



RACGP

*Female genital
cosmetic surgery*

**A resource for general practitioners
and other health professionals**



Female genital cosmetic surgery – A resource for general practitioners and other health professionals

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Preface

The subject of female genital cosmetic surgery (FGCS) has only recently been investigated in Australia. International medical research is also limited, with the few published articles that deal with the primary care physician's role available from a search of journal databases such as Medline and PubMed, having been published in the UK. Timeframe restrictions were not applied in these journal searches and saturation of material was achieved in early 2015, when no new papers were discovered in either database. Overall, the search showed there was a lack of evidence-based research in the literature.

References and publications used by key authors were analysed. The works of the most commonly cited and published researchers are from the UK, Canada and the US. Their material was searched by hand. The ethical discussion papers from various countries' colleges of obstetrics and gynaecology have also been very informative.

The range of information acquired was from sources as diverse as mainstream media, documentary programs, ethical and feminist publications, case studies and surveys by plastic surgeons, public discussion forums and web-based platforms. Exploration of online marketing of FGCS, available surgical procedures and discussions in women's magazines were also considered. FGCS raises many issues for the general practitioner (GP) and other health professionals, as well as the broader community.

Some compare FGCS procedures to female genital mutilation/cutting (FGM/C). The World Health Organization (WHO) defines FGM/C as 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or non-therapeutic reasons'.

Given the paucity of quality evidence in the area of FGCS, all recommendations in this document should be considered at National Health and Medical Research Council (NHMRC) practice-point level. However, the rising demand for this procedure means there is an urgent need to provide the profession with guidance. There are similarities in the rate of increase for FGCS in the UK, the US and Western Europe between 2000–14. Continuing research will serve to expand and broaden our understanding of the issues raised.

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Introduction

Female Genital Cosmetic Surgery (FGCS) refers to non-medically indicated cosmetic surgical procedures that change the structure and appearance of the healthy external genitalia of women, or internally in the case of vaginal tightening. This definition includes the most common procedure, labiaplasty, as well as others, such as hymenoplasty and vaginoplasty, also known as vaginal reconstruction and vaginal rejuvenation.^{1,2}

According to figures from Medicare, the number of women undergoing medicare-billed vulvoplasty or labiaplasty in Australia has increased from 640 in 2001 to more than 1500 in 2013, an increase of 140%.³ The highest number of claims was equally distributed between three age groups: 15–24, 25–34 and 35–44. However, these numbers do not reflect the whole picture as many may seek FGCS through the private health system without necessarily claiming a rebate or may not meet the criteria for this item number.⁴

There has been no concomitant rise in the incidence of congenital or acquired disease conditions that warrant this surgery.⁴ Rather, it appears that in response to changing cultural norms, this surgery is increasingly being sought by women who want to either feel 'normal' or look 'desirable'.² As a result, general practitioners (GPs) are increasingly managing patients who present seeking surgery due to concerns about the appearance of their genitalia.⁵

Labiaplasty is the most common form of FGCS requested and performed, accounting for around 50% of the procedures performed.^{4,5} The terms labiaplasty and FGCS will be used interchangeably throughout this document unless otherwise specified.

This guide aims to help inform GPs and health professionals about FGCS, including the factors influencing demand, and provide a set of recommendations on how to manage women requesting referral for FGCS or expressing concern regarding their genitalia.

1. Information on FGCS

1.1 Genital diversity

Exactly what constitutes 'normal' female genitalia is an area of medicine in which very few studies have been published. The handful of articles that do outline the measurements of female genitalia vary in their definition of hypertrophy and normal.^{4,6-10} There are currently no criteria that measure and describe normal female genital anatomy and medical textbooks also lack detail regarding range of diversity and measurements.

FGCS has been described as aiming to 'improve the appearance of the external female genitalia' and cure labial hypertrophy,⁹ yet it relies on little evidence of what exactly constitutes labial hypertrophy and, by extension, a normal labia which can include size, colour and shape.¹¹

1.2 Female genital cosmetic procedures

FGCS is also referred to in the public domain as 'designer vagina', 'vulvovaginal aesthetic surgery',² 'barbiplasty' and 'vaginal rejuvenation'. Documentation describes the labiaplasty procedure as being performed as early as 1976.⁹

1.3 Who performs FGCS?

FGCS can be performed by anyone with a medical degree, including cosmetic surgeons (usually a GP or dermatologist who performs cosmetic procedures), gynaecologists, plastic surgeons and urologists.^{3,5,9,12}

No formal training is required and there are currently no evidence-based guidelines that support the cosmetic procedures. For all specialties, guidelines need to be established from reputable long-term studies in order to support surgical procedures, but these have not yet been developed.⁴

1.4 Range of surgical procedures

Labiaplasty – the most commonly performed FGCS procedure, this involves removal of tissue from labia minora that extends beyond the labia majora and/or removal or increase tissue from the labia majora in order to achieve symmetry.

The procedure falls into two broad categories:

- Amputation technique, or labial trim, where the edge of the labium is cut out and the edges sewn over.¹⁰
- Removal of a section of the labia to preserve the natural contour, such as wedge resection^{4,5} and de-epithelialisation techniques.^{12,13}

Clitoral hood reduction – exposes clitoris and aims to increase sensitivity. This is sometimes combined with a labiaplasty procedure.

Perineoplasty – undertaken to strengthen the pelvic floor and, in the FGCS setting, aimed at establishing penile pressure with coital thrust.¹⁴ This procedure is technically similar to perineal reconstruction, in which the perineal length is restored following childbirth trauma or previous surgery. It is commonly performed as part of vaginal prolapse surgery. However, even in this setting there is no evidence that this procedure improves sexual function and, in fact, it may cause dyspareunia.

Vaginoplasty – the purpose of this procedure is vaginal creation in gender reassignment but, in the FGCS setting, it refers to tightening the vagina, which can be surgical or non-surgical – as in ‘laser vaginal rejuvenation’ or ‘designer laser vaginoplasty’.

