

Patients Seeking “Vaginoplasty” Deserve Assessment and Treatment by Experts in Female Pelvic Medicine and Reconstructive Surgery

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We are a group of obstetrician-gynecologists with expertise in female pelvic floor medicine and reconstructive surgery (FPMRS), and we write to you in response to your recent publication of “Posterior Vaginoplasty With Perineoplasty: A Canadian Experience With Vaginal Tightening Surgery” by Austin et al.¹ We are concerned that the depiction of vaginoplasty and perineoplasty in this paper does not represent the gold standard of pelvic floor medicine that patients deserve. Furthermore, the attitudes underlying this article undermine women’s healthcare providers and emphasize unjust influences on the healthcare system.

Perineoplasty and vaginoplasty, as described by Austin et al, are not novel. Gynecologists have performed and studied these surgeries as a part of the treatment for pelvic organ prolapse (POP) for over 50 years.² This technique, known commonly as a “rectocele repair” or “posterior vaginal repair,” is a validated surgical treatment for symptoms of pelvic pressure and bulge sensation. In presenting this as a new technique, the authors have seemingly dismissed an entire discipline of surgery.

We assert that all surgeons providing and reporting on vaginal and vulvar surgery should make use of the standardized terminology established by the International Urogynecology Association (IUGA) and the International Continence Society (ICS).³ This will improve their ability to access literature from other specialties, and will assist patients who wish to research these procedures during their decision-making process.

The authors of this paper describe their “vaginal tightening” operation as a treatment for isolated vaginal laxity

and a sensation of “vaginal gaping,” although they recommend a consultation with a gynecologist if POP is detected. However, the majority of patients who describe symptoms of vaginal laxity also have concurrent POP on assessment.⁴ An FPMRS specialist would perform a complete assessment of pelvic floor function, discuss nonsurgical and surgical treatment options, and explain the potential complications of such procedures. We are concerned that aesthetic surgeons are not trained in standardized assessment techniques, and that their patients may be missing out on comprehensive assessment and treatment.

This article also suggests vaginal “gaping” causes an altered ability to achieve orgasm and implies that “vaginal tightening” procedures improve orgasmic response. There is no evidence to support this claim.⁵

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Furthermore, Austin et al report a zero-complication rate in their case series of 30 patients. This is not consistent with the literature, which reports a high rate of dyspareunia following perineoplasty.⁵ Methodologically speaking, this case series was too small and lacked appropriate follow-up data to comment on a true complication rate. We applaud the authors for routinely administering the Female Sexual Function Index (FSFI) to their patients, but we were disappointed that FSFI scores were not reported in this paper. We would also recommend administering the PISQ-IR (Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire, IUGA-Revised) because this captures sexual function and distress and is validated in patients with pelvic floor disorders.

Finally, we must address this paper in the wider context of female genital cosmetic surgery. Both the American Congress of Obstetricians and Gynecologists (ACOG) and the Society of Obstetricians and Gynecologists of Canada (SOGC) have published position statements discouraging gynecologic surgery for cosmetic reasons. ACOG committee opinions are written by obstetrician-gynecologists who have reviewed evidence about an emerging topic in reproductive health. These practitioners may or may not personally perform female genital cosmetic surgeries. The ACOG committee opinion states: “‘Rebranding’ existing surgical procedures (many of which are similar to, if not the same as, the traditional ... posterior colporrhaphy) and marketing them as new cosmetic vaginal procedures is misleading.”⁶

This particular committee opinion also cites evidence that providers who publicize and pathologize depictions of normal vaginas and vulvas contribute to women’s distress and sexual dysfunction.⁶ This is why we were particularly disturbed to read that Austin et al named their procedure “vaginal tightening.” This is not appropriate medical terminology, and reinforces the patriarchal ideal that vaginas primarily serve to provide male sexual pleasure. It also implies that the sensation of a loose vagina—ie, to a partner during penetrative intercourse—is abnormal and should be surgically corrected. The authors even pathologize sounds made during penetrative intercourse, rather than normalizing female anatomy and sexual function.

A patient-centered approach would involve addressing any feelings of shame expressed by women through discussions based on empathy and education.

The authors of this study have taken a procedure from the domain of gynecology and claimed it for their own. We would urge the authors and their colleagues to reconsider their approach to this area of medicine.

Disclosures

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