



Academic cosmetic gynaecology and energy-based therapies: ambiguities, explorations, and FDA advisories

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Reading this article [1], the passion and enthusiasm for further exploring the role of energy-based therapies in urogynaecology are palpable. New concept terminology such as “academic cosmetic gynaecology” and “pre-prolapse” are introduced and questionable terms such as “vaginal rejuvenation” and genitourinary syndrome of menopause (GSM) are discussed. However this use of undefined nomenclature is one of our concerns with this editorial.

As you know, the IUGA Terminology and Standardisation committee has a duty to introduce and to define new terminology to be used in the description of female pelvic floor dysfunction. It is the responsibility of the writer to follow this guidance when presenting articles over the use of unsupported scientific opinion and terms. For example academia and cosmetic gynaecology or rejuvenating the vagina can be misleading.

“Pre-prolapse” can blur the line of what is normal or an asymptomatic mild prolapse with no clinical impact and therefore would not require treatment or further definition. “Vaginal rejuvenation” is another casual, non-scientific, unclear term that has been used by aesthetic industries. Several calls have been made for its accepted clarification; however, this has not transpired. The label has not lost fashion and has instead become the elephant in the room and the topic of

professional meetings and conferences. Our role should be to focus on the impact of known pelvic floor disorders rather than debate still undecided treatment concepts.

The concept of GSM is a dangerous one, as women can be labelled with the syndrome with just one sign or symptom. Alone, these are not all specific to hypo-oestrogenic changes and there is a risk that other conditions are overlooked and are not appropriately treated [2]. As referred by the authors, changes associated with vulvovaginal atrophy are a consequence of declining levels of oestrogens. Therefore, it is not only intuitive, but also safe and effective to better accomplish treatment with reposition of these hormones. Studies have shown that ultralow doses of topical oestriol are safe even in women with a history of breast cancer.

It is suggested in your article that vaginal LASER can be used to treat sexual dysfunction. However sexual dysfunction is complex, encompassing any part of the sexual response cycle that should be managed with multidisciplinary care. Previous studies have demonstrated the placebo effect in the management of sexual dysfunction; this needs to be balanced with the risk of complications such as vaginal stenosis, scarring, and dyspareunia that have been recently reported.

A theoretical mechanism of action of energy-based therapies on vaginal tissues has been proposed in your article. Histological studies suggest changes do occur; however the findings are also consistent with thermal injury. There are no long-term studies demonstrating histological changes and if these represent restoration of function.

The most important message from all reviews, best practice documents, and editorials is that there is a great need for well-designed, randomised sham controlled studies exploring the histological understanding, the use of energy-based therapies in urogynaecology, and long-term consequences of therapy [3]. As recommended by several societies, LASER treatments should not be performed out of the setting of proper clinical trials, and women should be informed of its experimental character.

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In our opinion the use of energy-based vaginal therapies should for the moment be on hold in the (unregulated) private sector. We must ensure that no long-term side effects are unforeseen and that practice is carried out with integrity for both patient safety and to avoid eager and misguided use.

Compliance with ethical standards

Conflicts of interest None.

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