Should gynecologists provide cosmetic labiaplasty procedures?

THE ISSUE: Women are seeking cosmetic gynecologic procedures in increasing numbers. Position papers from societies often discourage the gynecologist's participation in these procedures, while the surgical training and experience in the anatomic region would support that the gynecologist is the best-trained person to perform these procedures. Although efficacy and safety data are emerging, the majority of data are composed of noncomparative studies without validated outcomes measures. This debate addresses the topic of the gynecologist's role in providing cosmetic labiaplasty.

Contributed by Charles R. Rardin, MD, Department of Obstetrics and Gynecology, Women & Infant's Hospital, Brown University, Providence, RI.

We are the correct physicians to treat women requesting labiaplasty

Rachel N. Pauls, MD

Division of Urogynecology and Reconstructive Pelvic Surgery, Women's Center for Specialized Care, TriHealth Good Samaritan Hospital, Cincinnati, OH

Patient requests for labial reduction (labiaplasty) are on the rise.[1] Cultural shifts in pubic hair grooming (80% of today's women performing some or all pubic hair removal)[2] and greater visibility of the vulva (widespread access to images through media and Internet),[3,4] as well as increasing attention to sexual well-being, have fostered this demand. While the natural contours of the labia minora vary in symmetry, length, and width,[5] in our society small, nonprotruding, symmetrical structures are described as "normal" by the majority of women.[6-8]

Gynecologists care for women. We are their physicians from young adulthood through and beyond the menopausal transition. We are pelvic specialists, and the appropriate provider to address, but not promote, labiaplasty. Though we may not view ourselves as cosmetic surgeons, such requests may not be driven by appearance alone.

The principles of medical ethics dictate consideration of *autonomy*, *nonmaleficence*, *beneficence*, and *justice* when treating patients.[9,10] *Autonomy* states that an adult person without mental impairment has the final decision with regard to medical procedures received, provided there is not external influence for their choice, such as coercion, and

(*continued*)

The authors report no conflict of interest.

http://dx.doi.org/10.1016/j.ajog.2014.06.019

Most women who undergo labiaplasty have normal anatomy; we should not perform labiaplasty

Rebecca G. Rogers, MD

Departments of Obstetrics and Gynecology and Surgery, Division of Urogynecology, University of New Mexico Health Sciences Center, Albuquerque, NM

Modification of the external genitalia has become one of the top-20 most frequently performed cosmetic surgeries.[1] Increased demand for labiaplasty has been attributed to increased visibility of the vulva with shaving or waxing, access to pornographic images of the external genitalia, and advertising in the media. Of 482 women surveyed in a gynecologic practice, 78% found out about labial reduction through the media, and 14% believed that their vulva was abnormal in appearance. Increasingly, women are examining their external genitalia, with over half of women examining their vulva at least monthly. Thankfully, most women think that their vulva is normal and are satisfied with its appearance. Nonetheless, approximately 10% of women in one survey considered undergoing vulvar cosmetic surgery.[2]

The increased demand for vulvar surgery is spurred by the belief that the vulva is abnormal in appearance. What is normal in terms of labial anatomy? We know from limited studies as well as clinical experience that there are wide variations in labial size, symmetry, and coloration.[3] Proponents of labiaplasty aim to create labia that are symmetrical, small, and hidden by the labia majora; characteristics that are shared with prepubescent girls.[4] In fact, in adult women, complete labial symmetry is not common, and the labia minora commonly protrude outside the labia majora. Proponents of labiaplasty state that the procedure improves sexual function and body image,

(*continued*)

Dr Pauls (*continued*)

they are not experiencing body dysmorphic disorder.[10,11] Thus, understanding the rationale behind the woman's choice is critical. Nevertheless, the majority of these patients cite functional alone or a combination of functional and aesthetic motivators.[12,13] Prominent reports include difficulty grooming, discomfort with sports and exercise, and problems with intercourse.[14] Women who believe their labia are abnormal often avoid wearing certain clothing or bathing suits. Comments from these women include: "I am fed up of being embarrassed about my body. It prevents me having a sex life"; "I don't feel confident in changing rooms…"; and "the pain when I exercise and just walking can be awful."[3] Resultant low body image and feelings of self-consciousness may impact quality of life and mental well-being, as well as lead to sexual dysfunction.[15-17]

