

Editorial

Vaginal rejuvenation-current trends

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Female genital cosmetic surgery (FGCS) consists of surgical and non-surgical interventions for esthetic purpose. In the past 5 years, the demand for FGCS has picked up and has seen a nearly 200% increase. An Indian study showed growing demand for esthetic vaginal procedures, from 3.9% to 28.97% between 2012 and 2015. In America, plastic surgeons reported a 30% increase in the rate of vaginal rejuvenation procedures between 2005 and 2006.

Even though female genital anatomy has not changed during last decade or so, yet the impact of media and popular culture is very much visible. Now, young women prefer pubic hair removal, which allows for easier vulvar visualization and also to their partners. The ease of access to genital images through the internet has led many women to compare their genitalia to unrealistic standards, directing more women to pursue FGCS. The rise in FGCS procedures indicates the standards of normal or desirable anatomy appear to be shifting.

Although the popularity of surgical procedures has decreased slightly, the interest in energy-based devices (laser/nonsurgical interventions) has increased. The advent of nonsurgical methods and energy-based devices for these indications is receiving tremendous response and patient acceptance.

FGCS includes several surgical interventions (such as vaginal rejuvenation, labiaplasty, vulvar liposculpturing, revirgination with hymenoplasty, and G-spot amplification) aimed at reaching better female genital appearance and/or improved sexual functioning. In recent years, FGCS procedures – especially vaginal rejuvenation – have gained increasing popularity in Western countries.

The mean width of the labia minora is 2.5 cm with a range of 7–5 cm. The labia minora with a length of 3–5 cm are considered hypertrophic by FGCS providers. When the labia minora protrude past the labia majora or are disproportionately more prominent than the labia majora, patients may view this as esthetically unattractive. Labiaplasty may be a therapeutic intervention as well as a cosmetic surgical procedure.

Nowadays, labia minora labiaplasty ranks as one of the most frequently performed FGCS procedures. Surveys indicate that the edge trim and wedge resection techniques are the two most predominantly performed procedures.

Vaginal rejuvenation is a cross-discipline area that involves gynecology, plastic surgery, urology, dermatology, and 40 other fields. It consists of a range of surgical procedures to decrease the average diameter of the vagina, mainly for esthetic and sexual functioning reasons. It could be proposed to women who feel a sensation of a wide vagina due to vaginal delivery or aging.

In general, vaginal rejuvenation is often proposed to women who feel a sense of wide vagina due to vaginal delivery or aging to enhance the vaginal tone and thus sexual friction. The increasing request for FGCS derives from women's desire for a standardized, pre-pubertal genital appearance,

namely, the “Barbie doll look,” in which the labia minora are narrow and not visible, and the vagina opening appears very tight. Following this new ideal of the “perfect vagina,” some authors have proposed a novel concept of “genital beautification,” which involves a combination of different FGCS techniques: Labia majora augmentation, labia minora reduction, labial brightening by laser, mons pubis reduction, and vaginal tightening.

When vaginal laxity is the primary complaint, the esthetic procedures that seek to decrease the caliber of the vaginal canal are now more commonly called vaginal tightening or vaginal rejuvenation; they are frequently performed in combination with a perineoplasty. Often vaginal laxity is associated with pelvic laxity and genitourinary syndrome of menopause. Esthetic vaginal surgery to correct the vaginal issues is associated with increased rates of dyspareunia and diminished vaginal lubrication.

The surgical procedures employed in vaginal rejuvenation vary and include anterior colporrhaphy, high-posterior colporrhaphy, excision of the lateral vaginal mucosa, or a combination of techniques. These procedures help tightening of the vaginal canal and the introitus and perineum. Risks of vaginal tightening procedures include dyspareunia, wound disruption, and urinary incontinence.

Because of the invasive nature of the surgery and a desire to nonsurgically manage sexual function and treat sensations of the wide/lax vagina often while remaining parous or thinking of future pregnancies, there has been a surge in the availability of energy-based devices addressing the vulvovaginal area. Various modalities available under different technologies include lasers (carbon dioxide and/or erbium-doped yttrium aluminum-garnet), radiofrequency (monopolar and bipolar), and electromagnetic therapy. Numerous commercially available fractional CO₂ lasers are marketed, including the MonaLisa Touch, Femilift, and IntimaLase, with all products touting increased collagen growth and lubrication of the tissues to improve vaginal lubrication and reduced dyspareunia and atrophy. It is generally accepted that depositing a certain degree of thermal energy on the vaginal wall could stimulate the proliferation of the glycogen-enriched epithelium, collagen formation, and neovascularization. The vaginal dryness, vaginal burning, vaginal itching, dyspareunia, and dysuria were found to be improved after fractional CO₂ laser treatment.

Energy-based procedures are well tolerated by most patients because they are either totally pain-free or cause slight discomfort. There is no downtime and you can immediately resume your daily activities. Energy-based devices help improve symptoms of dyspareunia and lack of lubrication seen after surgery.

However, some authors have raised concerns about the safety of laser procedures, as tissue damage and remodeling resulting from

laser use may potentially increase urogenital pain and dyspareunia; moreover, the distal effect of the laser energy on proximal organs such as the rectum, urethra, and bladder is unknown.

The U.S. Food and Drug Administration recently warned about procedures that destroy or reshape vaginal tissue using lasers or other energy-based devices, such as radiofrequency. The warning elaborates that “the full extent of the risks is unknown. However, these reports indicate that these procedures can cause serious harm.”

Adjunctive therapies include hormonal preparation, platelet-rich plasma (PRP), growth factors, and hyaluronic acid. Clitoral hood reduction procedure is frequently done with labiaplasty.

Vulvovaginal lipofilling and injection of hyaluronic acid and combined PRP are proposed as novel procedures for vulvovaginal rejuvenation. Some authors recently introduced a novel technique for vaginal rejuvenation, that is, using Gore-Mycromesh, a biocompatible material composed of expanded poly-tetrafluoroethylene (ePTFE). The same authors also proposed a functional vaginal rejuvenation with elastic silicone threads in women with a feeling of a wide vagina.

G-spot amplification is a non-invasive dermal filler (hyaluronic acid, PRP, and collagen) injection technique used to expand the size of the G-spot, as identified individually by each patient. The G-spot refers to an erogenous zone located 1–2 cm from the urethra on the anterior vaginal wall, which increases sexual stimulation during friction with intercourse. The results of the G-shot may last 3 to 5 months. The danger with the G-spot injection is intravascular placement.

To correct labia majora atrophy, autologous fat, graft, or filler is injected into the subcutaneous fat layer of the labia majora. An alternative to this is to perform a labia majora plasty. Excision of the excess labia majora skin can produce a smoother labial appearance.

Genital PRP injections, fillers, peels, and vulvar bleaching/whitening are other treatment modalities used under FGCS. Still, they lack data regarding the role of these products in enhancing sexual function. Given the arguments for and against FGCS, proper patient counseling is needed before undergoing surgery.

FGCS has become more prevalent in recent years, likely because of a change in expectations of women’s genital appearance and function, increased marketing, and more clinicians willing to provide these services. Few studies have assessed the long-term impacts of these treatments, although initial studies show increased patient satisfaction after surgery.

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