Discussion

Unfavorable Long-Term Results of Rectosigmoid Neocolpopoiesis

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Discussion by Donald R. Laub, M.D.

The paper by Hage and associates on the use of rectosigmoid for neocolpoporrhaphy is welcome in the literature because little exists on these subjects in our peer-reviewed journals. The article is well written but conveys an impression that may not be correct.

Hage et al. report introital stenosis, neuroma formation, and diversion colitis. Each of these outcomes has “another side of the coin” that should be brought out clearly both for the experienced and for the uninitiated clinician.

Introital stenosis, of course, will occur in 100 percent of cases if the colon and skin are sutured without Z-plasties or Z-forming darts to break up the purse-string effect of a healing scar in such a concave or circular area. The scar without prophylactic longitudinal darts will in fact contract to a small diameter. However, generous longitudinal incisions made in the open end of the colon (three longitudinal 2-cm fish-mouth incisions equal 12 cm of additional circumference) will prevent contracture. Accurate suturing with fine suture material overseeing the pilot sutures and externalizing the colon to the exact point of introitus without allowing visibility of the colon are two additional methods to prevent stenosis at the suture line. Stenosis of the intestine itself, in sharp distinction to skin graft or even pedicle, will not occur, and there is a vast difference in the three methods in regard to this issue about stenosis.

Neuroma formation at the anterior vaginal introitus represents the cut ends of either the internal pudendal deep penile nerves (the erotic supply to corona and glans) or even the ileoinguinal and ileohypogastric (which supply the shaft skin). In cases where the glans (or with Hage et al. the ends of the nerves to the glans) is transposed to the clitoris position, these nerves will not become neuromas. If penis nerves are severed at the distal end of the penile skin flap, they are better placed in the area of the female G spot, near the prostate, where pleasurable sensation may very well occur.

My series includes 2 of 75 patients who reported painful neuromas at this site. In both these patients, the glans was not transposed, and in both, healing was delayed and associated with formation of more scar than usual. The symptoms tend to resolve with time.

The papers and discussion at the Genitourinary Reconstruction Surgery Society meeting in San Francisco suggested that cancer of the colon will eventually occur after urethral colonic anastomosis, and I was warned in that regard. Hage et al. have shown great insight into the factors regarding this predisposition. Diversion colitis, I suppose, may occur but can be treated. I have recently performed eight random biopsies of colonic neovaginas and have had the pathologist reread the tissue preparations; he found colitis, but no diversion colitis.

I have an experience of 75 cases of rectosigmoid vaginoplasty. Because the rectosigmoid itself does not contract, because it causes a certain definite sensibility, and because rectosigmoid in distinction to other methods of vaginal construction produces natural lubrication without excessive mucorhea and brings magnificent blood supply, this method produces the most
natural vagina and is the procedure of choice for vaginal atresia and most cases of gender dysphoria in my strong opinion. And I have an open mind.

The point is that these complications can certainly occur, and perhaps more often early in a series. They can be eliminated or reduced to a low percentage with prophylactic measures. Please don’t shoot the procedure until the risks outweigh the benefits. The shortcomings are correctable.

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