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Burden of Lower Urinary Tract and Genital Symptoms in Young Transgender Men: Prevalence and Impact on Daily Life

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ABSTRACT

Objectives: To investigate the prevalence of lower urinary tract symptoms (LUTS) and genital symptoms among transgender men in Japan, and to evaluate their impact on daily life, including limitations resulting from concerns about toilet accessibility.

Methods: We conducted a cross-sectional, single-center survey of assigned-female-at-birth individuals aged 16 years or older who had been approved for gender-affirming hormone therapy at our gender center. A self-administered questionnaire included the Core Lower Urinary Tract Symptom Score (CLSS), vaginal and urethral symptom items, toilet use outside the home, preferences regarding male urinals, and activity restriction related to toilet access. Data were analyzed descriptively, and multivariable logistic regression analyses were performed.

Results: Data from 322 participants (median age 33 years) were analyzed. Overall, 80% reported at least one LUTS, 46% reported at least one bothersome symptom, and 14% had a CLSS global quality-of-life (QOL) score of ≥ 4 . Vaginal symptoms occurred in 13% of participants, and 2% reported post-micturition leakage. Most participants (62%) did not use male urinals but wished to use them. Activity restriction due to toilet-related concerns, defined as avoiding or limiting activities such as travel, shopping, or going to the cinema, was reported by 20%, and higher total CLSS was associated with both activity restriction and poor urinary-related QOL.

Conclusions: LUTS and genital symptoms are common in young transgender men, and greater LUTS burden is linked to urinary-related QOL impairment and toilet-related activity restriction. These findings highlight the need for targeted clinical care and improved accessibility of public toilets for transgender men.

1 | Introduction

Transgender men are individuals assigned female at birth but identify and live as men [1]. Studies estimate that 0.4%–1.1% of adults are transgender, with many seeking gender-affirming

hormone therapy (GAHT) and surgeries to reduce gender dysphoria and improve quality of life (QOL) [1]. As access to gender-affirming care expands, urologists are increasingly likely to encounter transgender patients with both transition-related and general urological concerns [1].

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Transgender men experience various lower urinary tract and genital changes related to long-term GAHT, genital surgery, and pelvic floor adaptations [2–5]. Previous studies have reported lower urinary tract symptoms (LUTS), genital pain, dyspareunia, and urinary dysfunction after genital gender-affirming surgery in transgender and gender-diverse individuals, as well as underdiagnosis and undertreatment of these conditions in routine care [6–8]. In addition, qualitative and survey data indicate that transgender people often face harassment, discrimination, and safety concerns when using public restrooms, leading to toilet avoidance and restriction of daily activities such as work, school, shopping, and social participation [9–11].

However, little is known about the prevalence and impact of LUTS and genital symptoms among transgender men in Japan, and, to our knowledge, no population-based or clinical surveys have been reported to date. Japan has a unique medical context: genital gender-affirming surgery (GGAS), including metoidioplasty and phalloplasty, is relatively uncommon [12] and hysterectomy and oophorectomy are more frequently desired than GGAS among transgender men [13]. Consequently, a substantial proportion of transgender men retain their vagina despite long-term testosterone therapy [13].

The aim of this study was to investigate the prevalence and burden of LUTS and genital symptoms among transgender men in Japan and to evaluate their impact on daily life, including restrictions of social activities related to toilet-access concerns.

2 | Methods

Participants were recruited from the gender center at Okayama University Hospital. Eligible individuals were assigned female at birth and had been approved for GAHT at the gender clinic and subsequently attended the urology clinic. Participants were required to be aged 16 years or older, able to read Japanese and provide informed consent of their own free will.

During the study period, we identified 326 eligible individuals. Of these, three did not provide consent to participate and one 16-year-old reported difficulty understanding the questionnaire; these four were excluded, leaving 322 participants for analysis.

Data were collected using a self-administered questionnaire between 1 October 2024 and 8 October 2025.

2.1 | GAHT Protocol

GAHT for transgender men was provided with intramuscular testosterone enanthate. The dose was individualized within a range of 62.5–125 mg per week, titrated according to serum testosterone levels and clinical response, following our previously reported protocol [14].

2.2 | LUTS and Genital Symptoms

LUTS were assessed using the Core Lower Urinary Tract Symptom Score (CLSS), a validated 10-item questionnaire [15].

