Supplementary Material 1. Summary of statements reaching consensus-vaginoplasty (vaginal tightening surgery) Delphi questionnaire (n=29 experts; consensus set threshold ≥75%; the consensus was reached in round 3)

#	Statement	Agreement (%)	Disagreement (%)
Section 1: Contraindications			
1	Presence of urethra-vaginitis constitutes a contraindication to vaginal tightening surgery	93.8	19.2
2	Presence of active genital herpes constitutes a contraindication to surgery	96.2	3.8
3	Pregnancy or early postpartum period should be considered a contraindication to vaginal tightening surgery	100.0	0.0
4	Uncontrolled systemic diseases (e.g., diabetes, hypertension, cancer) constitute a contraindication to surgery	100.0	0.0
5	Presence of body dysmorphic disorder (BDD) should be considered an absolute contraindication to vaginal tightening surgery	84.6	15.4
6	Unrealistic patient expectations constitute a condition requiring postponement of surgery	100.0	0.0
7	Active smoking should be considered a relative contraindication with regard to surgical complications	76.9	23.1
8	Coagulation disorders should be considered an absolute contraindication to surgery	73.1	26.9
9	Vaginal tightening surgery in patients under 18 years of age should be considered a contraindication	96.2	3.8
10	Presence of an active sexually transmitted infection should be considered a contraindication to surgery	100.0	0.0
11	In cases of high-risk HPV positivity surgery may be planned following Pap smear and colposcopic evaluation.	100.0	0.0
12	In the presence of stage 3 or higher pelvic organ prolapse, isolated vaginoplasty is not appropriate	96.2	3.8
13	Surgical risk should be considered increased in patients with a previous history of vaginal surgery	100.0	0.0
14	Surgical risk should be considered increased in patients with previous history of vaginal surgery	92.3	7.7
15	Surgical risk should be considered increased in patients with connective tissue diseases or impaired wound healing	100.0	0.0
Section 2: Preoperative assessment			
16	Standardized preoperative photography is required.	84.6	15.4
17	Preoperative pelvic examination should be performed.	100.0	0.0
18	The POP-Q system should be used in routine preoperative assessment.	80.8	19.2
19	Urodynamic testing should be considered in patients in whom surgery would be investigated simultaneously for stress incontinence.	100.0	0.0
20	Perivaginal ultrasonography should be used in routine preoperative assessment.	80.8	19.2
21	Validated measurement tools (e.g., Vaginal Laxity Questionnaire; VLQ) should be used to assess vaginal laxity.	80.8	19.2
22	Perineal body assessment must be performed prior to surgery.	100.0	0.0
23	Validated scales (e.g., FSFI; PISQ-12/PISQ-IR) should be used routinely for pre- and post-operative sexual function assessment.	80.8	19.2
24	Pelvic floor muscle function should be assessed during the preoperative process.	96.2	3.8
25	Pap/human papilloma virus should be routinely performed prior to surgery.	100.0	0.0
26	Written consent must be obtained for preoperative photography	96.2	3.8
27	Functional systemic evaluation must be performed prior to surgery.	100.0	0.0
28	Skin thickness and tissue quality should be considered in surgical planning.	96.2	3.8
29	A standardized informed consent form should be used.	100.0	0.0
30	During informed consent, the potential positive and negative effects of vaginal tightening surgery on sexual function (e.g., dyspareunia, decrease in orgasm) should be explicitly discussed.	100.0	0.0
31	In the preoperative assessment, the patient's expectations, objective clinical findings, and planned surgical procedure should be documented in detail.	100.0	0.0
32	Possible complications and risks should be explained to the patient in detail.	100.0	0.0
33	The patient's sexual history and medical history should be evaluated.	100.0	0.0
34	Vaginal delivery history, obstetric trauma, and previous perineal repairs/episiotomy scars should be evaluated in detail preoperatively.	96.2	3.8
35	Perineal body should be evaluated in detail preoperatively and systematically evaluated.	100.0	0.0
36	Conservative treatment options should be discussed with the patient before surgery.	100.0	0.0
37	Preoperative hormonal therapy should be administered to women in perimenopausal or senile period.	100.0	0.0
38	The patient should be informed that sexual satisfaction is not determined solely by vaginal tightening but depends on many biological, psychological and social factors.	100.0	0.0
39	Vaginal tightening surgery should not be routinely recommended in nulliparous patients; it should only be considered after careful evaluation and detailed evaluation.	92.3	7.7
