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The Cartagena Declaration on Labiaplasty: A Joint Position Statement on Patient Safety and Surgical Competence

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Pablo González-Isaza [1], Manuel Sánchez-Prieto [2, 3], Diana Vélez [4], Judit Alemany [5], Corina Hidalgo [6], Manuela Cerón [4], Juan José Escribano Tórtola [7], José María Togo [8], Gustavo Parra [9], Anibal Nieto Diaz [10], Rafael Sánchez-Borrego [11]

1. Department of Urogynecology, San Jorge University Hospital, Pereira, COL 2. Department of Obstetrics and Gynecology, Hospital Universitari General de Catalunya, Sant Cugat del Vallès, ESP 3. Department of Obstetrics and Gynecology, Instituto Universitario Dexeus, Barcelona, ESP 4. Department of Urogynecology, Soranus Center for Aesthetic and Functional Urogynecology, Pereira, COL 5. Department of Obstetrics and Gynecology, Bellvitge University Hospital, Barcelona, ESP 6. Department of Obstetrics and Gynecology, Centro Mundo Salud, Lima, PER 7. Department of Obstetrics and Gynecology, Hospital Universitario Severo Ochoa, Madrid, ESP 8. Department of Obstetrics and Gynecology, Central Médica Quirúrgica, Mazatlán, MEX 9. Department of Obstetrics and Gynecology, Centro de Especialistas Sancancio, Manizales, COL 10. Department of Obstetrics and Gynecology, Clinic Universitary La Arrixaca Hospital, Murcia, ESP 11. Department of Obstetrics and Gynecology, DIATROS (Diagnósticos y Tratamientos Avanzados), Clínica de Atención a la Mujer, Barcelona, ESP

Corresponding author: Manuel Sánchez-Prieto, msprieto17@gmail.com

Abstract

Patient safety in labiaplasty requires careful attention to patient selection, psychosocial assessment, informed consent, surgical competence, and longitudinal follow-up. This joint position statement develops a pragmatic framework for safer clinical practice informed by a structured narrative review of professional guidance and relevant clinical literature. The scope is labia minora reduction, with separate consideration of concomitant clitoral hood reduction because procedure-specific evidence and long-term sensory outcomes remain limited. Anatomical variation alone does not establish a surgical indication, and persistent symptoms require assessment for alternative vulvar, pelvic floor, or psychosexual causes. Published studies report high satisfaction, but the evidence is predominantly observational and does not establish comparative effectiveness, durable sexual benefit, a universally preferred surgical technique, or validated minimum procedural-volume requirements. Eight practice statements address patient selection, psychosocial assessment, informed consent, individualized surgical planning, procedure-specific competence, perioperative safety, complication management, and outcome assessment. Clitoral hood reduction should have a separately documented rationale, anatomical assessment, and consent process rather than being regarded as a routine component of labiaplasty. These recommendations represent evidence-informed clinical positions rather than validated standards of care and do not establish surgical effectiveness for any particular indication.

Categories: Plastic Surgery, Obstetrics/Gynecology
Keywords: body-dysmorphic disorder, female genital surgery, informed consent, labiaplasty, patient-reported outcome (pro), patient safety, professional competence, surgical training

Introduction And Background

This joint position statement is issued by the Asociación Colombiana de Ginecología Estética, Funcional y Regenerativa (AGEOC), the Regenerative Gynecology Group of the Spanish Menopause Society, and the Spanish Menopause Society's MenoYoung Group. It sets out their shared position on patient safety, training, and professional competencies in labiaplasty. Labiaplasty is requested for appearance-related concerns, physical symptoms, or both. For clarity, the labia minora are the paired inner folds of the vulva, while the clitoral hood is the tissue fold surrounding and protecting the clitoral glans. Appearance-related dissatisfaction with normal anatomy should be distinguished from persistent functional symptoms that warrant further clinical evaluation. The American College of Obstetricians and Gynecologists (ACOG) emphasizes uncertain effectiveness and the need for counseling, psychological assessment when indicated, and disclosure of surgical experience [1]. Canada's 2022 guideline concludes that inadequate evidence prevents support for female genital cosmetic procedures performed for nonmedical indications [2].

