Extreme hypertrophy of the labia minora

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Hypertrophic labia minora are occasionally a concern of young adults or adolescent girls. The hypertrophy may cause local irritation and discomfort in walking or sitting, as well as problems of personal hygiene during menstruation. Labial hypertrophy is defined as a maximum distance of the labia from base to edge of 4 cm (1). Although most cases of subjectively reported hypertrophic labia minora require reassurance and no correction is necessary, some cases should be surgically corrected for several reasons. We have recently experienced a case of extreme protuberance of bilateral labia minora in a young Japanese woman without any appreciable causal factors.

Case report

The patient was a 19-year-old nuliparous Japanese woman with a chief complaint of unusual shape and vague discomfort of her labia minora. She began to recognize that her labia minora was becoming larger and longer when she was 12 years old. No injuries or chronic stimulations were reported. The elongation was more apparent on the left side but the right side was also thought to be considerably long. A further elongation was noted on the right side at 16 years old. She began to experience discomfort when sitting, as both labia became longer than 5 cm. She had become sexually active at 18 years old but she admitted recent withdrawal from sexual activity due to the fear and concern of her vulvar shape. No vulvar pain, injuries, abnormal discharges or pruritus were reported.

Her menstrual cycle has been regular with an interval of 28 days and she has never used oral contraceptives. Currently she is not sexually active. She denied any depressive mood changes but she has an obsessive concern with her labial shape and has therefore withdrawn from many social activities. Her family history and her developmental history were essentially normal. The patient’s mother denied any recognizable anomaly at her early childhood.

Upon examination, the patient had normal development of breasts, pubic hair and normal-sized clitoris. The vaginal orifice was slightly relaxed. The bilateral labia minora both protruded and were sagging from their base by more than 10 cm (Fig. 1). Pelvic examination showed a normal-sized, anteverted uterus. Both ovaries were also normal in size and ultrasonography confirmed the findings in addition to visualizing normal follicular development. Magnetic resonance imaging of the pelvis, an intravenous pyelogram and laboratory tests showed no abnormalities.

The patient underwent a bilateral labioplasty under general anesthesia. The redundant labial skin was excised and the labia were reshaped using 4–0 PDS running sutures (Fig. 2). Her postoperative recovery was excellent and she was discharged without event. A histological study showed that the labial tissue was edematous with occasional lymphocyte infiltrations (Fig. 3). No structural or cellular atypia was noted.

The follow-up visit at 12 weeks showed the normal appearance of the vulva and the patient reported satisfactory resumption of sexual activity.

Fig. 1. Markedly elongated labia minora of the 19-year-old nuliparous woman. The growth was first noticed at age 12 years of age and slowly but progressively increased.

Fig. 2. The excess labial tissues were excised and labial plasty was performed using 4–0 PDS sutures.
Discussion

It is not unusual that young adults complain about their unusually shaped vulvar area. The concern tends to be with regard to the labial shape or size but medical intervention is usually unnecessary. The surgical criteria for hypertrophic labia minora are not clearly established. Previous reports use a labial length of 4 cm (1) or 5 cm (2) as an indication for surgical correction but a large study by Rouzier et al. does not show an average length for the cases (1). Certainly the length itself is not an absolute indication. The esthetic aspect and some extent of dysfunction or discomfort should be considered for surgical correction. Histological examination shows somewhat dilated blood vessels and edematous stroma. Infiltration of lymphocytes in close proximity to blood vessels also suggests a possible inflammatory process. The number of nerve endings in hypertrophic labia may be higher than those in a normal labia minora (3).

The etiologic factor of the labial hypertrophy is unknown. *Filaria sanguinis hominis* infection may cause blockage of the lymph channels and as a consequence labial edema may occur to mimic true hypertrophy. Chronic stimulation such as constant pulling may also result in the elongation. Kato et al. reported hypertrophic labia minora in myelodysplastic women and this was attributed to chronic inflammation or stimulation of the labia by the constant use of a diaper (4). These factors are obviously not involved in the present case. In conclusion, we have experienced unusually hypertrophic labia minora in a young woman without any causal factors. In the present case, surgical correction was highly efficacious, safe and satisfactory.

References


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