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# Understanding the growing popularity of labiaplasty surgery

*By Dr Skoll*

Statistics on labiaplasty have been collected since 2015 by the American Society of Plastic Surgeons (ASPS). The 2016 ASPS statistics report showed that labiaplasty is more popular than ever, with over 12,000 procedures performed by ASPS members last year (a 39% increase).

**What is a labiaplasty?**

Labiaplasty is a plastic surgery procedure sought for cosmetic and/or functional reasons. Although there is a wide normal variation in size and shape of the inner labia, some women find it cosmetically unacceptable if the labia minora protrude past the labia majora. Enlarged or protruding labia minora can occasionally be an embarrassing problem, particularly in sexual situations, when wearing tight clothing or swimwear. Patients may also seek help for hygiene reasons. I usually re-assure patients that their labia are quite normal, and that much like noses, they come in an infinite number of size and shape variations, all of which are considered normal. It is therefore a choice, as in the case of a larger nose, to change one form of normal for another, rather than changing the abnormal to normal.

Technically, a labiaplasty reduces excess labia minora tissue and refashions it such that it is less protuberant. There are two main ways to achieve this surgically – one is using an "edge trim" technique and the other involves the resection of a roughly triangular wedge of labial tissue. Both techniques, and the plethora of variations there-of, have their proponents, and my favoured approach is based on the wedge resection procedure first published by Dr Gary Alter and subsequently modified by a group in Brazil. The operative principles remain the same, but the procedure is tailored to the specific anatomy and desires of the patient, while maintaining the normal anatomic relationships and appearance.

**The procedure:**

I usually do the procedure under local anaesthetic with light, oral sedation. It is generally very well tolerated, and the discomfort only minimal.

The patient is placed in the lithotomy position and a surgical marking pen is used to plan the extent and placement of the incisions taking care not to distort the normal anatomy. Once the markings have been checked, local anaesthetic is injected (using "normal" dental cartridges containing lidocaine and epinephrine) in to the labium to numb it completely, minimise bleeding, and distend the usually floppy tissue (tumescence) making it easier to accurately resect the tissue. In general, more mucosa than core tissue is removed and more so laterally (from the outside of the inner labia) than from the inside. Once careful haemostasis (stopping of any bleeding) is achieved using a Colorado tip cautery device, the core tissues are approximated using slow absorbing interrupted sutures, followed by accurate approximation of the mucosal edges using 4/5 x loupe magnification and faster absorbing suture material. The resultant scar is placed low down on the labia with a very short oblique scar traversing the labial edge, and then running within the groove between minor and major labia to the level of the clitoral hood laterally. All the stitches dissolve, and aside from some