Commentary

Commentary on: A Retrospective Study of the Psychological Outcomes of Labiaplasty

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The article "A Retrospective Study of the Psychological Outcomes of Labiaplasty"[1] by Sharp, Taggemann, and Matteske adds to our expanding knowledge base regarding the outcomes of elective women's genital plastic and cosmetic reconstructions, aka "female genital plastic and cosmetic surgery" (FGPS). This is a retrospective study examining the effect of labiaplasty (LP) on women's sexual satisfaction and psychological wellbeing. As such, it is a welcome addition to the accumulating literature, both prospective[2-4] and retrospective[5-9] regarding the outcome of the "intimate surgical procedures" engaged in by women to adjudicate a functional discomfort (LP) or diminishment of sexual pleasure (functional vaginoplasty) or to address aesthetic dissatisfaction(s) related to external genital appearance (LP or perineoplasty).

It is both evidence-based and intuitive that a woman's comfort with her body appearance (especially genital appearance) and function significantly impacts sexual satisfaction.[10-12] Women who feel embarrassed, uncomfortable, distressed, displeased, or sexually dissatisfied over the size, appearance, hygienic challenges, chafing, re-arranging, and sartorial "bulges" engendered by robust labia /clitoral hood, or by a "wide and smooth" vagina or gaping and ptotic introitus are certainly expected to be sexually distressed, and it is not unexpected that this conundrum would negatively affect their sexual universe. In this study, women's satisfaction with their surgical results additionally appeared to translate into improvements in their sexual satisfaction and psychological well-being, compared to recalled levels prior to their surgery.

It is clear from Sharp et al's article from "down under," as it is from every other retrospective and prospective article (representing four continents) in the aesthetic, plastic and reconstructive, psychological and sexual medicine literature, that LP and vaginal tightening operations "*work*." There is no literature to intimate that this satisfaction wanes over time. While it is certainly possible that satisfaction may wane with vaginal tightening, labia do not "grow back!"

Notable to this discussant is the fact that this study emanates from a group of psychologists and social scientists, independent of medical practitioners, as distinct from the great majority of outcome studies in the literature, which come from groups of, or including FGPS surgeons, thus eliminating "bias by specialty."

As in other studies in the literature, motivations for LP here include concern over appearance, physical discomfort, physical and/or emotional concerns with sexual relationships, and other psychological distresses. It is inappropriate for observers to negate these concerns as frivolous because the organ in question falls within a vaguely defined and wide range of "…normal." These are real concerns and as such are to be respected. In the present study, concordant with all others in the literature, "…the vast majority of participants were satisfied with their [post-surgical] appearance and function," and "…most [participants] agreed that their goals for having a labiaplasty were achieved."[1] The authors' comments on reasons for dissatisfaction of a minority of women in the group are equally important and revealing, and consist of "…unfulfilled expectations with labial appearance, experiencing significant pain and discomfort after surgery, and perceived incompetence by

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the physician who performed the procedure."[1] Additionally important is their sub-analysis revealing that "When the effect of time since surgery on satisfaction was examined, there were no significant differences between the short and long follow-up groups for all of labial appearance satisfaction,"[1] as this helps answer the question as to whether initial satisfaction with the results of LP might wane with the passage of time. The article's identification of "predictors for success" (LP to address a physical or functional concern) are benchmarks understood by all competent FGPS surgeons. The acknowledgement that LP to address a sexual concern is statistically an additional "predictor for success" is also evidence-based as the literature is clear that women undergoing LP report enhanced sexual function in all prospective and retrospective studies noted above. Sexual issues, however, are a double-edged sword, and a careful genital plastic surgeon must endeavor to weed out patients who hope for a surgical solution to a true sexual dysfunction. In this discussant's experience, this is especially true for that subgroup of women who hope that a clitoral hood reduction will improve orgasmic function. A supremely important consideration for genital plastic/cosmetic surgeons as it relates to outcome satisfaction are "reasonable expectations." The authors comment on this in their discussion of the diversity in patient's overall satisfaction with aesthetic appearance, reiterating that patient overall satisfaction is related to expectations vs outcome, commenting on the importance of surgeons including a discussion of how that patient's individual labia are likely to appear after surgery to assure that this is reasonably consistent with her specific expectations. The authors quote Alter's sage advice[13] that the consummate genital plastic surgeon be competent with more than one technique so as to be able to tackle the many anatomic variations encountered. A surgeon only proficient in one procedure, like one who fails to match patient expectations with anatomic reality, will have a far greater number of dissatisfied clients.

