GENDER AFFIRMATION SURGERIES IN AOTEAROA NEW ZEALAND

Aotearoa New Zealand Trans Health Symposium
Hamilton
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NZIPCS, Auckland
OUTLINE

- Self introduction
- Current practice/referral pattern
- Limitations encountered so far
- Considerations in genital gender affirmation surgeries
- Future
A BIT ABOUT MYSELF

- Auckland School of Medicine 2003
- PRS specialist training in NZ (Middlemore, Waikato & Hutt Hospital)
- FRACS plast & recon 2015
FELLOWSHIP EXPERIENCE 2015 – 2017

- Taiwan
  - Chung Gung Memorial Hospital
- Bangkok
  - Preecha Aesthetic Institute
  - King Chulalongkorn Memorial Hospital
- Gent
  - UZ Gent
- Belgrade
  - Belgrade Centre for Genital Reconstructive Surgery
- Amsterdam
  - VU University Medical Centre
- UK(visit)
  - St Peter Andrology grp
MY PRACTICE

- SMO in Counties Manukau DHB
  general plastic surgeon with a subspecialty interest in breast reconstruction and gender surgeries

- New Zealand Institute of Plastic and Cosmetic Surgery (NZIPCS), Auckland
  general and cosmetic scope
  gender/genital recon, breast and lymphedema
GENDER SPECIFIC REFERRAL

- Regional – CM DHB, both chest and genital affirmation surgeries
- MoH – HCTP (interim)
- Self referral –
  - Youth entering gender service
  - Adult
  - Revisions following overseas surgeries
    - retained erectile tissue
    - vaginal stenosis
    - pain/hypersensitivity
Challenges I face

- Demand grossly under-estimated
- Distribution of resources no longer reflects demographics
- No clear provision for revisional cases
- Lack of transparency in the current wait list
- Lack of funding for (full time) staffing
- Evidenced based vs. anecdotal data
- Readiness = realistic expectation in surgical outcomes and recovery
# Gender Affirming Surgeries

## For a transwoman
- Orchidectomy
- Penectomy and vaginoplasty
- Breast augmentation
- Facial feminisation
- Thyroid cartilage reduction
- Voice surgery
- Others: hair transplant, gluteal augmentation, lipofilling

## For a transman
- Oophohysterectomy
- Vaginectomy
- Scrotoplasty + implant
- Urethral lengthening
- Metoidioplasty or Phalloplasty + implant
- Chest contouring
- Others: liposuction, pectoral implant...
- Thyroid cartilage augmentation
GENITAL FEMINISATION
VAGINOPLASTY - TECHNIQUES

Penile skin inversion
- Preferred first choice
- Supplemented by scrotal flap or scrotal skin graft to line vaginal cavity
- Lubricant dependent
- Pre op hair removal
- Circumcision or previous orchidectomy may limit tissue available
- May not be first line in ten years

Pedicled intestine
- Currently reserved for revision (vaginal stenosis)
- Sigmoid colon or ileum
- “Natural lubricant”
- Additional risk of bowel anastomosis
- Increased role in the future with genital hypoplasia due to puberty blockers
OTHER ASPECTS/CONSIDERATIONS

- Functional oriented and risk stratified decision making → minimal/no depth vaginoplasty
- Smoke cessation at least two months prior
- Pre-op cessations of hormone not routine
- Hair removal and pelvic floor physiotherapy a must
- Fertility consultation
- Younger age at accessing surgeries
GENITAL MASCOULINISATION
**Decision Making Depends on Priority**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Priority Issues</th>
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<tr>
<td>Urethroplasty</td>
<td>Stand up to void&lt;br&gt;Appearance of meatus as part of neo glan&lt;br&gt;Flap (same or separate) or graft&lt;br&gt;Most challenging part of reconstruction</td>
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<tr>
<td>Phalloplasty</td>
<td>Weight in pants&lt;br&gt;Void standing&lt;br&gt;Add implant if desire penetrative sex</td>
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<tr>
<td>Metoidioplasty</td>
<td>Void sitting&lt;br&gt;No desire for penetrative sex&lt;br&gt;Unburied (mega)clitoris&lt;br&gt;Risk aversed or undecided</td>
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Specific considerations

- Multiple reconstructive options available => need to risk stratify and functionally prioritise
- Smoke cessation -> flap survival
- BMI criteria due to tissue thickness/availability
- Staged vaginectomy decreases urethral fistula
- Staged maetoidioplasty for the undecided
FUTURE DIRECTION

- Aging and longitudinal care
- Access care at a younger age – does that mean younger surgical age?
- Puberty blocker -> penoscrotal hypoplasia or megaclitoris
- Tissue Engineering and Transplantation
- Pluralistic view in transitioning
- Informed consent model
- Fertility options: surgical sperm / ovarian cortex extraction
FUTURE DIRECTIONS:
TISSUE ENGINEERING FOR VAGINAL LINING, ERECTILE TISSUE CULTURE

IDEAS AND INNOVATIONS

The Use of Cultured Autologous Oral Epithelial Cells for Vaginoplasty in Male-to-Female Transsexuals: A Feasibility, Safety, and Advantageousness Clinical Pilot Study

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Marco Mazzonechi, M.D., Ph.D.
Federico Gori, M.D.
Simone Cuccarelli, M.D.
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Summary Various vaginoplasty methods for male-to-female transsexuals have been described, but none is ideal. The use of cultured autologous oral epithelium to cover the neovagina walls is presented. Six patients were operated on. Complications encountered were one case of low-output rectovaginal fistula that was treated conservatively; one case of partial glans necrosis resulting in a scarred but sensitive clitoris; one case of large labia minora requiring resection; and one case of short vagina requiring surgical revision with autologous cultured oral cells that was successful. All patients had adequate vagina, experienced sexual intercourse, and were satisfied with results. Autologous cultured oral epithelium transplantation is feasible, safe, and advantageous. Satisfactory neovaginum was provided; the procedure is relatively easy to perform and provides a thin, mucosal-lined neovagina with a sufficient amount of secretion. (Plast. Reconstr. Surg. 135: 138, 2014.)

Modern techniques have evolved from the Abbe-McIndoe vaginoplasty. Several lining methods have been described, but none is ideal. Possible drawbacks are scar contracture, suboptimal sensation, no lubrication, neovagina shortness, insufficient labia minora, dryness, maceration, unpleasant odor, and hair growth. Recently, the use of oral mucosal grafts in transgender and cultured vagino-

Figure 1: Regeneration of the transgenic epidermis.

FUTURE DIRECTIONS: EXPANDING HORIZONS ON FERTILITY OPTIONS
WHERE DO I SEE THE SERVICE BY NEXT YEAR

- First self funded vaginoplasty July 2019
- First MoH funded vaginoplasty Sep 2019
- Received first HCTP funded transmans referral May 2019
- Recruitment of a colorectal surgeon in 2019
- Strategy for auditing/continuous medical education and eventually teaching
Questions / Feedback?

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