Original Article

Boomerang technique for female genital aesthetic surgery

Técnica Boomerang para plástica genital estética feminina

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ABSTRACT

Introduction: Hypertrophy of the labia minora combined with a redundant clitoral hood is a common complaint among women seeking aesthetic genital cosmetic surgery for functional, psychological, and aesthetic complaints. The objective of this study was to describe the boomerang technique, a surgical treatment for labial hypertrophy that extends to the entire clitoral hood. **Method**: A retrospective, analytical study was conducted to evaluate the medical records of forty-eight consecutive patients who underwent female genital cosmetic surgery between July 2017 and July 2021. The same surgeon performed all surgical procedures. The technique used in the patients consisted of longitudinal resection of excess small vaginal lips associated with resection of the boomerang-shaped clitoral hood associated with clitoroplasty. **Results:** The average age of patients undergoing surgery was 36.25 years (range 18-59 years), among whom 94.44% had aesthetic complaints associated or not with functional complaints, and 5.56% had only functional complaints. Two patients had bruises on the labia majora in the immediate postoperative period, and one patient had suture dehiscence on the labia minora. **Conclusion:** The boomerang technique is reproducible and provides aesthetic and/or functional benefits to the female genitalia.

Keywords: Genitalia, female; Vulva; Clitoris; Surgery, plastic; Plastic surgery procedures.

RESUMO

Introdução: A hipertrofia de pequenos lábios combinada com capuz clitoriano redundante é uma queixa comum entre mulheres que procuram cirurgia plástica genital cosmética por queixas funcionais, psicológicas e estéticas. O objetivo deste estudo foi descrever a técnica *boomerang*, um tratamento cirúrgico da hipertrofia labial que se estende a todo o capuz clitoriano. **Método:** Foi conduzido um estudo retrospectivo, de caráter analítico, para avaliar os prontuários médicos de 48 pacientes consecutivas submetidas a cirurgia estética genital feminina entre julho de 2017 e julho de 2021. Todos os procedimentos cirúrgicos foram realizados pela mesma cirurgiã. A técnica utilizada nas pacientes consistiu na ressecção longitudinal dos excessos de pequenos lábios vaginais associado à ressecção de capô clitoriano em forma de *boomerang* e à clitoropexia. **Resultados:** A idade média das pacientes submetidas a cirurgia foi de 36,25 anos (intervalo 18-59 anos), entre as quais 94,44% apresentaram queixas estéticas associadas ou não a queixas funcionais, e 5,56% apresentaram somente queixas funcionais. Duas pacientes apresentaram hematomas nos grandes lábios no pós-operatório imediato, e uma paciente teve deiscência de sutura nos pequenos lábios. **Conclusão:** A técnica *boomerang* é reprodutível e proporciona benefícios estéticos e/ou funcionais na genitália feminina.

Descritores: Genitália feminina; Vulva; Clitóris; Cirurgia plástica; Procedimentos de cirurgia plástica.

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INTRODUCTION

Female genital plastic surgery consists of a set of procedures that encompasses the surgical aesthetic and/or functional approach to the woman's intimate region with the aim of achieve a more aesthetic shape of the labia minora and adjacent regions, such as the clitoris, the clitoral foreskin, mons pubis, and labia majora. The most common among procedures are nymphoplasty or labiaplasty, which aim to improve and modeling of redundant tissue, as well as asymmetries, if any[1].

Labiaplasty brings great benefits to female sexual function, especially in factors such as pain and pleasure[2]. The woman undergoing the surgical procedure also reports improvement in self-image; however, when the improvement is exclusively linked to the labia minora, the untreated clitoris can be observed more by the patient post-operatively[3].

In some cases, there is an excess clitoral hood and hypertrophy of the clitoral gland. When the measurement is greater than 35mm, clitoral hypertrophy is suggested[2]. The average clitoris must be less than 5mm wide and 16mm long[4].

Currently, several techniques are described for performing nymphoplasty or reduction of labia minora. Labiaplasty is a surgical procedure to reduce the size of the labia. This intervention is most commonly carried out in labia minora, but it can also occur concerning the labia majora[5,6].

The elliptical or longitudinal technique was initially described by Hodgkinson & Hait[7]. It is the most performed technique in the world[6], followed by the "V" shaped technique or wedge technique, described by Alter[8]. The combination of the longitudinal technique with wedge resection is also carried out[9].

