Abstract Submissions

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WED-S1-T1: A NOVEL INTRAOPERATIVE PROTOCOL REDUCES HEMATOMA RATES AFTER MASCULINIZING CHEST RECONSTRUCTION

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Presented by: Sriya Nemani

Introduction/Background: Gender-affirming mastectomy has been shown to alleviate gender dysphoria and improve the psychosocial well-being of transmasculine patients. However, the incidence of hematoma after gender-affirming masculinizing chest reconstruction remains substantially high necessitating reoperation, prolonging hospital stay and increasing financial burden for patients. We developed an intraoperative protocol to reduce the rates of postoperative hematoma and reoperation in this patient population.

Specific Aim: This study aims to identify areas of improvement within the double incision mastectomy technique and implement a reproducible intraoperative protocol to reduce the rates of postoperative hematoma following gender-affirming mastectomy.

Materials and Methods: This retrospective cohort study evaluates the efficacy of our hematoma-reduction protocol by comparing the incidence of postoperative complications before and after protocol implementation. Our hematoma-reduction protocol consists of four main tenants: 1) meticulous dissection of the chest tissue to avoid violating the pectoral fascia and axillary region, 2) prospective hemostasis with the proper ligation of vessels, 3) careful manipulation and management of intraoperative blood pressure, and 4) execution of a Valsalva maneuver prior to closing. Patients who underwent gender-affirming bilateral subcutaneous mastectomy using a double incision approach between December 2019 and April 2023 were included and evaluated at least 30 days after surgery.

Results: A total of 428 patients were included in our analysis. One-hundred and seventy-four patients (348 breasts) underwent mastectomy prior to protocol implementation and 254 patients (508 breasts) post-implementation. Age (26.17 years vs. 27.56 years, p = 0.2536), BMI (29.72 kg/m^2 vs. 30.76 kg/m^2, p = 0.2361), and preexisting comorbidities such as coagulopathies (4.02% vs. 3.15%, p = 0.629), diabetes (5.17% vs. 2.76%, p = 0.196) and hypertension (5.75% vs. 7.09%, p = 0.582), did not differ significantly between the two cohorts. Operative time (95.40 minutes vs. 88.23 minutes, p = 0.0025), estimated blood loss (53.57 mL vs. 38.83 mL, p = 0.0007), and episodes of intraoperative hypotension (1.09 vs. 0.52, p < 0.0001) decreased after protocol implementation. The incidences of both total hematomas (6.90% vs. 2.76%, p = 0.041) and hematomas requiring evacuation (5.75% vs. 1.97%, p = 0.037) were significantly reduced after protocol implementation. In a multivariate logistic regression controlling for confounding variables, protocol implementation was significantly associated with a reduced incidence of total hematoma (Odds ratio (OR): 0.18, 95% confidence interval (CI): [0.05 – 0.69], p = 0.012) as well as hematoma requiring evacuation (OR: 0.16, 95% CI: [0.03 – 0.71], p = 0.016). Patients were 82% less likely to develop any hematomas, and 84% less likely to develop a hematoma that would require evacuation after the implementation of the protocol.

Conclusion: The risk of hematoma after gender-affirming mastectomy can be significantly decreased with an intraoperative protocol that refines surgical technique and enhances intra-operative anesthesia monitoring. We believe that our protocol is easily reproducible and can be implemented across private and academic surgical centers in the future.

WED-S1-T2: GENDER AFFIRMING MASTECTOMY IN ADOLESCENTS AGED 18 AND YOUNGER: OUTCOMES FROM A SINGLE INSTITUTION

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Presented by: Jennifer Hopkins

Introduction/Background: Gender dysphoria describes individuals who believe the sex they were assigned at birth is not aligned with their personal identity. It affects 0.17-1.3 % of adolescents worldwide.[1] This number has increased throughout the years and very sparse data has been published on adolescent populations. Many individuals gather experiences and awareness of gender identity beginning in childhood. This identity further develops in adolescence as they experience puberty and gain emotional maturity. Identifying as a gender not congruent with that of which you are born can poorly affect mental health and is associated with high levels of anxiety and depression. Gender affirming surgery has been shown to improve chest dysphoria, gender congruence and body image in trans/non binary adolescents and young adults. Previous studies comparing the addition of surgical intervention to hormone therapy alone suggest better outcomes in post-treatment gender dysphoria scales for surgical groups.

Specific Aim: There are limited studies assessing outcomes of Gender Affirming Surgery (GAS) in patients age 18 and younger. Data is also sparse for patient satisfaction in this population. In this study, we analyze a single institution's outcomes in GAS for adolescents age 18 and under.

Materials and Methods: This study looked at 47 patients age 13-18 who underwent GAS between December 2019 and January 2023. A retrospective chart review of over 340 patients was conducted to find those meeting criteria. Data using electronic medical records was collected and separated into groups dependent on surgical technique performed. Groups included neurotized and non-neurotized bilateral double incision chest mastectomy, and the concentric circle technique. Average age, BMI and anatomical measurements for all participants were determined pre-operatively. Follow up at 1, 3, 6, and 12 months were screened for complications post operatively. Rates of hematoma, seroma, infection, dog ears, revisions, and documentation of regret were also determined.

Results: Out of 47 patients, six patients (13%) underwent surgery based on the concentric circle technique and 41 (83%) underwent bilateral double incision mastectomy. Twenty-five (53%) underwent neurotized bilateral double incision mastectomy and sixteen (34%) underwent bilateral double incision mastectomy without direct neurotization of the nipple areolar complex. There were no documented hematomas post-operatively. Two patients (4.2%) developed seromas post-operatively, which were drained in office. Two patients needed additional surgery for dog ear revision (4.2%) and one patient had postoperative complications of dog ears but did not receive revisions due to future plans for additional weight loss. No reports of regret were seen up to 14 months post operatively.

Conclusion: Patients with average BMI of less than 18 kg/m2 and SN-N distance of less than 18 cm were more likely to undergo periareolar mastectomy versus double incision mastectomy. Complication rates in adolescents receiving gender affirming mastectomy is low. Limitations of this study include small sample size and lack of follow-up beyond one year. Future research should focus on patient-centered outcomes assessing improvement in gender dysphoria and patient satisfaction after mastectomy for gender affirming surgery.

WED-S1-T3: ASSESSING FACTORS INFLUENCING CONVERSION TO SINGLE-INCISION MASTECTOMY WITH FREE NIPPLE GRAFTS IN TRANSGENDER MALE AND NON-BINARY PATIENTS: A PREDICTIVE ANALYSIS

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Presented by: Christian Lava

Introduction/Background: Chest wall masculinization (CWM) is one of the most common gender-affirming surgeries (GAS) performed for transgender male and non-binary patients. Double-incision mastectomy (DIM) with free nipple grafts (FNG) is a common technique employed in CWM, but is associated with high scar burden. Intraoperatively, a plastic surgeon may opt for a single-incision mastectomy (SIM) with FNG along the inframammary folds (IMF) to minimize excess skin tissue and create a smoother contour, thereby optimizing aesthetic outcomes. However, there is limited information on factors that must be considered when determining the most appropriate approach.

Specific Aim: The aim of this study is to evaluate predictive factors affecting intraoperative conversion from DIM to SIM with FNG.

Materials and Methods: From February 2018 to November 2022, all transgender and non-binary patients who underwent CWM at a single institution were retrospectively reviewed. Data regarding patient characteristics, perioperative details, postoperative complications, and aesthetic satisfaction were collected.

Results: A total of 352 patients were identified. Median age and body mass index (BMI) at the time of surgery were 25 years (interquartile range [IQR]: 9) and 28.5 kg/m^2 (IQR: 8.5), respectively. Most patients received negative-pressure wound therapy (NPWT) (n = 184, 52.3%). Most patients received IMF incisions (n = 331, 94.0%); of whom, 66 (19.9%) underwent intraoperative conversion from DIM to SIM with FNG. Larger breast cup-size ($p < 0.001$) and greater degree of ptosis ($p = 0.002$) preoperatively were significantly associated with intraoperative conversion to SIM with FNG. There was no significant association between intraoperative conversion and the ratio between the medial borders of the breasts to the width of the chest wall ($p = 0.086$). Postoperatively, partial and total FNG loss occurred in 26 (7.4%) and 9 (2.6%) patients, respectively. Overall complication rates were significantly higher among patients with diabetes mellitus (DM) ($p = 0.015$) and a greater degree of ptosis ($p = 0.018$), which was also associated with higher rates of any FNG loss ($p = 0.025$). 77.8% (n = 274) of patients were satisfied with

their aesthetic outcome. NPWT usage was associated with higher rates of aesthetic satisfaction (83.6% vs. 77.8%; p = 0.005). 24 (6.8%) patients sought a revision; of whom, the most common indication reported was excess skin tissue (n = 16, 66.7%). Complication and aesthetic satisfaction rates did not differ significantly based on patient age, BMI, obesity, smoking status, psychiatric history, preoperative breast size, operative time, total breast tissue resected, incision type, or drain usage.

Conclusion: In the largest retrospective cohort study of patients undergoing CWM with FNG to date, we demonstrate that larger breast cup size and greater degree of ptosis were associated with intraoperative conversion from DIM to SIM with FNG. Furthermore, CWM with FNG is safe to perform across a variety of patient populations with high rates of aesthetic satisfaction.

WED-S1-T4: OPTIMIZING AESTHETIC OUTCOMES IN GENDER-AFFIRMING MASTECTOMY AT A SATEFY NET HOSPITAL WITH A PROPOSED SURGICAL TECHNIQUE ALGORITHM

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Presented by: Norwood Brown

Introduction/Background: As a tertiary safety net hospital that routinely performs gender-affirming mastectomy, we strive to improve techniques to optimize operative outcomes. The most common surgical techniques include the periareolar and double-incision approaches. The periareolar technique is desirable for many transgender patients due to short scars and avoidance of free nipple areolar grafts (NACs). However, it requires selective anatomy (i.e. lower BMI, smaller breast, no breast ptosis) to achieve the best outcomes. The double-incision technique with free NAC grafting is the most versatile and nonselective, as it allows for repositioning of the NAC in order to achieve masculinized nipple positions. However, this technique is also associated with longer mastectomy scars and increased care and monitoring of the NAC graft. In addition to these two techniques, we will propose a modified double-incision technique that involves a wedge resection of breast tissue along the inframammary fold, shortening the distance between the NAC and the incision. The NAC remains attached to the mastectomy flap superiorly, and the areolar diameter naturally decreases once the excess breast tissue is removed.

Specific Aim: Our study aimed to compare and contrast three different top surgery techniques used at our institution, to develop an algorithm to determine the appropriate technique for transgender patients based on their anatomy and the surgeon's experience. An additional aim of our study was to discuss an alternative surgical technique, in which the patient is able to maintain their original NAC through a modified double-incision mastectomy.

Materials and Methods: A retrospective electronic chart review of 195 patients that underwent gender-affirming mastectomy at University Health from 2016 to 2023 was performed. The symmetry of the breasts was assessed by a suprasternal notch to nipple distance. Chi-square tests were employed to analyze the statistical significance of categorical outcomes, while two-sample t-tests and ANOVA were conducted to examine the statistical significance of continuous variables.

Results: Of 195 patients reviewed, 26 patients underwent top surgery with the periareolar technique, 154 with the double-incision (DI) technique, and 15 with the modified double-incision (MDI) technique. The average breast tissue removed, nipple symmetry, and the degree of breast ptosis were significantly different between the three different techniques ($p<0.01$). The hematoma rate was the highest with the periareolar technique (11.5%, N=3), with one patient requiring operative evacuation. There was only one case of partial free nipple graft necrosis. Surgery length and estimated blood loss were similar among all techniques.

Conclusion: The elevated hematoma rate for the periareolar technique was not statistically significant, yet clinically significant. We have gradually moved away from utilizing this approach. The modified double-incision technique can be an alternative method for patients who prefer not to have NAC grafts

and with larger non-ptotic or pseudoptotic breasts. Patients who have concerns about NAC graft loss with the DI technique can be reassured that the risk of NAC graft complication was minimal. We hope that the proposed algorithm can provide guidance for surgeons and patients in determining the most appropriate technique to optimize aesthetic outcomes based on their nipple symmetry, breast ptosis, and skin laxity.

WED-S1-T5: DIRECT NEUROTIZATION OF THE FREE NIPPLE GRAFT WITH CADAVERIC NERVE GRAFTS FOLLOWING MASTECTOMY FOR GENDER AFFIRMING SURGERY

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Presented by: Atlee Loughran

Introduction/Background: Free nipple grafting following gender affirming surgery makes sensory recovery by axonal regeneration impossible. Nerve regeneration from collateral sprouting is possible but outcome data remains elusive. Direct neurotization of the NAC with intercostal nerves and nerve grafts has been described. This study is the largest of its kind examining post-operative outcomes following nerve coaptation with cadaveric nerve to reinnervate the NAC graft.

Specific Aim: This study provides quantitative data regarding return of nipple sensation following NAC graft direct neurotization.

Materials and Methods: Patients undergoing mastectomy for gender dysphoria desiring nipple preservation from 2020 to 2022 were offered cadaveric nerve allograft to restore nipple sensation. Patients who consented were enlisted in the study. Following mastectomy, a branch of the fourth lateral intercostal nerve was selected. The nerve was transected and coapted to cadaveric nerve allograft. The nerve graft was placed inferior to the mastectomy plane. The distal end of the nerve graft was placed below the free nipple graft. Total length of cadaveric nerve graft used was 50-70mm. Post-operative data was collected from 2020-2022. Semmes Weinstein testing was used to assess for nipple sensation. Assessments were made at visits within one year and greater than one year from surgery. Filaments used included size 2.83 (normal sensation), 3.61 (minor diminished sensation to light touch), 4.31 (diminished sensation to light touch), 4.56 (loss of protective sensation) and 6.65 (sensation to deep pressure only and loss of sensation).

Results: A total of 115 patients elected for direct neurotization of the NAC during the study period. Data on follow-up with Semmes Weinstein testing was limited to 46 patients. The average age was 23.6 years and average BMI was 27.3. The 46 patients represented 46 encounters and 92 nipples in the less than one year follow-up group and 24 encounters and 48 nipples in the greater than one year follow-up group. Of the 92 nipples within the less than one year group, 17 noted sensation for 2.83, 12 noted sensation for the 3.61 and 26 noted sensation for the 4.31 (59% with normal or diminished sensation to light touch). For the remaining 38 nipples, 22 noted sensation for the 4.56 and 16 noted sensation for the 6.65 (41% with loss of protective sensation or deep sensation only).
There were 48 nipples included in the greater than one year group. Of the 48 nipples, 7 noted sensation for 2.83, 6 noted sensation for 3.61 and 21 noted sensation for 4.31 (71% with normal or diminished sensation to light touch). For the remaining 14 nipples, 12 noted sensation for 4.56 and 2 noted sensation for 6.65 (29% with loss of protective sensation or deep sensation only).

Conclusion: Sensory outcomes in free NAC grafts used for reconstruction in patients undergoing double incision mastectomy for gender dysphoria remain poor. Normal and near-normal return of sensation can be restored in the majority of patients undergoing this procedure with coaptation of a branch of the fourth lateral intercostal nerve with cadaveric nerve allograft to the nipple graft via direct neurotization.

WED-S1-T6: PROSPECTIVE OUTCOMES FOR TARGETED NIPPLE AREOLA COMPLEX REINNERVATION (TNR) IN GENDER-AFFIRMING DOUBLE INCISION MASTECTOMY WITH FREE NIPPLE GRAFTS

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Presented by: Katya Remy

Introduction/Background: Gender-affirming mastectomy with free nipple graft (FNG) is the most frequently performed procedure in female to male transgender patients. During the standard surgical approach, intercostal nerves (INC) are transected which may result in impaired sensory function. Targeted nipple areola complex reinnervation (TNR) is a novel technique to improve postoperative sensory function. There is little evidence on relevant anatomy and postoperative outcomes.

Specific Aim: This study prospectively analyses the anatomy and sensory outcomes of targeted nipple areola complex reinnervation (TNR) in gender-affirming double incision mastectomy with free nipple grafting (FNG).

Materials and Methods: 25 patients were prospectively enrolled. Data included demographics, mastectomy weight, intraoperative ICN anatomy, and axon/fascicle counts. Sensory evaluation using Semmes-Weinstein monofilaments were completed preoperatively, and postoperatively at 1, 3, 6, 9 and 12 months.

Results: 50 mastectomies were performed. Per mastectomy, the median number of ICN used was 2 (1-5). The lateral 4th and 5th were most often used and reached the NAC directly. Axon and fascicle counts were not significantly different between branches ($p>0.05$). BMI ≥30kg/m^2 and mastectomy weight ≥800g were associated with significantly worse preoperative sensation ($p<0.05$). There were no associations between ICN, axon/fascicle counts and preoperative sensation ($p>0.05$). NAC sensation became comparable to preoperative values at 3 months postoperatively ($p>0.05$) and significantly better at 12 months ($p<0.01$). Chest sensation remained comparable at 1, 3, 6 and 9 months ($p>0.05$) and significantly better at 12 months ($p<0.05$). Postoperative sensation was significantly better when direct coaptation was performed versus allograft reconstruction at 1, 3, 6, and 9 months postoperatively ($p<0.05$) and comparable at 12 months ($p>0.05$). In the first third of mastectomies performed, an allograft was required in 100% of patients, in the second third in 88.2% and in the last third in 41.2% ($p<0.0001$).

Conclusion: TNR allows for restoration of sensation within 3 months postoperatively. The 4th and 5th ICN were most often used. Axon counts were not significantly different between ICN. Return of sensation was earlier with direct coaptation versus reconstruction with allograft. There is a learning curve associated with ICN preservation and coaptation.

WED-S2-T1: MULTIMODAL EVALUATION AND SALVAGE OF TRANSPROSTATIC OR INTRAPROSTATIC VAGINAL CONSTRUCTION

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Presented by: Nabeel Shakir

Introduction/Background: Transprostatic (traversing the prostatic capsule) or intraprostatic (within the prostatic parenchyma) vaginal construction (TIPIV) is a theoretical outcome with certain methods of penile inversion vaginoplasty. Potential complications of this mode of construction could include loss of canal depth, graft failure, urethral injury, urinary incontinence, or sexual dysfunction. The management of patients who seek revision of this specific postoperative anatomy has not been described to date.

Specific Aim: To describe the presentation, preoperative evaluation, surgical management, and initial outcomes of a single institutional series of patients with TIPIV.

