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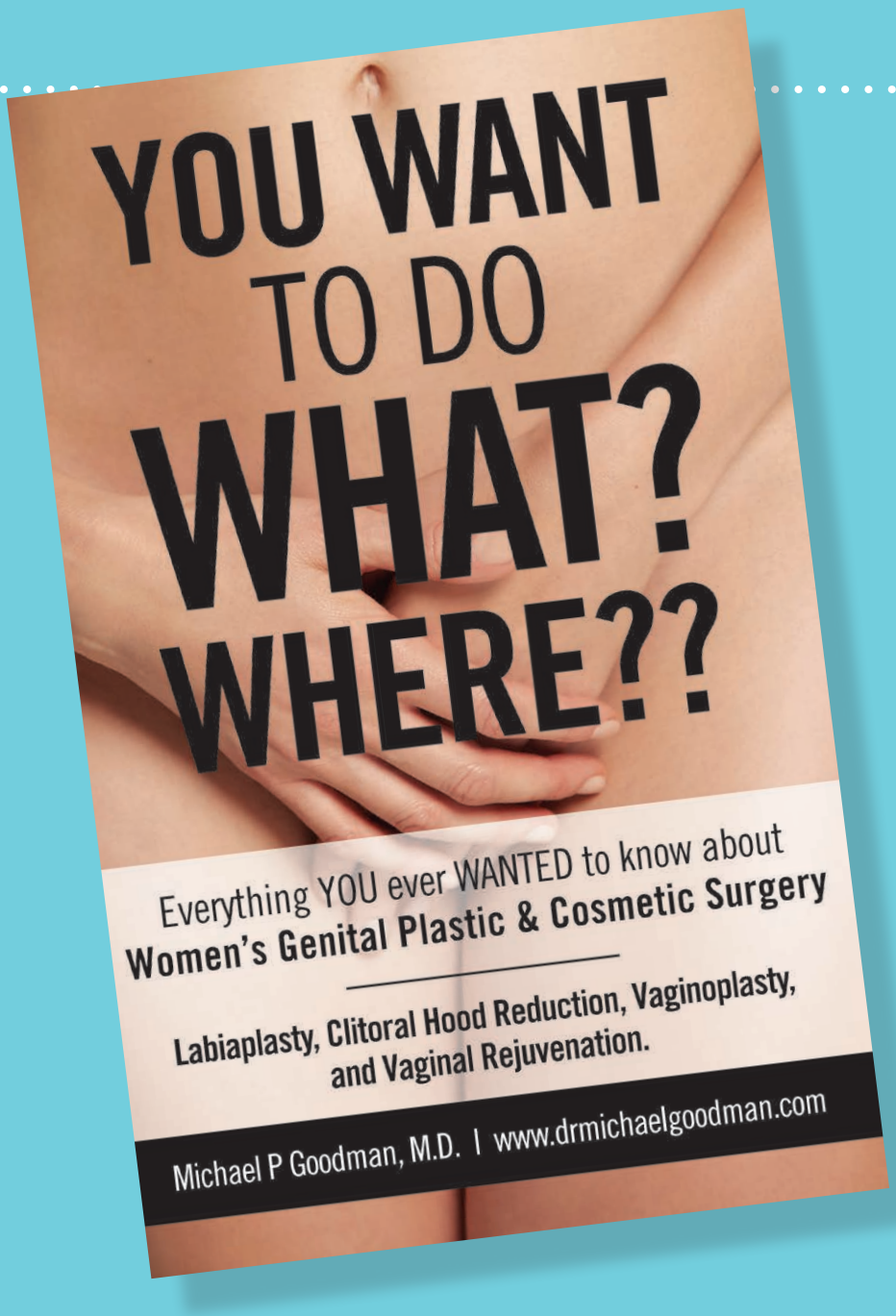
CHAPTER ONE

of Dr. Michael Goodman's book



Dr.. MICHAEL GOODMAN MD

The Anatomy and Rationale for Surgery

"From birth to age 18, a girl needs good parents; from 18 to 35 she needs good looks; from 35 to 55 she needs a good personality, and from 55 on she needs cash."
– Sophie Tucker

