

# The gynecologic examination of the transfeminine person after penile inversion vaginoplasty



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As more transfeminine patients (transgender and gender-diverse persons, sex assigned male at birth, who identify on the feminine spectrum of gender) are undergoing gender-affirming penile inversion vaginoplasty, gynecologists, as providers of vaginal care for both native and neovaginas, should be prepared to welcome these patients into their practice and offer long-term pelvic healthcare.

Many parts of the anatomy, clinical examination, and aftercare differ from both native vaginas and other neovaginal surgical techniques. Transgender and gender-diverse patients cite a lack of clinician knowledge as a barrier to accessing affirming and competent healthcare. Although publications are emerging regarding this procedure, most focus on intraoperative and postoperative complications. These studies are not positioned to provide long-term pelvic health guidance or robust instruction on typical examination findings.

This clinical opinion aims to address that knowledge gap by describing the gynecologic examination in the transfeminine person who has undergone a penile inversion vaginoplasty. We review the anatomic changes with surgery and the neovagina's physiology. We describe the examination of the vulva, vagina, and urethra and discuss special considerations for performing pelvic examinations on patients with a penile inversion vaginoplasty neovagina. We will also address common pathologic findings and their initial management. This clinical opinion originates from the expertise of gynecologists who have cared for high volumes of transfeminine patients who have undergone penile inversion vaginoplasties at tertiary care centers performing gender-affirming genital surgery, along with existing research on postpenile inversion vaginoplasty outcomes. Gynecologists should be familiar with the anatomic changes that occur with penile inversion vaginoplasty gender-affirming surgery and how those changes affect care. Providing transgender patients with comprehensive care including this sensitive examination can and should be part of the gynecologist's scope of practice.

**Key words:** gender affirmation surgery, gynecologic examination, neovagina, pelvic examination, penile inversion vaginoplasty, postoperative care, transfeminine persons, transgender, transgender surgery, transgender women, vaginal surgery, vaginoplasty

with vaginas. As such, gynecologists must understand the typical physiology and postoperative anatomy of patients who have undergone PIV to provide competent care.<sup>4</sup> TGD persons report a lack of clinician knowledge as a barrier to receiving appropriate care.<sup>5</sup> Gynecologists themselves (both who do and do not care for TGD patients) have identified education in TGD reproductive health as a current need.<sup>5,6</sup> Limited research exists on long-term complications and outcomes regarding PIV—most studies only follow patients a few months to a few years postoperatively, focus primarily on complications, and are not positioned to provide long-term pelvic health guidance or robust instruction on typical examination findings.<sup>7,8</sup> Thus, a need exists for experienced guidance.

Our institutions have multidisciplinary transgender surgical teams (urologists, plastic surgeons, and gynecologists) who perform and care for patients who have undergone vaginoplasties. At our institutions, gynecologists are the primary clinicians for long-term pelvic care of patients who have undergone PIV. This clinical opinion originates from our expertise of providing care for high volumes of these patients and incorporates existing literature when present. The aim is to empower other gynecologists to provide this care by offering guidance regarding the neovulvar and neovaginal examination.

## The Procedure

Appreciating the postoperative anatomy after a PIV requires a basic understanding of the procedure (Figure 1).<sup>9,10</sup> Before the procedure, patients undergo hair removal of the penile shaft and medial scrotum to decrease the risk of persistent hair inside the neovagina. The only permanent hair removal method is electrolysis; however, patients may use laser if electrolysis is unavailable.

## Introduction

Increasing provider training, insurance coverage, and accessibility has allowed more transgender and gender-diverse (TGD) patients to undergo gender-affirming surgery than ever before. The most common gender-affirming vaginoplasty sought by transfeminine persons is the penile inversion vaginoplasty (PIV).<sup>1,2</sup> The 2015 United States Transgender Survey (a national survey of the experiences of 27,715 transgender adults) noted 66% of transfeminine respondents had or desired to undergo a vaginoplasty.<sup>3</sup>

