REPORT

An Unusual Staged Labial Rejuvenation

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ABSTRACT

Introduction. There have been concerns about the safety and effectiveness of publicized procedures in elective female genital rejuvenation.

Aim. To present an interesting case in which a staged approach to rejuvenation of both the Labia majora and minora was performed safely and effectively.

Methods. A patient with an unusual redundancy of both the Labia minora and majora presented interested in reduction. The procedure was performed in two parts.

Results. Despite her complication following the first stage, 6 weeks after her second stage, the patient is satisfied.

Conclusions. Cosmetic reduction of the Labia minora is well tolerated and can offer pleasing results with little morbidity. Surgery of the Labia majora may be more commonly complicated by bleeding. **Di Saia JP. An unusual staged labial rejuvenation. J Sex Med 2008;5:1263–1267.**

Key Words. Reduction Labiaplasty; Female Genital Surgery; Reduction Labia Minora; Cosmetic Genital Surgery

Introduction

Recently there has been increased interest in surgical procedures of the female genitalia and the manner in which they have been presented to the public [1,2]. Concerns about the claims made in the marketplace and the relative lack of published data documenting safety and efficacy have been raised. It is true that there are few if any standards in nonmedically indicated surgery of this area. Published data involve a myriad of techniques predominantly presenting low patient numbers that lack statistical significance.

Women present themselves with increasing frequency interested in the modification of their genitalia. The most commonly cited reasons involve aesthetics, discomfort in tight clothing, and sexual embarrassment. An important question is what can be honestly and safely offered to these women.

The Case

The patient is a 42-year-old woman who presented displeased with the appearance of her genitalia. She was more concerned with the Labia majora, although she also complained that her Labia minora were also much larger than normal and "unattractive." Their size impeded her choice of undergarments and contributed to a feeling of embarrassment with any clothing that may indicate their size. The patient reported that no sexual partner had ever commented upon these issues. Her reasons for seeking evaluation were internal.

On examination, she had laxity along her superficial Labia majora atypical for her age. Her Labia minora were enlarged and asymmetrical. After fine-tuning her desires, a plan was devised involving a two-stage reduction of her external genitalia. First, her Labia majora were reduced, which was complicated by a post-operative hematoma requiring evacuation. She had some hypersensitivity with the improved exposure of her genitalia, but this was resolved over 4–6 weeks. Four months later, pleased with the outcome from this stage, she underwent reduction of her Labia minora. Six weeks later, she is pleased with the outcome (Figures 1–3).

It should be noted that the plan for surgery was presented to the patient as a cosmetic reduction or

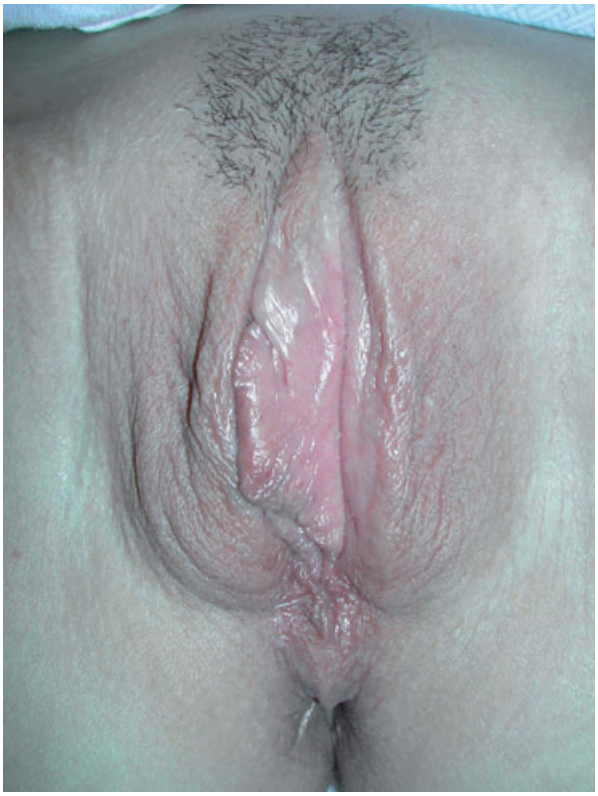

Figure 1 The patient's pudenda prior to the first stage of the surgery.

rejuvenation. No promises of improved sexual gratification or enhanced sexual function were made.