Hymenoplasty – also called ‘revirgination’ and is designed to restore the hymen. It is often advertised as a ‘gift’ to one’s partner.¹⁴ This procedure is occasionally requested by women of certain cultural backgrounds in which premarital sex is forbidden and an intact hymen is considered evidence of virginity.¹²

Vulval lipoplasty – removal of fat from mons pubis or augmentation of the vulva.

G-spot augmentation – involves autologous fat or collagen transfer via injection into the pre-determined G-spot location. There is no existing scientific literature describing this procedure. Similar procedures include G-spot amplification and G-shot collagen injection into the region.¹⁵

Orgasm shot (O-shot) – often described as a sexual and cosmetic rejuvenation procedure for the vagina using the preparation and injection of blood-derived growth factors into the G-spot, clitoris and labia.^{12,14}

Terms such as ‘vaginal rejuvenation’, ‘designer laser vaginoplasty’, ‘revirgination’ and ‘G-shot’ are commercial in nature. The consumers at whom they are targeted can then mistakenly believe such official-sounding terms refer to medically-recognised procedures.^{17,18}

Cosmetic surgery redefines the patient as a ‘consumer’, and uses advertising to promote the ‘product’. Advertising for female genital cosmetic surgery tends to reflect and reinforce sociocultural messages about the vulva and vagina, potentially creating dissatisfaction among women who do not meet the narrow ideal of normality. Advertising suggests that FGCS procedures are simple, and offer high levels of satisfaction. It normalises surgical procedures and is likely to create demand among those women who experience genital dissatisfaction.^{14,15}

1.5 Risks and complications

The potential risks associated with FGCS include:

- bleeding⁴
- wound dehiscence⁴
- infection⁴
- scarring, resulting in lumpy irregular margins of tissue or eversion of inner lining of labia, resulting in an unnatural appearance^{4,12}
- sensorineural complications secondary to poor healing or scarring
- dyspareunia^{4,19}
- removal of too much tissue, resulting in pain with and without intercourse – for example, clitoral hood reductions where too much clitoral tissue remains exposed and rubs onto undergarments and causes pain and discomfort³

- tearing of scar tissue during childbirth following previous FGCS procedures⁴
- psychological distress⁴
- reduced lubrication.⁴

The long-term outcomes of FGCS have not yet been researched.¹⁰ Trends change and the aesthetic ideal that is promoted now might alter with time.⁸

No controlled evaluation of short- and long-term clinical effectiveness of cosmetic procedures can be identified in published literature.^{4,16,20} According to Professor Helen O'Connell, urological surgeon at the Royal Melbourne Hospital, tissue that is excised in labiaplasty may appear to be 'just skin', but the labia minora are derived from the primordial phallus and its excision is likely to interfere with sexual pleasure.¹⁹

In the past, cosmetic genitoplasty has been criticised and debated because it can result in impaired sexual function.²¹⁻²³ The nerve density, epithelial qualities and vascular compartments of the labia minora that contribute to sexual arousal and orgasm are poorly defined. Surgical procedure development and counselling about surgical risks related to labiaplasty may be based on inadequate information.²⁴

2. *Factors influencing increased demand for FGCS*

2.1 Perception of ‘normal’ versus ‘desirable’

The sociocultural norms that are believed to influence women’s perceptions of ‘normal’ are considered to be significant in driving the climb in this group of procedures.^{1,25–27}

Not only does modern culture classify the minimalist vulva, where the labia minora do not extend beyond the margin of the labia majora, as ‘good’, but also the protruding labia as ‘bad’.^{27, 28–31}

Currently available research indicates that perceptions of ‘normal’ versus ‘desirable’ may be skewed and disparate, resulting in a narrow definition of normal.^{29–31} Labiaplasty has also been intensively marketed as an unproblematic lifestyle choice for women.^{1,14,18,20,27,32}

2.2 Digital communication, digitally modified images and pornography

There is little doubt that today’s digital age is changing the way we acquire information and communicate. As a result, people are influenced by information and digitally-modified images found on the internet. Despite access to these images and the plethora of internet-based pornography, there is little firm knowledge regarding female genital structure, function and vocabulary within the community.³³ Pornography mostly depicts digitally-modified images that portray women’s genitals with no labia minora protrusion, thus potentially skewing young women’s (and men’s) perceptions of what is considered normal.^{32,34,35,36}

Australian censorship laws prohibit the publication of illustrations of the labia minora and the clitoris.^{32,35} Vulvas are invariably made to resemble that of prepubescent girls, with pubic hair removed and a single crease placed between the labia majora,^{29–32} which contributes to the general lack of knowledge and understanding about female genital diversity.

A recent study from South Australia’s Flinders University revealed that women who had greater exposure to images of female genitals were more likely to consider labiaplasty. Of the 351 women aged 18–69 who were surveyed as part of the study, 17% were interested in having labiaplasty.²⁷

Most women who are contemplating any form of FGCS are likely to seek information from provider websites. These sites often describe aesthetically pleasing or desirable genitalia as the neat single slit. The quality and quantity of clinical information in FGCS provider sites is poor, providing erroneous information in some instances.^{14,28,29,34}

Health professionals are influenced by similar sociocultural forces that skew preferences for desirable versus normal.^{10,37,38} It is important to be mindful of this when addressing women who present requesting FGCS or have concerns regarding their own appearance (also refer to *Appendix 1* for information on the Australian media code of conduct on body image).

2.3 Lack of anatomy education throughout life

People have limited formal education in the areas of female genital anatomy and its variations^{10,33} and, to date, there is no evidence-based research that outlines what its normal spectrum is considered to be.

The most common complaint is protrusion of the labia minora beyond the labia majora.^{10,11,37} Given the paucity of textbook images that provide measurements and ranges of anatomical diversity, GPs who do not perform regular gynaecological examinations as a part of their routine practice may not feel comfortable stating that something is considered normal.

