The 15th World Congress on
Controversies in Obstetrics,
Gynecology & Infertility (COGI)
All about Women’s Health

Hainan, China, December 8-11, 2011

CONGRESS PROGRAM

A comprehensive Congress fully devoted to clinical Controversies, debates and consensus on a wide spectrum of topics in Obstetrics, Gynecology and Infertility

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### Gynecology

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<td>08:30-10:00</td>
<td><strong>COSMETIC GENITAL SURGERY</strong>&lt;br&gt;The reasons for the current surge in popularity of cosmetic genital surgery are not completely understood. Are they related to the surge in availability? To new methods and technologies that were introduced, to a real need or to a good marketing strategy? What are the methods, who are the patients, what are the perils and who should provide the services?</td>
<td>A. Ostrzenski, USA</td>
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<td>08:30-09:00</td>
<td>Deceptive and unethical procedures in cosmetic-plastic gynecology: Difficulties in identifying and eliminating them from the practice</td>
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<td>09:00-09:30</td>
<td>Progress in cosmetic-plastic gynecology: New surgical interventions combine gynecologic and general cosmetic-plastic operations, and natural or synthetic fillers</td>
<td>M.N. Scheinberg, USA</td>
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<td>09:30-10:00</td>
<td>Cosmetic-plastic gynecology: Complications and how to avoid them</td>
<td>A. Ostrzenski, USA</td>
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**Objectives**

* Anything you wanted to ask about Cosmetic genital surgery and never dared to ask……

| 10:00-10:20 | Coffee break |   |
| 10:20-11:50 | **CONTROVERSIES IN THE TREATMENT OF MALIGNANCIES**<br>Are there new aggressive procedures coupled with better survival rates?<br>Expert opinion on a variety of clinical dilemmas in oncology | C.O. Granai, USA |
| Discussants | R. Moore, USA | T. Levy, Israel | T.H. Cheung, Hong Kong | S. Wilailak, Thailand |

**Surgery**

* Oophorectomy at hysterectomy: Is there a cut off age?  
* Should Low Malignant Potential tumors be surgically staged?  
* Lymphadenectomy for early stage endometrial cancer?  
* Lymphadenectomy for ovarian CA: Is it really necessary?  
* Aggressive cytoreductive surgery should be the first step in the management of ovarian cancer?  
* Surgery or primary chemo-radiation for stage 1B2 cervical cancer?  

**Therapy**

* Adjuvant chemotherapy for ovarian malignant tumors of low potential  
* Neo-adjuvant chemotherapy for advanced-stage ovarian cancer and cervical cancer  
* Platinum-sensitive relapse ovarian CA outcome and quality of life?  
* Intraperitoneal chemotherapy in ovarian cancer  

| 11:50-12:10 | Poster viewing |   |
12:10-13:40  ENDOSCOPY
Supported by unrestricted grant from Karl Storz GMBA

Capsule
Should we continue to expand on indications for endoscopy?

Chairpersons
T. Levy, Israel
R. Campo, Belgium

12:10-12:40  Trophy’s choice? New generation of Hysteroscope
R. Campo, Belgium

12:40-13:10  Endometriosis of bowel, bladder, ureter, diaphragm, lumps and liver
CR. Nezhat, USA

13:10-13:40  A new approach to the diagnosis of adenomyosis “Hysteroscopic exploration of the sub endometrial myometrium”
R. Campo, Belgium

Objectives
To acquire knowledge of the following:
• Surgical treatment of endometriosis
• Introduction to Trophy’s choice
• The place of hysteroscopy in the management of infertility
• Diagnosis of adenomyosis

13:40-14:30  Lunch break

14:30-16:00  OPERATIVE PROCEDURES: TRICKS OF THE TRADE

Capsule
Results of surgery depend on choosing the right procedure for the right patient, and recognizing the pitfalls and risks of the operation. Good results also depend on a meticulous technique. How can all these be improved?

Chairpersons
R. Campo, Belgium
C.R. Nezhat, USA

14:30-14:55  Pain, infertility, pregnancy and endometriosis: Ancient conditions, ancient correlations and their ancient treatment
C.R. Nezhat, USA

A. Ostrzenski, USA

15:15-15:40  Intra uterine adhesions (IUA) "Prevention and Treatment" a major challenge
R. Campo, Belgium

15:40-16:00  Mesh vs. non-mesh reconstruction for urinary incontinence
D. Dodero, Italy

Objectives
Upon completion of this session, the audience will learn:
• Where we are in containing endometriosis pain?
• The new surge in popularity of cosmetic genital surgery
• Withstanding the challenge of IUA
• To mesh or not to mesh, this is the question!

16:00-16:30  Coffee break

16:30-18:00  CERVICAL CANCER AND HUMAN PAPILLOMA VIRUS (HPV)

Capsule
Does vaccination mark the end of cervical cancer?