Discussion

Reasonable questions in aesthetic genital surgery are what structures may be involved and under what circumstances should it proceed. Looking at the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion #378, procedures for labial asymmetry/hypertrophy were considered among the medically indicated [1]. Procedures placed under suspicion by the article specifically included "vaginal rejuvenation, designer vaginoplasty, revirgination, [and] G-spot amplification." The focus of the piece was upon the danger of the unproven and dubious expectations of sexual gratification.

There is a conceptual divide within female genital surgery in the mechanics of evaluation between traditional clinical medicine and cosmetic surgery. Perhaps it is this conceptual divide that makes the area so polarizing in the minds of many clinicians. Patients presenting for the most common procedure in this area, Labia minora reduction, tend to present for predominantly cosmetic reasons. The most common of these reasons is displeasure with the configuration of the Labia minora. Patients evaluate their results based also upon the same aesthetic concerns. The variability in individual patient considerations of beauty may be extreme. The desire within the academic community to construct a firm practice paradigm for surgery in this area may be difficult if not impossible to construct because of this variability. With this in mind, it seems reasonable to focus upon a few key points to make this surgery safe as well as gratifying for the patient.

Reductions of the labia minora have been characterized in the literature for years albeit utilizing a plethora of techniques [3–9]. The trouble in assessing morbidity and efficacy is partially this divergence. This patient population, like other cosmetic surgery patient populations, tends to limit long-term follow-up. Frequently at the point at which patients find themselves able to resume sexual function, they tend to discontinue themselves from follow-up. This limits the extent to which the outcomes can be monitored.

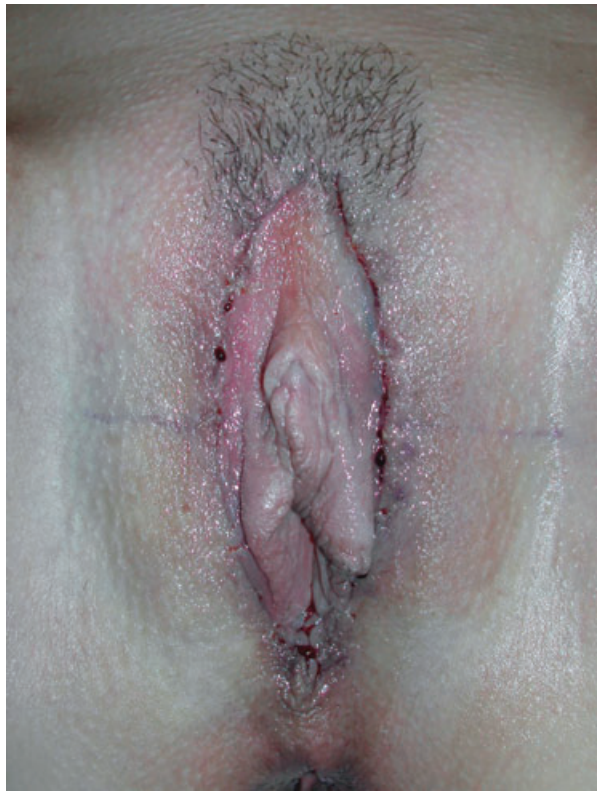

Figure 2 Immediately after stage I.

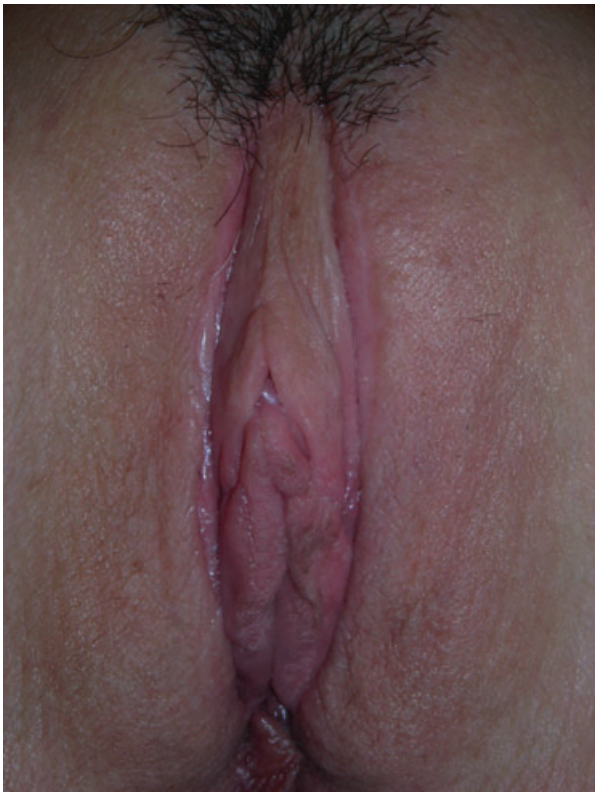

Figure 3 Six weeks following stage II of the surgery.