The CLSS covers storage, voiding, and pain-related symptoms, with each item rated from 0 to 3 to yield a total score of 0–30, where higher scores indicate more severe LUTS. For descriptive analyses, daytime and night-time frequency was defined as a CLSS item score ≥ 1 . In addition, participants were asked to nominate up to three symptoms they perceived as particularly bothersome and to indicate the single most bothersome symptom. The CLSS global QOL score (0 “delighted” to 6 “terrible”) was also assessed.

Vaginal symptoms were assessed using two items: abnormal vaginal discharge (malodorous or bloody) and vaginal itching or discomfort. We also added three urethra-related items: urethral bleeding, post-micturition leakage, and a history of intermittent urethral dilatation (yes/no). Genital status was classified according to surgical history: participants who had undergone metoidioplasty or phalloplasty were classified as having GGAS, typically including vaginectomy, whereas those without these procedures were considered not to have undergone GGAS.

2.3 | Toilet Use and Activity Restriction

Participants were asked whether they typically used toilets in various settings, including work or school, convenience stores, public facilities (hospitals, government offices, shopping centers), and public toilets in streets or parks. We also asked participants whether they used male urinals—defined as wall-mounted fixtures for men to void while standing—or would like to use them. Response options were “I would like to use them” or “I do not wish to use them”.

Participants were then asked whether toilet-related concerns led them to: (1) holding back urination, (2) restricting fluid intake, or (3) avoiding or limiting activities such as travel, shopping, or going to the cinema (yes/no responses). We defined “activity restriction due to toilet access” as a positive response to avoiding or limiting activities such as shopping or going to the cinema because of toilet-related concerns.

2.4 | Statistical Analysis

We primarily performed descriptive analyses. Continuous variables (age, duration of GAHT, testosterone level, and body mass index [BMI]) were summarized as medians with interquartile ranges (IQR) due to non-normal distributions. Categorical variables (CLSS items, genital and urethral symptoms, toilet use in each setting, and toilet-related behavioral changes) were summarized as frequencies and percentages.

The primary outcomes were: (1) the prevalence and severity of LUTS assessed by the CLSS (total score and distribution of item scores); (2) the prevalence of vaginal and urethral symptoms; and (3) the proportion of participants reporting any negative impact of urinary problems on daily life, including activity restriction due to toilet-related concerns. We also described patterns of toilet use in different settings and the current or desired use of male urinals.

As exploratory analyses, we compared demographic and clinical characteristics between participants who did and did not report restricting activities because of toilet access concerns, using the Mann–Whitney *U* test for continuous variables and the chi-square test or Fisher's exact test for categorical variables, as appropriate.

In addition, we performed multivariable logistic regression analyses for two binary outcomes: (1) activity restriction due to toilet access (avoiding or limiting activities such as travel, shopping, or going to the cinema because of toilet-related concerns), and (2) poor urinary-related QOL, defined as a CLSS global QOL score of ≥ 4 . The covariates in both models were age, history of GGAS, and total CLSS, which was used as an overall measure of LUTS severity to examine how global symptom burden related to urinary-related QOL and toilet-related activity restriction. GAHT duration was not included because of its collinearity with age, and hysterectomy because all participants with GGAS had undergone hysterectomy, precluding simultaneous inclusion of both variables. All statistical analyses were performed using Stata version 19.5 (Stata Corp LLC, College Station, TX, USA), and two-sided $p < 0.05$ was considered statistically significant.

3 | Results

Data from 322 participants were analyzed. At the time of the survey, participants' clinical profiles under ongoing or previous GAHT were as follows: the median age was 33 years (IQR 29–41), the median duration of GAHT was 101 months (IQR 22–165), and the median serum testosterone level was 5.4 ng/mL (IQR 2.8–9.7). Regarding gender-affirming medical and surgical history, 311 of 322 participants (97%) were receiving GAHT. Hysterectomy and oophorectomy had been performed in 148 (46%) and 147 (46%) participants, respectively. Metoidioplasty had been performed in 14 participants (4%), and phalloplasty in 10 (3%). Detailed participant characteristics are shown in Table 1.

