

Aesthetic Surgery of the Female Genitalia and Why is Important to Thing About body Dysmorphic Disorder: A Review

Jana Müllerová¹, Petr Weiss²

¹1st Medical Faculty, Charles University, Prague, Czech Republic

²Institute of Sexology, Charles University, Prague, Czech Republic

Abstract: ***Background:** Aesthetic surgery of the female genitalia is growing and more and more popular. A variety of procedures are performed. Cosmetic treatment is often solution for individuals with unrecognized Body dysmorphic disorder (BDD). This relatively common psychiatric disorder occurs around the world and often does unrecognized in plastic surgery setting. **Objectives:** The present review examines actual knowledge of plastic surgery in gynaecology and BDD, what is known about actual cosmetics procedures in gynaecology and about BDD in plastic surgery setting, approach to the patients seeking plastic procedures in gynaecology and screening for BDD in a gynaecologic cosmetic surgery field. **Methods:** Data sources and searches: We carried out a systematic electronic search in Medline, Web of Science and PubMed. We used a combination of relevant keywords to construct the search strategy including cosmetic surgery in gynaecology, female genital cosmetic surgery, cosmetics gynaecological procedures, body dysmorphic disorder, screening tools for body dysmorphic disorder, diagnosing BDD. Included studies were systematic reviews or primary studies of participants requesting gynaecological cosmetic procedures; published 1990-2016; containing either information about BDD and psychological or psychosocial measures and psychological outcome. There were retrieved total of 40 papers and 20 of them published in last ten years were used for describing cosmetics procedures in gynaecology and BDD risk. Reviewers independently assessed study eligibility, extracted data, and assessed quality, undertaking narrative synthesis. **Results:** The recent researches revealed a variety of plastic procedures available to women. Researchers categorized them as those that may be performed alone or in combination and described them. However, some women seeking cosmetic procedures may have Body dysmorphic disorder (BDD). BDD is a psychiatric disorder that needs appropriate psychiatric treatment and patients with BDD need suitable therapeutic interventions like psychological counselling or special psychiatric treatment. The disorder is giving the markedly poor functioning and quality of life. It also could relate to high lifetime rates of psychiatric hospitalization, being housebound or suicide attempts. Cosmetic treatment is not solution for individuals with unrecognized BDD because after surgery patients are often dissatisfied and continue to obsess about their perceived flaws. Guidelines recommend screening patients for BDD prior to cosmetic surgery. **Conclusions:** We have seen an increase in female genital cosmetic surgery. Procedures available to women to enhance genital appearance are: labiaplasty of labia minora or majora, vaginoplasty/perineoplasty (vaginal rejuvenation), hymenoplasty, liposuction to mons pubis, G-spot augmentation and clitoral hood reduction. Some patients unfortunately may have Body dysmorphic disorder (BDD). Psychological evaluation of patients with BDD is not standard in clinical plastic surgery nowadays. BDD needs to be identified before surgery in patients who are seeking cosmetic corrections and it is necessary to identify those who may require further psychological assessment. There is a grooming consensus that BDD should be considered as a contraindication for cosmetic treatments. Clinicians should use a multidisciplinary approach in management, including cooperation among specialists in psychiatry, cosmetic surgery, family practice and other specialties.*

Keywords: Aesthetic surgery, female genital cosmetic surgery, cosmetic gynaecological procedures, body dysmorphic disorder

1. Introduction

Cosmetic enhancement is on the rise. The demand for cosmetic surgery has been growing year on year (5). Concurrently, there is increasing demand for cosmetic specialists to perform procedures to enhance physical appearance. So, in both western and eastern societies, growing numbers of people are seeing cosmetic surgery to improve especially their appearance or to retain their youthfulness (22). Cosmetic surgery of the female genitalia is also becoming increasingly popular (27,22). Female Genital Plastic Surgery, a relatively new entry in the field of Cosmetic and Plastic Surgery, has promised sexual enhancement and functional and cosmetic improvement for women. As women become more comfortable with elective procedures on other parts of their bodies to enhance function, appearance and self – confidence, it is not surprising that they may wish to alter, “rejuvenate”, or reconstruct even more intimate areas (17). Reasons for the increase in interest in the vulvovaginal aesthetic procedures such as labiaplasty, vaginoplasty/perineoplasty (vaginal