Chairpersons
C.P. Zou, China
Discussants

R. Moore, USA
T. Levy, Israel
S. Wilailak, Thailand
T.H. Cheung, Hong Kong

Hot Controversies – Expert Opinions on:
1. The difference between quadrivalent or bivalent HPV vaccine
2. The efficacy of vaccination in adolescents and women over 30 years of age
3. For how long does immunization provide immunity? Booster after 10 years?
4. Whether current knowledge implies immunization against cancer, or merely precancerous stages?
5. Is there concern that migration to other types of HPV will become the main cause of HPV-related cervical cancer?
6. Should males be vaccinated?
7. Is the Pap smear obsolete in immunized patients?
8. Do we still need HPV-DNA typing?
9. Routine inclusion of colposcopy in a pelvic examination. If so, how often?

Fetomaternal Medicine

08:30-09:00 COMPLICATIONS OF PREGNANCY AND DELIVERY
Capsule
Life-threatening situations in obstetrics should be identified and treated early
Chairpersons
W.H. Tam, Hong Kong
I. Blickstein, Israel

08:30-09:00 New insights into the pathophysiology of preeclampsia: Consequences for prediction and prevention
W. Holzgreve, Switzerland

09:00-09:30 What is the best maneuver to relieve shoulder dystocia and safety limit for head-to-body delivery interval?
T.Y. Leung, Hong Kong

09:30-10:00 Stem cells from cord blood and other sources: What the obstetricians/ gynecologists should know?
W. Holzgreve, Switzerland

Objectives
Upon completion of this session, the audience will have learned:
• Managing Shoulder dystocia
• Prevention of complications by better prediction
• What to do with cord blood?

10:00-10:20 Coffee break

10:20-11:50 CERCLAGE
Capsule
Cerclage is being used in increasing frequency despite the lack of RCT
Chairpersons
T.Y. Leung, Hong Kong
H. Divakar, India

10:20-11:05 Debate
Does Cervical Cerclage with Bulging Membranes Extend Pregnancy Beyond Conservative Treatment?
What is the Evidence?
No Evidence: Conservative treatment will achieve similar results. The risk of infection is too high to keep experimenting
I. Blickstein, Israel
Selection of patients and meticulous technique is the key to success in emergency cerclage
W.H. Tam, Hong Kong
Discussion

11:05-11:30 The role of “repeated dose” steroids
T.Y. Leung, Hong Kong

11:30-11:50 Progesterone treatment for PTL
S. Luming, China

Objectives
Upon completion of this session, the audience will have learned:
• The place of late cerclage in the management of bulging membranes
• Technique, indication, and contraindication of late cerclage
• Use of corticosteroids
INVITED SPEAKERS’ ABSTRACTS

CLINICAL, ENDOCRINE AND METABOLIC PROFILES OF FEMALE FILIPINO PATIENTS DIAGNOSED WITH POLYCYSTIC OVARY SYNDROME IN A PRIVATE REPRODUCTIVE ENDOCRINOLOGY SPECIALIST CLINIC: A PILOT STUDY
E.M. Manalo, I.S. Ibaron, M.J. Alcantara

Polycystic ovary syndrome (PCOS) is characterized by hyperandrogenism, chronic anovulation, and oligoamenorrhea. PCOS has variable clinical phenotypes, biochemical features, and metabolic abnormalities. To determine the clinical, endocrine and metabolic profile of PCOS among Filipino women, we performed a cross-sectional study of 198 women of reproductive age, currently attending a Reproductive Endocrinology Specialist Clinic. Prevalence of obesity, hirsutism, insulin resistance, and metabolic syndrome were also determined.

Results: 198 Filipino women diagnosed with PCOS using the 2003 Rotterdam criteria were included in the study, and 30 age and weight-matched, non-hirsute, normoandrogenic women were recruited as controls. 89% of the women diagnosed with PCOS presented with menstrual irregularities. Majority of the patients with PCOS (71%) were classified as either overweight (BMI 23-24.9), or obese (BMI > 25%). 36% of the 198 PCOS patients (18.2%) strictly fulfilled at least 3 out of the 5 diagnostic criteria for Metabolic Syndrome (NCEP-ATP III criteria). The MetS subgroup had significantly higher body mass index, waist measurements, waist-to-hip ratio, systolic and diastolic blood pressures, mFG scores, testosterone levels, fasting plasma glucose and triglyceride levels, and lower HDL-C values. A family history of Diabetes Mellitus in a first degree relative was present in 32.6% of PCOS patients. The prevalence of impaired glucose tolerance (WHO cut-off values: FPG 110-126 mg/dL, 2hr OGTT 140-199 mg/dL) was seen in 17.6%, while 7.3% are overtly diabetic (2hr OGTT > 200 mg/dL). Hirsutism prevalence rate (using the modified Ferriman-Gallwey score of ≥ 8) in Filipino PCOS patients was a low 6.1%. Mean mFG among PCOS patients was 2.93, with the upper lip and nipple areas as the main contributors to the total hirsutism score. Among the endocrinologic parameters, only the testosterone levels, DHEAS and LH/FSH ratio showed significantly higher results than the control. Majority of Filipino patients with PCOS (62%) presented only with anovulatory bleeding and polycystic ovaries on ultrasound (normoandrogenic, ovarian polycystic type). However, the hyperandrogenic, ovulatory phenotype had the highest levels of testosterone and mFG scores, and registered higher prevalence rates for family history of Diabetes, metabolic syndrome, and dyslipidemia.