"If you want to look young and thin, hang around old fat people."
– Jim Eason

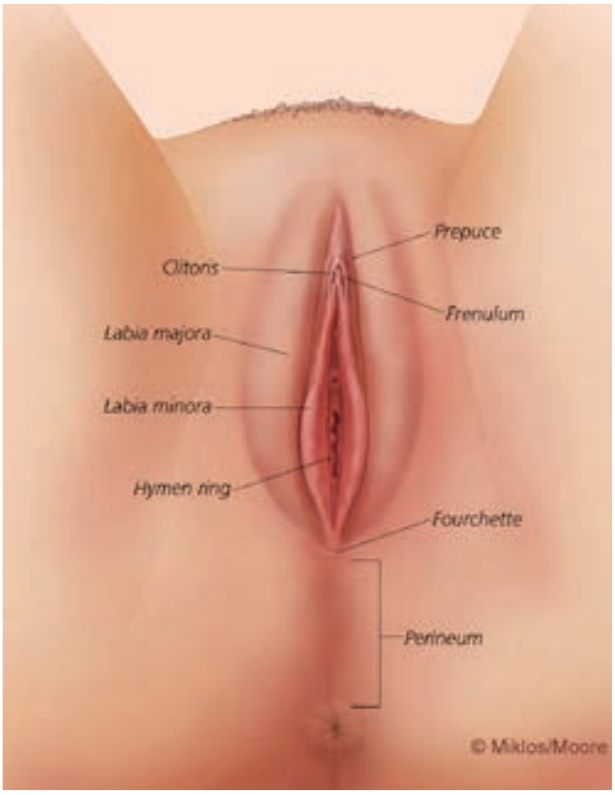
It is beyond the scope of this book to present a thorough discussion of vulvar and vaginal anatomy, but some explanation is necessary to understand the procedures we will be talking about.

The labia majora and labia minora in women act as "guardians of the vaginal opening." The former are wide cushions analogous to the male scrotum, and the latter, formed as side-by-side folds descending down from the clitoral hood, act as "curtains" for the vaginal opening, called the "introitus".

There is a wide range of normality. As in women's breasts, where "normal" can include everything from an AA to an EE cup, women's labia come in a wondrous array of shapes and sizes.

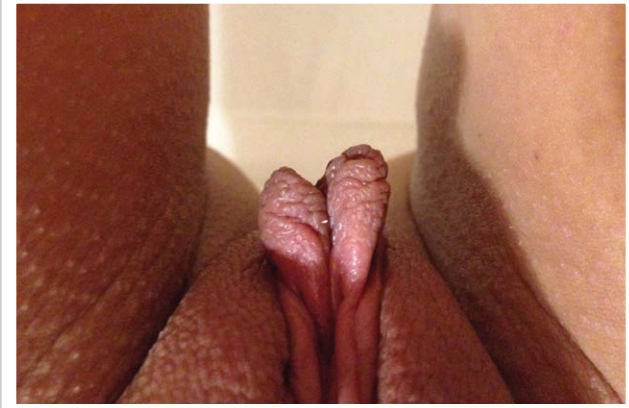
The upper portions of the labia minora begin as one or several folds descending down from the different parts of the clitoral hood. The frenulum (the fold that descends down from the clitoral head or "glans") joins the upper fold(s), curtaining the edge of the introitus. The labia minora can end just above the base of the vaginal opening, but sometimes, it continues over to the other side or descends down onto the perineum as the "fourchette" or "posterior commisure."