rejuvenation), hymenoplasty, liposuction to mons pubis, G-spot augmentation or clitoral hood reduction are multifactorial: media hype in medical reality television and talk shows, the anonymous accessibility of the internet to view pornography and the ubiquity of Brazilian waxing can lead to women’s concerns about their genital appearance. That is why, most of the women who seek cosmetic vaginal surgery do so for aesthetic reasons. Some, however, have discomfort wearing clothes, playing sport or during sexual intercourse. Sometimes, unequal size and appearance of genital parts can show through swimming costumes or interfere with insertion of tampons. A desire to undergo genital cosmetic surgery may also be based on the conflicting remarks women receive from their partners during sexual intercourse and health professionals during procedures such as the cervical smear test (7,46). Some women also believe that sexual satisfaction depends on the anatomical appearance of the genital organs and, hence, have low self-esteem after childbirth and with advancing age. They feel less sexually attractive after childbirth and feel that their vagina is too baggy and, therefore, seek

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surgical help (46). However, some women seeking female genital cosmetic surgery may have body dysmorphic disorder (BDD). This is characterized by a pathological preoccupation with a perceived defect that is not observable or appears slight to others but individuals concern is markedly excessive. The diagnosis of BDD often associated with a poor outcome of surgical operation. Therefore, there is a need for increased recognition, because BDD causes substantial suffering and impairment in functioning and is debilitating condition across all specialties (3).

2. Plastic Surgery and Cosmetic Procedures in Gynaecology

Cosmetic surgery is no longer exclusive to the rich and famous, movie stars and models. It has become readily accessible to the wide public. So, in recent years we have seen an increase in female genital cosmetic surgery procedures available to women(46). A variety of procedures have been proposed to improve genital appearance or performance including labiaplasty of labia minora or majora, vaginoplasty/perineoplasty (vaginal rejuvenation), hymenoplasty, liposuction to mons pubis, G-spot augmentation and clitoral hood reduction. These procedures may be performed alone or in combination as for example vaginal rejuvenation (49).

Labiaplasty – labiaplasty refers to reduction of the labia minora or majora, as well as to augmentation through injection of bulking agents or autologous fat transfer (17). The most frequently performed vaginal aesthetic procedure is surgical alteration of labia minora (24,1). Abnormal skin folds at the opening of the vagina (labia) can be distressing. If women have an uneven, asymmetrical or large labia, this can cause a lot of troubles. Many women experience discomfort, irritation or tissue rubbing during various types of activities such as sports or during sexual intercourse, so women seek labiaplasty for different reasons (4,16,17,21). Functional indications include: discomfort in clothing or during sports, dyspareunia due to invagination of the labia on penetration can be another functional reason but growing number of women seek this kind of surgery purely for aesthetic reasons (15). Labiaplasty techniques are improving all the time. Labiaplasty most commonly involves reducing the size of the labia minora, with goal of achieving minimal or no protrusion of the labia minora beyond the labia majora (48,25). Procedures to reduce the protrusion of the labia minora can be bestcategorized into edge trim techniques and wedge techniques. Each can produce cosmetically pleasing results when performed correctly. The choice of technique should be based on the anatomical variant. Reduction of labia majora – when speaking of redundant labia majora, a difference should be made between primary labia majora hypertrophy (volume excess) and secondary labia majora hypertrophy due to volume loss (skin excess). When there is a true volume excess, the enlarged labia majora can be reduced by liposuction. However, this might create sagging and skin excess. In case of skin excess due to volume loss, a reduction of the labia majora can be performed using a longitudinal wedge excision of the excess tissue with the incision along the length of the labia minora (15,26). Literature is very scarce on augmentation labiaplasty. The procedure is mostly done in the labia majora and consists of

augmentation through autologous fat injection or lipofilling. Fat can be harvested from the abdomen or the inner thigh (15,26). When performing a lipofilling of the labia majora a rather minor hypertrophy or the smaller labia can be masked. In case of a substantial labia minora hypertrophy, a reduction labiaplasty can be performed with lipofilling of the labia majora (15).

