and Human Procreation, namely Associate Professor Nițescu Vasile, Ph.D, through the numerous books of sexology published, among which the first book written in 1985 (“Adolescence”), all of them with an impressive scientific content, and through university and postgraduate courses, which concern the subject he called “Clinical Sexology”, can form well-trained doctors in this field who can replace the so-called “teachers” who hold courses, but who have no sexology papers. In concrete terms, I think that the notions of sexology should not be presented to learners (pupils, students) by non-specialists. The scientific notions of sexology taught must be clear and explicit.
Academician Prof. Bogdan Marinescu, (fig.3): “In Romania, in the private and public education, our colleague Nîțescu Vasile has introduced the subject “Clinical Sexology” several years ago, thus removing distorted and confused notions about this area of science”.

Being one of the members of the RSCSHP, I am pleased with the results of the scientific research department for adults and youth, which are under the leadership of Mr. Nîțescu Vasile, solving fundamental problems of sexology, integrating from this point of view the Romanian medicine into the international one. I congratulate him on the Journal of Clinical Sexology, the first one in Romania”.

If presented in a scientific and objective manner, the depth of these notions makes you think and judge differently, removing mediocrity and obscurantism.”
Academician Prof. Mircea Beuran, Ph.D (fig.4): “This is the first scientific session of communication at the Romanian Academy, where papers of clinical sexology, of particular interest, are presented also in Romania. I can mention, for example, the so-called “Hypereroticism area”, as Associate Professor Nițescu Vasile, Ph.D called it, an area that has long been known to offer “maximum pleasure,” but no one has explained so far the anatomy and physiology of the area that causes this erogenous effect. It should be stressed that this aspect of science was also introduced in Romania in the State and Private Medical Education by Associate Professor Nițescu Vasile, Ph.D, and the first academic books are edited by the Romanian Academy, by the same author. The editing of the “Treaty of Clinical Sexology” by Associate Professor Nițescu Vasile, Ph.D, shows again the value of Romanian Medicine in the world”.

Fig. 3 - Prof. Dr. Dulcan Constantin, Prof. Butoi Tudorel, Acad. Prof. Dr. Bogdan Marinescu, Assoc. Prof. Dr. Nițescu Vasile

Fig. 4 - Acad. Prof. Dr. Mircea Beuran
Associate Prof. Col. Tudorel Butoi (fig.5): “The notions of Normal and Pathological Clinical Sexology, as Associate Professor Nițescu Vasile, Ph.D called them, are necessary for the deepening of data from multiple medical specialties, but also from forensic or justice, judging the crimes, the acts of violence committed in the sexual intercourse”.

Associate Professor Nițescu Vasile, Ph.D: “The scientific communication session is organized by the Romanian Society of Clinical Sexology and Human Procreation. I confess that I am impressed by the significant number of participants, who are filling in today the registration form as members of the RSCSHP. If you have the time, please allow me to give you some information about the Society:

- The Society wants to develop research into this area of science in the two research departments, adult and youth, that have been running for a long time. I emphasize that the members of theses departments have actively participated in eight of the papers of this scientific session;

- The promotion in the media of the right notions, of the form of expression and of the content of the notions of sexology is intended;

- The promotion of collaboration and the development of interdisciplinary relationships in the area of medicine, as well as in areas such as justice, forensics, religion is intended;

- The organization of national and international scientific sessions;

- The provision of specialized advice to institutions interested, especially the Ministry of Health, the Ministry of Education, the Romanian Academy, and to all interested people;

- The continuation of the university and postgraduate courses of “Normal and Pathological Clinical Sexology”, respectively the training of competent people in promoting the correct notions of sexology;

- The publication of clinical sexology papers in the “Journal of Clinical Sexology”, following their endorsement by the Scientific Council of the Society;

- The development of relationships with specialized societies outside the country, of which some are already affiliated with our Society;

Thank you for your presence and I wish you a warm “Welcome!” at the Scientific Session of the Romanian Society of Clinical Sexology and Human Procreation.

The audience appreciated the scientific content of the papers presented.

At the end of the first part of the Scientific Session, the first Treaty of Clinical Sexology was launched (fig.6a, b), in English, the Romanian version being already launched in 2015.
1. Sexualitatea, Infecțiile Oncogene Specifice și Metodele Moleculare de Screening la bărbat și la femeie - Sexuality Specific Oncogenic Infections and Molecular Screening Methods in Male and Female, Authors: Nițescu Vasile, Ramba Doina, Nițescu Valentin.

2. Sexualitate ca finalitate - Sexuality as Purpose, Author: Dulcan D. Constantin


6. Fitoterapia ca tratament în unele disfuncții sexuale - Phytotherapy as treatment in some sexual dysfunctions, Authors Nițescu Vasile, Niculae-Porumbescu Violeta


8. Microbiomul uman și fertilitatea - Human microbiome and fertility, Authors Manole Cojocaru, Mocanu Cristina.


10. Actul sexual deviant la bărbat și femeie, în contextul afecțiunilor psihice, urmare a tulburărilor de sexualizare - Deviant sexual intercourse in male and female, in the context of psychological disorders, following sexuality disorders, Authors Nițescu Vasile, Dănăilă Leon.

11. Intersexualitatea și organogeneza - Intersexuality and organogenesis, Authors Nițescu Vasile, Ramba Doina, Nițescu Valentin.
The volume called “Treaty of clinical sexology” (fig.2) of Prof. As. Dr. Vasile Nițescu inevitably includes biological processes of great scientific importance and actuality, providing fundamental data in understanding the pathophysiology of reproductive system in the intercourse. In a didactic manner, the author shows the complexity of neuro-endocrine interrelations, their role in normal and pathological function of genitalia in the interpersonal relationship after the sexualisation of human body. This explains how the animal intercourse, subordinate to a primary, basic and instinctual impulse becomes in humans a complex neuro-psychic act, conscious and differentiated.
The presentation of neuroanatomy data and proper layout, very clear, allowing easy understanding by any specialist of the links between the centre of analysis and control (cerebral cortex) with the lower levels of the nervous system – through afferent and efferent nerve fibres, with the pituitary and gonads, who also play an essential role in intercourse.

In a rigorously scientific form, and based on original research, the author having a documentary conceptual background of interest and utility, describes the influence of sexuality on the human body, the types of sexual activity, the sexual intercourse in relation to age, or under certain physiological and pathological circumstances, the endogenous and exogenous factors that influence sexuality, or the three types of sexually transmitted diseases, exposed in a personal form. The elaboration by the author of the sexological summary of consultation, with specific clinical and laboratory data required for the diagnosis of sexual disorders in men and women is a real and necessary medical support. This proves that the clinical sexology treaty clearer shapes the sexology as a multidisciplinary speciality with complex and specific concepts, the sexologist often being forced to turn to the cardiologist, endocrinologist, psychiatrist, psychologist, urologist, obstetrician, etc. In his own conception, the author presents in the chapter “Pathological sexuality” the cardinal symptoms in sexual pathology, the classification of male and female sexual dysfunctions, or their treatment - all so useful in practice. His own classification of sexual deviation is particular. The differentiation of sexual pathology based on the etiopathology of genital or extra-genital diseases represents a new and original concept in understanding sexual dysfunctions and places them more precisely in position regarding diagnosis, prognosis, and especially curative and prophylactic treatment.

Presentation by the author of morally aberrant sexuality forms, degrading by libertinism and sexual perversions out of the way and procreation as a means of satisfying some playful, pathological impulses, is welcome at a time of advertising exacerbation of vulgar sexual forms.

Regarding major sexual deviations such as homosexuality, the author explains in particular the neostructural changes of the brain, which determine the physical and mental closeness of the two people of the same sex.

The author clarifies confusing and controversial notions, such as the so-called “G spot,” and proves and explains for the first time the morphological effect of hypereroticism of the area, which he called “the H Area”.

Fig. 2 - Treaty of Clinical Sexology cover
The author has also introduced fundamental scientific notions, which are new in sexology. Through this Treaty, Romanian Medicine is made known to the medical world.

As a result of a remarkable effort, this valuable monograph, the first nationwide release offers a unique and complex scientific documentation of the problems of sexual physiology and pathology problems that need to be made at a higher level in the human species.

Internationally, the book complements the substantive scientific data, currently down, serving to good documentation in the specialty.

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Is there a Vaginal Area of Hypereroticism (H Area) or a G spot?

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Abstract:

The Vaginal Area of Hypereroticism describes only the effect, namely the state of pleasure of the vaginal area of Hypereroticism and the lack of the description of the morphophysiology of the area, which by its structure determines the erotic state against which many specialists have brought countless arguments, invoking even the non-existence of the Vaginal Area of Hypereroticism.

The research proves that there is a zone of cellular bioexcitability even increased as compared to the rest of the vagina, the tissue with superior erectile properties being related to clitoris, so with the erectile border areas.

The area I called the Area of Hypereroticism, the “H” Area is part of the vulvo-vaginal erectile complex (fig.1).

The female’s first response to the male’s manual stimulation of the H-area is the lubrication of the vagina.

Key words:
Hypereroticism “H” area, bioexcitability, stimulus, anterior vaginal wall

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**Introduction: The motivation of the work (Purpose)**

The area has been known since antiquity, when it was shown that it “produces maximum pleasures”. In the 17th century, it was mentioned by Regnerus De Graaf and in 1950 by E. Gräfenberg, known as the “G” spot.

Absolutely all the authors mentioned only the effect, “the state of pleasure”, but no one explained why the erogenous effect occurred. This is why the existence of this area or its absence is currently under discussion.

This is the motivation of my work.