40	Nulliparous patients should be informed that planned future vaginal delivery may negatively affect surgical outcomes.	100.0	0.0
41	The patient should be informed that the current scientific evidence regarding the effects of vaginal tightening surgery on sexual function is limited and controversial.	92.3	7.7
Section 3: Surgical technique			
42	Objectively demonstrable vaginal laxity should be accepted as a surgical indication.	92.3	7.7
43	In the presence of objectively demonstrable laxity combined with the patient's subjective sense of laxity, surgical intervention should be considered appropriate.	84.6	15.4
44	Perineal body should be accepted as a surgical indication.	100.0	0.0
45	Obstetric trauma and perineal damage should be considered as surgical indications.	92.3	7.7
46	Aesthetic concerns alone should not be considered as an indication for surgery when appropriate patient selection is ensured.	92.3	7.7
47	Symptom severity and its impact on quality of life should be determinative criteria in the surgical decision.	96.2	3.8
48	Recurrent vaginal relaxation should be accepted as an indication for surgery.	88.5	11.5
49	The surgical decision-making process should be based solely on patient autonomy; partner expectations should not be determinative.	96.2	3.8
50	The anatomical and functional components of vaginal relaxation should be evaluated together before surgery.	100.0	0.0
51	Vaginal tightening surgery should not be considered a treatment method aimed at resolving relationship problems.	96.2	3.8
52	Surgical technique should be performed with the expectation of improving marital relations or increasing partner fidelity.	100.0	0.0
Section 4: Surgical principles and goals			
53	Preservation of natural anatomical structures and vaginal function should be the primary goal of surgery.	100.0	0.0
54	Pelvic floor muscle training and physiotherapy should be offered as a first-line treatment in patients with mild vaginal laxity and pelvic floor dysfunction.	92.3	7.7
55	Excessive tissue resection should be considered an undesirable outcome.	92.3	7.7
56	Vaginal canal diameter and length should be preserved in a controlled manner during surgery.	96.2	3.8
57	Preservation of vaginal rugae should be considered important for functional and aesthetic outcomes.	96.2	3.8
58	Perineal body reconstruction should be one of the core components of vaginoplasty surgery.	88.5	11.5
59	A combined approach with perineoplasty improves functional and aesthetic outcomes in patients with perineal laxity.	96.2	3.8
60	Excessive muscle dissection should be avoided to preserve pelvic floor muscle function.	100.0	0.0
61	The amount of muscle resection should be conservative to minimize tissue loss.	100.0	0.0
62	Tissue repair should be performed in layers with an anatomical technique selection.	100.0	0.0
63	Protection of neurovascular structures during surgery is important for functional outcomes.	100.0	0.0
64	Surgical technique should be individualized based on patient anatomy, symptoms and expectations.	88.5	11.5
65	Reconstruction of the posterior vaginal wall and perineal body has a significant effect on functional outcomes.	100.0	0.0
66	Hemostasis performed without muscle and fascial support repair is likely to yield suboptimal results.	100.0	0.0
67	Surgery performed without adequate preparation in postmenopausal or atrophic tissue seems inappropriate.	96.2	3.8
68	Energy-based devices can be used as an alternative to surgery in selected patients.	88.5	11.5
69	Vaginal tightening surgery should not be performed for aesthetic purposes (e.g., appearance, patient satisfaction) alone.	100.0	0.0
70	Avoiding excessive tightening in vaginal tightening surgery is important for functional outcomes.	100.0	0.0
Section 5: Technical Selection			
71	The degree and distribution of vaginal laxity (total vs. full-canal) are determinative factors in technique selection.	92.3	7.7
72	Pelvic floor weakness is a determinative factor in vaginal tightening surgery planning.	92.3	7.7
73	A limited surgical approach may be sufficient in patients with isolated introital laxity.	100.0	0.0
74	In patients with proximal vaginal support defect, a technique based solely on distal tightening is not appropriate.	100.0	0.0
75	The integrity of the perineal body, posterior fourchette, and perineal fascia should be evaluated together in technique selection.	100.0	0.0
76	Previously performed vaginal or pelvic surgeries are a factor that modifies technique selection.	96.2	3.8
77	Presence of scar tissue and fascial loss are determinative factors in technique selection.	100.0	0.0
