GUEST EDITORIAL

Examining the Controversy in Aesthetic Vaginal Surgery

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I write this editorial from my perspective as the founder of an 8-provider all-female Ob/Gyn group in a Houston medical center. I have a busy general Ob/Gyn practice with a staff of 40 and still do 20 deliveries a month personally; also, my practice sees more than 700 patients a week. I believe that qualifies me as an expert on women's health and what women want. About 4 years ago, I took a course on cosmetic vaginal surgery after realizing that this would be a valuable addition to my practice. With a medical spa already in place and an office surgical capacity, I added a cosmetic component to the practice. This cosmetic practice currently consists of about 8 cases per month. The results have been satisfactory to me, my colleagues, and my patients. Recurrent publication of negative articles in the popular and academic press regarding cosmetic gynecology portrays this unfairly. Authors imply that cosmetic gynecologists are sleazy, poorly trained, or otherwise not respectable.

In the apparent absence of any opposing voice, I began to write letters to the editors of several publications that ran negative pieces. The need to prepare these responses has forced me to think through the pros and cons of our subspecialty—cosmetic gynecology. Despite an academic training background and close association with the Gynecology community here in Houston, I have been criticized for arguing in favor of cosmetic gynecology. Although I understand other views, I do not agree with them.

Let's look at a few examples of the negative press I am talking about…

- In 2007, the *American Congress of Obstetricians and Gynecologists* (ACOG) *Committee Opinion* published a highly unfavorable report on "vaginal rejuvenation" and cosmetic vaginal procedures.[1]
- More recently, an article appeared in *Cosmopolitan* magazine called "Vaginas Under Attack…Don't Let Your Greedy Gynecologist Talk You Into This Horrible Mistake."[2] This article reflected this journalist's opinion after attending the January 2010 International Society of Cosmeto-Gynecologists (ISCG) meeting in Orlando.
- The cover article in March 2010 *OB/GYN News* was entitled, "Controversy Rages Over Cosmetic Gynecologic Surgery."[3] It was a very biased and negative piece full of so much nonsense that it spurred me to write the editors a long letter, which they did publish.
- Another negative article entitled, "Surgeons Clueless About Female Sexuality" appeared early in 2010 in *The Huffington Post*.[4] This was a different journalist's opinion after attending the last ISCG Global Symposium meeting on cosmetic vaginal surgery in September 2010. Each meeting seems to generate some form of viperous response, even as many of the attendees are learning important information about a new field.

After thinking about these articles and their potential influence, I would like to discuss the popular arguments against our subspecialty, as a way to organize our thoughts regarding what we do. I also hope to analyze from a woman's point of view what might be inciting our critics. Some of you probably don't care what they think, but we should. The hope is that together we can make cosmetic gynecology a respectable medical subspecialty. In developing a process that requires a deeper understanding of our critics, I have summarized the controversy into what I call the "Top 10 Arguments Against Performing Cosmetic Gynecology."

In reverse order, these are what I consider to be the most important arguments:

10. It's not medically indicated.

9. It's not been proven to be safe and effective; potential long-term complications may occur.

8. Women are not educated about the wide range of "normal."

Presented at the International Society of Cosmetogynecology 2nd Global Symposium on Cosmetic Vaginal Surgery, Venetian Hotel, Las Vegas, Nev, September 24, 2010.

7. Women requesting these procedures often really need psychological counseling.

6. Doctors are promoting an unrealistic ideal.

5. Doctors are doing it just for the money.

4. It's unethical.

3. Women are being forced by social pressures to seek these procedures; it's a women's rights issue.

2. Seminars offer industry secrets for a high price; dissemination of scientific knowledge is restricted.

1. ACOG doesn't support it.

I would now like to analyze these points one by one.

10. It's not medically indicated

This statement is absolutely correct. Labiaplasty is a cosmetic procedure; it should be considered no differently than breast augmentation, rhinoplasty, or any other purely cosmetic procedure. Arguing that there are medical indications for labiaplasty weakens our position. There is no doubt that some women experience some discomfort from large labia with exercise or other activities, but no worse than some women experience from their pendulous breasts before a breast lift or from their pannus prior to abdominoplasty. Psychological discomfort or distress may be associated with having a large nose, but we don't consider rhinoplasty to be medically necessary. Highlighting the discomfort aspect is rationalizing the true reason for the surgery, which is that the patient doesn't like the way it looks. As one astute critic pointed out, men walk around with things hanging down all day and can bike, exercise, and otherwise manage without having them removed.

