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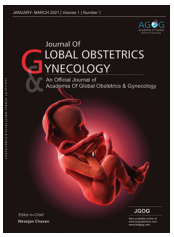
Review Article



Labiaplasty: Exploring Labiaplasty: Unspoken Problems, Treatment Strategies, and Patient Considerations

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ABSTRACT

The surgical alteration of labia majora and labia minora is known as labiaplasty. Demand of Vulvo-vaginal procedures and surgeries has increased as women are becoming more aware about their genitals due to depilation techniques. Labiaplasty is one of the most common procedures being performed by cosmetic gynecologists and plastic surgeons. The few reasons for women wanting a labiaplasty include aging, chronic irritation, excessive manipulation leading to hypertrophy, myelodysplastic disorders, and also a few might have a third labia. Many females who suffer from an enlarged labia experience low self-esteem, disparity in the size of their labia, difficulty with exercises, intercourse, chronic irritation due to chafing by clothes or walking, recurrent infections, and difficulty in wearing tight clothes. Despite the number of increased procedures being performed, there is a lack of consensus of standards of nomenclature, of care, and of outcomes. The present article discusses the unspoken problems, their effective treatment strategies, and different types of labiaplasty, pre-treatment consultation, and contraindications.

Key words: Labia majora, Labia minora, Labiaplasty

INTRODUCTION

"Female genital cosmetic surgery" is a broad term that comprises numerous procedures, including labiaplasty, clitoral hood reduction, hymenoplasty, labia majora augmentation, and vaginoplasty. Both patient interest in and performance of cosmetic genital procedures have increased during the past decade.[1]

Rising demand is also due to trends in pubic hair grooming leading to increased visibility of and greater focus on the labia, while images of female genitalia have increased in the media and on the Internet, including video or photographic pornography. The awareness regarding the availability of surgery has also contributed to the rising demand for the procedure. This cultural change is very important for the gynecologists to consider.

To achieve the best results in terms of both functionality and appearance with minimal complication rates and maximum patient approval, patients should be informed about normal disparities and the potential risks of surgery, undergo psychological evaluations (using a multidisciplinary approach), discuss realistic expectations, and customize the surgical technique. Most labiaplasties are performed on patients between the ages of 18 and 35. Nowadays, females in their mid-50 s and older are increasingly complaining of variations in their perineum in the form of enlarging labia minora and/or lax labia majora. Counseling is crucial, and women's treatment goals should be clearly understood.[2]

Before determining the necessity for any kind of surgical intervention medical, ethical, and psychosexual aspects should always be taken into consideration. Complaints of the woman can be practical, esthetic, and psychological. A few functional indications include chronic irritation, difficulties with personal sanitation, problems with intercourse, and actions such as cycling and horse riding while esthetic problems include awkwardness in wearing tights, and yoga pants or discontented with the appearance of the labia.

The American College of Obstetricians and Gynecologists reaffirmed Committee Opinion 378 from 2007 to 2019, stating that these operations are "unsustainable" since they lack proven safety and effectiveness. Committee Opinion 795 amended 378 in January 2020, using more lenient language that still maintains that vulvovaginal surgery for sexual and cosmetic purposes is not medically specified and carries a significant risk. Instead, women

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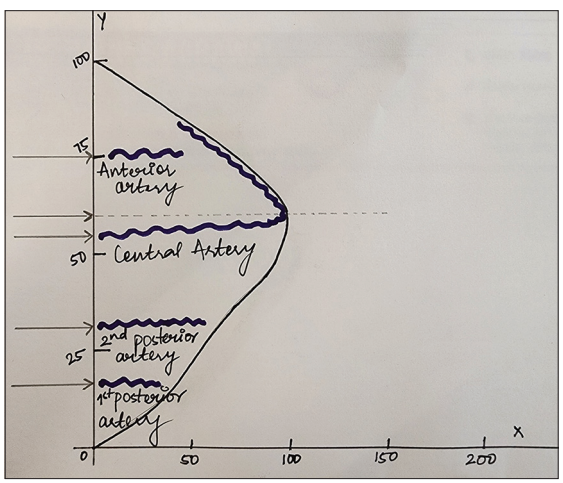
who are interested in surgery should be reassured that their anatomy is normal. Studies showing patient satisfaction with these operations "should not serve as suggestion that these procedures are clinically effective," according to the viewpoint. However, this ignores the beneficial impact on quality of life following the surgery.[1]

ANATOMY

Labia minora anatomy includes a broad range of sizes, thicknesses, and colors. Under the clitoral hood lies the glans clitoris. Starting from the glans clitoris, the frenula are skin folds that join the clitoral hood extension to form the labia minora. The external superficial pudendal artery, the internal pudendal artery, and the inner circumflex artery all contribute to the external blood flow to the female genitalia. In the labium majora, the posterior labial artery and the external superficial pudendal artery anastomose. The labia minora receives many branches from this first anastomosis.

