Evidence brief for Policy T33: Labiaplasty

The Royal College of Obstetricians and Gynaecologists is of the opinion that there is a lack of high quality evidence supporting the use of labiaplasty. The Royal College reports no data exist on the efficacy of labiaplasty for the treatment of functional problems. Labiaplasty carries the risks of bleeding and wound infection, with wound dehiscence (rupture or splitting open) reported in up to 30% of cases. This can require a second operation to correct. The Royal College warn of the risk of damage to sensitivity and sexual function following labiaplasty, as surgery can disrupt the nerve supply to the vagina and vulva. The labia minora are thought to play a role in sexual arousal – the area is densely innervated and contains oestrogen receptors and erectile tissue. Removal of this tissue could therefore result in decreased sensation and altered sexual experience. The surgery also carries the risk of scarring, and scar tissue has the potential to disrupt sexual function as the tissues become less contractile. This stance is mirrored by that of the American College of Obstetrics and gynaecology.

In a very recent (2014) study by Veale et al a group of 49 women receiving labiaplasty were compared to a group of 39 women not wanting labiaplasty. The two groups were matched for age, marital status, ethnicity and sexual orientation and the primary outcome measure was the Genital Appearance Satisfaction (GAS) scale. This study only contained 88 participants, and 19 of the 49 women in the group receiving surgery were lost to follow up. Whilst 96% (24/25) of the group receiving labiaplasty showed a clinically significant increase in GAS score 3 months post op, 26% reported minor side effects and the authors conclude that further larger studies are called for to look into the long term effects and side effects of the procedure. As with much of the literature in this area, the sample size is too small to be particularly generalisable.

The research by Veale et al highlights an interesting point: 9 patients in the labiaplasty group met the criteria for body dysmorphic disorder, and all but one of these lost the diagnosis following their surgery. Veale also led another study looking at the psychological characteristics of women seeking labiaplasty, in which 10 out of 55 women seeking labiaplasty met the diagnostic criteria for body dysmorphia. Compared with the control group of women not seeking labiaplasty, those seeking surgery were found to display more avoidance and safety seeking behaviours, and the authors suggest this could be clinically useful as part of a psychological intervention for women seeking labiaplasty. Given that research has shown patients with body dysmorphic disorder do not usually benefit from surgery it would seem unethical to perform labiaplasty in such cases, and instead psychological therapies should be considered.

Another big question in relation to labiaplasty is how to define ‘normal’ genital appearance, a prerequisite for classifying patients as abnormal (a potential justification for surgery). Moran and Lee conducted research into women’s perceptions of ‘normal’ genitalia. They asked women to rate images of various vulvae (some surgically modified, others not) in several categories, for example ‘normal’, ‘desirable’, ‘society’s ideal’. Some women were first shown the modified images, whilst others were shown the unmodified (representing ‘normal’) image first. The
authors found that exposure to images of modified vulvae altered women’s perceptions of what is normal. This supports the notion that media or porn industry portrayal of female genitalia may be influencing women’s views of themselves, and may explain why some of the women seeking labiaplasties have clinically healthy, ‘normal’ vulvae.

Given the dearth of evidence on the long term outcomes and safety of labiaplasty, and the debate around clinical appropriateness of offering the procedure to women who either have genitalia which falls within the confines of ‘normal’, or who would benefit more from psychological intervention (or both), the Clinical Commissioning Group will not fund labiaplasty except under specific circumstances as outline in the policy.

It is worth noting that there are women for whom labiaplasty is absolutely appropriate, for example in the case of a patient with hypertrophic labia minora which interfered with her ability to intermittently self catheterise, and caused recurrent urinary tract infections (UTIs). This patient had no difficulty adhering to the intermittent catheterisation regime following the labiaplasty, and had no UTIs during the 30 months follow up of the study. Another case study describes a lady who developed severe hypertrophy of both labia majora following long term antiretroviral therapy. The hypertrophy was so marked that it gave the appearance of male genitalia even when clothed, and severely limited her quality of life. The patient underwent labiaplasty, regained confidence and resumed sexual activity.

These two example are highly individual specific and the positive outcomes experienced by these patients are not generalisable. However, they illustrate the point that in exceptional cases, there may be clinical need for labiaplasty not accounted for in this policy, and clinicians are advised to follow the Individual Funding Request pathway.

References:
ACOG Committee Opinion ‘Vaginal “Rejuvenation” and Cosmetic Vaginal Procedures’, 378, (September 2007).