Topographic Labiaplasty

From Theory to Clinical Practice

Pablo Gonzalez-Isaza
Rafael Sánchez-Borrego
Editors

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To my wife Heidi Fruchtnis, my daughter Julieta Gonzalez, a permanent source of inspiration, they have been a witness to my professional career, to my parents who have allowed me to have a quality education, to my colleagues and friends who experience the great satisfaction of improving the sexuality and quality of life of patients.

Pablo Gonzalez-Isaza

Foreword

Many years ago, I had the opportunity to contact Dr. Pablo Gonzalez through a colleague who introduced us. We met at a conference in Bogota, and there for the first time I learned about some of the procedures of cosmetic gynecology. At that time, there was a lot of resistance from some positions—not so much theoretical or scientific but ideological—from sexual health professionals, and I found it interesting to dive deeper into the subject to have my own concept of the subject.

Shortly thereafter, I participated in the first Cosmetic Gynecology congress in the city of Pereira, and there I heard brilliant presentations from different doctors that made me understand that this is a science, and not a deceptive practice. Behind those conferences, there was the support of well-designed research, scientific publications, books, hundreds of operating room hours, and international scientific societies.

At this point is where we understand the difference between science and ideology, two perspectives that do not always speak the same language. And I think that not only from science but also from common sense a woman has every right in the world to have some kind of aesthetic intervention that allows her to feel more comfortable with her body, increase her self-esteem, overcome complexes, and fully enjoy her sexuality. In summary, it is her body, and not even radical feminist groups have more right than her to make the corresponding decisions.

In the following years, we continued to strength our professional relationship in different congresses, meetings, courses, and I observed the exponential growth of cosmetic gynecology, something that perhaps I would not have known about if it had not been for that first providential meeting.

My now friend Pablo Gonzalez was always concerned about being at the forefront, organizing large conferences, teaching, writing, publishing, and of course performing surgical procedures. But he still had something pending: to publish a book.

So, the time came, with some texts of his authorship and chapters of world-renowned professionals, he built this dream named: *Topographic Labiaplasty: From theory to practice*. Its contents, as its title suggests, range from historical, theoretical and, of course, practical aspects that give a complete picture of labiaplasty from a scientific perspective.

I have no doubt that this book will make history within the specialty, and I hope it will have the reception and repercussion it deserves. It has plenty of quality to achieve it. Enjoy it.

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Chapter 1
Introduction

Pablo Gonzalez-Isaza

Introduction

Labia minora hypertrophy, usually, is of multifactorial origin; it can be considered as an anatomical variant [1–4] or due to genetic alterations as reported in the current literature in studies with identical twins [5], by the accidental administration of androgens in pregnancy, by mechanical factors such as chronic irritation, neurodegenerative diseases such as myelodysplasia, adrenal hyperplasia, childbirth, lymphatic stasis, irritations, and chronic inflammation due to urinary incontinence. It has been described in some sexual habits such as the use of piercing, by the intentional stretching of the labia minora known in the African cultures of Khoikhoi, Hottentot tribe, among other [5, 6], and finally mentioned in some series without further support by excessive masturbation, or it simply can be classified as idiopathic origin, in general terms, which should be considered as a variant of normal anatomy.

Hypertrophy is defined as the disproportionate size of the labia minora with respect to the labia majora; it should be noted that the elongation of tissues in the vulva may have multiple components affecting not only the labia minora but also the clitoral hood, vestibule, and perianal region [7].

Among the most frequent reasons for consultation, we can find difficulty in managing vaginal secretions, vulvovaginitis, and chronic irritation as well as mass sensation and functional limitation for performing sports activities, such as cycling or horseback riding [1, 4, 8, 9], superficial dyspareunia, and secondary sexual dysfunction are frequent; it has also been reported the entrapment of the labia minora in the closure of the garments. They are generally patients who have a very important

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psychosocial component due to the alteration in their self-esteem and the impossibility of leading a satisfactory intimate life [6].

In most cases, despite of an adequate counseling to these patients, the management is surgical, with labiaplasty or nymphoplasty [10–13].

The main objective of this procedure is the resection of hypertrophic tissue, achieving a functional and cosmetic impact for these patients [8, 9, 14]. Multiple techniques have been described, ranging from a simple resection under local anesthesia to the use of devices with different types of energy, mainly multipulsed CO_2 laser, which has shown the best results to date [15, 16].

Radmann et al. in their series of adolescent patients, considered hypertrophy to labia minora with a length greater than 5 cm the degrees of hypertrophy, but in general it is said that the labia minora that protrude outside the labia majora and have a length greater than 5 ms can be categorized as hypertrophic [7].

