The Quest for the "Perfect" Vagina

Written by Cheryl B. Iglesia, MD; Sheryl Kingsberg, PhD

Given the growing popularity of plastic surgery for resculpting just about any part of the human body, perhaps it was inevitable that the trend would eventually encompass areas that few people—including the patient—ever see. As the line between functional and cosmetic surgery becomes more blurred, ObGyns are facing ethical dilemmas few could have foreseen.

Typical patient sexual concerns heard in the ObGyn's office include "I don't have the interest in sex that I used to have," "My body isn't what it used to be," and "Intercourse is uncomfortable and painful." According to the United Nations World Health Organization (WHO), it is the responsibility of the health care professional—in particular, the physicians who treat reproductive tract disorders—to manage patients' sexual health.[1] Approximately 44% of US women experience some form of sexual dysfunction, with the most common complaints being lack of sexual interest (38.7%), low arousal (26.1%), and difficulty achieving orgasm (20.5%).[2]

Added to the ObGyn's responsibility for managing patients' sexual health is the emerging concept of "sexual enhancement" surgery, which includes catering to the patient's quest for the "perfect" vagina and vulva. Now it is not uncommon to hear complaints such as "My lips are too big," or "My vagina is too loose." How did all this come about? Much of it is undoubtedly media-driven. Vaginas and vulvas have hit "prime time" network television thanks to *The Oprah Winfrey Show* and the writers on *Grey's Anatomy* coining the now-infamous term "va-jay-jay." Women's magazines may also do as much harm as good in terms of promoting women's self-esteem and body image. Whereas the articles offer simple "how-to's" for improving almost every

aspect of a woman's body and mind, the advertisements and models imply an impossible standard of beauty that most women cannot achieve. With specific regard to the genitalia, X- and R-rated

movies, "adult" cable channels, internet pornography, and traditional *Playboy* and *Penthouse* centerfolds feature close-ups of idealized female genitalia. In addition, advertisements for hair removal products and procedures target the genital area as well, again conveying the message that "natural" is not necessarily "chic."

What is the role of the physician in all of this? Is this sudden surge in vaginal/vulvar surgeries a result of physicians trying to "cash in" on the latest fads and earn money without the constraints of insurance reimbursement? Is this a way for ObGyns who have stopped practicing obstetrics due to exorbitant malpractice rates to fill up their practices and surgical schedule? On the other hand, it may be that the health care professional is also feeling the pressure to provide treatments to meet patients' demands—that is, elective cesarean delivery to avoid genital stretching or cosmetic surgery to correct such "damage."

Regardless of the causes, some women have become obsessed with the labia, vulva, and vagina, spawning one of the fastest growing areas of plastic surgery: vaginal rejuvenation procedures. According to the American Society for Aesthetic Plastic Surgery, nearly 11.7 million cosmetic surgical and nonsurgical procedures were performed in 2007.[3] Specifically, the American Society of Plastic Surgery reports the top 5 cosmetic procedures today are breast augmentation, rhinoplasty, liposuction, blepharoplasty, and abdominoplasty.[4] Vaginal rejuvenation surgery is the third fastest growing procedure, with 793 performed in 2005 and 1,030 in 2006. Notably, the figures continue to grow despite an extreme paucity of outcomes data.

The cosmetic vaginal procedures listed in Table 1 have been criticized by ACOG as "not medically indicated," noting that the safety and efficacy of these procedures have not been documented.[5] The costs of these procedures—which are usually not covered by medical insurance—range from $3,800 for laser hymenoplasty to $6,800 for laser reduction labioplasty and $8,400 for laser anterior colporrhaphy, posterior colporrhaphy, and perineoplasty.

Table 1. Cosmetic Vaginal Procedures

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Laser Vaginal Rejuvenation
Designer Laser Vaginoplasty
Revirgination with Laser Hymenoplasty
G-spot Amplification
Aesthetic Vulvar Liposculpting

Critics further cite the lack of data and unproven claims that these procedures can cure sexual dysfunction and stress incontinence without scarring, pain, or disfigurement that some liken to modern-age female genital mutilation. Others are

concerned with franchising or business models seeking to limit dissemination of proprietary information or scientific findings regarding these procedures.

Advocates of these procedures state they are providing a necessary service for women who have legitimate concerns about their bodies and the right to seek physical enhancement, even in the absence of dysfunction or disfigurement. For example, women with labial hypertrophy may experience both hygienic and sexual problems, and treatment is both safe and simple in the outpatient setting.[6] ObGyns who perform these procedures consider themselves the most qualified providers of cosmetic procedures due to their superior knowledge of the female genitalia and reproductive tract. Furthermore, the cash fee-for-service and "boutique" ambiance that can be created in the outpatient setting offer the potential for both provider and patient satisfaction.

