A New Technique for Aesthetic Labia Minora Reduction

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A new technique has been developed to reduce the labia minora yet maintain the normal labial edge and color. Labia minora enlargement can be congenital or acquired by chronic irritation, exogenous androgenic hormones, and stretching with weights. This can cause inflammation, poor hygiene, interference with sexual intercourse, or intermittent urinary self-catheterization. Aesthetically, asymmetrical or enlarged labia minora causes self-consciousness sexually and when the subject wears tight pants. Previously labia minora reduction was performed by amputation of the protuberant segment and oversewing the edge. Now, rather than amputation, a wedge of protuberant labial tissue is excised and the labial edges are reaproximated. Four patients have undergone this aesthetic procedure with excellent results. No complications occurred. The new technique is relatively simple and can greatly enhance the patient's confidence.


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Although aesthetic surgery of the female genitalia has not been of significant interest among physicians, women have become more aware of differences in genital appearance owing to publication of nude pictures in magazines and nude presentation in movies. If the labia minora are enlarged or unequal in size, some women harbor secret feelings of being deformed or abnormal, causing embarrassment and loss of self-esteem. Labia minora protruding past the labia majora are considered aesthetically unacceptable to these women. Friedrich¹ suggested that a normal labia minora is less than 5 cm as measured horizontally from the midline when placed in lateral traction with minimal tension. However, aesthetic judgment is determined by the individual patient.

Labia minora enlargement can be congenital, as detailed by Caparo² and Radman.³ Exogenous androgenic hormones⁴ in infancy, persistent manual stretching or weight attachment of the labia as in the Hottentot tribe,² and chronic irritation can all produce enlargement.⁵ Such patients may desire labial reduction for hygienic reasons, to relieve chronic irritation, to make urinary self-catheterization easier, or to prevent interference with sexual intercourse.⁶ Women who have mild enlargement or asymmetry of the labia minora are increasingly becoming self-conscious in sexual situations or when wearing tight-fitting clothing.⁷

Previously labia minora reduction has been performed by excising the protuberant tissue and oversewing the labial edge.¹⁻⁷ This technique removes the natural contour and color of the edge of the labia minora. The normal, darkly pigmented labial border is replaced by an irregular suture line of more lightly colored inner labial tissue. Now a new technique has been developed to preserve the normal labial edge and anatomy. Without amputation, a wedge of protuberant labial tissue is excised and the labial edges are reaproximated.

Methods

The patient is examined preoperatively in the lithotomy position with her head elevated. By using a mirror to visualize her genitalia, she indicates what she considers an abnormal appearance. The proposed surgery is fully described and discussed.

With the patient in the lithotomy position, the procedure is performed under general or regional anesthesia. Because the labia minora varies among patients, the operative plan varies. Asymmetry is common. One labium may be may be more protuberant (Fig 1) or one may be thicker with two edges (Fig 2).

Care is taken to ensure that the labium is not overresected to prevent a tight introitus or pulling during sexual intercourse. When marking the area, the surgeon places several fingers inside the vagina and stretches the labia minora, thereby estimating the safe extent of resection. The anterior limit of the wedge excision should not ex-
tend to the fourchette, which must not be disturbed. Usually, the labium is diffusely enlarged from the clitoral hood to the posterior introitus. Reduction is performed by excising a V-shaped wedge centered over the most protuberant portion (see Figs 1D and 2D). The angle and extent of the wedge resection vary, depending on the anatomy. The labium minora may be protuberant throughout its extent or may not extend posteriorly, causing a protuberance in the upper portion only. In the latter circumstance the wedge is excised and the labium is advanced posteriorly along a linear incision made parallel to the posterior border of the introitus.

