Contents

Part I Introduction and General Instructions

1 Introduction to the Art of Aesthetic and Functional Female Genital Operations 3
1.1 Etymology and Terminology 4
1.2 Why Do Women Consult a Doctor? 5
1.3 Body Perception 6
1.4 Self-Esteem 6
1.5 Genital Area is the Mirror of the Patient 6
1.6 Aesthetic and Functional Genital Procedures Umbrella 6
1.7 Statistics 8
1.8 AGS Contraindications 9
1.9 Patient Selection and Surgery Planning 10
1.10 Female Circumcision 11
1.11 Types of Genital Mutilation in Women 11
1.12 History of Female Circumcision 13
Appendix 14
References 14

2 Should Aesthetic Genital Operations Be Done? 15
2.1 ACOG Declarations 15
2.2 FDA Warning 17
2.3 FDA Warning and a Review of Laser and Other Energy-Based Technologies 17
2.4 World Health Organization (WHO) Definition of "Health" 19
2.5 Patient Rights 19
2.6 Patient Perspective 20
2.6.1 Self-Esteem Issues 20
2.6.2 Being Ashamed, Avoiding Mutual Relations 20
2.6.3 Hygienic Problems 20
2.6.4 Protrusion while Wearing Trousers 20
2.6.5 Anatomical Defects and Dermatologic Pathologies . . 21
2.6.6 Vulvar Irritation 22
2.6.7 Functional Problems Due to Vaginal Relaxation 22
2.6.8 Dyspareunia 24

2.7 An Example of Legal Aspects: "*Artwork Contract*" in Turkey . . . 25
2.8 Aesthetic Treatment Contracts and Legal Qualifications . . . 26
2.9 Medical Ethical Aspect . . . 26
2.9.1 Autonomy . . . 26
2.9.2 First, Do No Harm (Non-maleficence) . . . 26
2.9.3 Benefit (Beneficence) . . . 26
2.9.4 Being Fair (Justice) . . . 27
Appendix . . . 27
References . . . 27

3 Ideal Vulva Concept and Anatomic Structures . . . 29
3.1 Reasons for Applying to a Physician for AGS . . . 30
3.2 Anatomical Structures and their Place in Cosmetic Gynecology . . . 31
3.2.1 Mons Pubis (Mons Veneris) . . . 31
3.3 Labium Majus Pudendi . . . 31
3.4 Labium Minus Pudendi . . . 31
3.4.1 Labial Blood Circulation . . . 32
3.4.2 Labial Morphology . . . 33
3.4.3 Labial and Clitoral Dominance . . . 33
3.4.4 Labial Asymmetry . . . 35
3.4.5 Labial Protrusion . . . 36
3.5 Vulvar Vestibulum . . . 37
3.6 Clitoris . . . 37
3.7 Hymen . . . 37
3.7.1 Hymenoplasty . . . 38
3.7.2 Excision of Hymen Protrusions . . . 38
3.7.3 Painful Hymen (Eserdag) . . . 38
3.8 G-Spot . . . 39
3.9 Innervation and Vascularization of the Vulva . . . 39
3.10 Normal Vulva Measurements . . . 39
3.11 Vaginal Anatomy and Histology . . . 40
3.12 Mucosal Layer (Superficial Layer) . . . 42
3.13 Muscular Layer (Second Layer) . . . 43
3.14 Adventitia Layer (Tunica Fibrosa, Deeper Layer) . . . 43
3.15 Pelvic Floor Muscles . . . 44
3.16 Perineal Body . . . 46
3.17 Derivatives of Embryological Structures . . . 46
Appendix . . . 46
References . . . 47

4 Skin Histology and Physiology . . . 49
4.1 Layers of Skin . . . 49
4.2 Epidermis . . . 50
4.2.1 Stratum Basale (Stratum Germinosum) . . . 50
4.2.2 Stratum Spinosum . . . 50
4.2.3 Stratum Granulosum . . . 51
4.2.4 Stratum Corneum (Keratin Layer) . . . 51

4.3 Dermis (Cutis) . . . 51
4.3.1 Superficial Dermis (Papillary Dermis) . . . 52
4.3.2 Deep Dermis (Reticular Dermis) . . . 52
4.4 Hypodermis (Subcutaneous Tissue, Subcutis) . . . 52
4.5 Skin Pathologies . . . 52
4.6 How Does Skin Color Occur? . . . 52
4.6.1 Melanocyte Structure . . . 53
Appendix . . . 54
References . . . 54

5 Vulvar Lichen Sclerosus . . . 55
5.1 Epidemiology . . . 56
5.2 Symptoms . . . 56
5.3 Etiology . . . 56
5.3.1 Autoimmunity, Molecular Mechanisms, and Genetic Factors . . . 57
5.3.2 Infections . . . 57
5.3.3 Hormonal Effects . . . 57
5.3.4 Local Factors . . . 57
5.4 Diagnosis . . . 57
5.5 Histopathology . . . 59
5.6 Pediatric Vulvar Lichen Sclerosus . . . 60
5.7 Differential Diagnosis . . . 60
5.8 Differences Between Lichen Sclerosis and Other Lichen Diseases . . . 60
5.9 Management . . . 61
5.9.1 Medical Treatments . . . 61
5.9.2 Topical Treatments . . . 61
5.10 Other Topical Treatments . . . 62
5.11 Systemic Treatment . . . 62
5.12 Surgical Treatments . . . 62
5.13 New Approaches in the Treatment of Vulvar Lichen Sclerosus . . . 64
5.14 Prognosis . . . 65
Appendix . . . 66
References . . . 66

6 Physiology of Wound Healing . . . 69
6.1 Phases of Wound Healing . . . 69
6.1.1 Hemostasis/Inflammation Phase . . . 69
6.1.2 Proliferation Phase . . . 70
6.1.3 Maturation (Remodeling) Phase . . . 70
6.2 Factors That Negatively Affect Wound Healing . . . 70
6.2.1 Lack of Oxygenation . . . 70
6.2.2 Development of Hematoma and Seroma . . . 71
6.2.3 Development of Infection . . . 71
6.2.4 Surgical Technique Defects . . . 71
6.2.5 Advanced Age . . . 71
6.2.6 Poor Diet . . . 71