Materials and Methods: We reviewed patients who presented to our institution between March and December 2022, and who requested surgical revision for loss of vaginal depth after having penile inversion vaginoplasty performed elsewhere. Patients who previously had minimal depth vaginoplasty, or those who had total canal loss, were excluded. Following office examination, patients were referred for comprehensive pelvic floor rehabilitation and manual therapy, and neuromuscular evaluation including biofeedback. Preexisting pelvic dysfunction, urinary, bowel, or sexual concerns were noted. Patients then underwent contrast-enhanced magnetic resonance imaging (MRI) with a protocol including intravaginal instillation of water based gel. Specific imaging parameters included the vaginal canal length, proximity to the rectum and urethra, and distance to the peritoneal reflection. Subsequently, patients underwent robotic assisted revision vaginoplasty, in which the existing canal was augmented with peritoneal flaps. A standardized follow-up pathway was used in which patients were hospitalized until at least postoperative day #6, after which vaginal dilation and pelvic rehabilitation were resumed. Demographic, perioperative, and postoperative data were collected.

Results: Four patients met study criteria, presenting at a median of 4 years (range: 3.3-5.5) since their index vaginoplasty, and having undergone a median of 3 (2-4) attempted prior revisions for loss of vaginal depth at other institutions. All patients reported being unable to dilate or have receptive vaginal intercourse. Following a median of 5 sessions of pelvic rehabilitation, patients underwent pelvic MRI. Figure 1 is a representative image from a sagittal T2-weighted MRI of a patient with intraprostatic vaginal construction; this patient presented with stress urinary incontinence. Revision vaginoplasty was accomplished for all patients preserving the existing canal, performing either transverse prostatomy or partial prostatectomy as needed to incise the vaginal apex, and direct anastomosis to peritoneal flaps without graft interposition. For all patients, median preoperative vaginal depth by MRI was 5.9 cm (4.5-7.0) and was correlated with intraoperative findings (Figure 2). At a median follow-up of 6.8 months, all patients had a vaginal depth of at least 14.5cm, and 3 reported return of orgasm with sexual activity. No patients experienced de novo urinary incontinence.

Conclusion: Patients with TIPIV may present with loss of vaginal depth and seek surgical revision. Providers should be cognizant of this potential anatomy. Multimodal evaluation with MRI and management with pelvic floor rehabilitation, followed by robotic assisted revision vaginoplasty, yields acceptable short term outcomes.

WED-S2-T3: The use of the glans penis in vulvoplasty in MTF sex affirmation surgery

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Presented by: Kitipong Kaewpichai

Introduction/Background: Sex affirmation surgery, a transformative procedure for transgender individuals, encompasses a range of interventions such as bilateral orchiectomy, penectomy, clitoroplasty, vaginoplasty, and vulvoplasty. Among these procedures, vulvoplasty assumes significant importance due to its impact on external appearance. A fundamental objective of sex affirmation surgery is to preserve arousal sensation, enabling patients to attain orgasm. The labia minor's inner lip, characterized by non-keratinized stratified squamous epithelium and sebaceous glands within a thin lamina propria, necessitates meticulous reconstruction, typically using the prepuce or glans penis as a suitable graft source. Notably, the labia minor, clitoris, and vestibules possess similar receptor types, primarily consisting of free nerve endings and genital corpuscles responsible for arousal sensation. However, the absence of genital corpuscles in the prepuce favors the utilization of the glans penis as a more optimal option for reconstruction.

Specific Aim: The objectives of vulvoplasty encompass optimizing the arousal sensation of the inner labial lips and ensuring the proper alignment of the labia minora, with the posterior fourchette serving as the ideal termination point. Recognizing the higher concentration of sexual receptors within the glans penis compared to the prepuce, the comprehensive utilization of all relevant components is employed during vulvoplasty procedures.

Materials and Methods: Our study outlines the methodology employed in vulvoplasty, whereby all anatomical elements of the glans penis are utilized for the meticulous reconstruction of the clitoris, labia minora, and vestibule. We documented postoperative minor and major complications.

Results: The principal complication observed is partial necrosis of the glans penis, which occurs in 10% of cases but can be managed effectively through mucosalization. Minor complications include clitoral synechiae (5%) and urethral obstruction resulting from labial synechiae (<1%). This technique offers several advantages, including enhanced erogenous sensation, tolerable shearing and pressure forces, and anatomical homogeneity. Conversely, the technique is associated with the drawback of increased thickness of the labia minora and clitoris.

Conclusion: The complete utilization of the glans penis for the reconstruction of the clitoris, labia minora, and vestibule has been demonstrated as a viable approach in vulvoplasty. The outcomes obtained from this technique have consistently displayed favorable results, thereby establishing it as a promising alternative within the field. The successful integration of the glans penis in these reconstructive procedures provides evidence of its effectiveness and further validates its inclusion as a valuable option for vulvoplasty.

WED-S2-T4: OBJECTIVE ASSESSMENT OF PENILE INVERSION VAGINOPLASTY OUTCOMES THROUGH EYE TRACKING

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Presented by: Nicole Sanchez

Introduction/Background: Evaluating the aesthetic outcomes of plastic surgery procedures is crucial for optimizing patient satisfaction. To achieve this, understanding the salient features that draw focus during aesthetic assessments becomes essential. Eye-tracking technology offers an objective and unbiased method for determining the specific features that capture attention in the evaluation of aesthetic outcomes in plastic surgery.

Specific Aim: The objective of this study was to characterize the viewing patterns of individuals when assessing postoperative images of penile inversion vaginoplasty through Eye Tracking Technology

Materials and Methods: Forty volunteers viewed randomized frontal images of post-penile inversion vaginoplasty patients and control cisgender female images while an infrared camera (EyeTech Digital Systems, Mesa, AZ) tracked their gaze. Images were standardized, consisting of n=40 postoperative vulva photos of transgender patients and control cis-female vulvas. Look zones included clitoris, labia majora, minora, introitus, perineum, mons pubis, and scars in postoperative images. Eye movement monitoring captured various parameters including eye position, net dwell time, fixation count, fixation time, and revisits in predefined areas of interest. An online survey collected anonymous demographic information from the observers correlated with volunteer numbers. GazeTracker Full 10.0 software was used for analysis.

Results: The study included transgender female patients with a mean age of 41 ± 15 years (range: 20-72) at the time of surgery. The average photographic follow-up period was 7.4 ± 12 months (range: 2-52). Out of the 40 observers, 37 responded to the survey. Their mean age was 27.94 ± 3.12 years, and the distribution included 37.84% cisgender female, 54.05% cisgender male, and 2.7% non-binary individuals. All participants had some level of medical training, while only 24.3% had prior exposure to transgender

surgery results. In terms of viewing patterns, the labia majora were the primary area of interest, with the highest recorded values for net dwell time (2.67 ± 0.91 ms), fixation count (2.70 ± 1.97), fixation duration (0.60 ± 0.39 ms), and revisits. The labia minora also elicited a relatively high net dwell time (1.88 ± 0.74 ms), followed by the clitoris (1.61 ± 0.89). No significant difference was found between parameters obtained from control vs patients' group ($p > 0.05$).

Conclusion: This study provides valuable insights into the viewing patterns and areas of interest when assessing post-penile inversion vaginoplasty images. The findings highlight the significance of labia majora, labia minora and clitoris in attracting attention during aesthetic evaluations. Understanding these salient features can contribute to the refinement of surgical techniques and enhance the overall outcomes and satisfaction of transgender patients undergoing vaginoplasty procedures. Eye-tracking technology proves to be an objective tool for analyzing aesthetic evaluations, aiding our understanding of visual attention in plastic surgery. Further research in this area can lead to improved surgical approaches and personalized aesthetic outcomes.

WED-S4-T1: USE OF BEDSIDE-ULTRASOUND TO PREDICT PEDICLE LENGTH IN RADIAL FOREARM FREE FLAPS

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Presented by: Sangeeta Subedi

Introduction/Background: Prediction of pedicle length is a key component for design of a radial forearm free flap. This is especially in phalloplasty, where a longer flap is desirable, but may be limited by the length of the pedicle. Pedicle length is a limiting factor for free flaps, as maximizing the vascular supply is necessary to prevent complications (e.g., flap loss due to inadequate oxygenation). Currently, the radial forearm flap is designed using surface landmarks and experience-based estimates of pedicle length, but variations in patient anatomy exist. One critical location for flap design is the radial artery take-off point. Accurate pre-operative prediction of radial artery point helps surgeons to optimize flap size and location. Ultrasound is an increasingly ubiquitous, quick, and cost-effective way to pre-operatively identify the location of many structures, and we propose its use for radial forearm free flaps.

Specific Aim: Our study aims to demonstrate the accuracy and efficacy of using ultrasound to pre-operatively identify the radial artery take-off point in radial forearm free flap phalloplasty. We hypothesize that the ultrasound predicted radial artery take off point location will be accurate to the location chosen intraoperatively by the surgeon.

Materials and Methods: We recruited and consented thirteen transgender men (N= 13, M_{age}= 23.1 years) undergoing radial forearm free flap phalloplasty at our institution between May 2021 and March 2023. Before incision, bedside ultrasound was used to identify the radial artery take-off point. The radial artery take-off point was then identified intraoperatively after dissection of the pedicle, with the same measurements taken.

Results: Paired-subjects t-tests were used to compare means between pre-operative ultrasound and intraoperative predictions of radial artery take-off point. There was no significant mean difference [$t(12)=.24$, $p=.81$] between the radial artery take-off point (M_{cm}=1.89, SD=0.43*)* and the intraoperative measurements (M_{cm}=1.86, SD=0.35*)*.

Conclusion: Pre-operative bedside ultrasound is a quick and cost-effective way to accurately identify a spectrum of tissue structures. Our study demonstrates that it can also be used to accurately detect the radial artery take-off point in radial forearm free flaps. This finding may help ensure optimal flap design even in patients with anatomic variations, allowing for minimization of donor site size and morbidity in cases where a smaller flap is desired and permitting maximization of flap dimensions in others. By

utilizing ultrasound, a safe device that provides real-time data found in many clinical settings, the collaborative decision-making process between patient and provider could be enhanced to maximize surgical expectations. This is especially useful for phalloplasty patients and could lead to higher levels of surgical satisfaction.

WED-S4-T2: A VOLUMETRIC ANALYSIS OF THE RADIAL FOREARM PHALLOPLASTY DONOR SITE: DO DERMAL MATRICES IMPROVE DONOR SITE MORBIDITY?

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Presented by: Jessica Marquez

Introduction/Background: Phalloplasty can be integral to genital gender affirmation for transgender masculine and gender diverse individuals. The radial forearm free flap (RFFF) is often chosen to construct the neo-phallus because of its long pedicle, supple skin quality, and consistent nerve and blood supply. However, the flap size required for phalloplasty is associated with a large scar burden that has aesthetic and functional concerns. The high visibility of the Radial Forearm Phalloplasty (RFP) donor site can be a major drawback for individuals who have undergone phalloplasty by inviting unwanted inquiries, highlighting the importance of optimizing donor site cosmesis.

Specific Aim: 1. Investigate donor site functionality, cosmesis, and volume deficits in a cohort of individuals who have undergone RFP at our institution.
2. Compare donor site outcomes in those who received Split Thickness Skin Graft (STSG) only, Biodegradable Temporizing Matrix (BTM) with STSG, or Integra with STSG.

Materials and Methods: All individuals who underwent RFP from May 2019 to June 2022 were queried. Patient demographics, technique of donor site closure and postoperative donor site complications were collected. Donor site functionality was assessed using the quick DASH (qDASH). Patient and clinician reported cosmesis were assessed using the POSAS scar scale. An Artec Leo 3D scanner was used to obtain 3D images of the donor site forearm and contralateral, non-operated forearm. The donor site forearm and contralateral forearm were superimposed and volumetric differences were calculated for each patient. Volumetric heat-maps were used to identify areas of the donor site forearm that most frequently experienced volume deficits.

Results: Fifteen (n=15) patients who underwent RFP agreed to participate. Of these 15, two received STSG only, eight BTM with STSG, and five received Integra with STSG. No statistically significant differences were identified between different donor site closure methods with regard to qDASH, patient reported POSAS, or total volumetric deficits. Blinded clinician reported POSAS approached significance at 4.7 for BTM, 4.2 for Integra, and 3.0 for STSG (p=0.05). No statistically significant differences were identified with regard to distal, middle, and proximal volume deficits, however, a trend was observed in total volumetric deficits with BTM experiencing the lowest mean deficit (11 cm^3) and skin graft experiencing that highest deficit (21.5 cm^3, p=0.82). On multivariate analysis, no statistically significant differences were identified between Integra (OR 10.9, p=0.51) and STSG (OR 28.5, p=0.18) when compared to BTM. BMI was not associated with greater or lesser total volumetric deficit (OR 2.02, p=0.13). The areas of the forearm that experienced the greatest volume deficit on volar side overlay the flexor carpi radialis (FCR) tendon, and dorsally overlay the outcropping muscles (abductor pollicis longus, extensor pollicis brevis, and extensor pollicis longus).

Conclusion: The addition of dermal matrix to the treatment algorithm for RFP did not show significant improvement in donor site volume deficits, patient reported cosemesis or functionality. As fat grafting can be employed to improve donor site cosmesis and restore volume deficits, information regarding where patients experience greater volume deficits may be used to guide fat grafting techniques.

WED-S4-T3: RETROSPECTIVE ANALYSIS OF PHALLOPLASTY BY A SPECIALIZED TRANSGENDER SURGERY CENTER

Brenna Briles[1], Jessica Gondran[2], Emma Linder[3], Galen Wachtman[2], Curtis Crane[2], Richard Santucci[2]
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Presented by: Brenna Briles

Introduction/Background: 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 complication rates. Urethral lengthening remains the main cause of overall complications.

Specific Aim: The objective of our study is to observe the specific urinary, emergent, donor site, and aesthetic complications associated with this complex procedure in the rapidly evolving field of transgender care.

Materials and 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 (RFF), 34% (94/280) received anterolateral thigh flap (ALT), and 0.4% (1/280) received a musculocutaneous latissimus dorsi flap (MLD). The average length of phallus was 5.7 inches (range 4.5-8.5). 57% (159/280) of patients required delay of glansplasty while 43% 121/280 had glansplasty at the time of phalloplasty. Patients with prior masculinizing genital gender affirming surgery included: 23 with metoidioplasty, 3 with phalloplasty, and 28 with 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 (Table 1). 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 (Table 1). 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). Of those receiving liposuction, 94% were amongst patients with ALT and 4% were RFF, and 2% were MLD. 32% received a penile prosthesis after phalloplasty at the time of this writing. 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).

Conclusion: This is the first report of phalloplasty results from a US, high-volume (~100 cases year), dedicated phalloplasty unit which has completed over 1000 phalloplasties. This detailed analysis of complications of this hypercomplex surgery should prove useful to practitioners, patients and payors alike.

WED-S4-T4: GLANSPLASTY AS A COMPONENT OF GENDER-AFFIRMING PHALLOPLASTY: OUTCOMES AND PATIENT SATISFACTION

Lyz Boyd[1,2], Peter Mankowski[1,2], Richard Wassersug[2], Smita Mukherjee[1,2], Alex Kavanagh[1,2], Krista Genoway[1,2]
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Presented by: Lyz Boyd

Introduction/Background: Glansplasty is an optional component of phalloplasty surgery for transmasculine patients wherein a local flap around the glans of the neophallus is rolled to create a coronal ridge. This procedure is largely cosmetic, as it does not have a functional impact on standing urination or sexual intercourse. However, glansplasty may enhance the gender-affirming quality of the phalloplasty by increasing the resemblance of the neophallus to a circumcised natal penis.

Little research has been done regarding the outcomes of this part of the phalloplasty procedure, although surgeons have anecdotally noted that effacement and flattening of the coronal ridge is a common complication of this procedure.

Specific Aim: We aim to assess glansplasty outcomes at least 1 year after the procedure with respect to coronal ridge height and patient satisfaction.

Materials and Methods: Eligible patients followed by the Gender Surgery Program of British Columbia were identified, invited, and consented to participate. Participants were surveyed regarding their satisfaction with the glansplasty outcome, their prior knowledge of glansplasty, and demographics. Photos of the neophallus of each patient were collected. The distance from the contour of the shaft to the peak of the coronal ridge and depth of the coronal sulcus in the dorsal midline were measured on the lateral views using ImageJ. Data collection is ongoing for this study, with a current n = 7 of a targeted 10-20 participants.

Results: Five patients (5/7 or 71.4%) had a measurable negative deflection of the coronal sulcus below the contour of the penile shaft, ranging from 0.2-1.7 mm (mean = 1.0 mm). In these 5 patients, the measurement from the contour of the shaft to the peak of the coronal ridge ranged from 0.4-2.1 mm (mean = 1.3 mm). In the remaining 2 participants, significant effacement occurred and there was no defined sulcus or coronal ridge; instead scar buildup had formed a positive deflection where the negative deflection of the sulcus should be. The heights of these positive deflections were 1.3 mm and 1.7 mm.

Four patients (57%) reported being satisfied or very satisfied with the overall appearance of their glans penis and 3 (43%) were neither satisfied nor dissatisfied. Regarding the appearance of the glans scar, 4 patients (57%) were satisfied or very satisfied, 2 patients (29%) were neither satisfied nor dissatisfied, and 1 patient (14%) was dissatisfied. There was no strong correlation between coronal measurements and reported patient satisfaction. Patients were either satisfied (5/7, 71%) or neither satisfied nor dissatisfied (2/7, 29%) with their sexual activity after glansplasty.

Conclusion: Our preliminary data demonstrate outcomes for glansplasty 1+ years after surgery that range from an intact coronal ridge and sulcus, with maximum heights and depths of 2.1 mm and 1.7 mm respectively, to complete glans effacement and no coronal sulcus or ridge. Patient satisfaction with this procedure is highly individualized and did not correlate with coronal ridge height nor sulcus depth. These data will form the foundation for a more rigorous study of glansplasty outcomes that can better inform decision making for future phalloplasty patients.

WED-S4-T5: SURGICAL REPAIR OUTCOMES FOR PARS FIXA URETHRAL STRICTURES FOLLOWING GENDER-AFFIRMING PHALLOPLASTY AND METOIDIOPLASTY

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Presented by: Hoyoung Jung

Introduction/Background: Phalloplasty and metoidioplasty are common options for transmasculine individuals seeking gender-affirming genitourinary surgery. Both procedures involve reconstruction of the labia minora to create an extended neo-urethral segment called the pars fixa (PF), which enables transmasculine individuals to urinate while standing. Urethral strictures are a common complication of

gender-affirming genitourinary surgery. Urethral strictures in the PF present a reparative challenge given its unique anatomy and vascularization.