W-shaped resection, Z-plasty, posterior resection, and epithelial resection as well are techniques described for the resection of labia minora. However, these are not so common as the previous ones[10-13].

Surgical resection of excess labia minora can be associated with resection of the clitoral hood in its lateral, cephalic region or both[1,5,8,14-16] and can be associated or not with clitoripexy, which means the fixation of the clitoris to the pubis[8,11,14-20].

In cases of lipodystrophy in the pubic region, in the mons pubis, it is possible to perform liposuction of this region[21].

Another classification also described is that of Motakef, which refers to the protrusion of labia minora in relation to the labia majora. The author defines class I (0 to 2 cm of protrusion), class II (2 to 4cm of protrusion), and class III (greater than 4cm of protrusion). The letter "A" is added for cases of asymmetry and the letter "C" for cases of excess clitoral hood. In this classification, cases of hypotrophy and sagging of the labia majora. These signs become evident as women age[22].

According to the most recent data released by the International Society of Aesthetic Plastic Surgery in 2020, referring to procedures performed in 2019, the Brazil is the champion country in the number of labiaplasties, nymphoplasties, or labia minora reduction surgeries. There were 20,334 compared to 13,697 in the United States, considering a total of 142,119 of this type of surgery performed worldwide. Furthermore, in comparative between the years 2016 and 2020, at a global level, the performance of this procedure increased by 3%, despite the drop, when compared to 2019 and 20202[3]. The specialties that perform this type of procedure in the greatest proportion are plastic surgery and urogynecology. It is estimated, therefore, that these data must be even greater, since, in the present study, only data relating to plastic surgery is included.

Several factors are associated with the growth in the number of procedures. Among them are greater access to information, sexual freedom, a greater number of professionals trained and cultural and paradigm changes concerning sexuality[24]. The main sources from which the results regarding the dissemination of nymphoplasty are extracted refer to websites, videos, and reports in newspapers, magazines with a large circulation and women's magazines. In these vehicles, in general, the opinions of experts and some testimonials from women are presented.

Material produced by doctors themselves is also very common, mainly plastic surgeons and gynecologists, whether on their personal pages or in professional profiles on social networks, on their clinic websites, as well as YouTube channels[25].

Other surgical procedures in the genital area aim, in addition to hypertrophy of the labia minora, enlargement and/or reduction of the labia majora, as well as reduction of the clitoris and/or clitoral hood.

There are different types of vulva and, not always, the woman feels uncomfortable with her genital area from an aesthetic point of view. Thus, the intention to alter or improve the appearance of external genitalia and undergoing cosmetic genital surgery is not always present.

OBJECTIVE

The objective of this study is to describe the boomerang surgical technique and the surgical results. The vulva procedure is performed extensively to improve the aesthetics of the region, including repositioning of the clitoris and resection of the clitoral

hood, reduction of labia minora and labia majora augmentation, when indicated.

METHOD

A retrospective, analytical study was conducted to evaluate the medical records of 48 consecutive patients who underwent female genital aesthetic surgery at a private plastic surgery clinic (Instituto Tatiana Turini de Cirurgia Plástica) and at the Hospital Regional Asa Norte (HRAN), in Brasília, Brazil, between July 2017 and July 2021. The study was carried out following the ethical standards of the 1964 Declaration of Helsinki and its subsequent changes. The study was approved by the Research Ethics Committee of the Education and Research Foundation, under number 4842358. All patients signed the Free and Informed Consent Form for the procedure, use of clinical data, and photographic records for scientific and publishing purposes. Patient anonymity was guaranteed.

The patients presented type III hypertrophy (labial hypertrophy that extends to the entire clitoral hood), according to the classification by Cunha et al.26 (Figure 1) with or without clitoral hypertrophy, which justified the procedure that extends to the clitoral hood. Some patients still had sagging and reduced volume of the labia majora. The standard vulva can be seen in Figure 2.

Pre-operative and post-operative photographs were taken with a frontal view. (where the upper limit is half the distance between the xiphoid and the navel and the lower limit are the knees with the legs positioned at the same width as the shoulders and with the arms behind of the body). And lithotomy position (with knees flexed and thighs flexed and abducted) at an angle of 45° in the previous vertical position.

Surgical procedure

The patients were operated on by the same plastic surgeon under local anesthesia, neuraxial block or general anesthesia, in a lithotomy position.