The proposal of topographic labiaplasty is a compilation of experiences of more than 14 years performing labiaplasty, which allowed to understand the great anatomical variability and complexity of the anatomy of the vulva, finally achieving a simple, reproducible, and safe technique for the approach of patients with labia minora hypertrophy; by reading this book, the reader will be able to easily understand and comprehend the approach to this type of patients.

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Chapter 2
Historical Aspects

Jack Pardo Schanz

History of Labiaplasty

The labia minora and clitoral hood have a common embryological origin with the foreskin of the penis. The first surgery recorded in antiquity related to the genital area is inside the Bible, in Genesis, when God ordered the Prophet Abraham to circumcise his son Isaac and previously circumcised himself to formalize as God said: "A covenant between me and you [1]." In antiquity, for unknown reasons, but apparently related to decrease or abolish female sexual pleasure, female circumcision, or female genital mutilation (FGM) began to be practiced initially in Ancient Egypt, which, depending on each culture, ranged from the removal of the clitoris alone to the so-called pharaonic circumcision [2], which consists of an almost total vulvectomy, removing the clitoris, its hood, and labia minora, besides closing almost completely the introitus. The practice of FGM is still carried out—unfortunately—even in the twenty-first century. Although it is mostly performed in Muslim countries, its origin predates the appearance of Muhammad by hundreds of years (sixth century), and current Muslim theologians consider it an unnecessary practice and contrary to Islam. I have referred to FGM in this chapter expressly to make it absolutely clear that it has no medical, cultural, or surgical relationship to any of the surgeries that comprise female genital aesthetics or cosmetogynecology. Moreover, leading cosmetogynecologists, such as Dr. Amr Seifeldin of Egypt, are experts in performing FGM repair surgery [3]. There are feminist movements, especially, and some medical societies that have tried to relate and even catalog female genital cosmetic and plastic surgery, mainly labiaplasty with FGM [4], nothing further from reality since the latter are aimed at improving the quality of life, sexuality, and genital aesthetics, which contrasts with FGM that is oriented to the opposite.

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As for surgeries of the female external genitalia, we have very old citations of procedures performed by physicians.

Soranus of Ephesus (98–138 A.D.), a Greek physician who practiced in Alexandria and Rome in the late first and early second centuries, provides us with the first record of cosmetic genital surgery in history for an aesthetic defect [5]. He describes the excision of a hypertrophic clitoris for cosmetic reasons and to "decrease excessive sexual stimulation." In any case, he refers in this surgery to the procedure described by Philomenus, a contemporary of him. Later, another doctor, with the same name as the previous one, Philomenus of Alexandria, in the third century, also performed a partial clitoridectomy for hypertrophic clitoris because he considered it "ugly" [6].

Continuing the timeline in the seventh century, Paulus of Aegina, physician of the Byzantine Empire, described two different operations, one of which was a partial clitoridectomy and the second a partial resection of the labia minora which he called "cauda pudenda" (pudendal tail) [7].

Although this operation may have been performed many times in the following centuries, it is not until the sixteenth century that François Mauriceau, a great French obstetrician–gynecologist of the time, in his treaty on "The Diseases of Women" [8], describes the nymphae or labia minora as "small membranous wings" whose purpose is to protect the vaginal entrance and, surprisingly, explains how they help to conduct the urinary stream correctly so that it does not disperse down the thighs. This is remarkable since all of us who perform labia minora labiaplasty know that total amputation of the labia minora in women with very flat labia majora produces this undesirable effect on urination. Mauriceau tells how some women have such large labia minora that for convenience they are forced to place them inside the labia majora. He relates the case of a young lady who was in severe discomfort because of her large labia minora and also because they affected her especially in equestrian activity. He operated on his patient performing a reductive labiaplasty and achieving the necessary success for the lady to be able to ride again. Another interesting fact is that he explains that "the labia minora are red and evolve to a darker color with age."

Later, Pierre Dionis, a Parisian surgeon described the excision of the nymphae (labia minora) in his treatise *Cours d'operation de chirugie* in 1707 based on his experience assisting the nobility of the court of Louis XIV, the Sun King. The military surgeon, Lorenz Heister, first described the labia minora in detail in his 1739 publication, *Institutiones Chirurgicae*, which is considered one of the most popular surgical atlases of the seventeenth century. He explains in detail: "The nymphs of women are sometimes very long, not only hang outside the labia (majora) but cause discomfort in walking, sitting, and sexual intercourse, and may require the assistance of a surgeon. The operator must sit in front of the patient in a suitable position, take the lip with his left hand and cut what he considers necessary using scissors with his right hand, having at hand preparations that help control bleeding and medications that prevent the patient from fainting. When the surgery is over, the wound should be treated with some kind of ointments and will heal without much difficulty with common methods. It is noteworthy that it does not mention any type of suture,

which is not so incredible, since it is described that a labiaplasty can be performed without sutures."

