Life Survey (HerQLes). Cost was calculated using hospital billing data. Patient demographics were collected and statistical analyses were performed using Fisher’s exact tests, Mann-Whitney U tests, and regression modeling.

**RESULTS:** Mean BMI of the VHR-P AN and VHR alone group was 38.9 kg/m² and 33.5 kg/m², respectively. Hernia defect size (p=0.516), mesh placement (p=0.644), component separation (p=0.5063) and hernia recurrence rates (p=1.000) were similar in both cohorts. Additionally there was no significant difference in operative time (p=0.834) or days to drain removal (0.711) between both groups. Rate of prior bariatric surgery (p=0.0533) trended towards significantly different in the VHR-P AN group. 64% of patients completed QoL surveys, showing significant improvement from pre- to post-operative scores, regardless of whether a panniculectomy was performed (p < 0.02). Mean direct hospitalization costs were not significantly different between the two groups (p=0.165), as well as mean hospital stay (p=1.00). After regression modeling, the procedure performed did not significantly contribute to differences in cost, wound complications, including wound dehiscence and SSI, or hernia recurrence between the two groups. Higher wound class (p=0.0105) and longer hospital length of stay (p=0.0481) were independently associated with an increase in total direct cost, while higher BMI trended towards significance (p=0.0501) with increasing total direct cost.

**CONCLUSION:** The addition of a panniculectomy to VHR does not significantly increase cost or complication rates, including wound events or hernia recurrence. This study highlights the safety and efficacy of performing concurrent ventral hernia repair with panniculectomy in obese and overweight patients, as evident through equal improvements in QoL, post-operative outcomes, and cost. Furthermore, a prospective, randomized controlled trial is needed to continually assess long-term outcomes of VHR-PAN.

**Affiliation: Mayo Clinic Rochester, Rochester, MN**

**PURPOSE:** The lack of erogenous sensitivity in the neo-vagina is one of the major shortcomings for patients undergoing male to female genital confirmation surgery. A clitoral flap derived from the glans penis serves as the only source of erogenous sensitivity for these patients. A cadaveric and histological based comparison of the branches of the dorsal nerve of the penis (DNP) utilized in and remnant after the harvest of the clitoral flap is done to assess the feasibility, optimal design, and potential benefits of a sensate neurovascular pedicle flap for erogenous vaginal sensation in this patient population.

**METHODS:** An anatomic dissection of the DNP was performed in 10 male pelvises to identify major trunks and their branches. Their location, diameter, branching pattern along the dorsal aspect of the penis were recorded. Main branches of DNP within the medial dorsal aspect of the penis were preserved for a clitoral flap, while those more lateral were used as innervation for the sensate vaginal flap. The number of main branches in the lateral dorsal aspect of the penis were calculated to ensure sufficient erogenous innervation to vaginal flap. The number of main branches in the lateral dorsal aspect of the penis were calculated to ensure sufficient erogenous innervation to vaginal flap. Cross-sections of the penis at proximal and distal points were used for histological analysis with similar medial and lateral compartmentalization. An optimal width and length of the sensate vaginal flap was recommended based on these cadaveric findings.

**RESULTS:** The DNP was composed of on average 4, 5, 6 main branches in 2 (20%), 4 (40%), and 4 (40%), cadavers respectively. Lateral main branches with 1, 2, and 3 main branches in the lateral compartment seen in 2 (20%), 6 (30.7%), 2 (42.8%) cadavers, respectively. These findings were consistent with histological cross-sectional analysis, and further showed increasing branching with more distal cross-sections. A sensate vaginal flap from the lateral aspect of the glans penis with a mean width of 1.14 cm (range, 0.9 – 1.28 cm) ensured at least one main branch of the DNP for erogenous sensitivity. This sensate vaginal flap and its neurovascular pedicle had mean length of 9.8 cm (range, 8.7 to 10.3) allowing its rotation into the anterior vaginal canal.

