No. 300, December 2013

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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Disclosure statements have been received from all members of the committees.

The literature searches and bibliographic support for this guideline were undertaken by Becky Skidmore, Medical Research Analyst, Society of Obstetricians and Gynaecologists.

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 Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline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).

J Obstet Gynaecol Can 2013;35(12):e1–e5

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

Epub ahead of print.
This document will be published in:
J Obstet Gynaecol Can 2013;35(12)

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 have been raised that these surgical interventions may be inappropriate and complicated by issues of autonomy and ethics. Surgery is increasingly viewed as an intervention to improve the quality of a person's life, not merely to save it. The dilemma thus arises of how to balance the patient's desire for surgical intervention with the Hippocratic requirement to do no harm. We must also ensure FGCS does not contravene laws regarding female genital mutilation, a subject of controversy and debate around the world. Therefore, societies of obstetricians and gynaecologists including ACOG, The Royal College of Obstetricians and Gynaecologist, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Malaysian Society of Obstetricians and Gynaecologists are putting forward recommendations and policies to guide their members and the women who request such surgeries.[1–4] These societies universally agree that any FGCS that is not medically indicated is both lacking in evidence of safety and efficacy and fraught with challenges.

ANATOMY AND FUNCTION OF THE VULVA AND VAGINA

There is a wide spectrum of normal anatomic variation in female genitalia. Women's health care professionals should play an important role in helping women to understand their anatomy and to respect individual variation. In particular, pubertal development of the external genitalia includes evolving changes in the appearance and relative prominence of the labia minora and majora before the woman reaches full maturity. The labia continue to remodel with childbirth and can again undergo significant change with menopause.

Changes in menopause can include partial resorption of the labia minora, with attendant loss in elasticity of the tissues. Thinning and stenosis can occur with atrophic change, and pain or difficulty with intercourse is a common concern. No data exists that tracks outcomes through these life transitions.

Sexual function is complex and related to many factors other than anatomy. During the normal female sexual response the vagina must be able to dilate and "balloon." This capacity can be adversely impacted by both physiological processes such as menopause and iatrogenic causes such as cancer treatments, radiation, and surgery. Urethra, bladder, and bowel are intimate with the vagina, and surgery to the vagina carries inherent risks of compromise of these important structures.

Recommendation

1. The obstetrician and gynaecologist should play an important role in helping women to understand their anatomy and to respect individual variations. (III-A)

MEDICAL INDICATIONS FOR VULVAR AND VAGINAL REPAIRS

In conditions such as pelvic prolapse, perineal tears at delivery, congenital malformations, or tumours a surgical correction is medically indicated, and in these cases a gynaecologist is often the most highly skilled surgeon to address the specific condition. In cases of significant anatomic variation surgical reconstruction may also be medically indicated. These surgeries carry risks which may be outweighed by the benefits and the patient should be informed of the procedure, the risks, and the expected outcomes. Genital surgery for gender reassignment or for the repair of obvious anomalies are not considered cosmetic surgeries and are not addressed in this policy statement.

REQUESTS FOR VULVO-VAGINAL COSMETIC PROCEDURES

As with any surgical consultation, counselling for FGCS is an essential part of the process and a woman's motivations for treatment should be carefully explored. The possibility of coercion or exploitation, or requests for surgery at the behest of a partner or parent, should be ruled out. A complete medical, sexual, and gynaecological history should be obtained, and the absence of any major sexual or psychological dysfunction should be ascertained. If any psychological concerns are identified, counselling should include appropriate referral for assessment prior to consideration of a genital cosmetic surgical procedure.

There is little evidence to support improvement in sexual satisfaction or self-image from cosmetic "rejuvenation" of the vagina or vulvar cosmetic surgery. Evidence from studies thus far for labioplasty is all either Level III or anecdotal. Studies for "G-spot augmentation" are only anecdotal.[7,8] Recently, there have been two non–peer-reviewed publications regarding the use of laser procedures for treating "vaginal relaxation syndrome" including stress incontinence. Neither paper presents robust evidence, and many concerns arise regarding longer term effects. Of the 21 patients in the pilot study by Gaviria et al., 8 were nulliparous and 19 were pre-menopausal; follow-up was limited to 3 months.[9] The small study by Fistonic et al. claimed increased muscle contraction with only 6 of 39 patients followed to 6 months.[10] One published study that addressed colpoperineorrhaphy, and included level

II-3 evidence from women who made a decision to get surgery after appropriate counselling, reported a very high satisfaction rate at 6 months postoperative.[11] Physicians choosing to proceed with these cosmetic procedures should not promote these surgeries for the enhancement of sexual function.