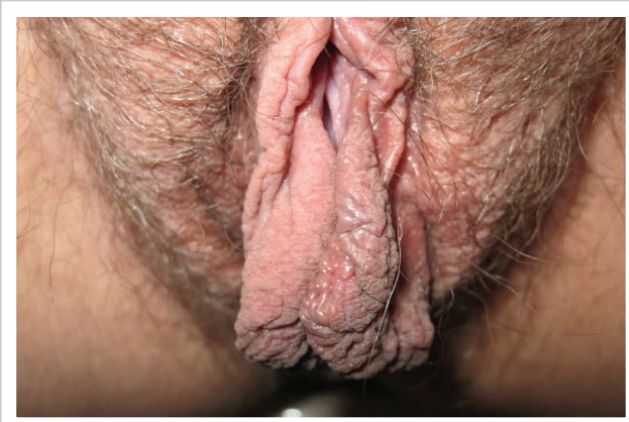
Standing, many women's labia minora are tucked away, not visible from above. Protrusion beyond the labia majora (the outer, wider and more "puffy" lips) while standing is often a cause of significant concern.



Vulvar Anatomy. *Photo: courtesy of John Miklos MD and Robert Moore MD of Atlanta Urogynecology Associates. Used with permission.*

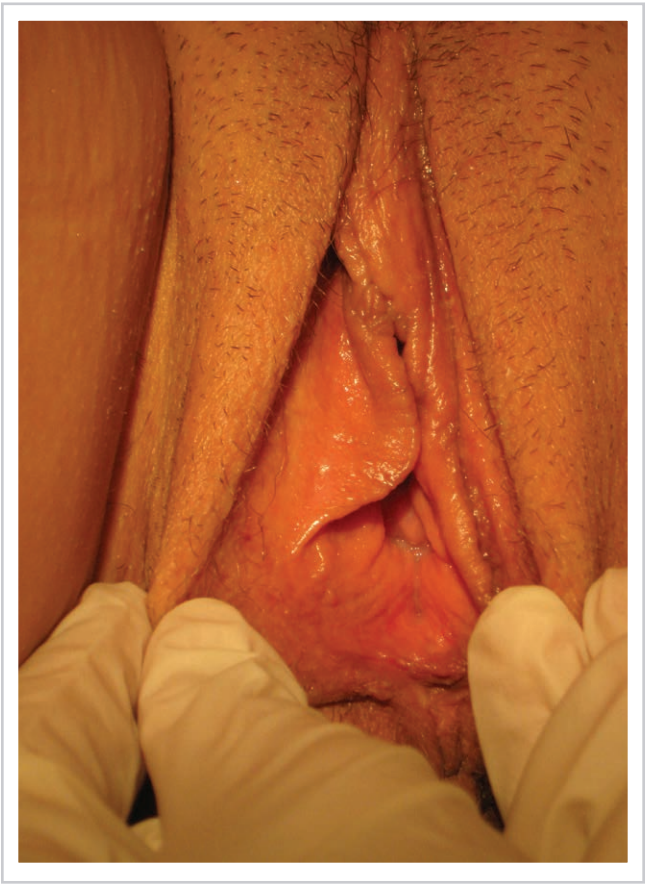
Likewise, especially with childbirth and aging, the outer lips, the labia majora, may become enlarged, redundant, and "droopy" and be a source of cosmetic dissatisfaction.





