



Labial Surgery



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Deformities of the vaginal labia and pubic area are of significant concern to patients and represent a growing area of aesthetic surgery practice. The author discusses her 17-year experience with “pubisplasty” or “labiaplasty” techniques. (*Aesthetic Surg J* 2007;27:322–328)

Over the past 17 years, I have performed “pubisplasty” or “labiaplasty” in more than 500 patients. Although most surgeries have been for the reduction of hypertrophic labia minora and, less commonly, for hypertrophic labia majora, I have also augmented deficient labia, as well as the pubic area, using autogenous fat grafting. While there has been little attention focused on aesthetic surgery of the female genitalia, even a minimal variation from what is perceived as the “norm” can cause significant emotional distress and impact on the patient’s quality of life. Here, I discuss my clinical experience with aesthetic and functional surgery for the correction of deformities of the pubic area and vaginal labia.

During the 15-year period, from 1989 to 2004, I performed 449 pubisplasty procedures in 412 women and 37 men, ranging in age from 20 to 68 years. The overall complication rate was 2.65%, which includes not only reoperation rates, but all complications in pubisplasty.¹ With regard to complications, 5 patients (1.11%) reported “no satisfaction”; 3 patients (0.66%) underwent reoperation for persistent hypertrophy; 2 patients (0.44%) were allergic to the catgut suture; and 2 patients (0.44%) had hematomas of the labia minora.

Although hypertrophy of the labia minora was by far the most common deformity treated (229 of the 449 reported cases, or 51.04%), I also treated hypoplasia or atrophy of the labia majora (31 of 449 cases, or 6.9%), hypoplasia or atrophy of the pubic area (17 of 449 cases, or 3.78%), lipodystrophy of the pubic area (12 of 449 cases, or 2.65%), and hypertrophy of the labia majora (8 of 449 cases, or 1.78). Augmentation of the labia or pubic area may often be successfully accomplished by autogenous fat grafting, using syringe transfer technique,^{2,3} but recontouring these areas also requires familiarity with other techniques using grafts and flaps.

Anatomic Considerations

It is important to note that the labia minora are naturally not perfectly symmetrical, and that one of the labia minora is normally larger than the other, perhaps playing a role in sealing the vaginal introitus and protecting against vaginitis (Figure 1).⁴ In the Joani Blank Atlas⁵ there are 32 photos of genitalia of women from different ethnicities, all having one labia minora larger than the other. I have consistently observed that same asymmetry in my patients.

It is not unusual, however, for patients to request the reduction of only the larger labia minora because they believe that the asymmetry is abnormal. Usually, the asymmetry is only a matter of degree, and in most cases the asymmetry is normal. In these patients, I explain that corrective surgery is not necessary.

Hypertrophy of Labia Minora

In 1993 Talita Franco described “Hipertrofia de Ninfas.”⁶ For consistency in description, hypertrophy of the labia minora may be classified as follows⁷:

Type I: Less than 2 cm (Figure 2)

Type II: From 2 cm to 4 cm (Figure 3)

Type III: From 4 cm to 6 cm (Figure 4)

Type IV: Greater than 6 cm (Figure 5)

Surgical Technique

I perform labia minora reduction using local anesthetic, administering lidocaine HCl 40 mL without epinephrine, and using benzodiazepine sedation. Before surgery, I administer antibiotics, usually cefazolin, and instruct patients to continue with this medication for 1 week after surgery.

I reduce the labia minora, using an S incision to avoid a linear contracture of the extremely elastic labial tissue (Figure 6).

I always keep in mind that it is important to maintain some degree of natural labial asymmetry, with one of the labia minora larger or longer than the other, to allow the vaginal introitus to seal properly. I perform wound repair with continuous absorbable sutures of 4-0 Vicryl or 4-0 Chromic Gut.