Cosmetic issues aside, Labia minora reduction patients frequently complain of difficulty or pain with intercourse and discomfort in clothing [3,7]. Physical criteria for reduction were formulated by Rouzier et al., namely that the maximal distance between the base and the edge of the Labia minora was >4 cm. They reasoned that this requirement would assure that reduction would alleviate physical discomfort at this size or greater. It is of course relevant to note that the operations studied appear to have occurred within the public health system in France. These were not aesthetic cases. In this study, patients without the predetermined amount of hypertrophy were actually counseled against surgery.

Among the concerns elucidated by the ACOG Committee Opinion #378 of surgery in these patients were those of potentially altered sensation, dyspareunia, adhesions, and scarring. Rouzier et al. reported a rate of post-operative wound dehiscence of 7% utilizing their technique of Labia minora reduction [3]. Dyspareunia was frequently present post-operatively, but had resolved in less than 1 month in all but 3 of 163 patients. Patient satisfaction was reported at 96%. Although another such large series is not available for review, other authors report similarly high patient satisfaction rates [7,8]. Significant adhesions, scarring, prolonged dypareunia or sensory losses have not been described in any of the studies reviewed in the production of this report.

The case presented in this report is unusual in that it involved both the Labia minora and the Labia majora. This is the first case for which the author performed a staged procedure. The bleeding complication seen after stage I did not result in delayed wound healing or distortion. This may be because the scope of the procedure had been deliberately limited by the chosen staging. If an additional suture line medial to the hematoma had been present (as it may have been for concomitant Labia minora reduction), it is reasonable to postulate that breakdown may have occurred along with distortion as healing ensued. There is a relative lack of data in the literature concerning aesthetic surgery of the Labia majora or internal "sexual gratification" procedures.

In aesthetic surgery, it is frequently difficult to devise more than the most basic guidelines as the bottom line is beauty, which is by definition subjective. The limited data from the literature seem to support surgery upon the Labia minora more than other structures. Surgery of the pudenda is probably safer than surgery of more internal structures such as the vagina. Aesthetic surgery is predominantly visual, so it would seem to be practically limited to the external genitalia anyway.

It is the author's opinion that surgery in this region should be presented in physical terms starting at consultation. Trying to promise improved sexual gratification and the like seems a pathway to patient dissatisfaction. The data from the literature seem to indicate that at least for reductions in Labia minora, patient satisfaction is high and complications are limited. Being generous with time in consultation with prospective Labia reduction patients has been worthwhile. Patients looking for promises of intangible benefits are probably best denied surgery. Review of pre-operative and post-operative images with patients in follow-up reinforces the physical changes achieved. These key points have been effective in providing high patient satisfaction rates in the author's practice.

The patient presented here emerged from her experience pleased with the improved "normalcy" of her appearance. She reports no loss of sensation and normal, if not improved, sexual function because her self-consciousness about the issue has resolved.

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Statement of Authorship

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Category 2

(a) Drafting the Article
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(b) Revising It for Intellectual Content
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Category 3

(a) Final Approval of the Completed Article
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Commentary on Di Saia JP. An Unusual Staged Labial Rejuvenation

This case brings up the interesting question of whether some women, in partnership with their surgeon, are continuing to strive for what Pygmalion, a sculptor and a prince of Cyprus, pursued according to the Greek myth entitled Pygmalion and Galeta. As the story notes, Pygmalion longed for the ideal woman, and the only way that he could fulfill his dream was to carve this woman from an ivory stone. Unfortunately, ancient humans and modern ones alike offer no clear and objective description of what "ideal" is, be it the entire body or specific body parts such as the labia minora. Therefore, although I strongly believe that women and men should have the right to alter their anatomy in safe and non-debilitating manners, as this woman did in the current case study, I also believe that this type of surgery should be referred to as cosmetic surgery and not cosmetic rejuvenation or cosmetic reduction. There is a wide range of variation in women's labia minora and there are no data that one size or shape is more normal or preferable to others. The decision to perform cosmetic surgery on any body part should be labeled to reflect exactly what it is—cosmetic surgery.

