



Impact of wedge labiaplasty with or without adjunctive procedures on genital self-image and sexual function

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ABSTRACT

Objective: To evaluate the motivations of women undergoing wedge labiaplasty and to evaluate the effect of the procedure on female sexual function and female genital self-image by comparing preoperative and postoperative outcomes.

Materials and Methods: A total of 54 sexually active women who underwent wedge labiaplasty performed by the same surgeons were prospectively enrolled in this study. Demographic characteristics, labial morphology, and surgical details were recorded. Patient motivations for surgery were documented preoperatively. Female genital self-image and female sexual function were assessed using the female genital self-image scale (FGSIS) and the female sexual function index (FSFI), administered before surgery and at three months postoperatively. Preoperative and postoperative scores were compared using paired-samples t-tests.

Results: The mean age of the participants was 39±5.2 years. Aesthetic concerns were reported by all patients, although a subset also described functional complaints as contributing factors. Concomitant procedures included labia majoraplasty in 64.8% and clitoral hood reduction in 87% of the patients. Partial wound dehiscence occurred in 9.3% of the cases and required revision surgery. The mean total FGSIS score increased significantly from 10.6±1.7 preoperatively to 25.9±1.1 postoperatively ($p<0.001$). The mean total FSFI score improved from 16.6±2.5 to 27.4±2.4 after surgery ($p<0.001$), with statistically significant improvements observed in all FSFI domains; arousal, lubrication, desire, satisfaction, orgasm, and pain.

Conclusion: Wedge labiaplasty, frequently performed in combination with adjunctive procedures, appears to be a safe and effective approach associated with significant improvements in genital self-image and sexual function. However, given the high rate of concomitant procedures, the specific contribution of the wedge technique alone should be interpreted with caution. Comprehensive preoperative counseling and individualized surgical planning remain essential to optimize outcomes.

Keywords: Wedge labiaplasty; genital self-image; female sexual function; FGSIS; FSFI; cosmetic gynecology

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INTRODUCTION

Labiaplasty, defined as a surgical procedure aimed at reducing the size of the labia minora, is currently the most commonly performed type of female genital cosmetic surgery (FGCS).¹ In recent years, the number of labiaplasty procedures has increased substantially worldwide, and the procedure is carried out by both gynecologists and plastic surgeons. This trend is reflected in the annual statistics of the International Society of Aesthetic Plastic Surgery (ISAPS) as well as various national societies.² According to the 2021 ISAPS Global Survey, a total of 171,088 labiaplasty procedures were reported, representing a 20.4% increase compared to 2020 and a 23.3% increase compared to 2017.²

Labiaplasty is often perceived primarily as a cosmetic procedure; however, in a substantial subset of patients, it is indicated for functional reasons. Labia minora hypertrophy may lead to pain and discomfort caused by friction, traction, and mechanical pressure during daily activities such as walking, sitting, wearing tight clothing, and engaging in physical exercise, thereby significantly limiting routine activities and exercise tolerance.^{3,4} In addition, protruding labial tissue may promote moisture retention and reduced aeration of the vulvar region, predisposing patients to recurrent irritation, chronic vulvar discomfort, and an increased susceptibility to infections.⁵ Some patients also report difficulties in maintaining adequate hygiene and reduced comfort during menstruation. Furthermore, during sexual intercourse, infolding or traction of hypertrophic labial tissue may contribute to dyspareunia and functional sexual dysfunction.⁴ Pronounced labial asymmetry can similarly result in localized pressure and repetitive microtrauma. In this context, when performed with appropriate patient selection and surgical techniques that respect vulvar anatomy, labiaplasty should be regarded not merely as an aesthetic intervention but as a therapeutic surgical procedure aimed at alleviating mechanical symptoms, improving functional comfort, and enhancing overall quality of life.^{4,5}

The labia minora and clitoral hood exhibit considerable anatomical variability with respect to size, shape, prominence, thickness, rugosity, pigmentation, and symmetry, underscoring the need for individualized surgical approaches. The two most commonly employed techniques for labiaplasty are the edge (trim) technique and the wedge technique. Although the edge (trim) technique is reproducible, this procedure disrupts the natural contour of the labia minora and may result in an irregular suture line that fails to achieve satisfactory aesthetic outcomes. In the wedge technique, a V-shaped segment of tissue is excised and subsequently closed, a procedure first described

and refined by Alter.¹ Postoperative outcomes of labiaplasty procedures performed using the wedge technique have been reported to preserve the natural labial edges, thereby achieving more aesthetically favorable results.⁶

The present study aimed to systematically analyze the motivations of women undergoing wedge labiaplasty and to evaluate the effects of the procedure on body image, genital self-image, sexual satisfaction, and body confidence in the preoperative and postoperative periods.