The gynecologists' scope of practice includes the pelvic health of all persons

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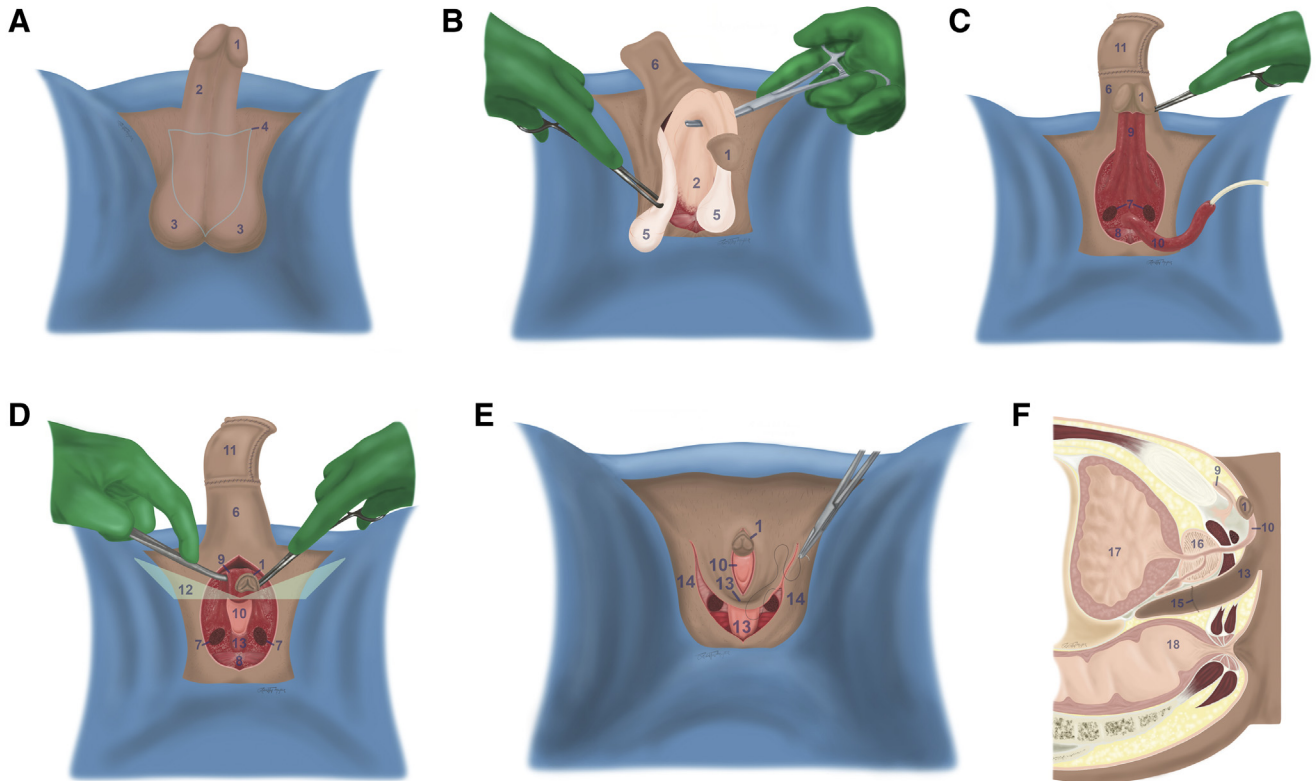
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**FIGURE 1**  
Steps of the penile inversion vaginoplasty



**A**, The perineal skin is incised. **B**, The perineal and scrotal skin is removed, the penile skin is degloved, and bilateral orchiectomy is performed. **C**, The neurovascular bundle is dissected, the erectile tissue is removed, and the scrotal skin is formed over the mold for the distal neovagina and sewn to the penile skin. **D**, The neurovascular bundle with glans (neoclitoris) is folded back on itself at the level of the adductor longus tendon, the urethra is transected and sutured to the overlying skin, and the neovaginal path is developed. **E**, The skin tube is inverted into the neovaginal path, wounds are closed, and the labia are created. **F**, The final path of the neovagina and the location of the neoclitoris. Key: 1, glans; 2, penile shaft; 3, scrotum; 4, incision; 5, testicle; 6, degloved penile skin; 7, truncated erectile tissue; 8, perineal body; 9, neurovascular bundle; 10, urethra; 11, scrotal skin; 12, level of adductor longus; 13, vaginal plane/neovagina; 14, neovulva; 15, suture line between penile and scrotal skin; 16, prostate; 17, bladder; 18, rectum.