Vaginoplasty and Vaginal tightening procedure – because of childbirth and ageing many women experience vaginal relaxation due to muscle separation and loss of tone. During life, up to 76 % of women experience decreased vaginal sensation, most commonly with a feeling of a widened vagina. Vaginal laxity, as it is called, is common complaint among parous women. This can result in lessened sexual gratification for the couple. Surgery may be a good option to restore the vaginal shape and tone. Vaginoplasty is a surgical procedure that can restore the shape, size and muscle tone of vagina, resulting in improved sexual experience. This can be performed alone or in combination with other cosmetic enhancement procedures of female genital tract. Vaginal tightening surgery has been around since the mid-fifties, where gynaecologists used to tighten the entrance of a woman's vagina with an extra stitch while repairing vaginal and perineum tears or episiotomies after giving birth. The goal of these procedures is to reconstruct or to narrow the lower third of the vagina. The procedure enhances vaginal muscle tone strength and control, and decreases internal and external vaginal diameters. In vaginal tightening procedures, portions of mucosa are excised from the vaginal fornixes to surgically “tighten” the lower third of the vagina. Presently there is no standardization of this procedure: It can be an anterior colporrhaphy, a high-posterior colporrhaphy, an excision of lateral vaginal mucosa, or a combination (17,46). More recently another technique has appeared, the vaginal tightening through injection of autologous fat or bulking agents such as hyaluronic acid (6,15). Unfortunately, hyaluronic acid is never a definite solution, it resorbs over time, and multiple injections can be necessary to maintain the wanted result. With lipofilling, mention has been made of a possible effect on mucosal trophicity in postmenopausal women, but also on the risk of partial resorption and granuloma formation.

Hymenoplasty – the hymen is the mucous membrane that partially closes the entrance to the vagina, named after the god of marriage in classical Greek mythology, Hymenaios (15). The hymen can tear due to injury, tampon use or during the sexual activities or during the sport. Hymenoplasty can be done for many different reasons and in some cultures, the status has become emblematic of family honour and worth and young women sometimes go to great lengths to get their hymen repaired. Hymenoplasty can restore the tissue that covers the vaginal opening to be intact. The hymenoplasty procedure mostly consists of surgically tailoring the hymenal remnants so that they can be sutured together with absorbable interrupted sutures to narrow the vaginal orifice (15,44). The procedure can be repeated as many times as desired. Another delicate matter concerning hymenoplasty than is monetary coverage.

Clitoroplasty, Clitoral hood reduction – the clitoris is the embryonic equivalent of the male penis. A clitoris that is too

large or is given the chance to grow too long through maturity is regarded as socially or medically abnormal, making a woman too masculine, and thus (hetero)sexually strange and unattractive (15). Women request revision of their clitoral hoods usually for two reasons. Occasionally, the clitoris is “buried” under an overabundant prepuce, or “trapped” under a tight, phimosed hood, leading to little direct stimulation, regardless of manoeuvres attempted. Second, as with hypertrophied labia, many women find their generous preputial folds unsightly and source of embarrassment, although rarely do their sexual partners find this to be a problem (15,17,26,28). Clitoral hood reduction involves a size reduction of redundant or hypertrophic clitoral hood folds for cosmetic reasons or less frequently, for separation of a phimotic hood to provide more “exposure” of the clitoral glans, theoretically providing improved sensation. In this area, thus surgeons can provide clitoropexy or clitoral reduction. In clitoropexy clitorises viewed to be longer than usual and deemed to look more like a penis than a clitoris must be reduced to ensure social acceptance as a female (15,20). Clitoropexy consists of a V-to-Y plasty, moving the clitoris and its attached labia minora in an anterior and superior direction. A deep holding suture from the suspensory ligament of the clitoris to fascia or periosteum of the pubis is helpful (15,25). This should be made at the medial and the lateral side of the clitoris and never in the midline where the neurovascular pedicle is located (15,29). On the other hand, clitoral reduction differs from clitoropexy in that it reduces the length of the clitoral shaft or /and head, with preservation of sensitivity. Correction of a clitoral hypertrophy is often more a reconstructive functional procedure rather than a purely cosmetic procedure (15).

G-spot augmentation – the G-spot or Gräfenberg spot was first described in the 1950s as a highly erogenous zone inside the vagina that enlarges when directly stimulated. The erotic zone can be found on the anterior wall of the vagina along the course of the urethra, which seems to be surrounded by erectile tissue much like the corpora cavernosa of the penis. Although recently the King’s College London published an article in the Journal of Sexual Medicine involving 1800 women between 23 and 83 years old, and found no proof of the existence of the G spot (15,31). Later as a counterattack, an Italian group published an article saying that they could locate the G-spot using ultrasound scans (15,31). So, the quest for the G-spot remains: To be or not to be? G-spot amplification was first described by Matlock in 2001 (15,33). The procedure is mostly focused on a functional improvement: It is believed to enhance the sexual stimulation to the to the G-spot through increased projection of the G-spot into the vagina (3-5 mm). In a nonaugmented state, the G-spot lays beneath the surface of the vaginal wall and needs to be stimulated indirectly, when projected into the vagina the g-spot is more accessible for stimulation. The amplification is performed by collagen or by hyaluronan injections under local anaesthetic. It is an office procedure where the patient first indicates the right zone to be augmented by palpation. The effect of the current bulking agents is not permanent because of resorption, it is usually lasts for 6 to 9 months. In Matlock’s pilot study, up to 87% of women undergoing G-spot amplification surveyed anenhancedsexualarousal (15).

