

SUBCLITORAL ANESTHETIC INFILTRATION TARGETING VENTRAL CLITORAL NERVES

A novel, safe and effective technique for intimate surgeries

Paulo G¹ • Palma P² • Luksenburg A³

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RATIONALE

- Modern intimate surgery requires precise analgesia and preservation of clitoral innervation.
- Traditional blind infiltration may be non-selective and may distort surgical planes.
- A targeted midline subclitoral block may increase safety and reproducibility.

CLINICAL EVALUATION

50

patients

26-65

years

VAS 3

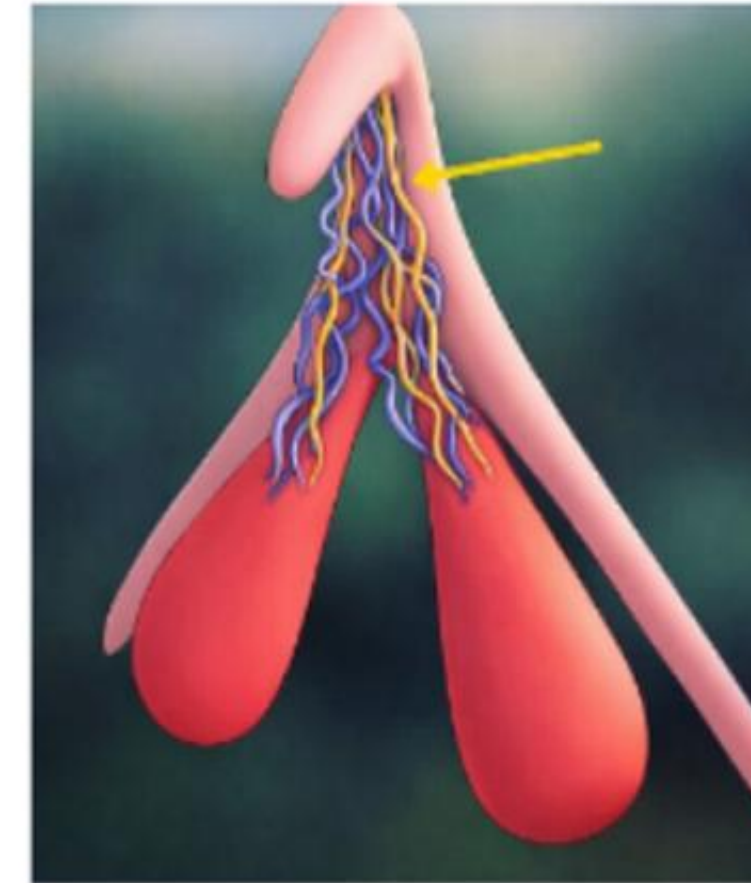
mean score

- Procedures: clitoroplasty (n=30) and Luksenburg Plus (n=20).
- Pain quantified using Visual Analog Scale.
- All cases completed with effective local anesthesia.

TAKE-HOME MESSAGE

A low-volume, midline subclitoral infiltration at 1-1.5 cm achieved effective analgesia with no vascular or neurological complications in 50 cases.

ANATOMICAL TARGET



Ventral clitoral nerve distribution

- Ventral branches form a dense subepithelial network.
- The midline approach aims to reach the ventral sensory network while sparing deeper dorsal neurovascular structures.
- Target depth: 1.0-1.5 cm.

SAFETY OUTCOMES

0

vascular injury /
hematoma

0

neurological
deficits

High

reproducible

No long-term sensory loss was recorded in this preliminary clinical evaluation.

INTERPRETATION

This anatomically guided block may represent a practical shift from blind infiltration to precision, nerve-sparing anesthesia for intimate surgery. Larger controlled studies and long-term sensory follow-up are required for validation.

STANDARDIZED TECHNIQUE



1.8 mL

lidocaine +
epinephrine

1-1.5 cm

target depth

- Lithotomy position; strict midline subclitoral insertion.
- Low volume reduces tissue distortion and potential toxicity.
- Precision protects the dorsal bundle from lateral needle trauma.

PAIN ASSESSMENT



- Mean VAS score of 3 indicates tolerable intraoperative experience.
- The technique aligns analgesia with functional, nerve-sparing surgical principles.