The International Federation of Gynecology and Obstetrics (FIGO) states that obstetrician-gynecologists should not recommend, perform, or refer for cosmetic genital surgery in women without structural or functional abnormalities [3]. These positions require clinicians to distinguish symptom-directed care from cosmetic alteration of normal anatomy. The present statement addresses patient selection, professional competence, and continuity of care, including care of patients presenting with complications. Informed consent and technical competence alone do not establish a surgical indication. Choosing not to operate remains an appropriate outcome. A broader clinical governance framework for regenerative, functional, and

aesthetic gynecology has recently emphasized patient selection, diagnostic accuracy, clinician competence, and procedure-related factors as interacting determinants of procedural safety [4]. Labiaplasty nevertheless raises procedure-specific questions concerning surgical indication, psychosexual context, irreversible tissue alteration, sensory outcomes, technical competence, and postoperative complications. These considerations support development of a focused safety framework rather than extrapolation from broader principles alone.

This statement focuses on labia minora reduction and the additional considerations required when concomitant clitoral hood reduction is contemplated. Vaginal tightening, labia majora augmentation, reconstruction after trauma or genital cutting, gender-affirming surgery, energy-based tissue treatments, injectables, and regenerative interventions are outside its scope. The aim was to synthesize the evidence relevant to patient selection, informed decision-making, surgical competence, perioperative safety, complication management, and outcome assessment, and to derive pragmatic practice recommendations without assuming surgical effectiveness for any particular indication.

Review

Statement development and evidence review

Representatives of AGEOC, the Regenerative Gynecology Group of the Spanish Menopause Society, and the Spanish Menopause Society's MenoYoung Group developed this joint position statement through iterative drafting and written review. The recommendations reflect the participating groups' clinical judgments informed by the reviewed evidence. The final text was approved by the designated representatives of the participating organizations and groups on November 3, 2026.

A structured narrative review was undertaken to inform the practice statements. PubMed/MEDLINE was searched from inception to October 30, 2026, supplemented by targeted searches of professional-society guidance and backward citation searching from key reviews. Search concepts included labiaplasty, female genital cosmetic surgery, indications, anatomy, patient selection, complications, sexual and sensory outcomes, body dysmorphic disorder, patient-reported outcomes, training, and surgical competence. Professional guidance, systematic reviews and meta-analyses, comparative and observational studies, anatomical and psychometric studies, and literature directly informing procedural safety or competence were prioritized.

Sources supporting the practice statements were critically reviewed for study design, population, procedures, outcome definitions, follow-up, methodological limitations, directness to labiaplasty, consistency, and clinical applicability. Evidence selection was relevance-based, and the synthesis narrative; no meta-analysis, formal risk-of-bias assessment, or certainty-grading framework was applied. No Delphi process, nominal-group technique, voting threshold, or other formal consensus method was used.

The recommendations were organized into eight domains: patient selection, psychosocial assessment, informed consent, individualized surgical planning, surgical competence, perioperative safety, complication management, and outcome assessment. The statements integrate direct evidence, professional guidance, and expert clinical judgment. Where direct labiaplasty-specific evidence was insufficient, recommendations were framed as pragmatic safety principles rather than evidence-based standards of care. They require prospective evaluation and should not be interpreted as a validated care pathway, training curriculum, or proof of surgical effectiveness.

Anatomical variation and patient selection

A review of labiaplasty indications found insufficient evidence to establish consistent selection criteria [5]. In a cross-sectional study of 657 White women aged 15 to 84 years, vulvar measurements varied with age and other characteristics [6]. These descriptive measurements cannot define disease or predict benefit from reduction and have limited generalizability across populations. The reviewed literature did not identify a validated labial measurement threshold that establishes a surgical indication. Labial dimensions alone should not determine eligibility for surgery.