Citing medical indications also gets into gray areas with insurance coverage; medically necessary equates with "paid for by insurance," and neither the insurance industry nor the cosmetic surgeon wants that. In my practice, I am very clear with every patient that this is entirely a cosmetic procedure; the potential benefit is limited to improvement in patients' self-perception. I don't claim that it will do anything else for them; I specifically do not claim that labiaplasty will improve sexual function, comfort level, or anything else. It will just change the way the labia looks. If the patient happens to be more physically comfortable as a side effect of her cosmetic surgery, then everyone is happy, but this is not the primary reason for the surgery. However, I strongly believe that a woman has the right to change the way any part of her body looks if she feels that this will improve her self-esteem.

Vaginoplasty is less clear as far as "medical indications." In my practice, I screen for any functional problems that may occur; a patient with stress incontinence or other medical symptoms quickly becomes a medical patient and is not even in my cosmetic practice any more. I still fix the problem, but the patient is billed through insurance and is considered an entirely different animal. Patients with no functional problems who simply want a tighter vagina are the ones we are talking about here. Again, I make no promises other than that vaginoplasty will decrease the diameter of the vagina and introitus. I cannot promise that this will improve sexual function, but if the patient wants a tighter vagina, I can do that. I discuss with my patients that some evidence indicates that sexual function may be improved, but that this is not guaranteed. I absolutely would not use vaginoplasty alone to correct stress incontinence; we all know that anterior repair offers poor results for long-term correction of stress urinary incontinence.

Citing medical indications increases criticism suggesting that we are "disease mongering," or are creating problems that don't really exist, to generate surgeries. Critics correctly point out that in other cultures, larger labia are perfectly acceptable and may even be preferable. Saying that labiaplasty is medically indicated suggests that there is something inherently wrong with large labia that needs to be fixed, which of course is not true. Clearly, there is nothing "wrong" with large labia, large noses, or large breasts. This is all about personal preference and personal choice and cultural norms—not medical necessity.

I don't "sell" these procedures; frankly I almost try to talk patients out of them by negating any of their preformed ideas about what they believe surgery will do for them. We owe it to our patients to be completely honest. This is cosmetic surgery, nothing more and nothing less.

9. It's not been proven to be safe and effective; potential long-term complications may occur

A recurrent theme from our opponents suggests that cosmetic gynecologic procedures lack long-term and specifically prospective data on efficacy and risk. I think if we agree that there is no medical indication, efficacy largely depends on safety and satisfaction. If we are doing purely cosmetic procedures, then the most important end point is patient satisfaction. If we can document, as we have in retrospective studies, that a great majority of patients are happy that they had the procedure, then that problem is solved. But if

we insist that there are medical indications, we then have to prove that our procedures actually fix these medical conditions.

As far as complication rates, a recent study of outcomes[5] has confirmed, as have other smaller studies, that the risk of complications from cosmetic gynecologic procedures is very very low, and that outcomes are very good.[6–8]

Think about other cosmetic surgeries. People may die during major procedures such as abdominoplasty and not infrequently have long-term adverse effects such as chronic pain and lack of sensation. All surgery is associated with risk, but the risk involved in these procedures is exceedingly low. When it comes to vaginoplasty, data on risks and outcomes are much more abundant, because we could look at more than 50 years of data on cystocele, rectocele repair, and colpoperineoplasty. Although complications no doubt differ based on the surgeon and his or her level of experience, I have yet to see any evidence at all supporting the ideas quoted in many articles about serious long-term problems. These ideas are based on fear and come from the authors' imagination, as absolutely no data are available to back up these statements, and well-trained gynecologic surgeons who understand and are respectful of anatomy simply will not have these problems, which I call "imaginary risks."

The *Cosmopolitan* article suggests that these procedures cause pain, loss of tissue, disfigurement, and loss of sexual function. These suggestions were based not on data, but simply on the author's fears. Rare anecdotal reports do not equate to evidence against these procedures.