Women considering these surgeries should be informed of the risks of the procedure, including bleeding, infection, scarring, dyspareunia, alteration in sensation, pain, wound dehiscence, decrease in sexual pleasure, and possible dissatisfaction with cosmetic or other results.[10] There are no available long-term data on the safety or efficacy of these procedures.[7–10,12–14] Additionally, there is currently no evidence available regarding the effects of the physiological changes associated with pregnancy and childbirth or menopause on the postoperative outcomes of perineal or vaginal cosmetic surgeries.

Many women will be satisfied with the information and reassurance they receive from the care provider and may not proceed to surgery.

Physicians who choose to undertake cosmetic procedures to the vagina and vulva should be appropriately trained in the gynaecologic and/or plastic surgery aspects of cosmetic surgery of the lower genital tract. This is not a skill set currently required by the Royal College of Physicians and Surgeons of Canada for accreditation of postgraduate training programs in obstetrics and gynaecology.

Recommendations

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)

REQUESTS FOR VULVO-VAGINAL COSMETIC PROCEDURES IN ADOLESCENTS

Women seek cosmetic procedures for aesthetic, functional, or psychological reasons.[11] Girls and adolescents have different presenting complaints leading to consultation for labioplasty. Girls 9 to 13 years old request consideration of surgery for relief of symptoms such as rubbing, chaffing, and interference with sports. The second most common reason in this age group is the mother's perception of an abnormality in her daughter. Adolescents of 14 to 17 years of age are primarily concerned with their own appearance and have further concerns that their sexual partner may find them abnormal and unattractive.

Apart from the usual preoperative considerations and counselling, in adolescents particular attention must be paid to the purpose of the surgery, the degree of specific anatomic concern, and the level of physical maturity. The social costs to the patient, the patient–parent decision-making dynamic, and the post-surgery patient attitude must also be considered.

Given normal physiological and developmental changes, especially in the vulva, procedures on girls under the age of 16 should usually be discouraged to ensure that their final decision is based on mature genital development.

Canadian courts have rejected the notion of "age of majority" to define the age at which an individual is able to consent. Common law recognizes the mature minor as a person who is capable of understanding the nature and consequences of the proposed treatment. When a minor is deemed to be "mature," no parental consent is required for FGCS procedures.[10,15]

Recommendation

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)

ADVERTISING

Advertisement of FGCS cannot be viewed solely as an indication of the physician's necessary knowledge and surgical skills. The absence of evidence of efficacy and safety combined with the revenue generated from such procedures inevitably creates some level of conflict of interest. The advertising of cosmetic procedures such as labioplasty and vaginal rejuvenation, or the posting

of images of external genitalia to advertise services, by gynaecologists in print or via the Internet or any other medium, is susceptible to misinterpretation, can create a false sense of need for surgical intervention, can be very misleading, and should therefore be considered unethical.

Recommendation

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)

FEMALE GENITAL MUTILATION

Traditional female genital mutilation or cutting is not specifically included in this policy statement. According to the UN interagency group, "Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons."[16,17] Removal of the labia minora is specifically classified as Type IIa FGM by WHO,[16,17] A separate SOGC policy statement addresses FGM.[18]

SUMMARY

The weight of evidence currently available does not support female genital cosmetic surgery, and the proliferation of non-medically indicated surgery to the genital area is of great concern. Education and counselling should be a priority to ensure that women have reliable information about normal variations and physiological changes in the vagina and vulva over the lifespan and about possible unintended consequences of cosmetic surgery to the genital area. Counselling should be a priority prior to any informed consent process for women requesting FGCS. Surgeons performing FGCS should be appropriately trained in the required knowledge and skills, noting that these are not part of the Royal College of Physicians and Surgeons of Canada post-graduate training. The SOGC's position does not support non-medically indicated female genital cosmetic surgery procedures considering the available evidence of efficacy and safety.

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