Editorial

# Dilators for the Vajayjay



I have long been on a campaign to use anatomically correct names for body parts. My daughter will attest that she knew about her vagina from a young age; when we were teaching her the names of other body parts, I made sure to also talk about her vagina. I can say that she was as proud of her vagina as her younger brothers were about their penises. But those of us who see young girls for gynecologic concerns may need to ask moms about the colloquial words that are used in their family to describe the female genitals. We could all compile our lists of our favorite terms that our patients have used and that make us smile.

The term vajayjay was first uttered on TV during an episode of Gray's Anatomy when the executive producer wanted to use the word vagina, but was told that there had already been too many utterances of the word that season (never mind that there was once an episode that included the word penis 17 times).[1] The term was later catapulted into fame when it was used by Oprah Winfrey. It has subsequently been enshrined in the Urban Dictionary. This and other euphemisms suggest secrets and shame, as illustrated by Eve Ensler in her widely performed series, "The Vagina Monologues". It is my contention that one of our tasks as pediatric and adolescent gynecologists is to help girls and young women to become more comfortable with their bodies, using the correct words for the correct parts. We will talk about the vagina or the vulva or the labia.

We all know that often when a mom states that her daughter's "vagina hurts", mom Is likely referring to the vulva, the labia, or the clitoris, or perhaps the perineum, or sometimes the vaginal vestibule. Many adults women also mis-use the term vagina to refer to the entire external genital area.

In this issue of the Journal of Pediatric and Adolescent Gynecology (JPAG), we feature a fabulous review of the use of vaginal dilators by Drs. Anne Marie Amies Oelschlager and Kate Debiec.[2] The authors' subtitle focuses on the key take-home points, which are that clinicians need to be able to assess readiness, and that individuals are more likely to be successful in the use of dilators when they are completely ready to do so. There may be a significant interval of time from the time that a dx of Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome or complete androgen insensitivity syndrome (CAIS) is made to when a young woman is ready to use a vaginal dilator. Other situations in which a vaginal dilator may be indicated include: post surgery for a transverse vaginal septum, cloacal anomalies, or vaginal atresia; after radiation therapy or with vaginal graft versus host disease; with inflammatory conditions such as Stevens-Johnson syndrome; or with vaginismus.

A young women with the diagnosis of MRKH must first understand the anatomy, and then should be ready and interested in using her vagina for penetrative sexual activities. Drs Oelschlager and Debiec do an excellent job of discussing how to go from that initial discussion of the vulvar anatomy, using anatomically correct terms to demonstrating the use of vaginal dilators to supporting patients during dilator therapy. The parents of the first girl in whom I made the diagnosis of MRKH were both psychologists, and they suggested that I refer to the vaginal as "closed" rather than "absent", a suggestion that I feel is an important one that has stood the test of the last 35 years of my PAG practice. The process of vaginal dilating is a journey, and as Dr. Sarah Creighton and colleagues noted in the last issue of JPAG, many young women with vaginal agenesis engage in a variety of sexual activities up to and including vaginal intercourse prior to their choosing to use dilators.[3] Thus the process of dilating should be placed in an appropriate context of young women as sexual beings who may choose to engage in a variety of sexual behaviors.

JPAG has published a number of previous studies that inform our understanding of women's experiences with vaginal agenesis and dilators, and Dr. Oelschlager and her fellow PAG clinicians who are members of the American College of Obstetricians and Gynecologist (ACOG) Committee on Adolescent Health have recently published the ACOG Committee Opinion on the diagnosis, management, and treatment of Müllerian agenesis.[4–8] There have also been previous studies reporting clinicians' experiences with supporting patients' use of vaginal dilators.[9,10] The recently published ACOG Committee Opinion on Obstructed Vaginal Anomalies addresses the use of vaginal dilators postoperatively in patients with these often complex anatomic differences.[11] One concept that typically receives scant mention, but that is noted in the review of dilator use in this issue of JPAG, is the suggestion that vibrators may be used by our patients to decrease pain and improved the experience of dilating.[2] Clinicians unfamiliar with this topic may be interested in a recently published clinical refence guide on sexual devices.[12]

There are many other articles of interest in this issue of JPAG including a discussion of vulval/vulvar pain in PAG patients,[13] a reminder of the potential for infection and risks associated with imperforate hymen with two case reports,[14,15] and a review of marijuana use in adolescent girls.[16]

Finally, for those who like podcasts to get a taste of JPAG articles, I commend to your attention the newly initiated JPAG Podcast Series, available via the NASPAG website

1083-3188/$ - see front matter © 2019 Published by Elsevier Inc. on behalf of North American Society for Pediatric and Adolescent Gynecology.
https://doi.org/10.1016/j.jpag.2019.07.002

https://www.naspag.org/news/458557/New-JPAG-Podcast.htm and through a number of podcast portals.

Happy reading, and may JPAG inform your clinical care.

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