Protruding labia minora. *Photos: Copyright M. P. Goodman MD*

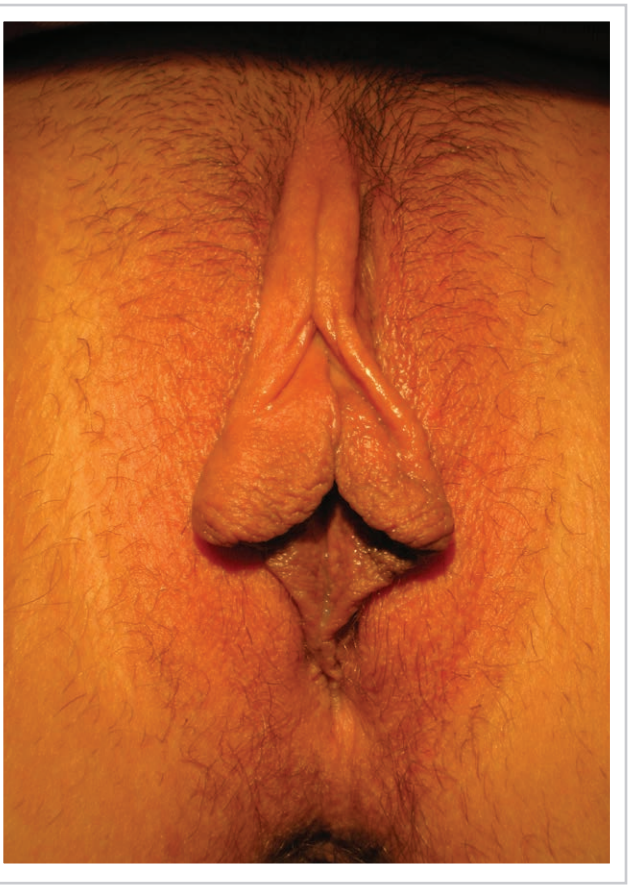
The labia majora and outer surfaces of the labia minora consist of a skin-type covering over loose fibro-connective tissue. The labia minora contain sensitive nerve fibers, especially in the uppermost portion where the hood and frenulum come down to form the topmost portion of the minora. During sexual arousal they become engorged and contribute to erotic sensation and pleasure. The inner surfaces of the labia minora exhibit a mucosal epithelium similar to the inside of the mouth. The outer vagina, urethral opening, clitoral complex, hood, perineum, vestibule and labia minora may be considered as a relatively unified structure, as their blood and nerve supply is intimately entwined.[1.]



Redundant labia majora. *Photos: Copyright M. P. Goodman MD*

Attempts have been made to define "normal" as it relates to labial size. This is admittedly difficult to do, as defining exactly where to measure from, and how much to "stretch" (or not stretch) this elastic tissue, has not been satisfactorily defined. One published medical study measured labial width and found an average of 1.54 cm (~ 2/3's- ¾'s inch) for patients not requesting surgery, while those requesting alteration averaged 3.52 cm (~1.5 inches) width. Another study has classified hypertrophy, or enlargement, as more than 4 or 5 cm (~ 1.5-2 inches.)[2.] Size definition may be a moot point however, even if a body part is considered to be "within the normal range," it does not automatically follow that its form or function is satisfactory to its "wearer."

It is important to note that, although there are several reoccurring anatomic "types," I have never seen two women's labia that look exactly alike or, for that matter, two sides of the same woman that exactly "match." There is such a wide range of normality.

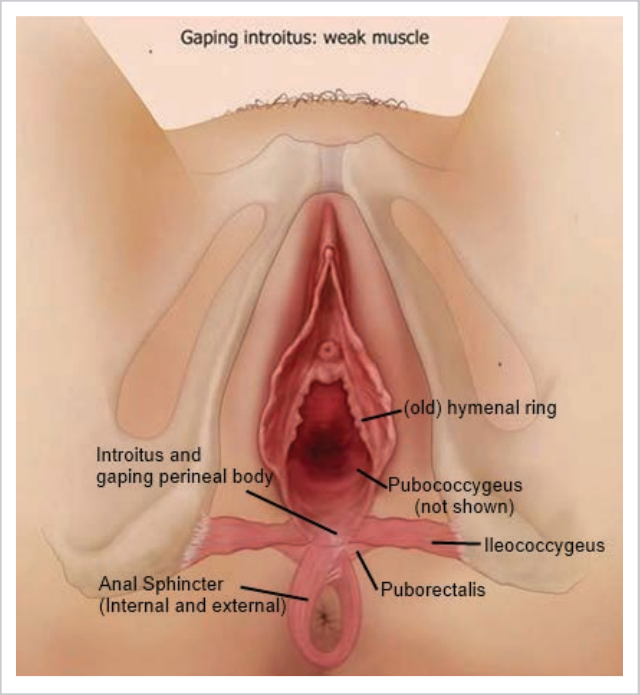


Larger than "average" labia, exhibiting components from the frenulum and central hood. *Photos: Copyright M. P. Goodman MD*

The vagina is a barrel-shaped, but slightly curved structure, genetically designed as a "tunnel" for penile deposition of sperm on their way towards union with a woman's egg. It also acts as a later outlet for the product of that union. The vagina consists of fibrous-type connective tissue covered by, if estrogen levels are adequate, a relatively thick, corrugated type of mucosa, mostly devoid of muscles except at its mid and outer portions where it is backed by the "levator" muscles. The levator muscles are the muscular bastion of the pelvic floor and pelvic support and help "grip" the penis to assure deposition of semen into its depths. The muscular diaphragm formed by the various pelvic floor muscles is pierced in the midline by the urethra, vagina, and rectum, each of which is loosely supported by fibers from the inner portions of this musculature.

