

## Nonsurgical Vaginal Rejuvenation



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### KEYWORDS

- Vaginal rejuvenation
- Vaginal relaxation syndrome
- Genitourinary syndrome of menopause
- Vulvovaginal atrophy
- Laser
- Radiofrequency
- Urinary incontinence

### KEY POINTS

- In the past 5 to 10 years, a surge of interest in female intimate wellness, specifically vaginal rejuvenation, both surgical and nonsurgical, has been witnessed.
- For both cosmetic and functional reasons, increasing numbers of women have sought alternatives to traditional therapies for dealing with the common but unwelcome changes that occur to the vaginal and vulvar tissues induced by maternity, weight fluctuation, hormonal change (sometimes following cancer care), natural aging, and menopause.
- Traditional nonsurgical options of improving vaginal well-being for the premenopausal as well as postmenopausal woman have proven to have limited long-term benefit, and therefore, patient compliance with these methods can be poor.
- Not only do many of the conditions and symptoms of vaginal relaxation syndrome and genitourinary syndrome of menopause and its associated symptoms of vulvovaginal atrophy affect female intimate wellness over time, affecting quality of life, self-esteem, and the quality of interpersonal relationships, but also these conditions, if left untreated, tend to worsen with age.
- In order to offer patients the most effective and up-to-date therapies, the treatment approach should be individualized, and each practitioner should have a thorough breadth of knowledge regarding the cause of the conditions patients present with as well as a thorough understanding of technology that now exists to treat these issues.

Nearly 5 decades ago, gynecologists and plastic surgeons pioneered the integration of lasers for the ablation of diseased tissue by vaporization, ablation, and tissue contraction [1,2]. Since then, a host of energy-based devices have emerged to treat pelvic pathologic condition, improve fertility, and rejuvenate skin of the face and body. Current fractional (carbon dioxide [CO<sub>2</sub>] and erbium:YAG) and hybrid laser-based technologies, nonablative and resurfacing radiofrequency (RF) technologies, and even a novel electromagnetic therapy device may now be used to treat patients dealing with genitourinary syndrome of menopause or vulvovaginal atrophy (GSM/VVA) and

vaginal relaxation syndrome (VRS) symptoms as well as their frequently associated symptom complexes of sexual dysfunction, urinary incontinence (UI), and even true skin disorders, such as lichen sclerosis.

### INTRODUCTION

The American Society for Aesthetic Plastic Surgery procedural statistics reported an increase of 23% in surgical labiaplasty procedures performed in 2016 by its members compared with 2015 (the first year for which such statistics were available). Thirty-five percent of plastic surgeons now perform surgical labiaplasty, and they

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performed more than 10,000 labiaplasty procedures last year [3]. This number does not include the number of surgical labiaplasties performed by gynecologists. Along with this newer area of surgical interest, there has also been a rapid growth in the number of treatment options for nonsurgical vaginal rejuvenation. Accordingly, more than half a million nonsurgical feminine rejuvenation procedures were performed in 2016, generating \$500 million in incremental fees for practitioners [4]. It is thus very important to catalog the most current and effective advances in this rapidly growing field of care of the female patient, so that treatment indications and efficacy remain at the forefront of procedures offered to patients by a variety of practitioners.

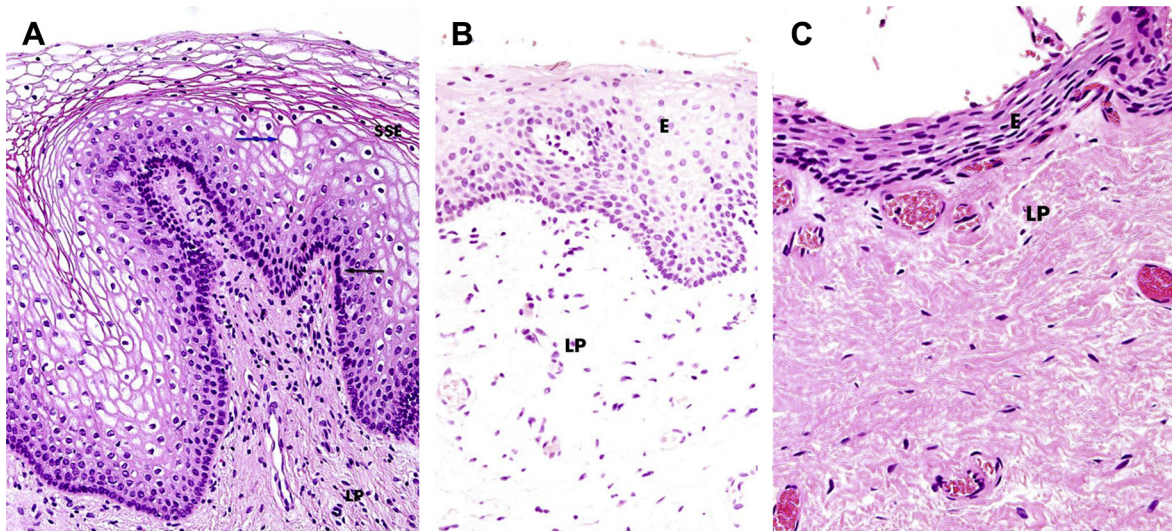
### PATHOPHYSIOLOGY

GSM or VVA represents a constellation of symptoms [5] that, although underreported, has been estimated to affect up to 50% of postmenopausal women [6] and affects quality of life [7,8] as a result of the natural decrease of estrogen levels after the onset of menopause (naturally or iatrogenic). Before menopause, with normal circulating levels of endogenous estrogen, vaginal canal physiology is characterized by the

presence of a thickened, rugated, nonkeratinized epithelial layer that is well vascularized and self-lubricated. As estrogen levels decline (or are deprived as in some patients with hormonally treated malignant conditions), the vaginal wall loses collagen and elastin and becomes thinner, there is a reduction in blood flow, and there is a changed quality and quantity of vaginal secretions. The epithelial surface becomes pale with loss of rugation, more friable with petechiae, and irritation and bleeding may occur after minimal trauma. There is a decrease in the normal epithelial cell metabolism due to loss of normal blood flow and decreased nutritive vaginal transudate, glycogen stores of healthy epithelial cells falls, leading to a reduction in the amount of protective lactobacilli content, which need glycogen to thrive. The latter leads to an increase in the normally acidic pH to a more alkaline state, and some of the protective function of the vaginal wall is lost, allowing the increased susceptibility to trauma, infection, vaginitis, lower urinary infections, and urogenital pain (Fig. 1) [5,9–11].

### CLINICAL TREATMENT INDICATIONS

The symptoms of GSM/VVA commonly include, but are not limited to, reductions in the diameter and elasticity



**FIG. 1** Histologic sections of the vaginal wall. (A) Normal. (B) Moderately atrophic. (C) Severely atrophic. (A) Estrogenized vaginal histology. The 2 upper layers of the vaginal wall are shown: stratified, squamous epithelium (SSE) and the lamina propria (LP). The stratified squamous epithelium is rich in glycogen (larger cells with abundant clear cytoplasm—blue arrow) and is nonkeratinizing. The basal cell layer (black arrow) consists of a single layer of columnar cells. (B) Moderately atrophied vagina: atrophy is shown by thinner epithelium (E) and loss of maturation (smaller cell size with less cytoplasm) on the surface. (C) Marked vaginal atrophy. (hematoxylin and eosin stain and  $\times 40$  magnification). (Courtesy of Ahinoam Lev-Sagie, MD, Hadassah-Hebrew University Medical Center Jerusalem, Israel; with permission.)

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