Case Report

Postoperative Clitoral Hood Deformity After Labiaplasty

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Abstract

Aesthetics of the female genitalia have come under increasing scrutiny with the popularity of Brazilian waxing trends and media promotion of sheer fashions. Women seek to have a clean and youthful appearance of the vaginal region, with minimal if any labial minora show beyond the labia majora. Labiaplasty by edge resection of the redundant labia minora tends to be the preferred method of treating labia minora hypertrophy by most gynecologists and plastic surgeons. This technique is effective in removing the excess circumferential rim of the labia minora, thus decreasing bulk and protrusion from the introitus. However, in select patients with redundant clitoral hood tissue, edge trim techniques may result in an imbalanced postoperative result where the hood actually looks larger. These patients complain of a prominence of the clitoral hood not present prior to their labiaplasty. In this case report, the author describes 2 cases of excess clitoral hood prominence after free-edge resection labiaplasty. Both patients were unhappy with the result of their labiaplasties and sought surgical correction. Presentation, anatomical findings, options for treatment, and avoidance of such deformity are discussed.

Keywords

labiaplasty, clitoral hood reduction, extended wedge labiaplasty, complications of labiaplasty, edge trim labiaplasty, body contouring

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Over the past several years, there has been a 5-fold increase in the number of patients seeking cosmetic surgery of the vaginal region. The increasing vulvar visibility in the media, popularity of Brazilian waxing (where all pubic hair is shaved or waxed away), and the anonymity of the Internet to view pornography have contributed to this trend. Surgical techniques to reduce the redundancy of the labia majora, minora, and clitoral hood have been described. Labiaplasty or surgical reduction of the labia minora is the most common procedure in cosmetic gynecology. Basically, 2 types of surgical reduction of the labia minora have been described in the literature: wedge resections and free labial edge reductions, where the scar is placed along the length of the labia minora. Each technique creates aesthetic improvement of the area, resulting in less protrusion of the labia minora on the standing view. There is a high rate of overall patient satisfaction and improved body image with labiaplasty. Intuitively, free-edge resections seem less technically demanding than wedge or deepithelialization techniques. Hence, many gynecologists and some plastic surgeons seem to prefer this technique.

In most patients, free-edge trim or sculpting delivers a pleasing cosmetic result with minimal visible scarring and happy patient outcomes. However, in a select group of patients where the native clitoral hood is enlarged in addition to labia minora redundancy (Figure 1), the free-edge trim technique alone may result in an imbalance between the postoperatively flattened labia minora and the remaining, more apparent clitoral hood. Postoperatively, in the standing position, patients complain of fullness of the anterior clitoral hood despite the absence of visible labia minora and may refer to this area as having the appearance of a “small penis.”

Many women want a small, less developed, and petite labia minora and clitoral hood. This consists of minimal if any labia minora show and youthful, plump labia majora with no visible clitoral hood protruding between the anterior labial commissure (Figure 2). This nearly prepubescent look appears in print media and on the Internet. Labiaplasty to reduce the dangling of the labia minora

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alone may not result in the desired youthful appearance. Imperative in meeting the goals and expectations of these patients is a careful preoperative discussion of the functional anatomy, natural asymmetries, and risks/limitations of surgical techniques in creating the cosmetic vision of the patient. It is incumbent upon the surgeon to point out redundancy of the clitoral hood preoperatively and choose a labiaplasty technique most suited to achieving a youthful, balanced appearance of the vulva.

Wedge resection techniques, popularized by Dr Gary Alter, address the enlarged clitoral hood better than edge trim techniques. The closure of the labia minora wedge defect addresses not only dangling of the labia minora inferiorly but also minimizes the projection of the clitoral hood anteriorly by placing it on posterior tension. The width of the clitoral hood may be addressed by closing the wedge defect with superior dog-ear excision along either the clitoral hood (Figure 3) or more laterally, placing the scar in the vulvar-labial sulcus. Below, I describe my clinical experience with 2 patients who sought reduction of the clitoral hood.

**PATIENT DESCRIPTIONS**

Patient 1 was a 41-year-old woman who presented 10 months after free-edge trim labiaplasty by another surgeon. (The details of her previous procedure were unavailable.) She complained of a masculine, “penis-like” appearance of her clitoral hood. In addition, she stated that although her labia minora were shorter since the surgery, she disliked the shape of her labia minora. The unusual look of the area was bothersome to the patient, who said she felt embarrassed to be nude in front of her boyfriend.
Upon examination in the standing position, the patient had a wide clitoral hood at the anterior vulvar commissure separating the labia majora (Figure 4A). In lithotomy, the patient had a large, prominent clitoral hood with flattened, centrally scalloped labia minora (Figure 4C). Palpation of the clitoral area revealed no clitoromegaly but excess width and length of the clitoral hood as compared with the labia minora.

Patient 2 was a 46-year-old perimenopausal woman who presented 6 months after edge trim labiaplasty by another surgeon. (B, D) Two months after labiaplasty with inverted “V” clitoral hood resection and small wedge labia minora resections. (E) Intraoperative view of the patient’s procedure.

Figure 4. (A, C) This 41-year-old woman presented with an enlarged clitoral hood 10 months after labiaplasty (via an unknown technique) by another surgeon. (B, D) Two months after labiaplasty with inverted “V” clitoral hood resection and small wedge labia minora resections. (E) Intraoperative view of the patient’s procedure.
another surgeon (the details of her previous procedure were also unavailable). She complained of an excess clitoral hood and a flattened appearance of her labia minora. The standing view bothered the patient the most, as the clitoral hood protruded excessively between her labia majora. She stated that it was not that way prior to her labiaplasty. She felt that this problem was “ruining [her] sex life.”