6.2.7 Smoking and Alcohol Intake 71
6.2.8 Poor Postoperative Care 71
6.2.9 Medication Use 71
6.2.10 Chronic Diseases 72
6.2.11 Pain 72
6.3 Wound Complications 72
6.3.1 Bleeding 72
6.3.2 Infection 72
6.3.3 Wound Dehiscence 72
6.3.4 Excessive Wound Healing 72
Appendix 73
References 74

7 Preoperative Evaluation and Patient Selection 75
7.1 Preoperative Evaluation Stages 75
7.1.1 Detailed Anamnesis 75
7.1.2 Gynecological Examination 76
7.1.3 Planning the Surgery and the Following Process 78
7.2 Photographs and Archiving 78
7.2.1 Important Issues to Consider When Taking Photos 78
7.3 Body Dysmorphic Disorder (BDD) 79
Appendix 80
References 80

8 Instrumentation, Set-Up, and Anesthesia 81
8.1 Tools and Devices Used 81
8.2 Suture Materials and Needles 84
8.2.1 Polyfilament (Braided) Sutures 84
8.2.2 Barbed Sutures 84
8.2.3 Monofilament (Non-braided) Sutures 84
8.2.4 Needles 85
8.3 Marking 86
8.4 AGS Anesthesia 89
8.4.1 Surgery at Office Conditions 89
8.4.2 Surgery at the Hospital 93
Appendix 93
References 93

Part II Surgical Operations in the Art of Aesthetic Genital Surgery

9 Labiaplasty 97
9.1 Labiaplasty Indications 98
9.2 Labial Hypertrophy 98
9.3 Labial Asymmetry 99
9.3.1 Labial Asymmetry Classification (Eserdag) 99
9.4 Other Psychological Causes 103
9.5 Operation Principles 104

9.6 Historical Background . . . 104
9.7 Labiaplasty Techniques . . . 106
9.7.1 Curvilinear Excision . . . 106
9.7.2 Wedge Resection (V-Plasty) . . . 109
9.7.3 Extended Central Wedge Resection . . . 110
9.7.4 Bilateral De-epithelialization . . . 113
9.7.5 Zigzag Technique . . . 113
9.7.6 Modified Double Wedge Resection (Star Labiaplasty) . . . 113
9.7.7 Laser Labiaplasty . . . 113
9.8 Labiaplasty According to Patient Expectations: *"Queens, Princesses, and Venuses" (Eserdag)* . . . 114
9.8.1 Queens . . . 114
9.8.2 Princesses . . . 114
9.8.3 Venuses . . . 115
9.9 *Eserdag* 'Venus Vagina' Aesthetics Concept . . . 117
9.10 Office Labiaplasty . . . 120
9.11 Combined Procedures . . . 120
9.12 Botched Labiaplasty and Revision Surgeries . . . 121
9.13 Neolabiaplasty *(Eserdag)* . . . 129
9.14 Common Complaints After the Operation . . . 131
9.14.1 Vasovagal Reflex . . . 131
9.14.2 Bleeding . . . 131
9.14.3 Pain . . . 131
9.14.4 Itching . . . 132
9.14.5 Edema . . . 132
9.15 Complications . . . 132
9.15.1 Acute Term . . . 132
9.15.2 Subacute Te . . . 134
9.15.3 Chronic Term . . . 134
9.16 Vulvar Hematoma and Management . . . 136
9.16.1 Approaches in Hematoma . . . 136
9.17 The Postoperative Term . . . 138
9.18 Long-Term Results . . . 139
9.19 Postoperation Psychological Effects . . . 141
Appendix . . . 141
References . . . 141

10 Clitoral Hoodoplasty and Frenulaplasty . . . 143
10.1 Why Is Hoodoplasty Required? . . . 143
10.2 Isolated Hoodoplasty . . . 143
10.3 Classification and Management of Clitoral Hood Abnormalities . . . 144
10.4 Hoodoplasty Techniques . . . 145
10.4.1 Bilateral Longitudinal Skin Excisions (Classical Method) . . . 145
10.4.2 Inverted V-Plasty and Extended Central Wedge Resection . . . 146

10.4.3 Hydrodissection with Inverted V-Plasty 149
10.4.4 Inverted-Y Plasty (Eserdag Technique) 150
10.4.5 Inverted-U Extended Hoodoplasty (Eserdag) 154
10.4.6 Hat Trimming (Eserdag) 155
10.4.7 Subepithelial Hoodoplasty 156
10.4.8 Edge-Wedge Labiaplasty (Edge-Wedge Technique) 156
10.5 Complications 156
10.6 The Postoperative Term 156
10.7 Clitoromegaly 156
10.8 Clitoral Protrusion 157
10.9 Frenulaplasty 158
Appendix 160
References 160

11 Vaginoplasty 163
11.1 Ideal Vagina Concept 163
11.2 Juicy Vagina Syndrome *(Eserdag)* 164
11.3 Vaginal Wind (Flatus Vaginalis, Queef) 164
11.4 Vaginal Gaping 164
11.5 Lost Penis Syndrome 165
11.6 Vaginal Relaxation Syndrome (VRS) 165
11.7 Surgical Vaginoplasty Techniques 166
11.7.1 Posterior Colporrhaphy Technique (Posterior Vaginoplasty) 166
11.8 Surgical Results 169
11.9 Combined Procedures 170
11.10 Common Complaints After the Operation 172
11.10.1 Vasovagal Reflex 172
11.10.2 Bleeding 172
11.10.3 Pain 172
11.10.4 Itching 172
11.10.5 Edema 172
11.11 Complications 172
11.11.1 Acute Term 172
11.11.2 Subacute Term 174
11.11.3 Chronic Term 174
11.12 The Postoperative Term 176
11.13 Vaginoplasty Revision Surgery 177
11.14 Neovaginoplasty Due to Vaginal Aplasia 179
11.14.1 Management 180
Appendix 182
References 182

12 Perineoplasty 183
12.1 Perineoplasty Indications 183
12.1.1 Perineal Traumas 184
12.2 Perineoplasty Techniques 184
12.2.1 Diamond-Shaped Excision 185