MATERIALS AND METHODS

This study included 54 patients who underwent wedge labiaplasty performed by the same surgeons. The study received ethical approval from the Istanbul Medipol University Non-Interventional Clinical Research Ethics Committee (approval no: 1130; date: 11.09.2025) and all participants provided written informed consent. Although the study included surgical procedures, all interventions were performed as part of routine clinical practice, and the study design was observational. Therefore, approval was obtained from a non-interventional clinical research ethics committee. Data on demographic variables, including age, parity, and mode of delivery, were obtained.

During the preoperative genital examination, labia minora morphology was classified into three types: Type I (hypertrophy confined to the introitus), type II (hypertrophy extending laterally toward the superior region of the clitoral prepuce), and type III (hypertrophy extending across the entire clitoral prepuce).⁷ Labial asymmetry was also recorded. Patients younger than 18 years and those without a history of sexual activity were excluded.

Participants were asked to specify their primary motivations for surgery, including functional complaints, aesthetic concerns, or symptoms associated with labial hypertrophy. At the preoperative planning stage, the wedge excision technique and any concomitant procedures, including labia majoraplasty or clitoral hood reduction, were documented. Wedge labiaplasty was planned with preservation of the free edge of the labia minora. A full-thickness wedge-shaped resection area was marked on the mid-portion of the labia minora using a sterile marking pen. The marked tissue was excised with cold scissors. After achieving hemostasis, layered closure was performed to reduce tension. The deep tissues and mucosal surface were closed using absorbable suture material. Interrupted sutures were placed using polyglytone monofilament sutures (Caprosyn®, 4-0/5-0, round needles). The procedure was completed after confirmation of symmetry and adequate tissue perfusion (Figure 1). Postoperatively, all patients were hospitalized overnight.

Following discharge, patients were prescribed oral antibiotics twice daily for one week and were instructed to cleanse the surgical area with an antiseptic solution three times daily for ten days. Representative photographs obtained preoperatively and at the 1-month postoperative follow-up in three patients are presented in Figures 2 and 3.

Clinical follow-up assessments were carried out at postoperative week 1, and at months 1 and 3. Resumption of sexual activity was permitted one month after surgery. Postoperative complications as well as any revision procedures were recorded during the follow-up period. Sexual function and genital self-perception were assessed using the female sexual function index [(FSFI), 19 items] and the female genital self-image scale [(FGSIS), 7 items], administered preoperatively and at three months postoperatively. Questionnaires were completed by the patients in private within a designated room.^{8,9} To reduce potential response bias, patients were asked to complete the questionnaires independently in a private environment.

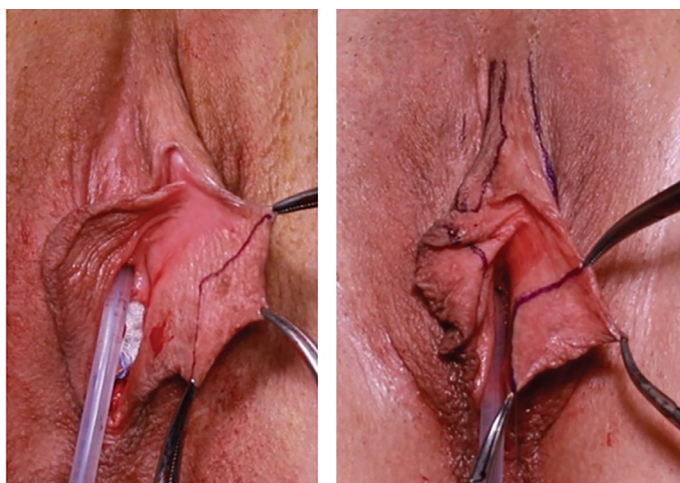


Figure 1. Intraoperative marks are made for wedge labiaplasty

Standardized Measures

Female sexual function was evaluated using the FSFI, a validated 19-item instrument assessing six domains: Desire, arousal, lubrication, orgasm, satisfaction, and pain. Total scores range from 2 to 36, with higher scores reflecting better sexual function. A score below 26.55 indicates the presence of sexual dysfunction.^{8,10}

