



Going in the Wrong Direction With Monsplasty

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Two recent articles in *Aesthetic Surgery Journal*—by Alter¹ and Bloom et al²—have addressed techniques for monsplasty, combined with either labia majora reduction or abdominoplasty, for massive weight loss patients. The techniques by Alter and Bloom et al also have a common theme: defatting and vertical pull.^{1,2}

The problem with these techniques is that the defect is not vertical excess. If anything, the mons that needs monsplasty is short and fat and has a width greater than its height. When a vertical lift technique is used, the hair-bearing skin is pulled up, elongating the mons and giving the appearance that the tissue has been pulled too high.

Using the subunit principle, there are defining landmarks to the mons—it is a triangle with boundaries. These boundaries are the lateral junction with the thigh, the superior boundary with the abdomen at the end of the hair-bearing line, and the inferior margin where the mons transitions into the labia majora, creating the vaginal cleft (Figure 1).

Realistically, the only place that hides a dog-ear in skin removal is the vaginal cleft. When removing bulk, why not place a vertical incision, extending the dog-ears upward and downward? With this technique, the upper extension can be hidden in the preexisting abdominal contouring incisions and the lower extension in a body crease. The mons is decreased in size in the lateral dimension. Liposuction decreases the bulk and deflates the mass, allowing skin to be removed in the center (Figure 2).

To achieve this aesthetic result, the patient is first evaluated in a standing position. The width of the mons, amount of ptosis, and tissue laxity are noted. The midline of the mons is marked on the lower abdomen. When the patient is supine, the amount of fat and skin that can be excised without lateral tension is tested. The V-wedge for excision is marked from the pubis/mons junction to the vaginal cleft; it can be an ellipse, or if there is a preexisting scar from a cesarean delivery or abdominoplasty, there can be lateral extensions at the abdomen. A video of this technique is available at www.aestheticsurgeryjournal.com. You may also scan the code on the first page of this article with any smartphone to be taken directly to the video on www.YouTube.com.

The tissue is excised through the skin, and ample subcutaneous fat depth is limited to deep investing fascia. The suspensory ligament is not visualized; the neuromuscular bundles from the pudendal nerve approach laterally to the

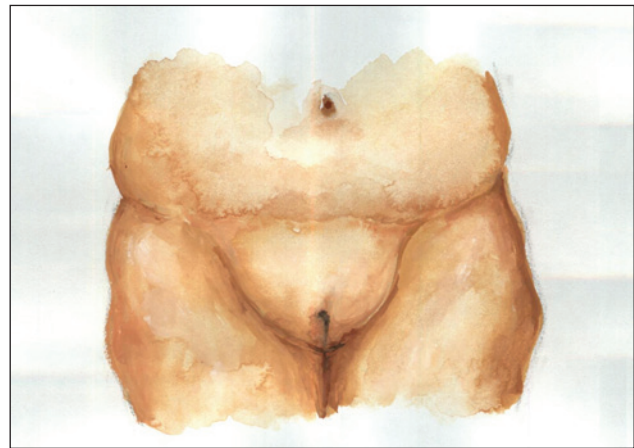


Figure 1. Mons as triangle. This mons is wider than it is tall.



Figure 2. Wedge method incision.