The Huffington Post piece suggests that the labia are sexual organs, and that removing them diminishes sexual function, although no evidence to that effect has been put forth. Nor have I ever met a woman post labiaplasty who felt that her arousal was altered adversely. It is just nonsense to contend that the labia are essential elements in sexual function. Of course we all obtain consent for any surgical procedure. I have a detailed consent form for each procedure, and I am sure we all have one. The idea that patients are not being told about potential risks is, I hope, incorrect. I go through this consent form personally with each patient line by line several days before the procedure. I tell patients that I don't expect any of these complications, but that they are possible. I tell them honestly which problems I have seen before (such as asymmetry) and how I corrected them and which problems are largely hypothetical (such as significant bleeding). We need to not brush over potential complications to make a successful outcome sound more likely. Again, this comes down to avoiding all sales techniques. We are not selling these procedures; we are presenting facts and allowing the patient to choose.[9]

A lot of talk has focused on the potential impact of childbirth on these procedures. Generally, this argument focuses on labiaplasty, because vaginoplasty is usually offered to patients who have completed childbirth. I am not really sure what all the fuss is about. The worst case scenario is that the postoperative labia will tear; the argument is that scarred tissue is not as elastic as virgin tissue. Guess what! Labia and other genital parts tear all the time during childbirth, and we fix them, so I do not see the problem. Will they look different after childbirth? Sure they will, so will the breasts, abdomen, and everything else. The body changes after childbirth, whether the patient has had surgery or not. Patients frequently have breast augmentation or reduction surgery before pregnancy, and no one gets upset about the obvious fact that childbirth will alter the surgical results, or even that breastfeeding may be prevented by certain incisions. This is the patient's choice.

I have read several times the argument that because businesses have sprung up to offer repair of so-called botched labiaplasties, there must be a lot of complications. Obviously, every field has a handful of bad doctors who provide work for others who fix their mistakes; no one should venture into this field without the right innate skills and adequate training.

Here is a problem: How does one get adequately trained? A 3-day course in which participants observe a few cases is valuable but in no way qualifies an individual as an expert. I hope that in the future, we are able to offer more hands-on courses, preceptorships, or even fellowships to ensure adequate training. I admit that I dodged a number of bullets in my first 10 or so cases through careful consideration, and because of my years of previous surgical experience. A beautiful, symmetric labiaplasty that includes a prepuce reduction is extremely challenging and requires time, patience, and meticulous attention to detail. One of my colleagues asked me, "What's the big deal? Don't you just chop them off and whip stitch the edge?" A cosmetic case may take 1½ hours of supreme concentration, and every single case is different. No data are available to support claims of a large number of botched cases coming out of the offices of board certified gynecologists. We as a group need to make

absolutely sure that our critics' fears in this respect are never validated.[10,11] Informed consent includes information indicating that scars may result that require revision, or that some cases may require more than one procedure before the patient is satisfied with the result. This occurs in the hands of even the most experienced cosmetic surgeons, working in all areas of the body. The need for repeat surgery does not indicate "botched" surgery. Educating the patient about expected outcomes is one of the keys.

8. Women are not educated about the wide range of "normal"

My patients are generally way more savvy than that. To suggest that they are not is insulting. Patients generally come in after having looked at hundreds of pictures on the Internet and after having done their homework. They have studied the befores and afters of 10 surgeons and have no question that there are lots of different "befores." As part of my initial consultation, I discuss the many shapes and sizes of labia and that the patient has a very common type, but if she prefers to change them, it is her right to choose, just as she could change the size of her nose or breasts if she wished to.

Obviously, we should never suggest that a patient's anatomy is "abnormal." I DO think that it is important for the patient's self-esteem that she hear that we have seen her type of anatomy many times before, and that she has nothing unusual (even when she does). This is just compassionate. I have yet to have a patient present requesting labiaplasty who hears me say that her labia are actually not unusual and then changes her mind. Patients come in knowing what they want. I am just following their instructions. As I said, I have made a point of trying to talk the patient out of the surgery. I pretend each patient is a mole from *The Huffington Post* who is trying to catch me in an unethical hard sell. I tell her she is fine and that she doesn't have to change anything if she doesn't want to. She always says, "Yes, I know, but can you do it?" And I say "Yes, I can."

Women may be very educated and still have trouble with some of the terminology that we use. Some basic terms such as *clitoral hood*, *prepuce*, and even *labia minora* may be confusing to some patients, and the use of diagrams or models is very helpful in ensuring that you are on the same page as the patient.

I personally use the term *labial hypertrophy* (as most of us do) to describe the indication for a reduction labiaplasty, but critics make a valid point that if there is no such thing as normal, how can we define "hypertrophy"? Use of this term implies that it is "too big" or "abnormal," so perhaps to be completely politically correct we would use the diagnosis "patient perception of labial hypertrophy."