Specific Aim: To evaluate the outcomes of three urethroplasty techniques for PF urethral stricture repair in phalloplasty and metoidioplasty patients.

Materials and Methods: A total of 41 urethroplasties performed on 41 patients between March 2018 and June 2021 were reviewed at two surgical centers. A Heineke-Mikulicz (HM) repair was done for strictures under 20 mm when the proximal and distal urethral segments were mobile and supported a tension-free closure. Substitution urethroplasty with ventral onlay buccal mucosal graft (BMG) was utilized for strictures under 40 mm not suitable for HM repair. Complex or long (≥ 40 mm) strictures were treated by two-stage Johansen urethroplasty. Success of each surgical approach was defined by a minimum of 12-month follow-up without the need for a repeat intervention.

Results: Mean follow-up was 30.2 months (range: 12.4 – 52.0 months). Mean stricture length was 16.9 mm (range: 2 – 55 mm). Most strictures (46%) were located at the distal PF, which includes the anastomosis between the PF and the pars pendulans. HM urethroplasty had a success rate of 44% (n = 16). Substitution urethroplasty with ventral onlay BMG had a success rate of 92% (n = 13). Two-stage Johansen urethroplasty had a success rate of 75% (n = 12). Post-surgical complications were limited; three patients who underwent two-stage Johansen experienced proximal urethral stenosis which required a repeat first stage procedure.

Conclusion: In this preliminary study, we found that treating PF urethral strictures after phalloplasty and metoidioplasty has a highly variable success rate ranging from 44% to 92% depending on the type of urethroplasty. Substitution urethroplasty with ventral onlay BMG has a high success rate, while HM urethroplasty has a low success rate. Our results demonstrate a high failure rate of repeat HM urethroplasty following initial HM urethroplasty failure, and substitution urethroplasty may be a preferable alternative in this setting. Staged urethroplasty has reasonable success rates for complex or long segment strictures.

WED-S4-T6: WHAT PENIS GLANS AND SHAPE DO PEOPLE MOST LIKE? A STUDY OF PREFERENCES, AND THE DEVELOPMENT OF A NOVEL APPROACH USING "PENIS STENCILS" SELECTED BY PATIENTS DURING PHALLOPLASTY

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Presented by: Sandeep Sandhu

Introduction/Background: Phalloplasty offers many opportunities for improvement and patient-focused innovation. One example in the realm of masculinizing surgery relates to patient preferences re. length and shape of the phallus glans, and the prominence of the glans ridge. To date, there is no published literature about penis glans-aesthetics preferences among trans, or cis men. Subtle differences in the shape of the glans penis can have dramatic impacts on the overall appearance of the penis itself. Hence, we saw an opportunity to first, better understand what trans and non-binary men undergoing phalloplasty like and don't like regarding glans size and shape, and then separately, to offer trans men undergoing phalloplasty the opportunity to give input and *choose* the shape and length of the glans that they like.

Given the variability in glans shapes in cisgender men, it is important to ascertain what constitutes a cosmetically appearing glans shape for both individuals who are born with a penis, for those who are undergoing phalloplasty as part of their gender affirmation, and for those who have a preference for partners with a penis.

Specific Aim: 1) To ascertain preferences in glans length and shape using different silicone penis models cast from cis-men's penises from a large sample of trans and cis men and women.
2) To design and test the efficacy of glans-shape stencils for use to guide intra-operative markings.

Materials and Methods: An anonymous online survey (Qualtrics™) showed 7 different common penis glans models and asked subjects to indicate which they most and least preferred regarding aesthetics (Figure 1a). In addition, transgender men undergoing glansplasty as part of their gender-affirming surgery were offered the choice to have their glans shape to be modeled after their selection.

Stencils were based on common cisgender mens' penises and were used with henna applied to their phallus 1-hour before glansplasty at stage II surgery (Figures 1b and 2). Results were also shown at 12 weeks post-op.

Results: To date, a total of 100 individuals took the survey (Average age 36.1, Range: 23-59). Of these, 33 cisgender men, 57 cisgender women, 6 transgender men, 2 transgender women and 2 gender non-binary individuals were included. With regards to preferences, the most liked options were A (28/81) and E (31/81). The least liked options were B (20/67) and D (24/67). There was variability amongst all other other options, save for option "B" which was not liked by any individual.

Transgender men undergoing glansplasty during phalloplasty reported extremely high satisfaction with the opportunity to give input to their phallus aesthetics. Post-op outcomes regarding shape outline closely resembled stencils.

Conclusion: In summary, this is the first work to query men's preferences for penis glans shape aesthetics. There is wide variability amongst people of different gender and sexuality regarding glans shape preferences.
The stencils we designed were highly appreciated by patients, easy to use, and yielded reproducible results. Gender affirming surgeons should consider other opportunities to include patients in the decision making process.
NB: US and International Patent Pending for Glans Stencils

WED-S4-T7: FUNCTIONAL AND AESTHETIC OUTCOMES OF THE USE OF INTEGRA FOLLOWING FREE RADIAL FOREARM PHALLOPLASTY

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Presented by: Peter Mankowski

Introduction/Background: For transgender patients, free radial forearm flap (FRFF) phalloplasty utilizes the skin and soft tissue of the distal forearm to create a neophallus. The resulting donor site is left with a depressed and irregular contour that has suboptimal cosmesis when covered by a split thickness skin graft. Integra artificial dermal matrix was introduced as an optional tool for donor site reconstruction of the forearm. Integra integrates into the donor site wound bed as a dermal substitute that can then be covered by a split thickness skin graft in a stage fashion. The use of Integra is thought to decrease the donor site deformity, improve scar cosmesis and minimize scar adhesions which can result in functional impairment.

Specific Aim: The goal of this study is to review a case series of patients that have completed donor site reconstruction after FRFF phalloplasty to identify the benefits and drawbacks of the Integra coverage technique.

Materials and Methods: Patient who are at least 6 months post FRFF phalloplasty and had received Integra reconstruction were identified within the UBC Gender surgery program records. These patients were evaluated by physical examination of their forearms assessing radial sensory neuroma, objective tendon glide, tendon adhesion and hypertrophic scar formation. Two scar metric tools, POSAS (The Patient and Observer Scar Assessment Scale) and the Vancouver Scar Scale (VSS) were also

completed by the patient to qualitative evaluate their healed scars. De-identified photographs of the donor sites were also obtained to correlate patient assessment with objective images.

Results: A total of 7 patients met study inclusion criteria. Assessment of objective tendon guiding revealed no restriction of forearm movement post operatively when compared to the contralateral arm. Patient scar assessment by the POSAS and VSS revealed a range of post-operative scar characteristics in terms of scar color and thickness. However, the majority of patients reported overall scar scores of 6/13 on the VSS suggesting a moderate degree of scar features remained notable at 6 month post-operative time period.

Conclusion: Integra reconstruction of the RFF is an alternative to the traditional sheet graft approach that provides effective coverage over the donor site. This two-stage approach minimizes adhesion risk and helps to ensure optimal functional status post procedure. Additional long-term evaluation of Integra reconstruction sites is necessarily to critical review final scar cosmesis.

WED-S4-T8: PHALLIC COMPARTMENT SYNDROME IN GENDER AFFIRMING PHALLOPLASTY: DEFINING A CLINICAL ENTITY, CAUSES, AND SEQUELAE

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Presented by: Monica Llado-Farrulla

Introduction/Background: Phalloplasty represents a complex and vital surgery for genital affirmation of many transmasculine individuals. While it builds upon techniques of microsurgical free flap reconstruction, it introduces additional potential complications due to the unique stresses placed on the flap from tubularization. Excessive post-operative swelling, venous congestion or intra-phallic bleeding can increase the volume in the confined space of the tubularized flap, leading to the clinical entity of phallic compartment syndrome (PCS).

Specific Aim: Our objective is to define phallic compartment syndrome (PCS) and to outline its incidence, the frequency of its underlying etiologies, and its clinical sequelae.

Materials and Methods: We conducted a single-center, multi-surgeon, retrospective review of all stage 1 phalloplasty cases performed from December 2016 to May 2023. Analysis included etiology of increased phallic compartment pressure, patient demographics, flap type and size, management, and hospital course.

Results: Over the study period a total of 147 phalloplasty surgeries (stage 1) were performed. Of these, 21 patients were diagnosed with PCS, translating into an incidence of 14%. Of the 21 cases of PCS, 8 (38%) were from intraphallic hematoma, 7 (33%) were from venous congestion and 6 (29%) were from excessive swelling. All patients with a diagnosis of PCS required some form of active intervention: either release of sutures at the bedside, reoperation, or both. The average time to presentation of PCS was 3.1 days postoperatively, with greater than 75 percent of cases presenting between postoperative days 0 – 3. Development of PCS and the subsequent treatment interventions led to increased surgical morbidity and a significantly longer length of inpatient hospital admission. BMI, flap length, flap circumference, flap area, single vs multi stage operation, flap construction (tube within a tube vs shaft only), and flap type were not significantly different between the patient population that developed PCS and the population that did not (Tables 1 and 2).

Conclusion: Single or multiple tubularizations of a fasciocutaneous flap for affirming phalloplasty introduces increased risk for flap compromise secondary to the development of excessive pressure and compartment syndrome. There is a paucity of literature on this subject, likely due to lower surgical volumes of phalloplasty relative to other autologous free flap reconstructions of the breast, trunk, or

extremities. Presence of PCS has the potential for long term functional implications and sequelae, especially if coupled with vascular insufficiency. Prompt diagnosis and management of increased intra-phallic pressure is paramount in mitigating short- and long-term morbidity. As such, phallic compartment syndrome represents a critical clinical entity not to be underestimated or overlooked in the early post-operative phalloplasty course.

WED-S4-T9: Strategies to Optimize Technique and Outcomes in First-Stage Gender-Affirming Free-Flap Phalloplasty

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Presented by: Edward Ray

Introduction/Background: Along with rising demand for genital gender-affirming surgery (gGAS) there has been growing interest in improving technique and outcomes for gender-affirming phalloplasty. As with any reconstruction, achieving good form and function while minimizing morbidity and ensuring tissue viability are key goals. Currently, the most widely used phalloplasty approaches are free-flap techniques. The radial forearm free flap has emerged as a preferred option for phallourethroplasty due to its reliable anatomy, long pedicle, and suitable thickness, which allow for creation of an aesthetically pleasing and functional phallus.

Specific Aim: In this study, we reviewed the evolution of our technique and resulting outcomes to formulate recommendations for optimizing the staged surgical approach to free flap phalloplasty.

Materials and Methods: We performed a retrospective review of all consecutive patients who underwent gender-affirming free-flap phalloplasty, phallourethroplasty, or urethroplasty from June 2017 through September 2021 at our institution. All patients were transgender men treated for gender dysphoria. Patients undergoing primary genital reconstruction (first gGAS) as well as those seeking revision (after prior gGAS) were included. Patient demographic data including age, body-mass index (BMI), comorbidities, and prior procedures were recorded. Operative details and postoperative outcomes were analyzed.

Results: During the time interval studied, 31 free flaps were performed. 9 of these were anterolateral thigh (ALT) flaps and 22 were radial forearm (RF) flaps (including 2 urethroplasties). Flap design evolved with our experience to optimize aesthetics and tissue perfusion. In every case, the deep inferior epigastric artery (DIEA) and at least one vena comitans (VC) tunneled from the preperitoneal space through the external inguinal ring served as recipient vessels. There were two surgical take-backs (6.5%), one for hematoma and the other for venous congestion. The latter was in an obese patient with kinking of the pedicle vein at the external inguinal ring. Late recognition led to flap loss. After this experience, we adopted the practice of performing saphenous vein outflow augmentation in all cases of suspected flap congestion (no others in this series), however mild. There were no partial flap losses and all patients went on to successful reconstruction. Urethral complications were the same or better than that reported in the literature with other approaches to phalloplasty.

Conclusion: In this paper, we describe our experience with optimizing the first stage of two-stage gender-affirming phalloplasty. We share our technical pearls for preoperative, intraoperative, and postoperative care. Thorough patient counseling is crucial for helping patients choose the surgical option that best suits their goals. We have reliably been able to achieve excellent outcomes using the DIEA and VC as free-flap recipient vessels that travel through the inguinal canal, a technique that has not previously been described in detail. This technique has several advantages, including a more natural trajectory to the recipient site, improved size match of vessels, and the avoidance of complications associated with groin anastomoses, such as symptomatic femoral artery pseudoaneurysms. Full thickness skin grafts from the infragluteal region have worked well for optimizing the RF donor site scar. Our flap design has evolved to address both aesthetics and optimal flap perfusion.

WED-S4-T10: A NOVEL PRE-EXPANDED PEDICLED ABDOMINAL FLAP PHALLOPLASTY WITH SURAL NERVE GRAFT

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Presented by: Diego Gomez

Introduction/Background: Phalloplasty is a core gender-affirming procedure that aims to create a functional, aesthetic, and sensate neophallus. While radial forearm free flap and anterolateral thigh (ALT) flaps can produce these results, they are associated with substantial donor site stigmata, typically either at the bilateral lateral thighs or the thigh and volar forearm.

Pedicled abdominal phalloplasty is a staged procedure that typically creates an insensate penile shaft, but without microvascular anastomoses or substantial visible scar burden.[1, 2] Tissue expansion has been known to facilitate wound closure, reduce scarring, and minimize ischemic complications through the delay phenomenon, though its value in phalloplasty remains unclear.[3,4] In addition, sensory nerve coaptation improves sensation following ALT phalloplasty, but abdominally-based phalloplasty contains no nerves to coapt.[5] Sural nerve grafting is routinely performed for peripheral nerve reconstruction due to its consistent anatomy, considerable diameter and length, and low morbidity of the donor site, but its use in phalloplasty has not been reported.

Specific Aim: The authors present the first reported pedicled abdominal flap phalloplasty using both tissue expansion and sural nerve grafting for sensory neurotization.

Materials and Methods: The procedure is completed in four stages. Stage 1 involves sural nerve graft harvest, coaptation to the dorsal clitoral nerve with subdermal tunnelling, and suprafascial tissue expander placement. Three months of weekly tissue expansion ensue. Stage 2 incompletely incises the flap to its pedicle to allow for delay phenomena. One week later, Stage 3 tubularizes the flap, releases it to the pubic area, and primarily closes the donor site. Stage 4 – glansplasty and scrotoplasty – occurs at six months. Erectile and testicular implant can be placed if desired.

Results: A 26-year-old transgender man with a BMI of 20.5 underwent abdominal flap phalloplasty. Tissue expansion of the flap with sural nerve graft and coaptation to the clitoral nerve were performed. Expansion with 575 cc was performed over a 3.5 month period. Periodic testing of skin overlying the expansion site revealed erogenous and light touch sensation along the sural nerve path, spreading cephalad and laterally during the expansion period. At time of tubularization of the abdominal flap, the neophallus was formed without ischemic complications, and primary closure of the donor site was achieved. The patient continued to report erogenous and light touch sensation in the neophallus after its creation.

Conclusion: This case report highlights the potential for sensory nerve grafting and tissue pre-expansion in abdominal-based phalloplasty. Direct expansion of the adipocutaneous flap promotes hypervascularization and allows for primary closure at the time of mobilization. Early sensation testing demonstrates the potential for sensory neurotization of the neophallus.

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WED-S3-M: Metoidioplasty: Preventing and Managing Complications and Improving Outcomes

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Presented by: Jennifer Anger, Daniel Dugi, Loren Schechter, Rajveer Purohit

Statement of Significance: This surgical symposium is being submitted for the Surgeon's Pre-Course. It will provide an interdisciplinary approach to the surgical management of metoidioplasty, with experts in reconstructive urology and plastic surgery. The goals of the symposium are: to optimize outcomes of metoidioplasty with a focus on surgical techniques to prevent complications, to manage complications, and to provide non-binary options (canal-sparing) for patients while optimizing outcomes. Belgrade and ring metoidioplasty techniques will be presented in a didactic format, including risks and benefits of each approach. Complications that will be addressed include fistula, stricture, vaginal remnant, and wound breakdown. Canal-sparing techniques and associated risks will be reviewed in a case-based format. The symposium will also address patient selection, managing patient expectations, and also techniques of converting metoidioplasty to phalloplasty.

Learning Objective 1: Avoiding complications (surgical urethral lengthening techniques presented- ring and Belgrade), including suprapubic tube management, staging, technique of testicle implants, and technique of conversion of metoidioplasty to phalloplasty. This will include didactics with videos.

Learning Objective 2: Managing complications: treating stricture, fistula, wound dehiscence, wound breakdown, and vaginal remnant after metoidioplasty. This will be a case-based discussion.

Learning Objective 3: Avoiding and managing complications in non-traditional/non-binary approaches: simple (shaft only), canal sparing with or without scrotum. This will also be case-based.

Method to Achieve Learning Objectives: We will use. combination of didactics with case presentations, allowing ample time for discussion and audience participation.

Thursday, November 2, 2023

WED-S5-T2: Coding Guidelines for Gender Affirmation Surgery

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Presented by: David Whitehead

Introduction/Background: From the creation of the Current Procedural Terminology (CPT) in 1965, there has been an effort to standardize a system of reimbursement for physician services provided. These "codes" are an attempt to represent the work required for individual services and procedures. For the myriad gender affirmation surgical procedures performed, there is a lack of consensus on appropriate CPT coding. The absence of comprehensive coding guidelines is especially concerning for cases with Medicare and Medicaid coverage where there is limited proactive review of the selected codes, and inappropriate coding by physicians can lead to allegations of fraud.

Specific Aim: This review seeks to evaluate the appropriateness of commonly-used CPT codes in gender affirmation surgery. Facial, chest, genital, and other body contouring procedures are discussed, and specific recommendations for code bundling are offered.

Materials and Methods: Common CPTs codes used by multiple surgical providers, recommended by the available literature, and recommended by commercial insurance companies were compiled. The lay

terminology, code edits, and relative value units (RVUs) of the procedure codes were reviewed with an independent senior coding compliance professional and assessed for appropriate use.

Results: Several commonly-used codes were noted to have more appropriate alternatives, especially in facial feminization (FFS) cases (e.g. 21256, 21127, 31750). Other coding strategies were noted to be controversial, but potentially reasonable with proper justification (e.g. 19303/19350 vs 19318).

Conclusion: This project helps improve the overall limited general guidance for CPT coding for gender affirmation procedures. Health professionals can help guide policy from the American Medical Association and the Centers for Medicare & Medicaid Services to ensure healthcare dollars are distributed equitably to serve our patient population.