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The procedure begins with perineal skin incisions followed by a bilateral orchiectomy (Figure 1, A and B). The perineal and scrotal skin is removed and used as a full-thickness skin graft for the neovagina. The penile skin is degloved with the glans preserved for clitoroplasty (Figure 1, B). The neurovascular bundle is dissected and the erectile tissue removed (Figure 1, C). The neurovascular bundle supplying the neoclitoris is folded back on itself to allow for it to fall at an aesthetically accurate location at the level of the adductor longus tendon (Figure 1, D). The urethra is transected, spatulated, and sutured to the overlying skin (Figure 1, D).

For the neovaginal path, the perineum is dissected and the perineal body divided, releasing its fixation to the bulbar urethra. The path of the neovagina (typically 14 cm in length) is then developed in the plane between the Denonvilliers' fascia (inferior to the urethra and prostate) and superior to the ventral rectal fascia, to the level of the perineal reflection (Figure 1, F). The scrotal skin is formed over a mold to create the distal neovagina and sewn to the penile skin (Figure 1, C). The skin tube is inverted into the previously developed plane to create the neovagina (Figure 1, E). All wounds are then closed, using existing tissues to create the labia (Figure 1, E).

Immediately after the procedure, dilation protocols are initiated (Tables 1 and 2) to maintain the vaginal patency while the patient is healing. Most complications occur during this time and are reviewed elsewhere.<sup>1,7,8,11</sup> The examination addressed here is for care after the acute postoperative period.

#### Indications for Examination

The American College of Obstetricians and Gynecologists no longer recommends annual pelvic examinations for asymptomatic patients, and no guideline for persons who have undergone PIV states differently.<sup>11,12</sup> Although we do not require routine pelvic examinations

**TABLE 1**  
**Dilation techniques<sup>a</sup>**

Technique	Steps
Preparation	<ul style="list-style-type: none"> <li>• Use the largest dilator that can be comfortably inserted.</li> <li>• Ensure the dilator is clean before use, and if not, clean the dilator with warm water, dishwashing liquid, or antibacterial soap and wipe dry.</li> </ul>
Insertion	<ul style="list-style-type: none"> <li>• Apply a water-soluble lubricant to the dilator before insertion (may also insert lubricant directly into the vagina).</li> <li>• Take a deep breath when inserting the dilator, to allow for the pelvic floor relaxation.</li> <li>• Gently insert into the vagina with the dilator tilted about 45 degrees downward until under the pubic bone and then continue straight inward.</li> <li>• A mirror can be helpful with putting the dilator in correctly.</li> <li>• A small amount of resistance and tenderness is normal, but if too much resistance or severe pain is felt, stop and try a smaller dilator.</li> </ul>
Dilation	<ul style="list-style-type: none"> <li>• Insert the dilator into the full depth of the vagina (until moderate pressure or resistance is felt) and leave in place for 15 to 20 min. Approximately 3 inches of the dilator should remain outside the vagina. Keep light pressure on the dilator so that it does not slide out.</li> </ul>
Aftercare	<ul style="list-style-type: none"> <li>• Clean the dilator with warm water, dishwashing liquid, or antibacterial soap and wipe dry.</li> <li>• Wipe the external genitals clean with a moist hand cloth or wet wipe.</li> <li>• Douche every day to every other day for the first 2 mo after surgery, then once or twice weekly to flush out the extra lubricant.</li> </ul>

<sup>a</sup> Adapted from the University of Kansas Medical Center and Boston Children's Hospital Center for Gender Surgery Dilation Instructions. These techniques are an example. Clinicians should always ask patients about their surgeon's specific schedule and protocol.

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for asymptomatic patients, some patients may request it (ie, based on counseling provided by their surgeon). However, more importantly, trans-feminine patients may present for care and bring up pelvic health concerns that necessitate examinations. Relevant indications for examinations include a wide variety of concerns or symptoms (eg, vulvar masses, vaginal discharge, dyspareunia, or sexually transmitted infection [STI] acquisition).<sup>1,10,13</sup>

Regardless of the examination indication, typical PIV pelvic anatomy and physiology knowledge is crucial to providing this care.