During the following centuries, labiaplasty is reported sporadically. Apparently, it was not given the importance it deserved, but we can be sure that in important cases of labia minora hypertrophy, if the patient dared to consult and if the surgeon was kind, it can be assumed that this surgery was performed constantly over time, but without giving it the importance it deserved to be published in the medical literature in a scientific manner, so, during my residency at the Hospital del Salvador in Santiago de Chile between 1988 and 1993, I saw only one labiaplasty. In my last year of residency, without ever having seen a case, my direct boss, a renowned gynecological surgeon, asked me to perform a "nymphoplasty" after a hysterectomy that we had scheduled, as when after a major gynecological surgery biopsy scraping wase left for the gynecology resident. I only remember performing it with scissors and suturing step by step to immediately stop the bleeding. I have no memory of having a complication or the final result. That was to this day the only labiaplasty I have ever performed in my life, with traditional surgical instruments, and as of writing this article in September 2020, I have performed over a thousand of these procedures.

Honoré et al., in 1978, described two cases of labiaplasty for bilateral hypertrophy. In 1983, Darryl Hodgkinson, published what is considered the first communication of labiaplasty. In it, he begins by describing the sociological and personal reasons that may lead a woman to request this procedure. He emphasizes gyms, sports, and even the greater influence of plastic surgeons in wanting to treat these cases. There he explains that labia surgeries in modern gynecology were reserved in practice almost exclusively to massive vulvar hypertrophies secondary to congenital adrenal hyperplasia. He notes that women of that time requested reduction of the labia minora for aesthetic as well as functional reasons. He describes, quite correctly in my opinion, how some patients also (or sometimes exclusively) request reduction of the clitoral hood, which he calls a "partial circumcision." As in this chapter, Hodgkinson refers to FGM from the historical point of view and highlights how in the "present day" of 1983 there were social and political movements aimed at the abolition of FGM, a situation which almost 40 years later has proved to be failed. Her communication is based on the description of three clinical cases, under general anesthesia in one case and one of the cases concomitant with breast surgery.

In the prestigious and traditional *American Journal of Obstetrics and Gynecology* in 2000, Rouzier et al., from France, published a series of 163 cases of labiaplasty, reporting excellent results and cataloguing the procedure as simple and with a high degree of patient satisfaction [9].

This was one of the first communications with an important series of cases.

During the 1980s and 1990s, the pornographic industry had a real exposure, especially when the internet became massified and the vulva began to be visualized in a much more in an explicit way, unlike the traditional exposure of the torso and buttocks of the 1960s and 1970s, led by *Playboy* magazine [10]. The breasts were already too exposed; they were not a novelty; it was the birth of the cult of the vulva. We cannot omit, in any way, the influence that pornography had in the massification

of labiaplasty, and with this we can add the total hair removal of the female genitalia named "Brazilian waxing." This epilation method "style" which consists of removing all the hair from the pubis, labia majora, and perianal area, was born in the early 1990s in New York in a female beauty center whose owners were six Brazilian sisters known as the "J Sisters." They imposed the fashion of total hair removal that left only a small part of the pubis with some hair, only as a decorative effect, or sometimes not at all. As the vulvas were left bare of hair in their entirety, in the 1990s the road to the interest of beautifying women's external genitalia was being paved. Mile zero of this road is in Los Angeles, California, specifically in Beverly Hills.

In 1997, an American gynecologist from California, Dr. David Matlock began the routine practice of what he called and settled on as "vaginal rejuvenation" which was a modification of the traditional colpoperineoplasty for prolapse surgery. Matlock, as described in "his path" in Michael Goodman's book, devised a concept and method that he could pass on to other physicians, supported by the knowledge he gained from his patients and from having completed an MBA. Gradually he realized that a large percentage of women he performed vaginal rejuvenation on were also requesting labiaplasty. His procedure was perfected with the use of a diode laser, free edge excision technique, and clitoral hood removal when necessary. He called this labiaplasty, *Designer Laser Vaginoplasty*, DLV®, meaning "laser-assisted vagina design." Like Laser Vaginal Rejuvenation, LVR®, both were trademarked. In the United States, you cannot offer to do a DLV® or LVR® if you have not taken the course taught by David Matlock. From 2000 to 2020, more than 400 gynecologists, urologists, and plastic surgeons from all over the world have taken Matlock's course. This is where my story with this surgery begins.

