**Mr Michael Cadier**

**BA MA (Oxon) MBBS (London) MS (Soton), FRCSEd, FRCS (Plast) President of BAAPS 2014-2016**

**Consultant in Plastic, Reconstructive & Aesthetic Surgery**

**LABIOPLASTY**

Labioplasty is an operation designed to correct labial excess within the external female genitalia. In most patients, this is as a result of labia minora excess. This may cause embarrassment or result in functional disturbance by causing pain during normal sexual activities, or embarrassment when the labias protrude through underwear or bikinis. In some patients, the labia majoras may be excessively large, and in others, the clitoris may be covered by an overly large hood.

**What types of surgical procedures are available?**

In most cases, labioplasty surgery involves the reduction of the overly large part of the labia minoras with the aim being to normalize the size, whilst avoiding conspicuous scars or scars that may interfere with normal sexual function. There are many different surgical techniques for correction. Simply trimming the excess has been performed, but this results in abnormal looking labias and most consider this an unsatisfactory technique. A form of wedge resection is used by Mr Cadier. This has the advantage in maintaining the normal appearance and pigmentation of the labias, and scars that are very inconspicuous. For labia majora excess resection of an ellipse of hair bearing skin is performed. The surgery can be undertaken either under local or general anaesthetic.

**Pre-operative advice.**

In order to optimize the result and minimize the risks a number of factors should be considered. Smokers have a much higher risk of developing complications. It is therefore advised that they should refrain from smoking for ideally four weeks prior to, and four weeks following surgery. Aspirin and related anti-inflammatories (other than those prescribed during the admission) should be avoided for one week before and 48 hours after surgery as these can significantly increase the risk of bleeding. Many supplements (gingko, ginger, turmeric, garlic) have anti-coagulant effects and therefore can increase the risk of bleeding and bruising and should be discontinued for a similar time period. The use of arnica is debatable with no clear evidence to support either its use or its avoidance.

It is recommended that patients on the combined oral contraceptive, and hormone replacement therapy, should stop these for four weeks prior to, and four weeks after surgery, as they may be associated with an increased risk of deep vein thrombosis (DVT). For patients on the pill alternative forms of contraception should be used.

Patients who are overweight also have a higher risk of complications. If patients are dieting, they should aim to get to their desired weight pre-operatively. Mr Cadier and his team have the policy that such surgery will only be offered to patients with a Body Mass Index (BMI) of less than 36. The BMI is calculated from the weight and height, and there are many simple tools available on the internet to help perform this calculation. Patients with a BMI of 36 or over have much higher risks both from the surgery and the anaesthetic and the risks therefore potentially outweigh the benefits.

**What happens before the operation?**

At the initial consultation with Mr Cadier after discussing regarding the specific concerns a full medical and surgical history will be obtained. As part of the consultation a psychological assessment is made to ensure that it is appropriate to undertake the surgery, and on occasions the completion of a psychological questionnaire may be required. In all cases Mr Cadier will write to the GP to request a past medical history. Patients may refuse this but need to be aware they are exposing themselves to more risks should they omit or forget some relevant past medical history. Also, in the post-operative period should there be any problems it is important that the GP is aware what has been undertaken in order to be able to offer effective help and advice. At the consultation details regarding the operation, the aims, the limitations, the recovery and the risks will be discussed. Before the operation you will usually attend for a pre-operative nurse led assessment. You may require a blood test. Any significant health problems not previously identified may be discussed with Mr Cadier or the anaesthetist, and a further assessment may be required to determine suitability for the procedure.

On admission, you will again be assessed by the nurses and you will be measured for a pair of compression stockings. These are worn to reduce the risk of thrombosis formation and should be worn for a minimum of 2 weeks postoperatively. If under general anaesthetic (most cases), you will be seen by the anaesthetist prior to surgery and be able to discuss issues pertaining to the anaesthetic and also pain relief in the immediate post-operative period. You will also see Mr Cadier who may make some pre-operative markings and will take photographs for the medical records.

**The operative procedure**

The operation takes 45-60 minutes and is undertaken either under a local or a general anaesthetic. Patients are positioned with the feet in cradles (as per childbirth). The labias are reduced and repaired using a multilayered sutural technique with, in the case of the labia minoras, the scar being concealed. When the labia minoras alone are treated, this is termed a standard labioplasty, and when the labia majoras are also treated, this is termed an extended labioplasty. In most cases, the surgery is performed as a day case procedure.

**What to expect immediately after the operation**

Your blood pressure and pulse will be taken regularly following your return to the ward. Following a general anaesthetic you may have an intravenous infusion (a drip), which is usually removed once you are able to tolerate diet and fluids comfortably. If you experience any pain or discomfort following surgery, painkillers are given either by injection or as tablets. A sanitary pad will be applied to the area that has been operated on as well as some antibiotic ointment. This will usually need to be re-applied several times a day for 5 days.

**What to expect after discharge**

Some swelling and bruising is inevitable, but this will usually resolve within 1 - 2 weeks. All the sutures are self-dissolving. Pain and discomfort is not normally very significant and simple pain relief is all that is usually required.

**Washing**

Patients are advised to avoid baths for about 10 days postoperatively and should shower instead, drying the area by dabbing, rather than wiping.