3.1 | LUTS, Genital and Urethral Symptoms

LUTS were common in this cohort (Table 2). Overall, 257 of 322 participants (80%) selected a score of ≥ 1 for at least one CLSS item, indicating the presence of at least one LUTS. Among these, 147 participants (46% of the total sample) identified at least one symptom as particularly bothersome, based on their nomination of up to three bothersome symptoms in the questionnaire. Total CLSS ranged from 0 to 16, with a median of 2 (IQR 1–4), indicating that most participants had a low to moderate overall symptom burden. When participants were asked to choose up to three bothersome symptoms, urgency was most frequently selected (19%), followed by a feeling of incomplete emptying (16%) and night-time frequency (8%). In exploratory univariable analyses, longer GAHT duration was moderately associated with greater overall LUTS burden (total CLSS; Spearman's $\rho = 0.28$, $p < 0.001$; Table S1). When asked to choose the single most bothersome symptom, urgency and a feeling of incomplete emptying were each selected by 11%, followed by night-time frequency (6%). In addition, 45 participants (14%) selected a score of ≥ 4

TABLE 1 | Baseline characteristics of transgender men attending the gender center at Okayama University Hospital.

Characteristics	
Age, years	33 (29–41)
Duration of GAHT, months	101 (22–165)
Serum testosterone, ng/mL	5.4 (2.8–9.7)
BMI, kg/m ²	23 (21–26)
Medication/surgical history, <i>n</i> (%)	
GAHT	311 (97)
Hysterectomy	148 (46)
Oophorectomy	147 (46)
Vaginectomy	24 (7)
Metoidioplasty	14 (4)
Phalloplasty	10 (3)

Note: Data are presented as *n* (%) or median (IQR). Medication and surgical history are shown for all 322 participants.

Abbreviations: BMI, body mass index; GAHT, gender-affirming hormone therapy; IQR, interquartile range.

(“mostly dissatisfied”, “unhappy”, or “terrible”) on the CLSS global QOL item.

Vaginal symptoms were assessed in 298 participants without GGAS, all of whom had a vagina, whereas urethral symptoms were assessed in all 322 participants (Table 2). Overall, 40 of 298 participants (13%) reported at least one vaginal symptom; 27 (9%) reported abnormal vaginal discharge and 21 (7%) reported vaginal itching or discomfort. Among non-GGAS participants, GAHT duration was shorter in those with any vaginal symptom than in those without (median 29 vs. 100 months, $p = 0.044$; Table S2). No participant reported urethral bleeding, whereas post-micturition leakage was present in 7 participants (2%) and a history of intermittent urethral dilatation in 3 (1%). In stratified analyses by GGAS status (Table S3), participants with GGAS were more likely to report voiding-related LUTS and urethral problems, including slow urinary stream, post-micturition leakage, and intermittent urethral dilatation, and tended to have higher total CLSS scores than those without GGAS.

3.2 | Toilet Use and Preferences

Use of toilets outside the home was generally high (Table 3). Most participants reported that they usually used toilets at their workplace or school (89%) and in convenience stores (91%). Toilets in settings such as government offices, hospitals, or shopping centers were also commonly used (93%), whereas public toilets on the street or in parks were used less frequently (63%). Among 301 participants who provided valid responses regarding male urinals, only 9 (3%) reported that they currently use them. The majority (185/301, 62%) reported that they do not use urinals but prefer to use them, whereas 107 (36%) reported that they do not use urinals and do not wish to use them. Responses from 21 participants who reported using male urinals despite no history of GGAS were excluded as difficult to interpret and

TABLE 2 | Lower urinary tract, vaginal and urethral symptoms in transgender men attending the gender center at Okayama University Hospital.

Lower urinary tract symptoms (LUTS)			
Variable	Any symptom <i>n</i> (%)	Selected as bothersome <i>n</i> (%)	Selected as most bothersome <i>n</i> (%)
Any LUTS	257 (80)	147 (46)	N/A
Daytime frequency ≥ 8	146 (45)	19 (6)	9 (3)
Night-time frequency ≥ 1	126 (39)	27 (8)	20 (6)
Urgency	132 (41)	62 (19)	36 (11)
Urgency urinary incontinence	18 (6)	13 (4)	9 (3)
Stress urinary incontinence	36 (11)	19 (6)	14 (4)
Slow urinary stream	68 (21)	21 (7)	8 (2)
Straining to void	82 (25)	16 (5)	6 (2)
Feeling of incomplete emptying	99 (31)	53 (16)	34 (11)
Bladder pain	16 (5)	5 (2)	2 (1)
Urethral pain	10 (3)	3 (1)	1 (0.3)
Total CLSS, median (Interquartile range)		2 (1–4)	
CLSS global quality-of-life score, <i>n</i> (%)			
0–2		147 (46)	
3		130 (40)	
4–6		45 (14)	
Vaginal symptoms, <i>n</i> (% of 298 participants with a vagina)			
Any vaginal symptom		40 (13)	
Abnormal vaginal discharge		27 (9)	
Vaginal itching or discomfort		21 (7)	
Urethral symptoms, <i>n</i> (% of 322)			
Any urethral symptom		9 (3)	
Urethral bleeding		0 (0)	
Post-micturition leakage		7 (2)	
History of intermittent urethral dilatation		3 (1)	

