Patients Will Be Asking About Cosmetic Gyn.

BY PATRICE WENDLING
Chicago Bureau

Chicago — A patient wants her hymen reattached as a 30-year wedding anniversary present to her husband. Would you perform the surgery?

Would your answer change if the patient was a 20-year-old woman seeking the same procedure because religious practices dictate that she be a virgin at her upcoming wedding?

It's necessary to understand what aesthetic vulvovaginal procedures are being pitched to patients, and be prepared to address the ethical issues surrounding these procedures, Dr. Hope K. Haefner said at a conference on vulvovaginal diseases sponsored by the American Society for Colposcopy and Cervical Pathology.

Television programs, direct marketing, and the Internet are providing patients with information on a range of procedures, including revirgination, designer laser vaginoplasty, labial reduction, augmentation labioplasty, hymenoplasty, vulvar lipoplasty, and genital bleaching.

A recent Internet search revealed more than 100,000 hits for vaginal rejuvenation and over 300,000 hits for G-spot amplification/enhancement, while a Medline search revealed scarcely a mention of these topics, according to Dr. Haefner, professor of obstetrics and gynecology and codirector of the University of Michigan's Center for Vulvar Diseases, Ann Arbor.

G-spot amplification involves injecting the Gräfenberg spot with collagen in an effort to enhance sexual arousal or gratification temporarily. Anal and vaginal lightening products are sold to reverse the discoloration that comes with aging and hormonal changes in the body.

The issue of whether the patient is symptomatic or asymptomatic can help in determining if a vulvovaginal procedure should be undertaken.

The exact procedure performed often is unclear because standard medical nomenclature is not used, notes the American College of Obstetricians and Gynecologists (ACOG), which takes up the issue in its Committee Opinion on Gynecologic Practice (Obstet. Gynecol. 2007;110:737-8).

The ACOG committee advises physicians to inform their patients about the lack of data supporting the efficacy of these procedures and their potential complications, including infection, altered sensation, dyspareunia, adhesions, and scarring.

What sets these aesthetic procedures apart from genital mutilation, such as female circumcision, is the age of the patient and consent, Dr. Haefner said.

Still, many cases demand a full work-up, including a psychological evaluation.

She presented a case of a young patient requesting clitoral reduction that included a complete physical examination, chromosomal and endocrinologic evaluations, and a visit to a pediatric urologist.

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Dr. Haefner recalled two patients who requested labial reductions, one of whom had irritation of the labia with exercise and one who had a history of urinary tract infections that may have been associated with her enlarged labia. Even with those histories, both patients received extensive counseling before the reductions were performed.

The same request becomes more vexing in an asymptomatic patient who asks for the procedure because she doesn't feel her labia are "normal." The average inner labia is thought to be 4.5 cm in width when extended to the side, but where that definition of normal came from, Dr. Haefner admits, is anyone's guess. What some patients and their physicians find acceptable, others will feel the need to alter.

Gynecologists aren't the only clinicians who may face these ethical dilemmas. Many procedures are being advertised to both men and women. Some centers package more traditional aesthetic procedures, such as breast augmentation, together with labioplasty.

But other centers are offering packages to couples, for example, who may want the man to undergo scrotal reduction or penile enhancement at the same time that the woman undergoes labial reduction or breast augmentation, she said.

In addition to the ACOG committee's opinion on cosmetic vaginal procedures, Dr. Haefner noted, differing opinions can be obtained from the American Academy of Cosmetic Gynecologists (www.aaocg.org) and the International Society of Cosmetogynecology (www.iscgyn.com). ■

Long-Term Survival for DCIS Found to Be Good in Two Studies

BY FRAN LOWRY
Orlando Bureau

Chicago — Ductal carcinoma in situ is associated with good long-term disease-specific survival, although the small percentage of tumors that do recur—particularly after radiotherapy—confers an increased risk of death.

The good outcomes were seen in two studies presented at the annual meeting of the American Society of Clinical Oncology. In a retrospective study of more than 50,000 women with ductal carcinoma in situ (DCIS) treated with total mastectomy or breast-conserving surgery plus radiation between 1988 and 2003, both treatments yielded similar 10-year disease-specific survival rates by Cox multivariate analysis, said Dr. Mohammed Nazir Ibrahim of Sligo General Hospital, Ireland.

The investigators analyzed the Surveillance, Epidemiology, and End Results (SEER) dataset of 543,261 individuals with invasive and noninvasive breast tumors.

Of these, 88,285 were in situ tumors; 33% of patients had total mastectomies and 30% had breast-conserving surgery (lumpectomy) with radiotherapy. Nearly all of the remaining patients had breast-conserving therapy only; 2.4% did not undergo surgery or radiotherapy, and 0.3% had radiotherapy only.

Women treated in the early part of the study were more likely to have total mastectomies, but breast-conserving surgery plus radiation became more common over time, he noted.

The analysis also revealed that the diagnosis of carcinoma in situ is increasing in the United States at a rate of 0.5% annually, Dr. Ibrahim said.

Tumor grade, ethnicity, and receptor status were found to be important prognostic factors in disease-specific survival.

Grade IV tumors had a hazard ratio (HR) of 1.7 compared with grade I tumors, African Americans had a more than twofold risk of death compared with Caucasians (HR 2.1), and hormone receptor–negative status likewise conferred a twofold increase in the risk of death (HR 2.2).

In another study, Dr. Irene Wapnir of the Stanford (Calif.) Comprehensive Cancer Center presented long-term outcomes after invasive breast tumor recurrence in women with primary DCIS in National Surgical Adjuvant Breast and Bowel Project trials B-17 and B-24.

The two trials included 2,612 women randomized between 1985 and 1994 to either lumpectomy alone or lumpectomy plus whole-breast irradiation (B-17), or to lumpectomy plus whole-breast irradiation with or without tamoxifen (B-24). The median follow-up was more than 12 years.

There were 336 deaths, 83 of which were from breast cancer. However, the breast cancer deaths included deaths that were potentially due to contralateral breast cancers, Dr. Wapnir said.

Breast cancer–specific survival ranged from 96% to 98%, and patients receiving lumpectomy, radiation, and tamoxifen had the best survival.

Adding radiation therapy reduced the risk of an invasive breast tumor recurrence by 59%, and adding tamoxifen to lumpectomy plus radiation further reduced the risk of an invasive breast cancer recurrence, Dr. Wapnir said.

Although overall mortality was low, the subsequent recurrence of an invasive breast tumor doubled the risk of death. Mortality risk was even higher for women who received lumpectomy plus whole-breast irradiation, Dr. Wapnir said. (See chart, below right.)

Among 242 cases of invasive breast tumor recurrence, there were 35 deaths, 22 of which were breast cancer–related. Of these deaths, 9 occurred in the lumpectomy-alone patients, 21 in the lumpectomy plus radiation patients, and 5 in the lumpectomy plus radiation plus tamoxifen patients. (See chart, below left.)

Although the recurrence of invasive breast tumor is the most common first-failure event in lumpectomy-treated patients with DCIS, overall breast cancer–specific mortality for all treatment modalities in the two trials is low, Dr. Wapnir concluded. ■