Conclusion: To our knowledge, this is the first study on the clinical, endocrinologic and metabolic profile of the Filipino PCOS women. Menstrual irregularity is the most common symptom among Filipino PCOS women, while the polycystic ovarian morphology is the most common manifestation. The mean BMI of Filipino PCOS women is comparable to that of other Asians, but is lower than their Caucasian counterparts. Filipino PCOS women have lower mFG scores and are less androgenic compared to other racial groups. Lowering the mFG score might help identify more hyperandrogenic women among the Filipino PCOS cohort, and possibly among Southeast Asian women. Significant predictors for MetS within the PCOS cohort were general and central obesity, HDL < 50 mg/dL, a family history of diabetes and an mFG score of ≥ 4.

DECEPTIVE AND UNETHICAL PROCEDURES IN COSMETIC-PLASTIC GYNECOLOGY: DIFFICULTIES IN IDENTIFYING AND ELIMINATING THEM FROM PRACTICE
T.R. Haliparn
Cosmetic Gynecology Center of San Antonio, San Antonio, TX, USA

Background: The cosmetic gynecology field has been inundated with marketing, teaching, and practice of deceptive and unethical medicine. Recent advances in cosmetic gynecology provide honest science-based alternatives for learning to practice and market without deception.

Objectives: Objectives of this study were to recognize the deceptive and unethical cosmetic-plastic gynecologic procedures, to identify the difficulties in eliminating them from practice and to establish alternatives for ethical and honest cosmetic-plastic gynecologic surgical interventions.

Methods: A review of the existing electronic data was conducted using the appropriate medical subject heading terms focusing on articles in cosmetic gynecology; a manual review of the Laser Vaginal Rejuvenation Institute™ (LVR™) of America syllabus, the LVR™ of America contract agreement, the advanced cosmetic gynecology course workshop syllabus of the Institute of Gynecology, Inc., St. Petersburg, Florida, and pertinent Congress proceedings. Marketing and advertising literature were analyzed as well.

Results: Laser Vaginal Rejuvenation™, Designer Laser Vaginoplasty™, G-Spot Amplification™ and Revirginization procedures are considered not to be medically indicated for cosmetic-plastic gynecology. It has been determined that they are traditional gynecologic procedures masked by misleading terminology and have been defined as deceptive and unethical practice by the American College of Obstetricians and Gynecologists (ACOG). Marketing and teaching of these mislabeled cosmetic gynecologic procedures needs to be abandoned. In the advertising literature provided by these physicians, patients are led to believe these trademarked procedures are medically indicated, routine and enhance sexual gratification; none of which has been scientifically validated. Furthermore, practitioners who participate in the Laser Vaginal Rejuvenation Institute™ educational courses must sign a non-disclosure contract which prevents course participants from unveiling the content being taught during these non-CME courses. Difficulties encountered in identifying the deceptive and unethical practice include the contract, which restricts the discussion, use and teaching of the knowledge learned and promotes secrecy, the misleading terms and trademarks and the absence of publications in the scientific literature. Alternatives for ethical and honest practice are available. As per ACOG, labioplasty and defubilation procedures are acceptable and cosmetic-plastic procedures can be offered when signs and symptoms are present.

Conclusion: Deceptive and unethical procedures are still being taught, marketed and practiced within the cosmetic gynecology field. New non-deceptive cosmetic-plastic gynecologic procedures have been developed and can be marketed ethically to prospective patients.

Evidence-based Level III

Introduction: During the last decade, demands for cosmetic-plastic services have significantly increased. This presented the opportunity for entrepreneurs to adopt traditional gynecologic operations and label them as cosmetic-plastic procedures. This dishonest practice of marketing and performing these surgeries was adopted globally. It has become imperative to advise practitioners who specialize in female cosmetic surgeries about the existence of these deceptive

BREAST CANCER RISK AND HORMONE REPLACEMENT THERAPY- IS THE CHOICE OF PROGESTOGENS IMPORTANT?
X. Ruan
Beijing, China

Ovar and other experiments have shown that progestogen addition to estrogen can increase the proliferation of breast cancer cells mediated by certain cell (membrane) components, but there are large differences between the progestogens if compared in same models. Faster proliferation to about 1,000 million cells can develop clinical cancer, because protective mechanisms (e.g. by the estrogen component) can less work. This can explain the different results in clinical studies suggesting lower risk using more natural progestogens compared to MPA, the progastin in the WHI study. Thus the choice of progestogen is important although more clinical studies are needed to answer the controversial questions.
methods and teach them how to avoid these practices and where to learn acceptable procedures.