Treatment of the pubic region, Liposuction of the mons pubis and Pubic lifting -the mons pubis is a rounded mass of fatty tissue that is situated over the pubic bones or pubic symphysis. Latin for “pubic mound”, it is also more romantically referred to as the Mons Venus or Mons Veneris, which means “mound of Venus”. The size of the mons depends on levels of hormones and fat in the body, and thus with women, enlarges and becomes covered with pubic hair in puberty. In menopausal years, when oestrogen levels drop, the area tends to decrease in size. Having an enlarged mons pubis area causes no clear medical issues, but it is often a cause for considerable embarrassment with some women. It can affect a woman’s confidence when wearing tight clothes, swimwear, certain underwear and more so, while naked during sexual activity. Other emotional/physical symptoms include:feeling that the mons drags or rubs against clothing, increased localised sweating, self-consciousness of a bulge, an uncomfortable feeling of carrying an external weight around (in extreme cases), health and hygiene issues due to bacterial or fungal infections that lie under the folds of fat (again, in extreme cases).For women suffering these symptoms, liposuction to the mons area can produce excellent results. Diet and exercise are still the best ways to reduce excess flesh, but as mentioned, even after making the best efforts to diet and exercise, often an annoying fleshy lump remains, that seems to be determined to stay!Mons pubis liposuction is a safe, sensible, transformative procedure that can-do wonders for restoring a woman’s confidence.Liposuction is most commonly performed to decrease the size of the mons pubis. The surgeon should utilize 3-mm cannulae and proceed conservatively to avoid contour irregularities. Compared with traditional liposuction, ultrasound-assisted liposuction shrinks the skin more evenly and leaves a smoother contour (34). Pubic lifting – reduction of the mons pubis for ptosis and excess tissue in this area usually requires direct wedge excision in a transverse direction. This procedure is usually combined with or part of an abdominoplasty procedure (15,26). Abdominoplasties pull the mons pubis upward because the skin is stretched (35,36). However, the effects of abdominoplasty on the mons pubis are temporary in obese patients and those who have undergone massive weight loss because the tissues are not attached to a fixed structure. To treat the pubic region effectively, it is important to predetermine whether the excess tissue is vertical, horizontal, or both. Vertically oriented excess tissue is more common and is resected as a horizontal wedge. This lifts the pubic area, shortening the distance between the mons pubis and the umbilicus to the ideal 10 to 12 cm. When the patient also presents with horizontally oriented excess tissue, both horizontal and vertical wedges are resected to achieve a narrow and youthful appearance.³⁷ Mons pubis pexy usually is performed with abdominoplasty but may be performed alone in patients without tissue laxity. For this procedure, an ellipse-shaped resection is made above the pubic crease. The fascia of the rectus abdominis can be accessed through this incision. When the resection is complete, the pubic tissues are fixed at 2 or 3 points to the fascia of the rectus abdominis to prevent them from descending (38,39). This surgical maneuver is essential to the success of the procedure (19).

