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## EDITORIAL COMMENT



The interest in and use of reconstructive urologic procedures for affirmation of gender interventions is increasing in both the numeric frequency of these surgeries and centers providing this care. This article presents an increasingly frequent scenario, that being the need for revision surgery or management of complications of primary surgery done at other institutions seen de novo by urologic and reconstructive surgeons. It would be reasonable to assume that the experience of this center is being encountered and repeated in multiple other centers in this country. Not surprisingly, these authors encountered urethral complications as being the most commonly encountered for male assignment procedures. Of this group of complications, urethral strictures were most frequently encountered followed by urethra-cutaneous fistulae. Some patients also had problematic vaginal remnants that required intervention. Interestingly, these complications often occurred together thus complicating the overall presentation.

This paper underscores the importance of experienced surgeons, in experienced centers, performing these procedures. These reconstructive specialists should also have the ability to provide comprehensive care and most importantly manage their personal complications. Many general and reconstructive urologists are now seeing patients with complications emanating from other centers with the expectation that management occur. This scenario can be very complicated given the fact that a preexisting relationship with of the patient, with an informed awareness of complications as explained by the operating surgeon, has not actually taken place with the remediating surgeon. The risk for dissatisfaction with any intervention, even those meant to temporize, until more optimal circumstances exist for formal revision therefore can be quite significant. It is incumbent on centers that perform these interventions to ensure patient awareness of the critical need for durable follow-up by the original reconstructive surgeon.

This paper, by design, does not mention feminizing genitoplasty and attendant complications. It is to be noted that these complications are also occurring more frequently, often specifically related either neovaginal creation and/or external genital cosmesis.

Informed consent is a critical aspect of the management of these patients as is the communication of reasonable expectations as “perfection” of the result is a difficult bar to attain under the circumstances of major reconstructive surgery. The above-noted urethral complication experience has been noted both historically and now in more recent publications and therefore should be a foundational concept in any informed consent dialectic.

The overriding message of these findings is the importance of preoperative planning, intervention by a skilled reconstructive surgeon who has had prior experience with these procedures and the awareness by the patient that complications are frequent, even in the best hands. These complications can result in a significant quality of life impact and over all dissatisfaction with the final result. In summary, this paper underscores the lack of an adequate quality of life assessment for these individuals and lacking that we are unable to determine the overall impact of the complications and the success of the procedure.

**Roger Dmochowski, MD, MMHC**, Department of Urology, Vanderbilt University Medical Center, Vanderbilt University Hospital, Nashville, TN

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