General practice and other medical training curricula do not currently include education in the area of genital anatomy and its diversity. With the absence of formal training, it is not surprising that GPs, surgeons and other health professionals are influenced by the same kind of sociocultural forces that skew preferences for normal versus desirable.^{10,34}

2.4 A woman's genital area is usually hidden

Women have few opportunities to see other women's genitals throughout their life due to the fact the region is concealed, for the most part, behind pubic hair and there is little opportunity along the educational lifespan of women (and men) to become better informed. The inherent lack of understanding of the diverse normal platform that exists in the community is, therefore, quite understandable.

Recent studies have shown that women have limited knowledge regarding the names and function of genital parts and the diversity of appearance.^{11,23,24,31}

2.5 'Brazilian' waxing, grooming and fashion trends

Grooming and fashion trends are believed to influence women's attitudes to their genital region. Practices such as 'Brazilian' waxing involve removal of most or all pubic hair, exposing sensitive genital tissue and areas that could not be seen prior to hair removal.^{11,24} This practice is now extending to permanent hair removal via laser treatments.

Tight-fitting clothing and sportswear tend to give definition to the genital area, and poorly-fitting undergarments, such as G-strings, cover a minimal portion of the mons pubis. These factors can create the feeling that women's genital size should be small and discrete.

Fashion that depicts genital contour has resulted in the evolution of new terms like 'camel toe' and 'outie', which appear in popular media. While women often comment that wearing these items can feel uncomfortable, they remain popular fashion items.

Few will dispute that the request for Brazilian waxing and genital hair removal has gradually become commonplace over the past 20 years. The results from a phone review of the course work undertaken by Australian beauty therapists during their training indicate they receive little formal training regarding all aspects of genital anatomy.³⁹ Given women are more likely to visit their beauty therapists than their GP, supporting this frontline group through the provision of information regarding genital anatomy and teaching them how to talk with women who might express concern at their appearance could also be a useful way of addressing women's lack of knowledge and provide reassurance.

3. *Recommendations for management of patients requesting FGCS or expressing concern about their genitalia*

3.1 Listen to the patient and explore the reasons for concern or request for FGCS

GPs should deal with a patient's concerns in a sensitive and appropriate manner, asking what influences have played a role in this desire for surgery. It is also important to address the issues, such as lack of knowledge of diversity, clothing, exposure to digital images, partner criticism, family or peer comments, or the result of pubic hair removal.

Discuss factors influencing patient's concern:

- Clothing, including G-string underwear, tight jeans and body-hugging sportswear that outlines genital detail.
- Images found on the internet, especially pornography. These images are often required to be airbrushed due to classification rules which deem explicit depictions of female genitalia to be inappropriate.^{4,35}
- Physical symptoms may relate to concerns regarding maintaining hygiene, such as during menstruation and with toileting. Pain or discomfort either when wearing tight clothing or during sporting activities such as walking, horse riding, cycling may also be described. Other symptoms may be related to painful intercourse such as with invagination of the labia minora at the time of penetration. Some women may be concerned regarding vaginal laxity, especially following vaginal childbirth. Assess the degree to which these issues impact the woman's life and wellbeing both physically and psychologically.
- Lack of knowledge of genital diversity due to limited education in genital appearance.
- Comments made by others, directed at them or otherwise, and why this path has been considered. Offer counselling where coercion from a partner, friend or relative is suspected. This is an opportunity for the GP to enquire about intimate partner abuse, a history of sexual abuse or other domestic or family violence. Appropriate counselling should be provided in these cases. Refer to section 3.3.
- Grooming habits, such as waxing, depilation, shaving and lasering of pubic hair expose more genital skin, while some women develop recurrent skin irritations from procedures such as folliculitis, ingrown hairs and chafing. Draw the distinction between the grooming practices and the complications that can result from them, emphasising the fact surgery will not diminish the likelihood of these complications.

3.2 Take a medical, gynaecological and psychosexual history

Documentation of psychosexual history as a baseline, along with a full gynaecological and medical history, is very important when discussing FGCS with a patient. The psychosocial context of the patient's request should be an integral part of the discussion, thereby ensuring the patient's decision-making is as well informed as possible.

Key aspects of a psychosexual history that will assist the GP:

- Assess the degree of anxiety/concern.
- Ask the patient how her concern affects her.
- Ask if the patient's concern is affecting her intimate relationships, self-esteem, confidence and ability to function happily.
- Ask the patient if there is physical discomfort with or without sex.
- Acknowledge how she feels about the issue.

Refer to *Appendix 2* for more information about how to take a psychosexual history.

3.3 Mental health and relationship or sexual abuse issues should be considered and referred accordingly

When a woman presents to her GP with dissatisfaction regarding the appearance of her genitalia, it is important to consider the fact that body image concerns could be linked with psychological or relationship issues that have not been identified or managed. If a mental health diagnosis is made or the request is related to a relationship issue, a referral for counselling should be given.

The spectrum of anxiety can range from women feeling embarrassed about the appearance of their genitalia to thinking they are abnormal. This level of concern can be resolved by provision of information that counters this belief through education in the consultation room and the display of images that depict the diverse range of appearances. At the other end of the spectrum there is a pervasive, unrelenting belief that they are ugly and abnormal to the degree that it affects their quality of life and relationships. For some, this can present as clinical depression, social anxiety, an eating disorder or body dysmorphic disorder.

A referral to a psychologist or psychiatrist, rather than a direct referral for surgery, would be recommended.^{5,29} A referral for counselling should be offered when the patient already has a history of mental health issues.

3.4 Examine the patient confidently and respectfully

In cases where the GP lacks specific skill in women's health, or is not granted permission to conduct a physical examination, referral to a women's health GP, sexual health clinic or a gynaecologist is recommended. Dutch guidelines recommend patients be offered a mirror to assist their understanding of the anatomy and what constitutes normal at the time of a physical examination.⁴⁰

If a referral to another medical practitioner is made, it should clearly state that it is for patient reassurance and examination, not for surgery.