Genital self-image was evaluated using the FGSIS, a validated 7-item instrument. Responses are rated on a 4-point Likert scale ranging from strongly agree to strongly disagree, producing total scores between 7 and 28, where higher scores represent a more positive genital self-image.^{7,9}

Statistical Analysis

Data were analyzed using IBM SPSS Statistics version 25 (IBM Corp., Armonk, NY, USA). Categorical variables were described as frequencies and percentages, and continuous variables were presented as mean $\pm$ standard deviation. The normality of data distribution was assessed using the Shapiro-Wilk test prior to the application of parametric tests. Paired-samples t-tests were used to compare preoperative and postoperative FSFI and FGSIS scores. Statistical significance was defined as $p < 0.05$.

A formal sample size calculation was not performed due to the exploratory nature of the study. However, all consecutive eligible patients within the study period were included, and the paired study design increased the statistical power to detect within-subject changes.

RESULTS

Patients had a mean age of 39 ± 5.2 years, with ages ranging from 28 to 54 years. Of the study population, 19 patients (35.2%) were smokers and 35 patients (64.8%) were non-smokers. According to the classification of labia minora morphology, type II was the



Figure 2. Preoperative and postoperative (1st month) photographs of patient



Figure 3. Preoperative and postoperative (1st month) photographs of patient

most common type in both labia, and labial asymmetry was observed in 26 patients (48.1%) (Table 1).

The surgical procedures had a mean duration of 98.8 ± 20.9 minutes, with operative times ranging from 60 to 150 minutes. Aesthetic concerns were reported by all patients, although 32 patients also described functional complaints as contributing factors in their decision to undergo surgery. In addition to wedge labia minoraplasty, labia majoraplasty was performed in 35 patients (64.8%), and hoodoplasty in 47 patients (87%) as adjunct procedures. In patients undergoing labia majoraplasty, hyaluronic acid injections were performed in 33 (61.1%), while lipid fillers were used in 2 (3.7%). The most commonly applied hoodoplasty technique was lateral hoodoplasty, which was performed in 39 patients (72.2%). Cold scissors or a scalpel was used for tissue resection in all patients.

Partial dehiscence was identified as the most frequent complication following wedge labia minoraplasty, affecting 9.3% of the patients. Postoperative local infections were treated with oral and topical antibiotics, and five patients who developed wound dehiscence underwent revision labiaplasty (Table 2). Postoperative wound dehiscence was observed only among patients who were active smokers. In the revision procedure, scar tissue at the dehiscence site was excised using cold scissors, with restoration of adequate vascularity in the surrounding tissue. Closure was performed using 5-0 polyglytone monofilament sutures. No recurrent dehiscence was observed on follow-up.

A statistically significant improvement was observed in the total FGSIS score, increasing from 10.6 ± 1.7 preoperatively to 25.9 ± 1.1 postoperatively ($p < 0.001$). The total FSFI score increased significantly from 16.6 ± 2.5 preoperatively to 27.4 ± 2.4 postoperatively ($p < 0.001$). Preoperative FSFI domain scores were 2.5 ± 0.6 for desire, 2.4 ± 0.4 for arousal, 2.4 ± 0.6 for lubrication, 2.5 ± 0.6 for orgasm, 2.3 ± 0.9 for satisfaction, and 4.5 ± 0.5 for

Table 1. Demographic data of patients

		Mean $\pm$ SD
Age		39 ± 5.2 (28-54)
Gravida		2.07 ± 1.06
Parity		1.88 ± 0.96 (0-5)
Smoking		19 (35.2%)
Left labium minor classification	Type 1	26 (48.1%)
	Type 2	24 (44.4%)
	Type 3	4 (7.4%)
Right labium minor classification	Type 1	25 (46.3%)
	Type 2	26 (48.1%)
	Type 3	3 (5.6%)
Presence of asymmetry	Present/observed	26 (48.1%)
	Absent/not observed	28 (51.9%)
SD: standard deviation		

pain. Postoperatively, domain scores improved to 4.8 ± 0.7 , 4.6 ± 0.7 , 4.5 ± 0.8 , 4.5 ± 0.7 , 5.4 ± 0.5 , and 3.6 ± 0.7 , respectively, demonstrating statistically significant improvements across all domains ($p < 0.001$) (Table 3). Before surgery, all patients had total FSFI scores below 27.2, while after surgery only 13 patients (24.7%) remained below this cut-off. In terms of FGSIS scores, 52 patients (96.2%) scored between 7-14, and 2 patients (3.8%) scored between 15-21 preoperatively. Postoperatively, no patients had scores within these ranges, and all patients (100%) scored between 22-28 points.