Retrospective design and relatively small sample size limitations notwithstanding, this article is another "brick in the wall" (thanks, *Pink Floyd*!) evidence-based study supporting both the rationale,[14-16] performance,[17] and outcome[2-9] of female genital vulvar and vaginal re-constructions. These evidence-based studies contrast with the many opinion pieces[18-24] written entirely by authors whose expertise is suspect given their absence of clinical and surgical experience in this emerging field.

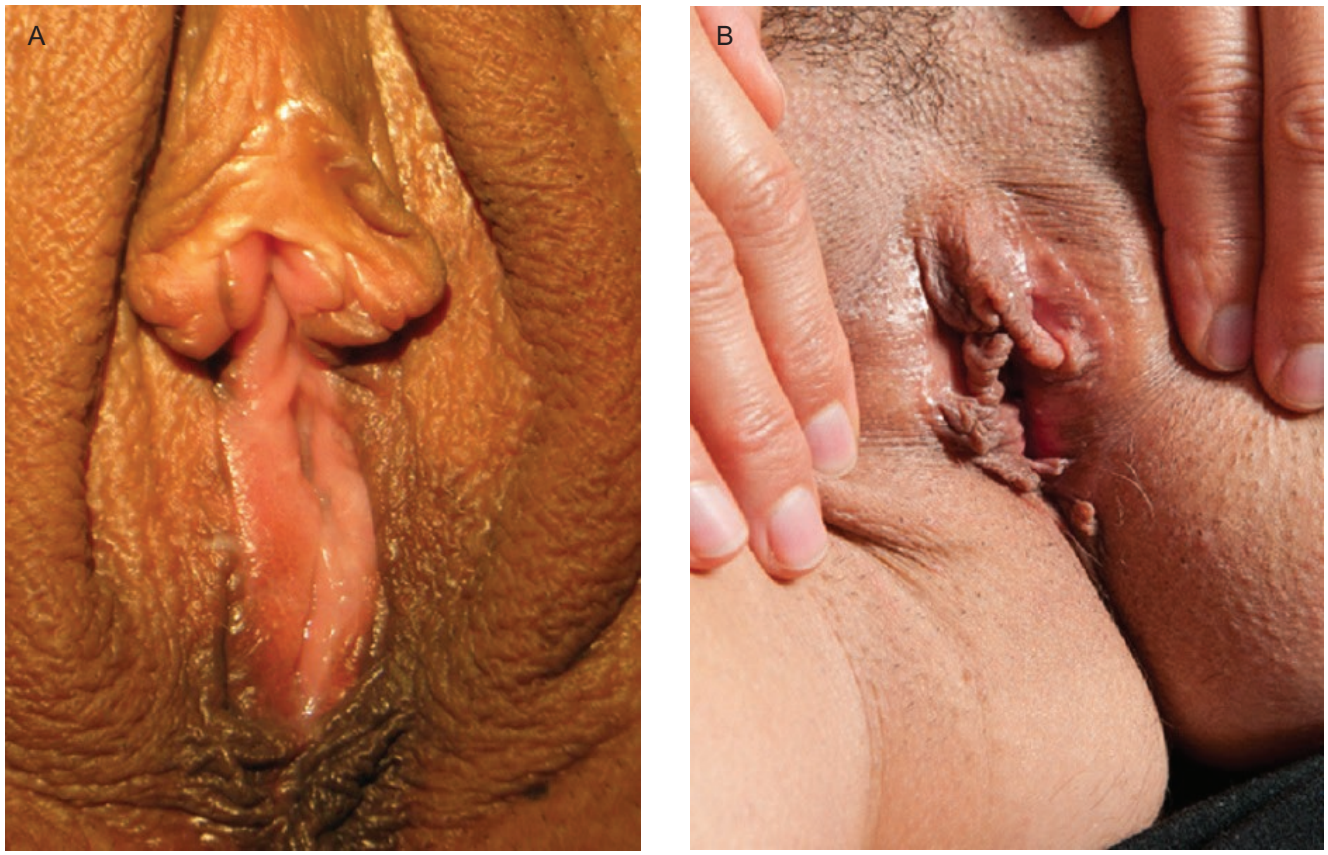

Figure 1. Six-month postoperative outcomes of (A) 31-year-old and (B) 43-year-old women who underwent aesthetic labiaplasty performed in-hospital by board-certified Ob-Gyns lacking specific training in aesthetic labiaplasty.

