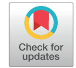
Sexual Function After Shallow and Full-Depth Vaginoplasty: Challenges, Clinical Findings, and Treatment Strategies—Urologic Perspectives



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KEYWORDS

• Transgender • Vaginoplasty • Shallow-depth vaginoplasty • Gender-affirming surgery • Sex reassignment surgery • Gender reassignment surgery • Sexual function • Male to female

KEY POINTS

- Shallow-depth vaginoplasty is an excellent option for a subset of women seeking gender-affirming vaginoplasty and should always be offered to all patients considering vaginoplasty.
- Vaginal depth cannot be seen or known from visual examination. A vagina is not defined by its vaginal depth.
- Poor sexual function before surgery is a reliable predictor of poor sexual function after surgery. Patients with difficulty or lack of experience achieving erogenous genital sensation should be encouraged to self-stimulate before their surgery.
- Depression, performance anxiety, and chronic pain interfere with recovery of erogenous sensation and/or orgasm after vaginoplasty.
- The rationale for frequent and varied erogenous self-stimulation postsurgery is neuroplasticity, where gray-matter changes and synapses strengthen in response to new stimuli and repetition.

INTRODUCTION

Sexual function is an important factor for all patients' quality of life. Transgender patients undergoing genital gender-affirming surgery (GAS) with vaginoplasty are faced with numerous challenges, which include recovering from major surgery and learning to explore and experience pleasure with entirely new genitalia, all while learning to urinate through and care for genitalia they have never experienced.

For many, a lifetime of gender dysphoria related to their genitals has resulted in deferring some degree of sexual function until they can undergo gender GAS.[1]

Decision making that affects sexual function, postsurgery recovery of sexual function, and even sexual activity after recovery from surgery are all integral topics in the dialogue between patient and surgeon before surgery. Because the details of these topics are naturally obvious or

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intuitive for patients, patients rely on their surgeon and related providers for guidance.[2]

This article presents an ordered review of the role of sexual function in discussion and planning before genital GAS, and through recovery to initiation of sexual activity after surgery. Strategies to optimize sexual function postoperatively are proposed. Clinical observations from the author's clinical series are reviewed, and genital and surgical anatomy to explain the rationale for the treatment strategies proposed is reviewed.

FEMINIZING GENITAL GENDER-AFFIRMING SURGERY WITH VAGINOPLASTY

The principal components of vaginoplasty surgery are[1,3,4]

1. Removal of male-appearing genitalia
2. Creation of a vagina (also known in medical terminology as a vulva)
   a. Neoclitoris
   b. Foreshortened urethra, with the urethral meatus located posterior to the clitoris and anterior to the location of the opening to the vaginal canal
   c. Vaginal canal introitus and posterior fourchette/commissure, with or without a true vaginal canal
   d. Vaginal canal (optional)
   e. Labia majora
   f. Labia minora

THE RELATIONSHIP BETWEEN BIRTH MALE GENITALIA AND SEXUAL FUNCTION

The importance of removal of the male genitalia (penis, elongated urethra, testes, and scrotum) among transgender women undergoing gender-affirming genital surgery with vaginoplasty, for satisfactory sexual function, cannot be understated.[1,2]

In the author's experience, a vast majority of women who identify as transgender associate significant dysphoria with their presurgery male genitalia. Women report that the dysphoria that they feel toward their male genitalia makes it highly uncomfortable for them to allow partners to touch their genitals or to use their penis or scrotum for sexual activity, which naturally limits physical intimacy and sexual function for them.[5] Over 90% of a series of more than 300 women at the author's centers report moderate to significant discomfort with prevaginoplasty physical examination. At these centers, when asked about the relative effect of removal of male-appearing genitalia versus creation of female-appearing genitalia on quality of life, more than 93% of transgender women responded that removal of their male genitalia was at least as important as undergoing creation of female genitalia to improve their quality of life and sexual function postsurgery.

CHOICE OF VAGINOPLASTY: VAGINOPLASTY WITH OR WITHOUT CREATION OF A VAGINAL CANAL

Not all transgender women who undergo vaginoplasty intend to have intercourse with men.[1] Just as with many cisgender women, a proportion of transgender women are sexually active only with other women. Among the first 300 transgender women the author saw in consultation for surgery, 34% reported having only female sexual partners.

Whether or not to undergo creation of a neovaginal canal with their vaginoplasty surgery is an important decision all women must make (**Fig. 1**). The choice for a vaginal canal is an important consideration, because vaginoplasty with creation of a vaginal canal requires a long-term commitment to dilation and douching of the canal, to maintain patency and hygiene. For patients with a paucity of genital skin, the need to use scrotal skin grafts to achieve vaginal depth is associated with an increased risk of failure of graft take[1,2,4,6–8] and, when use of scrotal or other hair-bearing skin is necessary, permanent hair removal delays surgery.[9]

It is useful to ask women considering surgery whether their sexual partners include men, women, both, or neither and whether they plan to have vaginal receptive intercourse.[1] This point of the discussion is an excellent opportunity to emphasize that the choice for whether to have vaginoplasty with or without creation of a canal is the patient's choice but that there are potential advantages, potential disadvantages, and risks associated with each. The author takes care to emphasize to patients that the choice to undergo creation of a vaginal canal requires a lifelong commitment to dilation and douching and, that at any point in their lives, failure to dilate and douche regularly can result in significant complications (vaginal stenosis, chronic infection and pain, and possible need for resection of the canal).[1]

In the author's series of the first 300 patients across centers, of the 213 who consulted at least 1 other surgeon beforehand, a majority of patients who presented for consultation for primary or revision vaginoplasty, 183 (86%), report not having been offered vaginoplasty without creation of a vaginal canal.

A neovagina without a complete canal can be constructed so that its appearance is

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