78	In posteriorsagal or atrophic tissues, tissue-preserving principles should be prioritized.	100.0	0.0
79	Presence of accompanying pelvic organ prolapse should be considered in technique selection.	100.0	0.0
80	Risk of excessive tightening should be considered a limiting factor in technique selection.	96.2	3.8
81	Technique selection should be primarily based on the individualized based on anatomical findings, functional goals, and patient expectations.	100.0	0.0
Section 6: Management of complications			
82	Suture material selection affects complication rates.	96.2	3.8
83	Excessive tension in the repair is a common complication risk.	100.0	0.0
84	Dorsal lithotomy is the most appropriate patient position.	84.6	15.4
85	When placing the patient in lithotomy position, care must be placed below the knees and checked by the surgeon throughout the surgery.	100.0	0.0
86	Layered closure helps minimize wound healing.	92.3	7.7
87	The hemostasis method (electrocautery vs. sharp dissection) affects surgical outcomes.	96.2	3.8
88	Minimizing dead space during repair prevents hematoma and seroma.	100.0	0.0
89	Excessive use of electrocautery increases tissue damage and raises complication risk.	88.5	11.5
90	Intraoperative assessment of the vaginal canal diameter is necessary.	100.0	0.0
91	The degree of vaginal tightening should be adjusted in a manner that does not impair functional penetration; does not create dyspareunia.	100.0	0.0
92	The degree of vaginal canal tightening should be adjusted in a controlled manner intraoperatively.	100.0	0.0
93	The tension applied to the vaginal mucosa should be carefully controlled.	100.0	0.0
94	Correct identification of anatomical planes during perineal body reconstruction improves surgical success.	100.0	0.0
95	Anatomical identification and separation of fascial planes reduces complication risk.	100.0	0.0
96	Unnecessarily entering deep planes during posterior vaginal wall dissection increases complication risk.	96.2	3.8
97	Preservation of tissue planes and dissection appropriate to anatomical layers improves surgical success.	100.0	0.0
98	Closure of vaginal mucosa under excessive tension adversely affects wound healing.	96.2	3.8
99	Preservation of vaginal rugae during surgery contributes to functional outcomes.	100.0	0.0
100	Prevention of excessive tightening through intraoperative evaluation is an important component of surgical success.	100.0	0.0
Section 7: Revision Surgery			
101	Revision vaginoplasty should be treated as a separate clinical category.	92.3	7.7
102	Complication rates in revision surgery are higher than in primary surgery.	100.0	0.0
103	Adequate healing (e.g., at least 6 months) is required for a standard before revision surgery	96.2	3.8
104	Patient expectations should be more carefully evaluated in revision surgery	100.0	0.0
105	In patients planned for revision surgery, preoperative photography, tissue quality, and available tissue amount should be comprehensively evaluated.	100.0	0.0
106	Presence of scar tissue makes revision technically more complex.	96.2	3.8
107	After excessive tightening, more conservative techniques should be preferred when revision is considered.	100.0	0.0
108	More targeted (patient-based) techniques should be applied in revision surgery following insufficient tightening.	92.3	7.7
109	Re-evaluation of indication for surgery is necessary in revision surgery.	96.2	3.8
110	More detailed psychosexual evaluation should be performed in patients planned for revision surgery.	100.0	0.0
111	Detailed analysis of previous surgical technique and approach is necessary in revision planning.	100.0	0.0
112	Revision surgery should only be recommended in the presence of a functional or significant aesthetic problem.	88.5	11.5
113	In situations with limited tissue availability in revision surgery, conservative techniques should be preferred.	96.2	3.8
Section 8: Complications			
114	Dyspareunia is one of the most important complications following vaginoplasty.	96.2	3.8
115	Excessive tightening is a clinically significant complication that must be prevented.	100.0	0.0
116	Infection risk is considered low with appropriate antibiotic prophylaxis.	100.0	0.0
117	Hematoma and early-period bleeding are among important complications.	100.0	0.0
118	Recurrent vaginal laxity is an important long-term complication of surgical failure.	84.6	15.4
119	Vaginal dryness or decreased lubrication after vaginal tightening surgery is a clinically significant outcome.	73.1	26.9
120	Sensation changes (decrease/increase) are important outcomes affecting patient satisfaction.	96.2	3.8