The organization representing the majority of obstetrician-gynecologists (Ob-Gyns), the American College of Obstetrics and Gynecology (ACOG) has found itself at the center of the debate on the propriety of women's genital plastic and cosmetic procedures. Since their initial Committee Opinion in 2007 questioning the propriety of "vaginal rejuvenation" in the absence of outcome data,[23] the ACOG has neither changed their opinion, nor taken steps acknowledging that women have the right to modify their genital appearance and function. Despite several peer-reviewed outcome studies published prior to or since their initial "Opinion,"[2,5-9] all of which note strongly positive outcomes, the ACOG in 2012 reiterated their 2007 position without modification. The ACOG has again opted towards caution as evidenced in their recent Committee Opinion in 2016,[24] eloquently commented upon by Hamori in her response to the May 2016 ACOG recommendations on labiaplasty in adolescents.[25] The 2016 Committee Opinion states, without providing references, "Although there may be a perception that labiaplasty is a minor procedure, serious complications can occur (eg, pain, painful scarring, dyspareunia, hematoma, edema, and infection)." The College has not encouraged training their prospective Fellows in the "rules" and techniques for FGPS and indeed the complications this Committee Opinion highlights are not seen in outcome studies involving surgeons well-trained in the "art" of genital plastics. Both of the outcomes reproduced here (Figure 1) were performed by board-certified gynecologists at hospital facilities under "boilerplate" privileging for "Partial Vulvectomy." Avoidable unintended mutilations similar to these are regularly viewed on legitimate online sites such as RealSelf, and are usually the work of gynecologists not trained or experienced in the specifics of genital plastic/cosmetic work. (information gained from posts on site) As Dr Hamori points out,[25] and is evidence-based, large published series of labiaplasties performed by *well-experienced/trained* cosmetic gynecologists or plastic surgeons show major complication rates, which include the complications alluded to by the ACOG committee, uniformly $<5\%$. No references are provided in this "Committee Opinion," which is just that: an "opinion" not supported by scientific fact, in concordance with other ACOG "opinions" on this subject. The complications warned about by the Committee Opinion, are most likely to be encountered by women operated upon by "family gynecologists," who have not received training adequate for the task at hand. Figure 2 represents the before and after results of a typical