**Method:**

The study (fig.2) that was conducted initially on a total of 200 people was later extended to 800 women aged 16-45. It showed that 72% of the studied people showed distinctly an increased erotic sensitivity of the “H Area” as compared to the rest of the vagina, 16% had the same sensitivity across the entire vagina, and a rate of 12% had no vaginal erotic sensitivity. It was also found that 68% of the people, consulted on the gynecological table, with an increased sensitivity experienced the need to urinate when touching the “H Area”, by unimanual examination.

The sensitivity assessment of the two vaginal areas, H area and rest of the vagina, was carried out by a subjective test (bi- and unimanual vaginal touch) and by measuring the biopotentials of the two segments.

Thus, I found that:

– the response to the electric stimulus occurred differently, respectively with a lower intensity in the H area, and with a higher intensity in the rest of the vagina, viewed on the electrogram. The threshold (liminal) intensity was 1/3 higher for the vaginal tissue as compared to the H Area. The collection and replaying of the electrical signal for the same amplitude on the electrogram was made by a lower stimulation in the H Area and a higher stimulation in the rest of the vagina, clearly showing the difference in potential for this action.

– the time between the application of the stimulus and the response was significantly shorter in the vaginal area of hypereroticism;

– the potential for resting is shorter for the cells in the H Area, proving the existence of a structure with particular morphology and a neuro-vascular system where the tactile receptors process and transmit the information collected from the H Area to the nerve ramifications differently from the rest of the vagina. They reach the brain, which will sensitize the erectile bodies of the H Area - anatomically different from the rest of the vagina.

**Description**

My research proves that, in fact, there is an “area”, (not a spot), located on the anterior-inferior vaginal wall, having a surface with markedly increased erectile sensitivity compared to the rest of the vagina, due to its particular neuro-anatomical structure, which I have called “the vaginal area of hypereroticism”.

The anatomic topography does not provide a good view of the area, when the patient is in a normal gynaecologic position, as the pubis symphysis covers with approximately 1-1.5 cm the edge of the H Area, context in which the surface can be endoscopically demonstrated (fig. 3a, b, c).
Fig. 3a, b, c - Hypereroticism Area shown by endoscopy

Fig. 4a, b - Different appearance and structure of the H area by comparison to the remaining vagina
The immediate retropubic part can, however, be demonstrated in the case of a genital prolapse, which, by the herniation of the pelvic organ, by the uro-genital hiatus engages the anterior-lower third of the vaginal mucosa (cystourethrocele), due to the insufficiency of the supporting mesenchyme. Due to the tension produced, the mucosa appears without folds.

I mention that the vaginal wall that constitutes the H Area has a special structure due to the intimate adhesion special to the urethral wall, by the suburethral tissue, which has a specific structure (fig.4a, b). Because of this, the surface of the mucosa has a different aspect. For this reason, the mobility of the vaginal mucosa is reduced on a distance of approximately 2-3 cm.

**The average dimensions in relation to the variable values of the types of vagina:**

- transverse diameter: 2/2.5 cm;
- anterior-posterior diameter: 2.5 cm.

The area represents about a quarter of the length of the anterior vaginal wall.

**Form:**

Trapezoidal, with single and precise topography.

**Course:**

Oblique, downward and forward.

**Appearance**

The vaginal mucosa is pink coloured (fig. 5) and is thicker than the H area. The surface with thicker transverse folds (*ruge vaginalis*) (fig. 6) is well perceived visually and upon touch. On the midline there is a longitudinal eminence (*columna rugarum*), which has on the anterior edge of the vulval opening of the vagina a small thickening (the vaginal tubercle), located just under the urethral meatus. On the upper side the longitudinal column splits, forming a transverse fold at the external opening of the cervix, thus detaching the “Pawlick’s triangle”.

**Relations**

Anterior: the urethra, totally;
Anterior-inferior: the pubic symphysis;
Inferior: the anterior-superior part of the hymen membrane or the hymen carunculii of the vaginal opening;
Superior: extends the anterior vaginal wall;
The anterior head of the vestibular bulbs is related to the opening of the urethra, causing during the erection the hyperemia of the area, namely of the urethral meatus. The corpus cavernosum of the clitoris, as well as the vestibular bulbs, have in their structure a cavernous tissue with arteriovenous anastomoses which fill with blood during the erection through the dilated helicine arteries, which are tensioned due to the albuginea, a little extensible membrane that covers, plugging the veins and the blood drain system. The zonal erectile tissue vascularization directly involves the urethral cushion, which is also composed of erectile tissue. Located in the suburethral space (urethro-vaginal) it affects directly the H Area. I emphasize that, since it is an erectile tissue, covered with albuginea, its unique functionality is determined, as compared to the one determined by a simple local hyperemia.

The direct link between the erectile tissue of the clitoris, the vestibular bulbs, the urethral tissue, the urethro-vaginal tissue and the vascular plexus of the H Area causes by the stimulation of the receptors of the H Area, the occurrence of a complex effect, rapidly erectile, with turgidity in large area, preparing the genital organs for copulation, amid an increased libido.

The anastomoses of the corpus cavernosum of the clitoris with the corpus cavernosum of the urethra are also explained by the venous blood leaking, directly and principally, towards the circumflex veins. In this context, the erection occurs as a complex neurovascular mechanism, where the relaxation of the cavernous spaces is the result of the influx of blood arriving in a large quantity through the arteries of the corpus cavernosum (active hyperemia), in response to the excitation of the nerve receptors, local and central, perceived by the person as an “erotic state” that induces the desire (libido) to perform the sexual intercourse (copulation).
To the aforementioned data we add the action of the constrictor muscle of the vagina, which is fixed to the corpus cavernosum of the urethra, posterior and on the tendon centre of the perineum, namely on the edges of the vagina and which by contraction increases the vulval-vaginal-perineal vascularization. Also, the muscles of the pelvic diaphragm intervene to achieve the erectile state, including the external sphincter of the anus, which crosses above the anus, the fibres passing medially to the bulbo-cavernosa muscles, which cover the external face of the vestibular bulbs, participating in the establishment of the vaginal sphincter muscle and the external urethral sphincter muscle going from one side and the other of the labia minora.

**Embryology**

The striated urogenital sphincters are made out of the genital diaphragm, including the urethrovaginal sphincter of which the proper sphincter (external sphincter) of the urethra is formed, located around the urethra and the proper sphincter of the vagina built around the vaginal channel. The topography of those muscles includes the urethrovaginal component, or the H Area, intricate in the erection, orgasm and ejaculation, and which has common vascularization and innervation, as I have shown. The differentiated morphology of 1/3 inferior of the vagina to the superior 2/3, is the result of different embryological origin, a process in which the superior 2/3 of the vagina come from the urogenital sinus, and the inferior 1/3 from the genital ridge, a context in which the blood vessels, lymphatics and nerves have a common topography with the vulva. Thus, the inferior third of the vagina results from the proliferation of the urethro-vaginal sinus tissue of which the urinary bladder is made, the urethra with the urethral vestibular and paraurethral glands, the vaginal vestibule, which explain clearly the special anatomical structure of the H Area regarding the close relationship with the

I mention the fact that the urethra is separated from the vaginal wall by the urethrovaginal septum, and between the urethra and the H Area of the vaginal wall, there is a cellular tissue denser than the rest of the area, explaining the strong adhesion and the reduced mobilization between the two anatomical structures.

The hypervascularization of the H Area by the connection with the urethrovaginal spongy tissue, just like the common innervation with the vulvovaginal erectile bodies explains the increased erotic sensation, induced by digital manoeuvres conducted in the H Area. But in the hyperemia of the automatically erectile bodies the vaginal area of hypereroticism is also affected by the above-mentioned connection. The inflow of blood - at the level of the venous plexus of the anterior wall of the vagina - sets a normal erectile state which, however, in the H Area is supplemented by the hyperemia of the spongy tissue, which increases the erection and the sensitivity of the receptors, increasing the excitation and the erotic impulse for copulation, ejaculation and orgasm, of varying intensity.

So, the hypervascularization of the H Area appears as an additional factor determined by the existence of the urethrovaginal cavernous structure, acting on an already congested vaginal wall, by Gussenbauer erectile tissue, during the local excitation period or by brain control.

The normal congestion of the vascular plexus, the vaginal wall, has lower erotic effects than the congestion of the cavernous tissue, which due to the presence of the albuginea provides a special anatomical shape and functionality to these organs in the act of copulation and the reach of ejaculation and orgasm. I mention that the erectile tone determined by the female genitalia is lower than in male, where the erect penis is so strong, that it penetrates the hymen of virgin females, the anus of females or the rectum in the case of homosexuality.
Innervation of the H Area

The H Area is richly innervated by branches of the dorsal nerve of the clitoris, accompanied by a specific vascular system. At the level of the clitoris, especially in the glans - the nerve fibres of the dorsal nerve of the clitoris make a nervous plexus with very high erotic sensitivity. From the dorsal nerve of the clitoris, a branch of the pudendal nerve, nerve fibres that innervate the clitoris tissue and the subclitorian part, the vaginal introitus and the H Area are starting, where a common innervation is achieved through labial, vaginal, vulvar branches - at the surface and in depth.

On this complex above-mentioned innervation intervene the nerve branches of the genital-femoral nerve, the large and small abdominal-genital, branches of the lumbar plexus, the small sciatic, the pelvic nerves and the internal pudendal nerve, sympathetic and parasympathetic autonomic branches, which innervate also the muscles of the H Area.