12.2.2 Elliptical Excision (Episiotomy Scar Revision) . . . 185
12.2.3 Triangle-Shaped Excision . . . 185
12.2.4 Z-Plasty . . . 185
12.3 Atrophic Scar Treatments . . . 188
12.4 Perineal Hernias . . . 188
12.5 Perineal Granuloma Fissuratum . . . 189
12.6 Complications . . . 190
12.7 The Postoperative Term . . . 190
12.8 Perianal Aesthetics . . . 190
Appendix . . . 191
References . . . 192

13 Labia Majoraplasty . . . 193
13.1 Vulvar Laxity . . . 193
13.2 Primary Hypertrophy . . . 193
13.3 Secondary Hypertrophy . . . 194
13.4 Labia Majoraplasty Surgical Techniques . . . 194
13.4.1 Elliptical Excision . . . 194
13.4.2 Horseshoe Excision . . . 195
13.4.3 Teardrop Incision (Eserdag) . . . 196
13.5 Majoraplasty with Adipose Tissue Excision (Fat Pad Debulking) . . . 197
13.6 Combined Procedures . . . 198
13.7 Complications . . . 201
13.7.1 Acute Term . . . 201
13.7.2 Subacute Term . . . 201
13.7.3 Chronic Term . . . 201
13.8 The Postoperative Term . . . 201
Appendix . . . 201
References . . . 201

14 Labia Majora Augmentation Via Fat Transfer and Monsplasty . . . 203
14.1 Historical Background . . . 203
14.2 Labia Majora Fat Graft Indications . . . 204
14.3 Methods . . . 204
14.3.1 Fat Harvesting (Liposuction) . . . 204
14.3.2 Fat Processing . . . 205
14.3.3 Lipofilling . . . 206
14.4 Combined Procedures . . . 207
14.5 Fat Transfer to Different Regions . . . 208
14.6 Operation Success . . . 209
14.7 Complications . . . 209
14.8 The Postoperative Term . . . 209
14.9 Monsplasty . . . 210
14.10 Mons Reduction Methods . . . 210
14.11 Surgical Methods . . . 212
14.12 The Postoperative Term . . . 213

Appendix . . . 213
References . . . 213

15 Hymenoplasty . . . 215
15.1 Hymenoplasty Techniques . . . 215
15.1.1 Long-term Operations . . . 215
15.1.2 Short-term Operations . . . 217
15.2 Psychological Influences . . . 218
15.3 Combined Procedures . . . 218
15.4 Complications . . . 218
15.5 The Postoperative Term . . . 220
Appendix . . . 220
References . . . 220

Part III Non-surgical Operations in the Art of Aesthetic Genital Surgery

16 Vaginal Laser Applications . . . 223
16.1 Laser Physics . . . 223
16.2 Laser Parameters . . . 224
16.2.1 Wavelength . . . 224
16.2.2 Distance . . . 224
16.2.3 Overlap (Stack) . . . 225
16.2.4 Moving Time . . . 225
16.2.5 Energy . . . 225
16.2.6 Power . . . 225
16.2.7 Energy Current (Fluence) . . . 225
16.2.8 Energy Density (Irradiance) . . . 225
16.2.9 Spot Size (Beam diameter) . . . 225
16.2.10 Pulse Duration . . . 226
16.2.11 Thermal Relaxation Time . . . 226
16.3 Properties of Laser Light . . . 226
16.3.1 Collimation (Alignment in One Direction) . . . 226
16.3.2 Coherence . . . 226
16.3.3 Reflection, Transmission, and Absorption Properties . . . 226
16.4 Which Laser Should Be Used in Which Indication? . . . 227
16.5 Lasers in Gynecology . . . 227
16.5.1 Carbon Dioxide Lasers . . . 227
16.5.2 Er:YAG (Erbium:YAG) Lasers . . . 228
16.6 Laser Indications: Use in Gynecology and Dermatology . . . 228
16.7 Vaginal Laser Contraindications . . . 230
16.8 Preparation . . . 231
16.9 Laser Applications for Vaginal Rejuvenation . . . 231
16.10 Steps of Laser Vaginal Rejuvenation (LVR) Procedure . . . 232
16.11 Application Protocol . . . 234
16.12 Some Laser Devices on the Market . . . 234

16.13 Laser Applications for Stress Urinary Incontinence (SUI) Treatment . . . 235
16.14 Laser Applications in Menopausal Genitourinary Syndrome (GSM) . . . 236
16.15 Laser for Symptomatic Treatment of Lichen Sclerosus . . . 237
16.16 Post-Laser Histological Changes . . . 238
16.16.1 Inflammation Phase . . . 238
16.16.2 Proliferation Phase . . . 239
16.16.3 Maturation Phase . . . 239
16.17 Collagen Structure and Types . . . 240
16.17.1 Collagen Types . . . 240
16.18 Comparison of Laser and Surgical Tightening Operations . . . 240
16.19 Survey Studies and Scientific Data . . . 241
16.20 Scientific Data . . . 241
16.21 Combined Procedures . . . 242
16.22 Complications . . . 242
16.23 The Post-Procedure Term . . . 242
Appendix . . . 243
References . . . 243

17 Genital Bleaching Treatments . . . 245
17.1 Skin Color Types . . . 245
17.2 Causes of Hyperpigmentation . . . 246
17.3 Hyperpigmentation Treatments . . . 246
17.3.1 Treatment Protocol . . . 247
17.4 Lasers with Q-switched Technique . . . 249
17.5 Post-procedure Term . . . 250
17.6 Contraindications . . . 250
17.7 Complications . . . 250
17.8 Postinflammatory Hyperpigmentation (PIH) . . . 251
17.9 Other Methods Applied in Bleaching Treatment . . . 252
17.9.1 Trichloroacetic Acid (TCA) . . . 252
17.9.2 Different Chemical Agents . . . 252
17.9.3 Ready-to-Use Solutions . . . 253
17.9.4 Injectable Mesotherapy Preparations . . . 255
17.9.5 Dermabrasion: Microdermabrasion . . . 255
17.9.6 PRP . . . 255
Appendix . . . 255
References . . . 255

