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TRANSGENDER HEALTH

A Longitudinal Study of Motivations Before and Psychosexual Outcomes After Genital Gender-Confirming Surgery in Transmen

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ABSTRACT

Background: Genital dissatisfaction is an important reason for transmen to undergo genital gender-confirming surgery (GCS; phalloplasty or metoidioplasty). However, little is known about motives for choosing specific techniques, how transmen benefit postoperatively, and whether psychosexual outcomes improve.

Aim: To evaluate motivations for and psychosexual outcomes after GCS.

Methods: A longitudinal study of 21 transmen at least 1 year after GCS was conducted. Participants were recruited through their surgeon. Data were collected when they applied for surgery and at least 1 year after surgery.

Outcomes: Data collection included semistructured questionnaires on motivations for surgery, postoperative experiences, and standardized measures of psychological symptoms, body image, self-esteem, sexuality, and quality of life (pre- and postoperative). Information on surgical complications and corrections was retrieved from medical records.

Results: Most participants underwent phalloplasty with urethral lengthening using a radial forearm flap. Although problematic voiding symptoms were prevalent, many participants were satisfied with their penile function. The strongest motivations to pursue penile surgery were confirmation of one's identity (100%), enabling sexual intercourse (78%), and voiding while standing (74%). No significant differences between postoperative and reference values were observed for standardized measures. After surgery, transmen were more sexually active (masturbation and with a partner) and used their genitals more frequently during sex compared with before surgery (31–78%).

Clinical Implications: The present study provides input for preoperative decision making: (i) main motives for surgery include identity confirmation, voiding, and sexuality, (ii) surgery can result in more sexual activity and genital involvement during sex, although some distress can remain, but (iii) complications and voiding symptoms are prevalent.

Strength and Limitations: Study strengths include its longitudinal design and the novelty of the studied outcomes. The main limitations include the sample size and the nature of the assessment.

Conclusion: Counseling and decision making for GCS in transmen should be a highly personalized and interdisciplinary practice. **van de Grift TC, Pigot GLS, Boudhan S, et al. A Longitudinal Study of Motivations Before and Psychosexual Outcomes After Genital Gender-Confirming Surgery in Transmen. J Sex Med 2017;14:1621–1628.**

Key Words: Gender Dysphoria; Phalloplasty; Gender-Confirming Surgery; Sexuality; Quality of Life

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INTRODUCTION

Gender dysphoria refers to the phenomenon in which a person experiences psychological distress resulting from incongruence between the assigned and the experienced gender identity.[1] As a result, a subgroup might apply for medical care. Gender-confirming medical care is generally conducted in interdisciplinary facilities and includes psychological counseling, cross-sex hormone treatment, and gender-confirming surgeries (GCSs).

Transmen are assigned female at birth but identify as male or masculine. Medical care for this group can include testosterone therapy, hysterectomy with bilateral salpingo-oophorectomy, subcutaneous mastectomy, and genital GCS.[2] Because much of the gender dysphoria might be related to female genitals,[3] approximately 30% of transmen apply for GCS.[4,5] Some reasons not to obtain GCS are associated risks, absence of genital dysphoria, and/or non-binary gender identities.[6]

The most performed and studied techniques of GCS in transmen include phalloplasty (eg, with free radial forearm flap [FRFF] or anterolateral thigh flap [ALTF]) and metoidioplasty.[2,7] The benefits of FRFF phalloplasty include pliable donor tissue, reliable vascularization, good phallic sensation, and the opportunity to implant erection prostheses.[2,8] Disadvantages include the high risk of flap-related complications and mutilating donor-site scarring.[2,9] Compared with FRFF phalloplasty, the advantage of ALTF phalloplasty includes less visible donor-site scarring, although the flap usually does not allow for a neourethra.[2,8] In general, in metoidioplasty, the hypertrophic clitoris, a consequence of testosterone therapy, is released by dissecting the urethral plate and suspensory ligaments. In addition, urethral lengthening can be performed using labia minora flaps and scrotoplasty can be performed using labia majora flaps.[10] Advantages of this procedure include lower complication rates compared with phalloplasty and good phallic sensation, although penetration is less frequently possible.[2,8]

Several studies have been published on complication rates and functional outcomes (eg, esthetics, voiding, and sensation) after GCS.[7,11] Most reported complications after phalloplasty are urethral fistulas and strictures, (partial) flap loss, and donor-site complications.[11] Phalloplasty in transmen generally yields a masculine genital appearance and good phallic sensation and voiding while standing is frequently possible.[7,11] However, problems with urinary function are observed after surgery, including postvoid dribbling, incontinence,[12,13] and an overactive bladder.[13] Penetrative sex is possible for approximately 20% of transmen who undergo FRFF phalloplasty,[11] although the implantation of erection prosthesis has not been specified. Erectile implants can facilitate (vaginal or anal) sexual intercourse, although implant malposition and dysfunction are possible issues.[14,15]

Because the various available GCS techniques have their pros and cons, surgery should be preceded by extensive counseling. In the literature, it is stated that a surgical technique is best selected based on the "individual's goals and expectations."[7] However, to date, little is known about the motivations of transmen to pursue GCS at all and why certain techniques are preferred.[16] Clinical experience and the scarce literature[17] suggest that a masculine genital appearance, voiding while standing, enabling the wearing of tight shorts, and sexuality play a role in the decision making of transmen. Nevertheless, data on the extent to which surgery contributes to resolving these issues remain largely unknown.

What is known is that metoidioplasty and phalloplasty are followed by high satisfaction rates of 93% and 78% to 100%, respectively.[11] Overall improvements of quality of life, lowered gender dysphoria, and lowered psychological symptoms after gender-confirming treatments as a whole have been reported,[5,18,19] although limited prospective data on the effects of genital GCS specifically on these parameters are available. For sexuality, participants report a satisfactory sex life after phalloplasty,[20–22] although testosterone treatment is a contributory factor.[23] Initiating sexual contacts and undressing in public spaces could remain problematic after phalloplasty.[24] Because these issues could be motives for transmen to pursue GCS, more knowledge on the motives and psychosexual experiences could improve preoperative counseling, surgical decision making, and ultimately postoperative outcomes.

AIMS

In this study we longitudinally assessed the functional and experienced outcomes after GCS in transmen. Preoperative motives to obtain certain surgical techniques were compared with postoperative experiences. We expected surgery would significantly improve psychosexual well-being and experiences would be influenced by more variables (eg, having a partner) than surgery alone.

METHODS

Procedure

From October 2015 through March 2016, all transmen who applied for GCS from 2011 through 2015 and were at least 1 year postoperative were invited to participate (N = 34). After obtaining written informed consent, participants received a paper questionnaire and voiding surveys. Non-responders were reminded by phone. Study participation was voluntary and the study was approved by the local ethics committee.

Surgical care was conducted according to the World Professional Association for Transgender Health standards of care.[7] Patients were considered eligible for surgery based on no smoking, a body mass index of 18 to 30 kg/m^2, and adequate epilation of the urethral donor site(s). In addition, preoperative counseling was conducted by (obligatory) consultations with a psychologist-sexologist, a plastic surgeon, and a urologist. If required, additional procedures before GCS included colpectomy and donor-site tissue expansion. The psychologist-sexologist standardly discussed expectations and support of the transman and performed standardized assessment of psychological topics such as body image, self-esteem, and quality of life (used as baseline measures in this study). The surgical techniques performed included phalloplasty (based on ALTF and FRFF) and metoidioplasty with or without urethroplasty. The postoperative regimen included 5 to 7 days of hospital observation, 6 weeks of abstinence from heavy physical activity, and outpatient clinic