Having experienced this deceptive teaching and marketing firsthand, this author decided to study these subjects and share not only the results of the study but also her own experience. At the First International Congress of Cosmetology and Cosmetic Gynecology, which was held in Istanbul, Turkey, Haliparn [1] presented how to practice cosmetic gynecology without deception and within the American College of Obstetricians and Gynecologists’ (ACOG’s) recommendations. During the same meeting, Scheinberg [2] discussed how to restructure one’s practice to avoid being deceptive and unethical. Ostrowski’s [3] recent cosmetic gynecology review concurred that deceptive practice and marketing literature exists that uses misleading terms giving the impression that these cosmetic gynecologic procedures are accepted and routine. In the last two years, new cosmetic gynecologic procedures not based on those traditional gynecology have been developed, taught, and published in the peer review journals [3, 4, 5, 6].

Objectives of this study were to recognize the deceptive and unethical cosmetic-plastic gynecologic procedures, to identify the difficulties in eliminating them from practice and to establish alternatives for ethical and honest cosmetic-plastic gynecologic surgical interventions.

Methods:
A search of the existing literature from 1900 to September 2011 was carried out utilizing Medical Subject Headings which were elected and used in a search on ISI Web of Science (including conference proceedings); 1990 PubMed, ACOGNET, ProQuest, OVID, Cochrane Collection, the Lancet on line collection, MD Consultant, The New England Journal of Medicine, American College of Physicians online resources, Highwire Journals and Citation Index Reference, and utilizing a manual search; a manual review of the Laser Vaginal Rejuvenation Institute™ (LVRI™) of America syllabus, the LVRI™ of America contract agreement, the advanced cosmetic gynecology course workshop syllabus of the Institute of Gynecology, Inc., St. Petersburg, Florida, and pertinent Congress proceedings. In addition, marketing and advertising literature was analyzed.

Results:
Laser Vaginal Rejuvenation™, Designer Laser Vaginoplasty™, G-Spot Amplification™ and Revirgination procedures are considered not medically indicated for cosmetic-plastic gynecology. It has been determined that they are traditional gynecologic procedures masked by misleading terminology and have been defined as deceptive and unethical practice by the American College of Obstetricians and Gynecologists (ACOG). It is also deceiving to claim that these procedures are accepted, routine and enhance sexual gratification due to the marked lack of scientific documentation [7].

The main difficulty encountered in identifying deceptive and unethical terminology and practice is the contract [8], which binds physicians from disclosing the procedures they learn, and reads: “Physicians will have access to certain Laser Vaginal Rejuvenation Institute™ (LVRI™) business secrets and confidential proprietary information. Physician acknowledges that LVRI™ training information such as unique surgical procedures and techniques, name and service marks, business management and marketing strategies, protocols, policies, procedures, manuals, reports, databases, documents and other trade secrets of LVRI™ are proprietary and confidential, and are to be used solely by Physician and his or her affiliates in his or her medical practice.” The contract [9] also reads “Physician shall not, during or after the term of this Agreement, use or disclose Laser Vaginal Rejuvenation Institute™’s confidential information or trade secrets to any person or entity for any reason or purpose whatsoever without the prior written consent of Laser Vaginal Rejuvenation Institute™.” Another provision in the contract reads [9] “During the term of this Agreement, and any extensions thereof, and for a period of five (5) years thereafter, other than as permitted herein, Physician shall not, without prior written consent of LVRI™, either directly or indirectly: Attempt to provide training of the same or substantially similar services to any person or entity.” This provision deters the dissemination of the scientific knowledge acquired. It is unethical to agree to withhold knowledge that can expose or bring progress to the medical field.

Other impediments include the trademarks, which prevent others from using them, and the terminology, which is not medical, and is misleading. In addition, although those who took the course have access, they are restricted by the contract from talking about them. Laser Vaginal Rejuvenation™ and Designer Laser Vaginoplasty™ procedures. The above has made it difficult for physicians as a whole and their governing bodies, such as ACOG, to identify exactly what these procedures are and what patients are being told [7].

Upon searching the literature, one article was found, by Pardo [10], that describes Laser Vaginal Rejuvenation™ but it does not mention the treatment of acquired sensation of wide vagina, revealing it to be a colpoperineoplasty and paravaginal repair (one-fit-all procedure). In 2006, it became formal knowledge that Laser Vaginal Rejuvenation™ was essentially a colpoperineoplasty and Designer Laser Vaginoplasty™ was surgery on the external structures.