18 Genital Radiofrequency Applications . . . 257
18.1 Increasing Trend in Vaginal Rejuvenation . . . 257
18.2 Radiofrequency (RF) Technology . . . 258
18.3 Mechanism of Action . . . 258
18.4 Indications for Use in Gynecology and Dermatology . . . 259
18.5 Some RF Devices on the Market . . . 260
18.6 Genital RF Contraindications . . . 261
18.7 Preparation . . . 262

18.8 Performing Genital RF Treatments 262
18.9 Effects on Orgasmic Function 263
18.10 Histological Studies 265
18.11 Combined Procedures 265
18.12 Complications 265
18.13 Post-procedure Term 265
Appendix 265
References 265

19 G-Spot Augmentation by Hyaluronic Acid 267
19.1 Historical Background 267
19.2 Scientific Data 268
19.3 Conflicting Thoughts 269
19.4 G-Spot Dermal Filler Injections 269
19.5 G-Spot Augmentation Indications 269
19.6 Contraindications 270
19.7 How is G-spot Augmentation Performed? 270
19.8 Complications 270
19.9 Post-Procedure Term 271
Appendix 271
References 271

Part IV Regenerative Treatments

20 Hyaluronic Acid Applications to Genital Area 275
20.1 Where Is Hyaluronic Acid (HA) Found? 276
20.2 Historical Background 276
20.3 Obtaining of HA 276
20.4 Indications of HA in Cosmetic Dermatology 277
20.5 FDA Declaration on Dermal Fillers (2020) 277
20.6 Applications in Genital Area 277
20.7 Use of HA in Gynecology 278
20.7.1 Functional Purposes 278
20.7.2 Aesthetic Purposes 279
20.8 HA Application Techniques 280
20.8.1 Linear Threading Technique 280
20.8.2 Point-by-Point Application (Serial Puncture) Technique 280
20.8.3 Fanning Technique 280
20.8.4 Cross-Hatching (Cross Radial) Technique 280
20.9 Some Fillers in the Market 281
20.10 HA Filler Applications for Labia Majora Augmentation 281
20.11 Vaginal and Vestibular HA 283
20.11.1 Fillers 283
20.11.2 Features in HA Selection: HA Rheology 283
20.11.3 Contraindications 283
20.11.4 Comparison with Autologous Fat Transfer 284
20.11.5 Combined Therapies 284

20.11.6 Complications and Undesirable Effects 284
20.11.7 Hyaluronidase Enzyme 286
20.11.8 Post-procedure Term 287
20.12 Different Tissue Fillers 287
20.12.1 Absorbable (Temporary) Materials 287
20.12.2 Non-absorbable (Permanent) Materials 288
Appendix 289
References 289

21 Genital PRP, PRF, and ACRS 291
21.1 What is the Platelet-Rich Plasma (PRP) Procedure? 291
21.2 Platelet-Rich Fibrin (PRF) 291
21.2.1 What is Platelet-Rich Fibrin (PRF)? 291
21.2.2 Comparison with PRP 292
21.2.3 How to Prepare PRF? 292
21.3 Autologous Cytokine-Rich Serum (ACRS) 293
21.3.1 How to Prepare Autologous Cytokine-Rich Serum? 293
21.3.2 Action of Mechanism 294
21.3.3 Difference from the PRP 294
21.3.4 Possible Indications 294
21.4 Platelet Structure 295
21.5 Platelets in the Wound Healing Process 295
21.6 Growth Factors (GF) 296
21.7 How to Prepare PRP? 297
21.8 Post-Centrifuge Values 297
21.9 Different Medical Applications of PRP 299
21.10 Use of PRP in Cosmetic Dermatology 299
21.11 Indications of PRP in Cosmetic Gynecology 299
21.11.1 Treatments for Functional Purpose 300
21.11.2 Treatments for Aesthetic Purpose 301
21.12 Different Indications of PRP in Gynecology 302
21.13 PRP Contraindications 302
21.14 Combined Therapies 302
21.15 Complications 303
21.16 Post-procedure Term 303
Appendix 303
References 303

22 Carboxytherapy 305
22.1 Mechanism 305
22.2 Cosmetic and Dermatologic Indications 306
22.2.1 Stretch Marks 306
22.2.2 Cellulite and Local Adiposity Treatment 307
22.2.3 Face Rejuvenation 308
22.2.4 Psoriasis 308
22.2.5 Alopecia 310
22.3 Genital Indications 311
22.3.1 Genitourinary Syndrome of Menopause (GSM) . . . 311

22.3.2 Mons Pubis Reduction . . . 312
22.3.3 Vulvar Rejuvenation and Lichen Sclerosus Treatment . . . 312
22.4 Other Indications . . . 312
22.4.1 Adverse Events . . . 312
22.4.2 Combined Treatments . . . 313
22.4.3 Post-procedure Term . . . 313
Appendix . . . 313
References . . . 313

23 Regenerative Medicine . . . 315
23.1 Regenerative Medicine Fields . . . 315
23.2 Autologous Fat Treatments . . . 316
23.2.1 Macrofat Transfer . . . 316
23.2.2 Microfat Transfer . . . 316
23.2.3 SEFFI (Superficial Enhanced Fluid Fat Injection) Transfer . . . 316
23.2.4 M-SEFFI (Micro-SEFFI) Transfer . . . 316
23.2.5 Nanofat Transfer . . . 316
23.2.6 SVF Transfer . . . 317
23.2.7 Alternative Techniques . . . 318
23.3 Exosomes . . . 319
Appendix . . . 319
References . . . 320

Patient Consent Forms . . . 321

example, pricking, piercing, incising, scraping, and cauterization.

"*Deinfibulation*" refers to the practice of cutting open the sealed vaginal opening of a woman who has been infibulated (Type III). This is often done to allow sexual intercourse or to facilitate childbirth and is often necessary for improving the woman's health and well-being.

Reconstructive surgery of Type III genital mutilation (34 yrs) is shown in Fig. 1.3.