The word "vagina" comes from the Latin word for "scabbard," or "sword sheath." The upper and lower vagina differs in shape, dimension and direction. The lower vagina (the mid-part, and that nearest to the opening) has a constant, smaller diameter while the upper vagina has a significantly greater diameter and lies more horizontally. There is substantial variation in the structure of its walls — The outer (side) walls, with their underlying loose connective tissue, are very different from the anterior and posterior walls ("roof," and "floor"). Their underlying organs (bladder and rectum respectively), both have a tendency to "bulge" or herniate with excesses of pressure caused by a large fetal head pushing down and then being forcefully expelled, and later by age and other forces of nature.

As time goes by, the vulva and vagina undergo several anatomic changes, including vaginal laxity, as they are weakened or stretched by age and/or childbirth. Aided by genetic predisposition, obstetrical forces (especially large fetuses), a long hard push and, eventually, age, the upper vagina may widen, and even the bladder can lose its fibromuscular support and herniate downward, pushing into the vagina and beyond. The rectum can also bulge into the vagina, and portions of vaginal skin push its way outward. In addition to obvious challenges to urinary continence and the ability to evacuate stool, these various "pelvic relaxations" very frequently impact a woman's sexual function.[4.]



Weakened perineum. *Photo: courtesy of Robert Moore MD and John Miklos MD. Used with permission.*

The processes of pregnancy and childbirth involve major adaptations of the vagina and pelvic floor to allow the opening necessary for childbirth and then later return to a near prepregnant state. Frequently, the recovery process is incomplete. Vaginal childbirth has been identified as an important risk factor for both prolapse as well as less dramatic changes in function of the pelvic floor, including distension, feelings of "looseness," and diminished "gripability." These are all physiologic sequelae of genetics and forces of childbirth, and have their consequences in the sexual arena.

More about the biomechanics of the vagina: What are the anatomical and physiological changes that take place after childbirth, how do they impact sexual health, how does everything work, and specifically how do vaginal tightening procedures enhance sexual function?

The vaginal canal and its environs, including the clitoral complex, are an interesting functional and anatomic unit. This unit is designed for both preservation of the species and the lustiness that makes members of our species wish to participate in the activities that will assure that preservation.

The vagina is anatomically designed to tilt downwards with a vertical inclination. The "proximal," or "upper" vagina has a more horizontal arrangement and, with arousal, deepens and expands cup-like to provide a "dish" for the deposited sperm, so that they don't just drain out. This allows more time for the cervix to dip into this vernal pool allowing spermatozoa to wend their way up into the uterus and tubes towards a meeting with destiny, aka the egg.

At the same time, so as to make the whole act pleasurable so that women want to do it in the first place, this tilt pushes the penis towards the top wall of the uterus, thereby both stretching the bulbs and crura of the clitoris, stretching the sensitive receptors imbedded in the upper wall of the vagina in the region of the "G-spot," and providing more pressure on the pubic bone and external clitoris. Voila!

This is great! However, a combination of childbirth(s), big babies, tough deliveries and genetics often conspire to stretch, relax and break down the muscular and fibrous supports of the vaginal wall. The result: A widened vagina and loss of downward tilt with much less penile pressure especially on the clitoris/anterior wall and "looseness," with more difficulty attaining, and less robust, orgasms.4.

