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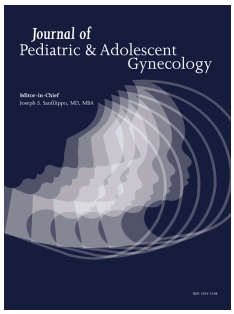

Surgical Decision Making in Pediatric and Adolescent Gynecology: Just because you can, doesn't mean you should

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Paula J Adams Hillard, MD

Surgical decision making is complex. It is among the most important things that we practice as surgeons, and among the most important skills that we teach our resident trainees. Surgical decision making involves considering many factors beyond whether the procedure can technically be performed. We also consider whether the evidence and our current state of knowledge provide sufficient information to indicate that a given procedure is the most appropriate one for our individual patient. Still, we need to ask, *should* the procedure be done. Searching PubMed for discussions of the coulds and the shoulds of surgical procedures, a number of references can be found, many with the conclusion that "Just because you can, doesn't mean you should."[1-3] Technically feasible procedures should not always be performed. Sometimes there just isn't yet sufficient evidence to justify the procedure, and sometimes, we may make the judgment that the procedure isn't the correct procedure for an individual patient. The decision-making process for an individual patient can be challenging, ethically. In weighing surgical recommendations, we consider the ethical principles of patient autonomy (and parental autonomy for our younger patients), beneficence, nonmaleficence, and distributive justice.

I have recently served a term on ACOG's Committee on Ethics, and the committee discussed principles related to a number of issues including patients' requests for elective surgery. Shared decision-making is a routine component of our interactions with our patients, but this is sometimes challenging. In recent years, many of us have seen adolescents with perfectly normal labia who have become convinced that their labia are "too large". These teens may have seen internet images promoting plastic surgical "labial beautification", or pornographic air-brushed images suggesting that there is a "normal" appearance, as opposed to the reality of the very wide range of normality celebrated by such online references as the Labia Library[4] and an article from Scarleteen[5]. ACOG's Committee Opinion on Breast and Labial Surgery in Adolescents from the Committee on Adolescent Health written with NASPAG Past President and JPAG Editorial Board Member Julie Strickland concludes that "labiaplasty in girls younger than 18 years should be considered only in those with significant congenital malformation, or persistent symptoms that the physician believes are caused directly by labial anatomy, or both."[6] The ACOG statement, and an even more strongly worded statement from the British Society for Paediatric and Adolescent Gynaecology, concluding "there is no scientific evidence to support the practice of labiaplasty and, for girls under the age of 18 years, the risk of harm is even more significant"[7], clearly support "just because you can, doesn't mean you should" with regard to surgical decision making around labial surgeries.

Those of us who provide gynecologic care for girls with complex and rare uterovaginal anomalies face the challenges of defining the individual patient's anatomy, reviewing the literature for possible surgical approaches and assessing the evidence supporting such approaches, explaining and translating this information to our typically young teen patient and her family, and assessing other factors that impact risks of surgery (such as co-morbidities). As