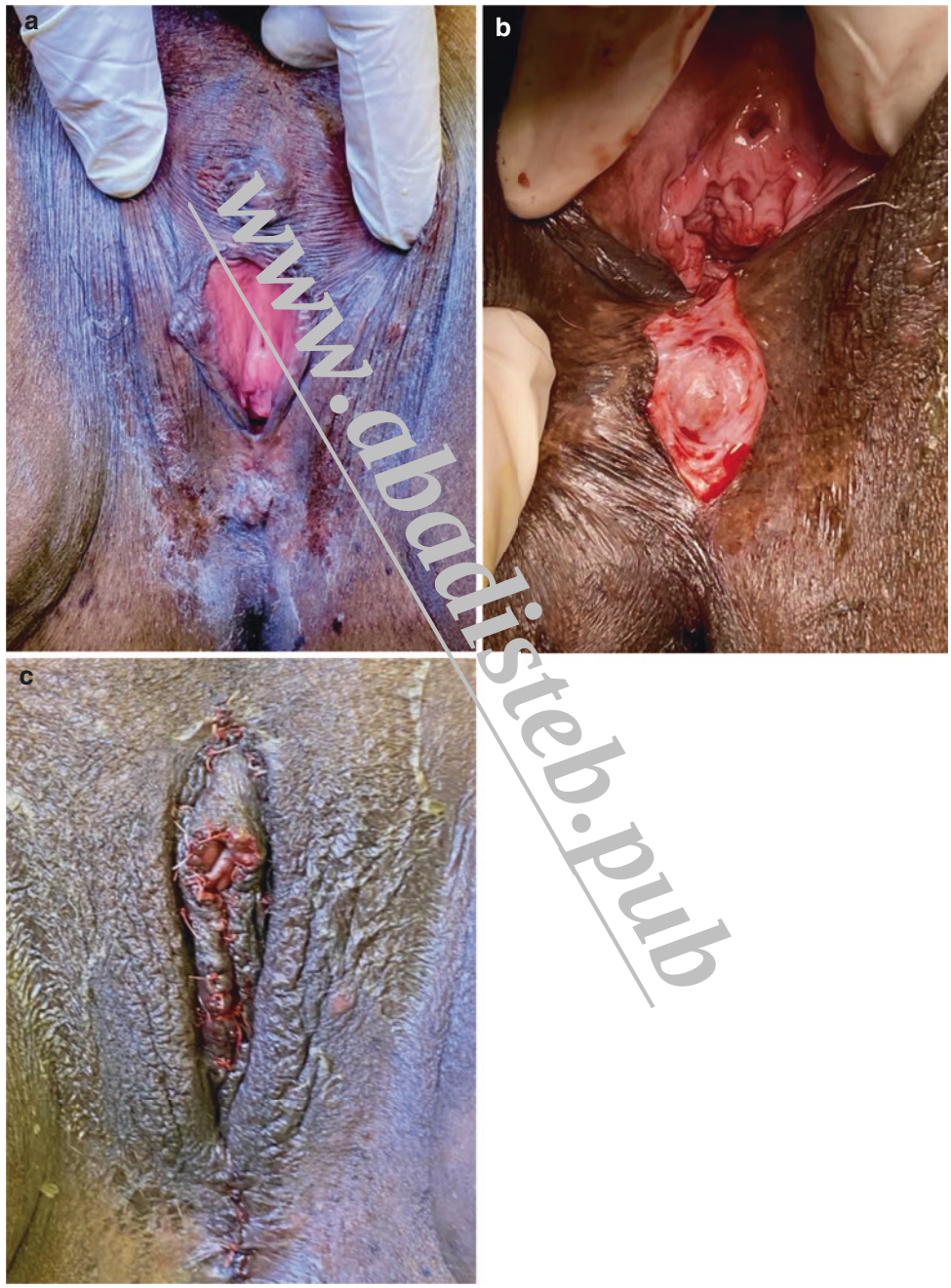

Fig. 1.3 Reconstruction of Type III genital mutilation (**a**). Separation of merged sides of both labia minora and majora, extirpation of the perineal inclusion cyst, perineal repair, revision of the labia minora and preputium, and liberation of the glans clitoridis (**b**). After the procedure (**c**)

In this context, female circumcision is quite different from genital aesthetic operations because:

- It is not recommended to perform genital aesthetic operations for aesthetic purposes under 18 years of age. Mutilations are usually performed in childhood, such as between the ages of 6 and 10 years.
- The purpose of genital aesthetic operations is aesthetic and functional correction. However, genital mutilation procedures are performed with the idea of preventing sexual pleasure.
- Genital aesthetic operations are performed in office or hospital conditions under aseptic conditions. Female circumcisions are usually performed at home, in the presence of neighborhood midwives, and without sterile conditions.
- Written and verbal consent is taken from patients before genital aesthetic operations. There is no consent requirement for mutilation.

1.12 History of Female Circumcision

It is accepted that the Prophet Abraham was circumcised at the age of eighty, that his children were also circumcised, and that the circumcision of men and women began at that time.

> *Prophet Abraham, who lives in Palestine and is married to Sarah (Sara in Arabic), has no children. Sarah offers her black slave Hajar to her husband Abraham and asks her to have a child. However, when Hajar becomes pregnant, Sarah becomes jealous of her and demands that her three limbs be amputated. Being worried about this situation, Abraham orders Hajar to pierce her ears and be circumcised. However, Sarah's anger does not end afterwards. For this reason, Abraham takes Hajar, takes the newborn child Ishmael (Isma'il) to Mecca and leaves them there. Mecca, which was a town that nobody visited at that time, quickly gained popularity with the rebuilding of the Kaaba by Hajar and Abraham who later came to her aid* [11].

The pictures on some papyri and the circumcision scenes on the wall of Karnak Shrine in Luxor are evidence of the prevalence of circumcision in ancient Egypt. Today, approximately 200 million women are circumcised in approximately 30 countries in western, eastern, and north-eastern Africa, in parts of the Middle East and Asia, and within some immigrant communities in Europe, North America, and Australia. In Sudan and Somalia, which are the leading countries for FGM, around 97% of girls are circumcised. Apart from Africa, girls are also circumcised in some parts of Yemen, Northern Iraq, Arabia, India, Pakistan, Malaysia, and in some countries in Asia and Latin America. FGM continues to persist among immigrant populations living in Western Europe, North America, Australia, and New Zealand. The citizens of these countries try to continue their customs in the countries they emigrate to. According to the information I received from my Indonesian colleagues, the ritual is performed by gently scratching the clitoris of girls born in that country with a small syringe needle.

