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Female Genital Cosmetic Surgery

This policy statement has been prepared by the Clinical Practice Gynaecology Committee and the Ethics Committee, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To provide Canadian gynaecologists with evidence-based direction for female genital cosmetic surgery in response to increasing requests for, and availability of, vaginal and vulvar surgeries that fall well outside the traditional realm of medically-indicated reconstructions.

Evidence: Published literature was retrieved through searches of PubMed or MEDLINE, CINAHL, and The Cochrane Library in 2011 and 2012 using appropriate controlled vocabulary and key words (female genital cosmetic surgery). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to May 2012. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

Values: The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table).

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Key Words: female genital cosmetic surgery, vulvo-vaginal, labioplasty, clitoral hood size reduction, perineoplasty, vaginoplasty, hymenoplasty, G-spot augmentation

Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.[19]

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.[19]

Recommendations

1. The obstetrician and gynaecologist should play an important role in helping women to understand their anatomy and to respect individual variations. (III-A)
2. For women who present with requests for vaginal cosmetic procedures, a complete medical, sexual, and gynaecologic history should be obtained and the absence of any major sexual or psychological dysfunction should be ascertained. Any possibility of coercion or exploitation should be ruled out. (III-B)
3. Counselling should be a priority for women requesting female genital cosmetic surgery. Topics should include normal variation and physiological changes over the lifespan, as well as the possibility of unintended consequences of cosmetic surgery to the genital area. The lack of evidence regarding outcomes and the lack of data on the impact of subsequent changes during pregnancy or menopause should also be discussed and considered part of the informed consent process. (III-L)
4. There is little evidence to support any of the female genital cosmetic surgeries in terms of improvement to sexual satisfaction or self-image. Physicians choosing to proceed with these cosmetic procedures should not promote these surgeries for the enhancement of sexual function and advertising of female genital cosmetic surgical procedures should be avoided (III-L)
5. Physicians who see adolescents requesting female genital cosmetic surgery require additional expertise in counselling adolescents. Such procedures should not be offered until complete maturity including genital maturity, and parental consent is not required at that time. (III-L)
6. Non-medical terms, including but not restricted to vaginal rejuvenation, clitoral resurfacing, and G-spot enhancement, should be recognized as marketing terms only, with no medical origin; therefore they cannot be scientifically evaluated. (III-L)

ABBREVIATIONS

ACOG	American College of Obstetricians and Gynaecologists
FGCS	female genital cosmetic surgery
FGM	female genital mutilation

INTRODUCTION

In recent years we have seen an increase in female genital cosmetic surgery procedures available to women. This policy statement is intended to provide Canadian gynaecologists with evidence-based direction for cosmetic vaginal and vulvar surgeries that fall well outside the traditional realm of medically-indicated reconstructions.

A variety of procedures have been proposed to improve genital appearance or performance including labioplasty of the labia minora or majora, clitoral hood size reduction, perineoplasty, vaginoplasty, hymenoplasty, and G-spot augmentation.[1–5] These procedures may be performed alone or in combination, for example the combination of vaginoplasty and perineoplasty has become known as "vaginal rejuvenation."[1–5]

A confusing array of terms and expectations are associated with these many FGCS procedures, all of which purport to improve upon the appearance and/or function of a woman's genitalia or her sexual satisfaction. Evidence is currently lacking for the safety and efficacy of FGCS procedures, most of which have no clearly accepted or consistent definitions. A comprehensive review by Braun thoughtfully explores all aspects of this topic.[6] Concerns