The labia majora, which are bilateral structures of the vulva, extend from bottom of mons pubis and rectum and are composed majorly of fatty tissues. The length is 7–12 cm with an average of about 9.3 cm. The labia majora are enclosed with squamous epithelium and comprise sebaceous glands, sweat glands and hair follicles. Underneath the skin lies dense connection tissue and adipose tissue. The adipose tissue is supplied by venous plexus. Discrete variation in shape and size could be due to inherited and environmental factors.

Below the figure shows plotting of the labial arteries. On the y-axis, the appearance of the arteries found in every subject is noted. An arrow specifies the mean value of development for every artery as a distance from the posterior fourchette. The anterior artery is small, the central artery is dominant, and there are two posterior arteries.[3]



TYPES

It involves shaping the lips of vagina

1. Majoraplasty (outer lips)
2. Minoraplasty (inner lips)

If combined majoraplasty should always be done before minoraplasty.

MINORAPLASTY

The labia minora vary in thickness, protuberance, proportion, and length (7 mm–5 cm). Health care providers for women are crucial in assisting patients in comprehending their normal anatomical variety.[4-6]

Although various authors have proposed various classifications, the Banwell classification divides labia minora into three morphologies based on the distance between the vaginal introitus and the most lateral prominence of the labium minus: Type 1 denotes upper third prominence, Type 2 denotes middle third prominence, and Type 3 denotes lower third prominence [Figure 1].[7]

TECHNIQUES

There are a few techniques to reduce the labia minora.

The curvilinear technique

Correcting uneven or protuberant labia minora involves over-sewing for closure and removing or clipping the extra material with a knife, scissors, or laser.[8-10]

Advantages

- Marked redundancies
- Excessive thickness
- Lesser reoperative rates
- Light colored labial edges (when patient is willing of a potential change in the color of the visible labia minora edge).

Disadvantages

- Scalloped or irregular scar
- Prominent clitoral hood
- Asymmetry or over-resection.

The trim procedure can cause unsightly "dog ears" on the superior and inferior sides, making it difficult to maintain the proper transition between the frenulum of the clitoris, the clitoral hood, and the labium.

The wedge technique

Advantages

- Preserves the normal labial edge
- Sensations are maintained.

Disadvantages

- Higher chances of fenestration
- Higher reoperative rates
- The rare persistence of darker labial edge pigment.[11,12]

Although de-epithelialization and pedicled flap procedures, as well as other versions of the aforementioned techniques, have been outlined, they have not yielded the expected and dependable results. With a 5.0 Monocryl or Vicryl, the subcutaneous tissue of the frontal and posterior labia is re-approximated in two layers. If there are internal or external subcutaneous "dog ears," they are removed. The interrupted, horizontal mattress 5–0 Monocryl is used to re-approximate the labial edges as well as the medial and lateral ends. Running subcutaneous 5–0 Monocryl and a running subcuticular 5–0 Monocryl are used to

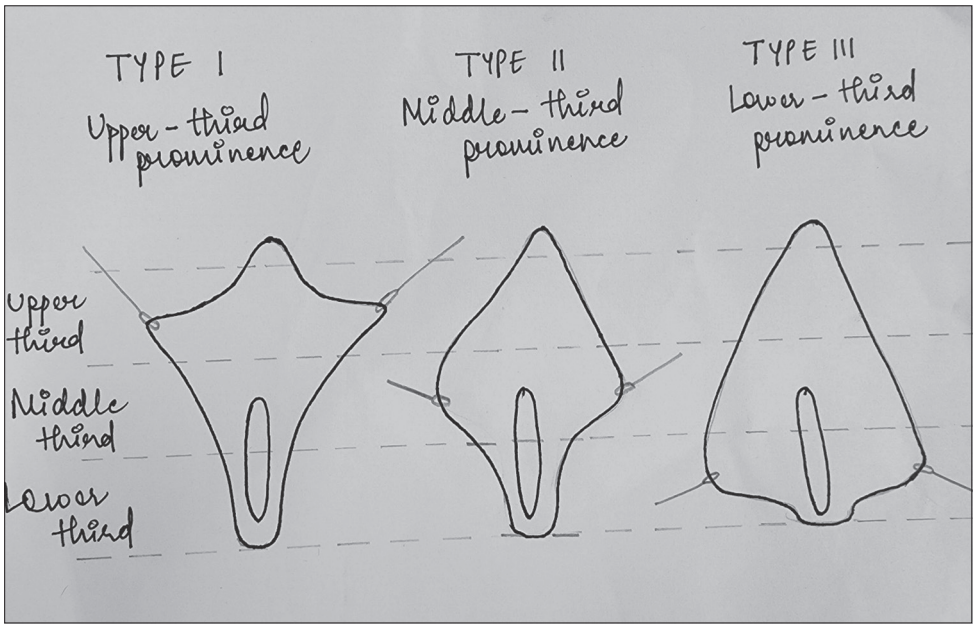


Figure 1: Banwell classification

seal the lateral clitoral hood. Only a small portion of the labia should extend past the introitus. Reduction of clitoral hoods patients may complain of a masculine, "penis-like" presence if they fail to report a significant clitoral hood at the time of a labiaplasty.

