# LETTERS

## Female Genital Cosmetic Surgery

I was very interested and equally disappointed in the page 1 article entitled, "Controversy Rages Over Female Genital Cosmetic Surgery" (March 2010). While the fact that I am writing a letter somewhat illustrates the point in the title, I am disappointed that the reporter presented what seems to be a very biased report in opposition to these procedures. Including the opinion of a Dr. Indman (who is an expert because?) as her major resource and highlighting his personal opinion below the title and at the end of the article adds an unfortunate and distasteful bias to what otherwise could have been a fair and informative piece.

The most important point in this controversy was alluded to in this article but not expanded upon. Why have we not explored the obvious double standard that this is cosmetic surgery, nothing more and nothing less, and if one objects to labiaplasty as being "unethical," then one must object to all cosmetic surgeries? As Dr. Matlock said, no one needs their nose or their breasts or their tummies done. These are patient-choice elective procedures. No one is suggesting that they are medically necessary. Why are the critics of cosmetic labiaplasty not attacking their plastic surgery colleagues, suggesting that their practices are unethical and that their patients should all be sent to a psychologist before having a rhinoplasty?

Dr. Indman's leading quote implying that performing cosmetic surgery and providing ethical care are not compatible is ridiculous. Isn't one of the basic tenets of ethics "autonomy"? If an educated patient requests cosmetic surgery, isn't it unethical to prevent her from consenting to this option if that's what she wants? His suggestion that labiaplasty surgeons all promote a certain aesthetic ideal, "destroy women's self-esteem ... and charge them a lot of money to fix what [they] have destroyed" is outrageous and uneducated. First, most labiaplasty surgeons don't promote any kind of ideal; they listen to what the patient feels is ideal for her and provide the expertise to create that for her, as would any cosmetic surgeon for any body part. The suggestion by Dr. Tracy that most patients requesting labiaplasty need counseling is paternalistic and demeaning to women. While a subset of women seeking cosmetic surgery suffers from lack of education, body dysmorphic disorder, or other psychological issues, this is clearly a small minority.

In my practice I am very careful to tell all patients seeking labiaplasty that they are "normal." I routinely show them pictures of other labia of various shapes and sizes and make no statements about which ones are best. Beauty is in the eye of the beholder. Small breasts, saggy eyelids, and big noses are "normal" too, but no one argues that we have a right to change them in an attempt to approach whatever aesthetic ideal appeals most to us if we want to. There seems to be a very fine line between "feminism" and paternalism. The same feminists who demand that women have equal rights and freedom then doubt a woman's ability to make an informed decision for herself when she seeks something that feminists don't approve of (cosmetic surgery). No doubt such feminists would not oppose body alterations such as piercings, tattoos, or even a sex change. Why labiaplasty is singled out as an evil amongst these is a true mystery to me.

The focus of some critics on the "lack of data" and particularly the absence of randomized controlled trials regarding labiaplasty again illustrates the lack of understanding that this is purely a cosmetic procedure, and that no claims are made regarding outcome other than meeting the patient's desire. As Dr. Pelosi said, the only important end point is patient satisfaction. As for the lack of randomized controlled trial (RCT) data, what a ridiculous idea. How on earth could one do an RCT on a cosmetic procedure? In fact, a number of prospective studies on the safety and satisfaction rates of labiaplasty have been done, and more are on the way. Universally the studies published have demonstrated a very low risk and excellent patient satisfaction.

Dr. Tracy's point that women should be educated about the risk of "bleeding, infection, pain with intercourse, and scar tissue" suggests that this is not part of the routine consent for a labiaplasty. In my practice, although I perform several cosmetic labiaplasties a month and have never had any complications, patients sign a detailed consent form, as they would for any surgery. Of course this is done, and suggesting that it is not is uneducated and insulting to cosmetic gynecologists. People die or suffer major complications during cosmetic surgeries such as abdominoplasty and liposuction fairly regularly. Labiaplasty is surgery and all surgery has risk, but compared with major cosmetic surgeries, the risks are minor and are discussed with every patient in detail prior to the procedure.

Another double standard that occurs to me surrounds the routine performance of male circumcision, which is generally understood to be a cosmetic procedure as well, and is routinely performed on newborns who cannot consent. Why is alteration of the cosmetic appearance of the penis acceptable, so acceptable in fact that it can be performed on a newborn, but cosmetic alteration of the female labia in an adult consenting patient is suggested to be unethical? What if an adult male seeks penis enlargement or circumcision because he doesn't like the way his penis looks? Should he be sent to a psychologist? If a urologist offered these services, would he be criticized?

The repeated suggestion that gynecologists are moving toward cosmetic surgery to make money, and that there is something wrong with that, is interesting. I personally added cosmetic surgery to my practice for lots of reasons. There was a demand, I had the skills, I found that I am good at it, I enjoy it, it makes patients happy, and I get paid well (in that order). Why are we embarrassed to admit that getting paid well is a legitimate motivation? Cosmetic surgeons learned to combine ethical practice with a lucrative income long ago and are not embarrassed about it. It is no wonder that we have not gotten anywhere negotiating with insurance companies for better payment when as a group we are so ashamed to place a monetary value on our skills.

As for the criticism that courses in cosmetic surgery are expensive and secretive, I have yet to go to a valuable educational course that was free. I was happy to pay for the cosmetic courses that I attended, they were open to anyone who was willing to pay the fee, and the information I learned was incredibly valuable.

In the past I have paid a high price for laparoscopy courses and a number of courses on various ob.gyn. topics. I am always happy to pay an expert for their time in training me to learn something new. Why is this any different?

I am happy that you published an article on this subject as it obviously illustrates some personal inconsistencies in many of our practices that should be examined. While I am disappointed in the author's bias, I am glad that the topic is getting some attention, and I hope to see more discussion of it in the future.

*Susan Hardwick-Smith, M.D.*
*Houston*


## Editorial Advisory Board

**Eric J. Bieber, M.D.,** Case Western University Hospitals, Cleveland, Pa.

**Constance J. Bohon, M.D.,** Georgetown University, Washington

**Edie Derian, M.D.,** Geisinger Health System, Danville, Pa.

**Bruce L. Flamm, M.D.,** University of California, Irvine

**Charles B. Hammond, M.D.,** Duke University Medical Center, Durham, N.C.

**Melissa Kottke, M.D.,** Emory University, Atlanta

**Charles E. Miller, M.D.,** University of Chicago

**E. Albert Reece, M.D.,** University of Maryland, Baltimore

**Ritu Salani, M.D.,** Ohio State University, Columbus

**Luis E. Sanz, M.D.,** Virginia Hospital Center, Arlington, Va.

**Lori Sevald, R.Ph., M.D.,** private practice, West Palm Beach, Fla.

**Jan Leslie Shifren, M.D.,** Harvard Medical School, Boston

**Cyril O. Spann Jr., M.D.,** Emory University, Atlanta



## LETTERS

Letters in response to articles in Ob.Gyn. News and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

**Mail:** Letters, Ob.Gyn. News, 5635 Fishers Lane, Suite 6000, Rockville, MD 20852

**Fax:** 240-221-4400

**E-mail:** obnews@elsevier.com


## VERBATIM

*'If you're considering induction for a VBAC candidate who has an unfavorable cervical exam, reconsider it. Research has also shown that women who require multiple agents for induction have the highest rates of uterine rupture—rates that are almost four- to fivefold higher than those for women who labor spontaneously.'*

Dr. George A. Macones, p. 28