significantly increases the risk of postoperative vaginal stenosis. This paper proposes a simple technique for the reconstruction of thin septa, utilising two interdigitating Y-flaps. The authors also present their 7-year experience of utilising this technique. Custom made illustrations and serial intraoperative photographs will accompany the podium presentation in order to facilitate better understanding of the technique.

THE TECHNIQUE: The transverse vaginal septum comprises an external and internal fibrous lamella, with interstitial areolar tissue interposed between the two. An inverted Y incision is made on the external lamella and the three resulting flaps are raised onto the interstitial tissue all the way to the lateral vaginal wall. A second Y incision is then made on the internal lamella, at 180 degrees to the previous incision; this produces three internal flaps. Finally, the internal flaps are everted and interdigitated with the external flaps which are inverted, producing a zigzag scar.

RESULTS: The authors run a national service for disorders of sex development comprising plastic surgeons and gynaecologists. In the last seven years, eight patients with this rare condition have been identified, with mean age 18.5 years (±4.3y). All patients had the procedure described above. No major complications were reported. Mean follow up was 5.7 months (3–14 months). There were no cases of postoperative vaginal stenosis. One of the patients carried a twin pregnancy to term and had spontaneous vaginal delivery without problems.

CONCLUSION: The authors present a simple technique for vaginal reconstruction in patients with transverse vaginal septa, based on two interdigitating Y flaps from each septal lamella. This technique obviates the previous need for septal tissue excision, thus maintaining the vaginal length; it also produces a zigzag rather than a circular scar, which reduces the risk of postoperative vaginal stenosis. The authors’ 7-year experience with this technique has shown that it is safe and yields very good postoperative outcomes.

REFERENCES:
1. Williams, C. E., Nakhal, R. S., Hall-Craggs, M. A., et al. Transverse vaginal septae: management and long-term outcomes. BJOG: an international journal of obstetrics and gynaecology 2014;121:1653–1658.

Jerry Chih-Wei Wu, MD; Tommy Nai-Jen Chang, MD; Jung-Ju Huang, MD; Neil Sachanandani, MD; Ming-Huei Cheng, MD, MBA

INTRODUCTION: The perforator of the anterior branch of the obturator artery is located at the uppermost gracilis territory. The perforator flap based on this vessel is thin and pliable, offering a good solution for loco-regional defects. In this study, we investigated the perforator topography of the anterior branch of obturator artery and propose a new flap, the obturator artery perforator propeller flap, for vulvar, vaginal or scrotal reconstruction.

MATERIALS AND METHODS: Identification and evaluation of the perforator at the uppermost gracilis territory was conducted during elevation of the gracilis flap, the obturator artery perforator flap or the profunda femoris artery perforator flap. Between January of 2011 and May of 2014, thirty-two thighs in 26 patients were evaluated. The distance of the obturator artery perforator from the ischiopubic ramus and the perforator types (musculocutaneous versus septocutaneous) were recorded. Among these, eleven patients underwent perineal reconstruction with the propeller obturator artery perforator flap(s), including a scrotal reconstruction and 10 vulvar/vaginal reconstructions. Patient age ranged from 22 to 85 years (mean, 66.1 years).

RESULTS: A single perforator from the anterior branch of obturator artery was found at the uppermost gracilis territory in all 32 thighs. The perforator was located at a mean of 1.1 cm (range 0.8 to 1.4 cm) lateral to the ischiopubic ramus; it was septocutaneous in 3 thighs (9.4%) and musculocutaneous in 29 thighs (90.6%). In 11 patients that underwent perineal reconstruction, seventeen obturator artery propeller perforator flaps were elevated. The flap area ranged from 4x7 cm² to 7x21 cm². The donor sites were primarily closed in all cases. Arc of flap rotation ranged from 90 to 180 degrees. All flaps survived completely. At a mean follow-up time of 5.1 months (range 3 to 10 months), all patients achieved normal daily activity with good functional outcomes.