**Restrictions and Activities**

Driving is not recommended for 4 - 5 days. Sports and sexual activities should be avoided for 4 weeks. The time required off work depends on the nature of your work and the degree of swelling, but usually a few days off will be sufficient.

**You are advised to refrain from flying for 4 weeks before surgery and for at least four weeks postoperatively. Please discuss any travel plans you may have around the time of surgery with Mr Cadier before proceeding with the booking.**

**Follow up Appointments**

Patients will be reviewed for a wound check by the nursing staff in the Outpatient Department once or twice in the first fortnight following surgery. Patients will be reviewed by Mr Cadier at a minimum of 1 – 2 months and five months postoperatively in the outpatients. Appointments for the wound checks and suture removal will be given prior to discharge and appointments to see Mr Cadier in Outpatients will be sent via the post.

**Risks and Complications**

As with all surgical procedures complications may occur. Early identification and prompt is important and should patients have any cause for concern they should either contact the hospital or Mr Cadiers’ Secretary. Potential risks include:

* Bleeding.
* Infection.
* Wound breakdown.
* Asymmetry.
* Loss of sensation.
* Deep vein thrombosis and life-threatening pulmonary embolism
* Anaesthetic complications – these will be discussed with you by the anaesthetist before surgery.
* Death

A small amount of bleeding is inevitable, but should it be marked, treatment may be required. Infections may occur and may necessitate antibiotic therapy. Wound breakdown is unusual but may follow an infection. Should this happen, a notch or even a small hole in the labia minora can result. This will require a revisional procedure. Although all attempts are made to achieve a nicely balanced result, occasionally a degree of asymmetry results that may necessitate a minor revisional procedure. Patients do need to be realistic as there will inevitably be some differences between the sides – this is normal.

Following any surgery there is a risk in developing a deep vein thrombosis (DVT). This is a clot in the calf vein of the leg. In itself it may result in pain and swelling. The risk is that should the clot separate from the vein it can move to the lungs resulting in a pulmonary embolism. This is a potentially life-threatening situation. All attempts are made to reduce the risk using compression stockings during and for two weeks after surgery, using pneumatic compression devices on the legs at surgery and in the immediate post-operative period, by encouraging early mobilization, advising patients to stop the combined oral contraceptive pill or Hormone Replacement Therapy (HRT) four weeks prior to surgery, and where it is felt appropriate using injections of blood thinning agents. All surgical and anaesthetic procedures have risks, and some are life threatening, these include pulmonary embolism, anaphylaxis (severe allergic response to a medication) and adverse drug reactions. Death however remains an extremely rare complication.

Risks and complications will be discussed, and all efforts made to minimize any risks. Patient safety is always our first concern. When complications do occur, all attempts are made not only to remedy the problem in as speedy a manner as possible but also to optimise the final result. As with all cosmetic surgical procedures undertaken by Mr Cadier, there is a fixed fee policy, which means that no further charges are incurred for the treatment of complications that are identified within 6 months following the initial surgery. Revisional policies for aesthetic concerns have changed and, in most cases, additional fees will be incurred. Patients need to be aware regarding the limitations of surgery and have very realistic expectations about outcomes.

Labioplasty surgery is associated with high patient satisfaction and will usually fully correct the functional problems and aesthetic concerns.

**Contact details:**

**Private Office:**

Address: 36 Batten Road, Downton, Salisbury, SP5 3HU

PA: **Nicola Haicalis**

Ph: **01725 511 550**

Email: **theoffice@michaelcadier.com**

Website : **www.michaelcadier.com**

**Hospitals : Nuffield Bournemouth**,67 Lansdowne Rd, Bournemouth Dorset, BH1 1RW.

 Tel: 01202 291866

**About your Surgeon:**

Michael Cadier was educated at the French Lycée in London, studied at Oxford University and undertook Medicine at St Thomas’ Hospital, London. After training in London, Salisbury and Bristol he became an NHS Consultant in the Supra-regional Plastic Surgery Unit in Salisbury in 1996, becoming Head of this Service in 1999. In his NHS practice he developed a breast reconstruction service in Portsmouth, and in 2000 was appointed as cleft surgeon to the newly established Spires Cleft Centre, for which he also became the first Clinical Director in 2002. He undertook yearly cleft lip and palate Charity missions in rural Pakistan from 1996 to 2009. He has a busy aesthetic surgery private practice along the South Coast, undertaking the full range of aesthetic surgery procedures. He has performed over a thousand facelifts, and over 1500 breast augmentations, with similar numbers for all of the more common aesthetic procedures. In 2015 he became fully private, concentrating solely on aesthetic surgical practice.

He is widely published and lectures and teaches on aesthetic surgery both nationally and internationally. In 2006 he was invited to become an examiner for the FRCS (Plast). He is the Program Director for the South Coast Reconstructive Cosmetic Surgery Fellowship, was part of the first UK delegation in the CEN in cosmetic surgery (European regulation) and chaired the CSIC Royal College committee on Clinical Quality and Outcomes in Cosmetic Surgery.

The British Association of Aesthetic Surgeons (BAAPS) is the leading organization for aesthetic surgery in the UK. He was elected to BAAPS Council in 2006 and was President of BAAPS from 2014 to 2016. One of his key objectives is to ensure that UK plastic surgeons of the future will practice aesthetic surgery to the highest possible standard and with that aim he has helped establish a comprehensive national training program in aesthetic surgery.