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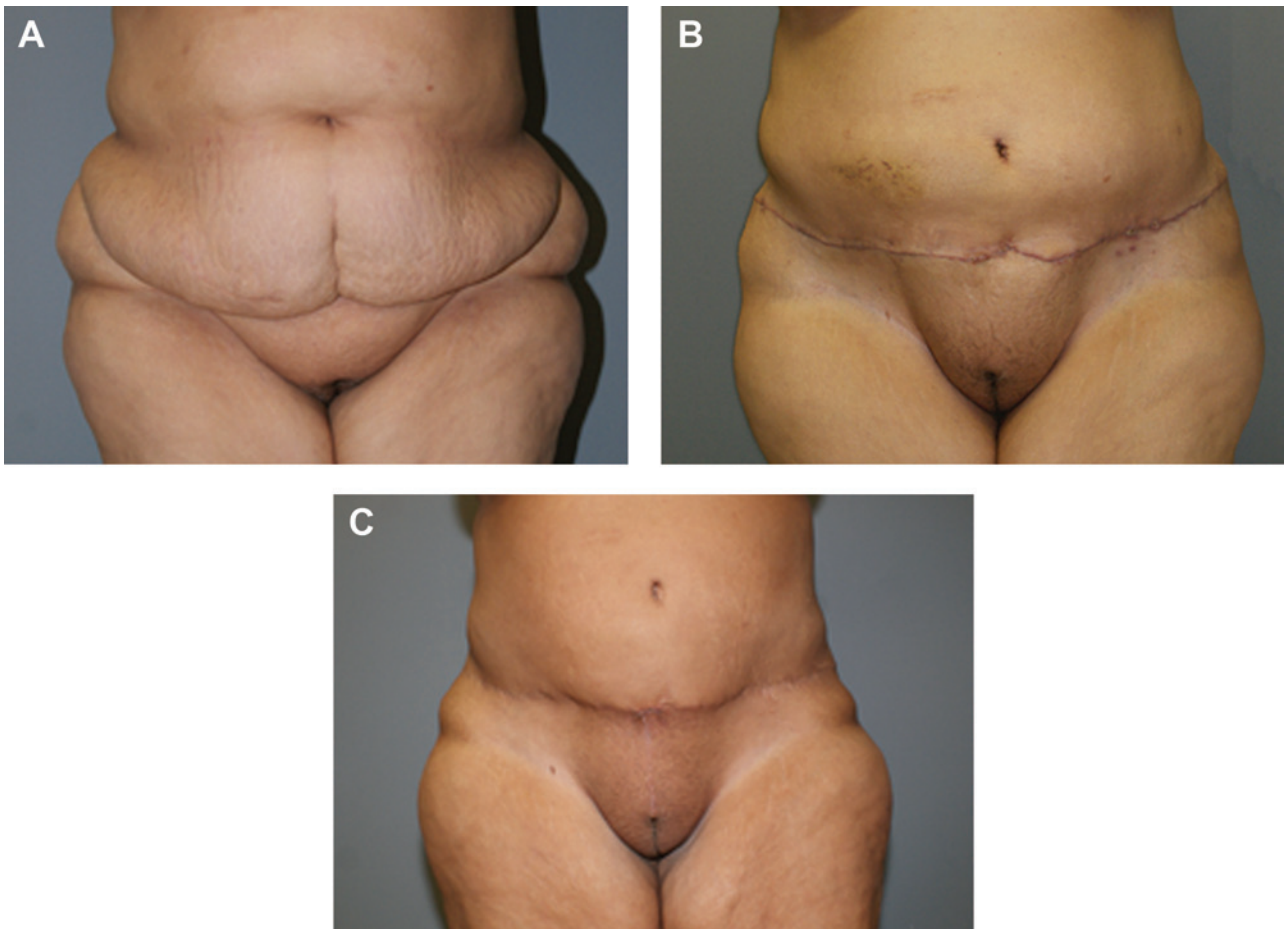


Figure 3. (A) This 46-year-old woman presented for abdominoplasty and liposuction of the mons. Note the wider, fatter appearance of her mons. (B) One month and (C) 5 months after abdominoplasty with mons liposuction. At 1 month, the mons is still too wide, despite some component of lift. At 5 months, the mons is debulked and elongated after touch-up liposuction of the abdomen with monsplasty. The mons shape is enhanced with a vertical excision. The T-junction is well healed. The vertical mons scar is flat and soft.

clitoris and are protected by their depth and inferior and lateral position. The closure is multilayer with imbrication of the deep investing fascia with 2-0 PDS and deep dermal and subcuticular 4-0 Monocryl (Ethicon, Inc, Somerville, New Jersey). We habitually use skin glue for an occlusive dressing.

Delayed wound healing at the T-junction is a risk with an abdominal contouring procedure (eg, fleur-de-lis). This technique has similar risks; however, in this case, delayed scar contracture raises the ptotic mons further, which is advantageous. The vertical component in the mons does not have hypertrophic or painful scar formation. Thickened scars at the mons-abdomen junction are handled in the same manner, with serial revision, as with scars resulting from a cesarean delivery, abdominoplasty, or panniculectomy.

We have treated several patients with this vertical monsplasty technique, with no revisions or corrections to date. The wound healing at the T-junction of the patient shown in Figure 3 has proceeded uneventfully.

Disclosures

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

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