In 2020, the COVID-19 pandemic has negatively and disproportionately affected girls and women, resulting in a shadow pandemic disrupting SDG target 5.3 on the elimination of all harmful practices including FGM. UNFPA estimates an additional two million girls are projected to be at risk of undergoing female genital mutilation by 2030.

Female circumcision is a practice that comes from tradition and is later associated with religion. It is not mentioned in the holy book Qur'an and there is no strong evidence that the Prophet said that girls need to be circumcised. According to the Hanafi sect, circumcision should only be applied to men [12].

Within the framework of "*International Day of Zero Tolerance for Female Genital Mutilation, 6 February*" announced by the United Nations, a wide-ranging global program against female genital mutilation was carried out in 17 African countries by UNICEF and UNFPA. In this context, many advertisements, booklets, and research reports were published against female genital mutilation. Thanks to all these studies, great success has been achieved and female genital mutilation has been prohibited in 24 of 30 countries.

Appendix

With the purchase of this book, you can use our "SN Flashcards" app to access questions free of charge in order to test your learning and check your understanding of the contents of the book.

To use the app, please follow the instructions below:

1. Go to https://flashcards.springernature.com/login
2. Create a user account by entering your e-mail address and assigning a password.
3. Use the following link to access your SN Flashcards set: ▶ https://sn.pub/tvlq7Q

If the link is missing or does not work, please send an e-mail with the subject "SN Flashcards" and the book title to customerservice@springernature.com.

References

1. Karcher C, Sadick N. Vaginal rejuvenation using energy-based devices. Int J Womens Dermatol. 2016;2(3):85–8.
2. Nikolić J, Janjić Z, Marinković M, Petrović J, Bozić T. Psychosocial characteristics and motivational factors in woman seeking cosmetic breast augmentation surgery. Vojnosanit Pregl. 2013;70(10):940–6.
3. Sarwer DB, Wadden TA, Pertschuk MJ, Whitaker LA. Body image dissatisfaction and body dysmorphic disorder in 100 cosmetic surgery patients. Plast Reconstr Surg. 1998;101(6):1644–9.
4. von Soest T, Kvalem IL, Wichstrøm L. Predictors of cosmetic surgery and its effects on psychological factors and mental health: a population-based follow-up study among Norwegian females. Psychol Med. 2012;42(3):617–26.
5. Honoré LH, O'Hara KE. Benign enlargement of the labia minora: report of two cases. Eur J Obstet Gynecol Reprod Biol. 1978;8(2):61–4.
6. Goodman M. Female genital plastic/cosmetic surgery. J Sex Med. 2013;10(8):2125–6.
7. https://www.plasticsurgery.org/documents/News/Statistics/2018/plastic-surgery-statistics-full-report-2018.pdf
8. https://www.surgery.org/sites/default/files/ASAPS-Stats2017.pdf. Accessed 20 May 2020.
9. https://www.who.int/health-topics/female-genital-mutilation#tab=tab_1. Accessed 19 May 2020.
10. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation. Accessed 18 May 2020.
11. Nebi Bozkurt S. İslam Ansiklopedisi. c. 38. İstanbul: Türkiye Diyanet Vakfı İslam Araştırmalar Merkezi; 2010.
12. Eryiğit Bader A. Sünnet Olma ve Kadın Sünneti. Eskiyeni. 2018;(37): 81–107.

Should Aesthetic Genital Operations Be Done?

2

Before practicing surgery one should gain knowledge of anatomy and the function of organs so that he will understand their shape, connections and borders. He should become thoroughly familiar with nerves, muscles, bones, arteries and veins. If one does not comprehend the anatomy and physiology one can commit a mistake which will result in the death of the patient.

(Al-Zahrawi, the greatest surgeon of middle ages, "father of modern surgery")

In this section, the opinions on genital aesthetic operations of some important obstetrics and gynecology associations, especially the American College of Obstetricians and Gynecologists (ACOG), the American Food and Drug Administration (FDA) warning, the World Health Organization (WHO) definition of health, Patient Rights, Patient Perspective, and Legal Aspects are discussed.

2.1 ACOG Declarations

For the first time in 2007, ACOG made a statement about genital aesthetic operations and declared some warnings (Nr 378). Despite the genital aesthetic operation techniques and developing new technologies, the same declaration was reaffirmed exactly 10 years later, in 2017.

According to the ACOG declaration in the bulletin Nr 378, "It is misleading to give patients the impression that vaginal rejuvenation, G-spot amplification, hymenoplasty, designer vaginoplasty or similar operations are *accepted and routine* procedures. These patients who are disturbed by their genital appearance or sexual problems may be further traumatized by unproven surgical procedures" [1].

In addition, the physician is obliged to discuss the following issues with his/her patient:

- Reason for requesting cosmetic gynecological surgery.
- Whether there are any physical signs or symptoms that warrant surgical intervention.
- Female genital organs may have various appearance.
- There is insufficient data on the efficacy and safety of gynecological cosmetic operations.
- Possible complications such as infection, change of sensation, dyspareunia, adhesions, and scarring in gynecological cosmetic operations.

Despite all these warnings, ACOG did not completely close the door to AGS operations completely and allowed operations with certain indications. Among the medical indications approved by ACOG, deinfibulation (female circumcision correction) and labiaplasty operations are included due to labial hypertrophy and asym-

S. Eserdağ, *Aesthetic and Functional Female Genital Surgery*,
https://doi.org/10.1007/978-3-031-16019-6_2

metry. Although labiaplasty can be performed for both the inner and outer labia, this is not clearly stated in this ACOG declaration. Conversely, according to ACOG's declaration Nr 378, sexual dysfunctions cannot be corrected by aesthetic operations, and sexual function can worsen with cosmetic gynecological operations that have not been proven effective. Behind ACOG's cautious approach to aesthetic genital operations is the scarcity of evidence-based scientific data in this field. Additionally, the fact that this bulletin, published by ACOG, was written by academicians who are not in the ACOG association and who do not have practice in cosmetic gynecology has been another criticism.