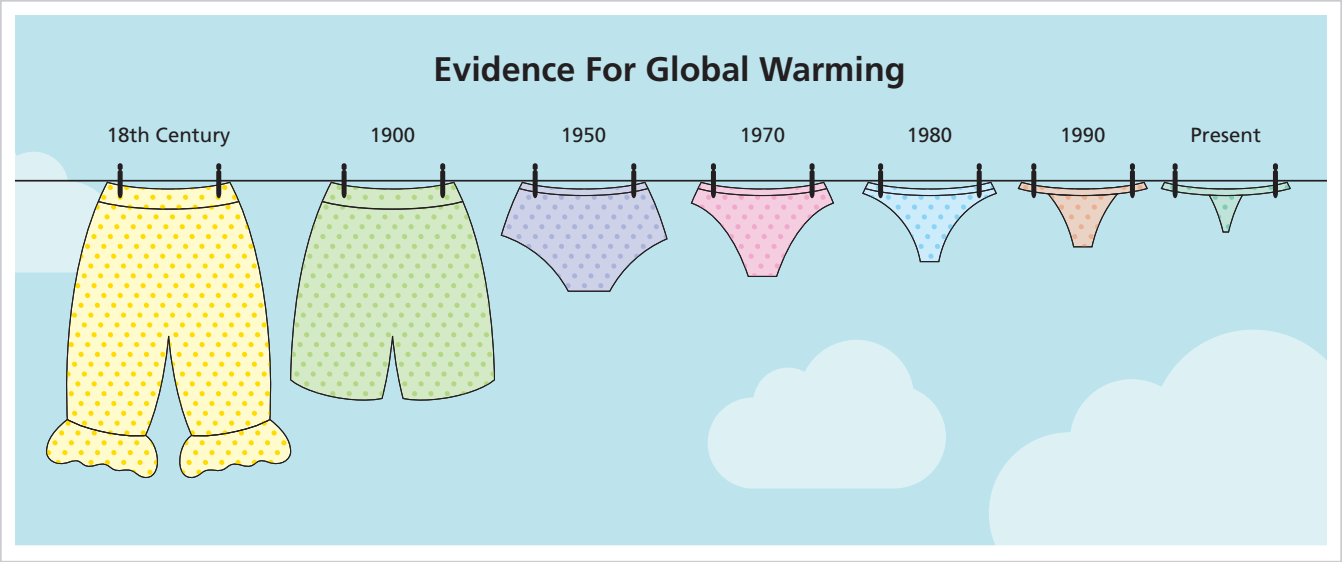
So, why on earth would an individual woman desire to undergo surgery in this intimate and sensitive area? What would lead her to consider this, much less discuss it with a healthcare practitioner she hardly knows? The rationale is real, and compelling. Actual quotes from women say it best:

"It's that when you feel bad about your body, especially this part of your body, it's kind of impossible to let your true feelings and passions show."

"I was very, very self-conscious about the way I looked. Now I feel free. I just feel normal. I have nothing to hide."

"I just felt that I keep myself in shape everywhere else… [the surgery] has given me more intense sexual enjoyment."

"It never bothered my husband, but it was always like 'Yuck!' All I know is that what I had I didn't like."



My experiences after over 15 years of providing genital plastic services for women parallel those of other experienced surgeons. Women requesting alteration of their labia and/or clitoral hoods do so for either cosmetic/self-esteem, or functional reasons.

"I feel self-conscious," "I don't want to do it with the lights on," "I'm so much bigger than everyone else," "I don't like those flaps sticking out between my outer lips when I stand: it's gross," "I just don't like how I look." The majority of women requesting alteration also note functional problems: chaffing with jeans and other tight clothing, self- consciousness wearing thong underwear or bathing suits, discomfort exercising, especially bike riding; pain with sex produced by the penis pulling in the large labial folds; hygiene difficulties, deviation or "splashing" of the urinary stream hitting the labia, and the frequent need to "rearrange" oneself.