Alternatives for ethical and honest practice are available. Medical procedures such as labioplasty and defibulation are accepted by ACOG and other cosmetic-plastic gynecologic procedures can be offered when signs and symptoms are present [7]. In the last two years, Ostrowski [3, 4, 5, 6] has published in peer review journals new cosmetic-plastic gynecologic procedures and new classifications not based on those of traditional gynecology that are not available online [11, 12] (based on personal communication), and is teaching CME advanced cosmetic-plastic gynecology in an ethical and non-deceptive manner. In lieu of Laser Vaginal Rejuvenation™, vaginal rejuvenation restoration by means of Vaginal Rupture Rejuvenation (VRR) has been developed, and instead of Designer Laser Vaginoplasty™, clitoral hood reconstruction with hydrodissection and reverse V-plasty [5] is an option; and classifications for both wide/smooth vagina and vaginal introital defects now exist to suggest new specialized vaginal rejuvenation interventions [3, 4, 5, 6, 11, 12].

For physicians who are planning to practice cosmetic-plastic gynecology, there is information available on how to restructure one’s practice to avoid being deceptive and unethical [1, 2, 3, 7]. As per ACOG [7], avoid deceptive and unethical practice, utilize accepted ACOG procedures, establish signs and symptoms, and utilize the WHO health definition [13]. Haliparn [1], Scheinberg [2], and Ostrowski [3] espouse learning pure cosmetic gynecologic procedures, stop labeling traditional surgeries as cosmetic, cease using and marketing the terms Laser Vaginal Rejuvenation™ and Designer Laser Vaginoplasty™, and remove references to Laser Vaginal Rejuvenation™ from one’s practice name, office, website and all advertising and marketing materials. Staff re-training and marketing within the ACOG guidelines are also recommended.

Discussion
The identification and condemnation of Laser Vaginal Rejuvenation™, Designer Laser Vaginoplasty™, G-Spot Amplification and Revirgination has put physicians on guard as to what they should be teaching and practicing in cosmetic gynecology. This author acknowledges the cost in both time and money expended to re-structure and re-market her practice as well as the need to obtain further education in cosmetic gynecology. The rapid evolution of this surgical field will dictate more training for all of those interested in expanding the honest practice of cosmetic-plastic gynecology.

The contract’s restrictions have delayed the deceiving of what was being done by the Laser Vaginal Rejuvenation Institute of America™. The ACOG Committee Opinion No. 378 surmised Laser Vaginal Rejuvenation™ and Design Laser Vaginoplasty™ procedures were based on traditional procedures, but they could not know for sure because of the non-disclosure contractual agreement. At the First International Congress of Cosmetology and Cosmetic Gynecology in Istanbul, Haliparn [1] and Scheinberg [2] confirmed these procedures were modifications of the traditional anterior colporrhaphy and posterior colpaceoplasty, and labioplasty, just done with a laser.

The fact that the Laser Vaginal Rejuvenation Institute of America™ continues to market [14, 15], practice and teach these procedures is as unethical as it is unprofessional. There is a great need for all physicians practicing cosmetic gynecology that has to be counterbalanced by non-deceptive alternatives with documentation in peer review journals [3, 4, 5, 6, 11, 12]. In the August 2011 edition of Ob.Gyn.News, the Laser Vaginal Rejuvenation Institute of America™ marketed Laser Vaginal Rejuvenation™ and Designer Laser
Vaginoplasty™ as “safe and effective outpatient procedures” however the criticized statement that the founder of LVRI™ developed them has been removed [14]. The definition of morality includes conformity to standards of right conduct, and the definition of moral includes being able to distinguish right from wrong. Therefore, after the 2007 ACOG Committee Opinion recommended not to use the LVR™ and DVL™ terms calling them deceptively and unethical, the continued use in marketing can be considered immoral [14].

Conclusion
Deceptive and unethical procedures are still being taught, marketed and practiced within the cosmetic gynecology field. New non-deceptive, science-based, cosmetic-plastic gynecologic procedures have been developed, and can be marketed ethically. Difficulties encountered in identifying the deceptive and unethical practice include the number of publications in the scientific literature. New cosmetic-plastic gynecologic procedures and new classifications not based on those of traditional gynecology have been developed and are being taught in an honest and ethical manner.

References

COSMETIC-PLASTIC GYNECOLOGY: CONTROVERSY AND PROGRESS
A. Ostrowski
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BACKGROUND: Controversies in cosmetic-plastic gynecology has been born when the deceptive and unethical surgical procedures of “Laser Vaginal Rejuvenation™”, “Designer Laser Vaginoplasty™”, “G-Spot Amplification™”, were introduced; when these slogans obtained legal trademarks; when the cosmetic-plastic field was controlled by the Laser Vaginal Rejuvenation of Loss™ by establishing the unethical and deceptive business model of practice, marketing and teaching. Recently, significant clinical and scientific progress have been made and elevated to the cosmetic-plastic field to higher level than before.