Functional and cosmetic motivations may coexist. Documentation should preserve this overlap rather than relabel cosmetic concerns as functional to justify intervention. Persistent symptoms despite appropriate conservative treatment may warrant specialist assessment, but do not automatically establish operative benefit.

Statement 1

A request for labiaplasty should initiate an individualized assessment rather than establish an operative indication. Document the patient's concerns, symptom duration, functional impact, goals, and examination findings. Evaluate alternative causes of symptoms before attributing them to labial anatomy. Before recommending surgery, document the clinical rationale, anticipated benefit, relevant alternatives, and remaining uncertainty. Defer the operative decision when expected benefit cannot be reasonably supported, or relevant psychological or safeguarding concerns remain unresolved. For adolescents requesting surgery

solely for appearance-related concerns, elective surgery should generally be deferred until genital development is complete, with age-appropriate counseling, safeguarding, and assessment of physical and emotional maturity [7]. Persistent physical symptoms or congenital abnormalities require specialist assessment according to applicable clinical and legal requirements.

Psychosocial assessment and voluntary choice

Body image distress deserves clinical attention without assuming that every patient requesting surgery has a psychiatric disorder. The Genital Appearance Satisfaction (GAS) scale and Cosmetic Procedure Screening Scale for labiaplasty (COPS-L) were validated in women seeking labiaplasty; COPS-L differentiated participants with and without body dysmorphic disorder (BDD) [8]. A screening result may support clinical assessment but neither establishes a diagnosis nor replaces an individualized clinical interview.

Statement 2

Explore expectations, persistent preoccupation, repeated cosmetic procedures, depression or anxiety, sexual pain, and pressure from partners, social media, or clinicians. Use a validated instrument in an appropriate language where feasible and within its intended purpose. Suspected BDD or another clinically significant untreated condition that may materially affect expectations, voluntariness, informed decision-making, or the operative decision should prompt appropriate assessment before proceeding with surgery. Discuss coercion privately and address safeguarding concerns through suitable services. Do not frame surgery as treatment for BDD or promise that anatomical change will repair relationships, self-esteem, or sexual difficulties.

Consent and nonoperative alternatives

ACOG identifies pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia, and repeat surgery as relevant risks [1]. Canada's guideline places anatomical education and counseling at the center of care and does not support cosmetic intervention on the available evidence [2]. Consent should therefore communicate uncertainty as well as foreseeable technical complications.

Statement 3

Discuss observation, anatomical education, changes in clothing or activities that provoke friction, and treatment of any identified vulvar or pelvic floor disorder. Offer psychological or psychosexual care when relevant. Present these as legitimate options, without guaranteeing that reassurance or counseling will resolve distress. Discuss the surgeon’s experience and available audited outcomes, including the number of patients assessed and the completeness of follow-up. Where reliable practice-level outcome data are unavailable, disclose this limitation. Consent for clinical photography should be distinct from consent for treatment. Authorization to obtain and store images for the clinical record should not imply authorization for teaching, presentations, publication, or other secondary uses; each intended secondary use should require specific consent in accordance with applicable law and institutional policy.

What the outcome evidence supports

A 2024 meta-analysis identified 86 eligible studies, of which 53 contributed quantitative data, and reported pooled satisfaction of 94% (95% confidence interval, 93% to 95%) [9]. Complication estimates varied by technique; for wedge resection, pooled wound dehiscence was 8% (95% confidence interval, 5% to 13%) [9]. These estimates describe selected study populations and should not be interpreted as individualized risk predictions or evidence of superiority over nonoperative care. Differences in patient selection, concomitant procedures, outcome definitions, and follow-up limit comparisons. Technique-level subgroup findings should not be treated as randomized comparisons.