In the standing position, the labia majora were dwarfed by the interposition of a prominent ovoid clitoral hood (Figure 5A). In lithotomy, there was an elongated “bishop’s hat” clitoral hood that widened inferiorly, just above

Figure 5. (A, C) This 46-year-old perimenopausal woman complained of excess clitoral hood and flattening of the labia minora 6 months after labiaplasty (via an unknown technique) by a previous surgeon. (B, D) One year after postlateral reduction of the widened clitoral hood and fat grafting to the labia majora. (E) Intraoperative view immediately after the patient’s procedure.
the irregular overshortened labia minora (Figure 5C). The labia minora appeared flattened, with posterior dog ears present bilaterally.

**SURGICAL TECHNIQUE**

In the first case, under local anesthesia, the excess clitoral hood skin was addressed in an inverted “V” resection over the dorsum of the clitoral hood. With this maneuver, attention must be paid to perform a very conservative dorsal hood reduction, as exposure of the glans clitoris is possible. The incision was conservatively marked and incised down to—but not into—the investing fascia of the clitoris. A 2-layer closure was performed with 5-0 Monocryl (poliglecaprone 25, p-1 needle) and 5-0 Vicryl Rapide (polyglactin 910, p-1 needle), both of which are manufactured by Ethicon (Somerville, New Jersey). The labia minora edge irregularities were then addressed with a series of small wedge resections perpendicular to the axis of the labia minora. The shortening of the minora in the anterior-posterior direction and reattachment of the hanging clitoral frenulum helped retract the clitoral hood posteriorly (Figure 4A-E).

In the second case, the problem with the clitoral hood was width rather than dorsal skin excess. This was addressed with a lateral triangular resection, placing the scar in the groove between the labia majora and the clitoral hood. Once again, markings were performed and local anesthetic was injected. Two triangles of lateral clitoral hood were resected, 1 on either side. A 2-layer closure was performed with the sutures described above. In addition, fat grafting of the mons pubis and labia majora was performed on the second patient to further conceal the prominent clitoral hood and restore a more youthful appearance to the area (Figure 5A-E).

**DISCUSSION**

Surgical procedures to improve the appearance of the female genitalia have increased dramatically over the past several years. Labia minora protrusion beyond the majora seems to be the dominant complaint of women seeking surgery. Conceptually, labiaplasty seems simple: shorten the labia minora by trimming the edge. This technique works well in most cases but may cause disharmony in select patients who present with prominent clitoral hoods in addition to labia minora excess (Figure 6). Bulky clitoral hoods have multiple drape-like folds and tend to separate the anterior vulvar commissure when viewed standing. It is only postoperatively, after edge trim labiaplasty, that the patient sees the hood as redundant. It is my opinion that aggressive labial trim or near-amputation may cause this imbalance to be more pronounced, even in the patient with a normal-sized clitoral hood.

There exists a great deal of anatomical variation in clitoral hood anatomy and, since the hood is contiguous with the labia minora, procedures to reduce the labia usually must address the clitoral hood as well. Excess submucosal tissue or extra folds of the mucosa overlying the clitoris may create a thick hood that protrudes anteriorly. If these anatomical variations are not taken into consideration preoperatively, excess clitoral hood projection is worsened by trimming the labia minora alone. The location of the frenulum of the clitoris is important to note at the time of labia minora reduction as well; inadvertent release of this structure’s attachments may further contribute to iatrogenic clitoral hood prominence.

In patients with prominence of the clitoral hood preoperatively, the wedge labiaplasty with a lateral extension may be a better option. Two cases of wedge labiaplasty
with lateral extension are shown in Figures 8 and 9. The photographs show redundancy of the clitoral hood preoperatively, which was ameliorated by performing the extended central wedge resection as described by Alter. Free-edge resection or mucosal deepithelization techniques only address labia minora redundancy; hence, in this subset of patients, the clitoral hood would have been made to appear even more prominent. The posterior traction placed on the clitoral hood with removal of the wedge helps reduce the anterior redundancy of the clitoral hood, and the removal of the dog ear superolaterally with the extension narrows the width of the hood (Figure 8B).

In patients who present with clitoral hood prominence after labiaplasty, it is important to restore balance between the clitoral hood and labia minora. Treatment of iatrogenic labial deformities includes small wedge resections along the labia minora for areas of persistent redundancy, reattachment of the frenulum of the clitoris, and lateral or central reduction of the clitoral hood. Care must be taken in dorsal clitoral hood reduction, as this may cause exposure of the glans clitoris (Figure 5A). If the patient complains of discomfort from an exposed clitoris, the clitoral hood may be advanced forward as a V-to-Y flap. Finally, redundant clitoral hood tissue may be used for reconstruction of amputated labia minora by means of rotational flaps, as described by Alter.

**CONCLUSIONS**

Surgery of the female perineum—specifically, labia minora reduction or labiaplasty—is on the rise. Labia minora edge trim techniques have been popular among surgeons for years and provide good results in most cases, but variations in the size and shape of the clitoral hood should be taken into account when choosing the appropriate labial minora reduction technique. Anatomy should be discussed with the patient preoperatively, with specific attention paid to the clitoral hood size and appearance of the area in the standing position. It is my opinion that...
modified wedge resections may be a better choice for patients with a prominent clitoral hood, and surgeons should exercise caution when performing edge trim techniques in these patients.

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