**Creating a Welcoming Space**

Any pelvic examination requires a trauma-informed and patient-centered approach.<sup>14,15</sup> This approach recognizes that potential past trauma can influence patient experiences of medical care. The physical and sexual trauma experienced

by TGD persons and intentional or inadvertent maltreatment by medical providers are well documented.<sup>3</sup> Clinicians should be sensitive to the impact of their own implicit bias, potential gender dysphoria, and past trauma experienced by the patient and discuss with them in advance all the components of the examination. Furthermore, patients should be informed that they are in control of the examination and asked how the examination can be made safer and more comfortable.<sup>11,16</sup> Finally, clinicians should ascertain patients' chosen terminology for their anatomy and respect these terms; when possible, consideration should be given to the use of these terms during the examination.<sup>17</sup>

**The Examination**

As with persons with native vaginas and those who have undergone other forms of vaginoplasty, the genitalia of persons who have undergone PIV vary greatly. Examples of examination findings and general anatomic position of genital structures are labeled in [Figure 2](#). Each section below addresses expected physiological changes and pathologic findings that may occur, with key pathologies summarized in [Table 3](#).

**TABLE 2**  
**Dilation schedule<sup>a</sup>**

Timeline <sup>b</sup>	Dilation frequency <sup>c</sup>
Wk 1–3	4 times per day
Wk 4–6	3 times per day
Wk 7–9	2 times per day
Wk 10–12	Daily
Ongoing	1–2 times per week <sup>d</sup>

<sup>a</sup> Adapted from the University of Kansas Medical Center and Boston Children's Hospital Center for Gender Surgery Dilation Instructions. This schedule is an example. Clinicians should always ask patients about their surgeons' specific schedule and protocol; <sup>b</sup> Dilation typically begins (defined here as week 1) roughly 1 to 2 weeks after surgery, depending on the surgeon's specific protocol; <sup>c</sup> If the vagina begins to feel tight, dilation frequency should increase; <sup>d</sup> Unless engaging in regular insertional intercourse.

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## Vulva

The examination of the vulva includes a thorough visual inspection moving anteriorly to posteriorly. The labia majora, which are constructed from the scrotal skin, may have rugae as is typical of the scrotum (Figure 2, A). Suture lines running anteriorly to posteriorly along the labia majora are often visible (Figure 2, A). When the labia majora are separated, the labia minora, urethra, and clitoris can be evaluated. The labia minora are constructed from the scrotal skin (Figure 2, A) and the clitoris from the penile glans (Figure 2, B). The urethral orifice is inferior to the clitoris. There is often a greater distance between the clitoris and urethra in a person who has undergone PIV than someone with a native clitoris.

