Commentary on: Postoperative Clitoral Hood Deformity After Labiaplasty

John G. Hunter, MD, MMM

Case reports usually do not merit commentary, but the primary topic raised by Hamori in this publication—namely, the consequences of failure to appreciate and appropriately address clitoral hood skin redundancy at the time of labia minora reduction—indeed warrants discussion. As labiaplasty has grown in popularity, the frequency of postoperative clitoral hood “deformity” complaints has, in my opinion, also increased. In my revision experience, clitoral hood skin redundancy is the most common reason women seek corrective surgery after labia minora reduction. Reporting 2 revision cases, Hamori highlights this often overlooked problem. Greater awareness is important as more surgeons who may be inexperienced in female genital cosmetic surgery increasingly market and perform labiaplasty procedures.

Labia minora reduction is viewed as a simple procedure by many plastic surgeons and gynecologists. In some cases, it is. Unfortunately, many women possess complex genital anatomic variations, including labia majora redundancy, mons pubis ptosis, excess labial tissue posterior to the introitus, and clitoral hood skin excess. These women often require more nuanced procedures to effectively achieve desirable, natural outcomes. Simply reducing the labia minora alone in women with complicated anatomic issues, regardless of the labia reduction technique employed, may result in an unnatural, imbalanced appearance of the external genitalia. A prominent clitoral hood, appearing proportional to large labia before minora reduction, will often appear larger and more noticeable to the patient after the minora have been reduced. Imbalance is further exacerbated if the labia minora are overreduced. Unfortunately, the result may be an unhappy, dissatisfied patient with a heightened sense of genital “deformity.”

Failure to address clitoral hood redundancy at the time of labiaplasty is, in my opinion, the consequence of inadequate preoperative evaluation, lack of awareness of treatment options, or concern about injuring the clitoris. The potential negative consequences for the novice operating in the vicinity of the glans clitoris, I believe, leads some surgeons to consciously choose not to address clearly evident clitoral hood skin redundancy.

Clitoral hood skin excess or redundancy may occur in the horizontal or vertical dimension, or in both. Horizontal redundancy, usually manifesting as lateral clitoral hood folds, is more often problematic to the patient than vertical hood redundancy. Accurate assessment of the dimension(s) of redundancy is important, since the surgical approaches required to treat them differ. Horizontal excess is addressed by lateral, vertically oriented skin excision, usually bilaterally, along the length of the clitoral hood and parallel to the labia majora–clitoral hood sulci. The excision can be done as an anterior extension of central wedge resections or by direct excision not in continuity with edge resection incision lines. Either works well. Vertical excess is corrected by transversely oriented excision. This is usually done, as Hamori describes, via an inverted “V” excision, cephalic to the free margin of the clitoral hood. When redundancies in both dimensions are present, both techniques should be employed to achieve an optimal result. The depth of excision must be superficial. I agree with Hamori that horizontal skin resection should be conservative. Resection should not expose the clitoral glans if it is covered or further expose a partially covered glans. Clitoral glans exposure is to be avoided, as the resulting sensory consequences are unpredictable and may be undesirable and permanent.

Overresection of the labia minora, which can more easily occur with labial edge excision than central wedge techniques, will indeed worsen the aesthetic “deformity” in women who have clitoral hood skin redundancy. This is apparent in Hamori’s 2 cases (Figures 4A and 5A). I mildly disagree with Hamori’s assertion that wedge techniques are inherently better than edge excision for treating the prominent clitoral hood. Central wedge resection of the labia minora, as classically described, and edge excision are both effective labia minora reduction techniques. Both, however, require addition or modification to satisfactorily address clitoral hood redundancy. Alter acknowledged this limitation of the central wedge technique.

Dr Hunter is an Associate Attending Surgeon, Division of Plastic Surgery, New York Presbyterian Hospital, Weill Cornell Campus, New York, New York, and Vice Chairman, Department of Surgery, New York Methodist Hospital, Brooklyn, New York.

Corresponding Author:
Dr John G. Hunter, 47 East 63rd Street, New York, NY 10065, USA. Email: Jgh2001@nyp.org
and subsequently described an “extended” wedge modification of his original wedge procedure to treat the clitoral hood.

Dr Hamori is to be commended for bringing needed attention to clitoral hood skin redundancy, which, when present, should be addressed during labiaplasty to achieve natural-appearing, desirable aesthetic results.

Disclosures

The author declared no potential conflicts of interest with respect to the research, authorship, and publication of this article.

REFERENCES