WED-S5-T3: Lines in the Sand: What factors impact surgeon comfort with gender-affirming surgical procedures?

Arya Akhavan[1], Justin Camacho[2], Nicole Eregha[3], Thomas Satterwhite[1], John Pang[1]
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Presented by: Arya Akhavan

Introduction/Background: Surgical practice often evolves by pushing the limits of societal norms. Physicians in decades prior believed that “any surgeon who would operate on the heart would lose the respect of his colleagues”, but cardiothoracic surgery now has its own residency. Likewise, gender affirmation surgery progresses from surgeon willingness to explore frontiers. Conference presentations describing gender-affirming surgery in legal minors, as well as “individually customized” procedures for non-binary patients, have received mixed reactions from gender-affirming surgeons. However, absolutely no literature examines surgeon-specific factors that contribute to conceptual comfort with these procedures.

Specific Aim: This study aims to survey gender-affirming surgeons to characterize how personal factors, such as upbringing, moral foundations, religious belief, and personal sexual orientation and gender identity, impact surgeon conceptual comfort with these procedures.

Materials and Methods: A survey was designed via Qualtrics to assess surgeon characteristics and conceptual comfort in performing various procedures (Figure 1), and was distributed to a pilot group of 70 gender-affirming surgeons and trainees. Surgeon data included personal background, upbringing, income, sexual orientation, gender identity, surgical training background, practice details, patient demographic mix, religious upbringing and beliefs, political beliefs, and a Moral Foundations Theory questionnaire.
Procedures were selected to include a mix of gender-affirming surgery in adults and minors, nearest-equivalent procedures in cisgender patients, and other potentially controversial plastic surgical procedures. Procedures were categorized by body region and type (face, chest, body, genital, “complex/transplant/other”), pediatric vs adult, and other factors. Statistical analysis was performed via Qualtrics Stats iQ.

Results: Of 70 surveys, 14 physicians responded (20%). Most completed plastic surgery residency programs (92.3%), and were fellowship-trained in gender affirmation surgery (50%) and/or microsurgery (21.4%). Most practice in a tertiary-care academic hospital (46.2%) or group private practice (30.8%), treating low-to-middle income patients (61.5%). Most grew up in a somewhat-religious (53.8%) environment but are non-religious (61.5%). Respondents’ moral foundations, scaled 0-30, were built heavily on Care/Harm (19.3 ± 2.5) and Fairness/Reciprocity (18.2 ± 4.1), and minimally on In-Group/Loyalty (8.9 ± 4.6), Authority/Respect (10.2 ± 5.8), and Purity/Sanctity (5.5 ± 5.1).

Participant gender identity and gender fellowship training were not associated with significant changes in comfort level for any individual procedure or procedure group. However, non-heterosexual participants

had significantly higher comfort with adult labiaplasty (p = .009), while heterosexual participants had significantly higher comfort with gender-affirming mastectomy in legal minors (p = .003). Increasing participant religiosity was significantly associated with *decreasing* comfort in performing transplantation procedures (p = 0.012), but had no impact on comfort with gender affirmation procedures, pediatric procedures, or non-anatomic procedures. Increasing age was significantly associated with increased comfort with breast, buttock, and calf implants (p < 0.049).

Conclusion: In this small pilot sample of gender-affirming surgeons, participant moral foundations were built heavily upon Care/Harm and Fairness/Reciprocity principles, with little contribution from Purity/Sanctity or In-Group/Loyalty concerns. Gender fellowship training, gender identity, and religiosity had no impact on conceptual comfort with gender-affirming procedures in adults or minors, or with individually customized or “non-anatomic” procedures. Further work on this topic is ongoing.

THU-S1-T1: BREAST SURGERY IN ADOLESCENTS: CISGENDER BREAST REDUCTION VERSUS TRANSGENDER CHEST MASCULINIZATION

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Presented by: Bashar Hassan

Introduction/Background: Breast reduction surgery (BRS) constitutes up to 5% of cosmetic procedures in cisgender female adolescents. Chest masculinization surgery (CMS) is a similar procedure performed in transgender and non-binary (TGNB) individuals. Despite the positive impact of both procedures on psychosocial outcomes, CMS in adolescents is highly contested due to concerns regarding safety and capacity for consent.

Specific Aim: Here, we compare BRS and CMS in cisgender and TGNB adolescents, respectively, to quantify trends in incidence, minimum age, and surgical outcomes.

Materials and Methods: The National Surgical Quality Improvement Program database was queried from 2018 to 2021 for cisgender and TGNB adolescents aged 18 years or younger who underwent BRS or CMS. Individuals who underwent breast surgery due to breast disorders or oncologic reasons were excluded. Our outcome was the incidence of postoperative complications within 30 days of surgery. Descriptive statistics were calculated. Bivariate analysis and multivariate logistic regression were performed to determine if CMS was associated with postoperative complications.

Results: Of *n*=2,504 adolescents who fulfilled inclusion criteria, the majority (*n*=2,186 [87.3%]) were cisgender females who underwent BRS, compared to TGNB individuals (*n*=318 [12.7%]) who underwent CMS. Cisgender females were on average, younger at time of surgery (mean [standard deviation (SD)] 16.7 [1.2], 17.5 [0.9], *P*<0.001). More strikingly, the minimum age for cisgender BRS ranged from 12.1 to 12.6 years over the four years in our study, compared to that of TGNB adolescents which ranged from 14.0 to 15.1 years. Cisgender females were significantly more likely to undergo BRS at ages 14 to 17 years, compared to TGNB individuals who were more likely to undergo CMS later, at age 18 years. A total of *n*=98 (4.5%) cisgender females and *n*=13 (4.1%) TGNB individuals developed at least one complication (e.g., unplanned reoperation or readmission, surgical site infection, wound dehiscence) within 30 days. There was no significant difference in the incidence or odds of developing at least one complication between the two procedures.

Conclusion: Cisgender female adolescents undergo breast surgery at nearly a 7-fold rate compared to TGNB adolescents and do so at significantly younger ages. Given the positive impact of both procedures on psychosocial functioning and the comparable minimal risk of complications, we advocate for parity in surgical access. At minimum, this study helps reframe the concerns with TGNB CMS in the context of cisgender female adolescents who already undergo a similar procedure without significant controversy over bodily autonomy and capacity for consent.

THU-S1-T2: CONSIDERATIONS FOR GENDER-AFFIRMING SURGERY IN LATER LIFE

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Presented by: Elijah Castle

Introduction/Background:
Little is known about older transgender adults' desire for gender-affirming surgery, nor have surgical outcomes in this population been well described. Given the prevalence of age-related bias in health care overall, older people may not be perceived as suitable surgical candidates or as interested in surgery. Further, older age can compound racial/ethnic and anti-trans biases to exacerbate disparities in access to high quality gender-affirming surgical care, especially for older trans persons of color. The lack of empirical data regarding older trans adults' access to and outcomes from gender-affirming surgery contributes to the barriers older trans adults face when accessing surgery.

Specific Aim: We will review the current state of the literature on outcomes of gender-affirming surgery in older trans adults and recommend strategies to improve research focused on older trans adults' access to surgery.

Materials and Methods: To summarize the state of evidence for gender-affirming surgery in older trans adults, we conducted a comprehensive review of published research on gender-affirming surgical procedures by patient age.

Results: A total of 52 studies were included in the final sample. Table 1 and Figures 1 and 2 display key data, including average and maximum age and follow-up time. Most (46.2%, 24/52) studies reviewed included patient populations with an average age between 30-39. While a few studies report on patients into their seventies, out of the studies reviewed that reported a maximum age, most have a maximum age in the 50-59 range. Average follow-up time for most studies was under 1 year (30.8%, 16/52), or between 1-3 years (30.8%, 16/52). Mastectomy (42.3%, 22/52) and vaginoplasty/vulvoplasty (38.5%, 20/52) were most commonly documented in the literature.

Conclusion: This review of the literature clearly underlines the need for a better understanding of surgical outcomes for older trans adults to support more informed, equitable access to and eligibility for gender-affirming surgery. Moreover, there is little data regarding how surgically-reconstructed genitals fare through the aging process, with implications for patient expectations and fully informed consent. Future gender-affirming surgical research should be intentional about including older trans adults, as well as stratifying findings by age to provide further research context and clarify age-related trends. More robust outcomes data will better support a shared decision-making process for patients and surgeons with regard to preoperative preparation and postoperative recovery. Beyond assessments for surgical candidacy and provision of surgical care, a better understanding of post-surgical outcomes also can help clinicians better meet primary and sexual health care needs for older trans adults.

THU-S1-T3: DEVELOPMENT OF A VAGINAL DILATOR DEVICE AND A HOME INSEMINATION DEVICE FOR CIS- AND TRANSGENDER PEOPLE, BASED ON THE ACTUAL ANATOMY OF THE PELVIS

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Presented by: Maurice Garcia

Introduction/Background: Transfeminine people undergoing vaginoplasty with canal creation must undertake long-term self-dilation and douching to maintain patency and hygiene.
Given that many neovaginal canals are lined by skin, there is an inherent lack of elasticity as compared to

cisgender women's vaginal canals. As such, a neovagina is sensitive to dilator shape and douche-nozzle length to allow douche water to reach the apex to optimize hygiene, reduce chronic inflammation and granulation tissue.
Commercially available vaginal dilators designed for cisgender women's anatomy are either straight, or, have an abrupt upward curve at the tip, inconsistent with the anatomy of the neovaginal canal.
Lastly, many LGBTQ+ people with a uterus seek to become pregnant without a male sexual partner. Few to no devices exist today for this population.

Specific Aim: We assessed the vaginal canal shape in transgender and cisgender women and sought to:
1) Design a vaginal dilator which reflects pelvic and canal anatomy.
2) Create a novel dilator that combines dilation, douching, and depth measurement functions.
3) To create a vaginal dilator that can be irrigated with semen by trans men and by cis women seeking pregnancy without a male sexual partner

Materials and Methods: A floppy radio-opaque catheter was placed into the neovaginal canal from the introitus to the vault apex of 12 transgender women who underwent vaginoplasty with neovaginal canal creation. C-Arm fluoroscopy delineated canal curvature based on the catheter. In addition, gynaecologic texts were reviewed and both current and historical surgical instruments were examined to ascertain the shape of a cisgender woman's vaginal canal.
Based on these findings, a novel dilator was designed using ink-drawings, whereupon a CAD-file was designed and 3-D printed. A sex-toy company made our initial prototypes.

Results: A smooth "S-shape" was found in the vaginal canal of both cis- and transgender women, consistent with the shape of modern and historic cervical dilators. In cisgender women, the vaginal vault, which is elastic, is located much closer to the introitus than that of transgender women, whose canal is inelastic and fixed. The cervix is typically located on the anterior surface of the canal, 0.5 to 4cm proximal to the posterior fornix.
Our vaginal dilators (Figure 1a) (five, each 8-12 cm circumference) and reflect the smooth S-shaped curvature observed, with depth markings, and, sidewall grooves to allow air and liquid to pass with insertion and withdrawal. Our dilator is hollow with distal holes and can be fitted with a douche-bulb.
Our insemination device (Figure 1b-c) is only 9 cm circumference, similar in shape but shorter, is hollow to accommodates a 10cc syringe (for introduction of semen), and has a recessed anterior wall, 0.5-4cm from the tip (where the cervix normally resides) for up to 6cc of semen to pool and bathe the cervix with sperm for conception.

Conclusion: The design improvements shown should make dilation and douching more comfortable, and, should improve hygiene and decrease the incidence of granulation tissue.
Our inseminator offers a private, at-home means of achieving fertilization for both cisgender and transgender individuals. (U.S. Patent 11638808; *Neovaginal and vaginal health devices*)

Surgeon Oral Accept: Social Determinants of Health/Health Equity

THU-S1-T4: A PHOTOGRAMMETRIC ANALYSIS OF GENDER AFFIRMING SURGERY RACIAL DIVERSITY IN PLASTIC SURGERY LITERATURE

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Presented by: Thayer Mukherjee

Introduction/Background: The racial distribution of transgender and gender diverse (TGGD) people in the U.S. is estimated by the Williams Institute to be 55% white non-Hispanic, 16% black non-Hispanic, 21% Latino, and 8% other by race. The plastic surgery literature has shown that surgeons who provide gender affirming care portray a disproportionate number of white TGGD people on their social media accounts. No study, thus far, has evaluated the plastic surgery literature for disparities in the way TGGD patients are portrayed.

Specific Aim: This study evaluates the portrayal of gender affirming surgery patients in major plastic surgery journals by photogrammetric analysis to evaluate for racial disparities in plastic surgery literature.

Materials and Methods: A photogrammetric analysis of 3 major plastic surgery journals (*Plastic and Reconstructive Surgery*, *Journal of Plastic, Reconstructive, and Aesthetic Surgery*, and *Aesthetic Surgery Journal*) was performed on articles written from 2019-2023 pertaining to gender affirming surgeries. Color photographs with skin containing patient images were extracted from the articles and were categorized by 2 independent evaluators based on the Fitzpatrick Scale. Those graded Fitzpatrick 1-3 were categorized as white and those graded 4-6 were categorized as non-white. Student T-tests were used to compare the mean white and non-white patient photos per article for all journals and the included journals individually.

Results: 31 articles were found with 219 skin containing photos comprising 106 patients undergoing gender affirming surgery. 86/106 patients (81%) were white and 20/106 were non-white (19%). Looking at all journals combined, there were more white than non-white patient photos (P = 0.0015). *Plastic and Reconstructive Surgery* (n=21, P = 0.0239) and *Journal of Plastic, Reconstructive, and Aesthetic Surgery* (n=7, P = 0.189) showed significantly more white than non-white patients. There was no significant difference in the racial representation of gender affirming patients in the *Aesthetic Surgery Journal* (n=3, p = 1.00) articles.

Conclusion: There is a statistically significant difference in the number of white versus non-white TGGD patients represented in the plastic surgery literature for gender affirming surgery. 81% of the patients depicted in 3 major plastic surgery journals from 2019-2023 were white, which is higher than the national estimated average for TGGD people (55%). Striving for equitable representation of gender affirming surgery patients in the plastic surgery literature can more accurately represent the TGGD populations served by plastic surgeons.

Surgeon Oral Accept: Surgery

THU-S1-T5: ARTIFICIAL INTELLIGENCE AND MACHINE LEARNING IN FACIAL FEMINIZATION SURGERY

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Presented by: Shelby Chun Fat

Introduction/Background: The number of transgender and non-binary individuals is increasing and therefore, so is the frequency of gender-affirming surgeries including facial feminization surgery (FFS). Facial characteristics have been reported to be one of the highest sources of gender dysphoria. Traditionally, preoperative planning utilizes bony landmarks and measurements. However, results are limited by a surgeon's skill and judgement. Artificial intelligence and machine learning (AI/ML) has the potential to assist in preoperative planning, overcoming common problems, and predicting outcomes. This technology may also be used to improve FFS outcomes.

Specific Aim: The aim of this study is to evaluate the utility of AI/ML in determining what makes a face more masculine or feminine and characterizing facial skeletal sexual dimorphism with the potential benefit of aiding in the preoperative planning of FFS.

Materials and Methods: Five orthogonal views using 2D images of facial CT reconstructions and 3D surface meshes created with convolutional neural network (CNN) analysis of facial CT studies from subjects assigned female or male sex at birth (AFAB or AMAB), aged 25 to 60 years old between 2017 and 2022 were used to train and test the algorithm. Patient demographics including self-reported race were also collected. Images with facial trauma, hardware, congenital deformities, or prior facial surgeries were excluded. 48 randomly selected images were used to test the algorithm.

Results: A total of 48 AFAB and 50 AMAB facial CT images were used in the training phase. Of these, 56 (57.1%) were white, 19 (19.4%) were black, 6 (6.1%) were Asian, and 17 (17.3%) were not reported. During the testing phase, the algorithm was able to correctly categorize an individual as male or female with 95% accuracy. It was also able to assign numerical scores to the images on a male to female scale with one end of the spectrum. Females tended to have more prominent cheeks, a more symmetric face, less convex nasal bones, and a narrower mandible. These features overlap significantly with historical data from studies of soft tissue features.

Conclusion: AI/ML is able to identify cranial sexual dimorphic features and will continue to learn with larger data sets. Future research should focus on comparing preoperative and postoperative results through patient reported outcomes to achieve better results after FFS.

THU-S1-T6: ASSESSING NIPPLE AND CHEST SENSATION FOLLOWING CHEST MASCULINIZATION SURGERY: CHALLENGING THE PERCEPTION OF DIMINISHED SENSATION

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Presented by: Sara Danker

Introduction/Background: Chest masculinization surgery, commonly known as "top surgery," is a gender-affirming procedure sought by transgender and non-binary individuals to alleviate gender dysphoria and achieve a more masculine chest contour. One aspect frequently discussed among both patients and surgeons is the potential impact of this procedure on nipple and chest sensation. It is widely believed that sensation is significantly diminished, or even lost altogether, following chest masculinization surgery.

Specific Aim: However, our study aims to challenge this prevailing perception by presenting data that suggests a more nuanced understanding of postoperative nipple-areola complex (NAC) and chest sensation.

Materials and Methods: In this retrospective study, we analyzed a cohort of 12 individuals who underwent chest masculinization surgery. Detailed surgical information, including the chosen technique was collected. Postoperative follow-up evaluations were conducted at regular intervals, assessing nipple sensation using standardized Semmes Weinstein filament testing (SWFT).

Results: A total of 12 patients were included in the study. 11 patients identified as male, while one patient identified as non-binary. All patients were non-smokers and had no history of diabetes. Ten patients underwent a double incision technique with free nipple grafts. One patient declined nipple grafting for personal preference. One patient requested a periareolar technique and incision pattern. 9 patients had a Prevena wound vacuum placed postoperatively as a dressing. Postoperatively, all patients retained sensation to their bilateral NACs (excluding the patient who declined NAC reconstruction). Median SWFT scores were 4.31 for both the right and left NACs, which correlated to “diminished protective sensation”. Median SWFT scores for the anterior skin of the chest, which includes sensation for the skin medial, superior and inferior to the NAC and inferior to the central incision, was 2.83 for the right chest (mean 3.29), and 2.83 (mean 3.47) for the left chest, which correlated to “normal sensation”.

Conclusion: Our preliminary findings challenge the prevailing notion that nipple and chest sensation is drastically diminished or lost after chest masculinization surgery. Our findings demonstrate that postoperative nipple sensation is not uniformly diminished across all patients. Understanding the variability in postoperative nipple sensation is crucial for informed decision-making and preoperative counseling. Future directions include expanding the sample size, comparison of techniques, and comparison of pre- and postoperative SWFT scores.