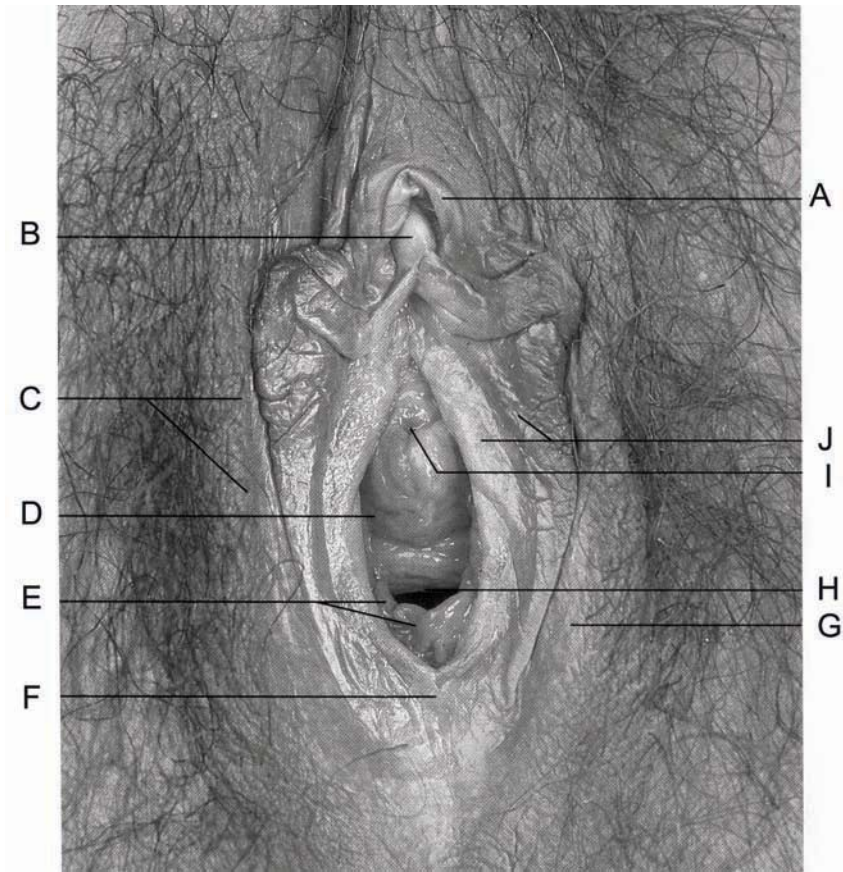


Figure 1. Female anatomy. **A,** Prepuce of clitoris. **B,** Glans of clitoris. **C,** Labia majora. **D,** Vestibule of vagina. **E,** Hymen. **F,** Posterior commissure of the labia. **G,** Labia majora. **H,** Vaginal orifice. **I,** Urethral orifice. **J,** Labia minora.