Other terms such as LVR and DLV are frankly confusing to anyone who thinks about them for longer than a few minutes. The use of such trade names in my opinion really does a disservice. It creates the perception that we are trying to confuse or coerce the patient into buying a procedure that is really something else. Using these terms supports the criticism from academic groups like the ACOG who correctly recognize that they are not meaningful medical terms.[12]

LVR, or laser vaginal rejuvenation, as we all know is really an old-fashioned A/P repair in which a laser is used for no longer than a few seconds as a cutting tool. There is certainly an implication that some type of extensive laser resurfacing or other use of the laser is a major part of the procedure, but it is not. There is also an implication that the laser somehow makes it better, which there is no evidence to support, unless you sell lasers or get a cut from those who do. The term "vaginal rejuvenation" is also nonspecific and is not a useful medical term. We could apply this term just as well to the use of vaginal estrogen or doing Kegel exercises.

DLV, or designer laser vaginoplasty, is even more confusing and potentially deceptive, as it actually describes a labiaplasty of the labia minora or majora, and it has nothing to do with the vagina or a vaginoplasty. I personally do not use these terms.

We also loosely use terms such as "clitoral hoodectomy" or "reduction of prepuce" for essentially the same procedure. In my opinion, we should standardize the terms that we use to describe known surgical procedures, both to help the public understand what we are really doing and to avoid criticism that we are creating a "mystique" as a way to sell procedures to gullible patients who think they are getting more than they really are.

7. Women requesting these procedures often really need psychological counseling

OK, does everyone seeking cosmetic surgery need psychological counseling? One could make that argument. Why is our self-esteem so wrapped up in the way we look? Labiaplasty is no different than any other cosmetic surgery. Occasionally, are there deep-seated emotional issues that cause a person to seek

body alteration of any type? I think because we are talking about sexual organs, we all tiptoe around these issues a little more than in other procedures. It is appropriate to try to figure out the patient's motivations for her sake and ours. No one wants to operate on a psychologically unstable patient, and if her problem is psychological and not physical, then surgery won't fix it, and she won't be satisfied.

I always meet the patient fully clothed in my office. We talk face to face for 15 minutes, and I get to know her a bit before performing the examination and taking preoperative photos. After the examination, I have her get dressed, and we talk in my office again and look at the pictures. You can learn a lot about the patient that way. Is she nervous or fidgety? Does she look you in the eye or look at the floor? Is she looking to someone else for reassurance or guidance in her decision? How does she dress and walk?

We have to be able to turn patients away. Sometimes their psychological issues are obvious, and sometimes you just get an uncomfortable feeling. I have learned to listen to that feeling as an indicator of potential trouble.

In my practice, asking a few simple questions can help the practitioner to isolate the reason why the patient is seeking surgery. I don't obtain this information by using a questionnaire, but by the end of the visit, I make sure I have answered these questions in my own mind. Is the patient being coerced or pushed into doing this by another person, particularly a male partner? Has she ever been told, particularly by a man, that there is something wrong with her, or that she is abnormal? Does she have realistic expectations about what the surgery will do for her? Does she have a history of multiple cosmetic procedures or eating disorders, which may suggest body dysmorphic disorder? Does she have an exaggerated idea of how "bad" she looks? Is she taking a handful of psychoactive drugs? These are patients who may require some preoperative counseling.

6. Doctors are promoting an unrealistic ideal

As I have said, I personally think it is important not to "promote" any ideal or make any statements about what looks best. I just sit back and listen to what the patient wants, then I help to create that for her. I can honestly say that I don't think any type of labia is better than another. In 30 years, the fashion may be to have longer labia, and then I may offer a service that provides that.

Whether communicating verbally or through patient literature or Websites, we should avoid using statements that imply judgment. Should we offer to create a "more beautiful" or "more youthful" appearance by making the labia smaller? Even terms such as "enlarged labia" or "labial hypertrophy" can be viewed as judgmental. Simply calling these procedures "cosmetic vaginal surgery" minimizes misunderstanding and avoids the use of cliches that are more appropriate for over-the-counter make-up sales. The Ob/Gyn doctor is seen by many as the patient's most trusted physician. This gives us an added ethical responsibility. Patients view us differently than they view traditional plastic or cosmetic surgeons. Perhaps when you go to the plastic surgeon, you are expecting a harder sell; you understand that judgments about beauty will be everywhere, and you won't be offended if physicians promote themselves or their services. Those readers who are full-time cosmetic surgeons may not have these issues because they are not blending traditional medical and cosmetic practices. My approach is to "offer" a variety of services, but to be very cautious in pushing or promoting them. Some people are offended when medical doctors are seen "marketing." We are held to a different standard than other businessmen, and we open ourselves up to personal attack when we are involved in promoting any service or procedure that may be seen to be solely financially motivated.