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As women become more comfortable with the idea of elective surgery on their faces, breasts, skin, etc. designed to enhance their appearance and self-confidence, it is not surprising that they may wish to alter, change, "rejuvenate" or reconstruct more intimate areas of their bodies.

Keeping pace with these needs and in the absence of official training programs, sanctions, and nomenclature, it is unsurprising that we are witnessing a proliferation of physicians, programs, and procedures touting, often without proof of validity, successes with both improved appearance and sexual functioning. In the absence of legitimacy in training, oversight, and a commonly accepted nomenclature, terms such as "Revirgination," "Designer Laser Vaginoplasty," and "Vaginal Rejuvenation," for example, thrive and multiply and may soon (if not already) become part of the vernacular.

My experience as a gynecologist and Vulvovaginal Aesthetic (VVA) surgeon is similar to that of Dr. Di Saia in this case report. Women tend to present to their plastic or gynecologic surgeon for VVA surgery for one of several reasons:

1. Younger women in their teens or 20s who, because of perceived hypertrophied appearance of their labia or because of a significant size discrepancy, find themselves self-conscious and sexually inhibited, with resultant diminished self-esteem.
2. Women of any age who experience discomfort with sports activities (e.g., cycling) or vaginal entrapment with coitus because of excessive labial size. Also included in this group are women who have diffculty wearing thongs, bikini underwear, swimsuits, for example, secondary to discomfort, self-consciousness, and actual prolapse of their enlarged labia.
3. Parous women at midlife who, secondary to age and childbearing and/or obstetrical injury, notice genital changes affecting self-perceptions of "beauty" and/or "gripability" and pleasurable coital sensation. These include hypertrophy and laxity of the labia minora and/or labia majora; laxity of the introitus, frequently with redundancy, posterior compartment defects, and exophy of vaginal mucosa; and laxity with resultant diminution of upper vaginal coital sensation secondary to "ballooning" of the vaginal fornices. The latter lead to diminished coital "gripability" coupled with the inability to perform Kegel's exercises secondary to wide separation of the levator muscles.

ACOG Committee members, as evident in their Committee Report # 378, take issue with what they see as unsubstantiated claims inherent in the promises of enhanced sexual gratification with procedures such as "Vaginal Rejuvenation," "Designer Laser Vaginoplasty" or "G-Spot Amplification" in the absence of adequately powered outcome data.

An acute need exists to develop a reasonable nomenclature to replace these proprietary terms before they become entrenched in the rubric of medical and lay terminology. It is also time for those of us who perform VVA procedures to come forth with evidence-based outcome statistics.

Proposed VVA Surgical Nomenclature:

I. VVA surgery of the Labia
   1. Reduction Labiaplasty—Minora
   2. Reduction Labiaplasty—Majora
   3. Reconstruction Labiaplasty—Minora (reconstruction secondary to old obstetrical or other injury)

II. VVA surgery of the introitus, vestibule, and perineum
   1. Perineoplasty (with or without reconstruction of the perineal body and reapproximation of levator muscles, with or without posterior compartment repair)
   2. Hymenoplasty (reconstruction of the hymenal ring)

III. VVA surgery of the vagina
   1. Anterior Compartment Repair (reduction of prolapsed anterior vaginal wall)
   2. Posterior Compartment Repair (reduction of prolapsed posterior vaginal wall)
   3. Vaginoplasty (reduction of size of the upper vagina/vaginal fornices, regardless of cutting tool—scalpel, laser, electrosurgery—utilized)

IV. Procedures involving injection of bulking agents into the vagina
   1. G-spot Augmentation

Establishing a descriptive, officially recognized, standardized nomenclature will suppress the validity of marketing terms that, in some eyes, discredit the legitimacy of patient requests for reasonable cosmetic enhancement procedures.

Dr. Di Saia, in a simple case report, has brought forth several important issues. Among them is the need for legitimate outcome data. It is hoped that this will soon be forthcoming from VVA surgeons.

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Author Response

To an extent, I am in agreement with the ACOG Committee Report # 378 in that I believe much of the "internal surgery" in this area may be unproven territory relative to risk and benefit. In that light, I have deliberately kept my discussion to external structures with which I have seen relatively predictable and benign outcomes in the right hands. Developing standard anatomical nomenclature does not validate surgery in the region. I believe good studies documenting outcomes (albeit hard to produce) should precede this nomenclature. Standardizing the terms may remove the proprietary aspect, but proven results are probably the best tool for dispelling the concerns of the academic community.