ACOG published a new bulletin on elective female genital cosmetic surgery in January 2020. This bulletin numbered 795 replaced the declaration numbered 378 published in 2007. In this declaration, it is stated that sexual dysfunctions can be improved by genital surgeries, but for this it is important that the physician is educated about sexual dysfunctions and psychiatric disorders [21].

According to ACOG's declaration in 2020 (Nr 795):

- Female genital cosmetic procedures include procedures such as labiaplasty, clitoral hood reduction, hymenoplasty, labia majora augmentation, vaginoplasty, and G-spot amplification.
- Patients should be made aware that surgery or procedures to alter sexual appearance or function (excluding procedures performed for clinical indications, such as clinically diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence, or gender affirmation surgery) are not medically indicated, pose substantial risk, and their safety and effectiveness have not been established.
- Women should be informed about the lack of high-quality data that support the effectiveness of genital cosmetic surgical procedures and counseled about their potential complications, including pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia, and need for reoperation.
- Obstetrician–gynecologists should have sufficient training to recognize women with sexual function disorders as well as those with depression, anxiety, and other psychiatric conditions. Individuals should be assessed, if indicated, for body dysmorphic disorder. In women who have suspected psychological concerns, a referral for evaluation should occur before considering surgery.
- In responding to a patient's concern about the appearance of her external genitalia, the obstetrician–gynecologist can reassure her that the size, shape, and color of the external genitalia vary considerably from woman to woman. These variations are further modified by pubertal maturity, aging, anatomic changes resulting from childbirth, and atrophic changes associated with menopause or hypoestrogenism, or both.
- As for all procedures, obstetrician–gynecologists who perform genital cosmetic surgical procedures should inform prospective patients about their experience and surgical outcomes.

  Advertisements in any media must be accurate and not misleading or deceptive. Rebranding existing surgical procedures (many of which are similar to, if not the same as, the traditional anterior and posterior colporrhaphy) and marketing them as new cosmetic vaginal procedures is misleading.
- Obstetrician–gynecologists who perform cosmetic procedures should be adequately trained, experienced, and clinically competent to perform the procedure. Extensive familiarity with appearance and function, as well as the ability to manage complications, is expected from obstetrician–gynecologists who perform these procedures.

Similarly, The Society of Obstetricians and Gynaecologists of Canada (SOGC) advises that physicians who will perform cosmetic procedures related to the vagina and vulva should be trained in gynecological and/or plastic surgery in terms of cosmetic surgery of the external genital system.

2.2 FDA Warning

On July 30, 2018, the FDA warned some laser and radiofrequency companies manufacturing energy-based technology (EBT), health care providers, and the patients who use it. They also provided additional information in November of the same year [3].

Here is the declaration:

We are aware that certain device manufacturers may be marketing their energy-based medical device for vaginal "rejuvenation" and/or cosmetic vaginal procedures. The safety and effectiveness of energy-based medical devices to perform these procedures has not been established.

Vaginal "rejuvenation" is an ill-defined term; however, it is sometimes used to describe non-surgical procedures intended to treat vaginal symptoms and/or conditions including, but not limited to:

- Vaginal laxity,
- Vaginal atrophy, dryness, or itching,
- Pain during sexual intercourse,
- Pain during urination,
- Decreased sexual sensation.

To date, we have not cleared or approved for marketing any energy-based devices to treat these symptoms or conditions, or any symptoms related to menopause, urinary incontinence, or sexual function. The treatment of these symptoms or conditions by applying energy-based therapies to the vagina may lead to serious adverse events, including vaginal burns, scarring, pain during sexual intercourse, and recurring/chronic pain.

Healthcare providers should discuss the benefits and risks of all available treatment options for vaginal symptoms with their patients. If any patients experience adverse effects from procedures that involved the use of energy-based devices to perform vaginal "rejuvenation," cosmetic procedures, or treat genitourinary symptoms of menopause, sexual dysfunction, or urinary incontinence, it should be reported.

Behind all these warnings from the FDA and ACOG, despite the rapidly developing technologies and the number of surgeries, there are still insufficient scientific evidence-based data. Conversely, the fact that many pioneering physicians in this field act in partnership with technology-producing companies or have direct commercial partnerships with these companies is also a source of trust.

2.3 FDA Warning and a Review on Laser and Other Energy-Based Technologies

(This article is an excerpt from an article I shared on my social media)

On July 30, 2018, the FDA (US Food and Drug Administration) issued a warning about laser and energy technology devices. Our colleagues expressed their concerns in some physician groups on this issue. I would like to share my thoughts on the subject with you.

First of all, laser and RF devices are technologies that have been used in cosmetic dermatology for years. These devices have been transferred to the treatment of the genital area since the early 2000s. Laser is used in cosmetic dermatology in many areas such as acne, wart, and flesh mole treatment and facial rejuvenation. RF has a place especially in facial and décolleté rejuvenation, regional obesity, and many physical therapy applications. We, gynecologists, met with the production of the vaginal probes of these devices with a delay (about 10 years ago). In fact, medical laser and RF technologies are extremely old. They already have FDA approvals for genital wart treatment and hemostasis.

The laser is obtained with energy-concentrated light waves of the same wavelength without scattering. Lasers can be liquid, solid, or gaseous, depending on the medium used. For example,

CO_2 lasers work on the principle of transferring the intense energy light beam produced by gas (CO_2) medium to the tissue. Each laser has an affinity for a chromophore. CO_2 and erbium: YAG lasers have affinity for water molecule, and when they encounter water in the tissue, they generate heat with a thermal effect. Lasers targeting the melanin chromophore lighten color, and those that reach the oxyhemoglobin chromophore are effective in the treatment of varicose veins.

In radiofrequency, the mechanism is different. With a wavelength of a certain frequency (at the frequencies of radio-TV signal waves where the name comes from), the electric current meets the water in the tissue and generates heat. The effect is again thermal.