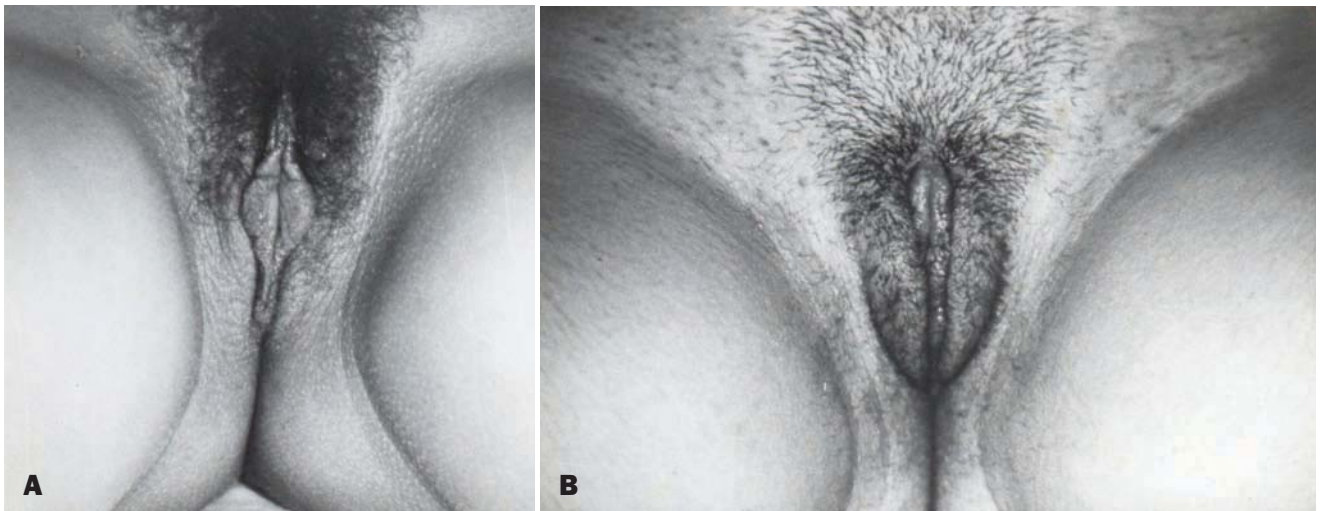


Figure 2. **A,** Preoperative view demonstrating “Type I” hypertrophy of labia minora. **B,** Postoperative view 40 days after undergoing S incision.

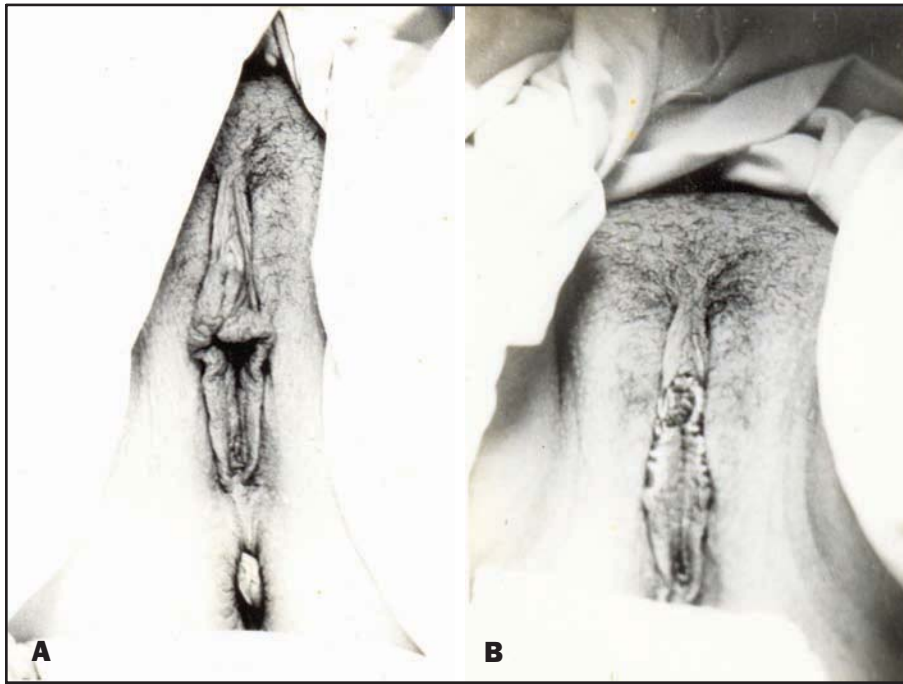


Figure 3. **A,** Preoperative view demonstrates "Type II" hypertrophy of labia minora. **B,** Postoperative view 40 days after undergoing S incision.

