Labiaplasty unpacked

DR CHRIS LADAS discusses the motivation behind undergoing labiaplasty surgery, as well as the techniques and results thereof.

While there is a wide spectrum of normal appearance of female genitalia, there has been a move towards a closely trimmed or hairless appearance of the external genitalia in recent years. This is largely due to the internet and its access to images and content on laser hair removal and genital piercing, as well as its easy exposure to pornography.

As a result, women tend to compare themselves to these images and create an ideal appearance of themselves. If a woman feels that she does not look normal, she may shun wearing tight clothing (such as gym wear or swim wear) or going for regular gynaecological examinations, or may feel uncomfortable during sexual intimacy. Moreover, this self-consciousness often prevents them from discussing their appearance with their partners, close friends or their doctor.

Although there is no standard ideal appearance, it is preferable that the labia minora (inner lips) are symmetrical and 'tidy', the labia majora (outer lips) full without loose skin, a clitoral hood that does not project far beyond the clitoris, and a mons pubis that is full but does not show through clothing.

Labia minora surgery

Surgical alteration of the labia minora (minoraplasty) has become the most common surgical procedure of the female genitalia, and was first performed in the mid 1980s. The generally agreed-on ideal is

that the labia minora should be symmetrical, thin, light-coloured and straight. The two commonly used techniques are wedge resection (cake slice), or edge resection (up-down or linear excision). The choice depends on careful examination and the position of the most redundant labia (front, middle or back), and whether there is much pigmentary contrast between the inner and outer surface of the labia minora.

Wedge excision is usually advocated when there is a continuous pigmentary edge or when the labia is thicker. Edge excision involves excising a strip of labia minora to bring them to the level of the labia majora.

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The 'Barbie look' has become recently popular, especially in Los Angeles. This involves complete or almost complete removal of the labia minora as an edge excision to give a child-like appearance.

Labia majora surgery

With age, there is a loss in volume of the labia majora, making them appear empty or having too much skin (wrinkly). This can be corrected by fat grafting to add volume to the labia.

Sometimes, conservative skin excision can be carried out at the same time. Recent use of hyaluronic acid fillers for smaller volume deficiencies has made volume correction of the labia an easy and convenient procedure. When larger volumes are involved, fat grafting is the procedure of choice.

Meanwhile, a bulky or prominent labia majora may create an embarrassing appearance in tight clothing (camel toe). Unfortunately, media has shown some celebrities unfairly, highlighting the camel toes in young women, who have otherwise completely

normal labia. That said, some women do have large labia, which are due to prominent fat pads and may therefore require surgical excision. The excision should leave enough skin so that there is no gaping of the labia minora.

Clitoral hood reduction

The clitoris is bound by a hood of tissue that arises from each labia minora. If this is excessive and hangs, or is low hanging, it may lead to micro-penis appearance, and is usually reduced as part of a labia minoraplasty. Care is taken to preserve the sensory function of the clitoris during dissection.

Mons pubis surgery

The mons pubis should have a gentle curve and blend with the genitalia. If it is too bulky, it can be reduced by liposuction – and if it is flat, it can be plumped by fat grafting.

This procedure is often carried out in conjunction with the other procedures.

Surgery

Labiaplasty can be carried out in the surgeon's room under local anaesthetic. Approximately one hour before surgery, numbing cream is applied to the area to minimise the discomfort of the injection of local anaesthetic. In some facilities, sedation can be provided in addition to local anaesthesia.

Prior to the injection of local anaesthetic, the patient is placed in a low lithotomy position and the surgical markings are drawn. The patient checks the surgeon's markings with a hand-held mirror and agrees with the proposed excision lines.

After excision, the edges are closed with absorbable sutures and a light pad with antibiotic cream is applied to the area (which is held in place by the patient's underwear).

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Post-operative discomfort is minimal as the local anaesthetic lasts for four to six hours, while discomfort and mild pain can be managed with analgesics and rest for two to three days. At home, the area is cleaned with soap and water, with antibiotic cream being applied.

Normal activity is possible after a few days, but exercise, gym and intercourse should be avoided for four to six weeks. A2

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