DISCUSSION

The heightened societal emphasis on female body image, coupled with aesthetic concerns and media influence, has contributed to the rising demand for cosmetic gynecologic procedures worldwide. The findings concerning the motivations and influencing factors of women seeking labiaplasty have

been corroborated by previous research. Aesthetic concerns emerged as the most prevalent motivating factor, followed by physical discomfort, diminished self-confidence, and critical remarks from sexual partners and peers.¹¹ Among these factors, aesthetic concerns (52.1%) and sexual dysfunction (46.5%) have been reported as the most prevalent indications.¹² In our study, all patients identified aesthetic concerns as their primary reason for pursuing labiaplasty. Previous studies have

demonstrated that dissatisfaction with genital appearance is the leading determinant for undergoing labiaplasty.⁵ Furthermore, it has been well established that labia minora hypertrophy adversely impacts patients in both functional and aesthetic domains. In our study, patients undergoing wedge labiaplasty demonstrated significant improvements in body image, along with increased satisfaction with genital appearance compared to the preoperative period.

Table 2. Surgical characteristics

		Mean $\pm$ SD	n (%)
Operation duration (min)		98.8 $\pm$ 20.9 (60-150)	
Reason for operation	Hypertrophy		27/54 (50%)
	Functional		32/54 (59.2%)
	Aesthetic concern		54/54 (100%)
Procedures performed	L. minoraplasty		54 (100%)
	L. majusplasty		35 (64.8%)
	Hoodoplasty		47 (87%)
L. majoraplasty technique	Hyaluronic acid		33 (94.3%)
	Lipid filler		2 (5.7%)
Hoodoplasty technique	Lateral hoodoplasty		39 (83.0%)
	Central hoodoplasty		4 (8.5%)
	Wedge hoodoplasty		4 (8.5%)
Suture material	4.0		9 (16.7%)
	5.0		45 (83.3%)
Energy modality used	Cautery		0 (0%)
	Cold		54 (100%)
Complications observed in wedge labium minoraplasty	Infection		0 (0%)
	Dehiscence (partial)		5 (9.3%)
	Dyspareunia		0 (0%)
	Contracture		0 (0%)
Revision operation	Yes		5 (9.3%)

Patients were allowed to report more than one reason for surgery; therefore, percentages may exceed 100%; SD: standard deviation

Table 3. Evaluation of FGSIS and FSFI scores before and after surgery

		Before surgery Mean $\pm$ SD	After surgery Mean $\pm$ SD	<i>p</i> *
FGSIS total score		10.6 $\pm$ 1.7	25.9 $\pm$ 1.1	<0.001
FSFI	Desire	2.5 $\pm$ 0.6	4.8 $\pm$ 0.7	<0.001
	Arousal	2.4 $\pm$ 0.4	4.6 $\pm$ 0.7	<0.001
	Lubrication	2.4 $\pm$ 0.6	4.5 $\pm$ 0.8	<0.001
	Orgasm	2.5 $\pm$ 0.6	4.5 $\pm$ 0.7	<0.001
	Satisfaction	2.3 $\pm$ 0.9	5.4 $\pm$ 0.5	<0.001
	Pain	4.5 $\pm$ 0.5	3.6 $\pm$ 0.7	<0.001
	FSFI total score	16.6 $\pm$ 2.5	27.4 $\pm$ 2.4	<0.001

FSFI: female sexual function index; FGSIS: female genital self-image scale; SD: standard deviation; *: Paired-samples t-test

The labia minora constitute essential anatomical structures that contribute not only to female sexual pleasure but also to the overall perception of the genital area. Women's perceptions of their genitalia have a considerable impact on their sexuality and overall sexual quality of life. Previous studies have shown a close relationship between body image and sexual satisfaction.^{13,14} In this study, assessment with the FGSIS demonstrated that participants had a negative genital self-image in the preoperative period. However, postoperative evaluations revealed a significant improvement in self-perception scores, indicating that surgical intervention exerts a positive impact on both body image and sexual well-being. Although the FSFI pain domain score decreased postoperatively, this finding should be interpreted cautiously, as higher scores indicate less pain. This may reflect variability in patient perception or early postoperative adaptation.