I specify the fact that the nerve branches of the erectile “H” area disappear with the removal of the vulvar erectile organs, establishing in this case, the innervation of the rest of the vagina, which comes from other nerve sources. In this context, by the direct nervous connection between the clitoris, urethra, vagina and vulva, a “vulval-vaginal-urethro-clitoral functional complex system” is achieved, in which the urethra takes part not only in the act of micturition, but also in the specific physiological genital changes, such as those caused hormonally in the monthly cyclic changes, which, automatically determine a local hypervascularization. This also explains the favourable pre, intra, and post-menstrual erotic status.

As shown, the erectile tissue is found below the vaginal mucosa, and in the inferior part, the sensitive corpuscles receive the manual stimuli by transmitting the impulse received to the nerve branches. These nerve branches are connecting with the vulvar erectile bodies, especially with the tactile corpuscles (of voluptuousness), the labia minora and the clitoris. Nerve branches get anastomosed constituting plexuses, and between these and the erectile organs there is a complex neuro-vascular link, which causes the erection. These nerve fibres coming from the pudendal nerve (N. pudendus), are reached by fibres from S2 and S3. It goes to the perineal nerve and the dorsal nerve of the clitoris, that sensitively innervate the erectile structures, the clitoris thus being the most powerful erogenous support in female, even if in the study conducted, many patients said that the erogenous effect of the H Area sometimes exceeded that of the clitoris.

This peculiarity explains why the erotic sensitivity of the H Area is net superior, for example, to the sensitivity of the posterior vaginal wall.

The perineal nerve branches (N. perinealis) make the connection with the labias and its lateral branches make the connection with the urethral triangle, explaining the erotic sensitivity and specific congestion of the urethro-vaginal area. The muscle branches innervate the transverse perineal muscle, superficially and in depth, and they reach the bulbocavernosus and the urethra sphincter. A branch of the bulbocavernosus reaches the corpus cavernosum of the urethra (corpus cavernosum urethrae), or the urethral mucosa, explaining the connection of the vulvar erectile bodies with the urethra, and by this with the vagina – the H Area. By the dorsal nerve of the clitoris and its branches, innervating the urethra, the H Area, vestibular bulbs and the superior third of the labia minora - a nerve network is created, which explains the increased sensitivity of the whole area only when touching one of these structural components, as well as dete-
The increase of sensitivity in the H Area is explained by neural synapses, made by the process of neurogenesis, where the growth of the axon and the dendritic spines form the interneuronal connections, enabling the transmission of the nervous influx (the stimulant) between organs with a strong erogenous constitution of the area.

Discussions

As noted, the H Area is innervated by nerve fibre that come mainly from the dorsal nerve of the clitoris and vegetative fibre accompanying the neurovascular plexus, responsible for the cavernous tissue turgor. These fibres get to the H Area receptors by the urethra-vaginal tissue, which take the information from the receptors. Nerve branches ensure the sensitivity of the somatosensory receptors and transform the stimulus into a nerve impulse, which reaches the brain, the control centre of the genital structural functionality. In this case, as shown in the research conducted, the minimum intensity that caused a cellular response, namely the excitation triggering as a manifestation in the biological system, was obvious in the H Area, as compared with the rest of the vagina. The neuroanatomy of the vulvovaginal bodies and the perineum shows that they are well differentiated in the cerebral cortex, even if they have a common and precise role in the physiology of sexual intercourse. The anatomic masses with spongy structure, by the inflow of blood and the increase of local tension boost the degree of eroticism and the clear desire of copulation. I emphasize that between the vascular plexuses and the cavernous tissue, as shown, not only are there direct connections, but the vessels have common origin and drainage. This does not mean that all morphological elements de-
scribed above are not distinctly differentiated in terms of anatomy, the incorporation of an organ into another is an aberration. In this context, regardless of the interested point of stimulation, the erection embraces the entire vulvovaginal area, especially the copulating structures. According to the research conducted, as shown, the increased eroticism of the H Area is determined by the decrease of the excitation threshold of tactile receptors in the H Area, explaining the increased sensitivity of receptor cells, where the cellular depolarization is markedly increased as compared to the rest of the vagina, producing, in turn, the turgor of the H Area cavernous structure, and, therefore, of the surrounding areas by the neurovascular links with the vulvovaginal erectile bodies. Also, the number of receptor proteins (receptors), their density and capacity of reception at the cellular level, on or within the cell is significantly higher in the H Area than in the rest of the area. In a simplistic form, the stimulant, in this case the vaginal stimulation, through manual pressure of the receptors in the H Area, namely of the membrane sensors, controls the cell membrane permeability change, that opens the gates of ion channels, thus responding rapidly to the stimulant. By stimulating the H Area and getting a stronger response (on average with 72%) thereof to the rest of the vagina, it is concluded that the cellular bioexcitability of the H Area is significantly increased as compared to the adjacent vaginal area.

The cellular sensitivity of the H Area, variable from one person to another, is increased by 0.5-1.2 as compared to the rest of the vaginal mucosa.

This feature is explained by the existence of the internal pudendal nerve fibres, the short nerve fibres, thicker and with a high degree of myelination. At the level of the excited cellular membrane, the nerve impulse transmitted by action potential responded faster from the mechanical stimulation place, along the nerve branches membrane inner-vating the H Area and entering into direct contact with the other erectile, vulvar nerve branches, especially of the clitoris and vestibular bulbs, in their turn erogenous areas with strong sensitivity through their anatomical structure. In this context, by the excitation of the H Area the triggering of the erotic condition, on average, occurs in 5-7 seconds. The explanation is given by the fact that the H Area cells, when in contact with the (mechanical, electrical, chemical) excitation factor change the cell membrane permeability by activating the ion channels, responding to the stimulant by triggering the erotic excitation condition. The minimum intensity that induces an initial response of the cellular or tissue biological system, is much lower than the intensity required to achieve the same effect in the rest of the vagina, since there is an erotic sensitivity difference of the two areas. Increasing the permeability of the cellular membrane, namely opening the gates of ion channels that was also favourably influenced by the increased vaginal temperature, the pH of the vagina and the vaginal secretion content, which improved the kinetic energy of the molecules, the dimensions and the number of the membrane openings channels. In fact, it is known that membrane proteins are the receptors for the chemical substances, which provide the vaginal content and the pH, giving the increased specific sensitivity. Membrane receptors specific changes activate, each of them or grouped together, the intracellular proteins changing the excitability of the cell in relation to extracellular signals, these explaining different cell sensitivity between the H Area and the rest of the vagina. The study that I conducted has revealed that, in reality, there is a clearly increased sensitivity of the H Area in laboratory investigations, as compared to the one resulting from physical examination. I also believe that the lack of local sensitivity ranging to 12% is one of the major explanations of anorgasmia in female.
Conclusions

The existence of the Vaginal Area of Hypereroticism is demonstrated and explained by the local morphological structure. This Area is integrated into the functional erectile vulval-vaginal-urethro-clitoral complex system.

The electrovaginal activity and its role in the sexual intercourse has also been studied by other authors (Shafik A. et al.) who recorded electrical waves transmitted cranio-caudally involving a pacemaker at the top of the vagina that would represent the G spot. Vaginal contractions would trigger at the time of vaginal penetration and copulation. Histologically, the cells that make up a “pacemaker” center work synchronously through electrical interactions between the cells.

In our study, the vaginal area of Hypereroticism (the H area) is located caudally (in the retropubic space) and cannot be a “pacemaker-type” center, because the H impulse (the erotic sensation) is guided from the H area by specialized vascular-nerve pathways with the clitoris, the most powerful erogenous support of the female.

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Sexuality, sexually transmitted diseases by oncogenic viral genotypes and importance of molecular screening methods

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Abstract

Viral infections bearing oncogenic potential play a vital part in cancer lesions identified in the heterosexual, homosexual and bisexual relationships.

Links have been set out between the genotypes of the human papilloma virus, HPV, a virus that has non-enveloped icosahedral capsids and a high oncogenic potential, those being 14 strains, and the herpes simplex virus (HSV2), meaning the form of premalignant and malignant lesions in the case of anogenital and oral-pharyngeal-laryngeal condition pathology, by HPV viruses mainly contacted by fellatio and cunnilingus, as well as by other infection sources.

In fact, the genome enters the transcription site from the nucleus of the infected cell (Longworth MS and Laimins L.A. 2004), the HPV receptor being integrin Alfa6.

Key words:
koilocytes, genome, genotype, oncoprotein p16 Ink4a, Ki-67, HPV, HSV2, fellatio, cunnilingus.

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Main text:

Introduction:

Scope:
- to set the significance of screening by immunochemical tests, in this case by simultaneously detecting the proteins p16 INK4a and Ki-67 for early identification of the evolving forms of intraepithelial cervical lesions prone to lead to cancer, in a situation involving an infection with oncogenic genotypes of HPV.
- can the molecular screening methods replace the histopathology examination?
- what is the value of the dual immuno-cytochemical test, simultaneously for proteins p16 Ink4a and Ki-67, as molecular screening method, before and after the treatment?
- what is the treatment to follow in the case of HPV oncogenic genotypes in the structure of the cervix?
- form of removing the oncogenic genotypes at the time of finding them?
- importance of the immunocytochemical tests for correctly assessing the lesions.

Methods:

The epithelial lesions caused by viral infections with HPV and Herpes Simplex Virus Type 2, with oncogenic potential, transmitted by sexual intercourse, can be
1. Anogenital (fig.1.a, b, c)
   - anal: anus, rectum, perineum
   - genital: pubic region, vulva, vagina, cervix
2. Penis (fig.2.a, b, c)
3. Oral-pharyngeal-laryngeal: lips, mouth, pharynx, larynx

In this case, the most common oncogenic HPV types are 6, 11, 16 and 18. The best researched, given its pathology and frequency of its severity, is the infection of the cervix with oncogenic genotypes of HPV.