**CONCLUSION:** Lateral branches of the DNP can be preserved after clitoroplasty for reconstruction of a sensate vaginal flap that measures approximately 1 cm in width and has neurovascular pedicle between 8.7 to 10 cm in length. Inset within the anterior vagina wall, this sensate flap can provide patients with an erogenous vaginal “spot” during

**Erogenous Sensate Vaginal Flap for Male to Female Vaginoplasty**

**Presenter: Kian Adabi, BA**

**Co-Authors: Tony Chieh-Ting Huang, MD, MSc; M. Diya Sabbagh, MD; Jorys Martinez-Jorge, MD; Pedro Ciudad, MD, PhD; Ricardo Galan, MD; Oscar J. Manrique, MD**
male to female confirmation surgery. Future clinical studies are required to assess the erogenous function of the flap and impact on patient sexual function and quality of life.

**Sex Reassignment Surgery: Is It Good for Patients?**

**Presenter: Stephen M. Lu, MD, MDiv**

**Co-Authors: Dana Bregman, MD; Alan Matarasso, MD**

**Affiliation: Northwell Health, Zucker School of Medicine at Hofstra/Northwell, Lake Success, NY**

**PURPOSE:** In 1981, the Centers for Medicare and Medicaid Services (CMS) issued a National Coverage Determination (NCD) denying coverage for transsexual surgery as a treatment for transsexualism. This NCD was deemed invalid in 2014 by the Department of Health and Human Services, allowing local coverage determinations to adjudicate Medicare claims. Since that time, there has been a marked increase in interest in surgical procedures for sex reassignment, with plastic surgery playing a prominent role. While sex reassignment surgery (SRS) has undoubtedly become safer and more reliable over recent decades, the question remains: does SRS truly help patients with gender dysphoria over the long term? We performed a systematic review to investigate this issue.

**METHODS:** The literature surrounding sex reassignment surgery is broad, diverse, and uneven. We performed a PubMed search with a focus on SRS, patient satisfaction, and outcomes. References within relevant studies, chapters, review articles, and government publications were reviewed. Studies were assessed for level of evidence, quality of study design, and specific outcomes measured.

**RESULTS:** Among the over forty studies examined, the evidence is conflicting, generally of low quality, and lacking strength due to inconsistent methodology, lack of control groups, short-term follow up, small sample sizes, and/or variable outcomes. While subjective measures like patient satisfaction and quality of life are important and generally show improvement, objective outcomes like psychiatric treatment, requests for surgical reversal, and mortality are vital for evaluating the overall effectiveness of SRS. One of the most robust studies examined all patients in Sweden undergoing SRS over 30 years and compared them to random population controls; it found markedly increased adjusted hazard ratios for overall mortality (2.8), particularly death from suicide (19.1), as well as cardiovascular disease (2.5) and neoplasm (2.1); suicide attempts (4.9); and psychiatric inpatient care (2.8), with the overall mortality impact becoming apparent only after 10 years of follow-up. While the study did not examine the impact of SRS independently, it demonstrated that patients undergoing SRS do not return to normal population risk levels of morbidity and mortality, and that one of the most important metrics, survival, is not clearly affected until 10 years after surgery.

**CONCLUSION:** Sex reassignment surgery has progressed a great deal over the last sixty years, with substantive contributions from many medical specialties, including plastic surgery, leading to more safe, functional, aesthetic, and satisfactory outcomes for patients with gender dysphoria. However, what remains to be determined is how effectively SRS treats gender dysphoria over the long term; the literature seems indeterminate at this time. CMS has not issued a NCD regarding SRS “because the clinical evidence is inconclusive for the Medicare population.” Plastic surgery should be at the forefront of studying and providing the evidence that the government, physicians, and our patients need.

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**Gender Reassignment Surgery Using the Pedicle Transverse Colon Flap for Vaginal Reconstruction: A Clinical Outcome and Sexual Function Evaluation Study**

**Presenter: M. Diya Sabbagh, MD**