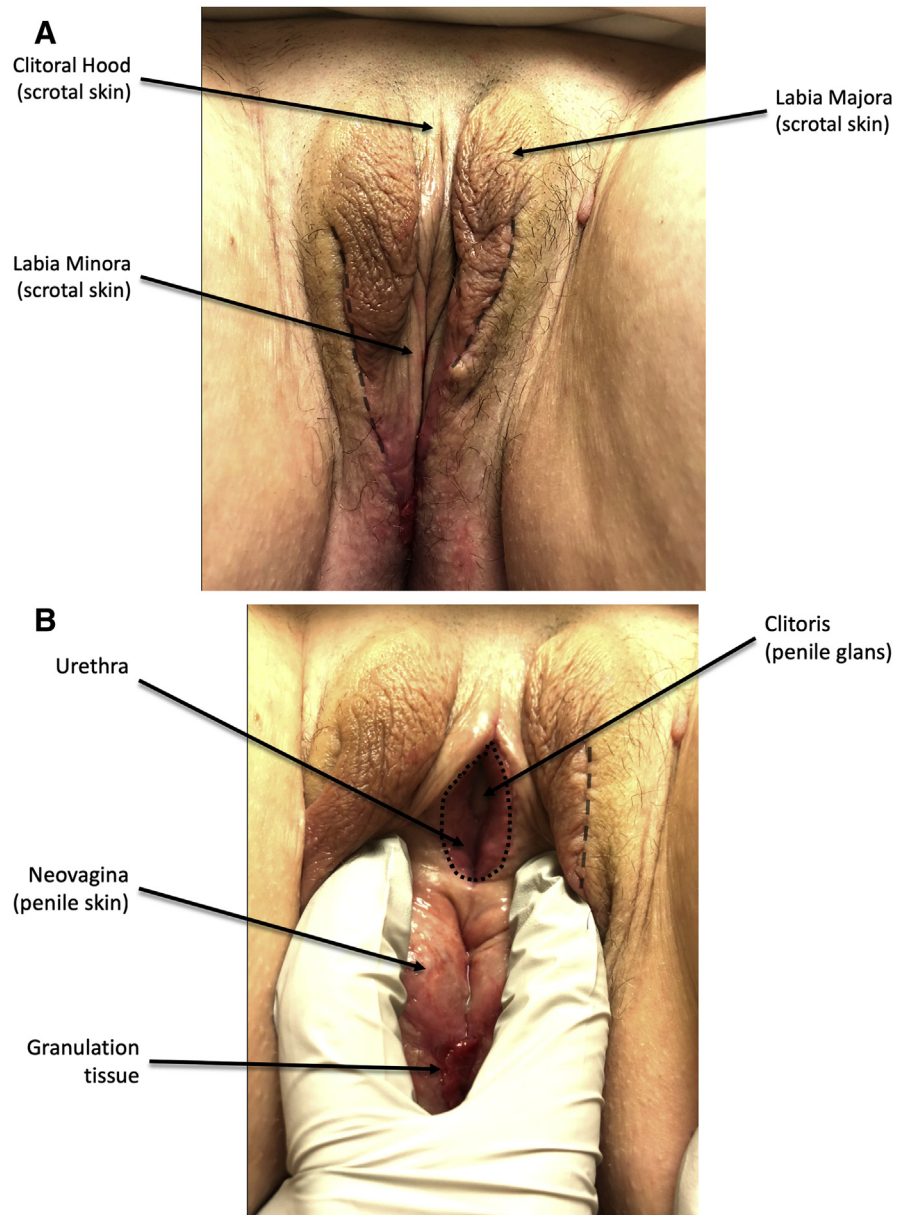
Because the neovulvar tissues are scrotal, they carry the same risk for lesions and infections. Herpes, condyloma, syphilitic chancre, and chancroid are all possible infectious pathologies, and lesions suspicious for these should be evaluated and treated as per standard guidance.<sup>18</sup> The human papillomavirus (HPV) can also infect the scrotal skin, so it is possible to develop genital warts. HPV-related cancer has been found on the scrotal tissue.<sup>19</sup> We recommend HPV vaccination to all patients at the age of  $\leq 45$  years.<sup>20</sup> The scrotal skin can also carry the risk of dermatoses such as psoriasis, eczema, or lichen sclerosus.<sup>21,22</sup> Any visible or concerning lesion should be biopsied and followed up appropriately. Colposcopic assistance is reasonable.

Patients may also present with cosmetic concerns regarding the labia.<sup>8</sup> Postoperative healing may result in the labia majora spaced far apart or minimal labia minora or clitoral hood.<sup>11</sup> These should be referred to a surgeon who specializes in PIV.

## Vagina

We recommend beginning a vaginal examination with a digital examination using a single digit to assess the length and path of the neovagina and to palpate the pelvic floor musculature for tenderness or spasm or to palpate the bladder or prostate for tenderness. An anoscope

**FIGURE 2**  
Neovulvar and neovestibular anatomies after penile inversion vaginoplasty



**A**, Neovulvar anatomy after penile inversion vaginoplasty. **B**, Neovestibular anatomy after penile inversion vaginoplasty. Key: the symbol - - - indicates suture lines, and ••••• indicates urethral tissue.

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rather than a speculum can be considered, although a speculum is a more accessible tool and most patients tolerate the average Pederson speculum. We recommend discussing with the patient which size tool may be appropriate.<sup>13</sup> The clinician should examine the entire

length of the vagina beginning at the apex and moving distally.

Because the neovagina comprises keratinized stratified squamous tissue, it is less elastic than the epithelium of a native vagina. It also lacks a cervix and is often both narrower and more posterior