OBJECTIVES: To examine controversies in cosmetic-plastic gynecology; to evaluate the scientific and clinical progress of the cosmetic-plastic gynecologic field.

METHODS: Relevant scientific data and scientific proceedings of congresses were electronically and manually searched, selected, and analyzed.

RESULTS: The deceptive and unethical practice, marketing, and teaching of cosmetic-plastic gynecology were established. Business oriented and not medical oriented approaches were documented. The scientific progress of the cosmetic-plastic field was noticed. The evidence-based medicine level was elevated from the existing level III to the new level II-1, II-2, and II-3 in the quality ranking of the cosmetic-plastic articles. Also, a clinical progress in new cosmetic-plastic gynecologic procedures was well-documented.

CONCLUSIONS: Controversies in cosmetic-plastic gynecology was established. Significant scientific and clinical progress of the cosmetic-plastic gynecologic field was well-documented. Evidence-based medicine level III.

INTRODUCTION
The American College Obstetricians and Gynecologists (ACOG) and other authors clearly established that the Laser Vaginal Rejuvenation of Loss® violated medical code of ethics, established deceptive form of practice, teaching, and marketing. Also, created the business model which attempts to monopolies and to prevent dissemination of knowledge and prohibiting a clinical evaluation of methods being promoted by the Laser Vaginal Rejuvenation of Loss® (also known as the Laser Vaginal Rejuvenation of America®

The demands for cosmetic-plastic surgery have been growing. Especially, the public learned about cosmetic gynecology from media and the marketing literatures and this trend is impossible to stop. In order to meet the demands of the practice of cosmetic gynecology, a practitioner must find the way to deliver the services honestly and non-deceptively.

The objective of this study was to examine controversies in cosmetic-plastic gynecology; to evaluate the scientific and clinical progress of the cosmetic-plastic gynecologic field.

CONTROVERSIES IN COSMETIC-PLASTIC GYNECOLOGY
“Laser Vaginal Rejuvenation™” (LVR™), and “Designer Laser Vaginoplasty®” (DVL®)
The ACOG Committee Opinion No. 378 established that “Laser Vaginal Rejuvenation™” (LVR™), and “Designer Laser Vaginoplasty®” (DVL®) were new terms without meaningful description of the surgical techniques and was adapted from traditional gynecologic procedures. These terms originated from the Laser Vaginal Rejuvenation Institute of Los Angeles (later, renamed as the Laser Vaginal Rejuvenation Institute of America). ACOG changed LVR™ and DVL®, the original terms, to “Vaginal Rejuvenation” and “Designer Vaginoplasty.” This author assumed that these changes were made by ACOG for two reasons: 1. to avoid using terms in medicine that have been secured legally with trademarks, and 2. to provide practitioners and clinical researches with terms which can be used without fear of legal ramifications. ACOG concerns about “vaginal rejuvenation”, “designer vaginoplasty”, and “G-spot amplification” procedures could be summarized as follows: Safety and effectiveness have not been documented. Traditional gynecologic surgical techniques have been adapted and terms have changed to new nomenclatures as cosmetic procedures. Deceptive practice and marketing were identified. Unethical practice, marketing, national franchising, and controlling the dissemination of scientific knowledge were.

Today, we have definitive additional confirmations of A that “Laser Vaginal Rejuvenation™”, “Designer Laser and G-spot Amplification™” techniques are traditional procedures. The “Laser Vaginal Rejuvenation™”, “colposphereoplasty” or colpoperineoplasry procedure, “laser vaginoplasty™” procedure incorporates traditional labioplasty of the labia minora and reduction of the pubic prepuce. Why was the designer laser vaginoplasty ™ without any surgery being performed on the vagina? cannot be funded in the existing literatures. Simply, it unethical, immoral, and sociopathic behavior to continue practicing, and teaching these procedures, since the dishonesty of these procedures is discussed and many occasions. The use of “Lase Vaginal Rejuvenation” “Designer Laser Vaginoplasty™” terms as marketing to patients for treatments and physicians for participation of gynecologic workshops must stop. Also, the ACOG Opinion expressed ethical concerns about LVR™ and DVL® procedures in the context that they...
may indicate the need for surgical intervention” and the WHO’s health
definition. 1, 6
CONCLUSIONS: Controversies in cosmetic-plastic gynecology was
established. Significant scientific and clinical progress of the
cosmetic-plastic gynecologic field was well-documented.
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COSMETIC-PLASTIC GYNECOLOGY: COMPLICATIONS AND
HOW TO AVOID THEM
A. Ostrenski
Institute of Gynecology, Inc., St. Petersburg, FL, USA

BACKGROUND: Complications related to cosmetic-plastic
gynecologic procedures have never been published or presented
in any congress.