Some patients do not outwardly state that they wish to modify their genital anatomy. However, the GP may take the opportunity to explore any such concerns at the time of a routine Pap smear or gynaecological check-up if and when a woman expresses embarrassment or even apologises for her appearance. Look for dermatological conditions that require appropriate management.

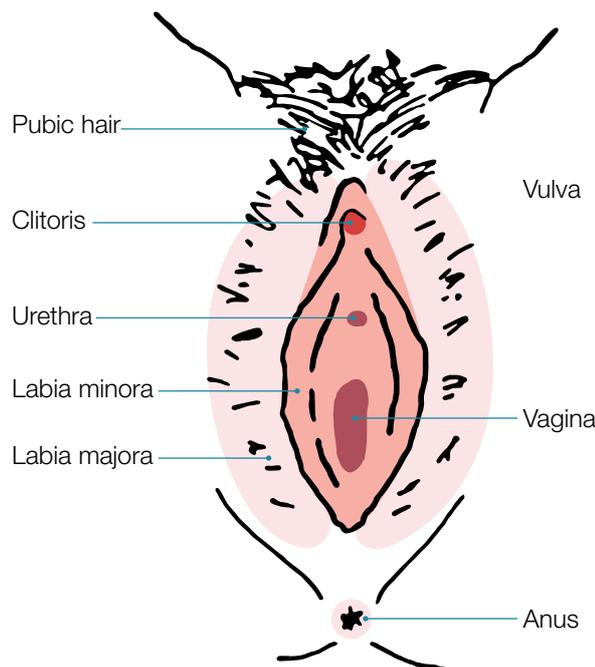
Refer to *Appendix 3* for more information on how to examine the patient.⁴¹

3.5 Use diagrams to educate the patient at the time of examination and during the consultation (refer to *Figure 1*)

Refer patients to appropriate online resources, such as the Labia Library⁴² or other publications, including *101 vagina*⁴³ and *Femalia*⁴⁴, in which there has been no digital enhancement.

When discussing female anatomy, it is important to focus on the sensorineural and functional aspects, and to clarify the differences in terminology.

Figure 1. Anatomy of female genitalia



Reproduced with permission from Women's Health Victoria.

3.6 Reassure the patient

Upon examining the genital region, use non-judgemental language to reassure the patient of their normality (provided there is no medical basis for the concern).

Care should be taken not to 'medicalise' cosmetic concerns and minor physical symptoms, such as chafing and discomfort from grooming procedures and clothing.

3.7 Address all symptoms and concerns

Physical symptoms, if any, need to be discussed with the patient. Identify whether these symptoms are related to the dimensions of her anatomy or due to other factors, such as recurrent infections, tight or poorly-fitted clothing, and skin irritations that are a result of chemical irritants or over-washing.

The medical conditions that constitute reasonable cause for the surgery to be performed have been changed as of November 2014, following the Australian Attorney-General's investigation into reasons why labiaplasty and other forms of FGCS were being performed and claimed under Medicare. Currently, Medicare item 35533 is intended for the surgical repair of female genital mutilation/cutting (FGM/C) and major congenital anomalies of the uro-gynaecological tract not covered by existing item numbers. It is valid only for inpatient services and will not be paid for outpatient procedures.

A new Medicare item number, 35534, is for 'localised gigantism which causes significant functional impairment and where non-surgical treatments have failed'. This item number now requires a specific application to the Department of Human Services, which will then be reviewed by the Medicare Claims Review Panel, to determine if there is enough evidence to qualify for the item number. Medicare benefits can no longer be claimed for non-therapeutic cosmetic genital surgery.

In summary, the clinically relevant indications for vulvoplasty include non-inflammatory disorders of the vulva and perineum, congenital disorders and to repair or reconstruct normal female anatomy following trauma, harmful traditional practices or pathologic processes⁴ (refer to *Appendix 4* and *Appendix 5.3* for more information).

3.8 Refer the patient

Refer the patient for a second opinion. A gynaecologist is likely to provide education and resources regarding the range of normal diversity of the anatomy.³³ It is important to clearly state that the referral is for opinion and not surgery, unless it is medically indicated.

Referral of adolescents (younger than 18 years of age) for genital cosmetic surgery is not advised unless it is to a specialist adolescent gynaecologist. Full genital development is not normally achieved before 18 years of age, therefore FGCS should not be carried out on adolescent girls^{27,46} (refer to section 5 for further information).

3.9 Explain what the FGCS procedures entail, including risks and potential complications (refer to *Section 1.5*)

If the patient is still considering undergoing FGCS, encourage them to describe exactly what they wish to have removed. Discuss the lack of long-term data on outcomes and satisfaction, as the potential for injury or complications.

Patients should be warned that the benefits of FGCS are not proven and they are not approved medical procedures. Genital cutaneous sensitivity, erotic sensitivity and orgasmic capacity, which can all be effected by FGCS, have important implications for women's quality of life.^{19,24}

Providing the patient with a list of current, publicly-available position statements and recommendations from peak bodies around the world may be helpful (refer to *Appendix 5*).

Where appropriate, referral to appropriate colleagues (gynaecologists, women's health GPs, plastic surgeons, etc) can be made. The Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia* should also be considered (refer to *Appendix 6*).

3.10 Referral pathway for patients who state that their surgery has 'gone wrong'

Given FGCS is classified as a set of procedures conducted for cosmetic reasons that have no set guidelines and can be performed by a range of practitioners as diverse as GPs, urologists, cosmetic doctors, gynaecologists and plastic surgeons, patients should be aware that outcomes might not be as expected. When a patient presents with postoperative complaints, it may be helpful to refer them to the psychosexual or gynaecological service at the women's and children's hospital in their state or territory.