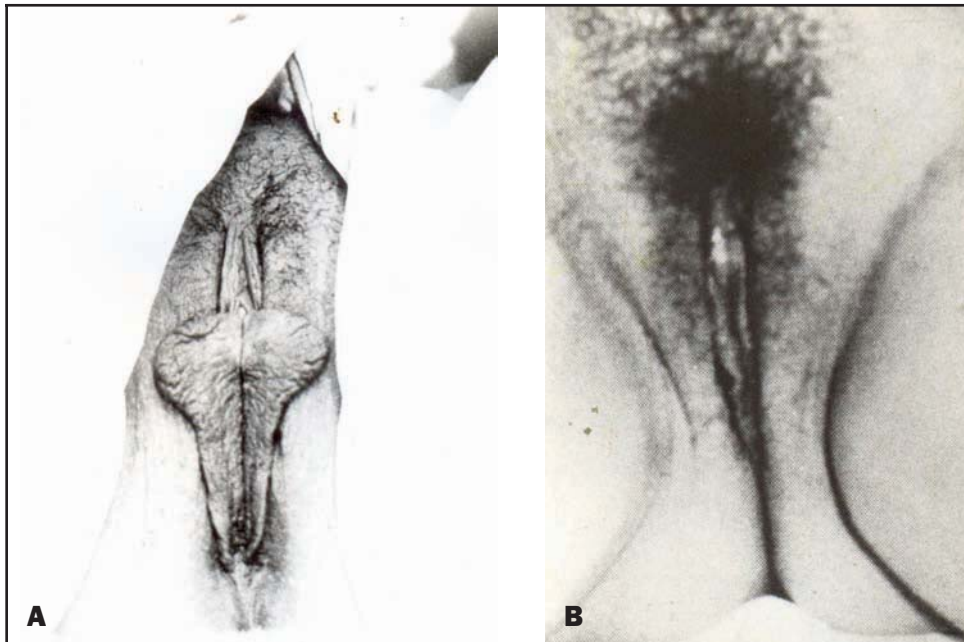


Figure 4. **A,** Preoperative view demonstrates "Type III" hypertrophy of labia minora. **B,** Postoperative view 1 year after undergoing S incision.