When the procedure was performed under local anesthesia, precautions taken were to administer an anti-inflammatory and an analgesic tablet orally one hour before surgery.

The incision area was outlined with a marking pen, with the patient in the position of lithotomy. The incision line was marked in the shape of a boomerang on the clitoral hood (preputial skin), extending to the groove between the labia majora and minora. Posteriorly, the excess labia minora was marked for resection (Figure 3). There was attention to the width minimum of 1cm for positioning within the margins of the labia majora (Figure 4). Resection of the labia minora is performed longitudinally, with excision of the mucosa throughout its extension. The hemostasis of this region is of great importance. The asymmetry in the pre-labiaplasty surgery is not uncommon. Therefore, care must be taken when marking the labia minora so that they are as symmetrical as possible post-operatively. Another important precaution is to maintain the scar in the region of the anterior vaginal wishbone.

Antisepsis was performed with aqueous chlorhexidine in the vulva and vaginal introitus region and degerming chlorhexidine and alcoholic chlorhexidine in adjacent regions such as the lower abdomen and thighs. Lidocaine spray of 10% was used

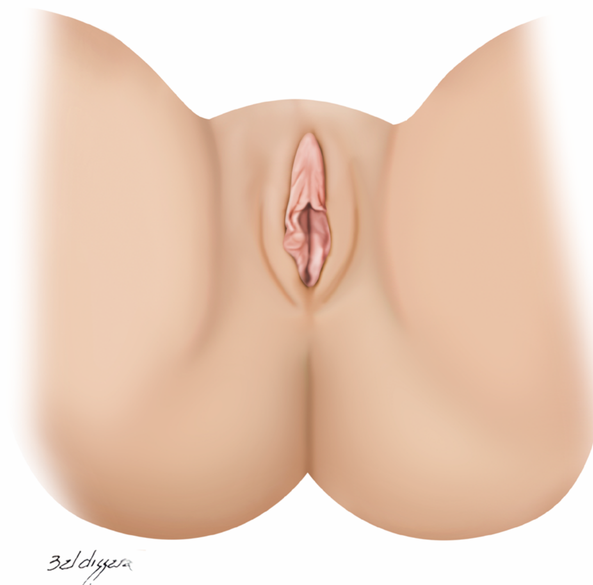

Figure 1. Hipertrofy type 3.

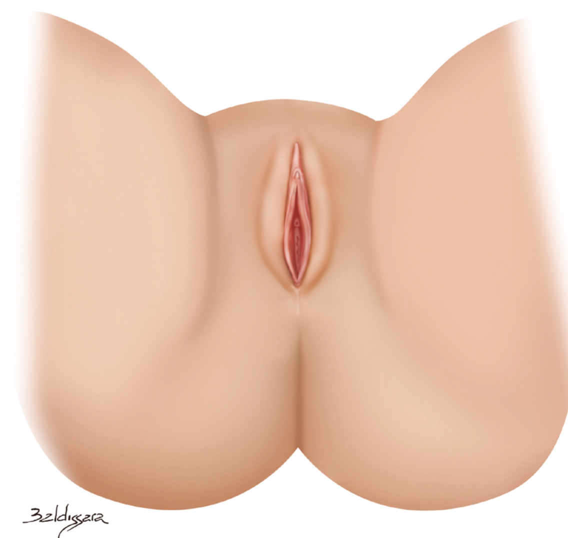

Figure 2. Standard vulva.

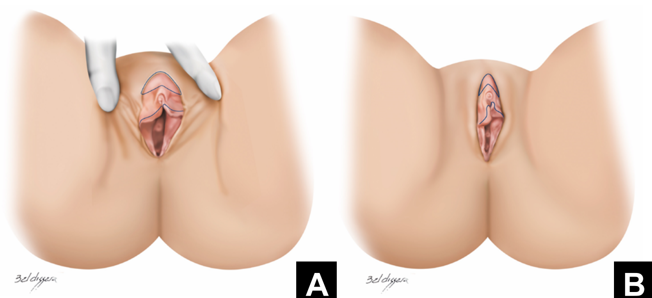

Figure 3. Preoperative marking of the boomerang technique.

