



Surgery in Motion

Passerini-Glazel Feminizing Genitoplasty: Modifications in 17 Years of Experience with 82 Cases

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Abstract

Objectives: To describe modifications of Passerini-Glazel feminizing genitoplasty and report on long-term functional outcome.

Methods: Modifications include vaginal dissection and disconnection from the urethrovaginal sinus as the initial stage of the procedure; large dissection of the neurovascular bundle on both dorsal and lateral faces of the clitoris; plication of the skin around the reduced clitoris; and suturing the lateral edge of the proximal portion of the mucocutaneous plate with the labia majora's medial edge to a plane deeper than the subcutaneous tissue. These modifications reduce bleeding and operating time, better preserve clitoral sensitivity, form the clitoral prepuce, and create labia minora.

Results: Eighty-two patients underwent modified Passerini-Glazel feminizing genitoplasty. Mean operating time was 120 min (range: 100–180). Forty-six patients (46 of 82, 56%) were assessed at a mean follow-up of 5 yr (range: 2–9). There were no cases of clitoral vascularization defect or urethrovaginal fistula. The urethral meatus was never hypospadiac. The vaginal introitus was large and elastic in all cases. Vaginal caliber at the internal suture line was as large as the vaginal introitus and the distal native vagina in 20 (43.5%) of the 46 girls. All mothers and patients reported satisfaction with external genital appearance.

Conclusions: These long-term results suggest that our modifications of one-stage Passerini-Glazel feminizing genitoplasty facilitate the procedure and produce good cosmetic results.

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1. Introduction

In 1989 Passerini-Glazel presented a one-stage procedure for the correction of severely masculinized

female pseudohermaphrodites in whom a high, short vagina was detached from the urogenital sinus (UGS) and then exteriorized through a cylinder of tissue made of “penile” skin and UGS, which was inserted in

to the perineum and anastomosed to the native vagina [1]. The use of all available tissue was thought to avoid introital vaginal stenosis, a complication that plagued genitoplasty techniques in the past.

We describe modifications of Passerini-Glazel feminizing genitoplasty that are aimed at facilitating the procedure and obtaining good long-term cosmetic results. We performed these modifications in 82 patients.

2. Materials and methods

2.1. Patients

Between 1988 and 2005, 106 consecutive patients with ambiguous genitalia were referred to our institute. All were raised as females, except for 3 patients with mixed gonadal dysgenesis. Of the 106 patients, 82 (77.4%) underwent one-stage Passerini-Glazel feminizing genitoplasty, performed by the same pediatric urologist (A.B.) with some modifications.

In 60 (73.2%) of the 82 cases, the Passerini-Glazel procedure was performed at a mean age of 2 yr (range: 6 mo–13 yr). In this group 47 patients had congenital adrenal hyperplasia, 2 had drug-induced virilization, 4 had partial androgen insensitivity syndrome, 6 had mixed gonadal dysgenesis, and 1 had Denys-Drash syndrome. Prader classification was as follows: grade 3 in 8 patients, grade 4 in 47 patients, and grade 5 in 5 patients. All patients in this group had not undergone previous surgery.

The remaining 22 cases (22 of 82, 26.9%) were patients with congenital adrenal hyperplasia who had previously undergone surgery elsewhere (clitoroplasty in 22 cases, pull-through vaginoplasty in 14 cases, cutback vaginoplasty in 8 cases). These patients were referred to our institute at a mean age of 13 yr (range: 6–21) because of poor outcome and exhibited one or more of the following: buried clitoris (2 cases), residual clitoral hypertrophy (20 cases), urethral hypospadias (22 cases), or stenotic or deep vaginal introitus (22 cases) due to simple longitudinal opening of the UGS to urethrovaginal confluence and external eversion of the UGS plate around the vaginal introitus. In these 22 cases our first step was to debulk previous surgery and return to a pathologic anatomy suitable for modified Passerini-Glazel procedure.

2.2. Surgical technique

The patient was placed in the lithotomy position for the best exposure of the perineum. Abdomen and perineum were prepared and the perineum was draped in a sterile field.

2.2.1. Panendoscopy

Panendoscopy is an initial, integral step of feminizing genitoplasty. The bladder, UGS, and vagina were inspected carefully with the use of a 13F pediatric cystoscope. The communication between the vagina and the UGS was localized with the use of the same instrument. In the majority of cases the cystoscope was passed into the vaginal cavity and the ectocervix was visualized. At that point a 6F silicone Fogarty catheter was inserted into the vaginal cavity through the operative channel of

the cystoscope, and the retention balloon was inflated to 5 ml. The permanence of the balloon in the vagina was tested with traction. The distal end of the catheter was cut off to enable complete removal of the cystoscope.

2.2.2. Perineal approach

An inverted U-shaped perineal incision was made above the anus. This incision permitted creation of an inverted U-shaped flap of skin and subcutaneous tissue, with the apex posterior to the opening of the UGS and the base between the ischial tuberosities. A vertical incision on the midline was then extended from the top of the inverted U-shaped incision up to the meatus of the UGS. The incision was also extended in a Y-shape around the UGS opening and completed with circumferential circumcision of the hypertrophic clitoris (Fig. 1).

2.2.3. Anterior vaginal wall dissection

After complete dissection and turning of the inverted U-shaped cutaneous flap, the inferior aspect of the UGS was dissected and exposed. The inferior aspect of the vaginal pouch was identified by palpation of the Fogarty catheter balloon, which was previously inserted into the vagina and which served as a guide during dissection when traction was applied to the vaginal catheter. We have had no difficulty

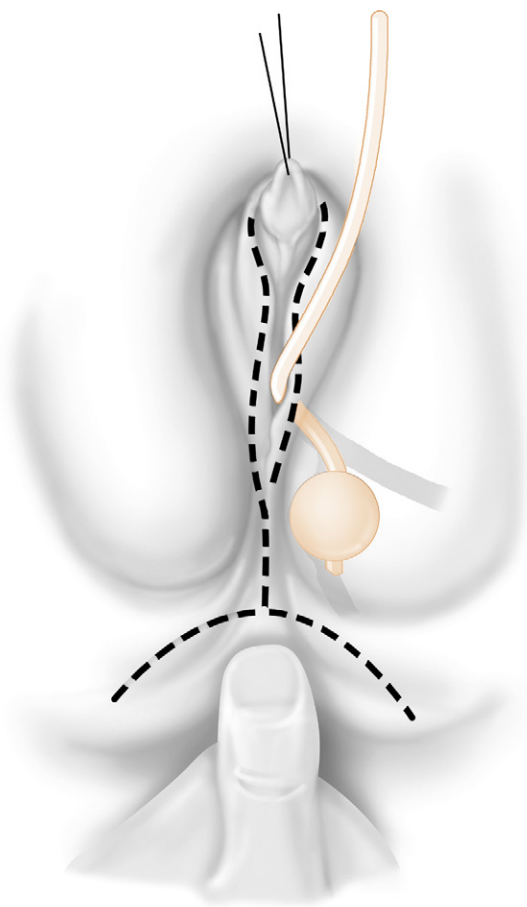


Fig. 1 – The line of incision described an inverted U above the anus, a vertical line up to the meatus of the urogenital sinus (UGS), a Y-shape around the UGS, and a circumferential circumcision of the hypertrophic clitoris.

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