Viral infection of the cervix with oncogenic genotypes

- The screening program, initially by the Babes-Papanicolau cytology test (Pap smear), now by employing the Bethesda System, for early finding and treating the precancerous and cancerous lesions, has significantly diminished the death rate caused by the cervical carcinoma, the second most frequent cancer type in females after breast cancer.

HPV affects the mucosa in various ways:
- without determining a cervical lesion, HPV infiltrating the mucosa (fig.3.a,b); the infection is certified by a cytology test and genotyping. The valve speculum examination does not indicate a cervical lesion, especially in the case of endocervical cancer forms, which renders impossible to see the lesion in its early stage; sometimes, abnormal postcoital intermenstrual post-menopause vaginal bleeding occurs, vaginal purulent discharge, and foul smell. If HPV oncogenic genotypes were found on a macroscopic non-lesion cervix, which was modified as indicated by colposcopy (leucoplakia, mosaic, acetowhite, punctuation, atypical vessels, cuffed glands, iodine negative epithelium, invasive carcinoma), proven by HPV DNA and HPV DNA genotyping, I employed the molecular screening methods systematically, thus following the value of the progression risk of the intraepithelial cervical lesion to neoplasm. When needed, the histopathology examination was performed.
- it can cause cervical lesion or peripheral ulceration, which easily bleed when performing a valve speculum examination (fig.5a, b), and the damaging of the cervix and the upper and lower Douglas pouch following even the smallest trauma, when the cancer lesion has not invaded the Douglas pouch and the vagina;
- virus enters by the existing damaged mucosa (fig.6), which is an aggravating factor in connection to the speed of virus inoculation and
Fig. 1a - Anogenital warts by infection with HPV genotype 6; b - Condylomata acuminata positioned beneath the clitoral gland; c Cervical neoplasia; HPV infection, genotype 18

Fig. 2a - Herpetic vesicles located on the body of the penis b, c - Penile infection with HPV genotype 11 and HSV 2
disease progression, by breaking the DNA chains, which then leads to mutations by fast mitosis cell division.

The presence of koilocytes (Meisels and Fortin) in the biologic sample taken from the cervical surface has explained the existence of the HPV infection in which 65-77% of the cervical cancer is determined by genotypes 16 and 18 (Munoz NM et al. 2004). The rapidity of setting a diagnosis by RNAm detection for the viral oncoproteins E6 and E7, by molecular screening, renders a differentiation of the pre-cancerous and cancerous lesions, thus resulting in a correct treatment. The viral load of a cell with genotype 16 or 18, by adding other HPV oncogenic or non-oncogenic genotypes, or with HSV type 2 increases the oncogenic risk of the infection and the risk that the intraepithelial lesion of the infected cervix would evolve, a fact proven by the sensitivity and specificity of the molecular methods, such as Real Time PCR and PCR Multiplex. Those are “in situ” hybridization or double detection techniques, which involve the qualitative simultaneous identification of proteins p16 and Ki-67.

Genital infection with oncogenic HPV genotypes is contracted in the first year after the onset of sexual activity, according to most authors, by 80% of females, while reaching a peak around 25-30 years, after which the prevalence decreases (Kjaer SK at al. 2000). That is because the organism of the infected person synthetizes specific antibodies, which directly affect the vital protein L1 of the infecting genotype in which the anti-oncogenic genes (against the vital oncoproteins HPV E6, E7) block the gene 53 (tu-
**Fig. 4a** - Colposcopic view for ASC-US and LR-HPV 42 and 82; **b, c** - L-SIL and DNA HPV negative; **d, e** - Colposcopic examination for L-SIL and HR-HPV types 18 and 51; **f, g**-colposcopic view for ASC-US and HR-HPV type 16
mor suppressor protein). The cell removes the genomic lesions caused by the oncogenic virus, before the cancer sets, thus determining the natural healing of the infection and removal of the virus from the cell immune system in 70% of the cases, during the first year and 90% of the cases, 12-36 months later, including in the case of infection with high risk genotypes (Giuliano AR et al. 2002).

RNAm demonstration for oncoproteins E6 and E7, which differentiate the precancerous of the cancerous lesions, indicates the oncogenic risk of the infested cervix, in a progressive manner from CIN II to CIN III or CIS, everything being proven by PCR or real time PCR molecular methods.

Zhou and his collaborators believed that the immune response in the HPV infection appears in only 54-69% of the females infected with genotypes 6, 16 and 18; thus, there is not a 90% healing of the initial infection.

I mention that the organism acts in complex manners for removing the oncogenic genotype. The HPV infection affects the basal layer of the cervical epithelium, especially the keratinocytes in progress of differentiation. The cellular immune response is acknowledging the infected cells and stimulating the Th1 lymphocytes, which activate the T cytotoxic lymphocytes that would then destroy the virus. Other defense manners are physical barrier (cell integrity), chemical barrier (acid pH, mucous, and fatty acids), and humoral factors-interferon, lysozyme (A. Guyton), thus explaining the great healing degree in patients of 90%.

But immunity can increase or decrease in certain situations as, for example, pregnancy, case when the anal and vulvar condyloma disappear after curettage.

In that situation, the gestation process diminishes the immunity by increasing the immune tolerance with the aim of keeping the product of conception, which is an allograft. After the pregnancy is removed, the patient’s immunity is restored and the vulvar condylomatosis subsides.

Immunity can drop also in the case of a dysimmune status, such as the existence of a chronic condition, like diabetes mellitus, kidney failure, chronic hepatopathy, chronic extragenital infection, or autoimmune or malignant disease located somewhere else, while the level of the molecular biomarkers can vary.

In the case of oncogenic genotypes persistence, one must consider the coexistence of a precancerous lesion, which might evolve towards malignant pathology, case when the immunocytochemical investigations would provide relevant data of great concern.

Infection with oncogenic viruses is much more severe when it is associated with other local or general infectious diseases, such as HSV type 2, B or C virus hepatitis, HIV, Lues, cytomegalic virus, Chlamydia, the use of oral contraceptives because HPV has structures activated by steroid hormones, particularly progesterone, vaginal or of spermicides that damage the vaginal mucosa and that of the cervix, while favoring the inoculation of the oncogenic viruses. To this the difficult cervical epithelium regeneration adds because the surgery made has not completely eliminated the pathologic tissue (fig. 5 - clinical case).

I must state in that such a context, the lesion cervix, which did not heal following the surgery performed, not even after several months – 1 year, can be a sign of cancer lesion.

On the sexuality and high oncogenic potential of some genotypes, I must emphasize the part played by the early start of sexual activity (12-15 years), too. Right now, in many countries, Romania included, the sexually transmitted disease (STDs) are contracted much easily due to the low immunity background to which the insufficient somatic, neuropsychic and sexual maturity add.

I mention that the oncogenic viruses are easily contracted at that age also because the cervical epithelium of the cervix becomes much more sensitive to the mutagen factors (cancer is usually caused by mutations), such as the oncogenic genotypes of HPV and HSV type 2, due...
Clinical case

Patient aged 32, unmarried, first sexual contact at 22. She had 7 sexual partners. She came for a specialty gynecology examination because after 2 LEEP surgeries on the cervix, within 2 years, the initial lesion was not eliminated. As well, lately she had begun experimenting postcoital, pre and postmenstrual bleeding.

The previous investigations indicated that the reason for the surgeries made was Bethesda cytology test (ASC-US) and HPV genotype present (genotype 16).

Valve speculum examination: In the vagina, there was abundant leukorrhea with polymorph appearance and foul smell; cervix indicated no births, with a large erosion area surrounding the opening. Marginal ulceration bled lightly when the cervix and the Douglas pouch were touched by the speculum with the aim of clearly seeing the extent of the lesion.

Biological sample was taken from the vaginal discharge (Candida); cervical canal bacteriological culture (Staphylococci), HPV genotyping (genotypes 51, 53, IS39 present), and immunocytochemical test for markers p16/ki67 (positive) were performed.

Given that the colposcopy showed the presence of atypical terminal capillaries, much dilated, having irregular size and shape, located under the very thin pavement epithelium on the tumor lesion (abnormal vascular system easily seen also macroscopically), the need to perform an emergency was set out histopathology examination (H.E.).

During the surgery performed, the histopathology examination for the sample taken on the spot proved the existence of a carcinoma.

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squamous carcinoma cases, and the strain 18 in 89% of the adenocarcinomas in females under 40 years old and 40% in females over 40 years old. The persistence of a high risk oncogene genotype over 3 years can last 10-20 years, thus explaining the appearance of cancer in older females. In this case, we are now investigating, including by molecular screening, many persons aged between 45 and 58 years old, with high risk oncogenic genotypes.

As a rule, the molecular screening and genotyping methods are assessed while considering ASC-US (ASC-US= Genotyping). (fig. 8.)

The therapy adopted based on the Bethesda system classification (fig. 9.):

Koilocytes present → HPV genotyping → HPV present= Molecular screening

If high risk oncogene genotypes are present, that being the immunocytochemical tests for p16 and Ki-67, which are prone to metaplasia, which were performed on the cervix without any macroscopic lesions or with colposcopy-related modifications, deep LEEP, conisation or cervix amputation was performed, thus referring directly to the cervical pathology, particularly that from the squamocolumnar junction outside the cervix, as well as the areas that were changed due to colposcopy.