A 2026 systematic review of sexual function included 11 studies involving 671 participants; seven studies were rated weak, four moderate, and none strong [10]. Another 2026 meta-analysis found postoperative improvement in predominantly uncontrolled cohorts but judged certainty low because of study design and bias [11]. Their findings may reflect overlapping primary evidence and should not be counted as independent confirmation. Before-and-after changes cannot separate treatment effects from expectations, concurrent care, or selective follow-up. Neither review justifies promising sexual enhancement.

The clinically useful conclusion is that favorable reported experiences coexist with substantial uncertainty. Satisfaction, symptom relief, genital self-image, sensation, and sexual function are different outcomes. A patient can be satisfied with appearance while experiencing persistent pain or altered sensation. Consent and audit should preserve these distinctions rather than compress them into a single success rate.

Individualized surgical planning and concomitant procedures

Technical safety literature emphasizes vulvar anatomy, preservation of tissue and neurovascular structures, anesthesia, positioning, and perioperative risk assessment [12]. Edge and wedge resections have different

implications for contour, blood supply, tissue tension, and the free labial margin [5,9]. Understanding these differences is necessary for selection and referral; current evidence does not establish one technique as universally preferable. Individualized technique selection based on labial anatomy and patient expectations is also emphasized in a recent narrative review [13]. Evidence specific to concomitant clitoral hood reduction remains limited and is predominantly observational. In a prospective study of 37 women undergoing combined labia minora and clitoral hood reduction, standardized sensory testing did not demonstrate diminished clitoral-hood sensitivity during follow-up, but the study lacked both a nonsurgical control group and a labiaplasty-only comparator [14]. More recent evidence syntheses include procedures performed with and without clitoral hood reduction, limiting procedure-specific inference [11]. Accordingly, outcomes after isolated labiaplasty should not automatically be extrapolated to combined procedures.

Statement 4

Individualize the surgical plan according to labial anatomy, patient goals, and demonstrated procedural competence. Any concomitant clitoral hood reduction should have a separately documented rationale, anatomical assessment, and consent discussion addressing the additional tissue alteration and uncertainty regarding procedure-specific sensory outcomes. It should not be treated as a routine component of labiaplasty.

Procedure-specific competencies and supervised training

Training evidence is limited. A nonvalidated US survey obtained 96 resident responses, of whom 87.5% disagreed that they felt comfortable performing the included cosmetic gynecologic procedures independently [15]. These findings concern a heterogeneous group of procedures and self-reported confidence, not measured labiaplasty competence. They cannot establish national skill levels, specialty comparisons, or the effect of training on complication rates.

Statement 5

Independent practice should depend on documented, procedure-specific competence and applicable local credentialing. Training should progress from observation to supervised operating, with assessment against predefined criteria covering planning, tissue handling, hemostasis, closure, postoperative decisions, and recognition of personal limitations. Feedback and further supervised practice should address identified deficiencies. A specialty title, course attendance, or case count alone should not establish readiness. The reviewed literature did not identify a validated minimum case threshold or a requirement to master a specified number of techniques. Surgeons should understand alternative approaches and refer patients when clinical needs exceed their competence.

Table *1* summarizes the recommended assessment domains.

Domain	Recommended capability	Potential assessment
Assessment and selection	Relate symptoms to examination; consider other diagnoses, body image, and voluntary choice [1-3,5-8].	Observed consultation and review of documented decisions, including decisions not to operate.
Consent	Explain uncertainty, alternatives, tissue loss, sensory risks, and each planned procedure [1,2,12,14].	Observed consent discussion and record audit.
Anatomy and planning	Identify labial and clitoral structures and choose an approach within personal competence [5,9,12-14].	Structured case discussion and documented assessment of operative planning by an experienced supervisor.
Operative and perioperative care	Preserve appropriate tissue and perfusion; achieve hemostasis and suitable closure; assess anesthesia and positioning risks [9,12,13].	Direct observation using predefined performance criteria, documented feedback, and reassessment when further training is needed.
Complications and referral	Recognize bleeding, wound problems, tissue compromise, persistent pain, and limits of local care [1,9,12].	Scenario assessment and review of escalation and referral arrangements.
Outcomes and accountability	Record symptoms, patient-reported outcomes, adverse events, revisions, and incomplete follow-up [8,9,16-18].	Review of a consecutive case log and outcome audit.