OBJECTIVES: To categorize actual cosmetic-plastic complications
and how to avoid them.

MATERIAL AND METHODS: Materials for the study were collected
from practitioners who have entertained consultations related to
cosmetic-plastic gynecology and also, from subjects who have
requested second opinions from this author. The photo-
documents have been electronically transmitted from multiple
sources. The study has been systematically arranged by the organ
which had been affected by complications: clitoral hoodoplasty
complications, labia minora labiaplasty complications, labia majora
labiaplasty complications, and vaginal rejuvenation complications.

RESULTS: Clitoral hoodoplasty complications were related to: 1.
inappropriate procedure selection such as labia minora central V-
plasty extended clitoral hoodoplasty or reductive central clitoral
hoodoplasty; 2. surgical technical incompetence or lack of experience
either related to clitoral hoodoplasty or frenuloplasty, or both.

The following complications have been recorded: transient or permanent
clitoral neuropathy, the clitoral glans surgically divided into two
separate fragments, clitoral cyst of inclusion formation, clitoral hood
phimosis, priapism, adhesions and agglutination formations. There
are then published labia minora labiaplasty techniques. Aesthetic
and/or somatic complications are high among five out of nine which
are responsible for the unacceptable high rate of complications. The
following complications have been documented: the base of the labia
minora opening, suture line separation, infections, injury of nerve
ingredients, and superficial and deep dyspareunia. Labia majora
labiaplasty complications were related to herniation of the Colles’s
fascia severe infections which resulted in significant anatomic
deformities, selecting inappropriate initial incision location, and vulvar
neuropathy. Vaginal rejuvenation complications have been identified
as reoperation, surgical closure of suture line separation, superficial
or deep dyspareunia and small intestine prolapse.

CONCLUSIONS: Severe complications related to cosmetic-plastic
gynecology can occur and have been recorded.

INTRODUCTION
In the last decade, the cosmetic-plastic gynecologic field has been in
the rise. The deceptive and unethical form of practice, teaching, and
marketing of some cosmetic-plastic gynecologic procedures has been
recognized and denounced (Laser Vaginal Rejuvenation7 and
Designer Laser Vaginoplasty8, Newer and vaginal rejuvenation9,10). New, honest and non-deceptive
procedures have been developed and published in peer review
journals or in proceedings of the congresses.7-10 Only one document
was identified in which potential complications of cosmetic
gynecology were suggested such as infection, altered sensation,
dyspareunia, adhesions and scarring.7 The objective of this study was
to identify actual cosmetic-plastic complications occurring
intraoperatively or postoperatively and how to avoid them.

MATERIALS AND METHODS
A search for the existing literature was carried out from 1900 to May
2010. Using Medical Subject Headings (MeSH), which were selected
and used in a search on ISI Web of Science (including proceedings
proceedings); 1950 PubMed; ACOG, ProQuest, OVID,
Cochrane Collection, the Lancet on Line Collection, MDConsultant, New
England Journal of Medicine, American College of Physican on
Line Resources, Highwire Journal, and Citation Index Reference, and
utilizing a manual search, indicated that cosmetic-plastic gynecologic
documented complications have never been published or presented
in any congress.

Materials for the study were collected from practitioners who have
entertained consultations with this author related to cosmetic-plastic
gynecology and also, from subjects who have requested second
opinions from this author. The photo-documents have been electronically
provided from multiple sources. The study has been systematically
arranged by the organ which had been affected by complications:
clitoral hoodoplasty complications, labia minora labiaplasty
complications, labia majora labiaplasty complications, and vaginal
rejuvenation complications.

RESULTS
Clitoral Hoodoplasty Complications
Clitoral hoodoplasty complications were related to: 1. inappropriate
procedure selection such as labia minora central v-plasty extended
clitoral hoodoplasty or reductive central clitoral hoodoplasty; 2.
surgeons’ lack of experience and/or adequate training, or
incompetency, either related to clitoral hoodoplasty or clitoral
frenuloplasty, or both. The following complications have been
recorded: transient or permanent clitoral neuropathy, the clitoral glanssurgically divided into two separate fragments, clitoral cyst of
inclusion formation, clitoral hood phimosis, priapism, adhesions and
agglutination formations.

Labia Minora Labiaplasty Complications
There have been nine published labia minora labiaplasty techniques
identified in the scientific literatures.7,10,12 Aesthetic and/or somatic
complications among five out of nine had been responsible for the
unacceptable high rate of complications (partial or straightforward
amputation labiaplasty; inferior wedge labiaplasty; myomectomy with
gluteal labiaplasty; central v-plasty labiaplasty7,10,12,13). Deficiency in surgical experience or lack of competency in cosmetic-
plastic gynecologic field was linked to several and serious surgical
complications such as: gaping at the base of the labia minora post-

A-5
opatively; suture line separation (dehiscence); infections; injury of nerve endings; and superficial and deep dyspareunia. The high rate of superficial dyspareunia had been reported particularly among these subjects with an untreated inferior wedge resection; too low a partial amputation labioplasty or straightforward amputation labioplasty.