The second principle of medical ethics is *nonmaleficence*, or "first do no harm." Anatomic studies suggest the labia are innervated along their edge, and bear an erectile core.[18,19] However, ability to achieve orgasm from stimulation of these areas is not robust,[20] nor have these studies assessed the role of the labia minora in the sexual response of women seeking labiaplasty. Furthermore, satisfaction following these surgeries is overwhelmingly high, at 90-100%.[14,21-30] Additionally reassuring is the low risk (2-6%) of complications, with most being minor.[31] These rates are far lower than those reported after breast augmentation and other widely accepted procedures.[32,33]

Beneficence dictates that medical providers act in the patients' best interest and be familiar with appropriate techniques. As gynecologists, we understand the anatomy, and operate on the vulva and vagina, and we should be comfortable doing these repairs. Several methods of performing labiaplasty have been described, with none deemed superior. Central wedge, linear resection, Z-plasty, or de-epithelialization have all been employed with good outcomes.[31]

Finally, *justice* states that these surgeries should not take resources from other medically necessary allocations, and patients should bear the costs of the procedure.[10]

We are dedicated to caring for our female patients. We can best educate about the wide range of size and symmetry to the labia, and advise regarding risks. Yet we are also cognizant that despite reassurance and meticulous counseling women may experience "…psychological distress, loss of self-esteem …and diminished libido" if their condition is not appropriately attended to,[34] and continue to seek repair.[5] In such situations, we should feel secure healing these women. Given reassuring outcomes and low complications from labiaplasty, it is possible to respect autonomy, while upholding nonmaleficence. ■

Dr Rogers (*continued*)

however, limited published data do not confirm improved sexual function in either the patient or her partner.[5,6] A review of labiaplasty Internet marketing found unsubstantiated claims for physical, psychological, and sexual benefits on most sites.[7] In reality, prospective comparative data using validated outcome measures are lacking regarding the safety and efficacy of labiaplasty.

The World Health Organization defines female genital mutilation surgery as procedures that involve the partial or total removal of external female genitalia for nonmedical reasons. Of course, female genital mutilation surgery is largely performed on nonconsenting children, and female cosmetic surgery is performed on consenting adults. Nonetheless, labiaplasty does fit the definition of nonmedically indicated removal of part of the external female genitalia. One wonders if the marketing of "ideal" labial appearance purporting to improve the lives of women is just another form of furthering exploiting the social vulnerability of women.

Proponents of labiaplasty most often quote the ethical principle of autonomy, stating that a woman has the right to choose or refuse treatment, including labiaplasty. Autonomy must be weighed against other important ethical principles including beneficence, nonmaleficence, and justice. "Beneficence" is defined as acting in the best interests of the patient; "nonmaleficence," that the physician should "first, do not harm"; and "justice," that we pay attention to the distribution of scarce resources. Our patients' trust is based on the principle of beneficence; patients are confident that there is no incentive, financial or otherwise, for their physician to perform a particular procedure. The fathers of medical ethics, John Gregory (1724 through 1773) and Thomas Percival (1740 through 1804) wrote "…surgeons should protect and promote the patient's health-related interests as their primary concern and keep their economic and other forms of self-interest systematically secondary." In addition, they wrote "…surgeons should not [act] as a merchant guild that exists to protect the economic, political and social interests of its privileged members."[8] Often accompanied by concurrent cosmetic surgeries such as labia major augmentation, G spot amplification, vaginal rejuvenation, hymenoplasty, or clitoral hood reductions, labiaplasty is nearly always performed on a fee-for-service basis that is costly for the patient and lucrative for those who offer these services.[9] In 2007, Dr Pauls wrote "What is unique to this area is the patented and secretive nature of some of the most marketed technologies and the large financial gain driving this industry."[10] Unfortunately, the widespread marketing of labiaplasty and other vulvar cosmetic surgeries undermines the principle of beneficence and calls into question the motivation underlying these practices.

The principle of nonmaleficence has not been met with the performance of labiaplasty. While a relatively minor procedure, the majority of publications regarding labiaplasty are either case series or expert opinion written by

REFERENCES

1. Crouch NS, Deans R, Michala L, et al. Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG 2011;118:1507-10.