THU-S1-T7: Strike a Pose, and…Virtual Visit? Examining virtual vs. in-person consultations for gender affirmation surgery.

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Presented by: Arya Akhavan

Introduction/Background: During the peak of the COVID-19 pandemic, many medical service lines began offering new patient consultations via virtual services (video or phone call), to avoid unnecessary potential viral exposure. These services have expanded to surgery, including postoperative visits and virtual wound checks. Prior work suggests that telehealth visits significantly reduce unnecessary emergency department visits, complication-associated healthcare costs, and no-show rates for appointments. However, very little research examines telehealth in the gender affirmation surgery setting, virtual vs. in-person initial consultations in a surgical setting, or surgical conversion rates by initial consultation venue.

Specific Aim: This study aims to examine differences in patient “conversion rates” (completion of surgery) based on modality of initial consultation – phone call, video, or in-person, as well as by other patient factors.

Materials and Methods: All patients at a single gender affirmation surgery practice from inception of practice to March 31, 2023 were reviewed. Data was gathered regarding initial consultation appointment modality, patient demographics, payor mix, surgeon, and conversion to surgery. Groups were compared using chi-square independence testing for categorical variables.

Results: Of the 3581 patients who had initial consultations, 1728 (48.3%) pursued surgery. Over half of patients selected video-based virtual visits (55.8%), while 31.2% chose phone visits and only 13% chose in-person visits. However, there were no significant differences in surgical conversion rates between groups (46.1-47.9%, $p = 0.81$). Subgroup analysis by type of surgery showed no significant differences in conversion rates versus consultation modality. Patients undergoing genital surgery had significantly lower conversion rates than facial, chest, or body surgery regardless of whether or not they had consultations in person ($p = 0.005$), by video ($p < 0.0001$), or by phone ($p < 0.0001$).
Patients were also subgrouped by age and by insurance status. Patients under 18 years of age showed no significant differences in conversion rates. Private-pay patients had significantly higher conversion rates with in-person visits as compared to phone or video visits (46.6% vs. 42.2% vs. 34.5%, $p = 0.002$). On the other hand, privately insured patients had significantly *lower* conversion rates with in-person visits, with highest conversion rates through video visits (40.7% vs. 45.4% vs 51.2%, $p = 0.012$).

Conclusion: Patients at the studied multi-surgeon gender affirmation practice predominantly have virtual initial consultations, rather than in-person visits. Virtual consultations for gender affirmation surgery do not demonstrate significantly different surgical uptake rates compared to in-person visits.

THU-S2-T1: THE ASSOCIATION OF BMI CATEGORY AND POSTOPERATIVE COMPLICATIONS IN GENDER AFFIRMING MASTECTOMY FOR CHEST RECONSTRUCTION

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Presented by: Jessica Marquez

Introduction/Background: Gender affirming chest masculinization surgery is associated with increased quality of life and lower rates of morbidity and mortality in transgender, non-binary, and gender non-conforming individuals. Often, body mass index (BMI) thresholds may be used to determine surgical candidacy, but evidence for using this as a surgical criterion has not been established for these surgeries.

Specific Aim: To analyze a national cohort of patients undergoing mastectomy for gender affirmation to assess the risk of postoperative complications amongst different BMI categories following gender affirming chest surgery.

Materials and Methods: The NSQIP database from 2010 to 2020 was queried to identify all encounters of mastectomy for gender affirmation. Cases were stratified by BMI categories and 30-day postoperative medical and surgical complications were compared.

Results: A total of 10,775 patients were included in the analysis. The overall proportions of medical complications remained extremely low for all groups. The risk for any medical complication was higher in underweight (0.5%), overweight (0.8%), obesity I (1%), II (1.7%), and III (1.7%) when compared to normal weight (0.3%, $p<0.001$). Incremental increases in the proportion of readmission, return to operating room, wound infection, and wound dehiscence were observed with each increase in BMI category ($p=0.001$). A multivariate regression model controlling for confounding variables including age, diabetes, ASA class, and operative time demonstrated a statistically significant increase in odds of complications in the obesity II (OR: 1.59, $p<0.001$) and obesity III (OR: 1.85, $p<0.001$). Age (OR 1.08, $p<0.001$), diabetes (OR 1.4, $p=0.016$), and increased operative time (OR 1.22, $p<0.001$) were independently associated with an increase in odds of surgical complications.

Conclusion: While the obesity II and III cohorts experienced increased odds of complications, the authors suggest that these complications are not prohibitive, and in the setting of a comprehensive informed consent conversation with patients, obesity alone should not act as a contraindication to surgery in suitable candidates.

THU-S2-T2: High and Low BMI Extremes are Both Associated with Increased Serious Complications After Transgender Phalloplasty

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Presented by: Lauren Sederholm

Introduction/Background: Phalloplasty is a complicated procedure performed for many reasons, frequently transmasculine gender embodiment. The phalloplasty surgical approach varies depending on patient needs, goals, surgeon skill and technique and involves complex decision-making. Gender affirming surgery is associated with reduced negative mental health outcomes despite complication risks. Phalloplasty patients report high satisfaction in spite of high complication rates.
Body mass index (BMI, measured in kg/m^2) cut-offs are often used in attempt to mitigate risk as high and low BMI is associated with comorbidities and complication risk. BMI is increasingly criticized as biased and a nonphysiologic measure of health. Currently the relationship between BMI and major surgical complications from phalloplasty is understudied.

Specific Aim: To examine the relationship between BMI and major phalloplasty complications among transgender patients at a dedicated gender affirming surgery center.

Materials and Methods: Data were gathered through retrospective chart review of 137 patients undergoing phalloplasty at the Crane Center from February 2021 to February 2023 with radial forearm (RFA), single-stage and delayed anterolateral thigh (ALT), and musculocutaneous latissimus dorsi (MLD) as flap donor sites. BMI was calculated primarily at preoperative visits. Major complications were defined as aborted procedure, return to operating room (OR) within 72 hours or 60 days of phalloplasty, non-viable flap removal, hospital readmission within 60 days of surgery, flap necrosis, ED visit, or major surgical site infections requiring readmission or return to OR.

Results: Data was evaluated based on RFA (n=92) or single-stage ALT (n=31) donor sites totaling 123 patients. Overall rates of major complication for the RFA and single-stage ALT cohorts was 24% and 29%

respectively.
After RFA, complications increased significantly in patients with BMI ≥37 [RR 2.7 (t = 0.032)]. After single-stage ALT, complication rates were 67%, 11%, and 60% in BMI <20, ≥20-29, and ≥29 respectively. Significantly increased complications were observed after single-stage ALT in patients with a low BMI <20 compared to BMI ≥20-29 (t= 0.0035) and with a higher BMI ≥29 compared to BMI ≥20-29 (t= 0.013).

Conclusion: A significant increase in major complication rates was observed for RFA phalloplasty patients with BMI ≥37. Major complication rates were also significantly increased in patients undergoing ALT phalloplasty at both low and higher BMI levels of <20 and ≥29, suggesting an "optimal" BMI between 20-28 for this procedure. Our data is consistent with prior literature indicating a relationship between both high and low BMI with surgical complications.
While extremes of BMI appear to correlate with higher complication rates after phalloplasty BMI alone is controversial and an inadequate measure of general health and should not be a sole criterion for restricting access to surgery. These data may be used to counsel patients on their expected relative risk of complication after phalloplasty and may spur further inquiry into potential mechanisms and therapeutic responses to this effect.

THU-S2-T3: NO BODY LEFT BEHIND: A RETROSPECTIVE COHORT STUDY EXAMINING BODY MASS INDEX AS A RISK FACTOR FOR RETURN TO THE OPERATING ROOM WITHIN 30 DAYS OF GENDER-AFFIRMING MASTECTOMY

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Presented by: Zilin Cui

Introduction/Background: Gender-affirming mastectomy (GAM) is a life changing procedure that is generally considered safe and can significantly improve quality of life. One of the most common factors precluding patients from surgical candidacy is body mass index (BMI). Some providers and institutions implement maximum BMI cutoffs, though there is no consensus for these limits and no prominent professional guidelines suggest an upper BMI limit. The literature on BMI and complication rates following GAM is mixed.

Specific Aim: We aim to evaluate the association between BMI and complications requiring return to the operating room (OR) within the first month following GAM.

Materials and Methods: Patients who underwent GAM between 2011 and 2021 at a tertiary health system were identified using a combination of CPT and ICD-10 codes. Exclusion criteria included history of radiation exposure or breast cancer, and incomplete charts. We collected information on demographics, BMI at the time of surgery, preoperative testosterone use, smoking status, mastectomy technique, American Society of Anesthesia physical status classification (ASA-PSC), and complications requiring return to the OR within 30 days. Logistic regression was used to determine if BMI or other recorded variables predicted return to OR independently. BMI was explored both as a continuous variable and as a categorical variable using standard cutoffs (<30, 30-35, 35-40, 40+). This study was granted exemption by the IRB.

Results:
1,013 patients were initially identified; 49 did not meet inclusion criteria. 964 patients were included in the final analysis. The average age was 25.9 years. 75% of the sample was white. Mean BMI was 27.2. 73.2% of patients had a BMI <30, 14.9% 30-34.9, 7.5% 35-40, and 4.4% >40. 79% of patients used testosterone preoperatively. 10% of patients smoked within 2 months of surgery. Most patients (77%) fell into the ASA 2 category. The majority (86%) of surgeries used double incision technique.

Logistic regression demonstrated that no variables were independently predictive of complications

requiring return to the OR. Variables investigated included age (OR = 1.03, 95% CI 0.99 - 1.07), race/ethnicity (OR = 1.24, 95% CI 0.24 - 5.04), BMI at time of surgery (OR = 0.98, 95% CI 0.92 - 1.04), preoperative testosterone use (OR = 1.93, 95% CI 0.67 - 5.50), smoking (OR = 0.91, 95% CI 0.27 - 3.04), ASA-PSC (OR = 0.52, 95% CI 0.25 - 1.07), and incision technique (OR = 1.04, 95% CI 0.35 - 3.02).

Conclusion: BMI was not associated with return to OR in 30 days. Our data adds to a growing body of research which suggests reconsidering BMI cutoffs in evaluating patients' surgical candidacy for GAM.

Limitations include documentation of postoperative care and an inability to assess care or scheduled revisions outside our institution. Furthermore, our sample was composed of only surgical candidates, introducing the selection bias of a healthier population. Future research should assess longitudinal patient outcomes and explore if BMI impacts other important parts of the experience, including satisfaction with cosmetic outcomes.

THU-S2-T4: THE EFFECT OF OBESITY ON VAGINOPLASTY OUTCOMES

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Presented by: Christian Lava

Introduction/Background: In the United States, 1.4 million people currently identify as transgender. Some surgeons employ body mass index (BMI) criteria within the patient selection processes prior to vaginoplasty, thereby limiting access to select obese patients. However, no studies have directly assessed the effect of obesity on outcomes following various vaginoplasty techniques, thereby precluding a standardized perioperative management approach among patients with obesity seeking vaginoplasty.

Specific Aim: The aim of this study is to better characterize the effect of obesity on postoperative outcomes across multiple vaginoplasty techniques.

Materials and Methods: A single-center retrospective review of all transfeminine patients undergoing primary vaginoplasty procedures from December 2018 to July 2022 was conducted. Patients were stratified into cohorts according to the World Health Organization Obesity Class criteria. Data regarding demographics, comorbidities, operative details, postoperative complications, and all-cause revision were collected.

Results: A total of 237 patients met inclusion criteria. Included patients had a median BMI of 27.1 kg/m^2 (IQR: 13) and comprised the following subgroups: 40.1% underweight/normal weight (n=95), 31.2% overweight (n=74), 21.1% class I obesity (n=50), and 7.8% class II/III obesity (n=18). Average follow-up duration was 9.1 ± 4.7 months. Multivariate regression revealed patients with class I and class II/III obesity were associated with higher odds of developing vaginal stenosis (class I: OR 7.1, p=0.003; class II/III: OR 3.4, p=0.018). Obesity class I and II/III remained positive predictors of all-cause revision (class I: OR 3.7, p=0.021; class II/III: OR 4.8, p=0.027). The most common short-term complication was delayed wound healing (n=102, 43.0%), which occurred more often among those patients who underwent penile inversion compared to zero depth, robotic intestinal, or robotic peritoneal (p<0.001). Undergoing either robotic peritoneal or robotic intestinal vaginoplasty was associated with lower odds of delayed wound healing (peritoneal: OR 0.2, p<0.001; intestinal: OR 0.2, p=0.011). Lastly, post-hoc pairwise analysis revealed that patients with class II/III obesity reported adherence to vaginal dilation regimen significantly less often than all other groups (underweight/normal weight: p<0.001, overweight: p=0.001, class I obesity: p=0.011). Adherence to dilation regimen was negatively associated with development of hematoma (OR 0.1, p=0.014) and vaginal stenosis (OR 0.04, p<0.001).

Conclusion: Patients with obesity may be at a higher risk of developing vaginal stenosis after vaginoplasty, which may ultimately necessitate operative revision. While patients with obesity may remain surgical candidates, proper preoperative counseling and adherence to postoperative vaginal dilation regimens are critical to optimizing outcomes.

THU-S2-T5: Body Mass Index Does Not Impact Complications, Revisions, or Patient Reported Outcomes Following Gender Affirming Mastectomy

Megan Lane[1], Cole Roblee[1], Tannon Tople[2], Alexander Khouri[1], Jennifer Hamill[1], Lauren Marquette[1], Jessica Hsu[1], William Kuzon[1], Edwin Wilkins[1], Shane Morrison[2]
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Presented by: Cole Roblee

Introduction/Background: Body Mass Index (BMI) is increasingly understood as a crude measure of medical comorbidity. BMI cutoffs in gender affirming surgery are a known barrier to surgical care, especially for patients who are at baseline risk for disordered eating. Previous literature suggests BMI has no significant effects on complications or revisions, but these studies lack patient reported outcomes assessments and sufficient numbers of patients with BMIs over 40. In this cross-sectional study, we aim to evaluate the effects of BMI on patient reported outcomes in gender affirming mastectomy.

Specific Aim: The aim of this presentation is to examine the impact of BMI and resection weight on clinical and patient reported outcomes following gender affirming mastectomy.

Materials and Methods: Individuals over the age of 18 who underwent gender affirming mastectomy from 1990-2020 at our institution were contacted for a cross-sectional survey including the BODY-Q and Gender Congruence and Life Satisfaction (GCLS) chest subscales, measuring chest-specific body image. A chart review was performed on all individuals, and demographics, complications, revisions, mastectomy approach, ASA class, and resection weight were collected. Bivariate analysis and logistic regression were performed to determine associations between complications, revisions, BMI categories, resection weights, and patient reported outcomes.

Results: A total of 227 individuals were eligible for the study of which 137 responded to the survey. The mean age was 29.1 (SD=9.0) and the mean BMI was 30.9 (SD=8.0), with 12.8% (N=29) of our cohort having a BMI>40. Most of the cohort (N=159, 71%) had an ASA class of 2 or higher. The median BODY-Q chest module score was 87 (IQR 73-100) on a 100-point scale and the median GCLS was 5 (IQR 4.75-5) on a 5-point scale. These did not vary significantly with BMI (BODY-Q p=0.68, GCLS p=0.87) or resection weight (BODY-Q p=0.45, GCLS p=0.09). Revisions were associated with lower BODY-Q (70 (IQR 53.5-83) vs 93 (IQR 73-100), p<0.01) and GCLS scores (4.75 (IQR 4.4-5) vs 5 (IQR 4.8-5) p=0.05).

A total of 41 individuals (18.1%) had a complication, with 16 (7.1%) requiring readmission and/or reoperation. Approximately 18% (N=41) of individuals underwent a revision. BMI (complications p=0.60, revisions p=0.50), ASA Class (complications p=0.67, revisions p=0.48), and resection weight (complications p=0.22, revisions p=0.22) did not effect rates of complications or revisions in bivariate analysis. Mastectomy through a periareolar incision was associated with a greater likelihood of later revision (p=0.01). After adjusting for age and resection weight, BMI had no significant effects on complication or revision rates.

Conclusion: In this single-center, cross-sectional study of gender-affirming mastectomies, chest-specific body image scores did not vary significantly by BMI or resection weight. Individuals with revisions reported poorer chest-specific body image. Similar to previous literature, BMI was not associated with higher complication or revision rates. Surgeons should re-evaluate the role BMI plays in patient selection and counseling.

THU-S3-M: A CLOSER LOOK AT BODY MASS INDEX REQUIREMENTS FOR GENDER-AFFIRMING SURGERIES

John Taormina[1], Michelle Cordoba-Kissee[2,3], Lisa Brownstone[4], Frances Grimstad[5,6], Avery Hendrixson[7], Sean Iwamoto[1,8]
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Presented by: John Taormina, Michelle Cordoba-Kissee, Lisa Brownstone, Frances Grimstad, Avery Hendrixson

Statement of Significance: Gender-affirming surgery (GAS) is life saving for many transgender and gender diverse (TGD) people. However, as many as one fourth of patients presenting for GAS consultations are denied because of elevated body mass index (BMI) (Martinson et al, 2020). TGD people have higher prevalence and odds of having obesity (BMI ≥ 30 kg/m^2) compared to the general population (Dragon et al, 2017; Brown et al, 2016). Gender-affirming hormone therapy (GAHT) is associated with increases in body weight; masculinizing GAHT is associated with increased lean and decreased fat mass and feminizing GAHT with the reverse changes (Klaver et al, 2017). Furthermore, socioeconomic inequities and gender minority stress contribute to disparities in healthful behaviors and worse health outcomes, indirectly contributing to obesity (Streed et al, 2021). For some TGD people, increased body weight may be gender-affirming in attaining their desired body contour (e.g., breast development) (Silva et al, 2021). Nonetheless, there is concern about the potential for obesity to exacerbate cardiometabolic risk trajectory (Pribish & Iwamoto, 2023).
Obesity is associated with higher rates of perioperative wound infection, venous thromboembolism and reoperation (Bigarella et al, 2022). Thus, surgeons commonly set BMI cutoffs (often 30 or 35 kg/m^2) that patients must meet prior to scheduling non-emergent surgeries, including GAS. Multiple small, retrospective studies have shown minimal or no difference in perioperative outcomes after GAS, leading some to question the validity of presurgical BMI requirements (Brownstone et al, 2021). These requirements can be discriminatory as strict BMI cutoffs may not be enforced for cisgender patients pursuing similar surgical procedures. Many call on surgeons to abandon BMI cutoffs given the significant mental health benefits of GAS (Almazan et al, 2021). In the meantime, TGD people deserve resources to address their unique needs in managing their weight. This includes mental health resources with experience working with TGD patients; inclusive and safe spaces to engage in physical activity; and appropriate social services, if needed. For many patients, reaching presurgical BMI targets will also require medication and/or surgery as adjunctive treatments for weight loss. Appropriate and affirming weight management interventions for TGD patients have yet to be determined and require further investigation (Martinson et al, 2020)
This symposium fits USPATH's Interdisciplinary Approaches focus with diverse perspectives on BMI requirements for GAS from endocrinology, obesity medicine, behavioral health, and surgery. Importantly, a patient's lived experience will be featured to illustrate meeting presurgical BMI requirements from their perspective. The session will provide discussion on the unique barriers and needs faced by TGD people in pursuing weight loss, the current evidence regarding weight management interventions for TGD patients pursuing GAS, and the need for future research in this area.