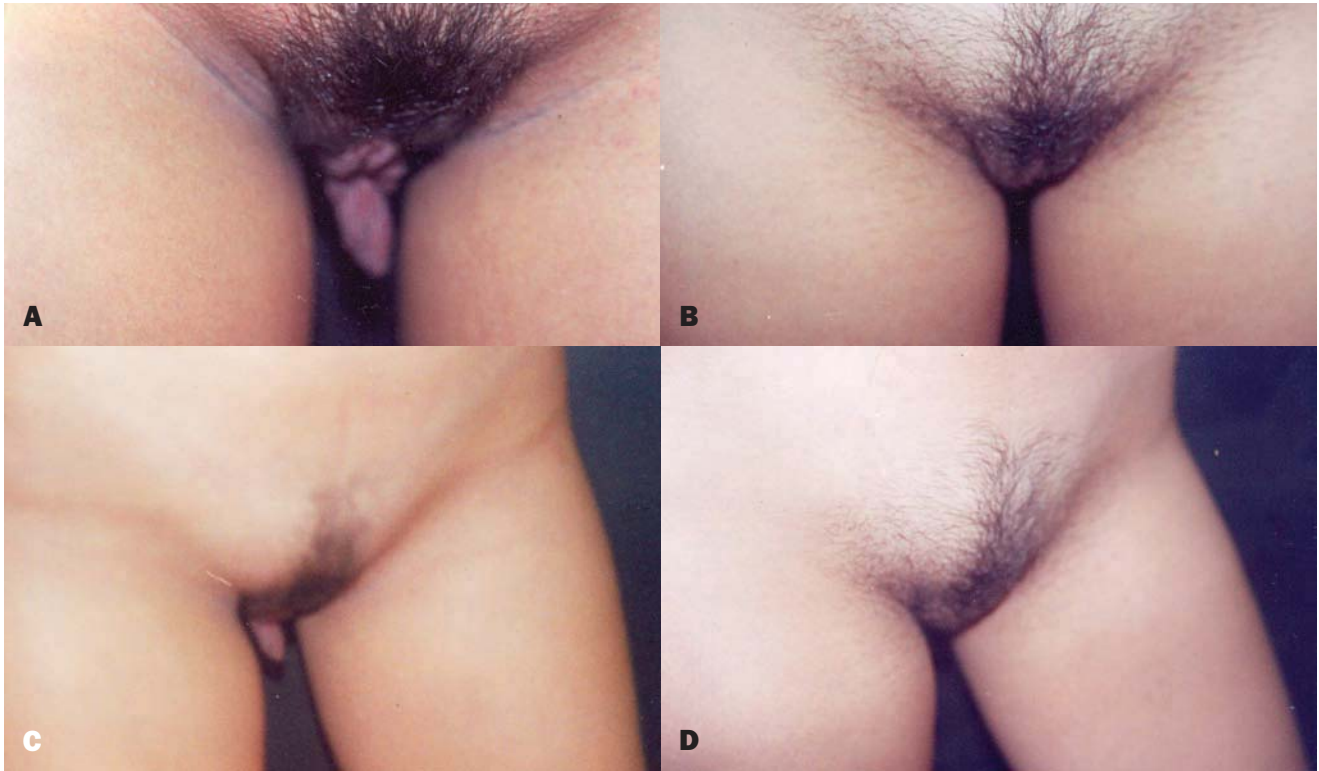


Figure 5. A, C, Preoperative views demonstrate “Type IV” hypertrophy of labia minora. B, D, Postoperative views 1 year after undergoing S incision.

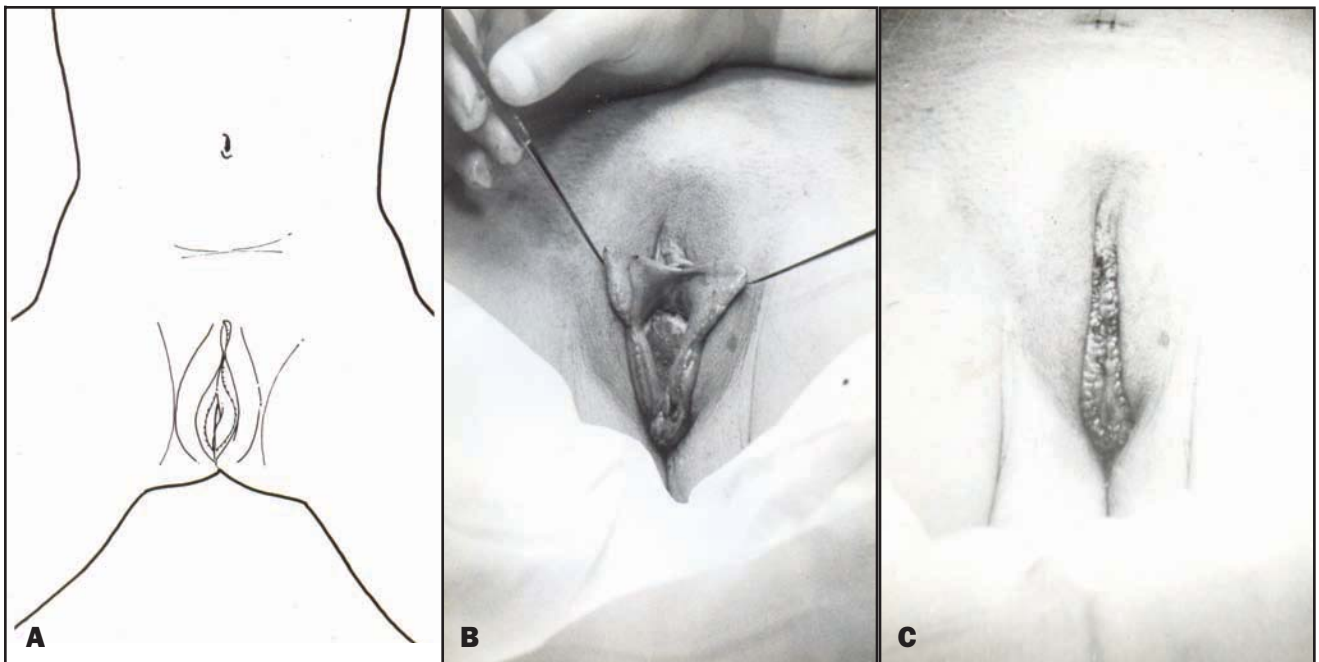


Figure 6. A, Diagrammatic representation of patient needing labial reduction. B, Intraoperative view of S incision for reduction of the labia minora. C, Immediate postoperative view.