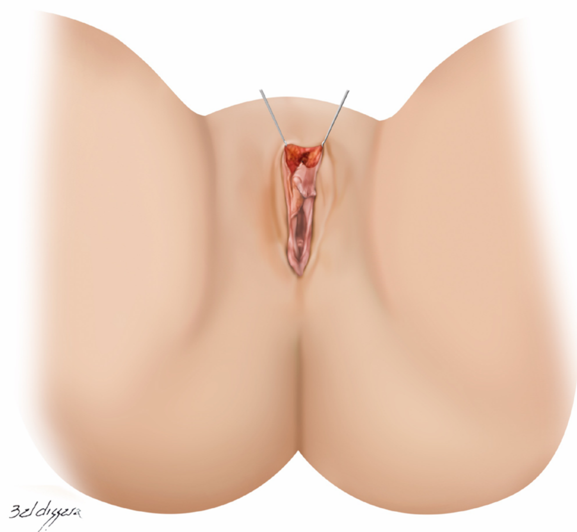

Figure 4. Incision at 12 o'clock made towards the suspensory ligament of the clitoris.

in the operated region 15 minutes before infiltration using 2% xylocaine solution, in the labia minora, bonnet, and region close to the pubic periosteum, normally no more than 20mL of infiltration is used.

After skin resection, using the boomerang format in the clitoral hood region, an incision and dissection was made at 12 o'clock towards the clitoral suspensory ligament in the bulbar region (Figure 5). The clitoral body was sutured to the anterior pubic periosteum using 4-0 nylon. Excess tissue from the labia minora was removed by longitudinal resection performed in a medially inclined plane, leaving minimal and hidden scars. Removal of excess tissue must be carried out carefully to avoid excessive resection. Clitoripexy was performed with a point in the clitoral body, bulb region at 12 o'clock, and fixed in the periosteum of the pubis and synthesis of the labia minora and clitoral hood with continuous stitches using 5.0 catgut thread.

Hemostasis was achieved by electrocauterization. Finally, a continuous stitch using 5.0 catgut thread was performed. Vicryl 5-0 rapid may be an option for suturing this region. Postoperative care includes the use of vaginal cream with lidocaine, calendula, menthol, witch hazel oil, and copaiba. This cream was created by the surgeon himself with pharmaceutical assistance. Hygiene after urinating and bowel movements and the use of underwear for incontinence are also post-operative guidelines.

Data on surgical outcomes and complications were collected by reviewing the patients' medical records. Numerical data is demonstrated as mean, standard deviation (SD), and ranges.

RESULTS

In this retrospective analytical study, the medical records of 49 patients who underwent the procedure described during the study period were reviewed. One patient was excluded from the analysis due to her age being under 18 years old, thus totaling 48 patients. More than half of the sample (64.68%) had access to the surgical procedure via the Unified Health System (SUS).

Data analyses were carried out using the IBM SPSS (Statistical Package for the Social Sciences) 23, 2015 program. The significance level used throughout the study was 5%.

In the procedures performed, local anesthesia was the most prevalent form of anesthesia, being applied to 39 patients (81.25%), mainly in cases where only intimate surgery was performed. Epidural anesthesia was performed in 12 patients (12.5%) and general anesthesia in three (6.25%), as shown in Table 1. Epidural and general anesthesia occurred in combined surgeries, such as mammoplasty and liposuction, which have the highest recurrence among procedures performed together with female genital plastic surgery.

The patients' ages ranged between 18 and 48 years (SD: 9.68). The majority of patients (41.67%) were aged between 28 and 37 years, with an average of 36.25 years (+ 9.76%) and a median of 35.5 years. Nine patients were married or had a marital partner and nine were single (Table 1).

As shown in Table 1, there were three cases of early complications (6.25%), two of labia minora hematoma and one of wound dehiscence. Only three patients (6.25%) sought medical advice to undergo a secondary procedure due to late complications from surgeries performed with other surgeons.

Surgical refinement was performed on six patients. In one case, this practice was performed to improve small asymmetry, through small unilateral resection; in another case, there was also redundancy of the labia minora, in which a new resection was performed of fabric. In three cases, clitoral plication

Table 1. Sociodemographic and surgical characteristics of patients undergoing female genital plastic surgery procedure, Brasília, DF, Brazil, 2022.

