Aesthetic Surgery of the Female Genitalia

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1 Introduction

The first cosmetic vaginal surgery was reported in the literature by Hodgkinson and Hait in 1984 [1]. Recently, there has been an increased interest in cosmetic surgical procedures of the female genitalia [2–5]. The National Health Service (NHS) reported a doubling of the number of labia reductions carried out in the UK in 2004 compared to 1998 [6].

The indications for labia reduction are generally organized in the literature by three categories – women who suffer from physical or functional complaints associated with a genital abnormality, women without physical complaints but want surgical intervention for cosmetic reasons, and women who seek surgery for both functional and aesthetic reasons [7]. In the physical complaint group, several specific complaints were vulvar pain and irritation riding a bike, horseback riding, wearing tight underwear or clothes, and superficial dyspareunia. Enlarged labia can significantly impair a woman’s quality of life – causing constant irritation, difficulty maintaining hygiene, discomfort or embarrassment with clothing, and impairment or pain with exercise or sexual activity [8, 9]. Many women feel emotional embarrassment with enlarged labia. Women often compare themselves with others and protrusion of the labia minora past the labia majora is considered by many women to be unattractive [10]. Miklos et al. found that 93 % of patients sought surgery for purely personal reasons and 7 % admitted to being influenced by a male of female partner, spouse, or friend [7].

2 Embryology and Anatomy

The external female genital organs include the mons pubis, the labia majora and minora, the clitoris, and the vestibule of the vagina. The mons pubis is the fatty tissue on top of the pubic symphysis that forms a round prominence and is covered by hair. The labia majora are paired cutaneous longitudinal folds that extend from the mons pubis to the perineum. Each labium has an outer, pigmented surface and an inner smooth surface covered with sebaceous follicles. The labia minora are also paired cutaneous folds medial to the two labia majora that begin at the clitoris, extend posteriorly along the orifice of the vagina, and end at the posterior edge of the labia majora. Anteriorly, the labium minora divides into an anterior and posterior fold. The anterior fold passes anterior to the clitoris forming the clitoral hood and the posterior fold passes posterior to the clitoris forming the clitoral frenulum. The clitoris is an erectile structure situated between the two folds of the labia minora and is homologous to the penis.

3 Surgical Techniques

3.1 Labia Minora Reduction

Labia minora hypertrophy is variable but has been defined as labia with a longitudinal length longer than 4 cm [11, 12]. Ideally the labia should protrude slightly past the introitus at about 1 cm [13]. In practice, there are wide variations in female genital anatomy and what is normal should be defined by the patient (Fig. 1). Traditionally, labia minora reductions have been performed by trimming the labial edge and then oversewing the cut edge [5, 14–16]. This technique was described by Girling in Plastic and Reconstructive Surgery in 2005. The tissue that protrudes beyond the labia majora is excised and the internal and external edges of the labia are sutured [17]. Before suturing, if there is a disproportion or step-off between the clitoral hood and the newly sized labia

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