121	Delayed wound healing is associated with infection and tissue loss.	100.0	0.0
122	Development of vaginal stenosis should be accepted as a rare but serious complication.	100.0	0.0
123	Prolonged postoperative pain is a clinically significant complication.	88.5	11.5
124	The possibility of pelvic floor dysfunctions (e.g., defecation difficulty) occurring after surgery should be kept in mind.	88.5	11.5
125	Suture line dehiscence is an important and clinically significant complication.	96.2	3.8
Section 9: Perioperative management			
126	Antibiotic prophylaxis should be routinely applied in vaginoplasty surgery.	96.2	3.8
127	Postoperative pain follow-up should be performed in the early period.	100.0	0.0
128	Pain management should be individualized according to patient characteristics.	100.0	0.0
129	Anesthesia selection (local, sedoanalgesia, general) should be determined according to patient and surgical characteristics.	92.3	19.2
130	The patient should be hospitalized for at least one night depending on the situation.	96.2	3.8
131	Preoperative patient preparation (hygiene, skin preparation, antisepsis) should be standardized.	96.2	3.9
132	Surgical site shaving should be performed with clippers.	100.0	0.0
133	Perioperative risk assessment should be an integral part of surgical planning.	100.0	0.0
134	A smoking cessation process should be recommended before and after surgery in patients who smoke.	92.3	7.7
135	Early postoperative mobilization reduces complication risk.	84.6	15.4
136	Postoperative hygiene recommendations are an important factor affecting the healing process.	100.0	0.0
137	Routine postoperative vaginal exam is not necessary.	92.3	7.7
138	Management of postoperative edema and inflammation should be standardized.	92.3	7.7
139	Written information should be provided to the patient regarding the postoperative process and signs of complications.	100.0	0.0
140	The time to return to sexual activity should be standardized.	100.0	0.0
141	The time to return to intense physical activity should be restricted.	100.0	0.0
Section 10: Postoperative care			
142	The sexual intercourse restriction period should be at least 4-6 weeks.	100.0	0.0
143	Postoperative wound management is critical for healing.	100.0	0.0
144	Patient education is necessary for early recognition of complications.	100.0	0.0
145	Physical activity restriction should be planned.	88.5	11.5
146	Postoperative wound care is a critical factor affecting the healing process.	100.0	0.0
147	Postoperative pain control affects patient comfort and early mobilization.	100.0	0.0
148	Cold application and supportive therapies are effective in edema control.	92.3	7.7
149	Postoperative infection and pain follow-up should be performed in the early period.	100.0	0.0
150	Postoperative control timing and monitoring frequency should be standardized.	92.3	7.7
151	Patient should be called for follow-up on the 7th day for the healing and suture monitoring.	100.0	0.0
152	Patients should be encouraged to return to their daily activities in a controlled manner in the early period.	96.2	3.8
153	Postoperative hygiene recommendations are important in reducing infection risk.	100.0	0.0
154	Pelvic floor rehabilitation or dilator use in the postoperative period is recommended or selected patients.	73.1	26.9
Section 11: Outcomes			
155	Patient satisfaction is high after vaginal tightening surgery.	88.5	11.5
156	At least 3-4 months should be waited to evaluate final outcomes after vaginal tightening surgery.	96.2	3.8
157	Sexual function largely improves after surgery.	80.8	19.2
158	Long-term outcome data should be collected.	96.2	3.8
159	Sexual function in the postoperative period should be evaluated using patient-reported outcome measures (PROMs).	96.2	3.8
160	Consultation with postoperative reproductive endocrinology and andrology should be determined by patient satisfaction.	100.0	0.0
161	Functional outcome determine patient satisfaction as much as aesthetic outcomes.	100.0	0.0
162	Significant improvement in quality of life is achieved after vaginal tightening surgery.	92.3	7.7
163	Need for revision surgery should be evaluated in the long-term follow-up.	88.5	11.5
164	Development of complications after surgery directly affects patient satisfaction.	96.2	3.8
165	Psychosexual improvement is an important outcome in a clinically significant outcome.	96.2	3.8
166	Surgical failure is defined as recurrent vaginal laxity, patient dissatisfaction, or functional deterioration.	96.2	3.8
167	Long-term follow-up outcomes are important in assessing the efficacy of vaginal tightening surgery.	100.0	0.0

