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Case Report

Simultaneous Labia Minora and Majora Reduction: A Case Report

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ABSTRACT Labia minora enlargement may constitute a cosmetic or functional problem for a woman, potentially leading to surgery. However, more rarely, the labia majora may also be problematic for women. This case describes the rare situation of a woman presenting with enlargement of both the labia minora and majora and her subsequent simultaneous surgical treatment. Journal of Minimally Invasive Gynecology (2011) 18, 378–380 © 2011 AAGL. All rights reserved.

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Cosmetic genital surgery is becoming a more commonly requested procedure than in the past [1–4]. Although many patients pursue labia minora reduction surgery for cosmesis, most patients do have a functional reason for pursuing surgery [5]. Most of the published medical literature focuses on labia minora reduction surgery, and there is less emphasis on labia majora reduction surgery. Recently a case report was published describing the staged operation for labia minora and majora reduction [6]. Di Saia [6] describes the case of woman who had a labia majora reduction complicated by a hematoma, followed 4 months later by a labia minora reduction with satisfactory cosmetic results. This case report describes treating the patient's problem simultaneously during one operation.

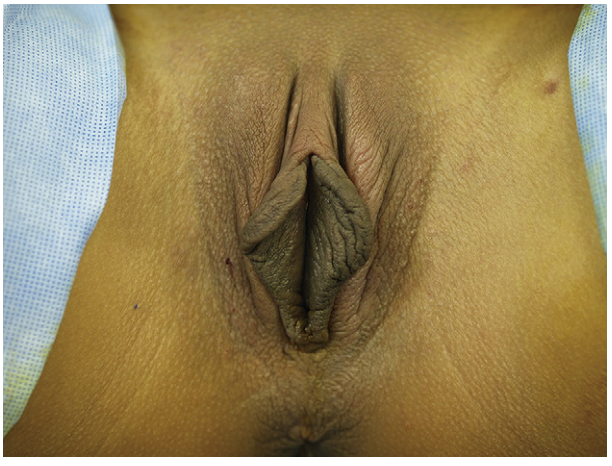
Case Report

The patient is a 36-year-old white woman, gravida 1 para 1, who presented with a chief complaint of "hanging labia majora" and enlarged labia minora. The patient stated that her labia minora protrude passed the labia majora, and this caused her discomfort with tight clothing, with working out, and on occasion with intercourse. She also stated her labia minora were unattractive because they protruded and had darkened skin edges. She expressed she would prefer her labia minora not protrude beyond the labia majora. She described her labia majora as "hanging" and "not tight to her body." She explained that she was extremely self-conscious about wearing a bathing suit because she felt as if she had a protrusion in this area.

On examination with the patient in the lithotomy position, she had darkened labia minora protruding 2 cm passed the majora edges (Fig. 1). To identify her areas of concern, the patient used a mirror and a cotton-tip swab. After examining the labia minora, she then directed the authors' attention to the labia majora. She used her thumb and forefinger to

Fig. 1

Preoperative view reveals labia minora and labia majora hypertrophy. ©Miklos & Moore.



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pull on the majora redundancy. Both of her labia majora could be stretched 3.5 cm from its resting position with gentle tension. I (J.R.M.) then examined her in the standing position to better understand her concerns. After an informed consent and explaining that her desired surgery was not medically necessary, the patient elected to proceed with surgery.

The patient was taken to the operating room, and under general anesthesia she was placed in the dorsal lithotomy position. The labia majora was reduced first with a semi lunar incision on the medial border of each labia majora (Fig. 2). Hemostatsis was secured with electrosurgery. Interrupted delayed-absorbable sutures (5-0 monocryl suture; Ehticon, Juarex, Mexico) were used to approximate the subcutaneous fat of the labia majora. Once the labia majora incision site was closed with a running suture, the labia minora was addressed. The labia minora reduction was accomplished by use of a vertical linear incision amputating the protruding portion of the minora (Fig. 3). The free edges were then closed in a mattress type fashion with interrupted delayed-absorbable sutures (Ethicon). No local anesthesia was used before or after the incision.