	Item	n	%
Age range	18 to 27 years old	8	16.67
	28 to 37 years old	20	41.67
	38 to 47 years old	14	29.17
	≥ 48 years old	6	12.50
SUS / Private	SUS	31	64.58
	Particular	17	35.42
Resection of excess labia minora	No	1	2.08
	Yes	47	97.92
Anesthesia	Local	39	81.25
	Epidural	6	12.50
	General	3	6.25
Refinement	No	42	87.5
	Yes	6	12.5
Complications	No	45	93.25
	Yes	03	6.25
Combined surgery	No	39	81.25
	Yes	9	18.75
Total		48	100.00

surgery (clitoripexy) was performed in patients who previously had clitoral hypertrophy secondary to hormones. There were no cases of infection. For most patients, it was the primary surgery, that is, they had never had surgery on the vulvar region previously.

According to Table 2, it can be seen that the majority of patients (97.65%) underwent resection of the labia minora. And in 85.4% of cases, labiaplasty was performed comprehensively, in which the procedure included the clitoral hood and clitoris. Hood resection using the boomerang technique was performed in 87.5% of patients. The association of fat grafting in the labia majora was performed in six patients (12.5%). In just three cases (6.28%), labiaplasty was performed alone. There were no cases of a decrease in sensitivity, only one patient reported increased sensitivity due to greater exposure of the clitoris, but without any harm to sexual intercourse and orgasm.

When asked about the improvement in sexual activity after the procedure, 83% of patients reported improvement during sexual intercourse and self-confidence in their body and 12% of the total reported that there was no difference in their sexual performance. No patients reported worsening. And one patient did not have sexual intercourse after the procedure.

Pre-operative and post-operative photographs of patients included in this study can be seen in Figures 5 to 12.

Table 2. Distribution of operated genital areas of study patients, Brasília, DF, Brazil, 2022.

Female genital plastic surgery		
Female genital areas	**N**	**%**
Labia minora (nymphoplasty/labioplasty)	**3**	**6.28**
Labia minora + labia majora	1	2.08
Labia minora + clitoral hood + clitoris	**41**	**85.4**
Labia minora + clitoral hood	1	2.08
Labia minora + posterior vaginal wishbone	1	2.08
Clitoral hood + clitoris	1	2.08
Total	48	100

DISCUSSION

Patients undergo labiaplasty for a variety of reasons. Miklos & Moore[27] evaluated 131 labiaplasty patients who underwent surgery only due to aesthetic complaints (37%), only functional complaints (32%), such as discomfort and pain, or functional and aesthetic complaints (31%). In this study, patients sought labiaplasty only because of aesthetic complaints (44%), demonstrating their great interest in improving genital appearance, due to aesthetic and functional complaints (33.33%), due to aesthetic, functional, and psychological complaints (5.56%) and due to functional complaints (5.56%).

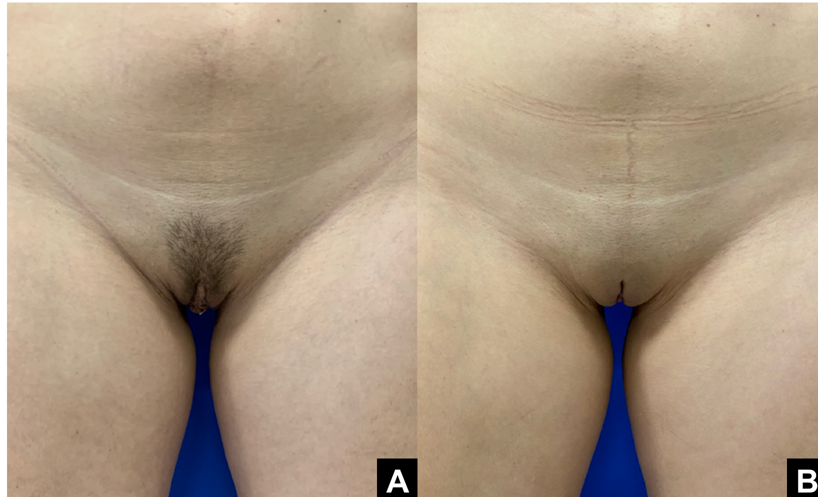

Figure 5. (A) Preoperative and (B) six-month postoperative photographs of a patient standing.