Section 12: Guidelines and Future Directions

168	Establishing a multidisciplinary approach in vaginoplasty surgery is necessary.	96.2	3.8
169	Multidisciplinary approach (gynecology, plastic surgery, physiotherapy, psychosexual support) should be the gold standard.	100.0	0.0
170	More high-quality prospective and randomized controlled studies are needed.	100.0	0.0
171	Standardization of techniques in vaginal tightening surgery is possible and necessary.	88.5	11.5
172	Integration of PROMs into clinical practice is necessary.	100.0	0.0
173	Standard short- and long-term follow-up protocols for evaluating vaginal tightening surgery outcomes are needed.	96.2	3.8
174	Data registry systems evaluating long-term outcomes should be established.	100.0	0.0
175	Standard training and certification programs for vaginal tightening surgery are needed.	92.3	7.7
176	The effects of vaginal tightening surgery on sexual function and quality of life should be more clearly defined.	100.0	0.0
177	Studies comparing surgical and non-surgical treatment methods should be increased.	100.0	0.0
178	Development of personalized treatment algorithms will improve vaginoplasty outcomes.	96.2	3.8
179	Standardization of patient selection criteria in vaginoplasty surgery is necessary.	100.0	0.0
180	More clearly defining the indications for vaginal tightening surgery will improve clinical practice.	96.2	3.8

Section 13: Advanced technology and innovation

181	In preoperative assessment, vaginal mapping should be performed to identify anterior, posterior, and apical support defects along with the degree of laxity.	92.3	7.7
182	Visual Techie imaging can be used for objective assessment of vaginal laxity.	76.9	23.1
183	In cases with no anatomical support defect but a complaint of vaginal laxity, fiber exercises, pilates, foot exercises, vaginal laser applications, and sexual counseling may be considered as adjunctive or alternative treatments.	92.3	7.7
184	The vaginal wall thickness of the vagina can be measured with transvaginal ultrasonography before and during pelvic examination, or approximately 3 cm.	84.6	15.4
185	Absorbable suture (4.0 or 5.0) can be used in vaginal mucosal repair.	92.3	7.7
186	Enhanced Recovery After Surgery protocols should be applied following vaginoplasty.	96.2	3.8
187	The vaginoplasty approach should be chosen by the surgeon's experience and technique should be taken into account in vaginal tightening procedures.	92.3	3.9
188	Anterior vaginal wall repair/plication (the last step) minimal to avoid damaging the vaginal sensory system; site-specific natural tissue repair should be prioritized.	88.5	11.5
189	Vaginal tightening surgery should not be performed in the absence of appropriately address not only the distal vaginal but the proximal vaginal support defect.	96.2	3.8
190	Classic ultrasonic ointment tissue has a high failure rate in long-term outcomes.	80.8	19.2
191	In the treatment of postmenopausal patients, estrogen therapy in vaginal mucosal repair surgery has be recommended.	88.5	11.5
192	Concomitant procedures identified in the preoperative assessment and new problems emerging in the postoperative period should be recorded separately for the anterior, apical, and posterior compartments of the pelvic floor, and appropriate surgical plans should be made.	100.0	0.0