TABLE 1: Proposed competency domains for procedure-specific assessment in labiaplasty

These domains are pragmatic recommendations of the participating groups and have not been validated as a competency assessment instrument, curriculum, or licensing standard.

Perioperative assessment and safety

Statement 6

Preoperative assessment should address relevant comorbidities, medications affecting hemostasis, tobacco use, factors affecting wound healing, and anesthesia-related risks. Modifiable risks should be addressed before elective surgery. Venous thromboembolism risk assessment and prophylaxis should follow applicable perioperative guidance and be individualized to patient and procedural risk. The planned procedure, postoperative monitoring, and access to emergency care should be appropriate to the patient's risk profile and clinical setting.

Complication management and referral

Wound separation, bleeding, hematoma, infection, contour problems, persistent pain, and sensory symptoms require explicit aftercare planning [1,9,12]. Published complication estimates depend on surveillance and definitions. The available evidence does not establish that complication rates are increasing, and procedure volumes or adverse-event anecdotes cannot demonstrate a trend.

Statement 7

Establish an accessible postoperative contact route, planned early review, and pathways for urgent assessment and transfer before surgery is undertaken. Expanding hematoma, ongoing bleeding, systemic illness, threatened tissue viability, or urinary difficulty warrants prompt clinical assessment. Provide written recovery advice and individualized guidance regarding activity and sexual contact. Document complications transparently and manage them within the clinician's competence, with timely referral when required.

Persistent pain, suspected nerve injury, substantial tissue loss, or complex dissatisfaction may require multidisciplinary review involving vulvar specialists, reconstructive surgeons, pelvic floor clinicians, and psychosexual services. Distinguish urgent treatment from elective revision. Avoid offering further excision as the default response to dissatisfaction; reassess diagnosis, anatomy, expectations, and psychological factors before additional intervention.

Outcome assessment and service accountability

Clavien-Dindo grading categorizes surgical complications by the treatment required [16]. It can support consistent reporting, but does not fully capture sensory change, sexual pain, or dissatisfaction. A systematic review of patient-reported measures found limited procedure-specific validation and important measurement gaps [17]. GAS captures genital appearance dissatisfaction and its impact; COPS-L screens for dysmorphic concerns and should not be substituted for an outcome measure of surgical benefit [8,17].

A Spanish adaptation of GAS (GAS-S), evaluated in 200 women attending gynecologic consultations, provides a culturally adapted option for assessing genital appearance dissatisfaction [18]. Validation in that setting does not establish responsiveness after labiaplasty or the ability to predict surgical benefit. Its suitability for other Spanish-speaking populations and for longitudinal surgical assessment requires consideration of the population and purpose of use.

Statement 8

Collect baseline symptoms, including pain, dyspareunia, and pre-existing sensory symptoms, together with patient-defined goals, indication category, relevant comorbidity, operative technique, and concomitant procedures. Record complications, unplanned contacts, revisions, and referrals with explicit denominators. Assess appearance concerns and functional outcomes separately, including pain and sensation. Use suitable validated instruments with attention to language, population, and intended purpose. Follow-up should include early recovery, an intermediate assessment at approximately three to six months, assessment at 12 months, and longer-term evaluation where feasible. These intervals are pragmatic recommendations rather than validated standards. Report loss to follow-up and missing outcomes.

Research priorities

Prospective registries should capture consecutive procedures, indications, concomitant interventions, complications, revisions, patient-reported outcomes, sensory outcomes, and missing data. Where feasible, prospective cohorts of patients choosing nonoperative care should use comparable baseline and follow-up measures while accounting for treatment-selection differences. Priority areas include prospectively defined functional indications, standardized assessment of pain and sensation, long-term outcomes, comparative evaluation of surgical approaches, and reproducible assessment of procedure-specific competence.

