hernia occurred at the peritoneal flap closure site, and in the other care the hernia occurred at the peritoneal flap donor site.

CONCLUSIONS: Intra-abdominal complications following robot assisted peritoneal flap vaginoplasty require prompt surgical attention. In addition to hematoma and abscess, small bowel incarceration and internal hernias are important complications for the surgeon performing peritoneal flap vaginoplasty to consider.

**Table 1.** Patient demographics, preoperative exam, and intraoperative details.

| Patient | Age (years)* | BMI (kg/m²)* | Medical history | Stretched penile length (cm) | Operative time (min) | FTSG used | Intraoperative complications | Length of stay (days)* |
|---|---|---|---|---|---|---|---|---|
| 1 | 34 | 20.6 | None | 12.5 | 169 | Yes | None | 5 |
| 2 | 22 | 18.3 | Asthma | 9.0 | 251 | Yes | None | 5 |
| 3 | 33 | 24.2 | None | 9.0 | 139 | Yes | None | 5 |
| 4 | 24 | 19.4 | Depression, anorexia | 7.0 | 202 | Yes | None | 5 |
| 5 | 22 | 24.2 | None | 9.0 | 185 | Yes | None | 5 |
| 6 | 21 | 16.6 | Smoking, spontaneous pneumothorax | 10.0 | 132 | Yes | None | 5 |

BMI, body mass index; FTSG, full-thickness skin graft
*At time of index surgery

**Table 2.** Postoperative complications, management, and long-term outcomes.

| Patient | Postoperative Complication* | Complication Management | Follow Up (days) | Vaginal Dilation | Vaginal Intercourse? | Neoclitoral Orgasms? | Difficulty Urinating? |
|---|---|---|---|---|---|---|---|
| 1 | POD3 Intra-abdominal hematoma | Diagnostic laparoscopy, hematoma evacuation | 188 | 15.2cm deep with 3.8cm dilator | No | No | No |
| 2 | POD41 Intra-abdominal abscess | Diagnostic laparoscopy, abscess aspiration | 608 | 15.2cm deep with 3.8cm dilator | Yes | Yes | Yes—urinary spray |
| 3 | POD131, POD 172 Recurrent intra-abdominal abscess | Diagnostic laparoscopy, abscess aspiration (OSH) | 370 | 3.8cm deep with 2.9cm dilator | No | Yes | No |
| | | Diagnostic laparoscopy, lysis of adhesions, transneovaginal abscess drainage, colpopexy | | | | | |
| 4 | POD25, POD33, POD96, POD170, POD235 Recurrent SBOs | Bowel rest | 635 | 15.2cm deep with 3.8cm dilator | No | Yes | No |
| 5 | POD7 Internal hernia with SBO | Diagnostic laparoscopy, internal hernia reduction | 370 | 15.2cm deep with 3.8cm dilator | No | Yes | No |
| 6 | POD417 Internal hernia with SBO | Diagnostic laparoscopy, internal hernia reduction | 433 | 15.2cm deep with 3.8cm dilator | Yes | Yes | No |

POD, postoperative day; OSH, outside hospital; SBO, small bowel obstruction
*Post-operative day refers to number of days from the index operation that the return to the operating room occurred. In patients who did not require return to the operating room, post-operative day refers to days from index operation that readmission to the hospital occurred.

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## PD29-12
## IS A BMI CUTOFF FOR GENDER AFFIRMATION SURGERY SCIENTIFICALLY SUPPORTED?

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INTRODUCTION AND OBJECTIVE: Gender-affirming surgeries (GAS) are increasingly in demand. Though these procedures are elective, there is a significant morbidity and mortality benefit. Access to GAS is an ongoing discussion and must balance operative risks, individual risk factors, and potential benefit. Many of those offering these procedures list an ideal or inflexible upper limit of body mass index (BMI). The objective of this work is to determine if there is a relationship between BMI and surgical outcomes for GAS, both chest and genital, both masculinizing and feminizing. Additionally, we seek to evaluate whether any such relationship between BMI and outcomes suggests that a cutoff should (or should not) be considered for access to GAS.

METHODS: The scientific literature was searched for original articles reporting on any GAS, including chest, genital, masculinizing, and feminizing procedures. Review articles and abstracts were excluded. We extracted BMI cutoff criteria, reported BMI of each cohort, and statistically evaluated outcomes from each article. A similar search was performed for selected analogous soft-tissue surgeries for comparison.

RESULTS: The highest and lowest BMI reported were 54 and 14.6, both for masculinizing chest surgery. 6 groups reported using BMI upper limits of 25-33 or morbid obesity to undergo GAS. 3 recommended or required an alternative surgical approach for BMI greater than 27-30. 2 specified that BMI is not considered a contraindication for GAS at their institution(s). Of those that reported BMI, 77% (n = 34/44) did not specify using BMI to qualify for GAS. It was common for reported BMI mean, standard deviation, and/or ranges to suggest that GAS may have been discouraged or considered contraindicated in obese patients (e.g. $24.8 \pm 1.84$), though this is of limited credibility without known ranges. 48% (n = 21/44) evaluated surgical outcomes in relation to BMI. 11 individual criteria were found to be statistically significant; most commonly choice of surgical approach (n = 7/11, 64%).

CONCLUSIONS: In a comprehensive review of the literature, we found limited evidence that suggests high BMI is associated with higher risk of complications. The available data supports using high BMI as a proxy for more dangerous health conditions (i.e. diabetes, hypertension, cardiac disease) which must be optimized preoperatively for safety, as in any patient. A higher risk of uncommon or non-life threatening complications may not justify BMI limits to GAS, as long as patient and surgeon acknowledge the higher risk of common obesity related complications, as in other elective but indicated surgeries.

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