I mention that the modification of the volume of tissue extracted by conisation (the so-called “small conisation”) decreases the value of the diagnosis by 10-25%, according to I. Chiricuță.

In that situation, the post-surgery monitoring indicated that in 97-98% of the cases, the previous oncogenic genotypes disappeared (survey made on 2 experimental batches of females aged 25-55 years old – each batch had 40 persons). During the checkup performed subsequently, sometimes new HPV genotypes were found.

Regarding the contamination manner, it is done by penile-vagina intercourse, by the infected (contaminated) hand that entered in contact with the male’s or female’s genitalia, during the manual maneuvers on the erectile areas, contaminated underwear of the person, sperm, saliva, blood, the partners’ genitalia coming close to each other, towel, etc.

Our research proved that cervical neoplasia is 7 to 10 times more frequent in wives of males with penile cancer, respectively HSV type 2, HPV oncogene genotype 16 and 18, who experienced repeated marriages, repeated viral infections of the cervix, and numerous pregnancies. Over 70% of the persons carrying HPV infection display no symptoms, which determines a very high risk of contamination.

The HPV infection can be transmitted during delivery, from mother to newborn, on a hema-

Fig. 6 - Macroscopic aspect of cervix with PAP-ASC-H associated with HPV genotypes 18 and 33
Fig. 7a, b, c, d - Immunocytochemical tests for p16 and Ki-67-positive

Fig. 8 - Medical conduct in cervical pathology

PAP CITOLOGY:
ASC-US, ASC-H, L-SIL, H-LSIL

MOLECULAR SCREENING
p16^INK4a /Ki67

Treatment
LEEP
Surgery+ H.E.
Periodic Monitoring

DNA HPV
Penile cancer

For a long time, it was stated that it was a very rare type of cancer and that it represented 1-2% of all neoplasia in European males and up to 19-20% in men in Africa and Asia, around 50-60 years old. In fact, obviously, it is more frequent in Africa, Asia and the Middle East, which explains in a way, among others, the practice of circumcision in those regions, which decreases the prevalence of HPV infection. The penile cancer is an epidermoid carcinoma. The primary form, usually the epithelioma, is the most frequent by comparison to the secondary penile neoplasia, which occurs as complication or metastasis, next to the rectum, testicular, bladder, kidney and liver neoplasm. Intestinal metastases are very rare.

The tumor affects the glans, balanopreputial sulcus, foreskin, and body of the penis.

HPV was found (according to Rintala M et al. -2000) in the urethra epithelium, vas deferens, seminal vesicles, semen and sperms coming from asymptomatic males, as well as in the glans, neck or body of the penis. The HPV infection is more frequent in homosexual males. In general, the HPV infection has a subclinical manifestation, with asymptomatic carriers, while the infection with HSV type 2, with oncogenic potential, is very painful and macroscopically visible (fig. 2a, b, c).
Risk factors

They are scars or phimosis, which shrinks the balano-preputial separation while favoring the infection and inflammations at the level of the glans and neck of the penis in connection with precarious local hygiene. I mention also the transformation of precancerous lesions, such as leucoplakia, caused by HPV genotype 6, 11, showed by HPV DNA methods, anogenital Bowen papulosis connected to HPV 16, 18, 33, Queyrat erythroplasia occurring on the glans, foreskin, and the body of the penis.

In fact, the oncogenic genotypes of HPV and HSV type 2 provide without a doubt a high potential of the precancerous lesions progressing into cancer.

The HPV infection is easily transmitted from males to females, a fact explained by the different anatomical structure of the genitalia, as well as by the manual maneuvers performed on the female’s genitalia by the male, while using an infected hand. I underline the fact that the male hand carries more infection than that of the female.

The infection of the penis with HPV is connected to anal cancer, according to some authors in 90% of the cases, and to oral cancer.

Although the penile-anal intercourse is much more frequent in females, by the vulva coming close to the anal orifice, the rectum penetration is much easier also due to the pelvic floor structure. In theory, the possibility of developing anal cancer is much faster; practically, the anal cancer is much more frequent in homosexual males.

However, the HPV infection is present in 70-80% of the females, while in males, in 20-30%.

The patient goes to the sexologist for varied symptoms, in general complaining of “pain during intercourse and pain of the penis, with a slightly increased tone”. He is experimenting libido, but at a low level. The present symptomatology does not allow him to complete an intercourse.

The clinical situation and particularly, the superficial inguinal lymphadenopathy, which can ulcerate, respectively the adenopathy of retrocrural lymph nodes and sometimes of the external iliac lymph nodes, display early onset, being a consequence of the infection.

The biological sample taken from the existing tumor leads to setting out the diagnosis and to establishing adequate treatment.

As in all cancer forms, early setting the diagnosis and the treatment can lead or not to the total healing.

The immunocytochemistry tests, with antigen detection (e.g. oncogenic proteins) in the cross section of a cell or by genotyping have a low significance because the histopathology examination is performed directly, often before the immunocytochemical tests.

The penile cancer due to HPV infection is rarer (HPV genotype 16 in 55.65% of the cases, HPV genotype 18 in 13% of the cases, HPV 6 and 11 in 8-8.5%).

The anogenital HPV DNA in males is most frequently found in the balano-preputial separation and then in the urethra. The rate of infection decreases by age due to rarer intercourses, as well as the experience of those involved in them.

Oral-pharyngeal-laryngeal lesions

The mucosa, lips, tongue, gums, mouth cavity, soft palate, pharynx, and larynx are contaminated especially in persons with a low immune system, by fellatio and cunnilingus, sexual deviations present in 15-75%, while considering the age (V. Nițescu).

In general, the viruses enter the skin or mucosa lesions and appear in persons with weaken immune systems given diseases such as HIV/AIDS, radiotherapy, cytostatic, or immunosuppression treatment.

The oropharyngeal cancer develops in any area, especially on the lip (fig. 10 - Cases of University Professor Dr. Alexandru Bucur- a, b, c, d, e, f), tongue or floor of the mouth, being caused in 15-25% of the cases by fellatio and cunnilingus, particularly by the oncogenic HPV
genotypes (Mark D. DeLacure – New York University) proven by immunofluorescence methods. HPV acts on the intact or damaged tegument or mucosa.

The frequency of fellatio (by penis – mouth contact in females, homosexual males, and bisexual males) is present in 62-78% of those practicing it while considering their age. The females practicing it leads to orgasm in 72-75% of the cases. Cunnilingus, as orogenital maneuver practiced by males to females and by females within homosexual intercourses, is 50-58% by considering their age.

The infection with oncogenic HPV is transmitted by saliva (kissing), blood, sperm, mother’s milk, vulvovaginal discharge, penile discharge, urethral discharge, hand, infected items or self-inoculation.

Sperm stored in the oral cavity has mutagen properties given its DNA content and has a direct action on the epithelium, thus determining the disease.

Right now, the oral sexual practice with partners infected with HPV is gradually more frequent in young females, under 18-20 years, who do not engage in penile-vaginal intercourse but in penile-oral and/or penile-rectum intercourse given their desire to maintain their virginity before their family and the society.

Adopting abnormal sexual practice determines infection with other STDs, too, particularly B and C hepatitis virus, syphilis, gonococcus,
and HIV. Given the infection transmitted, they lead to a very severe pathology, which is sometimes lethal (case discussed in 2017- female, aged 27).

The HPV infection is easier transmitted from males to females and the males’ hands are more infected with HPV than those of females, although the persistence of infection is 18-20% in females as against 5-6% in males, in the case of oropharyngeal, airway, esophageal and laryngeal lesions.

Cancer develops in any area, particularly on the lip, tongue or floor of the mouth, those areas being prone to HPV infection.

Some researchers have set out that 15-20% of the oropharyngeal cancer forms display infections with HPV oncogenic genotypes.

By applying the immunocytochemical methods, particularly PCR, p16 –Ki 67, the HPV infection in laryngopharyngeal carcinoma was identified in 75-80% of the cases. Right now, according to some authors, the oropharyngeal tumors connected to the HPV oncogenic genotypes are over 70-80%.

A major immune-histamine marker in the appraisal of pharyngeal cancer progress is the absence of the E-cadherin protein (Pascuale H.et.al -quoted by Cernescu), which facilitates the link between “keratinocytes and dendritic cells or Langerhans cells which trigger the immune response.”

The oropharyngeal cancer determined by the infection with HPV oncogenic genotypes, particularly 16 and 18, is very frequent in 40-50 year-old persons, mainly those that had over 6-8 oral sexual partners and who contacted the virus at 16-22 years of age.

I emphasize that the HPV infection is the result of the unprotected penile-oral intercourse, in theory, because infection can occur even when the person engages in a protected penile-vaginal intercourse.

One must notice the fact that in the persons displaying oro-pharyngo-laryngeal lesions, the histopathology examination is made directly by using the sample taken by surgery, while classifying the lesion at once, from a histology standpoint. Usually, the pre-histology genotyping misses because its significance in that case is low (no importance) for the surgeon.

Genotypes with oncogenic potential can also affect the squamous epithelium of the oropharyngeal, esophageal, and laryngeal areas.

Although the body has complex forms of fighting the HPV and HSV2, the number of oro-pharyngo-laryngeal infections by STDs has increased enormously, a fact demonstrated by researchers all over the world.

Annually, in Romania die approximately 3,500-4,000 persons due to cervical cancer, 1,000-1,200 persons due to anal cancer, 1,200-1,400 persons due to vulvar-vagina cancer, 200-300 persons due to penile cancer, and approximately 5,000 persons due to oral cavity, pharynx, or larynx cancer (C. Cernescu, modified).
Conclusions

The HPV virus has non-enveloped icosahedral capsids, which multiply their genome in the nuclei of the infected host cells (Longworth MS and Laimins LA-2004).