Female Genital Cosmetic Surgery and Body Dysmorphic Disorder Risk

Nowadays cosmetic procedures conducted to alter body shape and contour are a fact of life. They are opportunities for individuals to make a physical change in their appearance, correct a (sometimes self-perceived) "defect", change how they look and function, address a physical problem of discomfort, enhance their self-esteem, look better in clothes, etc. (17). The patients that are interested in genital cosmetic surgery are like any patients interested in plastic surgery. They want to improve their appearance with minimal scarring and downtime (19). Although the women seeking genital cosmetic surgery have a variety of motivations for wanting to undergo this plastic surgery, concern about their genital appearance is the most commonly reported motivation (14,48,50,51). But some women seeking genital aesthetic surgery may have Body dysmorphic disorder (BDD). This is characterised by a pathological preoccupation with perceived defect that is not observable or appears slight to others while the person's concern is markedly excessive. To fulfill the diagnostic criteria for BDD, however, the perceived defect must be either significantly distressing or cause impairment in social, occupational or other important areas of functioning (51). Body dysmorphic disorder has been reported in numerous countries and continents around the world (34,52). This is a relatively common somatoform disorder in both nonclinical and clinical settings (31,32). Epidemiologic studies have reported a point prevalence of 0,7 % to 2,4% in general population (16,35,47). These studies suggest that BDD is more common than disorders such as schizophrenia or anorexia nervosa (4,35). BDD has long history, but has been researched in a sustained and systematic way only for less than two decades. Much has been learned, including clinical features, epidemiology and treatment of this disorder. BDD is becoming better known, but despite of that fact, it remains unrecognized very often (3,36,51). Individuals suffering from BDD present frequently to dermatologists and plastic surgeons. About 9 % - 12 % of patients seen by dermatologists have BDD and about 6% - 15% of patients seeking cosmetics surgery (17,19,31,37). Body dysmorphic disorder associates with substantial impairment in psychosocial functioning and markedly poor quality of life (3,52,53). Disorder is also connected with high lifetime rates of psychiatric hospitalization (48%), being housebound (31%), and suicide attempts (22%-24%) (34,35,52). Social impairment is nearly universal. Individuals with BDD may have only few or no friends, and may avoid dating and other social interactions (34,51). In an early study, 97 % of 30 subject with BDD reported a history of avoiding usual social or occupational activities because of embarrassment over their perceived appearance defect (Philips et al.,1992). Most patients also have impaired academic, occupational, or role functioning. BDD obsessions, behaviours, or self – consciousness about being seen often diminish concentration and productivity. They not uncommonly drop out of school or stop working (34,38). Approximately 80 % of individuals with BDD report past or current suicidal ideation, and about one quarter have attempted suicide, which is often attributed to BDD symptoms and approximately one third of persons with BDD report violent behaviour that they attribute primarily to BDD symptoms (3,13,33,35,39,52). People with

BDD were for example attacking someone or damaging property (3,32). Many individuals with dysmorphic disorder also abuse alcohol or drugs. Furthermore, there are also high levels of perceived stress (34,40). Because of that all above individuals with BDD have, on average, much poorer mental health, emotional well-being, social functioning, and overall quality of life than the general population, and scores on quality of life measures are poorer than for patients with diabetes or clinical depression (3,34,40). For example, on the field of labiaplasty David Veale in his first controlled study identified ten of the 55 women seeking labiaplasty met diagnostic criteria for Body Dysmorphic Disorder (50,51). There are several reasons, why it is important to recognize BDD in cosmetics surgery settings (18). Even if the treatment outcome is for other people objectively acceptable, it appears that most BDD patients are dissatisfied and continue to obsess about their perceived flaws (8,41). So, that cosmetic procedures are rarely beneficial for these patients. Most of them who have passed through cosmetic surgery report that it was unsatisfactory and did not diminish concerns about their appearance (10,41,52). Occasionally, this results in litigation or even violence towards the treating physician (4,12,51). It is also important to remind that BDD is a treatable disorder. Serotonin-reuptake inhibitors and cognitive behaviour therapy have been shown to be effective in about two-thirds of patients with BDD (12,10,51). Thus, there are compelling reasons for plastic surgeons and psychiatrists to work together to identify patients with BDD and provide effective psychiatric treatment (50,53).

3. Recommendations

Patients that come for consultation regarding aesthetic improvement of the vaginal area usually present alone (24). They are often embarrassed and frequently do not want anyone to know they are seeking surgery of the genitals (the one exception would be a teenager accompanied by her mother). So, considering this, beware of patients that are accompanied by a significant other very involved in the surgical details and postoperative appearance of the area. Input from anyone other than the patient regarding operative goals and postoperative results should be considered a red flag, as is the case with most situations in plastic surgery. It is also very important to determine whether the patients are choosing to undergo surgery for purely aesthetic or functional reasons or eventually with the hope of enhancing sexual satisfaction because there are many psychological, hormonal, and anatomical reasons for sexual dysfunction. Patients need to be made aware that plastic surgery of this area is not intended to directly improve a person's sex life. The consent form should address the presence and orientation of scars, potential for scar sensitivity and hypertrophy, infection, hematoma, wound dehiscence, asymmetry and infection. Postoperative pain with intercourse or dyspareunia is rare with these cosmetics procedures but must be discussed as a possibility (2,24). There is the great variation in anatomy of the perineal area and the high incidence of asymmetry, so meeting the patient's aesthetic goals may be very challenging. Because of that preoperative photographs in both the standing and lithotomy positions are crucial for all cosmetic perineal procedures. That is why, patients frequently do not look at themselves carefully with a mirror in lithotomy position before the operation, as they

are primarily concerned with the standing view. However, postoperatively, they tend to scrutinize irregularities that may be native to their anatomy. Review of the preoperative photographs with such patients is instrumental in assuaging these worries (24).