Note: Data are presented as *n* (%) unless otherwise indicated. Any symptom *n* (%) indicates participants who reported the symptom at any frequency (“rarely”, “sometimes”, or “often”). Selected as bothersome *n* (%) indicates participants who listed the symptom among up to three bothersome symptoms. Selected as most bothersome *n* (%) indicates participants who identified the symptom as the single most bothersome symptom. Any LUTS indicates participants who reported at least one LUTS item at any frequency; “selected as bothersome” for Any LUTS indicates participants with any LUTS who listed at least one LUTS item among up to three bothersome symptoms. Total CLSS ranges from 0 to 30, with higher scores indicating more severe lower urinary tract symptoms. CLSS global quality-of-life score ranges from 0 (“delighted”) to 6 (“terrible”). Percentages are rounded to the nearest integer; values < 0.5% are shown to one decimal place.

were considered likely to reflect misinterpretation of the question given the rare use of stand-to-pee devices in Japan.

3.3 | Impact on Activities and QOL

Toilet-related behavioral changes were common in this cohort (Table 3). A total of 184 of 322 participants (57%) reported holding back urination and 134 (42%) reported restricting fluid intake because of concerns about toilet access (Table 3). In addition, 63 participants (20%) reported avoiding or limiting activities such as travel, shopping, or going to the cinema for this reason, indicating activity restriction in one-fifth of the cohort

(Table 3). As shown in Table S4, activity restriction due to toilet access was more frequent among participants with GGAS than among those without GGAS (33% vs. 18%, $p=0.104$).

As exploratory between-group analyses, we compared symptom burden and age by activity restriction and urinary-related QOL. Participants with activity restriction had significantly higher total CLSS than those without restriction (median 4 vs. 2, $p=0.004$), whereas age and history of GGAS did not differ significantly (Table S5; Table 4). Similarly, participants with poor urinary-related QOL (CLSS global QOL score ≥ 4) were older and had higher total CLSS than those with good QOL (both $p<0.05$; Table S6; Table 4).

TABLE 3 | Use of toilets and accessibility issues among transgender men attending the gender center at Okayama University Hospital.

Use of toilets outside the home (<i>n</i> = 322)	
Workplace or school	286 (89)
Convenience stores	292 (91)
Hospitals, government offices, or shopping centers	302 (93)
Public toilets on the street or in parks	204 (63)
Male urinals use preference (<i>n</i> = 301)	
Using	9 (3)
Not using, prefer to use	185 (62)
Not using, no wish to use	107 (36)
Impact on daily activities (<i>n</i> = 322)	
Holding back urination	184 (57)
Restricting fluid intake	134 (42)
Avoiding or limiting activities such as travel, shopping, or going to the cinema	63 (20)

Note: Data are presented as *n* (%). Twenty-one individuals reported “using” male urinals despite not having undergone metoidioplasty or phalloplasty. These responses were excluded because of inconsistent interpretation, leaving a total of 301 respondents for this item.

TABLE 4 | Multivariable logistic regression model for two outcomes of activity restriction and poor urinary-related quality of life in transgender men attending the gender center at Okayama University Hospital.

Variables	Adjusted OR	95% CI	<i>p</i>
Activity restriction			
Age	0.98	0.95–1.02	0.322
History of GGAS	2.28	0.85–6.15	0.103
Total CLSS (per 1-point increase)	1.18	1.07–1.30	0.001
Poor urinary-related QOL			
Age	1.01	0.97–1.05	0.524
History of GGAS	0.58	0.14–2.43	0.454
Total CLSS (per 1-point increase)	1.54	1.34–1.76	<0.001

Note: Data are presented as adjusted odds ratios (ORs) with 95% confidence intervals (CIs). Activity restriction was defined as avoiding or limiting activities such as travel, shopping, or going to the cinema because of toilet-related concerns. Poor urinary-related quality of life (QOL) was defined as a Core Lower Urinary Tract Symptom Score (CLSS) global QOL score ≥ 4 . Models were adjusted for age, history of genital gender-affirming surgery (GGAS), and total CLSS.

