which the catheter is removed, and the ureters can be seen to efflux via cystoscopy. The authors describe no observed adverse events, but they did not prospectively assess for them. Beyond the minor risk of a (very!) sticky operative field if spilled, the obvious concern would be an increased risk of abnormal serum glucose particularly in patients with impaired glucose metabolism and increased risk of urinary tract infection. It does seem likely that these risks are low, but these do need to be assessed. This article does offer clinicians another viable option for intraoperative assessment of the upper urinary tract, and we will need to watch for the safety article assumed to follow.—ACW)

Patient Satisfaction of Surgical Treatment of Clitoral Phimosis and Labial Adhesions Caused by Lichen Sclerosus

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ABSTRACT

Anogenital lichen sclerosus (LS) is a chronic inflammatory dermatosis that can cause scarring of genitalia including narrowing of the introitus and clitoral phimosis.

Chronic inflammation can lead to recurrent tearing during intercourse (vulvar granuloma fissuratum [VGF]) and decreased clitoral sensation. Lichen sclerosus is usually initially treated with topical ultra–high-potency corticosteroids. When the disorder is well managed, scarring is less likely; medication noncompliance increases progression to scarring. Many women present after scarring has already occurred. Surgery can correct VGF and clitoral phimosis. There are few data, however, on patient satisfaction and complications after these procedures.

The aim of this study was to evaluate patient experience and outcomes in women undergoing surgical correction of vulvar scarring caused by LS. A retrospective chart review was performed at a vulvar disorders clinic to identify women who had undergone surgical correction of clitoral phimosis or lysis of vulvar adhesions for VGF secondary to LS. Data were collected between 2003 and 2014.

A total of 45 patients were identified; 28 of these were contacted via telephone between 4 and 130 months postoperatively. Patient experience and outcomes were evaluated using an 8-question survey, which included the following: patient's satisfaction with the surgery; effects on clitoral sensation, orgasm, and dyspareunia; postoperative symptoms or complications; and recurrent vulvar scarring.

Of the 25 participants who completed the questionnaire, 11 patients (44%) reported that they were very satisfied, and 10 (40%) reported being satisfied with the procedure. Sixteen women experienced decreased clitoral sensation before surgery; 12 (75%) of these had increased clitoral sensitivity postoperatively. Of the 13 patients who had dyspareunia before surgery, 4 women (31%) reported having pain-free sex, and 7 (54%) reported improved but not completely pain-free sex after surgery. None of the patients had complications or any symptoms made worse by the surgery.

These data show that patients with LS have high satisfaction and low complication risk associated with surgical correction of clitoral phimosis and lysis of vulvar adhesions for VGF. Moreover, there is improvement in clitoral sensation, the ability to achieve orgasm, and decreased dyspareunia. In appropriate candidates with anogenital LS, surgical correction of vulvar scarring is a viable option to restore vulvar anatomy and sexual function.

EDITORIAL COMMENT

(The scarring associated with lichen sclerosus (LS) can wreak havoc for women’s ability to have and enjoy sex. Repetitive tearing and chronic scarring at the introitus can produce dyspareunia and narrowing. Chronic anterior scarring can trap the clitoris within adhesions under the clitoral hood (phimosis), which can decrease sexual sensation and cause painful clitoral engorgement

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during arousal. Early diagnosis and full adherence to an ultra–high-potency steroid treatment regimen can reduce the risk of these consequences. However, once painful anatomic alterations are established, surgical treatment is often considered. Resection of a chronic fissuring scar (vulvar granuloma fissuratum) may be performed as part of a perineorrhaphy with reapproximation of healthy nonscarred tissue and careful wound care to assure optimal healing. Lysis of adhesions can release clitoral adhesions and disrupt smegmatic pseudocysts between the clitoris and prepuce, and the prepuce may be partially incised to improve access for the procedure. Some experts recommend a topical steroid taper to reduce inflammation (Goldstein AT, Burrows LJ. Am J Obstet Gynecol 2007;196:e1–e4). Because these procedures are rarely performed, it is difficult to counsel patients regarding the outcomes most important to them. As with other challenges we encounter in gynecology, achieving anatomic success does not guarantee symptomatic and functional success.

The abstracted study reports outcomes from a series of 48 patients from a single-referral center who underwent surgical procedures for LS-associated scarring during an 11-year period. Patient-centered outcomes were not systematically collected during the postoperative period. Instead, the investigators contacted patients by phone 4 to 130 months after their procedures and asked them 8 questions regarding their satisfaction and sexual functioning. A high degree of satisfaction and improvement in sexual functioning was reported by the 25 patients who could be reached by a research assistant. Unfortunately, a variety of important methodologic limitations undermine the validity of these data. The response rate (25/48) raises concern that the patients who could not be reached (20) or refused to be interviewed (3) may have been extremely dissatisfied. Despite similarities in baseline characteristics, to assume that the 25 respondents represent the whole is dubious. There are also several problems with the 8-item phone survey. The questions were not taken from a validated sexual functioning measure. Most questions forced a dichotomous (yes/no) or 3-level response, which can obscure important subtleties in the data. Recall of events up to 130 months after the procedure opens the door to inaccuracy and recall bias. No information is provided regarding the research assistant conducting these calls. Was a script used? Was the research assistant blinded to the investigators’ expected study findings? In their conclusions, the authors underscore the importance of postoperative treatment including topical steroids to reduce the risk of adhesion formation. Although sensible, this recommendation is not justifiable based on the study design (a case series) and lack of analysis comparing outcomes based on postoperative treatment.

Many of these limitations were recognized by the authors; however, their final conclusions were not appropriately cautious. Balancing these concerns is the considerable experience of this referral center, which performed approximately 4 surgical cases per year for LS-associated scarring—far more experience than most practicing gynecologists will accumulate in their careers. When I counsel patients with LS-associated scarring and sexual dysfunction, I will describe this study’s findings as supportive of a surgical approach. However, with outcomes available for only 25 of 48 patients, I will not use the specific data on rates of satisfaction and improvement.—LAL)