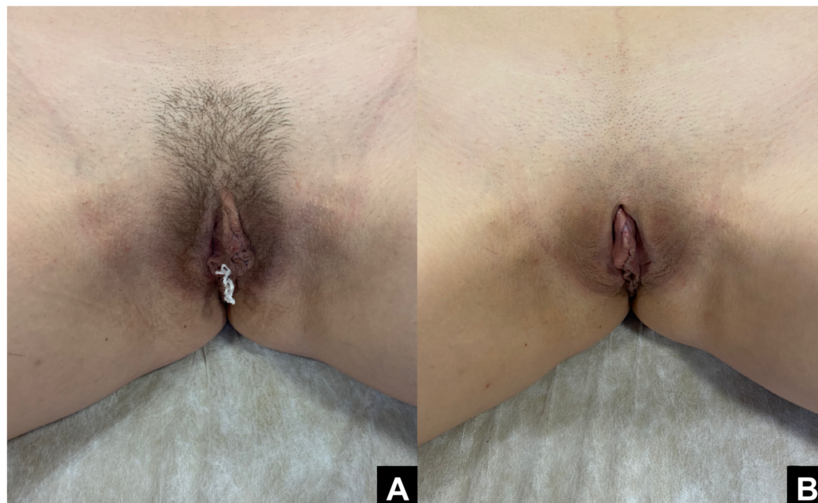

Figure 6. (A) Preoperative and (B) six-month postoperative photographs of a patient in the lithotomy position at 45°.

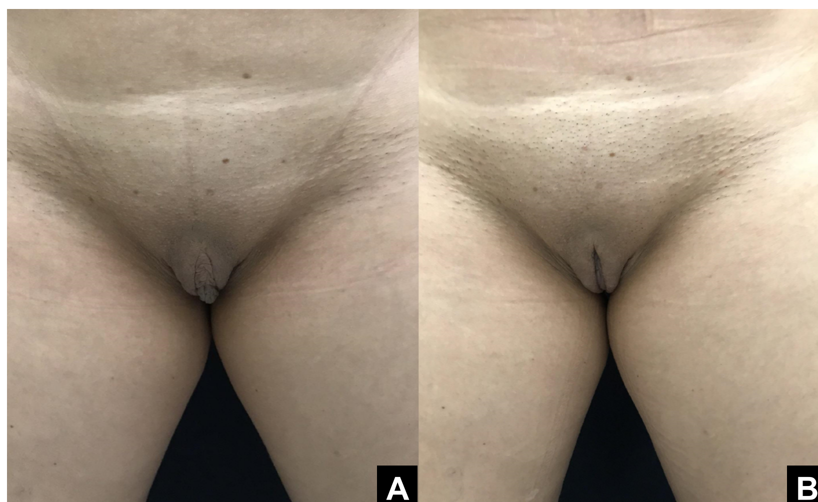

Figure 7. (A) Preoperative and (B) 20-day postoperative photographs of a patient standing.

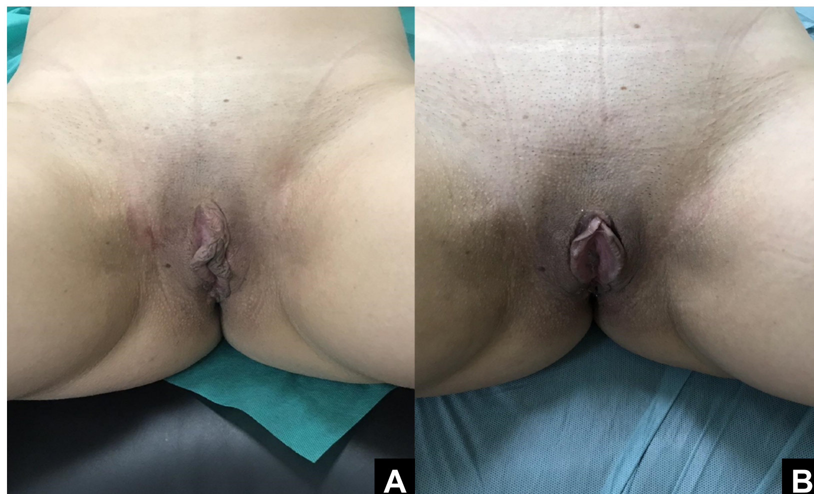

Figure 8. (A) Preoperative and (B) 20-day postoperative photographs of a patient in lithotomy position at 45°.