While many cosmetic problems are easily treated, and have a good treatment outcome, specialists need to be alert to patients become exhausted through efforts to “improve” every detail of their looks, even slight or imaged defects (12). Most of them might be patients with body dysmorphic disorder (BDD). Individuals with this unrecognized and severe psychiatric disorder often present to cosmetics dermatologists or plastic surgeons, but they unfortunately respond poorly to cosmetic procedures (10,12). Patients with BDD often seek surgical correction of “deformities”. While BDD is a recognized psychiatric disorder that responds to appropriate psychiatric treatment, many sufferers do not seek such treatment, as they either do not see their problem in psychological terms or are too embarrassed to discuss their concerns with anybody (10,42). Cosmetic procedures are rarely beneficial for these patients. Most of them who have passed through cosmetic surgery report that it was unsatisfactory and did not diminish concerns about their appearance (10,41,53). Psychological evaluation of patients is not standard in clinical plastic surgery practice but recognition and deferral of surgery for BDD patients is advised right because findings have shown the propensity of these patients to litigate, threaten, and even harm or kill their surgeon (43). Patients with BDD need psychological counselling and referral to psychiatrists with a special interest in body image. Guidelines recommend screening patients for Body Dysmorphic Disorder prior to cosmetic surgery to identify those who may require further psychological assessment.

Proper evaluation of patients with BDD is essential for understanding the individual’s suffering and for setting a management plan. For patients with BDD is very important selection of suitable therapeutic interventions. The assessment may include taking a history, a physical and mental state examination, routine workup to rule out medical causes, and discussion of various psychological and pharmacologic options (30). Moreover, counselling should be a priority for women requesting female genital cosmetic surgery. Topics should include normal variation and physiological changes over the lifespan, as well as the possibility of unintended consequences of cosmetic surgery to the genital area. The lack of evidence regarding outcomes and the lack of data on the impact of subsequent changes during pregnancy or menopause should also be discussed and considered part of the informed consent process.

Suggestions for BDD management are as follows:

- 1) The main clinical features are appearance preoccupations and repetitive behaviours.
- 2) Possible complications may include anxiety, depression, and suicide.
- 3) BDD should be differentiated from other psychiatric disorders such as psychosis and other somatoform disorders.
- 4) Clinically significant distress and impairment in the level of social and occupational functioning may be present.

- 5) Insight is usually impaired.
- 6) Once the diagnosis of BDD is confirmed, psychoeducation should be offered to the patient regarding the disorder and its treatment options. Attempts to correct the perceived defect, medically or surgically, are not useful. It is better to use SSRIs such as fluoxetine, fluvoxamine, escitalopram, and clomipramine.
- 7) Treatment with CBT should be used if available. The choice of treatment depends on many factors, such as patient preference, motivation, and the availability of CBT. However, both CBT and pharmacotherapy may be combined for better outcome (30,31).

4. Conclusions

More and more the aesthetics of the female genitalia have become an area of concern among women in both western and eastern countries. Nowadays a variety of procedures have been proposed to improve genital appearance. Unfortunately, cosmetics treatment is often the solution for individuals with unrecognized Body dysmorphic disorder. Despite BDD’s long history, prevalence, severity and it’s better knowing this disorder remains underdiagnosed in plastic surgery setting. Given the markedly poor functioning and quality of life connected with high lifetime rates of psychiatric hospitalization, being housebound, suicide attempts, and even becoming aggressive and violent to themselves or towards their surgeon, it is important BDD is recognized and accurately diagnosed. Education and counselling should be a priority to ensure that women have reliable information about normal variations and physiological changes in the vagina and vulva over the lifespan and about possible unintended consequences of cosmetic surgery to the genital area. It is necessary for the plastic surgeon to be aware of BDD patients of that fact, they do not mostly benefit from cosmetic surgery at all. It appears they are dissatisfied and continue to obsess about their perceived flaws. Psychological evaluation of patients is not standard in clinical plastic surgery practice nowadays. But BDD needs to be identified before surgery in patient who are seeking plastic corrections and identify those who may require further psychological assessment. Only this way patients can receive the best and adequate treatment.

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