Abstract

Objective. To evaluate what the appropriate indications are for vulvovaginal (V V) plastic surgeries in our environment.

Materials and Methods. This is a retrospective study of 73 consecutive patients who were seen on consultation at the gynecologic aesthetic unit between January 2008 and January 2009 asking for a V V aesthetic surgery.

All patients completed the Female Sexual Function Index questionnaire and received information on sexuality.

Results. Of the 73 patients seen on consultation, 32 (43.8%) underwent surgery, and the main reason for this was reduction labioplasty in 19 patients, widening vaginoplasty in 6, reduction vaginoplasty in 1, and resection of asymmetries in 6 patients. None of the patients seen on consultation for vulvar bleaching, G-spot amplification, or augmentation labioplasty underwent surgery. Postoperative complications included wound dehiscence in 3 patients (9.3%) and a vulvar hematoma in 1 patient (3.1%). Postoperative sexual satisfaction was optimal for 30 patients; only 2 complained of dyspareunia.

Conclusions. Most patients seen on consultation for VV plastic surgery had no need for it and only received information regarding female anatomy and sexuality. Reduction labioplasty owing to hypertrophy of the labia minora represented the most frequent reason for consultation and surgery. Indications for VV plastic surgeries should be based not only on surgical results but also on the reported satisfaction achieved by those patients who did not undergo surgery and only received appropriate information during consultation.

Key Words: aesthetic gynecology, labioplasty, vaginoplasty, labia minora, G-spot amplification

There is an increasing demand for vulvovaginal (VV) aesthetic surgeries because their aim is not only to improve the appearance of the genitalia but also to allow the patient to attain greater sexual gratification. However, there is no scientific evidence relating these surgeries to sexual pleasure enhancement [1, 7].

There are no scientific parameters that indicate that a vulva is aesthetic or not. There are many normal variants on the anatomic morphology of the inferior genitalia. Many women feel they are abnormal because their labia minora overpass the labia major or because their vulva is hyperpigmented or because the introitus is enlarged [2]. Who can answer when a vulva is “beautiful” or not? Are there parameters for these? Which are the valid medical indications for these surgeries, if there is any?

Many of these surgeries are associated with marketing or with exaggerated expectations that sexual disorders can be surgically resolved rather than with a real medical indication.

One of the more demanding surgeries is the labioplasty of labia minora [2]. Some authors define hypertrophy when the labia minora is 3 to 4 cm greater than the labia majora, measured horizontally from the midline when placed in lateral traction with minimal tension [3]. This situation may be associated with discomfort in exercising and local irritation, and this may cause a psychological effect during intercourse [2–6, 8]. Therefore, these factors should be carefully assessed before indicating a surgery.
We review the cases of the consultant patients to the gynecologic aesthetic unit to try to clarify what the indications are for these surgeries and review the ethical parameters for this practice.

The aim of this study was to evaluate what the appropriate indications are for VV plastic surgeries in our environment and to share the experience in a specialized VV aesthetic surgery unit (VVASU) functioning within the general Department of Gynecology (institutional review board approval).

**MATERIALS AND METHODS**

We reviewed the records of 73 patients who consulted at the VVASU at the Italian Hospital of Buenos Aires from January of 2008 to January of 2009, requiring an aesthetic surgery either for improving the appearance of their genitalia or in relation to functional problems.

The VVASU was created based on the increasing demand for VV aesthetic surgeries. The creation of this section required approval by the following committees within the hospital:

- Obstetrics Service Commission,
- Scientific Committee,
- Ethics Committee, and
- Committee for the Evaluation of Informed Consents.

Once the necessary steps were taken and the VVASU was approved by the hospital, work started in the month of January 2008.

All the patients who consulted the VVASU in relation to these surgeries received sexual counseling from the VVASU’s specialists. Taking this into consideration, the appointments were scheduled to last 1 hour to have enough time to provide the patient with all necessary information relevant to her consultation. In most cases, the specialists explained to the patients that their situations could be considered to fall within “normal” parameters and, thus, did not indicate surgical corrections.

To evaluate the patients, the specialists used the Female Sexual Function Index (FSFI), translated to Spanish, together with a specific questionnaire created by the surgeons. The patients answered the 2 questionnaires before and 2 months after the procedure.

In cases where surgery was indicated, and before it, VVASU’s specialists provided the patients with technical explanations of the procedure, and all patients signed an informed consent form in which they were informed of the possibility of dyspareunia and alteration of sensitivity in the affected area as possible adverse effects of the surgery. The protocol determined that patients younger than 21 years needed written consent from their parents to undergo treatment.