5. Doctors are doing it just for the money

Speaking of financial motivation, I am personally not doing it JUST for the money, but why are we embarrassed as Ob/Gyns to admit that getting paid well is a legitimate motivation? Cosmetic surgeons learned long ago to combine ethical practice with an income and are not shy about it. It is no wonder that we have not gotten anywhere by negotiating with insurance companies for better payment, when as a group we are so ashamed to place a monetary value on our skills.

People love to talk about whether the fees for any cosmetic procedure are reasonable. As a doctor, I think it is important to be subtle and humble about it, to avoid the perception that we may have made our money at our patients' expense. But those of us who accept insurance know that the public misunderstands how little we are paid for traditional services.

The *Cosmopolitan* article included a comical comment, saying that doctors get paid twice as much to do labiaplasty as to deliver a baby! Although this is

intended to shock the reader into thinking that doctors charge outrageous amounts of money for labiaplasty, any Ob/Gyn would read it differently—that we are paid outrageously low to do a delivery! In Houston, the average global insurance payment for a delivery is $1700, which for those not in the business means that for 9 months of prenatal care, the delivery itself, and the postpartum visit, this is all you get. This is obviously completely unreasonable. My fee for a labiaplasty is $3500 to $5000, which I believe is entirely reasonable and is consistent with the local market; this is indeed about twice what I get to deliver a baby. Misunderstanding about what we are paid is widespread. We polled our patients and learned that the average patient thinks we get $10 000 for a delivery. Maybe the *Cosmopolitan* author thinks the same, and that we must therefore get $20 000 for a labiaplasty!

4. It's unethical

We are all familiar with the principles of medical ethics, which are the focus of this article. I believe strongly in patient autonomy. If an educated adult patient requests this surgery from a surgeon who is trained to perform it, I think it is unethical to deny her this right. It all goes back to the same point. It is cosmetic surgery that is not medically indicated and has a small but measurable risk, and if the patient is aware of all this and wants to proceed, she should be allowed to do that. Cosmetic gynecology respects the patient's autonomy; procedures do no more harm than any other elective surgery with minimal risk, and they potentially do some good (from the patient's point of view). I cannot imagine an argument that creates an issue with "justice." I agree that it is unethical to tell people that they need a labiaplasty to promote a certain ideal, or to sell your procedures as something they are not, but as advocates of women's rights, we have to allow women the right to choose to alter their bodies however they desire.

3. Women are being forced by social pressures to seek these procedures; it is a women's rights issue

This is one of my favorites, as it seems to single out labiaplasty as a lone evil among all other body altering or beauty enhancing services. I suppose social pressures "force" us to do almost everything we do in life; philosophers may ask whether any of us is truly "free," because society largely dictates what we think we want. The cosmetic gynecology industry is no more a result of social pressures than the diet industry, the fashion industry, every aspect of antiaging medicine, and obviously all other cosmetic surgeries.

As a woman, I am able to criticize certain feminists more freely than some of my male counterparts. So I will say that there seems to be a fine line between feminism and paternalism, which is essentially its opposite. The same feminists who demand that women have equal rights and freedoms doubt a woman's ability to make an informed decision when she chooses something those feminists don't approve of (cosmetic surgery). No doubt such feminists would not oppose body alterations such as tattoos, piercings, or even a sex change. Why labiaplasty is singled out as an evil among these is truly a mystery to me.

What is the alternative… imagine telling women that they are not allowed to choose to alter their own bodies. Imagine telling the patient, "You just think you want that done, but it's not really what's best for you. You might think it is, but you don't make good decisions, and I know better what is best for you." This is the definition of *paternalism*, an outdated paradigm of medicine. Think of women in other countries who are "forced by society" to wear constrictive brass bands around their necks. Do they need psychological counseling or to be rescued from their own bad choices? Clearly their body alterations are the result of social pressures, but on some level we think they are kind of cool and amazing. We could rush to save these women from the oppression of their neck rings and tear them off, but they would put them right back on again because they like them. They don't want to be saved. It's their life, and their choice.

