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PD29-10
RETROSPECTIVE ANALYSIS OF PHALLOPLASTY BY A SPECIALIZED TRANSGENDER SURGERY CENTER

Brenna Briles, Houston, TX; Jessica Gondran, Austin, TX; Emma R. Linder, Chicago, IL; Michael Safir, Curtis Crane, Richard Santucci, Austin, TX*

INTRODUCTION AND OBJECTIVE: Phalloplasty is a masculinizing genital gender affirmation surgery, requested by 91% of patients seeking surgical transition. Due to the complexity of reconstruction involved, phalloplasty has been associated with high complications, with all cause urinary complications being reported as high as 70%[1]. The objective of our study is to observe the specific urinary, emergent, donor site, and aesthetic complications associated with this complex procedure.

METHODS: Data was gathered via retrospective chart review of 280 transmasculine patients undergoing phalloplasty at our center between 7/17 and 10/20 (38 months).

RESULTS: Patients had an average follow up period of 17 months. Average age at phalloplasty was 34 years (range 18-64). 66% (185/280) received a radial forearm flap, 34% (94/280) received anterolateral thigh flap, and 0.4% (1/280) received a musculocutaneous latissimus dorsi flap. The average phallus length was 5.7 inches (range 4.5-8.5). Patients with prior masculinizing genital gender affirming surgery included: 23 metoidioplasty, 3 phalloplasty, and 28 vaginectomy. Thirty patients (11%) experienced a complication requiring urgent surgery or emergency room admission, and 19 patients (7%) experienced complications of the donor site requiring surgery. Many patients experienced urinary tract complications (Table 1) while 21 patients (7.5%) did not have urethral lengthening. No patients experienced rectal injury. Total phallus loss occurred in two cases (0.7%), due to vascular insufficiency and subsequent necrosis. Eighteen patients experienced infection of the phallus, which were resolved with antibiotics or minor incision/drainage. Seven patients (2.5%) had no phallic sensation. There were a variety of procedures done for aesthetic and hygienic purposes post-phalloplasty (Table 1). Overall, patients experienced an average of 3.6 complications requiring surgery (range 0-18) and had an average of 2.8, usually planned, visits to the operating room after phalloplasty (range 0-12).

CONCLUSIONS: This is the first report of phalloplasty results from a US, high-volume (~90 cases year), dedicated phalloplasty unit. This detailed analysis of complications of this hypercomplex surgery should prove useful to practitioners, patients and payors alike.

Table 1. Complications requiring surgery after phalloplasty

Emergent		Donor site		Urinary tract		Necrosis		Aesthetic/Hygienic	
Flap revascularization	16	Scar contracture	11	Urethral stricture	147	No intervention	58	Phallus liposuction	70
Urinary retention	8	Debridement	3	Urethral fistula	85	Bedside debridement	37	Penile lift	56
Hand revascularization	2	Venous congestion of arm	2	Meatal stenosis	44	Surgical debridement	15	Penile plication	49
Penectomy	2	Infection	1	Cystolithiasis	3	Total phallus loss	2		
Pulmonary embolism	1	Carpal tunnel release	1						
Abscess rupture	1	Knee pain	1						

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PD29-11
INTRA-ABDOMINAL COMPLICATIONS FOLLOWING PERITONEAL FLAP VAGINOPLASTY

Isabel Robinson, Rachel Bluebond-Langner, Lee Zhao, New York, NY*

INTRODUCTION AND OBJECTIVE: The peritoneal flap vaginoplasty is a technique for achieving substantial neovaginal depth. Intra-abdominal complications following robotic peritoneal flap creation are rare but prompt diagnosis and management is critical to preventing patient harm. The purpose of this study was to describe the authors' experience with managing intra-abdominal complications following peritoneal flap vaginoplasty.

METHODS: Retrospective chart review identified patients undergoing robotically assisted peritoneal flap vaginoplasty by the senior authors between 2017 and 2020 who subsequently developed intra-abdominal complications requiring readmission and/or return to the operating room. Patient charts were analyzed for preoperative demographics, medical comorbidities, intraoperative details, postoperative complication presentation, diagnosis, management, and long-term outcomes.

RESULTS: Out of 274 patients undergoing peritoneal flap vaginoplasty during the study period, six patients were identified who developed intra-abdominal complications (2.2%). One patient developed postoperative hematoma requiring return to the operating room for diagnostic laparoscopy and hematoma evacuation. Two patient developed intraabdominal abscesses requiring diagnostic laparoscopy and abscess drainage. One patient developed recurrent episodes of small bowel obstructions that resolved with bowel rest. Two patients developed incarcerated internal hernias requiring diagnostic laparoscopy and internal hernia reduction. In one case, the