4. *How female genital mutilation/cutting legislation applies to FGCS*

The World Health Organization (WHO) defines FGM/C as 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'. It is generally performed on children or adolescents who are not able to provide informed consent. There are no known health benefits and it is known to be harmful to girls and women in many ways.⁴⁷

All Australian states and territories have enacted legislation banning FGM/C and a variety of health and educational activities are in place to promote health and support cultural change required to eliminate its practice. Some people from countries that have traditionally practised FGM/C regard the selective application of the legislation to FGM/C but not FGCS, both of which could be considered to be culturally determined, to be discriminatory and unfair.⁴⁸

There is some debate about whether FGCS is covered by legal definitions of FGM/C and, therefore, illegal under existing regulations. The adequacy of outcome data considered is central to informed consent for FGCS, as for all medical procedures.⁴⁹

According to medical defence organisation, Avant:

'purely cosmetic procedures may not trigger the exceptions under each Act, particularly in NSW and VIC where the procedure must be necessary for the health of the person. However Acts do not define the words 'necessary' and 'health'. Legal concern is heightened given the fact that the patient's consent is not a defence.'^{49,50}

The Australian Government's *Review of Australia's Female Genital Mutilation legal framework – Final report* is a valuable source of further information and is available at www.ag.gov.au/Publications/Pages/ReviewofAustraliasFemaleGenitalMutilationlegalframework-FinalReportPublicationandforms.aspx

5. Adolescents and FGCS requests

According to the British Society for Paediatric and Adolescent Gynaecology (BritSPAG) position statement on adolescents and FGCS requests issued in 2013:⁴⁶

There is no evidence that the incidence of labial pathology has changed. The increase in activities cannot be accounted for in medical terms. Labiaplasty does not tackle the cultural and economic factors that are giving rise to vulval appearance distress. There is no scientific evidence to support the practice of labiaplasty and, for girls under the age of 18 years, the risk of harm is even more significant.

Frontline and specialist clinicians should improve their skills and confidence in educating and supporting the girls and, where appropriate, their parents. Further development of age-appropriate resources for girls and their parents should be a priority for clinicians. Information on the following should be presented sensitively and clearly with opportunities for discussion:

- labial anatomy and its development
- diversity in vulval appearance
- the distortions in popular culture
- the unknowns about labiaplasty
- the measures for managing labial discomfort and
- where distress is significant, the importance of a psychological assessment.

Reproduced with permission from British Society of Paediatric and Adolescent Gynaecology (BritsPAG). Position statement: Labial reduction surgery (labiaplasty) on adolescents. London: BritsPAG; 2013.

6. Summary of recommendations for GPs and other health professionals

FGCS incidence is climbing. Informed GPs can reduce unnecessary anxiety regarding vulval/genital anatomy, thereby deflecting a climb in FGCS.

Patient examination should be performed by the GP or referred to a doctor experienced in women's health. This is an opportunity to educate female patients about genital anatomy.

It is important to consider mental health and relationship abuse issues and refer accordingly.

Educate patients about genital diversity, using tools such as the online resource Labia Library and the publication *Femalia*, and possible complications of surgery.

It is recommended GPs initially refer patients for a gynaecological assessment.

If the patient is younger than 18, they should be referred to a specialist adolescent gynaecologist.

7. Appendices

Appendix 1 – Australian media code of conduct on body image

Australia's *Voluntary media code of conduct on body image* was designed to encourage the fashion, media and advertising industries to place greater emphasis on diversity, positive body images and a focus on health rather than body shape. In doing so, it aims to reduce young people's susceptibility to feelings of low self-esteem, eating disorders and negative body image that are associated with exposure to idealised and unrealistic images seen in the media and advertising.^{4,35,51}

The code of conduct:

- discourages the use of digitally enhanced or altered pictures and suggests these digitally pictures be identified as such
- encourages the use of images that represent the diversity of body shapes
- encourages the considered placement of advertising on dieting, cosmetic surgery, etc
- discourages the 'glamourisation' of models and celebrities who are particularly underweight and instead encourages a focus on models with a healthy body shape.

Appendix 2 – Taking a psychosexual history

When taking a psychosexual history, it is important to offer a chaperone and ask the patient about:*

- Personal history:
 - At what age did you reach puberty/menarche?
 - What was your parent's attitude toward sexual matters?
 - How did you attain sexual information?
 - What is your sexual orientation?
- Relationships and marital history:
 - At what age did you have your first sexual relationship?
 - How long was your longest relationship? What were some of the reasons for break ups? Any extramarital affairs?
 - Do you practice safe sex? Has that always been the case? Have you had any sexually transmitted infections?
 - Are you currently in a relationship? Any problems? Is there any inconsistency between your partner's and your sexual desire? How does that affect you? Are you and your partner committed to each other? How would you describe the communication in your relationship?
 - Do you have children? Have you had any abortions? Are you in contact with your children?
 - Do you have any sexual difficulties? Have you noticed a change in desire? Do you know how to achieve orgasm? Can you achieve orgasm and do you enjoy having sexual relations with your partner?
 - Do you have any problems with penetration (vaginismus) and pain during intercourse?
 - Do you use any street drugs?
 - Are you on any regular medications?
 - Have you ever been hurt in any way? Any violence in any of your relationships?
 - Do you have a history of depression, anxiety or other mental health concerns, including eating disorders?

**Adapted with permission from the Royal College of Psychiatrists (UK) for use in the primary care setting.*

Appendix 3 – Guidelines for gynaecological examinations and procedures

The gynaecological examination of women is a formal process and potentially intimidating to women, some of whom may have suffered various degrees of physical or sexual abuse during their lives.

Doctors should consider the information provided by women, listen and respond sensitively to their questions and concerns.

According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) *Guidelines for Gynaecological Examinations and Procedures C-Gyn 30*:⁴¹

Awareness of cultural or religious factors is essential when discussing and offering gynaecological examination.