In multivariable logistic regression analyses including age, history of GGAS, and total CLSS as covariates, a higher total CLSS was the only variable independently associated with activity restriction and poor urinary-related QOL (Table 4). Each one-point increase in total CLSS was associated with higher odds of activity restriction (OR 1.18, 95% CI 1.07–1.30; $p = 0.001$) and poor QOL (OR 1.54, 95% CI 1.34–1.76; $p < 0.001$). In contrast, age and history of GGAS were not associated with either outcome after adjustment, likely reflecting the limited number of participants with GGAS ($n = 24$).

4 | Discussion

A substantial proportion of young transgender men reported LUTS, with total CLSS ranging from 0 to 16 and a median of 2, indicating a generally mild to moderate symptom burden. Approximately one in seven participants experienced reduced QOL and one in five reported activity restrictions due to reluctance to use toilets outside the home. These findings indicate that LUTS are common and bothersome in transgender men and are associated with activity restriction and poorer urinary-related QOL during a pivotal period for social and occupational development. In stratified analyses, participants with GGAS showed a distinct profile of voiding-related LUTS and urethral problems compared with those without GGAS (Table S3). However, participants with GGAS were older and had longer GAHT duration, so these differences likely reflect a combination of surgical, age-related, and longer-term GAHT-related effects rather than the impact of GGAS alone.

Despite this overall low median CLSS, the symptom burden was already associated with impairments in urinary-related QOL and toilet-related activity restriction. Mitsui et al. recently reported an overall LUTS prevalence of 77.9% in the general Japanese population, in which three-quarters of participants were in their 40s or older and nocturia had the greatest impact on daily life [16]. In contrast, our cohort of transgender men showed a substantial LUTS burden despite their younger age, with urgency and a sensation of incomplete emptying being the most prominent symptoms. These findings suggest that transgender men may experience a LUTS pattern and burden not aligned with age norms. A recent prospective study found no significant short-term changes in LUTS among transgender men during the first 3–12 months of GAHT [17], suggesting that the LUTS observed in our cohort may be related to longer-term GAHT exposure and other factors rather than the acute effects of GAHT.

For transgender men, vaginectomy both alleviates genital gender dysphoria and enables urethral lengthening in GGAS, which is often regarded as the final step of gender transition [18]. However, GGAS is a complex, frequently multistage procedure with a high rate of urological complications [7, 8] and considerable financial burden [13], so only a minority of transgender men undergo these surgeries [13]. Consequently, many transgender men continue to live with a retained vagina.

In October 2023, the Japanese Supreme Court ruled that a legal requirement to lose reproductive capacity in order to change

gender status is unconstitutional under the Act on Special Cases in Handling Gender Status for Persons with Gender Identity Disorder [19]. This decision, based on the right to pursue happiness and freedom from invasive procedures, may accelerate the trend that more transgender men will retain their uterus, ovaries, and vagina while socially and legally living as male.

In this context, our finding that 13% of young transgender men reported vaginal symptoms is particularly noteworthy. These symptoms may reflect testosterone-induced hypoestrogenism and genitourinary syndrome of menopause (GSM)-like changes of the lower genital tract, as prolonged exposure to exogenous testosterone has been linked to vaginal atrophy, vulvovaginal discomfort, and a high prevalence of pelvic floor dysfunction and pelvic pain in transgender men on hormone therapy [2–5, 20]. These pathophysiological changes could plausibly contribute to storage symptoms such as urgency and the sensation of incomplete emptying, although we did not assess pelvic floor function or perform standardized gynecological examinations in this study. In our cross-sectional data, current vaginal symptoms were more frequently reported by participants with shorter GAHT duration, suggesting a complex and potentially transient relationship between testosterone exposure and vaginal symptoms that requires confirmation in longitudinal studies.

Despite their potential impact, such vaginal symptoms can be difficult to address in clinical practice because transgender men may hesitate to access gynecologic services, while urologists often lack training or facilities to examine a vagina in a male-identified patient. Our data therefore highlight the need to develop care pathways that provide timely, gender-affirming pelvic health care for transgender men with vaginal anatomy. More broadly, these findings suggest that Japanese health-care systems should reorganize gynecologic and urologic services to ensure equitable access for transgender men and to provide gender-affirming support for managing toilet-related concerns.