In some cases of labia minora hypertrophy, there may be an associated hypertrophy of the clitoral prepuce or hood. If this is not corrected at the same time as the labial hypertrophy, the clitoris may take on the appearance of a micropenis. Hypertrophy of the clitoral prepuce or hood is corrected most effectively with a fusiform excision lateral to the clitoris on each side. With this surgical technique the clitoris is exposed. It needs to be maintained in the midline in the same position relative to both the labia minora and majora. If both labial and clitoral surgeries are performed at the same time, more prolonged edema, perhaps persisting up to 3 months, may be anticipated. An understanding of the anatomy of this area, as well as an appreciation of the nature and contractility of its tissues, is necessary to prevent undesirable scar positioning or contracture.

For the first 15 days after surgery, discomfort is great. I prescribe antiinflammatory drugs and instruct patients to intermittently apply ice packs to increase comfort and

minimize edema. Meticulous local wound hygiene is important to prevent infection, and I tell patients to avoid immersing themselves in a bathtub or engaging in sexual relations for the first 40 days.

It is important to never combine surgery for hypertrophy of the small labia with surgery of the perineum; intense edema will result because of the presence of many lymphatics, and the patient will be subjected to great discomfort that may persist for as long as 6 months. After combining these procedures in one patient, I will never do it again.

Hypertrophy of the Labia Majora

This problem may be addressed with 2 approaches, which may occasionally be used in combination: an S incision/excision (Figure 7) or lipoplasty by syringe. In some patients a “pubic lift” or resection of redundant pubic tissues may also be necessary (Figure 8).