Where examination is indicated, doctors should ensure that:

- an adequate explanation is provided about the nature of an examination and the information that it will provide
- the patient has the opportunity to decline examination
- permission is obtained, especially for breast and/or pelvic examination
- privacy is provided for disrobing
- suitable cover is provided during examination, for example, gown or cover sheet
- a chaperone is available to attend any patient undergoing physical examination when requested, irrespective of the gender of the doctor.
- the patient must be made aware in advance of the presence of medical students and the right to decline their attendance at any examination
- it may be appropriate to delay examination until a follow-up appointment.

With respect to examination of young women and children, see the Royal Australasian College of Physicians (RACP) policy *Genital Examinations in Girls and Young Women: A Clinical Practice Guideline*, available at <https://www.racp.edu.au/docs/default-source/advocacy-library/genital-examinations-in-girls-and-young-women-a-clinical-practice-guideline.pdf>

In addition to these RANZCOG guidelines, it is recommended that patients watch the examination with a mirror to assist their understanding of the anatomy and what constitutes normal.⁴⁰

The doctor should refrain from using language that is judgemental, expresses surprise or can be construed as derogatory when performing the examination.

Reproduced with permission from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) College Statement C-Gyn 30. Melbourne: RANZCOG; 2004.

Appendix 4 – How FGM legislation applies to cosmetic procedures



RACGP fact sheet Female genital cosmetic surgery and the law

Currently, each state and territory has provisions in their respective criminal law statutes which make the practice of female genital mutilation (FGM)¹ illegal. These laws apply extraterritorially in all jurisdictions, which means people who are involved in FGM overseas or in another state or territory can be charged under these laws. In all states except NSW, it is also an offence to remove someone from the jurisdiction with the intention of having FGM performed on that person. The penalties range from seven years to 21 years' imprisonment.

All jurisdictions define FGM. These definitions are broadly consistent with each other and cover the same conduct for FGM as defined by the World Health Organisation (WHO). Under the legislation in each state and territory, having the consent of the person who is to be the subject of FGM, or their parent or guardian, is not a defence for the practice of FGM.

The legal definitions

The various statutes define FGM as the excision, infibulation or any other mutilation of the whole or any part of the female genitalia². The definitions would arguably apply to some procedures such as labiaplasty. However, the Acts state that it is not an offence if a procedure is performed for a "genuine therapeutic purpose"³; a "proper medical purpose"⁴; or is "necessary for the health"⁵ of the patient.

In a report released in March 2013, the Commonwealth Attorney-General's Department raised concerns about how the law and policy apply to female genital cosmetic surgery (FGCS). The report stated that anecdotal evidence suggests the incidence of FGCS has increased significantly since 1998, when the Model Laws (on which the legislation in each state and territory is based) were drafted. Statistics from the Australian Institute of Health and Welfare (AIHW) show the number of labiaplasty procedures performed annually has been steady for the last 10 years, at about 1,500 procedures per year.

It was contemplated in the Attorney-General's report that the legislation, and how it may apply to FGCS, would be reviewed and clarified. The report's recommendations were considered by the Standing Council on Law and Justice⁶ in April 2013 and agreed to by the Standing Council, but there have been no further developments as at the date of release of the toolkit. Therefore some legal uncertainty remains.

In the interim, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) released an updated statement in relation to FGCS in March 2015⁷.

Concerns and recommendations

It is arguable that the legislative exceptions for medical treatment would apply to a cosmetic procedure where consent had been provided and the procedure is performed by an appropriately qualified medical practitioner.

However, if a procedure is purely cosmetic, for example because a patient has anxiety about the appearance of their labia, it may not trigger the exceptions under each State and Territory Act. This applies particularly in NSW and Victoria, where the respective Acts state the procedure must be "necessary for the health



of the person on whom it is performed" but without defining the words "necessary" and "health". This concern is heightened given the patient's consent is not a defence⁸.

The absence of greater legal clarity does not mean that FGCS needs to be avoided altogether. Rather, it means that medical practitioners should be mindful of this when discussing FGCS with patients and documenting those discussions in their clinical records.

This uncertainty is likely to have a greater impact on the surgeons performing the procedures in question, rather than on general practitioners or other health professionals whose involvement will largely be limited to referrals. However, in the course of providing such referrals to patients, there is likely to be some discussion about the patient's reason for requesting the referral and you may find yourself giving them some information or advice about various options in general terms.

Given the legal uncertainty, it is even more important that doctors make sure their clinical records include notes addressing:

- The patient's presenting problem and concerns;
- Any options for treatment discussed with the patient;
- The nature and details of the referral provided;
- Any other matters discussed with the patient regarding the procedure or their concerns.

Avant will continue to monitor this issue and how it affects members. If in doubt, please contact Avant on 1800 128 268.

¹ See sections 73 to 77 inclusive of the *Crimes Act 1900* (ACT); sections 15, 32 to 34A inclusive of the *Crimes Act 1958* (Vic); section 45 of the *Crimes Act 1900* (NSW); sections 323A and 323B of the *Criminal Code 1899* (Qld); sections 186A, 186B, 186C and 186D of the *Criminal Code Act 1983* (NT); sections 33, 33A and 33B of the *Criminal Law Consolidation Act 1935* (SA); sections 178A, 178B, 178C and Schedule 1 of the *Criminal Code Act 1924* (Tas); section 306 of the *Criminal Code Act Compilation Act 1913* (WA).

² This includes the labia majora, labia minora and clitoris, as specified in some of the state and territory legislative definitions.

³ In the ACT, Northern Territory, Queensland, South Australia and Tasmania.

⁴ In Western Australia.

⁵ In New South Wales and Victoria.

⁶ Now called the Law, Crime and Community Safety Council (LCCSC).

⁷ "Vaginal 'rejuvenation' and cosmetic vaginal procedures" statement, C-Gyn 24, RANZCOG, reviewed and released in March 2015.

⁸ To date, there have been no successful prosecutions under the various Acts in the states and territories. As far as we are aware, there have only been two cases where charges have been brought in NSW and one case in WA. The charge in the first NSW case was against a medical practitioner but was not upheld by the jury because of the "medical necessity" defence (charges were subsequently brought and upheld under a different section of the *Crimes Act*). The WA case (against parents of the victim) and the second NSW case (against eight people including a retired nurse) have not yet been concluded.



