Clinics in Surgery

Case Report
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The Extended Clitoral-U Suspension and Unhooding

Steven P Davison, Kylie D Hayes and Gabrielle LaBove*

Department of Plastic Surgery, Georgetown University Hospital, USA

Abstract

Labiaplasty with clitoral unhooding is becoming a more common procedure. The authors discuss the extended clitoral-U suspension, and unhooding technique to address both the labia minora excess and clitoral hooding of the patient.

Introduction

As labiaplasty has become more main stream the labia minora reduction procedure has changed from discussing the amputation technique versus the wedge technique to a more tailored approach to each patient.

One of the a la carte additions to labia minora reduction has been the clitoral hood reduction. This has been particularly successful as it addresses the visible tissue show of the clitoral prepuce in the anterior labial commissure, a major concern for the patient [1]. Patients with significant clitoral hooding often present with frustration with the forward standing view presentation of their labia and clitoral hood in which three arches and two folds appear (Figure 1).

Case Presentation

Current techniques

Two main surgical techniques have addressed the clitoral unhooding. The first described by Gary Alter removes a horizontal central cleft of tissue midshaft on the clitoral hood [2]. The next technique, most effectively communicated by Hamori, reduces the overhang just dorsal to the clitoral hood [3]. Neither of the techniques observes the time-aged plastic surgery trick of hiding incisions at subunit transitions.

Technical Detail

We suggest that placing the suture line at the vaginal cleft rim and resecting the proximal one-third to one-half of the hood has considerable advantages. The clitoris can be suspended to the suspensory ligament of the pelvis with complete safety as the clitoral shaft originates from below the bone and the pudendal nerve branches are lateral to the tissue itself. The stitch is placed in the deep dermis of the resected hood without piercing the clitoral proper. The resection of tissue can be carried distally towards the base of the labia minora wedge incision as an extended U-shaped excision (Figure 2 and 3). This shortens the skin height from the minora/majora sulcus and reduces excess folds in the frenula of each side of the prepuce. The final incision line is placed in the minora sulcus extending all the way around to the anterior clitoral prepuce (Figure 4 and 5). As much as 1½ cm of skin can be excised and with it annoying hair follicles which were located on the hood. While the extended U technique has a longer incision than other clitoral unhooding techniques it is unperceivable at three months post-op due to the utilization of subunit transitions. The anterior

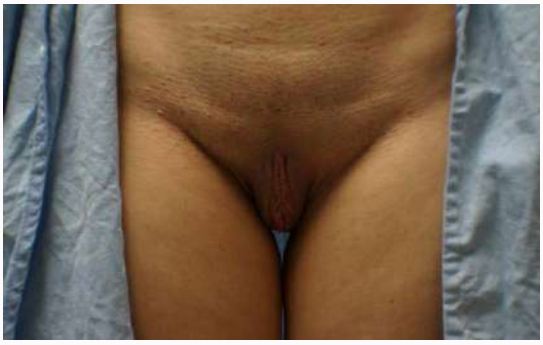

Figure 1: Standing view of patient A, a 39-year-old female with clitoral hood and labia minora excess.

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Correspondence:
Steven P Davison, Department of Plastic Surgery, Georgetown University Hospital, USA,
E-mail: davisonplastic@yahoo.com

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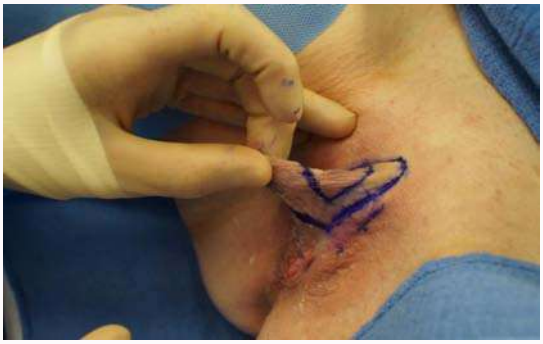

Figure 2: Markings for the extended clitoral-U labiaplasty on patient B, a 58-year-old female.

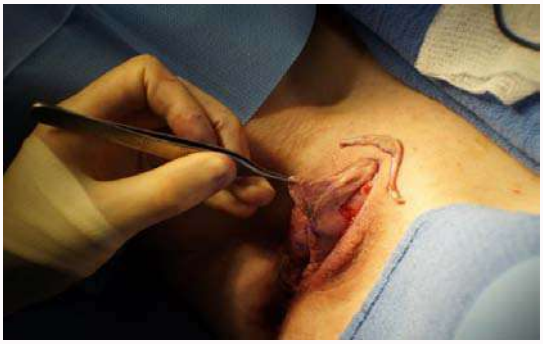

Figure 3: Intra operative photo of extended U-excision on patient B.

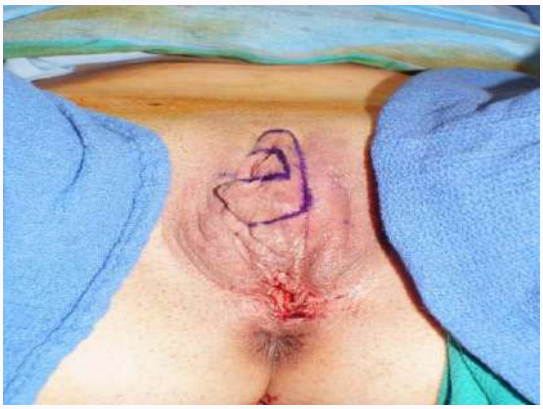

Figure 4: Markings for the extended clitoral-U with labiaplasty on patient A.

Figure 5: Intra operative photo of extended U-excision on patient A.

Figure 6: Pre-operative photo of patient A, taken the same day of surgery.

Figure 7: Three-month post-operative photo of patient A, demonstrating well-healed extended-U clitoral hood reduction incision.

displacement of the entire hood may require a modification to the wedge technique. In the extended central wedge, the anterior corner of the wedge is inset to the posterior corner with no tension; however, if the clitoral hood is pulled forward using the extended U technique a wider gap exists. To compensate, the posterior incision of the wedge is folded anteriorly at a T-junction closure. The T-junction eliminates all tension, maintains the closure in the sulcus, and secondarily shortens the height of the labia minora, which is often the patient's presenting complaint. No more than 1 cm of T-junction closure is necessary and minimal dog ear tailoring is at the surgeon's discretion (Figure 6 and 7).

Discussion and Conclusion

This technique is bespoke labiaplasty - it hides final closure in tissue transitions while minimizing anterior show and eliminating migrating hair follicles. Fundamentally, this is an expansion of an inverted T mastopexy where the lateral pillar is now the posterior commissure of the labia and is moved anteriorly. There is no compromise to blood supply of the posterior labial artery or pudendal artery and all suspension is clear of the dorsal nerve of the clitoris and pudendal nerve supply. The patients have been uniformly happy with no negative change in sensation; any reports of changes have been

positive with regard to sexual function. Furthermore, the scars are unperceivable as early as their 3-month follow-up. The extended U technique of clitoral unhooding uniquely presents as a reduction of tissue while simultaneously lifting and suspending the tissues, giving the area a more youthful appearance.

References

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