The virus is removed by the cellular immune system in 70% of the cases, in the first year and in 90% of the cases after 12-36 months, situation in which the surgery will be performed based on the solving manner, after the immune and medication treatment.

The occurrence of precancerous lesions following the infection can last 1-10 years, and some other 10 years would pass until the invasive cancer develops, which might explain the occurrence of the cervical cancer in females over 40-50 years old. That fact imposes a careful monitoring by the use of Bethesda cytology screening annually and when needed, more often, while considering the ASC-US value, genotyping, molecular tests, and colposcopy.

The molecular screening (histochemical witnesses that accumulate in the cells infected with HPV -10% in LSIL, 98% in HSIL, lack of E-cadherin, which appears in laryngeal cancers or increase of TERN-RNA expression – telomerase) and the histopathology test bring real benefits for setting the diagnosis.

The surgical methods of removing oncogenic genotypes performed as earlier as possible and when the tests call for them decrease the number of persons with cancer risk given the oncogenic HPV genotype.

In 99% of the cases, the cause for cervical cancer is given by the infection with oncogenic HPV genotypes (Harold Zur Hansen), and the nucleus and cytoplasm modification of proliferative cells can be shown, in theory, by molecular screening methods, such as the simultaneous detection of proteins p16 and Ki-67.

Early detection of E6 and E7 viral oncoproteins, by the molecular methods of setting the diagnosis allows one to establish the cellular oncogenic risk, provides the fastness of setting the diagnosis, differentiating the precancerous lesions of the cancerous ones and applying the adequate treatment.

Anal cancer is most frequent in homosexual males, although the penile-anal intercourse is most frequent in females.

The cytology screening tests by ASC-US, genotyping and molecular tests allow to set a correct diagnosis and treatment, in this case of 98%.

Removing the E6 and E7 oncoproteins by the person’s immune system, by the p53 gene (tumor suppressor protein), eliminates the genomic lesions caused by viruses posing oncogenic potential and explains the 90% healing in females after 3 years.

The mandatory cell screening, the molecular screening and HPV genotyping have decreased the number of deaths in some countries, such as Finland by 0.5% for every 100,000 females of 20-44 years old, Sweden by 0.9%, Bulgaria and Romania by 13.2%.

The molecular tests can emphasize the presence of malignant cells but they are unable to precisely replace the histopathology examination. The immunohistochemical test is not fail proof; sometimes, there are false positive results, both p16 and Ki-67 proteins can be present in cells that are no dysplastic, such as the mature metaplasia cells. This calls for a correlation of the immunohistochemical test to other investigations, particularly the histopathology examination. The molecular methods are useful for accurately assessing the lesions prior to performing the treatment meant to restore the local morphology.

In the case of oro-pharyngo-laryngeal lesions, when tumors are present, in general genotyping or molecular tests are rarely performed. The histopathology examination for samples taken from that tumor is able to correctly set the diagnosis of the disease (cancer type, differentiation degree, etc.), which iden-
tifies the cancer cell, the stage of the disease and the specific treatment.

Genital diseases are detected early, by comparison to the rectal and oropharyngeal ones, when the patient goes to see the doctor late, usually.

The abnormal colposcopic modifications impose the performing of genotyping and molecular tests, and when suggestive macroscopic modifications are present, we also perform the histopathology examination.

Protein p16 is directly connected to the oncogenic activity of the HPV oncogenic genotypes, its presence proving that the infection became malignant.

After surgery, the patient must be examined every 1-3-6 months, and a cytology test and HPV genotyping must be performed after 6 months, for finding whether the initial HPV genotype is present. In the case of normal evolutions and tests, the patient will be examined every year, when the normal tests will be performed.

I underline that the negative cytology has a 40% sensitivity (Danforth) and it does not exclude, for example, a HPV infection, situation in which the HPV genotyping will be performed for any suspicion, and if the HPV is present, the molecular tests will be performed, too.

The molecular biomarkers are always useful when the cytology test does not provide satisfying results.

By genotyping, one can set the presence of viral, oncogenic and non-oncogenic genotypes. Even if the non-oncogenic viruses are not as significant as the oncogenic genotypes, as indicated before, they too have a negative influence on the progression of the disease.

The result of the cytology test in Bethesda system, which indicates high degree lesions, "which cannot be excluded" (ASC-H, which is approximately 10% and a major risk potential by oncogenic HPV genotypes of over 80%) imposes the performing of molecular tests for p16-Ki67, which are particularly useful. In this case, the presence of E6 and E7 viral oncoproteins allows the differentiation of precancerous and cancerous lesions, the oncogenic risk, as well as assessing the severity of lesions. There is a direct relation between oncoproteins and precancerous lesions.

The diagnosis set by immunocytotest emphasizes the existence of the cancer cell by a specific coloration, while emphasizing the severity of the case and the emergency of the specific treatment.

The deeper alteration of cell layers has determined the 98-99% disappearance of the HPV oncogenic genotypes.

The diagnosis set by immunocytotest cannot replace the histopathology examination, which sets out the certain diagnosis of the disease. Such a diagnosis provides a different future to the patient, if the disease is found in a curable phase.

The cell modifications, such as the vascular and local ones, determine the ulceration and allow an easy entrance of the oncogenic HPV genotype and a faster development of the neoplasia, and the wound fails to heal.

The histopathology examination and the immunocytotest for diagnosis purposes decrease the number of investigations.

References

V. The risk of the intercourse undertaken by a patient with Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome

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Abstract:
A birth defect, the MRKH syndrome type 1 is characterized by uterine and vaginal agenesis.

It is the case of a patient aged 21 that had no uterus and the vagina had 5cm in the lower part, without any upper part, within the uterine and vaginal agenesis.

MRKH syndrome type 2, aside of the lack of uterus and vagina, indicates other defects, too, the most frequent affecting the kidneys, as in this case.

Abnormalities appear also in the morphophysiology of labia, in which the labia majora are hypotrophic and difficult to see, having an erotic sensitivity much under that of the labia minora, which are hypertrophic and have neurovascular and anatomic direct ties to the clitoris.

As well, also within the particulars, the vaginal introitus is small in size and determines difficult penetration and copulation, by the different defective structure of the vagina.

The short vagina (5cm in length) in its lower side, given its connections to the hyper-eroticism area located behind the pubis, and particularly to the clitoris, but to the other erotic areas, too, as well as the inner sides of the labia minora, determined a strong sexual arousal to the patient, which allowed the penetration of the vaginal introitus and copulation, within reasonable limits, but after the intercourse’s completion (orgasm and ejaculation), given that the pleasurable sensation disappeared, the patient began completely feeling local pain and bleeding, which made her rush into the hospital.

Key words:
Muller agenesis, MRKH syndrome, partial vaginal aplasia, unilateral renal agenesis, urogenital folds.

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Description:

The MRKH syndrome is a malformation of the female genitalia, determined in the embryonic period, at the end of the gestation week 4 and 5, by ceasing the development of Müllerian ducts in the embryonic mesoderm. As consequence, disturbances occur in the organogenesis process, determining uterine and vaginal agenesis and the lack of uterus and virginal. As well, there can be an agenesis of the 2/3 upper parts of the vagina, various degrees of vaginal hypoplasia, stenosis, caliber modifications, all making up the type 1 of MRKH syndrome.

The lower parts of the Müllerian ducts are the first influenced in the malformation process. The defects, which are extremely varied, affect the vagina and are explained by the fact that the biggest part of the vagina does not develop from the Müllerian duct, but from the urogenital sinus, the fused part of the Müller paramesonephric ducts, together with the organs of the urinary apparatus, as the bladder and the urethra. Thus, it explains the situation of the vagina being present while the Müllerian (Kirsch) duct misses and the urethra and bladder that are present.

By the complexity of the embryonic structures concerned, during the defect-creating process, type 2 of the MRKH syndrome, other defects appear, too, which affect the urogenital apparatus, such as ectopic kidney, unilateral renal agenesis, horseshoe kidney, disturbances in emptying the bladder, urinary incontinence by sphincter assessment, deaf-

![Figure 1](image-url) - Complete uterine agenesis and partial vaginal agenesis (author’s own sketch)
ness, heart defects, and skeletal abnormalities in the vertebrae, particularly C1-C7 cervical segment.

It was also described the existence of a facial asymmetry, which together with the uterine and vaginal agenesis, obviously enhances the depression of the patient during her puberty and adolescence in connection to whether her image as a female exists in the social environment, family, and in relation to her future.

Within the MRKH syndrome, the ovaries and Fallopian tubes have a normal morphophysiology, and the secondary sexual characters are present.

In fact, the external genitalia, the development of breast, pubic and head hair, respectively the value of female gonadotropin are normal.

The uterus aplasia determines primary amenorrhea (reason for the patient going to a doctor) and infertility, and the vaginal aplasia renders impossible to have intercourse.

Fig. 2 - Pre-sternal scar, post cardiotomy for cardiac malformation
The existence of a “uterus leftover” determines cyclical abdominal pain, the intensity being reported to it.

The relaxation of the narrow vaginal caliber or of the vaginal stenosis is painful and long lasting, and some of them determines, at times, impossibility of favorable relaxation and thus, the penile-vaginal intercourse cannot unfold.