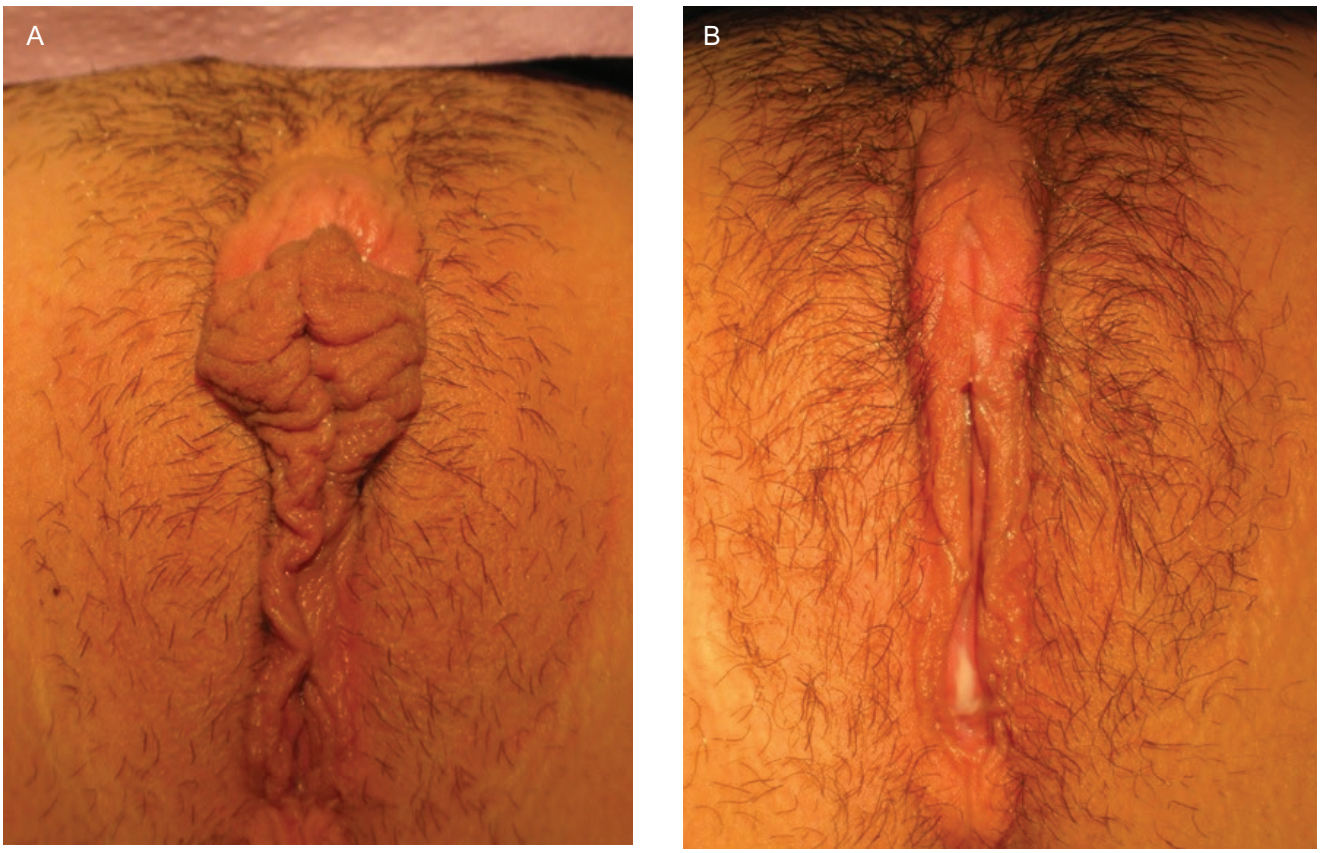

Figure 2. (A) Preoperative photograph of a 16-year-old adolescent female prior to undergoing elective labiaplasty. (B) One-month postoperative photograph of the patient after V-Y modification reduction labiaplasty.

labiaplasty performed by a trained specialist. The patient is a 16-year-old adolescent who presented supported by her mother who understood the repercussions of her daughter's robust labia on both sexual satisfaction and athletic endeavors. As stated by Kilimnik and Meston, "Women's sexuality is influenced by their perception of their bodies."[26]

The award of ACOG Fellowship is a recognition that the Fellow is a legitimate specialist, including surgical specialist, for women and has received training commensurate with the surgery performed. The ACOG has, in the opinion of this discussant, failed to ensure that their fellows have had both training in plastic and reconstructive technique and specific training in aesthetic LP and functional and aesthetic perineoplasty and vaginoplasty. This, plus hospitals' willingness to allow surgeons to perform aesthetic labiaplasties that they are not specifically trained to perform under the slippery privileging umbrella of "Partial Vulvectomy," or to perform the functional sexual vaginal tightening procedures they are not trained to achieve under the privileging umbrella of "posterior colporrhaphy," has led to an explosion of *avoidable unintentional genital mutilations* (aka "botched labiaplasties") and unsatisfactory vaginal tightening procedures that experienced genital plastic/cosmetic surgeons are seeing with regularity, either in their practices for potential revision, via online lamentations, or in a medical-legal context.

I truly hope that the article by Sharp et al,[1] the recent contribution in this journal by Goodman et al,[4] and other retrospective[5-9] and prospective[2-4] articles will convince the ACOG and other detractors to legitimize FGPS as evidence-based, women's-centric reconstructive procedures and support and sustain training programs both free-standing and as a residency elective. I would further hope that hospitals and surgical centers will realize that aesthetic LP is *not* the same thing as "partial vulvectomy" and an aesthetic and reconstructive "perineoplasty + vaginoplasty" is *not* the same operation as a [site-specific] posterior colporrhaphy. As in any other discipline, surgeons who cannot prove training or experience in a specific procedure should be disallowed from performing that procedure, as it puts both patients at risk, and increases institution liability. Only through such rigor will women be protected.

Authors, even those with impeccable academic credentials, have displayed bias in their editorial and position statements on elective genital reconstructions. The time has now come for the evidence to dominate unsupported opinions.

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