1 Center for Disaster Philanthropy. Refugees, asylum seekers and the US. July 9, 2024. https://disasterphilanthropy.org/disasters/refugees-asylum-seekers-and-the-us/ (accessed Oct 1, 2024).
2 Ward N, Batalova J. Refugees and asylees in the United States. June 15, 2023. https://www.migrationpolicy.org/article/refugees-and-asylees-united-states-2022 (accessed Oct 28, 2024).
3 Wu VK, Poenaru D. Burden of surgically correctable disabilities among children in the Dadaab Refugee Camp. *World J Surg* 2013; **37:** 1536–43.
4 Rfat M, Zeng Y, Yang Y, Adhikari K, Zhu Y. A scoping review of needs and barriers to achieving a livable life among refugees with disabilities: implications for future research, practice, and policy. *J Evid Based Soc Work* 2023; **20:** 373–403.
5 Mirza M, Trimboli C, Hartman J, et al. Examining barriers to rehabilitation and addressing rehabilitation needs among persons with forced migration experiences: interdisciplinary perspectives. *Arch Phys Med Rehabil* 2024; **105:** 1793–1806.
6 Naqui Q, Arastu N. Standing on our own two feet: disability justice as a frame for reimagining our ableist immigration system. *UCLA Law Rev* 2024; **71:** 236–314.

See Online for appendix

Problems in defining medicalised FGM and proposed solutions

WHO defines female genital mutilation (FGM) as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” and medicalised FGM as “situations in which FGM is practiced by any category of health-care provider, whether in a public or private clinic, at home, or elsewhere”.[1] Female genital cosmetic surgery (FGCS)—including the most common form, labiaplasty—similarly involves partial or total removal of the external female genitalia for non-medical (ie, aesthetic) reasons and is practiced by a health-care provider, usually a medical doctor, in a public or private clinic.

In other words, the distinction between FGCS and medicalised FGM is unclear.[2] In practice, the term medicalised FGM is applied exclusively to practices primarily performed by people of colour in countries in the Global South (such as in parts of Africa, the Middle East, and south and southeast Asia), and excludes anatomically comparable practices in countries in the Global North (such as in Europe or North America),[2] raising concerns about discrimination and double standards.

It will be objected that, in practice, medicalised FGM is performed on underage girls[3] and that FGCS is agreed to by consenting adults. We agree this is a crucial moral distinction, and we include it in our proposed ethical framework below. However, WHO’s definition of FGM, whether medicalised or unmedicalised, makes no mention of consent, and so conflates voluntary procedures chosen by adults with those forced on children (appendix). Moreover, in the USA, up to 20% of labiaplasties (ie, FGCS) between 2016 and 2019 were performed not on adults, but on legal minors.[4] Medically unnecessary surgeries to normalise the genitals of babies with intersex traits, including clitoral-reduction procedures, are also commonly performed in Global North countries, entirely without the consent of the individual.[5] Finally, virtually all groups that practise vulval cutting as part of a rite of passage (ie, FGM), also practise cutting of the penis or foreskin of boys of a similar age—in both cases often constituting the very ritual that confers adult status on the initiate.[6] If age or consent matters, it should matter for everyone.

Another objection holds that FGCS, unlike FGM, can be conducted for medical reasons—for example, to relieve psychological distress. Problems with this objection, and other shortcomings of the WHO definition, are outlined in the appendix. To address these issues, we propose a clear ethical standard that does not discriminate based on cultural origin, sex, or gender.[5] We define unethical genital modification as all procedures that involve partial or total removal of a person’s genitalia, or other injury to a person’s genital organs, that are medically unnecessary and done without the informed consent of the affected individual (the terms medically unnecessary and informed consent are defined and elaborated upon in the appendix).

We declare no competing interests.

*Arianne Shahvisi, Jasmine Abdulcadir, Mireia Garcés de Marcilla, Tammary Chepkoech Rotich, *Brian D Earp*
bdearp@nus.edu.sg

Brighton and Sussex Medical School, Brighton, UK (AS); Geneva University Hospitals, Geneva, Switzerland (JA); Law School, University of Exeter, Exeter, UK (MGdM); Amref International University, Nairobi, Kenya (TCR); Uehiro Centre for Practical Ethics, University of Oxford, Oxford, UK (BDE); Centre for Biomedical Ethics, Yong Loo Lin School of Medicine, National University of Singapore, Singapore 117597 (BDE)

1 WHO. Global strategy to stop health-care providers from performing female genital mutilation. May 28, 2010. https://www.who.int/publications/i/item/WHO-RHR-10.9 (accessed Sept 9, 2024).
2 Van Eekert N, Barrett H, Kimani S, Hidayana I, Leye E. Rethinking the definition of medicalized female genital mutilation/cutting. *Arch Sex Behav* 2024; **53:** 441–53.
3 The Lancet. Medicalised female genital mutilation must stop. *Lancet* 2024; **404:** 405.
4 Luchristt D, Sheyn D, Bretschneider CE. National estimates of labiaplasty performance in the United States from 2016 to 2019. *Obstet Gynecol* 2022; **140:** 271–74.
5 Brussels Collaboration on Bodily Integrity. Genital modifications in prepubescent minors: when may clinicians ethically proceed? *Am J Bioeth* 2024; **17:** 1–50.
6 Public Policy Advisory Network on Female Genital Surgeries in Africa. Seven things to know about female genital surgeries in Africa. *Hastings Cent Rep* 2012; **42:** 19–27.

Nakalanga syndrome and hypopituitarism

In relation to the Review on hypopituitarism by Maria Fleseriu and colleagues,[1] we would like to raise awareness about Nakalanga syndrome, a poorly understood condition most likely caused by hypopituitarism. This syndrome was first described in the late 1950s among the inhabitants of Mabira Forest, an onchocerciasis-endemic area in south-eastern Uganda.[2] This syndrome is characterised by emaciation, stunted