Women requesting a vaginal tightening operation often feel their labia are large and bothersome to them and request both surgeries. Women who come to see me inquiring about vaginal tightening rarely come in at the urging of their sexual partner, although the majority of the time they have discussed their concerns with him or her, if they are partnered. These women are quite clear of whose benefit they are considering surgery: Themselves. They tell me that sex is "not the same," that they experience less friction, less pressure, and often less arousal. Women frequently relate that, since childbirth(s) and with age, it takes them longer to climax and find their orgasms are less robust. They "feel loose," with a "sensation of a wide vagina." Although they may still experience "clitoral orgasms," their more robust "vaginal orgasm" no longer occurs. And though there are typically cosmetic issues with the appearance of the vaginal opening, this is always secondary to their functional, friction and orgasmic issues.

These decisions are not hastily made. Women requesting genital revisions are, for the most part, a well-educated group. The average woman I see for labiaplasty has felt she was "larger" for several years but wasn't aware that anything could be done until recently. Patients seeking vaginal tightening have noticed a change after childbirth, especially with age. Patients consulting with me have been considering surgery for an average of 2-5 years. They have visited several web sites, and many have gone to their family physician or their OB/GYN and have been rebuffed ("…you don't need to do that…") by health care providers less than savvy in regards to the significant psychological and psycho-sexual toll these real or perceived anatomical situations take on individuals.

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2. Comparison of mean labial width in normal patients and those seeking labiaplasty FASEBJ 2009 (meeting abstract.) D Murariu, DJ Jackowe, D. FD Parsa, GK Nakasone, A Parsa, and B Chun.

2. Hypertrophy of the labia minora Obstetrics and Gynecology 1976 HM Radman

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3. The impact of pelvic organ prolapse on sexual function in women with urinary incontinence.International Urogynecological Journal of Pelvic Floor Dysfunction 2006 B Ozel, T Whiute, R Urwitz-Lane.

3. Vaginal reconstruction and rejuvenation surgery: Is there data to support improved sexual function?American Journal of Cosmetic Surgery 2012, John R Miklos, Rob Moore.

4. Female orgasm(s): One, two, several. J Sex Med, 2012. EA Jannini, A Rubio-Casillas, B Whipple, O Buisson, BR Komisaruk and S Brody.

4. Colpoperineoplasty in women with a sensation of a wide vagina. Acta Obstetrica et Gynecologia 2006. J Pardo, V Sola, P Ricci, E Guiloff and D Freundlich.

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Erin's Story: Successful Labiaplasty Offers Renewed Hope and Happiness

(As told by Nicole Sanders, Office Manager, "Caring For Women".)

Erin was a 20-year-old vibrant and intelligent college student living here in Davis. She came to see us, along with her mother Sherry, for a consultation for labiaplasty. Erin was very shy, and her mother was uninformed and curious about what exactly her young daughter was interested in having done and why.

After Erin's visit, they called the office a few times, both with general questions about the process and procedure as well as to inquire about my own personal thoughts, opinions and experiences. I was happy to disclose any and all information possible to ensure that they were both comfortable and confident with the decision to proceed.

Approximately three weeks after her initial visit, Erin decided to go ahead with her surgery. She again was accompanied by her mother; both were visibly and understandably nervous. That's when they were both greeted by our experienced, warm, caring and friendly registered nurse. She introduced herself to Erin, shaking her hand, "Hi, I'm Lisa, your nurse, and I'll be taking care of you today."

Lisa has two young adult children of her own and could empathize with the mixed bag of emotions Sherry was experiencing. Lisa comforted Erin's mom saying, "Don't worry, she's in good hands. I'll be by her side the whole time." Both patient and parent took a deep breath and shared a hug before Erin was brought back to the surgical suite.

The procedure went well. After completion of her procedure, Erin was ready to view her results and requested that her mom be present as well. Together, they took a look at her newly reconstructed labia. Even immediately after surgery, with stitches all over the place, Erin was overjoyed with the difference; she couldn't help but shed a few tears. This in turn caused her mother to become emotional as well, and they embraced as they shared this unique and memorable moment.

When Erin returned for her one month post-operative visit, she came in a different young lady, smiling and bubbly. She also had with her a gift, a big hug and "THANK YOU!" for Dr. Goodman. She was so excited and looking forward to the new experiences she felt were now going to be possible for her—the things she was hesitant to do before having surgery.