Female Genital Mutilation and Female Genital Cosmetic Surgery - Legal Issues

Female Genital Mutilation (FGM) is currently a criminal offence in Australia.¹ The penalties for FGM range from 7 to 21 years imprisonment. Whilst there is some variation in each state and territory, the legislation is broadly consistent in defining FGM as including:

- a) a clitoridectomy or
- b) excision of any other part of the female genital organs ; or
- c) infibulation or any other similar procedure; or
- d) any other mutilation of the female genital organs.

Depending on the state or territory, the FGM legislation provides exceptions relating to medical procedures:

- for genuine therapeutic purposes, or
- if necessary for the health of the person, or
- performed on a person in labour or who has just given birth, and for medical purposes connected with that labour or birth, or
- for sexual reassignment procedures.

Cultural, religious or other social custom is not to be regarded as a genuine therapeutic purpose.

It is not a defence to a charge of FGM that the person on whom the procedure was performed, or their parent, consented to the procedure.

A 2013 review by the Attorney General's Department notes the broad definition of FGM and the removal of consent as a defence and that this raises issues in relation to female genital cosmetic surgery (FGCS) which may involve procedures that are technically very similar to those defined in the FGM legislation. The review further notes that the status of these procedures under existing laws is untested and that this is a complex issue.²

The incidence of FGCS in Australia is increasing³ and a number of clinics advertise various procedures. There are currently no Australian clinical practice guidelines for FGCS. It is arguable that some of the FGCS procedures fall within the definition of FGM and some of these procedures may be contrary to the FGM legislation, if the exceptions under the FGM legislation do not apply.

Conclusion

It is essential that medical practitioners who are involved in FGCS ensure they are familiar with the FGM legislation in their state or territory. The absence of comprehensive clinical guidelines for FGCS increases the risk that practitioners who perform these procedures may be prosecuted.

1. Crimes Act 1900 (ACT) s73-77; Crimes Act 1900 (NSW) s45; Criminal Code Act (NT) s186A-186D; Criminal Code 1999 (Qld) s323A-323B; Criminal Law Consolidation Act 1935 (SA) s33-33B; Crimes Act 1958 (Vic) s32-34A; Criminal Code Act 1924 (Tas) s178A, 178B, s389; The Criminal Code (WA) s306
2. Australian Government's Review of Australia's Female Genital Mutilation Legal Framework Final Report, issued March 2013. Available at: <http://www.ag.gov.au/publications/documents/reviewofaustraliasfemalegenitalmutilationlegalframework/review%20of%20australias%20female%20genital%20mutilation%20legal%20framework.pdf>
3. Australian Government Department of Health MBS Reviews Vulvoplasty Report, issued April 2014. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/0C64684BA76544CCCA257BF0001E0243/\\$File/Vulvoplasty_Review_Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/0C64684BA76544CCCA257BF0001E0243/$File/Vulvoplasty_Review_Report.pdf)

Appendix 5 – Statements from peak bodies

5.1 Royal College of Obstetricians and Gynaecologists and BritSPAG

According to the joint Royal College of Obstetricians and Gynaecologists (RCOG)–BritSPAG release, *Issues surrounding women and girls undergoing female genital cosmetic surgery explored*, the RCOG ethical opinion paper, *Ethical considerations in relation to female genital cosmetic surgery (FGCS)*, has been produced by the College's Ethics Committee and focuses on women of all ages undergoing FGCS.

FGCS refers to non-medically indicated cosmetic surgical procedures which change the structure and appearance of the healthy external genitalia of women, or internally in the case of vaginal tightening. This definition includes the most common procedure, labiaplasty, as well as others, such as hymenoplasty and vaginoplasty, also known as vaginal reconstruction and vaginal rejuvenation.

A number of recommendations are made in the paper, including:

- Women should be provided with accurate information about the normal variations in female genitalia and offered counselling and other psychological treatments for problems such as body image distress.
- Women must be informed about the risks of the procedure and the lack of reliable evidence concerning its positive effects.
- As full genital development is not normally achieved before 18 years of age, FGCS should not normally be carried out on girls under this age.
- Surgeons who undertake FGCS should keep written records of the physical and mental health reasons why the procedure was carried out.
- Advertising of FGCS should not mislead people on what is deemed to be normal or what is possible with surgery.
- In general, FGCS should not be undertaken within the National Health Service (NHS) unless it is medically indicated.

The paper offers clinicians recommendations for best practice, including:

- A genital examination should be offered and conducted sensitively.
- Information about normal variations should be offered.
- Surgical reduction before the completion of pubertal development may lead to long term problems and this should be communicated to the girl and her guardian where appropriate.
- Simple measures to relieve labial discomfort should be suggested.
- In case of significant psychological distress, the girl and family should be offered a referral to a paediatric clinical psychologist.

Reproduced with permission from the Royal College of Obstetricians and Gynaecologists. Female genital cosmetic surgery. Ethical opinion paper. London: RCOG; 2013.