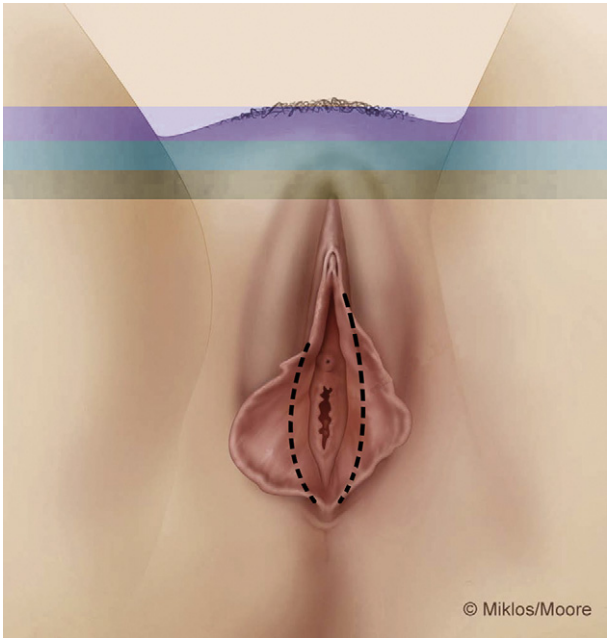
The patient was instructed to place an ice pack on her vulva every 30 minutes while she was awake for the first 24 hours after surgery. She was prescribed ketorlac 10 mg orally every 6 hours for 2 days, as well as oxycodone/acetomenophin (5 mg/325 mg) tablets every 6 hours as needed. She was also instructed to restrain from excessive physical and sexual activity for 6 weeks and to wear loose clothing that would not cling to incision sites for the first week after surgery. She returned for follow-up 6 weeks later and stated she was pleased with the cosmetic outcome of the surgery (Fig. 4).

Fig. 2

Incision sites – marking and incision site for labia majora reduction.

Fig. 3

Incision sites – marking and incision site for labia minora reduction.

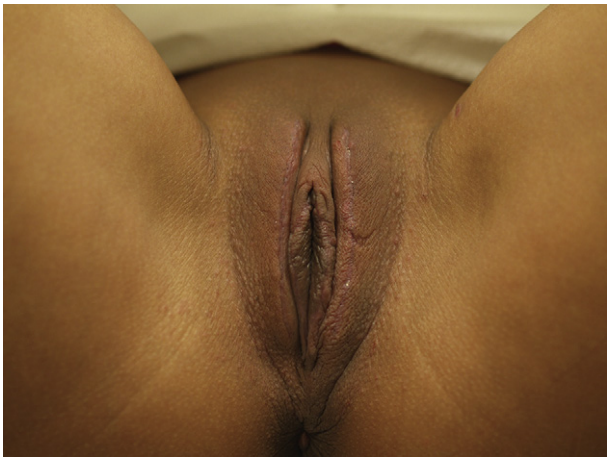


Discussion

Labia minora protruding past the distal edge of the labia majora can be of concern to women [7,8]. As mentioned earlier most cosmetic genital surgery medical literature focuses on labia minora reduction surgery. In a 2009 literature review of labial minora surgery for well women,

Fig. 4

Postoperative view 6 weeks after the revision of both the labia minora and majora. ©Miklos & Moore.



Liao et al [9] identified 40 articles between 1976–2009. Only 18 of the 40 reported surgical procedures, of which five specified labial amputation, 10 specified variations of wedge resection, and three did not give information about the technique used. Only 13 of the 18 articles addressed complications, and only five of the 13 articles specified the complications, including infection, bleeding, and wound dehiscence. There is limited medical literature that emphasizes labia majora reduction surgery for the treatment of hypertrophy [5,10]. Of the two case studies referenced, only one mentions a complication of a postoperative hematoma. Neither of these cases describes doing a labia majora reduction simultaneously with a labia minora reduction in one surgical setting. The authors of this article have used surgical staging in the treatment of cosmetic genital surgery but believe it is not always necessary.

This case study presents a woman who had both her labia minora and majora reduction performed in a single surgery. The authors believe by doing these two procedures in one setting, they can reduce financial constraints involved with a staged operation.

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