LETTER TO THE EDITOR

Comment on Editorial by Dr. Pauls: Nip, tuck and rejuvenate: the latest frontier for the gynecologic surgeon

John R. Miklos · Robert D. Moore

Received: 4 September 2007 / Accepted: 24 September 2007 / Published online: 20 October 2007
© International Urogynecology Journal 2007

Dear Editor,

Bravo for Dr. Pauls’ editorial “Nip, tuck and rejuvenate: the latest frontier for the gynecologic surgeon” [1]. We applaud Dr. Pauls for writing and Dr. Karram for accepting this editorial in the International Urogynecology Journal. We must say that we agree with much of which is written. Her principles on patient autonomy and nonmalfeasance are right on target. Surgeons often blindly jump into areas of treatment of which they have little or no knowledge. They lack the experience, expertise, or knowledge to make treatment decisions, which are in the best interest of the patient. This type of ignorance combined with ego is potential for disaster for the patient. This holds especially true in the realm of vaginal surgery when we see plastic surgeons, with no experience or training in vaginal surgery, advertising for “vaginal rejuvenation or vaginal tightening” surgery. We do not and never have succumbed to the old adage “see one, do one, teach one.” Just because many surgeons have been to our operating room to watch and attempt to learn a surgical procedure, we nor does anyone else give them the authority to perform these surgeries in which they are not adequately trained. We also applaud the recent American College of Obstetricians and Gynecologists (ACOG) statement regarding these procedures [2], as if this statement helps prevent one woman from going to an inexperienced or inadequately trained surgeon for vaginal surgery and saving her from being harmed, than ACOG did its job as a professional organization.

She is also absolutely correct in stating that there is a paucity of data in the literature regarding vaginal surgery and sexual function. Shame on us as a society for this, as one of our objectives in any vaginal repair is to “maintain sexual function.” We need more data, and it is up to the innovators and early adapters and experts in the field to collect and disseminate the data, before a mass release or acceptance of a procedure. So again, Dr. Pauls and ACOG are correct: Proceed with caution until we have more data, and allow the leaders in the field to do this. However, as scientists and women’s rights lobbyists, we owe it to our patients not to ignore women who present with sexual dysfunction from anatomic changes that may have occurred to the pelvic floor and vaginal support after childbirth, as this symptom may be one of the first symptoms of more pathology to come. In and of itself, sexual dysfunction is a major quality of life issue for many women that still today we are ignoring, just as we once did in the past with urinary incontinence; that is, women were and still today are told “Just live with it, that is normal for a woman that has had children!”

Physicians, surgeons, and healthcare providers should be exceptionally cautious about accepting any new surgical procedures, whether patented method or not. Allow the innovators to invent, the early adaptors to
adapt, and then the herd can follow after they (the inventors and early adaptors) research and test the concepts and technique at hand. Only through this process can any invention, idea, or patent gain acceptance through a safe and acceptable manner. The real results of surgery are in the hands of the surgeons, for surgery is not just a technique but also an art.

References