This study has several strengths. First, it is, to our knowledge, the first in Japan and among the first in Asia to systematically assess LUTS, urinary-related QOL, and toilet-related behaviors in transgender men. Second, a high response rate and use of a validated CLSS provided a detailed picture of LUTS prevalence, severity, and bothersomeness. Third, by concurrently assessing toilet access, activity restriction, and vaginal symptoms in transgender men who have largely not undergone GGAS, our data offer a holistic view of urinary and genital health.

This study also has limitations. First, it was conducted at a single university-based gender center among regularly engaged individuals, so those who receive GAHT or surgery elsewhere, or have limited access to gender-affirming services, may have different symptom and behavior patterns that were not captured. These unrepresented, structurally marginalized groups are unlikely to have a lower burden of LUTS or activity restriction than our sample. Second, although CLSS has been validated in Japanese cisgender populations, its measurement properties have not been formally evaluated in transgender men, and items on toilet-related behaviors, activity restriction, and vaginal symptoms have not been validated. This may limit the international comparability of our findings, particularly with studies using IPSS (International Prostate Symptom Score) or ICIQ

(International Consultation on Incontinence Questionnaire). Third, the cross-sectional design and reliance on self-reported data preclude causal inferences and may introduce social desirability bias. In addition, using total CLSS as a predictor of poor urinary-related QOL may appear tautological, as symptom burden and QOL are conceptually related; our aim was not to infer causality or specify pathways, but to quantify how overall LUTS severity relates to urinary-related QOL and toilet-related activity restriction. Finally, the number of participants who had undergone GGAS was small, and the multivariable analyses included only a limited set of covariates. We did not measure psychosocial factors such as fear of being stared at or harassed when using gendered restrooms, internalized stigma, or mental health burden, which contribute to restroom avoidance and “holding it” in transgender populations [9–11]. Thus, the observed associations between LUTS and toilet-related activity restriction should be interpreted with caution, as they may be confounded by unmeasured social and environmental factors.

Despite these limitations, our findings provide novel quantitative evidence that LUTS, vaginal symptoms, and toilet-related restrictions co-occur in a substantial proportion of young transgender men in Japan. These results underscore the importance of incorporating proactive assessment of urinary and genital symptoms, along with careful attention to toilet accessibility, into routine, gender-affirming care for transgender men.

Author Contributions

Tomoko Kobayashi: conceptualization, methodology, investigation, formal analysis, project administration, writing-original draft, writing-review and editing, supervision. **Takatoshi Moriwake:** investigation, conceptualization, methodology, formal analysis, writing – review and editing. **Yusuke Tominaga:** conceptualization, investigation, writing-review and editing. **Nariaki Ozaki:** investigation, writing-review and editing. **Satoshi Horii:** writing-review and editing. **Ichiro Tsuboi:** writing – review and editing. **Kasumi Yoshinaga:** writing – review and editing. **Tomoaki Yamanoi:** writing – review and editing. **Tatsushi Kawada:** writing – review and editing. **Takuya Sadahira:** writing – review and editing. **Takehiro Iwata:** writing – review and editing. **Satoshi Katayama:** writing – review and editing. **Shingo Nishimura:** writing – review and editing. **Kensuke Bekku:** writing – review and editing. **Yuko Matsumoto:** review and editing. **Miyabi Inoue:** supervision, writing – review and editing. **Masami Watanabe:** writing – review and editing. **Ayano Ishii:** writing – review and editing. **Toyohiko Watanabe:** writing – review and editing. **Motoo Araki:** supervision, writing – review and editing.

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Ethics Statement

The study protocol was approved by the Ethics Committee of Okayama University Hospital (approval number: K2407-010), and the study was conducted in accordance with the Declaration of Helsinki.

Consent

All participants received written information about the study and voluntarily indicated their agreement to participate by checking an “I agree to participate” box at the beginning of the questionnaire. This procedure was considered to constitute written informed consent, including consent by a legal representative for participants under 18 years of age when required.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Spearman rank correlations between GAHT duration and CLSS items. **Table S2:** GAHT duration by presence or absence of vaginal symptoms (non-GGAS participants, $n = 298$). **Table S3:** Lower urinary tract and urethral symptoms by genital gender-affirming surgery (GGAS) status. **Table S4:** Toilet-related behaviors by GGAS status. **Table S5:** Between-group comparison according to activity restriction due to toilet access in transgender men attending the gender center at Okayama University Hospital ($n = 322$). **Table S6:** Between-group comparison according to urinary-related quality of life in transgender men attending the gender center at Okayama University Hospital ($n = 322$).