Summary of the Cartagena Declaration

Table *2* summarizes the eight statements of the Cartagena Declaration.

Statement	Domain	Summary recommendation
1	Patient selection	Establish an individualized clinical rationale, evaluate alternative causes of symptoms, and defer surgery when anticipated benefit or readiness is insufficient [1-3,5-7].
2	Psychosocial assessment	Assess expectations, psychological concerns, and coercion; arrange specialist assessment when indicated [1,2,8].
3	Informed consent	Discuss nonoperative options, uncertain benefits, irreversible tissue changes, procedure-specific risks, and recovery [1,2,12].
4	Surgical planning	Individualize the operative plan and separately assess and obtain consent for concomitant clitoral hood reduction, including uncertainty regarding procedure-specific sensory outcomes [5,9,11-14].
5	Surgical competence	Require documented, procedure-specific competence supported by supervised practice and structured assessment [4,12,15].
6	Perioperative safety	Assess and address relevant medical, medication, wound-healing, anesthesia, and thromboembolism risks [12,13].
7	Complications and referral	Establish accessible aftercare, timely assessment, complication management, and referral pathways [1,9,12].
8	Outcomes and accountability	Record baseline and longitudinal outcomes, complications, revisions, referrals, and missing data; assess appearance and functional outcomes separately [8-11,16-18].

TABLE 2: Eight practice statements of the Cartagena Declaration on Labiaplasty

These summaries provide an overview of the joint recommendations. The complete statements, including their qualifications and considerations for adolescents, are presented in the corresponding sections.

Limitations and applicability

This review has several limitations. Although a structured literature search informed the recommendations, the review was designed as a narrative evidence synthesis rather than a systematic review. Evidence selection was relevance-based, and no formal risk-of-bias instrument or certainty-grading framework was applied. No formal consensus technique was used to derive the practice statements. The underlying

literature is heterogeneous and predominantly observational, with limited controlled comparative evidence, inconsistent outcome definitions, and incomplete long-term follow-up. Some recommendations therefore rely partly on professional guidance and expert clinical judgment where direct labiaplasty-specific evidence is insufficient. The statements have not been validated as a care pathway or competency framework and should be interpreted according to applicable legal, professional, and institutional requirements.

Conclusions

Current evidence does not establish a universal anatomical indication for labiaplasty, a preferred surgical technique, or a validated minimum threshold for independent practice. A safety-oriented approach should instead combine individualized clinical indication, assessment of psychological and functional factors, voluntary informed decision-making, procedure-specific competence, structured aftercare, and longitudinal assessment of functional and patient-reported outcomes.

Concomitant clitoral hood reduction should be assessed and consented separately rather than regarded as a routine extension of labiaplasty. The eight practice statements proposed here are evidence-informed recommendations rather than validated standards of care and require prospective evaluation and periodic reassessment as the evidence base develops.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Manuel Sánchez-Prieto, Pablo González-Isaza, Anibal Nieto Diaz, Rafael Sánchez-Borrego

Acquisition, analysis, or interpretation of data: Manuel Sánchez-Prieto, Pablo González-Isaza, Diana Vélez, Judit Alemany, Corina Hidalgo, Manuela Cerón, Juan José Escribano Tórtola, José María Togo, Gustavo Parra, Anibal Nieto Diaz, Rafael Sánchez-Borrego

Drafting of the manuscript: Manuel Sánchez-Prieto, Judit Alemany

Critical review of the manuscript for important intellectual content: Manuel Sánchez-Prieto, Pablo González-Isaza, Diana Vélez, Judit Alemany, Corina Hidalgo, Manuela Cerón, Juan José Escribano Tórtola, José María Togo, Gustavo Parra, Anibal Nieto Diaz, Rafael Sánchez-Borrego

Supervision: Rafael Sánchez-Borrego

Disclosures

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