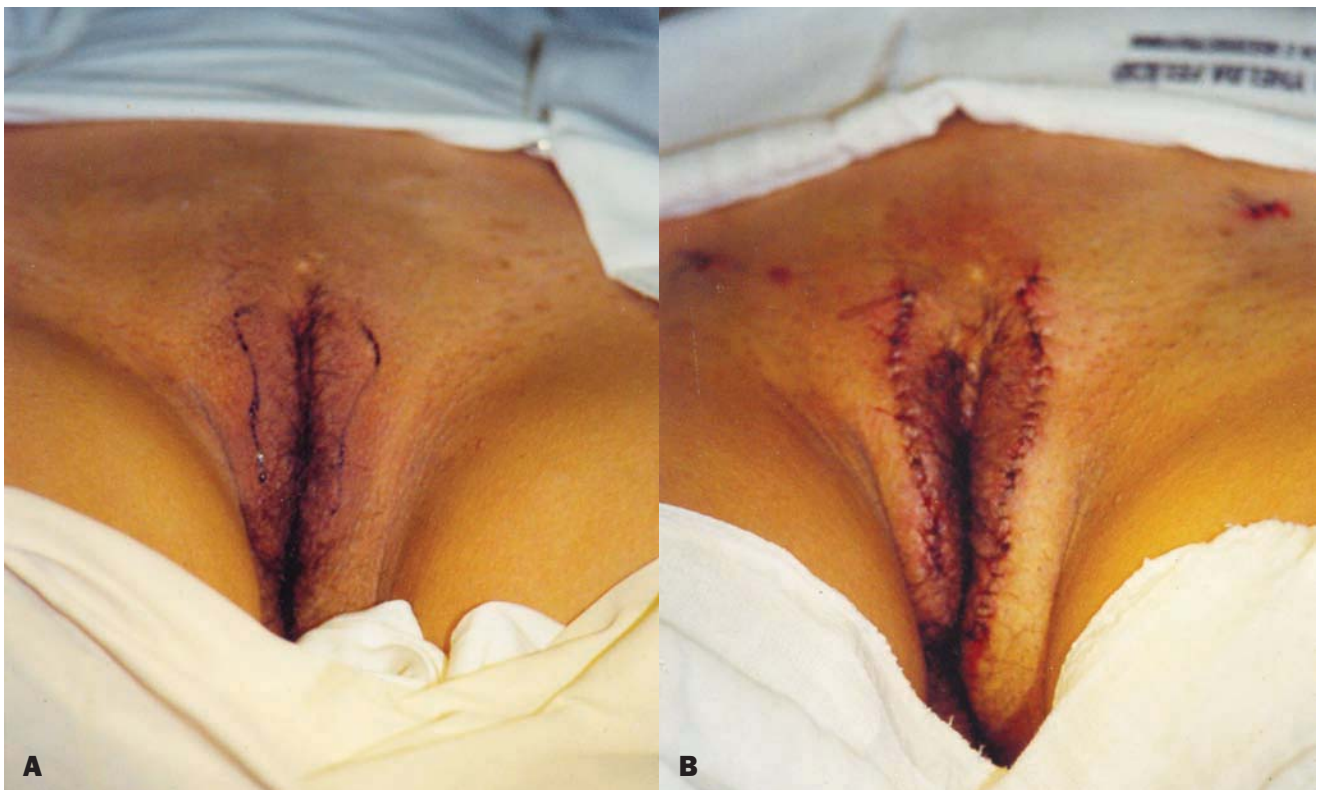


Figure 7. A, Intraoperative view of “S” incision reduction labia majora. **B,** Immediate postoperative view of completed S incision procedure.

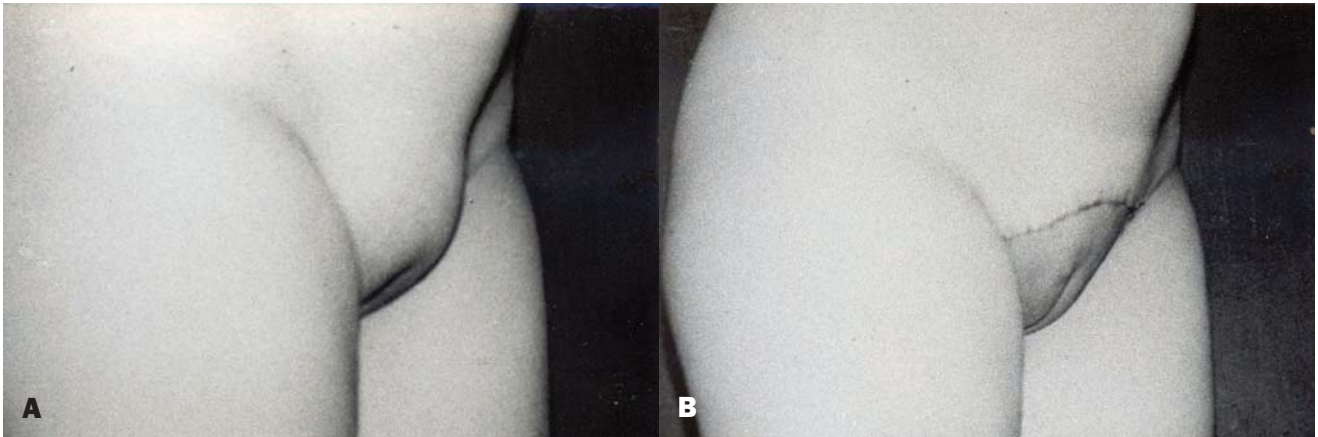


Figure 8. **A,** Preoperative view. **B,** Postoperative view after liposculpture by syringe of the pubis and labia majora and associated lifting of the pubis and labia majora.