If a particular case permitted it, patients were explained alternatives for anesthesia in detail and were allowed to choose the type of anesthesia, either general or local. Furthermore, all patients were asked for a basic laboratory review of hemogram and coagulogram (in the case of local anesthesia) and a preoperative full laboratory (in the case of general anesthesia).

Local anesthesia was conducted with xylocaine 2% with 1:200,000 epinephrine. Separate stitches were made with absorbable polyglycolic acid 4-0 or polydioxane 4-0.

For labioplasty surgery of labia minora, 2 surgical techniques were applied: (1) amputation of lips and (2) lower-wedge resection and superior pedicle flap reconstruction described by Munhoz [3].

All patients received detailed written guidelines and oral explanations for the postsurgical care. Postoperative controls were performed at 48 hours, 7 days, 15 days, and 1 month, prohibiting sexual intercourse, intense physical activities, and water sports for a minimum of 4 weeks after surgery. Residual stitches were removed 1 month later, if necessary.

**RESULTS**

From January 2008 to January 2009, 73 patients consulted in the gynecologic aesthetic unit of the Italian Hospital of Buenos Aires, Argentina.

Motives for consultations were as follows (Figure 1):

- 34 patients (46.5%) consulted for a reduction labioplasty owing to hypertrophy of the labia minora.
- 19 patients (26%) consulted for a reduction vaginoplasty and/or G-spot amplification owing to anorgasmia during sexual relations.
- 8 patients (10.9%) consulted for a widening vaginoplasty for vaginal narrowing owing to preexisting pathologies that made penetration during coitus impossible.
- 6 patients (8.2%) consulted for resection of asymmetries owing to fibroepithelial polyps or redundant folds.

![Figure 1. Motives of consultation.](Image)
- 5 patients (6.8%) consulted for vulvar and/or anal bleaching owing to hyperpigmentation.
- 1 patient (1.3%) consulted for an augmentation labioplasty owing to hypotrophy of the labia majora.

As a result of the preoperative questionnaires, it was observed that consultations were for the following mobiles:
- 58 patients (79.45%) related to aesthetic problems,
- 42 patients (57.3%) related to sexual problems,
- 13 patients (17.8%) related to discomfort wearing cloth (sporting clothes, tight pants, etc.), and
- 10 patients (13.6%) mentioned that the main reason was discomfort when exercising.

We would like to emphasize that most the patients linked an aesthetic problem with a sexual problem. This explains why the sum of the percentages is greater than 100% (Figure 2).

The mean age of the patients who consulted was 37 years, ranging from 16 to 62 years. If divided by pathologies, the statistics shows that, for labia minora labioplasties, the mean age was 27.4 years, ranging from 16 to 58 years. For reduction vaginoplasty, the mean age was 51.75 years, ranging from 49 to 56 years; and for widening vaginoplasty, the mean age was 42.71 years, ranging from 16 to 67 years (Figure 3).

Of the 73 patients seen on consultation, 32 underwent surgery (43.8%). The following surgical procedures were made:
- Reduction labioplasty: only 19 (55.8%) of the 34 patients required surgery, 13 for anatomical disorders and 6 due to psychological compromise. A total of 15 patients (44.1%) did not meet indications for surgery (they consulted to receive a medical opinion regarding the “normality” of their genitals because they had received negative comments from sexual partners).
- Widening vaginoplasty: 6 (75%) of the 8 patients seen on consultation underwent surgery. They presented organic pathologies including advanced lichen sclerosus, vaginal narrowing after surgery for vulvar carcinoma plus radiation therapy, and vaginal narrowing after reduction vaginoplasty performed at another center.
- Reduction vaginoplasty: only 1 (5.2%) of the 19 patients underwent surgery because of vaginal tear plus flatus incontinence during coitus. The rest received appropriate information on female sexuality.
- Correction of asymmetries: all 6 patients underwent surgery.

All the surgeries were performed in outpatients without need of hospitalization for any complication (Figures 4 and 5). All 100% of the reduction labioplasties were done under local anesthesia. And 100% of the widening vaginoplasties and the only reduction vaginoplasty were performed under general anesthesia.

There was no significant difference in the dehiscence of wound using absorbable polyglycolic acid 4-0 or polydioxane 4-0 suture.

