

LETTER TO THE EDITOR

Sexual Outlook for Post-Surgical Ambiguous Genitalia Patients

The December 2003 edition of *Growth, Genetics & Hormones* (Vol. 19, No. 4) abstracted, "The effects of clitoral surgery on sexual outcome in individuals who have intersex conditions with ambiguous genitalia: a cross-sectional survey."¹ This was a postal survey of the sexual function of 39 adults born with ambiguous genitalia, reared as girls. Those who had undergone clitoral surgery reported more sexual difficulties than those without surgery. The authors concluded, "Adult sexual function could be compromised by feminizing genital surgery." An editorial comment emphasized this finding, "The challenge is to devise a corrective procedure that does not do so." The implication is that such a procedure will be surgical in nature.

We wonder whether determination of a satisfying sexual outcome is more complex than this. Both surgical and non-surgical groups reported significantly more problems in several sexual domains than the general population sample. Sexual dysfunctions (particularly sexual aversion disorder and sexual pain disorders) are more common in women who have had genital surgery.² Surgical damage to the autonomic pelvic network may lead to iatrogenic sexual dysfunctions.³ However, Bancroft et al⁴ reported that physical aspects of sexual response in women (including arousal and orgasm) were poor statistical predictors of sexual satisfaction: "The best predictors of sexual distress were markers of general emotional well-being," though other variables such as mood, body satisfaction, sexual knowledge, and confidence may also play a role.¹ The authors acknowledge that the poor sexual outlook for intersexed adults may be related to psychological factors as much as to surgical sequelae.

In an accompanying commentary, Slijper⁵ comments on some of the psychological factors that modulate sexual functioning, including "sexual shyness" (which could be caused by dissatisfaction with the appearance of the genitals) and "gender behavior" (referring to masculine behavior in XY children assigned female sex). She advocates counseling prior to the onset of puberty to reduce the impact of these factors as a treatment strategy to enhance sexual satisfaction through comfort with one's body and gender assignment. Slijper's authority derives from her membership in a "Gender Team" at a children's hospital in the Netherlands. Unfortunately, there are very few centers such as this, where patients born with disorders of sexual differentiation will receive specialized psychoendocrine treatment. It is possible that such an integrated approach (medical, surgical, and psychological) will result in more positive outcomes for these individuals.

David E. Sandberg, PhD
Buffalo, New York

Nina Williams, PsyD
Highland Park, New Jersey

References

1. Minto CL, et al. *Lancet*. 2003;361(9365):1252-1257.
2. Green MS, et al. *Gynecol Oncol*. 2000;77:73-77.
3. Baader B, Herrmann M. *Clin Anat*. 2003;16:119-130.
4. Bancroft J, Loftus J, Long JS. *Arch Sex Behav*. 2003;32:193-208.
5. Slijper FM. *Lancet*. 2003;361:1236-1237.

First Editor's Comment: *This writer strongly believes that it is inappropriate to rear genotypic and potentially fertile girls with ambiguous or fully masculinized external genitalia as males under most circumstances. The neonate does not exist in isolation but as a member of a family in which the birth of an infant with ambiguous genitalia causes unimaginable stress that can be alleviated only to a modest extent by education, conversation, and reassurance. In most families, corrective genital surgery to conform with the selected sex of rearing is desired as soon as possible. Comparing (admittedly anecdotal and by personal experience) family outcomes in the decades when clitoral surgery in girls with ambiguous genitalia was performed between 2-5 years of age and the current practice of clitoral recession within the neonatal period, far more marital conflicts (spousal abuse, separation, divorce) arose with the delayed rather than early clitoral surgery. Recognizing that corrective genital surgery will be undertaken on the majority of girls with ambiguous genitalia, development of a surgical procedure that will both normalize genital appearance and maintain genital sensation is ideal. Certainly, long-term monitoring and counseling of the family and patient is highly desirable if the facility and personnel to do so are readily available and freely accessible. I agree that we have learned over the past several decades that the most important sex organ is the brain and that normalization of genitalia will not ensure "sexual satisfaction"; even in the normal female population there appears to be a surprising degree of sexual dissatisfaction – a driving force behind the pharmaceutical industry's effort to develop a "female sildenafil".*

Allen W. Root, MD

Second Editor's Comment: *Thanks to Drs. Williams and Sandberg for their comments. The Minto article raises so many important questions and they add two additional issues: (1) should surgery be avoided where possible and (2) how useful are "gender teams"? Clearly, methods and approaches, both surgical and psychological, have changed over the years. Those working in the field will continue to collect experience and share their insights through collaborations and multi-center trials. In an era of "the informed consumer", there does not yet seem to be a perfect approach—but as much information and openness as possible will help parents, families, and affected individuals make decisions that seem right for them.*

Judith G. Hall, OC, MD