

Patients' Priorities Regarding Female-to-Male Gender Affirmation Surgery of the Genitalia—A Pilot Study of 47 Patients in Sweden

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ABSTRACT

Introduction: No surgical technique is reported to be the best option for gender-affirmation surgery (GAS) of the genitalia in transmen. Although patients' preferences are central when choosing a surgical technique, no studies have evaluated this factor.

Aim: To investigate transmen's priorities and preferences regarding GAS of the genitalia.

Methods: From November 2015 to March 2016, 54 transmen with the diagnosis of gender dysphoria who were referred to Sahlgrenska University Hospital for discussion of therapeutic steps (surgery and hormonal treatments) were asked to complete a questionnaire on different attributes achievable with GAS, such as sexual and urinary function and appearance. Forty-seven patients (87%) completed the questionnaire. Age ranged from 18 to 52 years (mean = 26 years, SD = 7.4 years). At the time of interview, no patient had undergone GAS of the genitalia.

Main Outcome Measures: Answers to completed questionnaires.

Results: Seventy-six percent of patients identified themselves as male, and 24% wrote other terms such as "mostly male," "inter-gender" and "non-binary." Gender identity had a significant impact on patients' preferences for two questions: the importance of vaginal removal and the importance of having a penis that would be passable in places such as male dressing rooms. These items were more important to patients identifying themselves as male. The most important attributes requested were preserved orgasm ability and tactile sensation. The least important attribute was removal of the vagina, followed by having a penis of human material, minimal scarring, and size. The ability to urinate while standing was considered a high priority by some and a low priority by others. All answers ranged from "unimportant" to "imperative."

Conclusion: This series of patients demonstrates a considerable heterogeneity among transmen in their gender identity and preferences regarding GAS of the genitalia, which supports the need for several techniques. Patients must be accurately informed on the different techniques and their specific benefits and limitations to make an informed choice. **Jacobsson J, Andréasson M, Kölbj L, et al. Patients' Priorities Regarding Female-to-Male Gender Affirmation Surgery of the Genitalia—A Pilot Study of 47 Patients in Sweden. J Sex Med 2017;XX:XXX–XXX.**

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INTRODUCTION

The first penis reconstruction for gender-affirmation surgery (GAS) was performed in 1959 to 1960 and was considered successful. Since then, surgical techniques have been extensively developed.¹ The ideal technique should permit micturition in a

standing position, provide bulk inside underwear, and enable sexual function with erection, sexual penetration, and preservation of genital sensation sufficient for orgasm and should be achieved with minimal scarring and a good cosmetic outcome.^{1,2} However, the ideal technique for penile GAS reconstruction does not exist because each available option has benefits and limitations.³ In consequence, the technique chosen should fit the needs and preferences of each patient.^{3,4} Regrettably, patients often are offered the only technique available in a particular center.¹

No study has reported on patients' preferences for a specific technique or their goals and priorities.² Only one study from Hage et al⁵ reported on patients' attitudes toward phalloplasty: of

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150 transmen, 71 (48%) answered that they did not (yet) wish for phalloplasty, mainly because of the number of operations, the risk of surgical failures, and non-pleasing results. Seventy-nine persons (52%) requested phalloplasty; of these, voiding while standing was the most common (99%) request, followed by being able to wear a tight swimsuit (91%) and being nude (81%) without being spotted as a non-male. The most demanded donor area was the infraumbilical region, which the investigators concluded was due to cosmetic morbidity. For the length of the phallus, participants' answers ranged from 5 to 25 cm (mean = 13 cm).

The purpose of this study was to investigate patients' priorities and preferences based on the benefits and limitations of currently available techniques.

Techniques for GAS of the Genitalia

The techniques for penile reconstruction can be divided into four main groups: metoidioplasty, phalloplasty, penile epithesis (experimental), and penile transplantation.

Metoidioplasty

This procedure consists of displacement and elongation of a hypertrophied clitoris (as a consequence of hormone therapy) to construct a micropenis.

Benefits of this method include preservation of the erogenous sensation of the entire micropenis, relatively ease of procedure compared with free flap phalloplasty (eg, with radial forearm flap), shorter operative and recovery times compared with phalloplasty, and minimal donor site morbidity.^{1,2} The overall complication rate is relatively low (<20%).² Micturition while standing is often, but not always, achievable.^{2,3,6} The major limitation is its small size (mean = 5.7 cm, minimum = 2 cm, maximum = 10 cm).^{7,8} The small size is most likely inadequate for sexual penetration.^{2,3,6}

Phalloplasty

Phalloplasty consists of reconstruction of the penis with pedicled or free flaps harvested from different locations of the body. Pedicled flaps are from the thigh (most frequent), groin, and abdominal areas; free flaps are harvested from the forearm (most frequent), latissimus dorsi, and fibula.^{1,4}

All phalloplasty techniques produce a larger penis than metoidioplasty; also, phalloplasty allows for micturition while standing (by rolling the flap on itself, as for the radial forearm flap, or by combining two different flaps simultaneously, as for the anterolateral thigh flap combined with the groin flap); erection implants can be inserted during the phalloplasty, mostly when the reconstructed penis retains sensation, as can be achieved with the free radial forearm flap with nerve anastomosis. Micturition while standing is possible in most cases (eg, with the radial forearm flap). Limitations include the requirement for a multistage procedure, longer hospital stays, far higher

complications rates (>40%), donor site scarring, and the possible lack of sensation.²

Penile Epithesis

With this experimental technique, an external silicon penile epithesis is anchored to the pubis bone by osseointegrated titanium implants. The patient can attach a slack or an erected epithesis to the titanium bone-anchored applications. Benefits are a very simple technique, low rate of complications, and the possibility to engage in penetrative sexual activity. Limitations are the lack of sensation of the epithesis and the penis being of non-human material. Risks include possible loss of osseointegration.⁹ Further investigation is needed to standardize this procedure⁹ to add extra benefits such as the ability to urinate while standing by building an epithesis with an internal channel to pass urine, to extend its indication to patients after metoidioplasty to allow patients to urinate while standing through an apparently larger penis, and to engage in penetrative sex rather than use a strap-on penis.¹⁰

Penile Transplantation

To date, penile transplantation has not been performed on transmen. Major advantages are the esthetic outcome and the potential for complete functioning (urination and penetrative sex). The disadvantages are mostly related to the need for immunosuppressant therapy (ie, increased risk for infection), tumor development over the long term, and the risk for rejection; these complications raise ethical issues with this procedure.¹¹

METHODS

Study Population and Data Collection

From November 2015 to March 2016, 54 patients with the diagnosis of female-to-male (FtM) gender dysphoria (GD) who were referred to Sahlgrenska University Hospital (Gothenburg, Sweden) for hormonal treatments or mastectomy were enrolled in this study. Patients were asked to complete a questionnaire on their preferences of GAS of the genitalia. Forty-seven of 54 patients (87%) completed the questionnaire. Patients did not receive a formal preoperative consultation for GAS before completing the questionnaire. Some patients had started, and others were intending to start, hormonal therapy. Age ranged from 18 to 52 years (mean = 26 years, SD = 7.4 years).

Inclusion criteria were transmen diagnosed with GD, age at least 18 years (the age of majority in Sweden), and not having received any kind of GAS of the genitalia.

Questionnaire

The questionnaire was mostly composed by the senior author (G.S.), a surgeon with extensive experience in patients consulting for GAS of the genitalia. Assistance in composing the questionnaire was provided by the first author (J.J.). The questionnaire was non-validated and semistructured; it contained

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