Learning Objective 1: Examine the evidence for and against enforcing BMI requirements for GAS.

Learning Objective 2: Understand the contributors to weight gain and barriers to weight loss/management in TGD people.

Learning Objective 3: Describe the unique needs of TGD people pursuing weight management prior to GAS.

Method to Achieve Learning Objectives: Panel discussion providing perspectives from multiple disciplines on BMI requirements for GAS from multiple disciplines.

Presentation of a first-hand patient case.
Question and answer period.

THU-S4-T1: LONG TERM FATE OF TESTIS PROSTHESIS AFTER METOIDIOPLASTY AND PHALLOPLASTY

Brenna Briles[1], Curtis Crane[2], Richard Santucci[2]
[1]Baylor College of Medicine, Houston, TX, USA, [2]Crane Center for Transgender Surgery, Austin, TX, USA

Presented by: Brenna Briles

Introduction/Background: Testicle prostheses are a common component of masculinizing genital gender affirmation surgery, metoidioplasty and phalloplasty. Few studies have examined complications associated specifically with testicle prostheses, but existing data report replacement due to factors including infection, extrusion, leakage, malpositioning, urinary obstruction, and discomfort.

Specific Aim: The purpose of this study is to identify specific complications, either self-resolving or requiring surgical management, associated with testicle prosthesis at our dedicated transgender surgery center, over a long follow up period exceeding 5 years.

Materials and Methods: We conducted a retrospective chart review of all transmasculine patients undergoing testicular implants after metoidioplasty or phalloplasty between January 2016 to November 2019, stopping the series in 2019 to allow at least 3 year follow up.

Results: : 23 patients were identified, 16 (70%) of whom had a prior metoidioplasty and 7 (30%) with prior phalloplasty receiving only testicular implants (no penile implant). The average follow up period was 5.25 years (range 3.11-7.06 years). Average patient age at implantation was 44 years (range 22-62), an average of 0.85 (range 0.67-1.148) years after metoidioplasty or phalloplasty. Types of implants used included AART size #1 silicone (15, 65%), AART size #2 silicone (1, 5%), Coloplast Torosa saline-filled (3, 13%), and unknown (4, 17%). 20 (87%) patients received bilateral implants while three (13%) received unilateral. Four (17%) patients experienced a scrotal wound, either minor epidermal loss or a small eschar, on the scrotum that required no intervention. Zero patients experienced scrotal wounds requiring surgical or bedside debridement. Zero patients experienced prosthesis infection, extrusion, or implant leakage. One patient (0.04%) had their implant replaced due to malpositioning and went on to have a second implant placed without complications.

Conclusion: Amongst patients at our center, few experienced complications with testicle prostheses. The outcomes of testicle implants in our cohort compare very favorably to published reports.

THU-S4-T2: Restless Genital Syndrome in Transgender Women Post Male-to-Female Sex Affirmation Surgery: Two Case Reports

Krerkwit Visitsakulchai[1], Thiti Chaovanalikit[2]
[1]Ratchaphiphat Hospital, MEDICAL SERVICE DEPARTMENT BANGKOK METROPOLITAN ADMINISTRATION, Bangkok, Thailand, [2]Lerdsin Hospital, Bangkok, Thailand

Presented by: Krerkwit Visitsakulchai

Introduction/Background: Restless Genital Syndrome (RGS), also known as Persistent Genital Arousal Disorder (PGAD) is a condition characterized by persistent, physiological genital excitation in the absence of subjective sexual arousal. Symptoms are intrusive, unwanted, and persist even after orgasm(s). No case reports of Restless Genital Syndrome (RGS) have been identified in transgender women who have undergone male-to-female sex affirmation surgery

Specific Aim: We present a report of two cases of Restless Genital Syndrome (RGS) in transgender women who underwent male-to-female sex affirmation surgery

Materials and Methods: Case 1: A 35-year-old Thai transgender woman, 11 years post male-to-female sex affirmation surgery, reported a daily burning sensation or arousal at the clitoris, scoring 9-10/10 on a visual analog scale. These symptoms significantly disrupted her daily life, with no relief from medication. Case 2: A 29-year-old Chinese transgender woman, following primary colovaginoplasty, experienced persistent clitoral traction at the left side, beginning approximately three weeks post-surgery

In the given cases, where Restless Genital Syndrome (RGS) symptoms were reported as severe (scoring 9 or 10 out of 10 on the visual analog scale), interventions targeting nerve blockage were attempted to provide pain relief. Specifically, in case one, the dorsal nerve of the clitoris was blocked, while in case two, the pudendal nerve was targeted. Following the nerve block procedures, pain scores decreased significantly to 2 or 3 out of 10.

Results: In the presented cases, Neurectomy was performed on both the dorsal nerve of the clitoris in case 1 and pudendal nerve ablation in case 2 as a treatment for Restless Genital Syndrome (RGS) symptoms. Following these procedures, the patients experienced relief from their symptoms, and the symptoms did not return.

Conclusion: Restless Genital Syndrome (RGS) in transgender women post male-to-female sex affirmation surgery is often caused by operative trauma and significantly disrupts daily life. Medication interventions have limited success, and surgical resection or nerve ablation may be potential solutions to provide relief. However, further research is needed to evaluate the long-term outcomes and safety of these surgical interventions. Collaborative care involving experienced healthcare professionals is crucial to address RGS in this population.

THU-S4-T3: MANAGEMENT STRATEGIES FOR COMPLICATIONS IN FACIAL FEMINIZATION SURGERY: A SYSTEMATIC REVIEW OF CURRENT APPROACHES

Julian Marable[1], Christian Lava[1,2], Samuel Huffman[1,2], Karen Li[1,2], Kenneth Fan[2], Gabriel Del Corral[3]
[1]Georgetown University School of Medicine, Washington, DC, USA, [2]MedStar Georgetown University Hospital, Washington, DC, USA, [3]MedStar Franklin Square Medical Center, Baltimore, MD, USA

Presented by: Julian Marable

Introduction/Background:
Facial feminization surgery (FFS) plays a pivotal role in the gender affirmation process for transfeminine patients. While it has relatively low reported complications, there is a lack of literature and standardization of perioperative management guidelines for these complications.

Specific Aim: Thus, this study aims to summarize the best available evidence for the prevention and management of complications associated with FFS in transfeminine patients.

Materials and Methods:
A comprehensive literature search was conducted in electronic databases, including Ovid MEDLINE, Ovid EMBASE, Cochrane, and Web of Science, for articles pertaining to prevention and management of postoperative complications associated with FFS. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed. Data pertaining to study and patient characteristics, details of FFS, types and frequencies of complications, and management strategies were collected. Complications and management strategies were further categorized by upper, middle, and lower thirds of the face.

Results: Of the 168 citations initially screened, a total of 27 articles representing 2,352 patients and 6,244 surgeries were included for analysis; of which 1,406 (23%), 1,270 (20%), and 3,568 (57%) surgeries were performed in the upper, middle, and lower thirds of the face, respectively. By a mean

follow-up period of 20 months, 16 (59%) studies reported complications and 14 (52%) studies discussed management of FFS complications. Of the 23 (85%%) articles that discussed upper face surgeries, the most common complications reported were infection (n=77 patients), nerve hypoesthesia (n=16 patients), and contour abnormalities (n=9 patients). Management of infection and contour irregularities included antibiotics (n=4 patients) and revision surgery (n=4 patients). Nerve sensation returned spontaneously in all patients. Of the 14 (52%) articles that discussed middle face surgeries, hematoma (n=7 patients) and infection (n=7 patients) were the most common complications reported. Management included drainage (n=3 patients) and implant removal (n=2 patients). Of the 17 (63%) articles that discussed lower face surgeries, nerve hypoesthesia (n=154 patients), contour abnormalities (n=24 patients), and infection (n=12 patients) were the most common complications reported. Management included revision surgery (n=23 patients), antibiotics (n=6), and washout (n=2). All patients reported spontaneous resolution of nerve sensation.

Conclusion:
Our findings highlight the importance of infection control and close monitoring postoperatively in transfeminine patients after FFS. Management requires early identification, proper treatment, and maximal alignment with patient goals, which can be better achieved through the standardization of management protocols. Additionally, further action by plastic surgeons may be warranted particularly in the management of residual contour abnormalities in order to best achieve patient satisfaction with FFS.

THU-S4-T4: THE FALL OF THE NEOPHALLUS: A SYSTEMATIC REVIEW AND META-ANALYSIS OF PENILE PROSTHESIS COMPLICATIONS IN TRANSMASCULINE PATIENTS

Elad Fraiman[1,2], Devika Nandwana[1,2], Kelly Chambers[1,2], Stephen Rhodes[2], Rachel Pope[1,2], Kirtishri Mishra[1,2], Shubham Gupta[1,2]
[1]Case Western Reserve University School of Medicine, Cleveland, OH, USA, [2]University Hospitals Urology Institute, Cleveland, OH, USA

Presented by: Elad Fraiman

Introduction/Background: If the early stages of phalloplasty are successful, patients may receive a penile implant to aid in erectile function and insertive intercourse. Existing studies of complication rates after penile implants in trans men are small; therefore, there is a need to synthesize the results across studies. The prosthesis type or primary phalloplasty donor site that yields the fewest complications is unknown.

Specific Aim: To synthesize current literature on penile prosthesis implantation post-GAS to assess complication rates and explanation and how these vary with implant type.

Materials and Methods: A meta-analysis was initiated in December 2022. Inclusion criteria encompassed randomized clinical trials, cohort studies, and cross-sectional studies reporting on penile prosthesis complications post-GAS that reported complication rates separately for different implant types. An initial search of five databases yielded 1593 articles. Ten studies were included in the meta-analysis. Complication rates as a function of prosthesis type were synthesized via mixed effects meta-analysis. The prosthesis type was included as a predictor to test for a difference in complication rates. Study level differences were modeled via a random effect. Differences in complication rates between prosthesis types and residual heterogeneity in complication rates between studies were both assessed via Q tests. Time-to-complication was assessed for studies reporting individual-level follow-up times.

Results: The total number of patients who received inflatable prostheses was 550, and for malleable was 97. The overall meta-analytic complication rate for the inflatable group was 0.38 (95% CI: 0.21, 0.59), and for the malleable group was 0.37 (95% CI: 0.18, 0.62). The most probable complications in the inflatable group were infection (0.145), dysfunction (0.129), dislocation (0.057), and leakage (0.054). The most probable complications in the malleable group were dislocation (0.149), infection (0.112), dysfunction (0.091), and extrusion (0.076). There was no significant difference in the probability of complications between the groups.

The best estimate of explantation rates for any reason for the inflatable group was 0.19 (95% CI: 0.09, 0.38), and for the malleable group, 0.13 (95% CI: 0.04, 0.33). In a Cox Proportional-Hazards model, the explantation rate does not significantly differ for malleable vs. inflatable prostheses (HR = 0.97, 95% CI [0.50, 1.88], p = 0.93).
Kaplan Meier curves showed considerable uncertainty in the survival curve for an inflatable prosthesis (n=21) relative to malleable (n=41), and there is no clear indication that the curves differ.

Conclusion: Our best estimates of complication rates for penile prosthesis after GAS are roughly 20-60%. The most common types of complications were infection, dislocation, and dysfunction. There were no significant differences in either overall or specific complication rates, explantation rates, and survivability of prosthesis between the inflatable and malleable prosthesis groups.
Limitations of this analysis include the lack of background information (ie. medical comorbidities) reported by the studies, the lack of data poised to compare prosthesis complication rates among different phalloplasty flap types, and the lack of individual participant data or reporting of Kaplan Meier survival curves.

THU-S4-T5: ENHANCED RECOVERY PROTOCOL DECREASES POSTOPERATIVE OPIOID USE AFTER PENILE INVERSION VAGINOPLASTY

Vahe Fahradyan, Daniel Leon, Nicole Sanchez, Diego Gomez, Jorys Martinez-Jorge
Mayo Clinic, Rochester, MN, USA

Presented by: Vahe Fahradyan

Introduction/Background: Penile inversion vaginoplasty has high patient satisfaction rates but is associated with significant post operative pain and opioid use after surgery.

Specific Aim: To compare levels of self-reported pain and opioid use between two groups of patients receiving different pain management protocols after penile inversion vaginoplasty in a single institution.

Materials and Methods: The study was approved by Mayo Clinic IRB. A retrospective chart review was performed for transgender patients who underwent gender-affirming primary penile inversion vaginoplasty at a single institution. The study excluded patients who underwent minimal-depth vaginoplasty or revision cases. Pain levels were assessed by plastic surgery nurses on the surgical floor using the *Numeric Pain Rating Scale*. The amount of narcotic medication used orally and intravenously were recorded during the hospitalization, hospital length of stay was also reported. The average and maximum pain reported by patients were calculated per day and per hospital stay. The total amount of narcotics the patient received in the postoperative period was converted to Morphine Milligram Equivalents (MME). The Kolmogorov-Smirnov test was conducted to evaluate the distribution of the sample. If the sample proves to be normally distributed, a parametric test like Student's T-test would be used to compare both the reported pain levels as well as the total narcotic used.
The study compared two groups of patients who received different postoperative pain management protocols(Group A and Group B). Group A patients received standard post-operative analgesics: Oral acetaminophen, oral PRN narcotic, and intravenous PRN narcotic. Group B patients received an enhanced recovery protocol: Oral acetaminophen, oral PRN narcotic, and intravenous PRN narcotic, and additionally ketorolac, gabapentin, and celecoxib.

Results: Fifty patients underwent PIV within study period. The average hospital length of stay for all patients was 4.92 days (±0.237). Group A had a slightly longer average stay of 5.0769 days, with a lower standard deviation (±0.215) compared to Group B, which had an average stay of 4.75 (±0.429). The average level of postoperative pain for all patients was 4.2474 (±0.418) on a scale of 0 to 10. Group A had a slightly higher average pain level of 4.28 (±0.579), while Group B had a slightly lower average pain level of 4.2121 (±0.618). The maximum level of postoperative pain experienced by any patient was 7.8 (±0.423). Group A had a slightly higher maximum pain level of 7.8462 (± 0.602), while Group B had a slightly lower maximum pain level of 7.75 (±0.604). Kolmogorov-Smirnov test showed that the sample data is not significantly different from a normally distributed population (P= 0.9715). While overall reported

pain levels did not vary significantly between the two groups (P >0.05), there was a significant decrease in MMR used in the enhanced recovery protocol group (group A – mean 271 MME, group B – mean 138 MME).

Conclusion: Despite the overall high patient post-operative satisfaction, patients can experience significant post-operative pain after surgery which may lead to high levels of post-operative opioid use. This study highlights the effectiveness of non-opioid medications used in the immediate post-operative setting in significantly decreasing opioid use following penile inversion vaginoplasty.

THU-S4-T6: EFFECT OF REDUCING THE USE OF OPIOID MEDICATIONS ON POST OPERATIVE PAIN CONTROL AND RECOVERY FOLLOWING CHEST RECONSTRUCTION SURGERIES (TRANSGENDER TOP SURGERIES)

Ashu Garg, E. Antonio Mangubat
La Belle Vie Cosmetic Surgery Center, Tukwila, WA, USA

Presented by: Ashu Garg

Introduction/Background: Multimodal pain management techniques offer an effective approach to minimize opioid usage after surgery. This method combines various pain management strategies, including tumescent regional anesthesia during the operation, non-opioid pain medications, and Gabapentin for immediate postoperative neuropathic pain modulation. Implementing a multimodal analgesia regimen with reduced opioids brings several advantages to patients, such as improved pain control, increased satisfaction, enhanced physical function and mobility, as well as cost savings. By reducing opioid doses, patients can avoid adverse effects like nausea, constipation, drowsiness, tolerance, respiratory depression, and the risk of overdose.

Specific Aim: Opioids dose can be reduced or eliminated without affecting pain control, quality of recovery and recovery time. Use of tumescent anesthesia almost eliminates the pain for several hours in the immediate and early postop period, eliminating the typical postoperative spike in pain experienced on emergence from anesthesia that requires opioid analgesia. Concomitant use of NSAIDS and neuropathic pain modulator can help in decreased demand for opioids in both early and late post op period without affecting quality of pain control

Materials and Methods: A retrospective study was conducted, focusing on a homogeneous group of transgender patients who underwent FTM top surgery. Patient data was gathered through chart reviews. In the previous pain management approach, 45 subjects received regular doses of opioids as their main analgesic. In contrast, the new pain control regimen (multimodal analgesia) involved 45 subjects who were prescribed Gabapentin, Celebrex, and acetaminophen for primary pain management. Patients in this group were prescribed 20 tablets of Oxycodone and instructed to use it solely for breakthrough pain.

Results: Group 2 patients reported superior pain control and higher satisfaction levels compared to those who solely received higher opioid doses. The study findings indicate that the combination therapy of gabapentin, NSAIDs, and opioids is effective in managing postoperative pain, reducing the need for opioids and minimizing adverse effects. The prescribed opioids were specifically used for breakthrough pain, optimizing their efficiency. This combined approach is especially beneficial for patients at higher risk of opioid-related complications, including respiratory depression and constipation.

Conclusion: Multimodal analgesia, including Gabapentin, Celebrex, and acetaminophen, effectively eliminates opioid use for over 50% of patients undergoing chest reconstruction surgery. The remaining 50% require significantly reduced opioid doses, resulting in a 50% decrease in prescriptions. This reduction offers numerous benefits, such as improved pain management, increased patient satisfaction, and a reduced risk of opioid side effects like constipation and drowsiness. While multimodal analgesia successfully reduces opioid reliance in the postoperative period, opioids still have a role in managing breakthrough pain that non-opioid methods may not adequately address. Overall, this approach

represents significant progress in minimizing or eliminating opioid dependence after surgery, ensuring effective pain control and greater patient contentment.