After marking, conservative infiltration with Xylocaine and epinephrine is done without distorting the anatomy. The smaller labium is usually corrected first, then the second side is matched as closely as possible. If the labium still remains too protuberant anteriorly and posteriorly after the initial resection, internal triangular wedges of labium can be removed, creating anterior and posterior labial flaps. The wedge is closed, maintaining the normal labial edge and appearance (see Figs 1E and 2E). The very thin subcutaneous tissue of the labium minora is reapproximated with 4-0 absorbable sutures. The external suture lines are closed with 4-0 and 5-0.
Vicryl sutures. Internal dog-ears are easily eliminated. The only suture line on the labial edge is a small transverse line where the labial edges are reapproximated. A small V-shaped closure is sometimes used to prevent notching from scar contracture. Other suture lines are concealed on the medial and lateral labium. If possible, the labia should protrude slightly past the introitus, so the labial length should be about 1 cm. This ideal size may not be possible if the labia are massively enlarged. If one labium is thicker or has a double edge, a small vertical excision can be used to help achieve symmetry (see Fig 2E).

Postoperatively some Vicryl sutures can be removed after 1 week if irritation occurs. Topical antibiotics are applied on the suture lines. No vaginal packing or urinary catheterization is needed. The patients usually heal well, with normal-appearing labia minora (see Figs 1B, C, and 2B, C).

**Patient 1**

A 24-year-old woman complained of asymmetrical enlargement of her labia minora (see Fig 1). The abnormality was noticed when she was a child, and she was teased by her older sister. She was self-conscious of this throughout her growing years, and consulted several plastic surgeons and gynecologists, who refused surgery. She now underwent wedge resection of the protuberant labia, the left larger than the right. The patient has had an uncomplicated recovery with mini-
mal postoperative discomfort and is well satisfied with the result.

Patient 2

A 24-year-old woman was concerned about the asymmetrical appearance of her labia minora (see Fig 2). Because the left side was larger and had a double labial edge anteriorly, she was inhibited sexually and felt abnormal. A wedge resection was performed through the most protuberant portion of the labium and was advanced posteriorly. The left anterior double labial edge was partially excised. The patient had an uncomplicated recovery with minimal postoperative discomfort and is pleased with the result.

Patients 3 and 4

A 26-year-old woman and a 32-year-old woman, both with aesthetic concerns about large labia minora, had likewise been refused surgery by other physicians. After surgery was performed, they experienced uneventful recoveries with good postoperative results.

Discussion

Hwang and colleagues\(^8\) describe the extensive blood supply coming from the external superficial pudendal artery and the internal pudendal artery with frequent contributions from the internal circumflex artery. In the labium majus, the external superficial pudendal artery anastomoses with the posterior labial artery, a branch of the internal pudendal artery. Multiple arterial arches in the labium minora arise from this initial arch, thereby providing the labium minora with a rich blood supply. Thus, flaps can be developed safely anteriorly and posteriorly.

Previously, correction of protuberant or asymmetrical labia minora was performed by excising the abnormal area and oversutting it. This procedure was done for aesthetic reasons or to correct enlarged labia due to chronic irritation or inflammation, exogenous hormones, or congenital abnormalities. Massively enlarged labia cause difficulty with hygiene, interfere with sexual intercourse, hamper urinary self-catheterization, and cause chronic inflammation. Moreover, the woman may be uncomfortable or embarrassed when wearing tight-fitting clothing. A mild labial deformity may induce self-consciousness with respect to the appearance of the external genitalia, and such women are frequently refused surgery by their gynecologists. Reassurance concerning normal variations of the labia may be adequate to allay some women’s insecurities, but others seek surgical correction, which improves confidence.

Conclusion

Labia minora reduction is performed easily in about 1 hour by excising wedges of protuberant tissue, and achieves excellent aesthetic results and low complication rates. Care must be taken not to excise too much labia in an anterior-posterior position to avoid tightening of the introitus. The fourchette must not be violated. A careful closure and reapproximation will result in natural-looking labia minora with no obvious surgical sequelae. Aesthetic labia minora reduction need not be withheld from women, as normal genital appearance greatly enhances self-esteem. This new procedure is an improvement over the previous technique of amputation and closure.

References