

ORIGINAL RESEARCH

Vaginoplasty in Male-to-Female Transsexual Surgery: A Training Concept Incorporating Dissection Room Experience to Optimize Functional and Cosmetic Results

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ABSTRACT

Introduction. Learning a new technique, even for an established surgeon, requires a learning curve; however, in transsexual surgery especially, there is a lack of professional and public tolerance for suboptimal aesthetic and functional results due to a learning curve.

Aims. In this context, we have tried to build a learning concept for vaginoplasty that includes four steps: (i) formal identification of the surgical steps in order to provide both measure of surgical process and measures of outcomes; (ii) training on cadavers with expert assistance; (iii) performing the live surgery with assistance from expert; and (iv) performing the surgery alone. Herein, we emphasize the second step of our learning concept.

Material and Methods. Between September 2013 and December 2013, 15 cadavers were operated on by an established surgeon learning vaginoplasty under assistance from two expert practitioners. Mean global time and mean time necessary to perform each step of the operation were recorded by the experts. Intraoperative complications were systematically registered. The final depth and diameter of the neovaginal cavity were precisely measured. For each cadaver, the aesthetic results were assessed by one of the experts.

Results. Mean total operating time was 179 ± 34 minutes and decreased from 262 minutes for the first training attempt to 141 minutes for the last one. Intraoperative expert correction included modification of the scrotal triangular flap design and change of position of the urethra: This happened during the first training. No lesion of the urethra or of the anus occurred. The two experts judged the outcomes as excellent in seven cases, very good in four cases, good in two cases, and fair in two cases.

Conclusion. Despite the numerous reports on vaginoplasty in the literature, there is a real lack of published information on the learning curve of this operation. We make the hypothesis that introducing a learning concept with assistance from expert practitioners at the beginning of the surgeon's experience can optimize both the duration of his learning curve and reduce the risk of major complications. **Leclère FM, Casoli V, and Weigert R. Vaginoplasty in male-to-female transsexual surgery: A training concept incorporating dissection room experience to optimize functional and cosmetic results. J Sex Med 2015;12:2074–2083.**

Key Words. Vaginoplasty; Male-to-Female Transsexual; Learning Curve; Transsexualism; Sex Reassignment Surgery

Introduction

Vaginoplasty is the main surgical operation in male-to-female transsexual surgery (MTFSTS); It involves three main procedures, namely, clitoroplasty, new urethral meatoplasty, and vaginoplasty. The first report of vaginoplasty was in 1930 by Dr. Kurt Warnekros, a gynecologist from Dresden, who operated on male to female Lili Elbe [1]. Subsequently, many vaginoplasties in male-to-female transsexual patients were performed with a penile-scrotal flap or a reversed penile flap, either of which could result in an adequately deep vagina [2]. Large case series were reported by Dr. Burou, a French surgeon practicing at his “Clinique du Parc” in Casablanca [3], Drs. Hage in Holland [4], Dr. Meltzer and Dr. Bowers in the United States [5], Drs. Perovic and Djordjevic from Belgrade [6], Dr. Monstrey in Gent [7], Dr Preecha, Dr. Kunaporn, Dr. Watanyusakul and Dr. Tiewtranon in Thailand [8,9], to name a few.

In our own department, which is one of the biggest centers for MTFSTS in France, more than 250 patients were successfully operated on. Learning a new technique, even for an established surgeon, requires a learning curve. Unfortunately, in transsexual surgery especially, there is a lack of professional and public tolerance for suboptimal aesthetic and functional results. As a result, the learning curve phase must be optimized. Despite the numerous reports on vaginoplasty in the literature, there is a real paucity of reports on the learning curve of this operation.

In this context, we have tried to build a learning concept that comprises four steps: (i) formal identification of the surgical steps in order to provide both measure of surgical process and measures of outcomes; (ii) training on cadaver with expert assistance; (iii) performing the live surgery with assistance from an expert; and (iv) performing the surgery alone. In this article, we present a learning curve on fresh cadavers before performing this operation on MTFSTS patient. We discuss the need to receive assistance from expert practitioners during the whole learning process. Finally, we present the many advantages but also the limitations of a learning curve on fresh cadavers.

Materials and Methods

Subjects

This study was performed in accordance with the ethical guidelines of the University of Bordeaux and conducted on 15 cadavers (mean 74.9 ± 10.7

years) between September 2013 and December 2013. Individuals with any signs of severe disease or previous surgery on the urologic and gynecologic area were excluded from this study. The anatomical specimens, 15 men, were kept at a temperature of 2°C until their dissections.

Surgical Technique

After shaving, the cadaver was positioned in a dorsal decubitus position with the two legs over two tables to mimic the operative gynecologic position with the two legs in stirrups. The surgical technique included 14 steps as following (Table 1) [10]:

Step one—draping the cadaver: In order to mimic the clinical situation, the cadaver was draped accordingly.

Step two—urethral catheter placement: A 18 Fr. urethral catheter was placed in order to find the urethra during dissection.

Step three—scrotal incision and vaginal cavity formation: The inverse Y-shape scrotal incision is presented in Figure 1. A triangular flap was raised in the anovulvar area in order to ensure easy future introitus (Figure 1). The base of the penis was laterally dissected apart from scrotal fat, which was used to build the labia majora bilaterally. The cavity was created after resection of the bulbocavernosum muscles and dissection with monopolar cautery to the central tendinous point of the perineum (Figure 2), then carefully between prostate and rectum. A finger was regularly inserted into the rectum in order to control the accuracy of the dissection and to confirm absence of perforation. Dissection ended when a depth over 12–14 cm was achieved. At the end of step three, the size of the

Table 1 The 14 steps of our surgical technique for vaginoplasty in male to female transsexual

Steps	Description
1	Draping the patient
2	Urethral catheter placement
3	Scrotal incision and vaginal cavity formation
4	Bilateral orchiectomy
5	Penile skin inversion
6	Dismembering of the urethra from the corpora
7	Formation of the neoclitoris
8	Refinement of the neoclitoris
9	Formation of the neovaginalphallic cylinder
10	Fixation of the neoclitoris
11	Neovaginalphallic cylinder insertion
12	Labia majora contouring and positioning the neoclitoris and urethra
13	Tie-over dressing
14	Compression dressing

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