In 2003, along with Dr. Vicente Solá, we created the Pelvic Floor and Gynecologic Plastic Surgery Unit of Clínica Las Condes; I went to Beverly Hills, California to attend the vaginal rejuvenation course given by David Matlock. At the beginning of the course, David told me: "In addition to vaginal rejuvenation, I am going to teach you something else that will give you great satisfaction," and so it was that, with animal models (a fresh pig's ear); we learned to use a diode laser and practice to do laser labiaplasty.

When I returned to Chile, both labiaplasty and vaginal rejuvenation became part of my regular practice and absolutely integrated with other surgeries. It was very common to correct urinary incontinence with a mid-urethral tape and to perform laser-assisted vaginal rejuvenation and/or laser-assisted labiaplasty on the same patient. In 2005 we published the first series of laser labiaplasty in the world literature with excellent results, where we also proposed a classification and described the reasons that women had for requesting the surgery [11]. This was in addition to the first communication of vaginal rejuvenation in the world literature that we presented in 2006. Until that time, cosmetogynecology was a discipline formally and habitually practiced almost exclusively by Matlock's disciples.

From 2006 onwards, contributions of lectures in some congresses of laser medicine began to take place, and later a small eruption of gynecology courses with special chapters of cosmetogynecology began to take place, among which I must mention the advanced vision of the Paraguayan and Uruguayan Societies of

Gynecology, who early on invited me to show my experience and perform teaching surgeries with the aim of adding this discipline to the practice of gynecology and, above all, urogynecology.

It always seemed important to me to combine cosmetogynecology with urogynecology, since the association of patients with urinary incontinence seeking vaginal rejuvenation and/or labiaplasty was extremely important, as we have described in different publications. In fact, we have even described a case of labiaplasty and vaginal rejuvenation concomitant with a radical hysterectomy for stage I cervical cancer.

In 2011, Marco Pelosi, a great Peruvian gynecologist who has developed his career in the United States, held the first congress of cosmetogynecology with an important attendance. One of his disciples, Dr. Alexander Bader, from Greece, who is also a disciple of Matlock creates, a few years later, the *European Society of Aesthetic Gynecology* that brings together hundreds of cosmetogynecologists every year in different cities of Europe.

Among the most relevant advances of labiaplasty is the fact that it stopped being a surgery for extreme cases practiced with certain disdain by the resident at the end of the surgical program in the morning of the public hospital or university after the operations considered important, to become part of the usual practice of aesthetic gynecology and—why not to say it—functional gynecology. In the last decade, the number of courses and congresses of the specialty in all continents is countless, and within these courses, labiaplasty and female genital aesthetics are a fundamental chapter.

It is not yet defined with certainty the advantages of the cutting instrument, whether it is laser, radiofrequency, or simple scissors and/or scalpel, but it is very clear that, despite the furious opposition of feminist groups and certain medical associations, especially American, they have not managed to prevent thousands (yes, thousands) of women from voluntarily undergoing a labiaplasty every year.

The accusations of FGM, overdiagnosis of hypertrophy, and surgical indication are to underestimate the intelligence of those women who voluntarily choose a cosmetic gynecologist and request his services.

The great last step is perfection of the surgical technique until there are no more doubts about which is the best and with less complications; discussion that exceeds this chapter of the book, but on the other hand, to consolidate this surgery as an absolutely ambulatory procedure and that, in my personal case, following the experience of great cosmetogynecologists such as Michael Goodman and Red Alinsod, I have almost totally turned to local anesthesia. At the time of writing this chapter, I no longer perform a single labiaplasty of the labia majora or labia minora under general or regional anesthesia; all are performed under local anesthesia. The exception is in patients where another surgery requiring major anesthesia must be performed, such as a hysterectomy and/or concomitant urinary incontinence correction.

Since I started performing labiaplasty on a regular basis, I have performed over a thousand cases, and it is one of the surgeries that has given me the most professional satisfaction, due to the very high degree of satisfied patients and the very low rate of complications. The cases of women who have carried the burden of having

hypertrophic labia minora that have hindered and sometimes prevented them from having an acceptable sexual life are—in my experience—innumerable. The cry of relief after surgery that I have seen in many of my patients when they know that their burden is over continues to this day to thrill me. In reality and as I say in many presentations, cosmetic gynecology surgeries were not invented by cosmetogynecologists; they just did something that women were waiting for.

