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TRANSGENDER HEALTH

Long-Term Follow-Up of Transgender Women After Secondary Intestinal Vaginoplasty

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ABSTRACT

Introduction: Intestinal vaginoplasty with a sigmoid colon or ileal segment is an established surgical technique for vaginal reconstruction. Little has been reported on long-term (functional) outcome and postoperative quality of life.

Aims: To assess the surgical and long-term psychological outcomes of secondary intestinal vaginoplasty performed from 1970 through 2000 in transgender women.

Methods: Transgender women who underwent intestinal vaginoplasty from 1970 through 2000 were identified from our hospital registry. Demographics, surgical characteristics, complications, and reoperations were recorded. Traceable women were invited to fill out a set of questionnaires (quality-of-life questionnaire, Female Sexual Function Index, Amsterdam Hyperactive Pelvic Floor Scale for Women, Female Genital Self-Imaging Scale, and self-evaluation of vaginoplasty questionnaire) and attend the outpatient clinic for physical, endoscopic, and histologic examination of the neovagina.

Main Outcome Measures: Primary outcomes were complications, reoperations, self-perceived quality of life, and functional and esthetic self-evaluation.

Results: Twenty-four transgender women were identified who underwent intestinal vaginoplasty as a secondary procedure from 1970 through 2000. There were no intraoperative complications. Three intestinal neovaginas were surgically removed because of postoperative complications. Nineteen women (79%) underwent at least one genital reoperation, most commonly introitus plasty (n = 13, 54%). Five women were deceased at time of analysis. Nine women consented to partake in the study (median age = 58 years, range = 50–73; median postoperative time = 29.6 years, range = 17.2–34.3). They were generally satisfied with life and scored 5.9 of 7 on a subjective happiness scale. Neovaginal functionality was rated as 7.3 and appearance as 7.4 of 10.

Conclusion: In our institution, intestinal vaginoplasty before 2000 was always performed as a revision procedure after a previous vaginoplasty had failed. Although surgical corrections were frequently necessary, women reported satisfaction with the surgical outcome and with life in general.

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Key Words: Transgendered Persons; Gender Dysphoria; Sex Reassignment Surgery; Gender Affirming Surgery; Vaginoplasty; Intestinal Vaginoplasty; Surgery; Quality of Life

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INTRODUCTION

Surgical creation of a vagina (ie, vaginoplasty) is indicated for patients with vaginal agenesis, patients with acquired absence of the vagina, and transgender women as gender-confirming surgery. The absence of a functional vagina compromises psychosexual health and vaginoplasty could improve quality of life in selected patients.[1] Multiple techniques exist for vaginoplasty. In penile-inversion vaginoplasty, the surgical gold standard for transgender women, an inverted penile skin flap, sometimes combined with a scrotal flap, is used as neovaginal lining.[2] However, this technique provides inadequate neovaginal depth in patients who lack sufficient penoscrotal skin. These patients include previously circumcised patients, patients with penoscrotal hypoplasia from treatment with puberty-suppressing hormones, and patients who previously underwent penile-skin vaginoplasty that failed to provide adequate neovaginal depth. In these patients, intestinal vaginoplasty is indicated. In intestinal vaginoplasty, an intestinal segment, most commonly the sigmoid colon or ileum, is used to form the neovaginal cavity. Currently, intestinal vaginoplasty is an established technique for vaginal reconstruction. Pros (adequate depth, sufficient lubrication for penetrative sexual intercourse) and cons (abdominal surgery, risk of neovaginal bowel complications) of this surgical procedure have to be considered by the patient and the surgeon. Based on retrospective studies, intestinal vaginoplasty seems to be associated with a low complication rate.[3] Currently, long-term follow-up data on intestinal vaginoplasty are sparse, especially when it is performed as secondary revision vaginoplasty. There is no literature regarding (postoperative) quality of life.[3] In this study, we aimed to assess the surgical and long-term psychological outcomes of transgender women who underwent secondary intestinal vaginoplasty.

METHODS

Patients

This is a retrospective study with prospective follow-up on patients who underwent intestinal vaginoplasty from 1970 through 2000 at the VU University Medical Center in Amsterdam and elsewhere and were seen at our institution for postoperative follow-up during this period. Patients were identified from our hospital registry and patient demographics, surgical characteristics, (post)operative complications, reoperations, and neovaginal dimensions were recorded. This study was approved by our institutional medical ethical committee (2012/157). Informed consent was obtained from the subjects.

Prospective Follow-Up

Alive and traceable women were contacted by mail or telephone and asked to participate. After having provided informed consent, women were invited to our outpatient clinic for follow-up. Patients were asked to complete five questionnaires:

1. A quality-of-life questionnaire consisted of the Satisfaction With Life Scale (SWLS), the Subjective Happiness Scale (SHS), and a single-item indicator of well-being derived from the Cantril Ladder of Life Satisfaction.[4–6] The SWLS measures global life satisfaction with five items on a seven-point Likert scale. An average score of 4 indicates neutral, a score higher than 6.2 indicates extremely satisfied, and a score lower than 2 indicates extremely dissatisfied.[7] The SHS measures subjective global happiness, rated on four items on a seven-point Likert scale. Higher scores indicate a higher level of happiness. The single-item indicator of well-being derived from the Cantril Ladder of Life Satisfaction asks patients to grade their satisfaction with life as 0 (the worst possible life) to 10 (the best possible life).
2. A short questionnaire for self-evaluation of vaginoplasty addressed patient-reported satisfaction with esthetic and functional outcomes, graded from 1 (worst) to 10 (best), overall satisfaction with the result (yes, no, not entirely), and the possibility of sexual arousal and orgasm.
3. The Female Genital Self-Imaging Scale (FGSIS) addresses genital self-image in women through seven questions using a four-point response scale (strongly agree, agree, disagree, strongly disagree).[8] Scores on each item are summed for a total score ranging from 7 to 28, in which a higher score indicates a more positive genital self-image.
4. The Amsterdam Hyperactive Pelvic Floor Scale for Women (AHPFS-W) addresses 30 symptoms relating to pelvic floor hypertonicity.[9] Patients indicate how often they experience each symptom from 1 (never) to 5 (very often). When grouped, individual symptoms form subcategories: provoked vulvodynia, irritable bowel syndrome, lower urinary tract symptoms, urinary tract infections, rectal symptoms, and generalized stress. A summed score of at least 11 for these subcategories indicates hypertonic pelvic floor dysfunction.
5. The Female Sexual Function Index (FSFI) addresses sexual function in six subscales (desire, arousal, lubrication, orgasm, satisfaction, and pain) with 19 questions.[10] Each subscale has a maximum score of 6, for a total score of 36, in which higher scores indicate better sexual function. The cutoff value for sexual dysfunction is 26.55 in biological women.[11]

Endoscopic and Histologic Neovaginal Examination

In consenting women, neovaginal symptoms, such as discharge, (post)coital bleeding, pain, tenesmus, and malodor, were recorded by a physician with experience in transgender health care at our outpatient clinic. Physical examination was performed. Subsequently, the intestinal neovagina was endoscopically examined with a flexible video endoscope (Olympus GmbH, Hamburg, Germany) by an experienced gastroenterologist and evaluated for endoscopic signs of inflammation (eg, erythema, vascular pattern, friability, granularity, edema, ulceration, and resilience). Neovaginal biopsy specimens were obtained during endoscopic examination with a

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