In their Letter to the Editor, Drs Davison and LaBove pose an interesting question regarding the optimal scar placement for monsplasty and advocate that vertical pull on the mons elongates the pubic area by raising the hairline. While in many massive weight loss patients, the mons region can have both vertical and horizontal excess, the vertical component is easy to manage, as long as the scar is based 6 cm above the anterior vulvar commissure. We agree that if this scar is placed too high, the surgeon risks raising the hairline and giving the mons an elongated look. The horizontal excess is managed by “cheating” it out along the length of the abdominal scar. While this can sometimes lead to some initial pleating, we have found that this settles over time. An alternative technique is to place lateral mons incisions, which frame the mons region and assist in removing some of the horizontal excess. However, in our experience, this technique can lead to increased edema of the entire mons region.

The authors of “Going in the Wrong Direction With Monsplasty” advocate a vertical scar, extending from the standard abdominal scar down to the clitoral hood. Most surgeons, ourselves included, would not advocate making an incision close to the clitoris. Although these authors claim subjectively to have found no problems with sensation related to such an incision, it has the potential to cause permanent or even transient neuropraxia to the clitoris.

The authors provide a clinical example of a patient who was treated with mons liposuction and a high incision. Liposuction of this fibrous tissue is often difficult and can provide unpredictable results. Placing the scar 6 cm above the anterior vulvar commissure and directly excising the fat in the mons with resuspension allows for a predictable flattening of the region.

Their letter does go in the “wrong direction” by advocating a technique that increases scarring and the chance of a nerve problem with the clitoris, a dog-ear at the clitoral hood that could lead to difficult revisions, or a T-point wound. In addition, a fleur-de-lis abdominoplasty subjects the patient to a cruciate scar with a tenuous 4-corner incision. The authors state that they have treated several patients with this technique with successful results, but we look forward to a full evidence-based article that includes objective patient satisfaction data and photos of other patients who have undergone procedures using this technique.

Disclosures

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