The wedge resection technique preserves anatomical integrity while maintaining the natural mucosal edge of the labia minora. An important advantage of this method lies in its potential to enhance both aesthetic and functional outcomes. Previous studies have shown that wedge resection procedures are associated with significant improvements in sexual function scores.^{12,15,16} Zahedi et al.¹⁷ reported that the selection of a labiaplasty technique should consider functional expectations as well as aesthetic concerns, and proposed that the wedge technique may have a higher potential to improve functional outcomes depending on the preservation of residual labial tissue. Another study emphasized that the wedge technique offers advantages in preserving labial tissue, which may play a key role in achieving long-term sexual and functional satisfaction.¹⁸ Accordingly, the preservation of a larger amount of labial tissue during wedge resection may represent an important determinant of more substantial improvements in sexual function. Overall, these data support the use of the wedge resection technique, particularly in relation to sexual function outcomes.¹² In this study, in accordance with the existing literature, we observed significant improvements in sexual function parameters following wedge resection.

Study Limitations

One of the potential limitations of the wedge technique is the risk of vascular compromise due to disruption of labial arterial supply, which may lead to wound dehiscence or, rarely, tissue necrosis. For this reason, some surgeons prefer the trim technique despite its potential aesthetic disadvantages. Various intraoperative strategies, such as careful tissue handling and preservation of vascular structures, may help minimize these risks. Future studies directly comparing wedge and trim

techniques may provide further insight into their relative safety profiles.

It is crucial that patients are comprehensively counseled regarding possible postoperative complications of labiaplasty, including scarring, infection, altered sensitivity (either hypersensitivity or reduced sensation), and wound dehiscence. The literature presents heterogeneous findings concerning the safety profile and complication rates of this procedure.^{11,19} In a retrospective study of 753 patients undergoing wedge labiaplasty, Köle et al.²⁰ reported 3 cases of local infection and 21 cases of partial wound dehiscence. In our study, no postoperative infections were observed in any of the patients. In a comparable study, minor dehiscence occurred in 3 of 131 patients, and none of these cases required reoperation.²¹ In our study, minimal wound dehiscence was observed in 5 patients, all of whom subsequently underwent successful revision surgery. Notably, wound dehiscence in our cohort was observed only among active smokers, suggesting a possible association between smoking and impaired wound healing. This finding is consistent with the known negative effects of smoking on tissue perfusion and postoperative healing, and should be considered during preoperative patient counseling.

With the increasing global demand for FGCS, evaluating patient-reported outcomes such as female genital self-image and female sexual function has become increasingly important.²² Our findings support the growing evidence that wedge labiaplasty may improve both aesthetic perception and psychosexual well-being in appropriately selected patients.

In our cohort, wedge labiaplasty was frequently performed in combination with adjunctive procedures. Therefore, the observed improvements in genital self-image and sexual function cannot be attributed solely to the wedge technique. The high rate of concomitant procedures should be taken into account when interpreting the results. Comprehensive preoperative counseling and individualized surgical planning remain essential to optimize outcomes.

The relatively short follow-up period of 3 months represents an important limitation, particularly for assessing long-term outcomes such as scar maturation, sensory changes, and sustained sexual function. Additionally, factors that may influence sexual function, such as psychological status, partner-related variables, and hormonal status, were not fully evaluated.

CONCLUSION

Wedge labiaplasty, frequently performed in combination with adjunctive procedures, appears to be a safe and effective surgical approach associated with significant improvements in genital self-image and female sexual function. However, given the high

rate of concomitant procedures, the specific contribution of the wedge technique alone should be interpreted with caution. Further studies with larger cohorts and longer follow-up are needed to better define the independent effects of each surgical component.

ETHICS

Ethics Committee Approval: The study received ethical approval from the İstanbul Medipol University Non-Interventional Clinical Research Ethics Committee (approval no: 1130; date: 11.09.2025).

Informed Consent: All participants provided written informed consent.

FOOTNOTES

Contributions

Surgical and Medical Practices: Y.C., Ö.Y.A., E.Ç., Concept: Y.C., E.Ç., Design: Y.C., Ö.Y.A., E.Ç., Data Collection or Processing: Y.C., Analysis or Interpretation: Ö.Y.A., B.Y., Literature Search: Y.C., Writing: Y.C., Ö.Y.A.

DISCLOSURES

Conflict of Interest: No conflict of interest was declared by the authors.

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