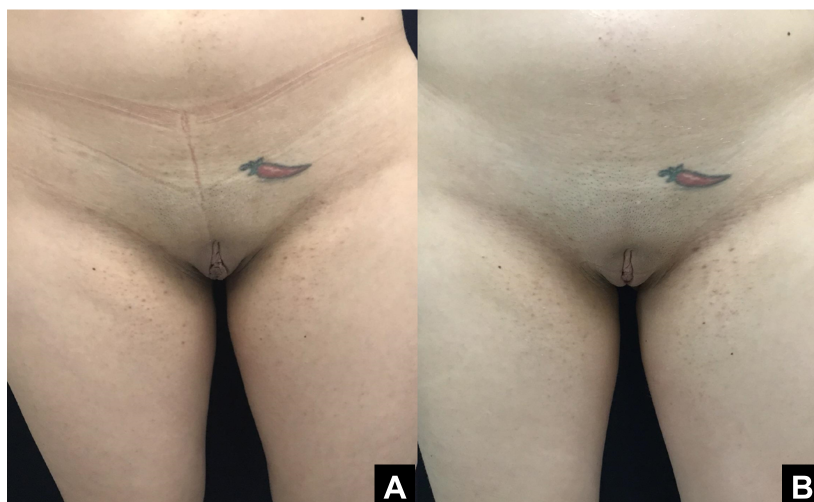

Figure 9. (A) Preoperative and (B) six-month postoperative photographs of a patient standing.

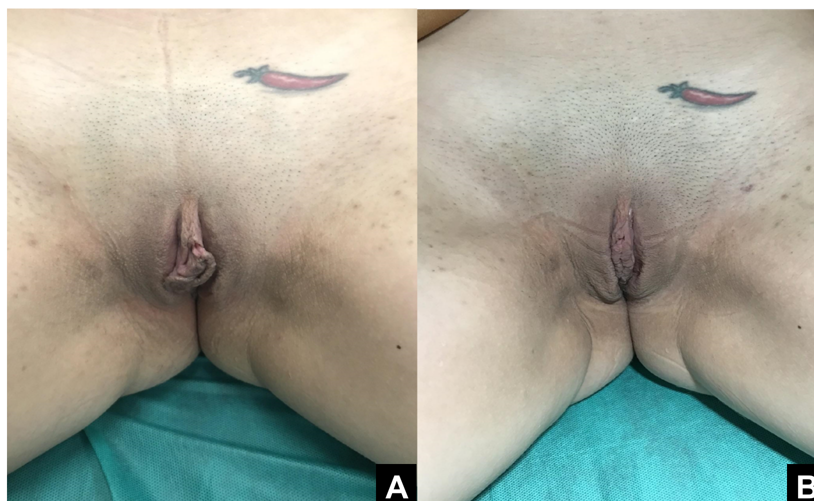

Figure 10. (A) Preoperative and (B) six-month postoperative photographs of a patient in the lithotomy position at 45°.

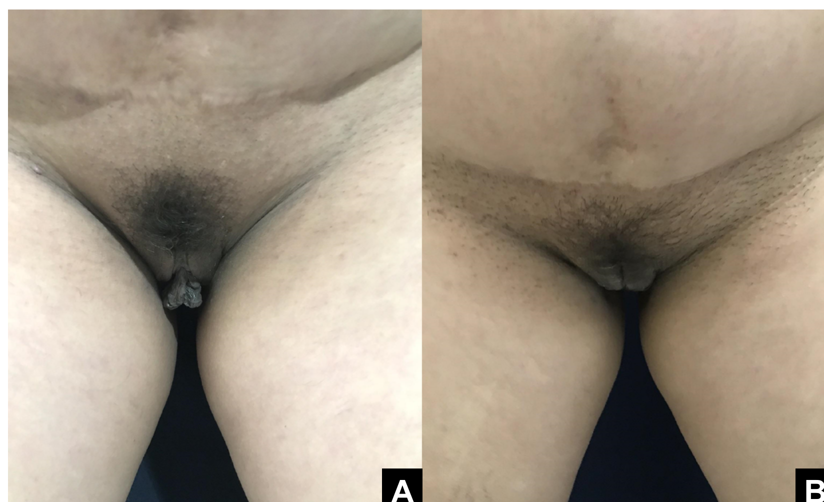

Figure 11. (A) Preoperative and (B) two-month postoperative photographs of a patient standing.