THU-S4-T7: CORRELATION BETWEEN SIGNIFICANT POSTOPERATIVE BLEEDING AND REVISION SURGERY IN VAGINOPLASTY: A RETROSPECTIVE ANALYSIS

Subha Karim[1,2], Helen Liu[1], Uchechukwu Amakiri[1], Joshua Safer[1,2], John Pang[1,3], Jess Ting[1,2]
[1]Icahn School of Medicine at Mount Sinai, New York, NY, USA, [2]Center for Transgender Medicine and Surgery at Mount Sinai, New York, NY, USA, [3]Align Surgical Associates, San Francisco, CA, USA

Presented by: Subha Karim

Introduction/Background: Postoperative bleeding is a major complication that can occur in vaginoplasty patients, which can potentially lead to the need for revision surgery.

Specific Aim: This abstract aims to investigate the correlation between postoperative bleeding and the subsequent occurrence of revision surgery in patients who have undergone vaginoplasty, and the risk factors that may cause it.

Materials and Methods: A retrospective cohort study was performed on 714 patients who received their primary vaginoplasty at an academic medical institution's center for transgender medicine and surgery between March 2016 to August 2021. Chart review was performed to collect demographic information such as age, body mass index (BMI), and race was also collected. Differences between cohort characteristics were analyzed using excel.

Results: Patients who had a history of significant postoperative bleeding had a higher rate of receiving revision vaginoplasty surgery than those who did not. 19 patients out of the total cohort were identified to have had significant bleeding and an emergency department (ED) readmission post vaginoplasty that required an unplanned return to the OR. Out of those 19 patients, 12 (63%) received revision surgery compared to only 14% of non-postoperative bleeding patients that required revision surgery. Among the revision patients who had post-operative bleeding, they had a medical history that included higher rates of anticoagulant use, bleeding disorders, cardiac disease, and previous pelvic surgery.

Conclusion: Among patients who received vaginoplasty, those who experienced postoperative bleeding had a higher rate of undergoing revision vaginoplasty compared to those who did not encounter those complications. This analysis allows for valuable insight into the management of postoperative bleeding and its impact on long-term surgical outcomes. These findings will be able to inform future surgical decision-making, optimize patient care, and enhance the overall success of vaginoplasty procedures.

Friday, November 3, 2023

9:45am - 11:00am

Mini Symp: Health Services and Systems

FRI-A1-M: BIOPSYCHOSOCIAL FOR REAL: INTEGRATING INTEGRATED HEALTH CARE

Whit Ryan[1], Carla Schnitzlein[2], Sarah Gromko[2], Megan Brennick[2]
[1]Connecticut Children's Medical Center, Hartford, CT, USA, [2]Hartford Healthcare, Hartford, CT, USA

Presented by: Whit Ryan, Carla Schnitzlein, Sarah Gromko, Megan Brennick

Statement of Significance:
"Integrated health care" is a term that has grown in popularity, in the literature, and in medical-model language. This multi-disciplinary group composed of psychiatry, psychology, occupational therapy (OT),

and speech therapy (ST) practitioners explores what an integrated approach can mean for transgender, non-binary, and gender expansive (TNBGE) individuals. Too often, integrated care takes the form of placing referrals and hoping for the best, leaving interdisciplinary services poorly understood and underutilized. In our model, we use multicultural, person-first approaches and emphasize individual needs and close collaboration between professionals, our patients, and their ecological systems. With changes to the WPATH's requirements surrounding biopsychosocial evaluations, we have begun collectively interrogating what the term can mean outside a lens of pathology; rather within a desire for understanding a human system. In this presentation, we ask a deceptively simple question, "what can it mean for our patients (and ourselves) when we truly collaborate on providing care?"

Rehabilitative service professionals can work with TNBGE patients towards individualized goals as diverse as non-surgical body modification, minimization of vocal distress, recovery after gender affirming surgeries or other care needs. Psychology and psychiatry work in concert to provide non-stigmatizing psychopharmalogical and mental health support throughout our patients' journeys. Often, our services afford us the most frequent and longest access to patients and we can become the backbone of holistic health for them. We contemplate best methods for incorporating rehabilitative services, psychology, and psychiatry into complex case presentations and dismantling harmful hierarchies among care providers in light of benefits and insight gained from collaborative, integrated biopsychosocial health care.

This group models an interdisciplinary approach that includes occupational therapy, speech therapy, psychology, psychiatry, and primary care. This approach opens up avenues of exploration and curiosity for us and for our mutual patients. Drawing on lived experience as providers and receivers of care, implementation of best-practices, understanding of current research, and approaches rooted in cultural humility, we question the history, discuss the present, and contemplate the future of care for and with TNBGE individuals. Rooted in case studies, this panel provides insight into the use of services that can be critical in creating a sense of psychological and physical safety and bravery as individuals travel their unique gender journeys.

Learning Objective 1: Provide at least one answer to the question, "what can it mean for our patients (and ourselves) when we truly collaborate on providing care?"

Learning Objective 2: Identify services occupational and voice therapy can provide in the care of transgender, non-binary, and gender expansive individuals

Learning Objective 3: Engage with curiosity about the nature of collaborative, holistic support of individuals across all gender presentations

Method to Achieve Learning Objectives: This panel, composed of providers from psychiatry, psychology, occupational therapy (OT), and speech therapy (ST), will lead a discussion that demonstrates the importance of integrated care that includes rehabilitation services. Each service will describe best practice for consultation and therapies and treatments they can provide for transgender, non-binary, and gender expansive (TNBGE) individuals. There will be conversation around how these teams work collaboratively. Time will be left for questions to allow vibrant discussion.

Poster: Research Methods (e.g., CBPR, measurement, epidemiology)

FRI-B1-T1: STORIES VS STATISTICS: WHAT TRANSGENDER YOUTH, PARENTS AND ADULTS WANT TO KNOW. A QUALITATIVE STUDY ON UNMET RESEARCH NEEDS

Danielle (Dani) Loeb[1,2], Natalie Nokoff[2,3], Sean Iwamoto[2], Leah Foster[4], Lindsey Warner[2]
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Presented by: Danielle (Dani) Loeb

Introduction/Background: A growing awareness surrounds the critical need for more robust research and evidence to guide gender-affirming healthcare. Clinicians and researchers often determine research priorities. Transgender and gender diverse (TGD) people and their families are best positioned to set this research agenda though we lack these critical perspectives.

Specific Aim: To illicit insights on a research agenda from the perspective of the TGD community and their families.

Materials and Methods: IRB-approved electronic surveys were sent to 2273 patients who sought care from the TRUE Center for Gender Diversity at Colorado Children's Hospital (TRUE) and University of Colorado Hospital Integrated Transgender Program (UCHealth ITP) in the last year. Participants were asked to rank the importance of research topics (qualitative questions) and to share their opinions in free text on research priorities in general and on the following topics: gender-affirming hormone therapy and side effects; gender-affirming surgeries; mental health; experiences with healthcare, work, and school; spiritual care (adults only). We conducted an inductive, participatory, team-based qualitative analysis of the free text answers. One researcher initially coded all answers; a second researcher reviewed all quotes and proposed modifications to the codes; then, multiple group discussions led to the development of the conceptual model.

Results: 414 individuals (219 and 195 responses from TRUE and UCHealth ITP, respectively) consented and responded to the survey (18% response rate). Respondents were largely under 30, white/ non-Hispanic, with a wide range of gender identities (Table 1).
We developed a conceptual model of TGD patients and families' priorities on both research topics and modalities. (Figure 1) Two primary themes emerged: 1) research on quantifiable outcomes (Quantitative) of gender-affirming treatments at the population level, 2) a need for narrative of TGD people and/ or families who have gone through similar experiences (Lived experience). One example of a request for a more narrative approach from a patient age 40-49: "The 'I can't put it into words,' demedicalized aspects of gender-affirming care, that doesn't necessarily focus on cause and effect." Respondents described the need for a better understanding of both Quantitative and Lived Experience outcomes for gender-affirming medical, surgical, and mental health care (Healthcare Environment). The Lived Experiences topics included healthcare and daily lived experiences (Larger Context) of TGD people. The Larger Context included questions regarding TGD people's sense of gender and sexual orientation identity and self-concept, and how they intersect and evolve with gender-affirming treatments (Self-Concept); their relationships with family, intimate partners and work (Relationships); and their experiences dealing with bias within their families, at work, and in society (Minority Stress).

Conclusion: The TGD community's research priorities should be used to inform TGD health funding and researcher priorities to ensure that research evidence leads to improvements in patient-centered gender-affirming care. Respondents expressed a desire for research based on the lived experiences of TGD people, consistent with phenomenological approaches that center the TGD community. Research on Lived Experiences may serve a therapeutic role for TGD people by offering insights into shared life challenges, coping strategies, and acquired knowledge.

FRI-B1-T2: FLUIDITY IN GENDER IDENTITY AND SEXUAL ORIENTATION IDENTITY IN TRANSGENDER AND NONBINARY YOUTH: IMPLICATIONS FOR RESEARCH AND CLINICAL PRACTICE

Sabra Katz-Wise[1,2,3], Lynsie Ranker[1,4], Aidan Kraus[5], Yu-Chi Wang[1,2,6], Ziming Xuan[4], Jennifer Green[5], Melissa Holt[5]
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Presented by: Sabra Katz-Wise

Introduction/Background: Transgender and nonbinary youth (TNBY) are at greater risk than their cisgender peers for adverse health outcomes, but research and clinical practice are often limited by a lack of understanding about gender identity (GI) and sexual orientation identity (SOI) fluidity. In part, these limitations stem from studies typically assessing GI and SOI at a single time point (e.g., in cross-sectional studies, or restricted to baseline measures in longitudinal studies). Prior research finds that youth commonly report changes in both GI and SOI, but such changes have rarely been studied in TNBY. Prior research with cisgender youth has typically examined change over multiple years, potentially missing change that may happen more frequently across smaller time periods. Documenting GI and SOI changes among TNBY, and particularly changes that may occur within a short timeframe, is important for understanding identity transition and supporting the needs of TNBY.

Specific Aim: The aim of this study was to examine the frequency and patterning of changes in GI and SOI among TNBY across short and long timeframes.

Materials and Methods: This study examined frequency of GI and SOI fluidity and patterning of changes across a short timeframe (3 months; T1 to T2) and a long timeframe (1.5 years; T1 to T4) among 183 TNBY (baseline age 14-17 years; 83.6% white, 16.9% Hispanic/Latinx) who participated in a longitudinal study of TNBY living in the United States. Participants completed online surveys at each timepoint, including measures of GI and SOI.

Results: The most common GI selected at baseline T1 (with or without another gender identity) was nonbinary (56.3%), and more than half (57.4%) of youth identified with a plurisexual identity (e.g., bisexual, pansexual). GI fluidity from T1-T2 was 13.2% and from T1-T4 was 28.9%. It was equally common to move toward a nonbinary gender identity as toward a binary gender identity. SOI fluidity was more common (30.6% from T1-T2; 55.8% from T1-T4) than GI fluidity. Shifts toward plurisexual identities were more common than shifts toward monosexual identities (e.g., straight, gay). Compared to T1 SOI, 8.7% moved toward an asexual spectrum identity at T2, 8.2% toward a plurisexual identity, and 8.2% toward questioning/unsure. Movement toward a monosexual identity was least common (5.5%). Compared to T1, 13.7% reported a sexual orientation identity at T4 that suggested a shift toward plurisexual identity.

Conclusion: The majority of TNBY did not change their GI or SOI over time; however, some TNBY did experience change in GI and/or in SOI. Findings highlight the need to assess GI and SOI more than once in research and clinical practice to understand how identities develop and change over time, to affirm such changes for TNBY, and to address the unique health needs of TNBY accurately and effectively.

FRI-B1-T3: TOWARD THE CONCEPTUALIZATION AND MEASUREMENT OF TRANSPHOBIA-DRIVEN INTIMATE PARTNER VIOLENCE: MAPPING SUBDOMAINS AND ASSESSING CURRENT SCALES

Beth Maclin[1,2], Sarah Peitzmeier[3], Natalie Krammer[3], Kieran Todd[3,4], Erin Bonar[3], Kristi Garamel[3]
[1]University of Pittsburgh, Pittsburgh, PA, USA, [2]George Washington University, Washington, DC, USA, [3]University of Mighigan, Ann Arbor, MI, USA, [4]Harvard University, Cambridge, MA, USA

Presented by: Beth Maclin

Introduction/Background: Transgender (trans) people face high rates of violence, including unique forms of abuse from intimate partners that specifically leverage transphobia. Past qualitative studies have explored this type of abuse, however, none have done so with the explicit intention of new scale development to quantitatively measure this phenomenon.

Specific Aim: The goals were two-fold: 1) to qualitatively map out the subdomains and boundaries of transphobia-driven IPV, a new term we propose to replace prior terms in the literature including trans-specific IPV and transgender IPV; and 2) to examine the degree to which existing trans-focused IPV scales adequately measure the construct.

Materials and Methods: The Empower study recruited English-speaking trans and gender diverse survivors of IPV, aged 18 years and older, who were residing in the United States, online through community-based organizations and Facebook/Instagram advertising. Twenty survivors representing diverse gender identities, racial and ethnic identities, and ages participated. In-depth interviews were conducted via Zoom by a trans/nonbinary interviewer using an online life-history calendar method. Multiple members of the research team took part in developing the codebook, coding, and conducting the thematic analysis of the interview transcripts.

Results: We identified four subdomains of transphobia-driven IPV: pressure to perform, disrupting gender affirmation, belittling gender identity, and intentional misgendering. When examining eight existing scales and measures that ask about IPV related to the survivor's trans identity, only one measure included questions related to all four subdomains. Further, the existing measures are either not psychometrically validated, only validated with a subpopulation of the trans community, or validated with a larger LGBT sample of which trans survivors made a small percentage.

Conclusion: This study highlights the need for new measures of transphobia-driven IPV that reflect all of the ways in which transphobia can be leveraged by abusers. Building from the existing research, new measures must be validated across subpopulations of the trans community in order to enhance content validity and assess the psychometric performance of the scales.

FRI-B1-T4: THE TRANS-SAFE PATIENT SAFETY LEARNING LAB: A FIVE-PHASE SYSTEMS ENGINEERING METHODOLOGY FOR IMPROVING PSYCHOSOCIAL SAFETY IN TRANSGENDER CARE

Kyle Okamuro[1], Alan Card[1], Jamie Finegan[1], Jill Blumenthal[1], Ravi Iyengar[1], Amanda Gosman[1], Jejo Koola[1], Maja Marinkovic[1], Tara Cohen[2], Jennifer Anger[1]
[1]University of California, San Diego, San Diego, CA, USA, [2]Cedars-Sinai, Los Angeles, CA, USA

Presented by: Kyle Okamuro

Introduction/Background: Transgender and nonbinary (TGNB) people experience worse mental and physical health outcomes compared to the general population. They are also vulnerable to marginalization and discrimination in healthcare settings, being consistently misgendered and mistreated—often as a latent design feature of health services. This breakdown in care may lead to direct psychosocial harm as well as secondary patient safety concerns.

Specific Aim: We received funding to create a Patient Safety Learning Lab (PSLL) funded by the Agency of Healthcare Research and Quality (AHRQ). Herein we delineate the proposed PSLL methods. Our ultimate goal is to improve the safety of healthcare for the TGNB population by identifying contributing factors to patient suffering, co-designing human-centered solutions, and evaluating the effectiveness of these solutions in simulated and real clinical environments. This four-year grant also included a scholarship program through WPATH.

Materials and Methods: Our study will employ a five-phase systems engineering methodology. Phase I (Problem Analysis) will utilize a multimodal approach consisting of a systematic scoping review, observations and interviews of patients and providers, process mapping, and systems analysis to identify sources of avoidable TGNB patient suffering. Phase II (Design) will apply participatory design tools and draw upon the Process for Active Risk Control (PARC) framework to produce interventions that address sources of avoidable patient suffering. Phase III (Development) will scale up the fidelity and scope of the design process, using iterative design and Plan-Do-Study-Act cycles to optimize the interventions. Phase IV (Implementation) will implement the developed interventions, employing human factors methods to facilitate adoption and sustainment. Phase V (Evaluation) will conduct a comprehensive mixed-methods evaluation of the final interventions, incorporating the Revised Eisenberg Pyramid framework to assess impacts on knowledge, policies, procedures, tools, real-world practice, and outcomes.

Results: Our results will elucidate contributing factors to avoidable patient suffering in TGNB healthcare interactions, lead to the development and implementation of interventions that address these factors, and evaluate the effectiveness of implemented interventions. As part of this we seek to develop TRANS-SAFE certification processes for healthcare systems, in collaboration with the WPATH Global Education Institute. We will also foster the development of TGNB research in the field of health services research.

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FRI-B1-T5: CREATING AN EVIDENCE-BASED TRAUMA-INFORMED APPROACH TO RESEARCH WITH TRANSGENDER AND NON-BINARY INDIVIDUALS

Augustus Klein[1,2], Sarit Golub[1,2], Amiyah Guerra[1], Alexander Harris[1], Lila Starbuck[1], Danielle Berke[2], Elijah Castle[1]
[1]Hunter Alliance for Research & Translation at Hunter College, New York, NY, USA, [2]Hunter College, City University of New York, New York, NY, USA

Presented by: Augustus Klein

Introduction/Background: Over the past two decades, transgender and non-binary individuals (TGNBI) have received increasing attention within HIV research. Such research has consistently documented the pervasive role stigma plays in creating and sustaining health inequities among this population. However, this research proliferation has also raised questions about practices that may unintentionally stigmatize or retraumatize the very communities they are designed to benefit. Little, if any, research has directly examined the experiences of TGNBI when participating in these studies, or identified specific research practices (e.g., recruitment materials/study framing, choice of specific survey measures, data collection protocols, researcher behaviors) that may influence study participation, retention, and data quality. Equally important, research has not adequately examined the potential for unintended harm due to emotional distress experienced by participating in such research and what specific strategies might mitigate against potential distressful research experiences.

Specific Aim: The purpose of this study is to develop evidence-based trauma-informed research guidelines to: a) increase researchers' capacity to recruit and retain transgender and non-binary individuals in stigma-related research; b) enhance the quality of data collected; and c) reduce unintentional harm in stigma research methodology.