CONCLUSION: The perforator of the anterior branch of the obturator artery is constantly present at the uppermost gracilis territory. The propeller obturator artery perforator flap is a versatile and reliable option for vulvar, vaginal or scrotal reconstruction.

DISCLOSURE/FINANCIAL SUPPORT: None of the authors has a financial interest in any of the products, devices, or drugs mentioned in this manuscript.
Outpatient Male-to-Female Vaginoplasty Is a Safe Procedure

Jenny Lee Nguyen, MD; Jesse T. Nguyen, MD; Thanh A. Nguyen, MD; Michael J. Wheatley, MD; Tuan A. Nguyen, MD, DDS

INTRODUCTION: Male-to-female vaginoplasty using penile skin inversion has traditionally been performed as an inpatient procedure.1 There have been no reported series of outpatient vaginoplasty,2,3 the closest being an office-based vaginoplasty after which the patient is monitored overnight by a doctor and nurse.4 This study reviews our 15-year experience with strictly outpatient vaginoplasty.

MATERIALS AND METHODS: A retrospective chart review was conducted of all outpatient penile skin inversion vaginoplasties performed in our practice from 2001 to 2016. Data collection included patient demographics and comorbidities. Operative time, combined procedures, pre- and post-operative antibiotic use, and estimated blood loss were recorded. Immediate and early postoperative complications were identified, including infection, dehiscence, graft loss, fistula, and vaginal stenosis, along with treatment to address such complications.

EXPERIENCE: Forty-four patients who underwent outpatient vaginoplasty were included in the study. Hormones were stopped 4 weeks prior to surgery. Preoperative and 5 days of postoperative antibiotics were given. Sequential compression devices were used during surgery. Ambulation was started the day of surgery. The senior author called patients the evening of surgery and visited them the next morning. Patients were then followed on an every other day basis, visited on postoperative days 3, 5, and 7. Out-of-town patients were allowed to return home after postoperative day 7. Patients were seen in clinic 2 weeks after surgery or followed up via phone call.

RESULTS: Patient ages ranged from 18 to 70 years. All were ASA Class III or less. Average BMI was 24.3. Relevant comorbidities included smoking, hypertension, coronary artery disease, diabetes mellitus, psychiatric disorders, and use of blood thinners. Most patients underwent combined vaginoplasty with clitoroplasty. 3 patients underwent clitoroplasty without vaginoplasty. 6 patients’ vaginoplasties were combined with other procedures. Postoperative complications included infection, rectal fistula, vaginal stenosis, vaginal prolapse, urinary retention, partial skin graft loss, and partial incisional dehiscence. All complications were within previously reported inpatient vaginoplasty complication ranges. 16 patients underwent secondary cosmetic revisionary surgery.

CONCLUSION: With proper patient selection, outpatient male-to-female penile skin inversion vaginoplasty has similar complication rates compared to those performed inpatient. Outpatient vaginoplasty is safe and can help reduce the cost of surgery by eliminating hospital admission.

DISCLOSURES: None of the authors has a financial interest in any of the products, devices, or drugs mentioned in this manuscript.

REFERENCES:
1. Selvaggi G, Bellring J. Gender reassignment surgery: an overview. Nat Rev Urol. 2011; 8: 274–82.
2. Amend B, Seibold J, Toomey P, Stenzl A, Sievert KD. Surgical reconstruction for male-to-female sex reassignment. Eur Urol. 2013; 64(1): 141–9.
3. Raigosa M, Avvedimento S, Yoon TS, Cruz-Gimeno J, Rodriguez G, Fontdevila J. Male-to-female genital reassignment surgery: a retrospective review of surgical technique and complications in 60 patients. J Sex Med. 2015; 12: 1837–45.
4. Reed H. Aesthetic and functional male to female genital and perineal surgery: feminizing vaginoplasty. Semin Plast Surg. 2011; 25: 163–74.