TABLE 3

## Complaints and findings that may arise in a transfeminine patient with a history of penile inversion vaginoplasty

Anatomic structure	Native tissue	Postoperative changes or complications	Infections	Other concerns
Neovulva	Scrotal and perineal	<ul style="list-style-type: none"> <li>Cosmetic concerns regarding labia majora spacing, small size of labia minora tissue, or small size of clitoral hood</li> </ul>	<ul style="list-style-type: none"> <li>Analogous to scrotal tissue (eg, herpes, condyloma, syphilitic chancre, chancroid, HPV)</li> </ul>	<ul style="list-style-type: none"> <li>Skin neoplasms (eg, melanoma, squamous cell carcinoma)</li> <li>Dermatosis (eg, eczema, psoriasis, lichen sclerosus)</li> </ul>
Neovagina	Penile and scrotal	<ul style="list-style-type: none"> <li>Loss of length or width</li> <li>Stricture or vaginal webbing</li> <li>Prolapse</li> <li>Granulation tissue</li> <li>Residual pubic hair (may be ingrown or infected)</li> <li>Fistulas (rectoneovaginal, ureteroneovaginal, vesiconeovaginal)<sup>a</sup></li> </ul>	<ul style="list-style-type: none"> <li>Analogous to penile tissue (eg, herpes, condyloma, syphilitic chancre, chancroid, HPV)</li> <li>Bacterial vaginosis</li> <li>Gonorrhea, chlamydia<sup>b</sup></li> </ul>	<ul style="list-style-type: none"> <li>Noninfectious discharge (eg, lubrication, semen, sebum, dead-skin sloughing)</li> <li>Skin neoplasms (eg, melanoma, squamous cell carcinoma)</li> <li>Dermatosis (eg, eczema, psoriasis, lichen sclerosus)</li> </ul>
Urethra	N/A	<ul style="list-style-type: none"> <li>Stream diversion</li> <li>Urethral stricture</li> <li>Residual erectile tissue</li> </ul>	<ul style="list-style-type: none"> <li>UTI</li> <li>Gonorrhea or chlamydia urethritis</li> </ul>	<ul style="list-style-type: none"> <li>Voiding dysfunction (eg, overactive bladder, incomplete emptying)</li> <li>Prostatic issues (eg, BPH, prostatitis, prostate cancer)</li> </ul>
Pelvic floor	N/A			<ul style="list-style-type: none"> <li>Pelvic floor dysfunction</li> <li>Vaginismus</li> </ul>

BPH, benign prostatic hypertrophy; HPV, human papillomavirus; N/A, not applicable; UTI, urinary tract infection.

<sup>a</sup> Most commonly identified during the intraoperative or immediate postoperative period; <sup>b</sup> The neovaginal tissue is generally resistant to gonorrhea and chlamydia. Infections are more likely to present in the urethra.

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in orientation than native vaginas (Figure 1, F). Suture lines may be appreciated in the upper half of the vagina owing to the grafting of penile and scrotal skin.

Patients who have undergone PIV require lifelong dilation of the vagina (Table 2). Of note, PIV dilators are typically larger than those routinely used in other neovaginal surgeries and are not meant to be left in overnight.<sup>23</sup> After surgery, patients should be dilating more frequently (Table 2). Many PIV surgeons have specific protocols. Routine gynecologic care of these patients includes evaluation and support of dilation care. This includes assessing the depth and width of the vagina as the patient tapers down their dilation schedule to ensure no diminishment of either and eliciting the patient's dilation history and personal experience of progress or regression. A common long-term finding is the loss of length.<sup>7</sup> If loss of either width or length is found, increasing the dilation

frequency is recommended.<sup>11</sup> Any persistent pain or blockage with dilation or insertional intercourse should be addressed with a surgeon skilled in PIV. Webbing across the vagina or stricture may need to be surgically addressed.<sup>1</sup> Physical therapy or botulinum toxin injections may be recommended depending on a surgeon's assessment.<sup>11</sup>

When assessing dilation, the dilator should be inserted into the full depth of the vagina with moderate pressure felt. We describe dilation techniques in greater detail in Table 3. For those who have lost length or width, a soft silicone dilator may be used because they are better tolerated with scar tissues.<sup>1</sup>

In contrast to a native vagina where douching is contraindicated and can increase the infection risk, a PIV neovagina contains keratinized epithelium and does not self-clean. As such, routine cleaning is recommended (eg, douching 2–3 times per week) to maintain hygiene and minimize buildup in the canal

(including lubrication during dilation or intercourse, semen from intercourse, sebum, or dead-skin sloughing). No publications address the optimal approach to douching for a PIV neovagina. We generally recommend a nonscented douche. Soap, water, and vinegar or 25% povidone-iodine are other suggested regimens.<sup>11</sup> Douching frequency may need to be increased in patients who have increased discharge or odor. Clinicians should assess for other causes (eg, infections, lesions, or granulation tissue) when douching does not resolve the discharge.