**Case study**

Patient aged 21 required gynecologic consult for vaginal bleeding that appeared after intercourse. Given that until 16 years she had no menstruation, she went for a checkup. After a specialty consult, the MRKH syndrome was diagnosed to the patient, which involved uterine agenesis, it being responsible for primary amenorrhea and agenesis of the upper part of the vagina (fig. 1). When examining the patient, the next matters were found:

- Minor facial asymmetry;
- Flattened sternum, with a long scar resulting from surgery (fig. 2), following a surgery performed for a heart defect;
- Frontal deformation of the dorsolumbar spine, with a moderate primary curve to the right and two adjacent compensation curves;
- Bilateral mammary glands with normal appearance;
- Gynecology examination: mons pubis covered with hair; under the tegument, adipose tissue can be found; labia majora are hypotrophic, they can be separated and seen with difficulty; labia minora are hypertrophic (fig. 3a, b) and stretch from the base of the clitoris obliquely down.

On the right labia minor, on the median side and towards the clitoris region, slightly bleeding tears were seen, which have been determined by the masturbation means used, as the patient reported.

The vaginal orifice (fig. 4) is oval and small in size, with fibrous edges and highly resistant. On the edges, in various spots, there are bleeding scars (fig. 4), which give the impression of profoundness right next to the hymeneal caruncle. The rigidity of the vaginal introitus renders difficult the penetration of the vaginal cavity by the use of valve speculum. The vaginal fornix can be seen through the vaginal orifice;

The vagina, which is present in the lower part, above the vaginal orifice, is 5cm in length. The vaginal walls have strictures and stenoses, which alter the vagina caliber. Bleeding lesions can be seen on the vaginal walls next to the scarred stenosis. The observed stenoses, scars and muscle structure modifications decrease the elasticity of the tissues;

The upper side of the vagina (its end) is an arch given the lack of cervix and obviously, of the Douglas pouch. Instead of the uterus, which misses given its agenesis, there are 2 uterine leftovers of 1/1.3 mm, without any cavity, located asymmetrically on one side and the other of the median line between the rectum and the bladder.

The Fallopian tubes and the ovaries are normal and located in the pelvic region;
- Unilateral renal agenesis (left kidney);
- Heart defect – surgery performed.

**Discussions**

The labia minora come from the urogenital folds and are separated; the labia majora come from the labioscrotal folds. The labia develop while the specific hormones lack. Given that the morphophysiological differences between the 2 types of labia are obvious (labia major are hypotrophic, difficult to notice, and the labia minora are hypertrophic and greatly surpass the labia majora), one can deem that this abnormality also represents a birth defect ancillary to the MRKH syndrome, with a different morphofunctional significance. The labia minora, which are over
developed (fig. 3a, b), spread from the base of the clitoris down, and have direct neurovascular and anatomical ties to the clitoris, by the clitoral hood, thus making up an important eroticism area. This is the explanation of the fact that any manual maneuver on that area, as in the case presented, induces strong sexual arousal, easily leading to 1-2 orgasms, fellatio and penile-anal intercourse being preferred and rarer the penile-vaginal intercourse, which is uncomfortable and painful to the patient.

On the surface of labia minor, special tactile corpuscles are found, which determine a high erotic sensation, the pain perceived being much more reduced, given that endorphins are discharged.

The sebaceous, sudoriferous and small vestibular glands, which are very numerous on the mucosa of labia minora, together with
the secretion of the ancillary glands, which spill into the vaginal vestibule, lubricate the surface of the labia and vaginal introitus, thus favoring not only penetration, but also completion of intercourse in the case presented. Given the content of female pheromones of the patient, inducing the state of sexual attraction is determined, as well as increasing the excitation state and erection of the partner. Thus, the strong tone of the penis determined the vulvovaginal lesions described above.

The labia minora, as well as the lower third of the vagina, which has a higher bio excitability by comparison to the upper two thirds of the vagina, benefits of the direct connection to all its surrounding erogenous areas (please refer to Hyper-eroticism area –Treaty of Clinical Sexology), thus offering enhanced erectile traits, present in the patient as well, as reported by her.
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Conclusions

The high number of sebaceous, sudoriferous and small vestibular glands, by the mucus they discharge, as well as the large vestibular ancillary glands, which open into the vulva, by lubricating the surface of the labia and vaginal introitus have allowed the vaginal orifice to be penetrated with difficulty and caused the bleeding lesions. On the vagina level, its penetration and the copulatory movements have determined bleeding tears on the relaxed muscle fibers, by stretching the walls of the vagina affected by hypoplasia, by affecting the stenoses and scars and by recalibrating the defective vagina.

The pain and the bleeding tears, weakly perceived during sexual arousal, due to the endorphins discharged, were perceived as such following orgasm and ejaculation and as consequence, the patient rushed into the emergency room, where she was admitted for hemostasis and analgesic treatment.
Clinical, ethic-legal and neuro-psychic repercussions of female genital mutilation in 21st century, in Europe. The legitimacy of tradition and the fight against extreme forms of discrimination

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Abstract:

This paper raises the issue of non-medical genital mutilation acts conducted on various individuals before marriage, carried out nowadays, in the 21st century, also in Europe (Belgium, France, England), as well as in Canada, Asia, Australia, New Zealand, USA too, due to immigrants coming from countries where genital mutilation is performed in 98% of women. For African countries, although in the constitution of Somalia - genital mutilation of women is not permitted, or declared forbidden (e.g. in Egypt), genital mutilation is frequently performed.

The evolution of the morpho-functional perfection of the human brain and body adds to the quality of sexual intercourse between males and females. Following mutilation, the capacity of external genital organs is removed for life, as is the protection of the biological future of the females in question.

The types of non-medical mutilation of the external genital organs of girls may be singular (partial or total clitoridectomy, excision of small labia and their suture) or complex and combined, causing very serious immediate complications (the latest case referred to by the press in July 2018 – in Somalia, where a 10-year-old girl was taken by her mother to have her traditionally circumcised, with the mutilation of the genital organs causing a haemorrhagic shock leading to her death).

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Immigrants respect their ethnic and religious traditions, including the ritual of female genital mutilation at puberty (on 14-15 years old girls) or in their teenage years. Upon marrying people from the country of adoption, women adopt the religion and traditions of their partner, as well as the non-medical mutilation of their daughter.

According to Beatrice Ioan and collaborators, the occurrence of genital mutilation has been on the rise, which indicates that the communities of refugees from Somalia, Yemen to Great Britain, circa 10,000 children are at the risk of genital mutilation, as a result of their parents conferring them identity as per tradition.

I emphasize the fact that immigrants comprise a social group bringing also their epidemiological pathology into the country of adoption, such as transmissible diseases characteristic of the place of origin.

**Key words:**

mutilation, female, external genital organs, tradition, brain.

**Background**

Originally, sexual intercourse was performed strictly for procreation purposes. Afterwards, the practice of mutilation attested before Christ, based on various motivations and performed as part of specific rituals, emerged. In principle, mutilation aims at preserving the “chastity belt”, preventing sexual intercourse from taking place before marriage. This should, however, not allow to cause their child to be damaged for life, let alone in the 21st century.

In the 19th century, clitoridectomy was also recommended for the treatment of nymphomania, epilepsy, hysteria or the prevention of masturbation, a practice with a different connotation in the 21st century.

I underline that in this case I do not mean acts of violence committed during the criminal forced sexual intercourse (rape) or acts of sadism, where investigation authorities are always notified, thus leading to a solution, but to practices of genital mutilation carried out in the context of “traditional or religious customs”, under insubstantial conditions and with rudimentary and improvised non-medical devices, by people with no medical training.

In this case, based on the justification that “their mother, their sister, and grandmother also underwent mutilation according to tradition”, the subjects feel offended that a notification of the relevant authorities is required, in absence of which this criminal act will not be eradicated even in the 21st century.

The mutilation of the external genital organs in a woman consists in the partial or total removal of the genitals, or the conduct of other injuries performed without medical indication. It was also called “feminine circumcision,” an improper and confusing term, which has nothing to do with the circumcision of the penis, which is why in 2017, the English called it “female genital cutting” (in 2017).
Method

Based on the analysis of the complex effects of the mutilation of genital organs, which the World Health Organization (WHO) divided into four types, we found the following:

**TYPE 1: Removal of the foreskin (clitoral hood) and of a part of the clitoris**

a) an odd, median organ, the clitoris is located at the anterior commissure of the vulva, between the labia majora and labia minora. It is one of the important erectile organs of the vulva, which, through its connection with the neighbouring erogenous areas, directly participates in the creation of the woman’s erotic feeling, enhancing her state of excitation.

During the excitation phase, the size of the gland can double, but after the partial clitoridectomy this does no longer occur.

The sensation from the gland receptors no longer reaches the medullary ascending pathways, or the brain, respectively, with the clitoris represented only by the remaining part of the clitoral body and the “roots of the clitoris “;

b) The urinary tract lies posteriorly and it may be involved in the empirical section, and the lesions may be responsible for the secondary frequent urinary pathology in the case of mutilation.

Normally, the increased influx of blood from the cavernous structures delimited by the albuginea, a slightly expandable membrane that increases local congestion, increases the erectile sensitivity and tactile corpuscles (which, after mutilation, remain in part) preparing the genital organs for copulation, ejaculation and orgasm.

The body covered by the clitoral fascia is hidden between the labia (Fig.1). When touching the clitoris during the copulatory movements the woman’s excitability increases, thus participating in the ejaculation and orgasm.

While normal clitoral vasoconstriction occurs within 3-5 seconds, or later in the case of older females, where clitoris ablation is no longer the case, clitoris ablation leads to its non-existence, as mutilation is a decisive factor of anorgasmia.