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Chapter 3
Topographical Anatomy

Pablo Gonzalez-Isaza

Introduction

Since our training in medical school, we may have seen and studied the same illustrations in different texts and atlases (Fig. 3.1), where the anatomy of the vulva is shown in a very basic way, for example, clitoral hood, clitoris, mons Venus, labia majora, labia minora, vestibule, and perineum, sometimes the frenulum of the clitoral hood is mentioned.

I consider that the anatomy of the vulva should be reviewed in a deeper way; we should talk about anatomical variants, particularities of the frenulum, aberrant insertions, as well as the innervation and vascularization, which together should be widely known at the time of performing a labiaplasty.

Now, I will describe the proposal of "topographic labiaplasty" (Fig. 3.2a, b), which is very useful when performing a labiaplasty; this concept arises from the need to identify not only anatomical landmarks but also to establish safe margins, to perform a labiaplasty in a reproducible and safe way.

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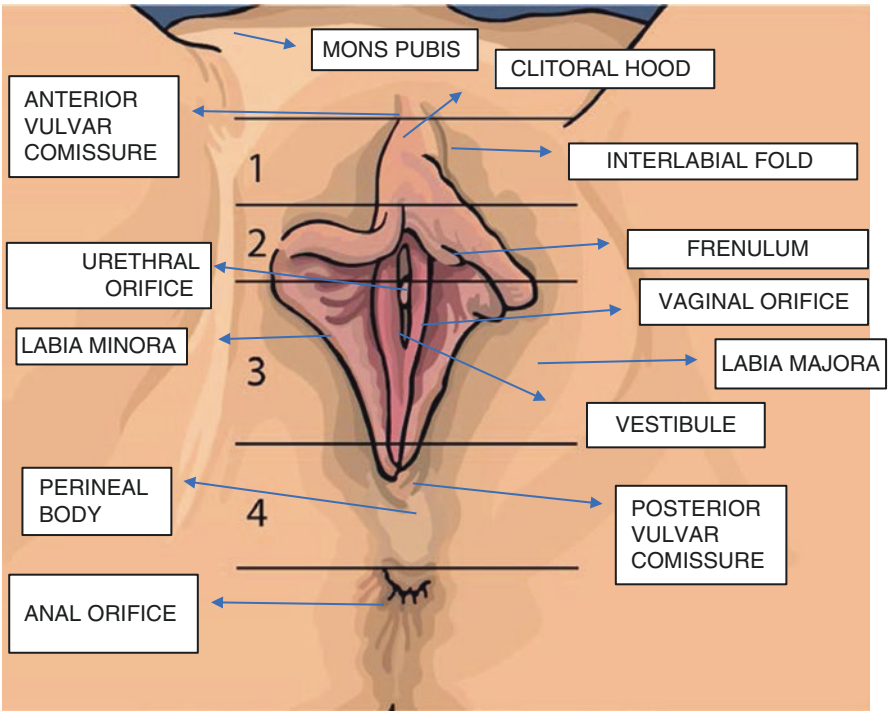

Fig. 3.1 Basic anatomy of the vulva. (PERSONAL DRAWING)

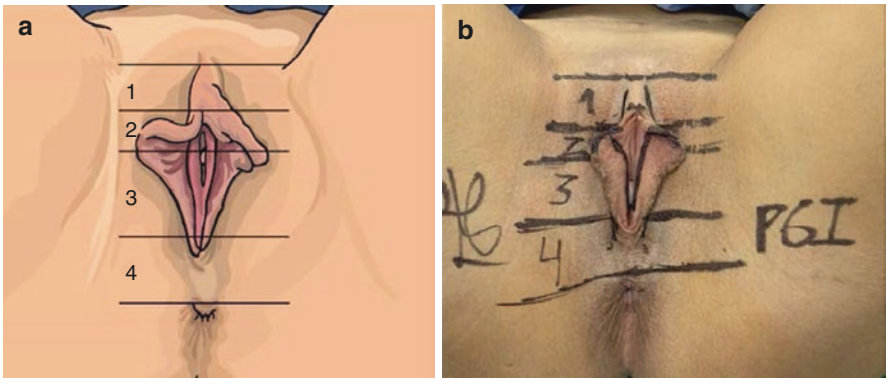

Fig. 3.2 (**a**, **b**) Anatomical zones

Anatomical Zones Fig. 3.2a, b

Zone 1

- Upper limit: anterior vulvar commissure
- Lower limit: apex (foreskin) of the clitoral hood