Regarding the surgical techniques, the results indicated that the amputation of the free wedge could be performed in any labia despite its shape and size, and it had the lowest wound dehiscence rate (amputation was applied in 12/19 surgeries, with only 1 dehiscence [8.3%]). The flap technique could only be applied to certain labias with specific shape and size. This technique had a higher wound dehiscence rate but, in our opinion, better aesthetic results (the technique was...
applied in 7/19 surgeries, with 2 wound dehiscence (28.5%).

The mean time for the labia minora reduction labioplasty was 45 minutes (range = 30–65 min) the mean time for those surgeries of vaginal widening was 39 minutes (range = 30–55 min), and the mean time for reduction vaginoplasty was 30 minutes.

On average, 96.8% of the patients (n = 31) obtained medical final discharge 30 days after surgery. Of the 32 patients, 30 (93.75%) had sexual intercourse satisfactorily in a lapse of 30 to 60 days after surgery. Only 1 patient did not have sexual intercourse because she did not have a stable partner and the other one was a 16-year-old adolescent girl, operated on for labia minora reduction, who was not sexually active at the time.

The postoperative complications were wound dehiscence in 3 patients (9.3%; of whom 2 had polydioxane 4-0 suture and 1 had polyglycolic 4-0 suture), vulvar hematoma in 1 patient (3.1%), and dyspareunia in 2 patients (of whom 1 had a reduction labioplasty and 1 had a widening vaginoplasty). The pain stopped 90 days after the use of lidocaine in gel 2% and promestriene cream.

Patients’ satisfaction was evaluated with the questionnaires 2 months after surgery.

On average, 96.8% of the patients who underwent surgery expressed satisfaction with the results (31/32 patients operated on).

Those patients who underwent widening or vaginal reduction were very satisfied with the aesthetic results, and satisfaction was observed as 100%. Regarding labioplasty of labia minora reduction, satisfaction was 94.73%. Only 1 patient who underwent a labia minora reduction was not satisfied with the aesthetic result (Figure 6).

**Case 1**

A 57-year-old woman who had vaginal reduction surgery 5 years ago. As an adverse effect of the previous procedure, the patient’s introitus was too small, which caused dyspareunia and inability to have sexual intercourse. It was repaired with a widening vaginoplasty.

**Case 2**

A 16-year-old adolescent girl who consulted for labia minor hypertrophy. She underwent a reduction labioplasty.
Case 3
A 20-year-old woman who consulted for labia minora asymmetry after labia minora labioplasty at the age of 16. A reparatory labioplasty was made.

Case 4
A 20-year-old woman consulted for labia minora hypertrophy. She underwent reduction labioplasty.

Case 5
A 60-year-old woman with labia major unilateral hypertrophy. She underwent reduction labioplasty surgery under general anesthesia.

DISCUSSION
Vulvar rejuvenation and vaginal lifting are words related to fashion, read in magazines, and mentioned in TV and even in certain medical congresses.

We, as a specialized cosmetic gynecology unit within the general Department of Gynecology of the Italian Hospital of Buenos Aires, wonder:
- Is it appropriate to talk about genital rejuvenation?
- Is a vaginal “lifting effect” achieved?
- Are there objective aesthetic parameters for the vulva and/or vagina?
- Can someone define these parameters objectively?

The answers to these questions seem evident to us: NO.

In our experience, we have noticed that there are exaggerated expectations on VV aesthetic surgery because the procedures are even expected to provide a solution to sexual disorders that do not have an anatomical basis.

We believe that there are aesthetic indications to these surgeries because we saw some examples in the photographs but not in medical cases.

Aesthetic aspects may have negative impacts on peoples’ lives, conditioning their social and sexual behaviors [8, 9]. But as gynecologists, we must be careful with the information we provide to our patients and we should take time to discover the real reasons of the consultation and provide adequate and integral sexual advice. Most consultations can be solved in the office and not require an intervention [1, 10].

CONCLUSIONS
More than half of the patients who were seen on consultation for VV aesthetic surgery had no need for it and only received information regarding female anatomy and sexuality.

The most frequent consultation was for a reduction labioplasty owing to hypertrophy of the labia minora. Only 1 of all the patients who were seen for reduction vaginoplasty met indications for surgery.

There is a high degree of satisfaction with these surgeries and a low rate of complication.

Patients should be thoroughly informed of the lack of sufficient scientific data supporting the efficacy of these procedures and their potential complications.

Our experience reveals that there are exaggerated expectations that VV plastic surgery can solve sexual disorders that have no anatomical basis.

Indications for VV plastic surgeries should be based not only on surgical results but also on the satisfaction
achieved by those patients who did not undergo surgery after receiving information during the consultation.

REFERENCES