Comparisons are even drawn between forced genital mutilation and cosmetic gynecology. The argument is that social pressures make a mother circumcise her young female child to preserve her sexuality until marriage. The same social pressures force us to think that our genitals are unattractive and need to be altered. If we follow that argument, then all patients seeking cosmetic surgery are victims of social pressures and are not truly consenting. As a woman and a fierce advocate of women's rights, I can understand that argument, but I would counter that genital mutilation is exactly the opposite of cosmetic surgery. Are the religious/social forces that require female genital mutilation a form of male-dominated social control and coercion, forced on girls too young to give any kind of consent? On the other hand, labiaplasty allows personal freedom to choose and to have control over one's own body.

Unfortunately, as hard as we try, women's heath is still plagued by sexism and standards that we do not apply to male health issues. An obvious double standard that comes to mind is that a number of respectable urologists offer penis altering/enlarging procedures, and I have yet to hear the suggestion that men seeking these procedures should be sent to a psychologist, or that the urologist is unethical. Even more of a double standard is the practice of male genital alteration in the form of circumcision, which is considered so routine that it is performed on newborns, even though it is regarded by most pediatric societies as not medically necessary. Numerous serious complications have been cited for newborn circumcision, yet the procedure is still performed on more than 70% of American newborn boys. This raises some serious ethical issues, which are generally ignored by the public and by most physicians. I am not saying that two wrongs make a right, and I have no particular opinion on newborn circumcision. But I would challenge any critic of cosmetic gynecology to examine his or her opinion on the subject, because if you oppose one view, you surely must oppose the other.

2. Seminars offer industry secrets for a high price; dissemination of scientific knowledge is restricted

The ACOG opinion and statements from other sources are critical that courses in cosmetic gynecology are restrictively and unreasonably expensive, and that information learned in these courses is not freely shared. Certainly if we had learned a cure for cancer, we would be ethically obliged to share it for the greater good. But if we agree that these procedures are not medically necessary, I suppose it is not unethical that those who learn the information hold their cards close to their chest, so that they may have a unique marketable skill. Courses are available to anyone who wants to pay the fee, so there IS no restriction.

Throughout my life I have learned a lot, but I have yet to attend a valuable course that was free. I for one have no problem with sharing my knowledge, although in certain settings I would charge by the hour for it. I think we should all do the same, because it strengthens our specialty if we can all learn from each other. I do disagree with groups who try to block the dissemination of their techniques by using patents and fear of lawsuits.

We should not be afraid of competition. I work in an area with 200 Ob/Gyns within a 3-mile radius, and 4 other groups practice in my building, but I make sure that my practice is the best and has a unique niche, so we are very successful.

1. ACOG doesn't support it

The September 2007 Committee opinion has been the greatest resource material for our critics. When people mention that "ACOG opposes cosmetic gynecologic procedures," I reply that this is like saying "Americans are Christian" or "Americans support abortion." It is a subgroup in a power position, but it certainly does not represent the position of the whole organization. Many of us are members of ACOG, and no one has asked our opinion. A small group of individuals wrote that opinion largely as a backlash against one particular surgeon's business model. It has very little to do with what most of us are doing today, and most of it I actually have no argument with. I agree that these procedures are not medically indicated, and patients should be educated about the risks. If you read it, you will see that it really doesn't say much. The arguments have all been addressed here; many are out of date and have been refuted by recent publications.

It is unfortunate that ACOG uses its political power to attack individuals by using this "opinion" vehicle, which does not require any scientific evidence. I like to hear facts not opinions when it comes to medicine. Keep in mind that the ACOG opinion changes regularly, as it should, to reflect new knowledge. Think about the past 10 years and changes in recommendations regarding breech vaginal deliveries and keeping the ovaries at the time of hysterectomy, and the very recent change in opinion about vaginal birth after cesarean. It is our job to teach opinion leaders why they should change their opinion by practicing good medicine, continuing to share and learn from each other, and continuing to publish studies, and to avoiding inflaming them with our behaviors.

Final Thoughts

"Perception is reality"—Why are some of us being perceived negatively, and is there anything we can do about it? Providing cosmetic gynecology services that are safe and effective, and that result in satisfactory outcomes, will begin to change perceptions. Doing outcomes research will contribute to the knowledge base. We should treat the field as carefully as we do our practices. I tell my staff that we may think we are fabulous, but if we get a negative comment on a survey, then we are not being perceived the way we intended. The comment is addressed seriously, and, if warranted, changes will be made. It is the testimonials from happy patients that make this worthwhile.

This is why I am a cosmetic gynecologist. The other arguments don't really matter.

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