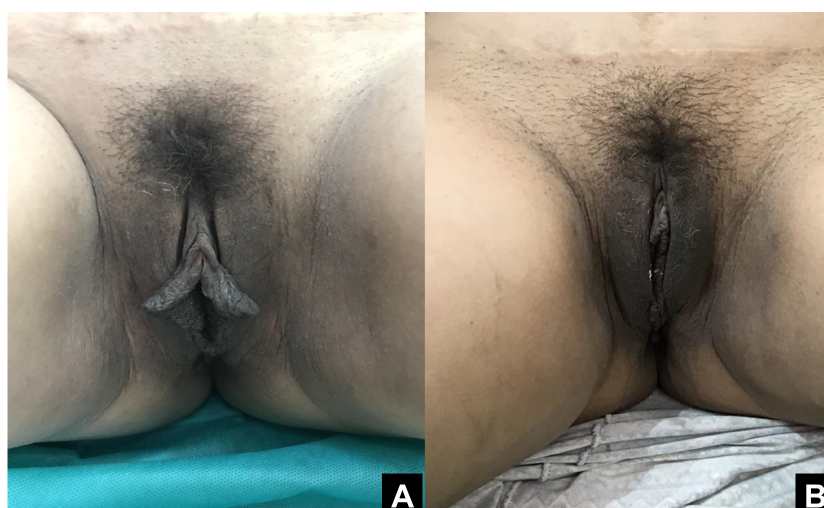

Figure 12. (A) Preoperative and (B) two-month postoperative photographs of a patient in the lithotomy position at 45°.

Many techniques for reducing labia minora have been described. However, few studies describing clitoral hood treatment were found in the literature. Hamori[28] described the inverted V resection to reduce the redundant clitoral hood. Oppenheimer[15] showed "horseshoe labiaplasty", a technique based on recontouring circumferential area of the labia minora and clitoral hood. Xia et al.[20] demonstrated in his work, the resection of the clitoral hood in the region of the sulcus associated with the resection of labia minora. Li et al.[11] described the technique in L. Yang & Hengshu[13] described the technique in which they adapted the W-plasty to resect both the labia minora as for the hood.

Gress[14], in her technique, described the reduction of the labia minora and the clitoral hood, combined with glans repositioning. After the resection of a segment of tissue cranially about 2 to 3 cm long (seen as the caudal extension of the hood clitoris), a segment of skin below the clitoris and a rectangular segment of skin above the clitoral hood are removed and the wound margins are brought together. This study demonstrates that approximately 35% of patients, after the technique, improved sexual aptitude in which there is combined resection.

Mañero Vázquez et al.[29] carried out, in their work, the resection of the clitoral hood in its lateral portion associated with the plication of the clitoral body next to the periosteum at 4 and 8 o'clock. Unlike the present study, in which resection of the clitoral hood is performed in its cephalic region with a point at 12 o'clock resulting in the rise of the clitoris.

There is already widespread concern about the treatment of the vulva, which is not limited to correction of hypertrophy of the labia minora, but includes

repair of the clitoral hood, involving the treatment of redundant clitoral hood and clitoral hypertrophy[14,18].

The term "clitoral relocation" (or repositioning) was first used by Lattimer[30], in 1961, to describe the treatment of the result of congenital hypertrophy of the clitoris, which came from maternal use of anabolic steroids during pregnancy. Concerns about loss of clitoral sensitivity are consistent with neuroanatomical studies of the fetal clitoris, showing that the greatest nerve density is located within the tunica of the dorsal aspect of the clitoris[31]. The surgical technique described in this study, the 12-hour innervation is not affected, but care must be taken to treat the 11- and 13-hour innervation due to the presence of nerve endings originating from the pudendal nerve.

The clitoral hood is a structure that covers and protects the clitoris (glans) when it has a normal size of about 2 cm long. However, in cases such as hypertrophy of the clitoris or redundant clitoral hood, reduction of the labia minora alone can lead to to unsatisfactory results, drawing attention to the clitoral hood, which was not so evident before the procedure. In contrast, removal of excess skin with exposure of the glans can result in increased sensitivity of the clitoris[19,31].

In the preoperative evaluation, patients may also present nodular edema in the labia minora, in the form of redundant tissue, which can be addressed by tissue repositioning, with positive results in a lithotomy view.

CONCLUSION

The boomerang technique described is a surgical procedure to improve excess tissue in the region of the clitoral hood associated with excess labia minora. Such technique is reproducible and has a low complication rate and high satisfaction rate, providing aesthetic and/or functional benefits to the patient.

COLLABORATIONS

TT Conception and design study, Final manuscript approval, Writing - Original Draft Preparation, Writing - Review & Editing.

MEAM Final manuscript approval, Writing - Review & Editing.

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