Section 14: Ethics and psychosexual evaluation

193	In patients planned for vaginoplasty, a structured psychosexual evaluation, clinical screening for body dysmorphic disorder is recommended as an integral part of the preoperative process when risk indicators such as unrealistic expectations, a history of multiple aesthetic procedures, or perception of defect/dissatisfaction is detected.	84.7	5.3
194	In cases where evidence suggests that the surgical decision is being shaped by partner pressure, it is recommended that the surgery be postponed and that a one-between-one psychosexual counseling be held to discover its ultimate motivation.	84.2	15.8
195	In patients requesting vaginal surgery without a functional indication, the potential effects of social media and commercial pressure on the patient's body image and surgical expectations should be incorporated into the informed consent process in an individualized manner based on the patient's psychological status.	89.5	10.5
196	In patients requesting vaginal surgery without a functional indication, psychosexual evaluation is recommended in cases identified on the basis of risk indicators or the clinician's judgment, conducted through a patient-centered approach.	94.7	5.3
197	The potential effects of social media content on genital appearance perception should be addressed during the preoperative psychosexual evaluation process, and the patient's level of awareness in this regard should be assessed to be shaping their motivation.	94.7	5.3
198	The gynecological planning surgical surgery should evaluate the patient's psychosexual motivation and the realism of the surgical expectation in the preoperative clinical interview and the surgical decision in cases where the referral does not stem from a functional pathology. The purpose of this evaluation is to identify patients who may benefit from surgery but to ensure informed consent and realistic expectations.	100.0	0.0

PETKOZ: Pelvic Floor and Genetic Gynecology, FGPI: Female sexual function index, HPV: Human papillomavirus.

Supplementary Material 2. Statements failing to reach consensus-vaginoplasty delphi consensus study (n=29 experts; consensus threshold ≥75%; 3 statements across 3 domains)

#	Statement	Agreement (%)	Disagreement (%)
Section 1: Contraindications			
1	Presence of condyloma acuminata constitutes a contraindication to surgery	50.0	50.0
Section 3: Indications			
2	Isolated labia majora relaxation - feeling of looseness - alone is a sufficient indication for surgery.	30.8	69.2
3	Sexual dysfunction or psychosexual distress is a sufficient indication for vaginal tightening surgery.	57.7	42.3
4	Partner pressure should not be a determinative factor in surgical decision-making process.	50.0	50.0
Section 6: Surgical principles and goals			
5	The use of energy-based devices as a direct surgical alternative is an appropriate approach.	26.9	73.1
6	Performing surgery while focusing solely on the patient's aesthetic expectations without functional evaluation is appropriate.	19.2	80.8
7	Levator ani plication should be included in surgery in selected patients.	69.2	30.8
Section 8: Complications			
8	Patient dissatisfaction is an important indicator of surgical success.	57.7	42.3
Section 10: Postoperative care			
9	Vaginal tightening surgery can be performed even under local anesthesia.	30.8	69.2
10	Placement of urinary catheter is routinely and unnecessarily implemented routinely in every patient.	57.7	42.3
11	The patient can be discharged on the same day.	50.0	50.0
Section 13: Advanced technology and innovation (vaccinewave set 2)			
12	Absorbable sutures of size 1 or 2 should be preferred for fascial and muscle repairs.	69.2	30.8
13	The use of non-absorbable sutures for fascial, muscle, and ligament repairs can be considered an appropriate option.	69.2	30.8

Supplementary Material 3. Domain-level agreement statistics across the consensus statements

Domain	Statements (n)	Mean (%)	Median (%)	IQR (%)	Min (%)	Max (%)
Contraindications	15	90.2	96.2	80.8-100.0	9.89	73.1	100.0
Preoperative assessment	26	95.6	100.0	96.2-100.0	7.11	84.6	100.0
Surgical indications	11	92.3	92.3	90.4-96.2	4.65	84.6	100.0
Surgical principles	18	97.0	100.0	96.2-100.0	4.65	84.6	100.0
Technical selection	11	96.5	100.0	94.2-100.0	4.77	84.6	100.0
Intraoperative management	20	97.1	100.0	96.2-100.0	3.90	84.6	100.0
Revision surgery	13	96.8	96.2	96.2-100.0	3.64	88.5	100.0
Complications	12	93.6	96.2	88.5-100.0	5.85	80.8	100.0
Perioperative management	16	95.2	96.2	92.3-100.0	5.85	80.8	100.0
Postoperative care	13	94.4	96.2	92.3-100.0	5.41	80.8	100.0
Outcomes & future directions	13	97.1	96.2	96.2-100.0	3.41	88.5	100.0
Advanced technology	12	87.9	92.3	84.6-96.2	7.69	69.2	100.0
Ethics/psychosexual	6	93.0	94.7	92.0-94.7	4.96	84.2	100.0
Overall	**196**	**94.1**	**96.2**	**92.3-100.0**	**3.41**	**69.2**	**100.0**

Agreement rates represent the percentage of experts (n=29) selecting "agree" or "strongly agree" for each statement in the final Delphi round. Values in the Ethics/psychosexual domain reflect the six statements added in round 3. IQR: interquartile range; SD: standard deviation; Min: minimum; Max: maximum.