Granulation tissue (Figure 2, B) is a common postoperative finding and may be the cause of bleeding, discharge, or pain complaints.<sup>7,8</sup> It can be exacerbated by repeated trauma from dilation or insertional intercourse. In cases that do not self-heal, we recommend considering silver nitrate as the first-line treatment. Alternatives include low-potency topical or intralesional steroids or surgical excision, possibly by the original

surgeon, as per standard approaches for granulation tissue.<sup>24,25</sup>

The keratinized stratified squamous epithelium of the PIV neovagina is colonized with skin flora and some vaginal species.<sup>26</sup> Bacterial vaginosis, herpes, condyloma, syphilitic chancre, and chancroid are all possible infectious pathologies. The University of California San Francisco (UCSF) Center of Excellence for Transgender Health guidelines note (and which our experiences are in agreement) discharge is less commonly an infectious etiology in patients who have undergone PIV compared with patients with native vaginas.<sup>11</sup>

Current data have not shown low pH in the neovagina compared with native vaginas.<sup>11</sup> Only a few cases of *Candida* have been reported.<sup>27</sup> Limited data exist regarding the transmission of gonorrhea and chlamydia in a person after PIV; the keratinized epithelium is likely more resistant to these infections.<sup>28</sup> However, urethral tissue can still become infected with these microbes, manifesting in either urethritis (explained in the Additional considerations section) or a neovaginal infection if the urethral tissue was used in its construction.<sup>26,29</sup> No published data address HIV transmission specific to PIV, although the prevalence of HIV in the broader transfeminine population in the United States is high (27.7%).<sup>3</sup>

For STI screening in patients after PIV, The Centers for Disease Control and Prevention guidelines on special populations recommend using anatomy-specific, rather than gender-specific, approaches.<sup>18</sup> The UCSF guidelines concur and add that the role of vaginal swabs for gonorrhea and chlamydia in a person after PIV is unknown, and as such, a urine test may be more valuable. These guidelines also recommend testing for any symptomatic patient with orifice-specific consideration depending on the patient's sexual history.<sup>18</sup>

Patients who have undergone PIV do not have a cervix and thus do not require routine Pap smears. Cancer risk is primarily related to skin cancers of the penile or scrotal skin.<sup>30,31</sup> Case reports have reported squamous carcinoma in neovaginas after PIV.<sup>32</sup> Penile

skin is also a known reservoir for HPV. As such, vaginal neoplasia similar to HPV-related penile cancer could theoretically develop.<sup>33</sup> Just as with the neovulva, these tissues also carry the same risk for dermatosis that can affect the penile and scrotal skin such as psoriasis, eczema, or lichen sclerosus. Any visible or concerning lesion should be biopsied. Colposcopic assistance is reasonable.

At this time, no Pap smear guidelines address sampling in the PIV vaginal vault. We do not recommend routine cytology or HPV collection.<sup>34</sup> One consideration is for patients living with HIV, as some recommend annual pelvic examinations for visual monitoring of HPV lesions after PIV because increased screening frequency is practiced for patients with a cervix living with HIV.<sup>35,36</sup> However, cervical cancer guidelines have not yet addressed this.<sup>37</sup>

Despite undergoing hair removal before surgery, some patients have residual pubic hair in the vagina, which may present along the entire length. This can cause pain during sexual penetration or dilation and may become infected or ingrown.<sup>38</sup> We recommend referring to a skilled electrologist for the management of bothersome hair. Referral to a surgeon skilled in PIV for counseling is also appropriate.

Fistulas may occur owing to trauma or injury and are mostly identified in the intraoperative or immediate postoperative period.<sup>7,8,13,29</sup> The most common is a rectovaginal fistula (0.5%–17%).<sup>1,7,8</sup> Presentation, even if immediately identified, may include flatus or stool passage from the vagina. Urethral or bladder fistulas are far less common (0.8%–3.9%) and may present with complaints of incontinence, leakage of vaginal liquid, or persistent discharge.<sup>8,39</sup> Owing to their presentation timing, it will be less likely that gynecologists providing long-term pelvic health will encounter these scenarios and they should be referred to a surgeon skilled in PIV.<sup>7,8</sup>