In comparative anatomy terms, the clitoris is the counterpart of the penis and, therefore, the erectile structures of the clitoris are considered to resemble the cavernous body of the penis. Thus, physiologically speaking, if a male’s first response to a sexually arousing factor leads to penile erection and discharge of a translucent liquid through the urethra, both required for the penetration of the vagina, in the case of females, the erection of the clitoris and the lubrication of the vagina normally occurring in 20 to 30 seconds, are no longer the case, in which context sexual intercourse becomes painful and unwanted.

The longer the clitoris, the more increased the excitation surface and the stronger the erotic state.

**TYPE 2: Clitoridectomy with the partial or total excision of labia minora, with their proximity and suturing until scarring.**

The labia minora, together with the labia majora, through the medial faces, delimit the vaginal vestibule where the corpuscles are found, which, when touched, especially when the mucosal surfaces are touched, trigger the erotic sensation of the woman.

On the labia minora, besides the special tactile corpuscles (of voluptuousness), there are other receptors (Meissner, Krause, Vater-Pacini and Carrard), smooth muscle fibres and a well-developed vascular-nervous system that provides erectile qualities, but also abusive bleeding in case of mutilation.

Accessory glands, large and small, on the labial mucosa are numerous. These glands drain the contents into the vulva, lubricate the surface of the vulva and the vaginal introitus,
offering the possibility to penetrate the vagina easily. The content of pheromones induces and increases the libido, the excitability and the penile tone of the partner.

The sectioning and suturing of the base of the labia minora no longer allow the normal discharge of the urinary jet and menstrual blood, which is why a small drainage hole is made. So practically there is no total suture of the labia minora.

The obstruction of the vaginal introitus will no longer allow the examination of the vagina and cervix, and the screening for cervical cancer can no longer be carried out, this form of mutilation causing further damage to woman’s health, including precancerous or cancer-induced lesions of the cervix, the second most frequent type of cancer after the breast cancer.

TYPE 3: The infibulation or pharaonic circumcision

It is the most mutilative procedure. Complex and with the greatest complications, it consists of clitoridectomy, the sectioning of the labia minora, the inner part of the labia majora with the suturing of the edges of the wound created. The bleeding is very high, the mutilation of the genital organs often resulting in death or serious complications. The mutilating effects remain for life.

The closure of the vulva no longer allows the penile-vaginal sexual intercourse, but there is the possibility of performing the penile-anal intercourse or the fellatio.

TYPE 4: Different types of cuts, perforations or other vulvar-vaginal lesions, the application and/or introduction of corrosive substances into the vulva and vagina.

Ethical and legal aspects:

These cases are worrisome, because not only do the individuals subjected to mutilation not file complaints with the courts, but they are also offended when the competent bodies request them to do so. The explanation is that “my mother and grandmother performed the mutilation procedure”.

Fig. 1 - The anatomy of the female external genitalia (sketch from Treaty of Clinical Sexology)
The performance of mutilation in front of community members by using empirical means, where the father approves of the girl/teenage girl being mutilated, thus endangering her life for the alleged purpose of safeguarding her virginity is an irresponsible and incomprehensible act for the 21st century. When the girl resists mutilation, thus breaching community principles, she is severely punished, her face and body cut and mutilated against her will, subjected to the action of corrosive substances, to rape and even murder.

The physiological pubertal and adolescent periods determine the secondary sexual characteristics with complex manifestations that mark the transition from child to adult life, namely the sexual maturity and human procreation. The mutilation during this period, namely the destruction of the insufficiently developed genital organs, causes irreparable disorders in the physiology of the person.

The mutilation of a person’s genital organs destroys the possibility of representing their functionality in the brain, causing severe neuro-psychic injuries, an infirmity that will remain until the end of life.

Mutilation is an act of abuse on the part of the family (who is paid money by the future husband) and of society, applying the structures of its own morality.

The decision to mutilate a girl is based on the decision of her family, who does not take into account the medical considerations imposed by the law of the country of residence.

Mutilation is a gross violation of women’s rights through a primitive method of removing external genital organs. The mutilation act takes place in front of the tribe, men and women alike, where the agent opens the woman’s vagina by using 3 fingers, or where the perineum is cut by way of a rudimentary knife. Afterwards, the woman is sexually raped by young men, the action exceeding the boundaries of morality and humanity, a criminal act after all.

Discussions:

- The change in the topography and structure of the external genital organs by mutilation remains for life, and the sexual life can only begin after a new surgery.
- In the long run, the pathology of genital sphere is complex, especially for the sexual intercourse, pregnancy and childbirth.
- During the excitation period, the clitoris can no longer increase/double after the partial or total clitoridectomy, reducing the state of excitation.
- By clitoridectomy, the sensation of the receptors is no longer transmitted through the medullary ascending pathways to the brain. The sensitivity of the clitoris also disappears, as the person loses the most important centre of sexual sensitivity, thus causing a disability to occur.
- The clitoral gland is not touched in the copulation, and so this form of excitation disappears; ejaculation and orgasm occur harder.
- The erection of the clitoris and lubrication of the vagina, which normally occur in 20-30 seconds, no longer occur, bringing major drawbacks to copulation, the sexual intercourse being painful.
- The excision of labia minora removes the sensory elements that give the erotic sensation of the person, and the disappearance of the small and large vestibular glands, that lubricate the vulva and the vaginal introitus, causes major negative effects of the penetration of the vaginal introitus and copulation for life.
- The excision of the labia minora removes the heat and pain receptors, the special tactile corpuscles, the pheromone secretion, the smooth muscle fibres and the vascular-nervous system,
destroying the erectile qualities of the area, unrecoverable over time.

- The absence of pheromones has a negative effect on the libido, on the partner’s arousal and erection. This will no longer be represented in the brain either, because the medullary ascending pathways no longer transmit anything by lack of receptors.

- The adhesion of the labia minora prevents the discharge of the vaginal content, which is difficult. The vaginal cavity can no longer be penetrated to perform the cervical screening and detect the precancerous lesions, decreasing the woman’s average life. Cervical cancer is the second most frequent type of cancer, after the breast cancer.

- The removal of the normal morpho-functional organs brings immediate and long-term repercussions.

**Consequences**

- **Immediate:** haemorrhage, haemorrhagic shock, urinary disorders, infections that may lead to septicaemia

- **Long term:** local morpho-physiological modification, complications in pregnancy and post-partum period, infertility, neuropsychiatric complications (nightmares, fear of having a sexual intercourse, pregnancy or childbirth, anxiety, depression).

- The memory of the tragic moments (the operation is performed entirely without any anaesthetics) and the psycho-social impact will last for a lifetime. The brain will keep the memory of the external genital organs now non-existent, as a “false presence” associated with the “Phantom Organ Pain Syndrome” triggered by emotional pain. Such “pain”, however, is different from that of the surgical wound pain – as confirmed by African students at the Bucharest Faculty of Medicine.

- The brain will no longer receive normal structural values along the genetic evolution of the body because those organs no longer exist. Nature has selected the values of a performing sexual intercourse in procreation. By mutilation these values are destroyed under various motivations.

- The connection between pleasure and sexuality disappears by destroying the decisive formations.

- Rudimentary, non-sterile devices are used for the mutilation, no anaesthesia is made - the procedure is very painful. There is no asepsis and antisepsis.

- Mutilation is opposed to scientifically-based medical data.

In this case, through the absence of receptors, with the removal of the external genital organs, the brain no longer receives specific information for a normal sexual intercourse, and the infirmity causes major harm to the female’s sexual life entirely, including during gestation, childbirth and post-partum.

In fact, the cerebral cortex receives sensory input through the internal granular layer cells, which make contact with the nerve impulses from the receptors of the genitals organs, through exogenous sensory and endogenous sensory stimuli, setting the sexual behaviour of the individual, depending on its biological potential and psychosocial environment. Bioelectrical impulses are the result of information processing by neuronal cell receptors, that lead the information received for processing to the external granular layer of the pyramidal cells, transmitting information to the cortical and subcortical areas. The glutaminergic predominantly pyramidal cells, are in fact neurons modulated by the impulses of the direct or interneuronal related pathways. Neuropeptides in the cerebral cortex (the most important, the dopamine, serotonin, norepinephrine) according to Mesulam (2004) and Lynch (2006), quoted by Leon Dănăilă, influence both neurons and lo-
Sexual behaviour is normally set by the brain, which regulates sex hormone values. As a consequence, the increase in the serum ratio of these hormones, which reach the brain, where they cross the blood-brain barrier, reaches the intracytoplasmic and intranuclear receptors of neurons in the cortex, the limbic system, the hypothalamus (fig. 2), where the mechanism of negative feedback reduces the concentration of serum sex hormones, thereby causing the normal, or abnormal, behaviour of the individual.

The excitability of brain neurons is prevented by the absence of receptors in the mutilated organs.

**Conclusions**

- the non-medical mutilation of female external genital organs, which causes a serious infirmity and inferiority to women, remains an issue subject to public debate, as in the 21st century there is no motivation for dialogue between the Governments of those States, the international institutions and specialists in medicine, biology, genetics, forensics.

- It is my opinion that it is necessary to eradicate the prehistoric non-medical principles and to preserve the structure of the performing values of the human body.

- the mutilation of female genital organs reduces the genetically acquired superior nervous system capacity resulting from evolution, causing the destruction of processes of the human psychic, thus leading to the degradation of women.

- the mutilation of female genital organs for non-medical reasons and therefore lacking scientific justification, is at the basis of this paper and casts a negative light on some countries’ Governments claiming that “mutilation is forbidden,” at the same time allowing this “traditional practice” to be performed in the case of 94-98% of girls.
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