Creation of a neovagina: what should our focus be when choosing the "right" operative technique?

The creation of a functional neovagina in patients with Mayer-Rokitansky-Kuester-Hauser syndrome is an essential goal to achieve the possibility of "neo-vaginal" sexual intercourse in these patients. The article by Vatsa et al. (1) reports the use of amnion to cover the operatively created neovaginal opening in a retrospective manner, and they should be congratulated. They conclude that, in developing countries, a simple operating technique appears to be a promising option due to its low cost, easy availability, safety, ease of procedure, no special instruments, and, with respect to physiological outcome, epithelialization of the vagina without hair growth and with a satisfying functional outcome (1).

Because the Mayer-Rokitansky-Kuester-Hauser syndrome occurs with an incidence of 1 in 4,000 newborn girls (2), even centers in developed countries will not encounter the need for enormous numbers of operations of this type. Therefore, especially when dealing with rare numbers of operations of a special type, we must choose a technique that is simple, safe, and effective (3).

The goal of any method is to create a neovaginal canal of adequate diameter and length to allow for sexual intercourse (3). Different techniques to cover this canal have been reported. Sigmoid colon vaginoplasty has been published as an effective approach, with satisfactory anatomical and functional results (4). However, operating time and hospital stay are long. In contrast, some articles focus only on surrogate outcome parameters, such as length and width of the neovagina. Patients will not measure the anatomy of their neovagina, but rather, long for a fulfilled sexual life, enhancement of their quality of life, and overall well-being. Therefore, the long-term follow-up of the creation of a neovagina should report on the main outcome parameter, the Female Sexual Function Index (FSFI) scores, to offer reliable and comparable results.

To my knowledge, there is no superior operative technique for the creation of a neovagina with respect to FSFI scores. Therefore, it is prudent to choose the simplest technique, following the principle of "reduce to the max." Any operation should be simple to perform and easy to learn. All procedures or any part of them carry characteristic complications and potential risks, such as infection, necrosis, or rejection. In our opinion, transplantation of any graft could be replaced by dilatation only (3). The major disadvantage of these operations is the need for lifetime dilators to avoid shrinkage. It would be interesting to see whether the use of a human amnion graft will decrease the tendency of the neovagina to shrink.

The article by Vatsa et al. (1) clearly demonstrates that, in the primary setting of creating a neovagina, we have to focus on the most effective and least invasive strategy. If progressive, passive, self-dilatation does not offer adequate results, a simple surgical creation of a neovaginal opening between the bladder and the rectum should be the next step. Whether a vaginoplasty should be covered by some transplant (in Vatsa's publication, amnion), or performed without a graft, needs further evaluation.

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