CONCLUSIONS: Labia majora flap scrotoplasty via a bilateral rotational advancement technique and perineal reconstruction can be safely done during or after phalloplasty. Minor wound complications are common and frequently heal with conservative management. Wounds that do not heal are often associated with a urethral complication. Hematomas of the scrotum and perineum are rare.

REFERENCE:
1. Monstrey SJ, Ceulemans P, Hoebeke P. Sex reassignment surgery in the female-to-male transsexual. Semin Plast Surg. 2011;25:229–244.

Use of a Split Pedicled Gracilis Muscle Flap in Robotic-assisted Vaginectomy and Urethral Lengthening for Phalloplasty

Presenter: Oriana Cohen, MD

Co-Authors: Lee C. Zhao, MD; Jamie P. Levine, MD; Rachel Bluebond-Langner, MD

Affiliation: NYU Langone Health, New York, NY

BACKGROUND: We describe the technique of robotic vaginectomy, anterior vaginal flap urethroplasty, and the use of a longitudinally split pedicled gracilis muscle flap to recreate the bulbar urethra and help fill the vaginal defect in female-to-male gender affirming phalloplasty.

METHODS: Vaginectomy is performed via robotic-assisted laparoscopic transabdominal approach. Concurrently, gracilis muscle is harvested and passed through a tunnel between the groin and vaginal cavity. It is then split longitudinally and the inferior half is passed into the vaginal cavity, where it is inset into the vaginal cavity. Following urethroplasty, the superior half of the gracilis flap is placed around the vaginal flap to buttress this suture line with well-vascularized tissue.

RESULTS: From May 2016 to March 2018, 16 patients underwent this procedure, of average age 35.1 ± 8.8 years, body mass index 31.4 ± 5.5, and American Society of Anesthesiologists class 1.8 ± 0.6. The average length of operation was 423.6 ± 84.6 minutes, with an estimated blood loss of 246.9 ± 84.9 ml. Patients were generally out of bed on postoperative day 1, ambulating on postoperative day 2, and discharged home on postoperative day 3 (average day of discharge, 3.4 ± 1.4 days). At mean follow-up time of 361.1 ± 175.5 days, no patients developed urinary fistula at the urethroplasty site.

CONCLUSIONS: Our use of the longitudinally split gracilis muscle in first-stage phalloplasty represents a novel approach to providing well-vascularized tissue to achieve both urethral support and closure of intra-pelvic dead space, with a single flap, in a safe, efficient, and reproducible manner.

Health Insurance Coverage of Gender-affirming Top Surgery in the United States

Presenter: Ledibabari M. Ngaage, MA Cantab, MB BChir

Co-Authors: Brooks Knighton, BS; Katie McGlone, BS; Caroline Benzel, BS; Erin M. Rada, MD; Rachel Bluebond-Langner, MD; Yvonne M. Rasko, MD

Affiliation: University of Maryland School of Medicine, Baltimore, MD

INTRODUCTION: Despite the medical necessity, legislative mandates, and economic benefits of gender-affirming surgery, access to treatment remains limited. World Professional Association for Transgender Health (WPATH) has proposed guidelines for transition-related surgery in conjunction with criteria to delineate medical necessity. We assessed insurance coverage of “top” gender-affirming surgery and evaluated the differences between insurance policy criteria and WPATH recommendations.

METHODS: We conducted a cross-sectional analysis of insurance policies for coverage of top gender-affirming surgery. Insurance companies were selected based on their state enrolment data and market share. A web-based search and individual telephone interviews were conducted to identify the policy. Medical necessity criteria were abstracted from publicly available policies.

RESULTS: Of the 57 insurers evaluated, bilateral mastectomy (female-to-male) was covered by significantly more insurers than breast augmentation (male-to-female) (96% versus 68%; \(P < 0.0001\)). Only 4% of companies used WPATH-consistent criteria. No criterion was universally required by insurers. Additional prerequisites for coverage that extended beyond WPATH guidelines for top surgery were continuous living in congruent gender role, 2 referring mental health professionals, and hormone therapy before surgery. Hormone therapy was required in a significantly higher proportion of male-to-female policies compared to female-to-male policies (90% versus 21%; \(P < 0.0001\)).

CONCLUSION: In addition to the marked intercompany variation in criteria for insurance coverage which often deviated from WPATH recommendations, there are healthcare insurers who categorically deny access to top gender-affirming surgery. A greater evidence base is