It is probably safe to say that most women are able to give informed consent to the " top 5" cosmetic surgeries/procedures despite social and media pressures that cause them to question their own adequacy and body image—ie, what cup size is "normal," or what makes a nose attractive? However, given their lack of knowledge about their own genitals, are women being unduly manipulated into believing that they have deformed or dysfunctional vulvas and vaginas? Should ObGyns be spending less time reshaping the labia and more time educating women about the wide normal range of perineal size, shape, and function? A paper by Lloyd et al delineates the great variation in normal female genitalia (Table 2).[7]

Table 2. Normal Female Genital Measurement

Size	Means	Range
Clitoral length	19.1 mm	5-35 mm
Labia minora width	1.8 mm	7-50 mm
Perineum	31.3 mm	15-55 mm
Vaginal length	9.6 cm	6.5-12.5 cm

Understanding the wide range of genital morphology covered by the term "normal" may help women who have become obsessed with their genital appearance. As women's health advocates, ObGyns should first explore the reasons why a patient is seeking vulvoplasty and/or vaginoplasty before agreeing to perform the procedures. The ethics of—as well as the correct approach to—these surgeries remain topics of considerable debate and lively discussion.[8]

Goodman et al refer to 4 medical ethical principles they believe are relevant to vaginal/vulvar cosmetic procedures, based on *Principles of Biomedical Ethics* by Beauchamp and Childress.[8,9]

Respect for Autonomy

According to the principle of autonomy, an adult woman without mental impairment must make the final decision about any medical procedure she undergoes. This is the

principle most commonly used to justify cosmetic procedures. However, the question of mental impairment is important in the field of plastic surgery. On the mild end of the spectrum, many women may anticipate that correcting a perceived physical deficiency will improve their body image and function, appearance, self-esteem, popularity, mood, and overall quality of life. Although these women have the right to undergo cosmetic surgery, their autonomy in choosing to do so may be debatable—largely due to potential coercion by a sexual partner or a surgeon describing a procedure as "scarless," "bloodless," or "painless."[8] On the more severe end of the spectrum are women with body dysmorphic disorder (BDD) who present for cosmetic surgery. Body dysmorphic disorder is characterized by excessive concern or preoccupation with an imagined or minor defect in their physical features. It has been estimated that up to 20% of patients requesting cosmetic surgery have BDD, and the incidence in the general population is 2% and rising.[9]

Nonmaleficence

Goodman et al argue the ethical imperative to "first do no harm" charges the physician with the responsibility for refusing to perform cosmetic surgery if the potential risk outweighs the potential benefit.[8] There is not yet sufficient outcomes data to provide a clear basis for a risk/benefit analysis.

Beneficence

Although the reported data indicate that the majority of labioplasty surgeries are performed for cosmetic reasons, there are medically indicated vulvar procedures such as repair of female genital cutting, labial hypertrophy, or asymmetrical growth secondary to congenital or acquired conditions or excessive androgen exposure. Labioplasty, clitoral reduction, and perineoplasty may certainly be required in these situations. ObGyns should also recognize that a preponderance of evidence has shown that traditional reconstructive pelvic procedures, such as anterior and posterior repairs and operations for prolapse and urinary incontinence, can improve sexual function.[10] However, *de novo* dyspareunia or exacerbation of vaginal constriction may also develop postoperatively in 26% to 37% of patients undergoing these procedures.[11] Therefore, patients who undergo elective vulvoplasty or vaginoplasty may also experience similar complications, so an adequate assessment of patient goals and expectations is mandatory.

Justice

Goodman et al apply the ethical principle of justice to address whether vulvar and vaginal surgeries performed for purely cosmetic reasons constitute a valid use of resources for the greater good of society. They are less concerned about this principle in the cases where patients pay out of pocket, but question the ethics of physicians claiming medical necessity to a third-party payer.[8]

The confusion regarding the ethics of performing procedures—specifically vulvar and vaginal surgeries—for purely cosmetic reasons will not abate in the near future. Although the accumulation of more outcomes data will certainly help to resolve the

issue of nonmaleficence, respect for autonomy and justice are more difficult for the surgeon to address. Perhaps plastic/cosmetic surgeons should emulate the multidisciplinary model used in bariatric surgery. Although often driven by the requirements of third-party payers, almost every candidate for bariatric surgery is evaluated by a mental health professional. The evaluation is geared not only to rule out candidates with major psychiatric barriers to either informed consent or postsurgical treatment nonadherence, but also to assess the candidate's motivations for wanting bariatric surgery. What does the candidate believe will happen as a result of surgery beyond weight loss? How realistic are the patient's outcome expectations? What psychological, social, and medical factors might contribute to perceived success or failure? These same issues are relevant for women seeking vulvar/vaginal surgery.

CONCLUSION

Women seeking consultation for sexual enhancement surgery should be appropriately counseled about their concerns, goals, and expectations. ObGyns and other professionals who offer female genital surgery specifically for sexual enhancement must possess the requisite knowledge, training, and experience to perform the procedures and provide appropriate counseling about potential risks, benefits, and alternatives, including nonsurgical options. Adherence to the ethical principles of respect for patient autonomy, beneficence, and justice must be rigorous when counseling patients about these procedures, but there is little evidence on which to base a position regarding the principle of nonmaleficence. Until such data have been disseminated, professionals performing these procedures should use a multidisciplinary approach for women requesting sexual enhancement surgery to include psychological or psychiatric counseling.

Current Procedural Terminology (CPT) stipulates that "inclusion of a descriptor and its associated five-digit code number in the CPT codebook is based on whether the procedure is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

Insurance companies rely on the AMA CPT Editorial Panel to determine whether a procedure should receive a code. If deemed necessary, a relative value unit is assigned for that procedure. As there is no CPT code attributed to the vaginal cosmetic surgeries described in this article, the patient would be responsible for the procedure's entire cost.

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