A labiaplasty is a surgical procedure that reduces the length of redundant labia minora. The procedure is increasing in popularity, with patients requesting it for both functional and appearance-related symptoms.1

The best technique is the one the plastic surgeon is most comfortable with and which achieves consistent results. Nonetheless, specific techniques offer unique advantages. For example, the wedge, among the most commonly performed techniques, can be an excellent option for the patient with thin, well-defined labia edges.2 The trim technique, on the other hand, can be a good choice in patients who dislike their thick, darkly pigmented, or rough edges.3–5

When performing a trim, also known as an edge excision, linear, or amputation labiaplasty, a surgeon’s good technique can help reduce complications, including bleeding, hematoma, scar contracture, painful or hypersensitive scars, and scalloped edges3–5 (see video, Supplemental Digital Content 1, which features an operative technique that aims to minimize such complications by observing anatomic landmarks to preserve sufficient labia length while also incorporating suture techniques that promote smooth, flat scars. This video is available in the Related Videos section of the Full-Text article on PRSGlobalOpen.com or available at http://links.lww.com/PRSGO/A445).

During the initial examination, the patient can hold a hand mirror to view her genitalia while she is positioned in stirrups as the surgeon discusses both her anatomy and the procedure. A redundant clitoral hood should prompt the surgeon to discuss reduction. Failure to reduce a redundant clitoral hood can result in an imbalance that can be distressing to the patient after a labiaplasty alone has been performed.

The case presented in the accompanying video shows a simple trim technique. Reducing a heavy clitoral hood and extremely long labia is a complex procedure beyond the scope of this video.

A labiaplasty is easily performed under local anesthesia with oral sedation. After being lightly sedated, the patient is placed on an operative table equipped with padded, supportive stirrups.

The frenulum serves as a landmark for marking. If it is transected, the frenulum will heal like a small ball, which may be distressing to the patient. Using a sterile marker,

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**Disclosure:** The author has no financial interest to declare in relation to the content of this article. The Article Processing Charge was paid for by the author.

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the surgeon should mark a gentle arc from the frenulum to the posterior labium.

Next the patient is injected with 1% xylocaine with 1:100,000 epinephrine, buffered 4:1 with sodium bicarbonate. Patients typically tolerate injection with a 30-gauge needle without topical anesthesia, which can swell and distort the labia.

Although a scalpel, scissors, radiofrequency, or laser can be used for resection, scissors allow fine control without thermal injury. After hemostasis, the central lamina of the labium is sutured with a horizontal running 5-0 chromic suture. One or 2 additional lengths of suturing, each more distal, help control hemostasis, prevent wound dehiscence, and create a pleasing shape. The mucosa is closed with a subcuticular 5-0 chromic suture.

Patients are instructed to take it easy for a week, during which they ice, elevate, and urinate in the shower or with a squirt bottle on the toilet. Tampons and intercourse are avoided for 4 weeks, and activities like cycling may be resumed after 6 weeks. Swelling can last 3–6 months.

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