**Labia Majora Labioplasty Complications**

Labia majora labioplasty complications were related to herniation of the Colles's fascia, severe infections which resulted in significant anatomic deformities, selection of inappropriate incision site, and vulvar neuropathy related to injury of the cutaneous nerve branches of the vulva.

**Vaginal Rejuvenation Complications**

Vaginal rejuvenation complications have been identified as reoperation, surgical closure of suture line separation, superficial or deep dyspareunia and small intestine prolapse following a laser vaginal rejuvenation procedure.

**DISCUSSION**

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion No. 378 included potential cosmetic gynecologic complications of infection, altered sensation, dyspareunia, adhesions and scarring; however, it did not provide any back-up data that such potential complications can occur. Contrary to ACOG’s Opinion, this presentation will document occurrences of real complications.

Citorral hoodoplasty executed by the of Alter’s technique should be avoided due to unaccepted aesthetic of visible scar formations and potential interference with the erectile tissue retraction. Also, citorral hoodoplasty should also be abandoned for the same reasons. Citorral frenuloplasty can cause severe potential complications of elevation of the citorral glans and retraction of the citorral prepuce over the natural length of the citorral glans (more than 7 mm). Also, inner excision of the frenulum can cause injury to the citorral root. Transient or permanent citorral neuropathy (numbness) can happen due to compression, within a very limited space, between the inner surface of the citorral prepuce and the body of the citorral glans, by large metal surgical instruments during the operation. The Ostrenzski’s hydrosedation with reverse V-plasty technique minimized, if not completely eliminated, this form of postoperative complications.

There are nine labia minora labioplasty techniques. However, only four out of nine are acceptable techniques for cosmetic gynecology.

6. There are nine labia minora labioplasty techniques. However, only four out of nine are acceptable techniques for cosmetic gynecology.

7. The remaining five techniques such as partial or straightforward amputation labioplasty, inferior wedge labioplasty, lymphectomy with 90° Z-plasty labioplasty, and central V-plasty labioplasty are not suitable for cosmetic gynecology due to either unacceptable aesthetic outcomes and/or high rate of complications. Surgical inaccuracies due to an incompetent surgeon can lead to significant intraoperative complications particularly at the base of the labia minora. This particular complication is difficult to cope with and requires significant surgical experience and skill. Too small, too tight or too shallow placement of the sutures can be responsible for wound infections, wound separations and injuries to nerve endings. Superficial dyspareunia can be associated with inferior wedge resection labioplasty, straightforward amputation labioplasty, and too low a partial amputation labioplasty.

Labia majora labioplasty can be associated with neuropathies related to injury of the cutaneous branches of the anterior ilioinguinal nerve, the iliohypogastric nerve, or the genitofemoral nerve following cosmetic-plastic surgical interventions. Herniation through the Colles’ fascia occurs when the fascia is not closed adequately. Resection of the skin with the fat tissue will flatten the labia majora appearance. Inappropriate incision site selection can cause derangement and scarring of the labia majora.

Vaginal rejuvenation surgical complications have been related to inappropriate procedure choices which did not correct the underlying causes of an acquired sensation of wide/smooth vaginal and required reoperation. Surgical closure line separation, superficial and/or deep dyspareunia, and small intestine prolapse following laser vaginal rejuvenation were also reported.

To avoid these complications adequate surgical training with a procedure, adequate instrument selection and appropriate patient selection for appropriate surgical intervention(s) may significantly reduce the rate of cosmetic-plastic complications. In order to improve surgical outcomes, surgeons must understand that there is no one-fleet all procedure and surgeons must master surgical interventions to reduce the rate of surgical complications in cosmetic-plastic gynecology.

**CONCLUSION**

Severe complications related to cosmetic-plastic gynecology can occur and have been recorded.

**REFERENCES**

1. ACOG Committee Opinion: Vaginal "Rejuvenation" and Cosmetic Vaginal Procedures. The American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 378; September 2007 (Vol.110, No. 3), Washington, DC.


**PROGRESS IN COSMETIC-PLASTIC GYNECOLOGY: NEW SURGICAL INTERVENTIONS COMBINE GYNECOLOGIC AND GENERAL COSMETIC-PLASTIC OPERATIONS AND NATURAL OR SYNTHETIC FILLERS**

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**Background**

Women around the globe demand more and more cosmetic-plastic gynecologic therapies. Initially, deceptive and unethical cosmetic-plastic gynecologic procedures of Laser Vaginal Rejuvenation®, Designer Laser Vaginoplasty®, and G-Spot Amplification® (G-Shot®) unfortunately led the cosmetic-plastic field. After recognizing the deceptive and unethical aspect of these...