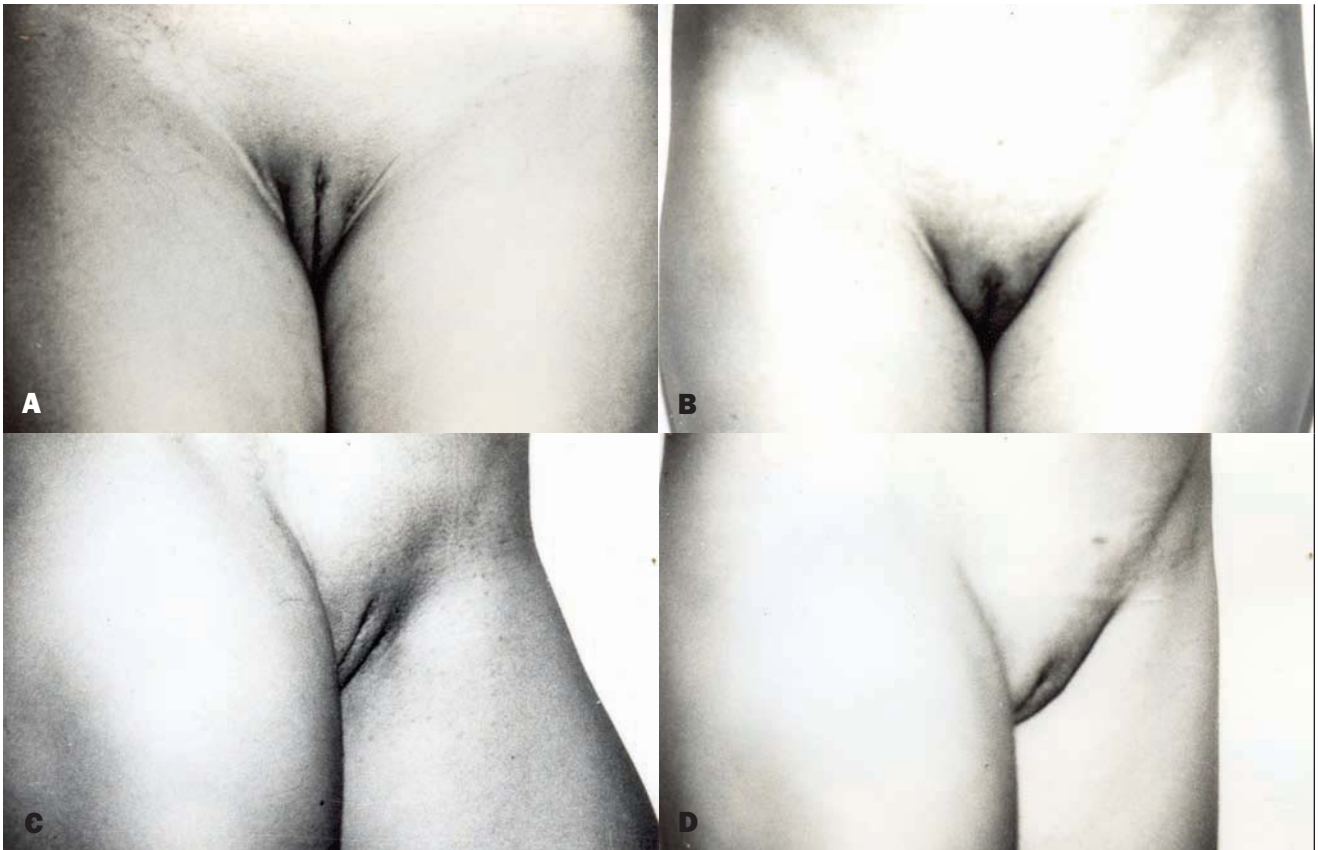


Figure 9. **A, C,** Preoperative views. **B, D,** Postoperative views after fat implantation in pubis and labia majora and correction of atrophy of the pubis and labia majora.

Atrophy or Hypoplasia of the Labia Majora and Minora

Although less commonly seen, these deformities can also be troubling. Many patients report greater comfort and sexual satisfaction with intercourse after fat graft augmentation of

these areas. The transferred fat appears to function both as a shock absorber and to tighten the vaginal space (Figure 9). The maximum amount of fat implanted is 60 mL in each labia majora and 20 mL in each labia minora. If more fat is transferred as a single procedure, it may be necessary to drain the area. Additional fat grafts may be added after 6 months.

Conclusion

In my 33 years of practicing plastic surgery and 17 years devoted to pubisplasty, I find that patients report more satisfaction from labial surgery than from any other procedure. Plastic surgeons need to recognize the importance of both pubic and vaginal labial surgery, the satisfaction it can bring to their patients, and the role it may play in their practices. ■

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