5.2 Society of Obstetricians and Gynaecologists of Canada

According to the article 'Female genital cosmetic surgery', published in *Journal of Obstetrics and Gynaecology Canada*:⁵²

Recommendations

1. The obstetrician and gynaecologist should play an important role in helping women to understand their anatomy and to respect individual variations. (III-A)
2. For women who present with requests for vaginal cosmetic procedures, a complete medical, sexual, and gynaecologic history should be obtained and the absence of any major sexual or psychological dysfunction should be ascertained. Any possibility of coercion or exploitation should be ruled out. (III-B)
3. Counselling should be a priority for women requesting FGCS. Topics should include normal variation and physiological changes over the lifespan, as well as the possibility of unintended consequences of cosmetic surgery to the genital area. The lack of evidence regarding outcomes and the lack of data on the impact of subsequent changes during pregnancy or menopause should also be discussed and considered part of the informed consent process. (III-L)
4. There is little evidence to support any of the FGCSs in terms of improvement to sexual satisfaction or self-image. Physicians choosing to proceed with these cosmetic procedures should not promote these surgeries for the enhancement of sexual function and advertising of female genital cosmetic surgical procedures should be avoided. (III-L)
5. Physicians who see adolescents requesting FGCS require additional expertise in counselling adolescents. Such procedures should not be offered until complete maturity including genital maturity, and parental consent is not required at that time. (III-L)
6. Non-medical terms, including but not restricted to vaginal rejuvenation, clitoral resurfacing, and G-spot enhancement, should be recognized as marketing terms only, with no medical origin; therefore they cannot be scientifically evaluated. (III-L)

Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care.

Quality of evidence assessment

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence from well-designed controlled trials without randomization.

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Classification of recommendations

- A. There is good evidence to recommend the clinical preventive action.
- B. There is fair evidence to recommend the clinical preventive action.
- C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.
- D. There is fair evidence to recommend against the clinical preventive action.
- E. There is good evidence to recommend against the clinical preventive action.
- L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

Reproduced with permission from Shaw D, Lefebvre G, Bouchard C, et al. Female genital cosmetic surgery. J Obstet Gynaecol Can 2013;35(12):1108–14.

5.3 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian
and New Zealand
College of
Obstetricians and
Gynaecologists



Vaginal 'rejuvenation' and cosmetic vaginal procedures

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in [Appendix A](#).

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: July 2008
Current: March 2015
Review due: March 2018

Background: This statement was first developed by Women's Health Committee in July 2008 and most recently reviewed in March 2015.

Funding: The development and review of this statement was funded by RANZCOG.

Surgical or laser techniques available which claim to improve the appearance of the female genital tract and enhance sexual function such as “vaginal rejuvenation”, “revirgination”, “designer vaginoplasty”, “G spot amplification” are poorly understood and what is involved in these procedures is often unclear since recognised clinical nomenclature is not being used.

The American College of Obstetricians and Gynecologists (ACOG) Committee on Gynecologic Practice and the Society of Obstetricians and Gynaecologists of Canada have produced documents discouraging the practice of female genital cosmetic surgeries which do not include medically-indicated reconstructions.^{1,2} Gynaecological conditions that merit surgery include genital prolapse, reconstructive surgery following female genital mutilation and labioplasties with clinical indications. Medical practitioners performing any vaginal surgery should be appropriately trained.

Recommendations by these bodies include that the obstetrician and gynaecologist should have a role in educating women that there is a large number of variations in the appearance of normal female external genitalia and that there are normal physiological changes over time, especially following childbirth and menopause. Patients requesting procedures other than for gynaecological conditions should be assessed thoroughly and the reasons for such a request assessed carefully. Sexual counselling is also recommended for patients requesting surgery that is purported to enhance gratification. The College is particularly concerned that such surgery may exploit vulnerable women. Doctors who perform these procedures should not promote or advertise that these surgeries enhance sexual function.

The College strongly discourages the performance of any surgical or laser procedure that lacks current peer reviewed scientific evidence other than in the context of an appropriately constructed clinical trial. At present, there is little high quality evidence, that these procedures are effective, enhance sexual function or improve self-image. The risks of potential complications such as scarring, adhesions, permanent disfigurement, infection, dyspareunia and altered sexual sensations should be discussed in detail with women seeking such treatments.³

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Reproduced with permission from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Vaginal ‘rejuvenation’ and cosmetic vaginal procedures C-Gyn 24. Melbourne: RANZCOG; 2008.

5.4 Medical Women's International Association

According to resolutions passed at the Medical Women's International Association (MWIA) 29th International Congress in Seoul, 2013:

MWIA recognises the autonomy of women and upholds the right of adult women to choose to undergo lawful medical and surgical treatments. MWIA advocates for the provision of informed consent for all patients undergoing medical and surgical procedures.

MWIA opposes the advertising of regulated health services (eg those usually provided by a healthcare practitioner) in a way that directly or indirectly encourages their indiscriminate or unnecessary use.

MWIA opposes the promotion of and use of surgical products and techniques that make unproven claims of enhancing female sexual satisfaction and/or attractiveness. MWIA believes that promoting and performing such surgery carries significant risks of physical and psychological harm to women and girls.

MWIA supports the use of gynaecological and plastic surgical techniques where the primary aim is to repair or reconstruct normal female anatomy following trauma, harmful traditional practices, pathologic processes or congenital anomalies.

MWIA opposes media depictions that directly or indirectly promote a prepubescent appearance of female genitalia as sexually desirable. MWIA opposes media images that directly or indirectly promote abnormal perceptions of the appearance of normal female adult genitalia.

Refer to: http://mwia.net/wp-content/uploads/2013/09/MWIA_update_september_2013.pdf

5.5 The American College of Obstetricians and Gynaecologists

The American College of Obstetricians and Gynaecologists released a committee opinion in 2007 titled *Vaginal 'Rejuvenation' and Cosmetic Vaginal Procedures*, available at www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Vaginal-Rejuvenation-and-Cosmetic-Vaginal-Procedures

5.6 The Royal Australasian College of Physicians

The Royal Australasian College of Physicians have released a clinical practice guideline in 2009, titled *Genital examinations in girls and young women: a clinical practice guideline*, available at www.racp.edu.au/docs/default-source/advocacy-library/genital-examinations-in-girls-and-young-women-a-clinical-practice-guideline.pdf

Appendix 6 – Good medical practice code of conduct

Under a set of draft guidelines released by the Medical Board of Australia in March 2015, GPs have a central role to play in advising patients considering cosmetic surgery.

According to a committee of the Australian Health Workforce Ministerial Council, the guidelines will be added as a supplement to the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia*, available at www.amc.org.au/about/good-medical-practice

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