In laser and RF, the mechanism is actually similar*: "reversible injury."* As a result of these slight injuries, an inflammatory process begins in the tissue, many cytokines such as TGF-Beta come into play, fibroblasts migrate to the area for repair, and as a result, collagen and elastic connective tissue synthesis starts again.

The term "rejuvenation" mostly used in laser and RF means *"the restoration of a youthful appearance to something."* The same term is used for other parts of the body, such as facial, hand, neck rejuvenation, etc. The terms intravaginal laser tightening or laser narrowing are wrong. With the reversible injury we have provided, the repair process begins, which is different from tightening.

Tissue penetration in lasers is very low (energy accumulates in the lamina propria), and the temperature produced is high (60–65 °C). In radiofrequency, the penetration is higher (subcutaneous tissue), but the energy is lower (40–46 °C). Both procedures are performed while the patient is awake, and the areas other than the perineum and introitus (vaginal entrance) are quite pain free. Since the patient is awake, there is no risk of burning during the procedure. In fact, the temperature given by the thermosensor apparatus at the probe tip of the RF device is constantly controlled, preventing exceeding the limit. Some RF devices even stop directly when the tissue temperature reaches a point.

Competitions between laser and RF companies are great. In our clinics we use both laser and RF. That's why we can evaulate it objectively.

No major problems such as severe burns, scar tissue development, or fibrosis have been encountered in more than 7500 laser and radiofrequency applications performed in our clinic so far. Moreover, there are no major complications mentioned in the literature. It is an unclear on what basis the FDA refers to when talking about side effects related to devices. They are completely non-invasive procedures and have slight differences between the indications.

On the other hand, while laser is slightly ablative, RF has no ablative effect. For this reason, even sexual intercourse can be recommended immediately after RF operation. The duration of sexual abstinence for laser is seven days.

Laser and genital RF can be used in areas such as stress urinary incontinence, vaginal dryness, lichen sclerosus, and menopausal atrophy (thinning of the genital area skin), except for vaginal rejuvenation. They are also used for cosmetic purposes for majora rejuvenation. Laser can be used for anogenital bleaching and cutting in labiaplasty operations. With the increased fibroblastic activity, the vaginal tightening effect becomes noticeable by the patient who undergoes the procedure and by her partner after an average of three weeks.

On the other hand, the decisions made by the FDA should also be questioned. For example, the FDA-approved synthetic meshes in 2001 for vaginal mesh applications. In 2008, they highlighted the complications of mesh erosion, pain, and urinary complaints. They talked about the risks of dyspareunia. In 2016, they changed their mind on the 2001 decision and included meshes in the high-risk group and warned the manufacturers about this issue. On April 16, 2019, the FDA asked all manufacturers to stop their sales and distribution of mesh for cystocele (anterior wall prolapse). We will see what kind of declarations will come later.

Half of women aged 60 and older are incontinent. It is a big social problem. Up to the age of 80, 12% of women are operated on due to POP (pelvic organ prolapse).

We are faced with the fact that many defects and recurrence rates of surgical methods and surgical techniques are high. The risk of dyspareunia in midsling mesh operations is 16%, and permanent hip and groin pain in 12%. This is why constant modifications of the technique are being developed.

Non-invasive laser and RF treatments can be performed easily under office conditions in obese, diabetic, and incontinent cases with poor general health. Anesthesia is not applied, and the procedure takes about 20 minutes. It is indicated in cases of SUI without POP or mild POP. If we set out with the quote of Dr. Victor Gomel *"Surgery is the incompetence of medicine,"* can we save some of the incontinence patients from surgery with these simple applications? It is necessary to think about it very carefully.

Genital aesthetics and technology uses are generally performed in private centers. University and training hospitals act more slowly and conservatively in this regard, which is why there are not enough RCT (randomized controlled trial) data. Most of the studies done are case studies. Behind the decisions made by the FDA commission, there are facts such as the scarcity of evidence-based scientific data and the fact that most of the studies in this area were commissioned by companies in the style of white papers.

It would be a great injustice to close the doors to new technologies so early. Similar mistakes were made by the Women's Health Initiative (WHI) study. All postmenopausal treatments were terminated due to an incorrectly designed study and news in the press. I hope the same will not happen to genital laser, radiofrequency, and other genital technologies.

2.4 World Health Organization (WHO) Definition of "Health"

Health is not just *"not having any disease."* WHO defines health as a state of complete *physical, mental (emotional),* and *social* well-being and not merely the absence of disease or infirmity. According to the Encyclopedia Britannica, health is the extent of an individual's continuing physical, emotional, mental, and social ability to cope with his/her environment. As described in these definitions, the mental and social dimensions of health should also be taken into consideration as well as physical. Therefore, most of the aesthetic medical procedures, although not for therapeutic purposes, are the methods of realizing the right to health, which includes one of the basic human rights, the mental well-being of the person. In this context, most of the aesthetic and reconstructive operations for the genital area are performed *"to be healthy."* For example, in most labiaplasty operations, which are frequently requested by patients, in addition to aesthetic concerns, there are physical problems such as frequent vaginal infections, urine flowing in different directions in the toilet, and irritation due to friction while wearing jeans. The number of women who see themselves as socially flawed or even disabled, who cannot flirt with their boyfriends, cannot marry out of shame, and cannot concentrate on the relationship due to being ashamed of their bodies when they are with their partners during intercourse is quite high. Some patients also face emotional problems such as self-deficiency, inability to feel like a woman, and lack of self-esteem. Therefore, is it enough to focus solely on physical diseases of an anatomical region, when this region has such great effects on a person's social life and psychology? Similar situations apply to women who experience postpartum vaginal enlargement and age-related insensitivity.

2.5 Patient Rights

The first written declaration on patients' rights is the declaration accepted at the 34th Congress of the World Medical Association (VMA), which was held in Lisbon in 1981. According to this declaration, the patient has the right to choose freely and change his/her physician and hospital or health service institution, regardless of whether they are based in the private or public sector.

In the declaration of European Consultation on the Rights of Patients, held in Amsterdam on 28–30 March 1994 under the auspices of the WHO Regional Office for Europe (WHO/