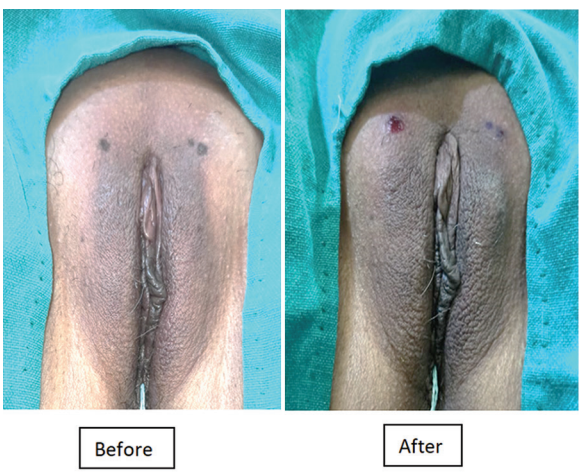
MAJORAPLASTY

Aim is to create youthful, full-appearing labia majora. Patients may present with either excessively protuberant and fatty labia majora or deflated and sagging labia majora. This also takes away the uneasiness of feeling a pinching feeling or of incapability to wear tight-fitting clothes because of the size of the labia majora.

In cases of sagging and wrinkles, the use of fillers or body fat is an alternative to surgery. Radiofrequency is fast emerging as an invaluable tool.

Fat grafting is commonest technique to volumize flat or to an atrophic labia majora. A volume of 10–25 mL injected, although injections of up to 120 mL have been reported. It is always better to undertreat than to overtreat.[8]

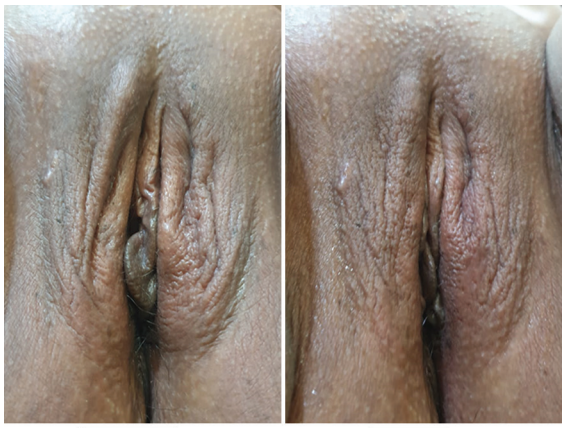
Hyaluronic acid is injected subcutaneously bilaterally and deep to the dartos fascia as a volume filler, with injected volumes ranging from 2 to 6 mL.[8]



To heat tissues to the desired temperatures of 40°C–45°C, radiofrequency is a temperature-controlled method. Over the next 3–4 months, neocollagenesis, angiogenesis, and elastogenesis are triggered by an inflammatory cascade brought on by this regulated energy delivery.[13]

POST-OPERATIVE INSTRUCTIONS

- Icing
- Painkillers
- Antibiotics
- Estrogen based creams
- No vaginal penetration for 6 weeks



- Avoidance of any pressures on the suture lines
- Abstaining from any activities that could lead to stiffness on the incisions.

  Patients must be made aware of the swelling post-operation.

COMPLICATIONS

- A slight separation of the labial edge closure
- Fenestration
- Major dehiscence is rare
- Chronic scar discomfort or interference with intercourse
- Occasionally, the labia or scars may stretch back over time.

CONCLUSION

About 90% of patients who have labiaplasty report a considerable improvement in their self-esteem, and the negative effects of labia on intimacy, twisting, physical discomfort, clothing restriction, soreness, exposure in a swimming suit, and visible outline in tight pants are significantly reduced. To achieve the best outcomes in both functionality and appearance with minimal complication rates and maximum patient satisfaction, surgeons should be trained well and should inform patients about different kinds of variations and also the potential risks of surgery, perform psychological evaluations (multidisciplinary approach), discuss realistic expectations and individualize surgery for all.

In India, the demand for labiaplasty has been rising during 2012–2015, and 95% of patients stated that they would definitely suggest the surgeon and/or procedure to a friend or coworker.[14]

CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest regarding the publication of this paper.

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