### Additional Considerations

Voiding complaints are not uncommon in patients after PIV. Some studies report that one-quarter to one-half of patients

may experience diverted streams, voiding dysfunction (including overactive bladder and incomplete emptying), and recurrent urinary tract infections (UTIs), in part owing to a shortened urethra.<sup>1</sup> Gynecologists should treat uncomplicated UTIs as per standard approach in cisgender female. However, those who have recurrent UTIs should be evaluated by a gender-affirming urologist for urethral stricture.<sup>11,40</sup> Gonorrhea or chlamydia can cause urethritis, because the use of urethral mucosa for reconstructive purposes creates environments particularly susceptible to these microbes.<sup>26,29</sup> It is appropriate to refer all other voiding concerns to a gender-affirming urogynecologist or urologist.<sup>1</sup>

Some patients may experience pain associated with residual erectile tissue because it can become engorged with arousal. It may be palpable on a digital examination. Residual erectile tissue would typically be found in the labia majora but may be deeper in the vagina. If the patient is experiencing pain predominantly with arousal and no erectile tissue is palpated, a T2-weighted magnetic resonance imaging may confirm its presence.<sup>39</sup> If it is present, they should be referred to a surgeon skilled in PIV.

Pelvic pain with dilation or insertional intercourse may also be caused by muscle spasms or vaginismus. The pelvic floor muscles are separated at the time of surgery to create the vaginal canal path. Patients who have undergone PIV may experience pelvic floor dysfunction just as patients with a native vagina, and the pelvic floor musculature may be assessed on an endovaginal digital examination as in cisgender patients. The authors encourage collaborative care with the growing number of gender-affirming pelvic floor physical therapists.<sup>41</sup>

Neovaginal prolapse may also occur (rates range from 1% to 7.5%) and present early or late. Some surgeons have reported placing suspensory sutures proactively during PIV (including into the Denonvilliers' fascia or prerectal fascia or through the sacrospinous ligament). However, this is not yet a common practice.<sup>42,43</sup> Only surgeons skilled in vaginal prolapse or PIV should



attempt these repairs. Consideration may be made for sacrospinous fixation or sacrocolpopexy.<sup>1</sup>

In general, patients should not experience decreased tissue sensitivity because this vaginoplasty technique preserves major sensory nerves.<sup>44</sup> However, gender-affirming hormone therapy and orchiectomy may decrease libido in some patients.<sup>45</sup> We recommend referring to clinicians skilled in managing gender-affirming hormone therapy or in medical and psychological support for low libido.

The prostate remains in situ after PIV and is located along the neovaginal anterior wall. Just as with routine pelvic examinations, a great deal has changed regarding the necessity for routine prostate screening examination. Current guidelines do not endorse routine examinations in asymptomatic cisgender male patients for the sole detection of prostate cancer.<sup>46</sup> Furthermore, antiandrogens and estrogens may reduce prostate cancer risk and benign prostatic hypertrophy (BPH), which may decrease a transfeminine person's lifetime risk of development.<sup>47</sup> In an asymptomatic patient, we do not recommend routine examination. However, for a patient experiencing urinary or other complaints for whom a prostatic evaluation would be recommended, an experienced examiner should perform an endovaginal examination of the prostate, because the new vaginal canal may affect the direct rectal assessment. On the endovaginal examination, the clinician should palpate the posterior aspect of the lateral lobes and the groove of the median sulcus.<sup>48</sup> A normal prostate is approximately 2.5 cm in diameter and feels smooth, round, rubbery, and nontender. A boggy, tender, or enlarged prostate may be concerning for infection. In BPH, the prostate is symmetrically enlarged, and there may be obliteration of the median sulcus. Further examination information can be found in any basic textbook of physical examination.<sup>48</sup> Because many gynecologists may have less experience with the prostate examination, patients may be referred to another practitioner.

Anorectal examinations do not change after PIV. Transfeminine patients with anorectal concerns should have these addressed as one would routinely in their practice.

### Conclusion

Gynecologists may provide care for individuals after PIV gender-affirming surgery and thus should learn about the anatomy resulting from such surgeries. This appreciation of anatomy will aid in the provision of the gynecologic examination for transfeminine patients after PIV. By learning to perform this examination, gynecologists can offer a wider spectrum of care and create an affirming environment for a marginalized population. ■

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