Supplementary Material 4. Consensus strength classification (196 statements)

Consensus strength	Agreement Threshold	Statements (n)	Statements (%)
Very strong consensus	≥90%	133	67.2%
Strong consensus	85-90%	40	20.2%
Moderate consensus	75-80%	25	12.6%
Total	≥75%	198	100.0%

Consensus strength categories were defined a priori: very strong consensus (agreement ≥90%), strong consensus (85-90%), and moderate consensus (75-80%). The consensus threshold was set at ≥75% agreement. Agreement was calculated as the percentage of experts selecting "agree" or "strongly agree" in the final Delphi round (round 3).

Supplementary Material 5. Domain-level Kendall's W and Kendall's coefficient of concordance (Kendall's W)

Domain	Mean ± SD	Min	Max	k	Kendall's W	χ^2	p value
Contraindications	3.77±0.663	2	5	15	0.1677	78.73/14	<0.001
Preoperative assessment	3.92±0.354	2	4	26	0.1522	98.95 (25)	<0.001
Surgical indications	3.83±0.750	2	5	11	0.2247	136.15/10	<0.001
Surgical principles	3.93±0.330	2	4	17	0.1476	95.26 (17)	<0.001
Technical selection	3.64±0.756	2	5	11	0.2724	177.2/10	<0.001
Intraoperative management	3.96±0.209	2	4	97.4	0.0776	38.30 (18)	0.006
Revision surgery	3.87±0.299	2	4	13	0.1538	89.54/12	0.474
Complications	3.89±0.420	2	4	12	0.2016	66.23 (11)	<0.001
Perioperative management	3.72±0.606	2	5	16	0.2386	132.05 (15)	<0.001
Postoperative care	3.94±0.298	2	4	94.4	0.0733	22.66 (12)	0.029
Clinical outcomes	3.95±0.379	2	4	13	0.1154	67.19/12	<0.001
Guidelines and future directions	3.96±0.240	2	4	97.1	0.0423	13.20 (12)	0.355
Advanced technical terms	3.67±0.778	2	5	12	0.2652	114.8/11	<0.001
Ethics and psychosexual evaluation	4.33±0.707	2	5	93.0	0.0861	7.61 (5)	0.179
Overall	**3.87±0.463**						

Kendall's W values range from 0 (no agreement) to 1 (perfect agreement). Values of 0.1–0.3 indicate slight concordance, 0.3–0.5 indicate moderate concordance, and >0.5 indicate strong concordance. Statistical significance was set at $p < 0.05$. Abbreviations: SD: standard deviation; Min: minimum; Max: maximum; k: number of statements within each domain; χ^2: chi-square statistic.

Supplementary Material 6. Comparison of Kendall's W between early and late Delphi rounds

Comparison	Kendall's W	χ^2	p value
Round 1 (n=196 statements)	0.0776	38.30 (18)	0.006
Round 2 (n=196 statements)	0.0733	22.66 (12)	0.029
Round 3 (n=196 statements)	0.0423	13.20 (12)	0.355
Early rounds (1 and 2)	0.0755	60.96 (30)	0.001
Late rounds (2 and 3)	0.0578	35.86 (30)	0.208

Kendall's W measures inter-rater concordance in the relative ranking of statements within each domain; significance assessed against the χ^2 distribution with $k-1$ degrees of freedom. Values of 0.1–0.3 indicate slight concordance, 0.3–0.5 moderate concordance, and >0.5 strong concordance. Early rounds: pooled Rounds 1 and 2; late rounds: pooled Rounds 2 and 3. Abbreviations: SD: standard deviation; χ^2: chi-square statistic.