Materials and Methods: For Phase 1 of this NIH-funded research project, we conducted sixty in-depth qualitative interviews with three groups a) TGNBI participating in HIV related stigma and discrimination (n=30); b) researchers conducting HIV-related stigma research (n=15); and c) mental health professionals providing services to TGNBI (n=15) to better understand experiences of stigma within the research context and to identify strategies for improving data quality and reducing unintentional harm in study recruitment, methodology, and/or implementation.

Results: Data indicate an immediate and sustained need for the creation and implementation of trauma-informed guidelines for research with TGBNI. Analyses revealed multiple concrete strategies for applying and implementing the five principles of a trauma-informed approach (choice, empowerment, collaboration, safety, and trustworthiness) to both the research process and research settings, including: (1) incorporating "informed consent" as an ongoing process within a research study, rather than a one-time event; (2) providing study participants with the information and ability to make informed decisions around their participation at every step of the research process; (3) conducting an evidence-based harms/benefits analysis when deciding which survey questions or measures and the types of procedures

to include; and (4) requiring all study staff to experience the study procedures that they are asking participants to complete, so that they have a better understanding of the participants' experience.

Conclusion: To make meaningful strides in transgender health research, it is imperative to not only develop a set of empirically-grounded practical recommendations for conducting research with TGNBI in a manner that is person-centered, trauma-informed and actively de-stigmatizing, but to assist individual researchers, potential research participants, institutional review boards, and grant funders to ensure that these guidelines are implemented and sustained.

Mini Symp: Health Professional Education

FRI-C1-M: Transgender and Gender Diverse Healthcare Education Across the Learning Spectrum: Finding the Right Fit for Your Institution

Joshua Smalley[1], Michelle Lawson[1], Noelle Larson[2], Brandy Hellman[2], Courtney Clutter[1]
[1]San Antonio Uniformed Services Health Education Consortium, San Antonio, TX, USA, [2]Walter Reed National Military Medical Center, Bethesda, MD, USA

Presented by: Joshua Smalley, Michelle Lawson, Noelle Larson, Brandy Hellman, Courtney Clutter

Statement of Significance: Intentional transgender and gender diverse (TGD) healthcare training and education remains elusive for healthcare professionals across disciplines. A new chapter devoted to education in the WPATH Standards of Care 8 (SOC8) attempts to highlight these concerns as "across disciplines, curricula at all levels - undergraduate, graduate, residency, or continuing education - historically have ignored TGD cultural or clinical education." The chapter concludes with the recommendation that "institutions involved in the training of health professionals develop competencies and learning objectives for transgender and gender diverse health within each of the competency areas for their specialty."

However, development and implementation of TGD education is challenging. Learners at various levels of training, spectrum of specialty area or discipline, competing content during rotations, stakeholder support and political climate are only some of the many challenges that make a standardized approach unattainable. While there are increasing attempts to teach TGD content, the instructional modality varies widely from single lectures and case-based discussion to simulated patient encounters and supervised patient care; often efficacy of the intervention is unknown.

The United States Department of Defense (DoD) has struggled with these challenges as policy changes allow for open service by transgender members since 2016. This demand for professional competency in TGD care delivery preceded adequate TGD healthcare training. In response, faculty across disciplines developed programs to address health professions education (HPE) gaps in military-affiliated undergraduate, graduate, and post-graduate settings. TGD instructional methodology and interventions were tailored to the dynamic needs in various training populations. Each program required identification of stakeholders, an understanding of specific needs of a HPE population and an analysis of available resources to balance aspects of curriculum design, including programming convenience, time limitations, associated costs, sustainability, and practice-changing content. This symposium assists participants in meeting SOC8 recommendations by highlighting both the latest research in TGD healthcare education and the interdisciplinary modalities developed in the DoD, as well as guiding the participant through considerations for development of a successful interdisciplinary approach to TGD healthcare education in their own institution.

Learning Objective 1: Know the current evidence base for effective TGD healthcare education curriculum at various levels of training.

Learning Objective 2: Describe various TGD healthcare educational modalities, analyzing the potential strengths and limitations of each.

Learning Objective 3: Evaluate your institution's needs, available resources and barriers to implementation of an effective interdisciplinary TGD healthcare education curriculum.

Method to Achieve Learning Objectives: 1. The symposium panel will review current literature to highlight published TGD healthcare education modalities at various levels of learning and disciplines. The panel will review results from their own QI initiatives as part of this review.
2. Participants will be asked to briefly work in small groups to brainstorm considerations for a successful educational curriculum, with emphasis on how varying modalities may address different learner levels and disciplines. The panel will then review these considerations formally, to include factors such as scope, cost, convenience, and flexibility.
3. Participants will be encouraged to scrutinize their own institutions using think/pair/share to identify learning opportunities as well as common barriers. With the panel, individuals will develop or select an educational framework.

Oral: Surgery

FRI-D1-T1: TIME TO HYSTERECTOMY IN TRANSGENDER AND GENDER DIVERSE INDIVIDUALS: A SINGLE INSTITUTION'S EXPERIENCE

Joseph Mulhall, Mary Baker, Michelle Roach
Vanderbilt University Medical Center, Nashville, TN, USA

Presented by: Joseph Mulhall

Introduction/Background: Hysterectomy remains a highly desired treatment by some gender diverse patients for the purpose of gender affirmation. Transgender and gender diverse individuals experience unique barriers to care when compared to cisgender patients, including insurance regulation, limited access to care, and local legislative restrictions. There is a paucity of data evaluating how these inequities affect the time it takes for gender diverse patients to undergo hysterectomy.

Specific Aim: The goal of this study is to evaluate differences in demographic data, surgical scheduling, and perioperative outcomes between gender diverse and cisgender individuals and their perceptions of the perioperative experience.

Materials and Methods: This was an IRB approved retrospective cohort study of transgender and gender diverse individuals undergoing hysterectomy by one of four gynecologists at a tertiary care center in the southeast United States from January 1 to December 31, 2022. Cases were compared to cisgender patients undergoing hysterectomy from the same attending surgeons during the study period. A patient experience survey was distributed via REDCap to all gender diverse patients who underwent a hysterectomy. Survey questions used a Likert scale (1-5), with higher numbers correlating with increasing levels of satisfaction. The primary outcome was number of days from surgery consult to completion of hysterectomy. Secondary outcomes included estimated blood loss during surgery, average length of hospital stay, and composite perioperative complications. Survey answers were quantified as a mean of the cohort responses. Categorical variables were evaluated by Pearson's $\chi 2$ analysis, while continuous variables were evaluated by two-sample t test. Significant differences between groups were defined as $p < .05$.

Results: There were 115 hysterectomies performed during the study period: 22 for gender diverse patients and 93 for cisgender patients. Gender diverse patients were significantly younger, had lower BMIs, and lived further away from the study hospital. Also, gender diverse patients more likely to be nonhispanic white and have private insurance. All gender diverse patients underwent a minimally invasive hysterectomy (18 laparoscopic and 4 vaginal). Gender diverse patients waited significantly longer to have a hysterectomy completed (149 vs 79 days, $p=.02$) despite having a similar rate of cases coordinated with other specialties (9% vs 3%, $p = .48$). Gender diverse patients had significantly lower estimated blood loss (45 vs 176mL, $p < .001$) and shorter length of hospital stay (0.09 vs 0.7 days, $p < .001$). The two

groups had a similar rate of perioperative complications (9% vs 5%, p = .80). The average satisfaction score from the survey data was 4.7 (answer range 4.3 to 5).

Conclusion: Transgender and gender diverse individuals wait significantly longer than cisgender patients to have hysterectomy completed despite no differences in perioperative complications. Despite these differences, patients report a high level of satisfaction in relation to their hysterectomy experience. Additional studies should determine the factors that contribute most to this inequity, and how to best mitigate these barriers to care.

FRI-D1-T2: DILATION OUTCOMES FOR TRANSGENDER AND NONBINARY PATIENTS FOLLOWING VAGINOPLASTY IN A U.S. COUNTY SAFETY-NET SYSTEM

Elizabeth Kvach[1,2], Shereen Sairafi[3], Krystyna Holland[4], Ryan O'Connell[2,5]
[1]Denver Health and Hospital Authority, Denver, CO, USA, [2]University of Colorado School of Medicine, Aurora, CO, USA, [3]Nymbl Science, Denver, CO, USA, [4]Inclusive Care Physical Therapy, Lakewood, CO, USA, [5]University of Colorado-Denver, Denver, CO, USA

Presented by: Elizabeth Kvach

Introduction/Background: Dilation is routinely recommended following gender affirming vaginoplasty to maintain vaginal depth and width, but this aspect of care has been poorly studied, including dilation outcomes, characteristics predictive of dilation success or failure and patient-oriented outcomes such as sexual function and satisfaction.

Specific Aim: The aim of this research is to describe dilation outcomes and identify factors associated with pain, dilation practices and sexual function for patients who have had gender affirming vaginoplasty.

Materials and Methods: The study employed a parallel, mixed methods study design with a cohort of transgender and nonbinary patients ≥18 years old undergoing penile-inversion vaginoplasty between May 2018 to April 2021 at a safety-net hospital through retrospective electronic medical record review and an electronic survey utilizing previously studied/validated instruments. Patients who had minimal-depth vaginoplasty were excluded. The survey was developed and pretested in collaboration with a patient advisory board.

Results: 140 patients underwent full-depth vaginoplasty, with a 45.7% survey response rate. Mean follow up time was 7.9 months (SD 9.1) and survey completion time was 796.2 days (SD 295.8) postoperatively. Patients received an average of 4.3 pelvic floor physical therapy (PFPT) visits (SD 2.9). Mean time of last PFPT visit was 12.4 weeks postoperatively (SD 10.8). Two-thirds of patients (n=90, 64.3%) achieved one of the two widest dilators (1 ⅜”-1 ½”) and half were able to dilate to a depth of ≥5.5 inches (n=50, 50%). The mean time to progress between one dilator to the next widest was 4.9 weeks (SD 3.9) beginning one-week postoperatively. From chart review data, twenty-nine (20.7%) patients reported having pain preventing dilation. Having minor or any surgical complication was associated with increased odds of pain preventing dilation (OR 5.7, 95% CI 1.3-25.0). Patients who reported pain preventing dilation had a higher prevalence of PTSD (n=8 [77.6%], p=0.008) and self-reported cannabis use (n=18, 62.1%, p=0.047) compared to those without pain. From the survey, 33 respondents (70.2%) reported dilating regularly with 27.7% (n=13) dilating weekly or less; 27.7% (n=13) dilating 2-3 times per week; 14.9% (n=7) dilating daily and 29.8% (n=14) with unknown dilation frequency. For those not dilating postoperatively, the mean time to stop dilating was 13.4 months (3.7 SD). As compared to respondents who were dilating, those who were not dilating were: younger (mean age 41.9 years [SD 14.6] vs. 33.8 years [SD 6.1], p=0.004); more likely to be lesbian, pansexual or asexual (p=0.004); and had higher rates of depression (36.6% [n=15] vs. 73.7% [n=14], p =0.012). Three-quarters of survey respondents (n=30, 75%) reported being sexually active in the past 6 months with 29 (72.5%) reporting receptive vaginal intercourse. Sexual activity and presence or absence of receptive intercourse were not significantly associated with pain during dilation. Thirty-three respondents (67.3%) reported pain during sex. Respondents self-reporting pain during dilation were more likely to be moderately or very dissatisfied with their sex life (n=10, 83.3%) compared to those without pain (n=12, 37.5%; p=0.016).

Conclusion: Patient dilation practices following gender affirming vaginoplasty differ from protocols recommended by surgeons. Dilation goals and support should be adapted to patient characteristics and needs.

FRI-D1-T3: Association of High Body Mass Index with Postoperative Complications Following Chest Masculinization Surgery

Bashar Hassan[1], Calvin Schuster[1], Mona Ascha[1], Gabriel Del Corral[2], Beverly Fischer[3], Fan Liang[1]
[1]Center for Transgender & Gender Expansive Health, Johns Hopkins University, Baltimore, MD, USA, [2]Medstar Georgetown University Hospital, Baltimore, MD, USA, [3]The Advanced Center for Plastic Surgery, Lutherville-Timonium, MD, USA

Presented by: Bashar Hassan

Introduction/Background: Body mass index (BMI) requirements for transgender and non-binary (TGNB) patients undergoing chest masculinization surgery (CMS) are not standardized because of insufficient data.

Specific Aim: We sought to determine the association between increasing BMI and complication rates following CMS.

Materials and Methods: The NSQIP database (2012-2020) was queried for TGNB patients with CMS. Patients were categorized into 6 BMI categories (Figure 1). The primary outcome was incidence of at least one complication within 30-days postoperatively. The secondary outcome was incidence of major and minor complications. Descriptive statistics were calculated. Multivariate logistic regression was used to evaluate the association between BMI and complications.

Results: Of 2317 patients, the median BMI was 27.4 kg/m^2 (interquartile range [IQR] 23.4-32.2 kg/m^2). The minimum BMI (kg/m^2) was 15.6 and maximum was 64.9. Notably, while increasing BMI was significantly associated with greater odds of developing at least one complication, no patients experienced severe morbidity in the form of pulmonary embolism, deep venous thrombosis, stroke, or cardiac arrest, regardless of BMI (Figure 2). On multivariate regression, higher BMI is associated with greater odds of readmission and minor complications.

Conclusion: Given the negligible risk for severe complications in higher BMI individuals, we recommend reevaluation of BMI cut offs for CMS patients.

FRI-D1-T4: PATTERNS OF PERIOPERATIVE HORMONE THERAPY FOR GENDER-AFFIRMING SURGERY

Sriya Nemani[1], Patrick Assi[1], Ya-Ching Hung[2], Benjamin Park[1], Sara Chaker[1], Teja Williams[3], Brian Drolet[1], Salam al-Kassis[1]
[1]Vanderbilt University Medical Center, Nashville, TN, USA, [2]Sinai Hospital of Baltimore, Baltimore, MD, USA, [3]Meharry Medical College, Nashville, TN, USA

Presented by: Sriya Nemani

Introduction/Background: Historically, gender-affirming surgeons have discontinued their patient's hormone replacement therapy (HRT) prior to gender-affirming surgery. This practice was meant to reduce the risk of postoperative complications such as venous thromboembolism (VTE), deep vein thrombosis (DVT) and hematoma. However, discontinuing HRT increases gender dysphoria in many patients, and induces negative biopsychosocial changes such as hot flashes and mood swings. The perioperative usage of HRT thus remains a debated topic amongst gender-affirming surgeons, with no clear guidelines currently in place.

Specific Aim: The aim of this study was to characterize international patterns of perioperative hormone replacement therapy usage across different surgical specialties.

Materials and Methods: This study utilized the modified Delphi method. A 27-item survey was emailed to 150 gender-affirming surgeons (94 plastic surgeons, 35 urologists, 21 gynecologists) identified through the WPATH member database. The survey included questions on surgeon demographics, the type of HRT prescribed, HRT discontinuation prior to surgery, and the use of deep vein thrombosis (DVT) prophylaxis following bottom surgery. Data was collected from September of 2022 to October of 2022. Three reminder emails were sent over this period.

Results: Thirty-four percent of surgeons (n=51, 35 plastic surgeons, 8 urologists, 8 gynecologists) replied to the survey. The majority of respondents practiced in the United States (n = 39, 76%). The route of HRT prescribed varied across specialties, with the majority of plastic surgery patients using HRT injections (n=18, 51%), while oral medications were more commonly used in urology (n=3, 38%) (p =0.003). The majority of surgeons do not discontinue HRT prior to gender-affirming chest surgery (feminizing chest reconstruction: n= 30, 86%, masculinizing chest reconstruction: n=29, 85%), gender-affirming hysterectomy (n=10, 83%), and facial feminization surgery (n-17, 81%). Approximately half of urologists (n=4) and 45% of plastic surgeons (n=9) discontinued HRT prior to feminizing bottom surgeries such as vaginoplasty. There was no consensus on discontinuation schedules, with 53.8% of respondents (n=7) discontinuing HRT 1-2 weeks prior to surgery, 38.5% of respondents (n=5) discontinuing HRT 2-4 weeks prior to surgery, and one surgeon discontinuing HRT 1-2 months prior to surgery. The majority of plastic surgeons and urologists who responded to the survey provided postoperative DVT prophylaxis for patients undergoing either feminizing (plastic surgeons: 88%, urologists: 86%) or masculinizing bottom surgery (plastic surgeons: 88%, urologists: 100%). While all urologists prescribed DVT prophylaxis for less than a week after surgery, 39% of plastic surgeons prescribed DVT prophylaxis for 1-2 weeks after feminizing bottom surgery (p=0.002). For masculinizing bottom surgeries, 57% of plastic surgeons prescribed DVT prophylaxis for less than a week, 29% provided DVT prophylaxis for 1-2 weeks, and 14% provided DVT prophylaxis for more than 2 weeks (p = 0.002).

Conclusion: There is a wide variation both between and within specialties regarding the route of hormone replacement therapy, the discontinuation of hormone replacement therapy prior to feminizing bottom surgery, and the prescription of DVT prophylaxis after feminizing and masculinizing bottom surgery. Data-driven guidelines should be established to ensure the standardization of care and the well-being of patients internationally and across specialties.

Sunday, November 5, 2023

3:00pm - 4:15pm

SUN-D3-T2: QUALITY OF LIFE OUTCOMES IN PATIENTS UNDERGOING FACIAL GENDER AFFIRMING SURGERY: A SYSTEMATIC REVIEW AND META-ANALYSIS

Michelle Bonapace-Potvin[1], Gavin Raner[2], Katrina Jaszkul[3], Khalifa AlGhanim[2], Gabriel Bouhadana[1], Andrée-Anne Roy[1], Éric Bensimon[1]
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Presented by: Michelle Bonapace-Potvin

Introduction/Background: From professional headshots for job applications to social media profiles, the face is the foundation for social impressions and is a core element of an individual's identity in our society. As such, transgender individuals' transitions may involve changing their facial appearance to better outwardly express the gender congruent with their internal identity. This can be achieved through hormone therapy, injectables, and/or surgical interventions. Facial gender-affirming surgery (FGAS) is an

overarching term to describe surgical procedures used to feminize the faces of transgender women and trans-feminine or gender diverse patients.

Specific Aim: The purpose of this study was to quantify changes in quality of life (QoL) following facial gender-affirming surgery (FGAS). FGAS, one of many transition-related surgeries (TRSs), "feminizes" the faces of transgender and gender diverse (TGD) patients undergoing transition. However, unlike other TRSs, only two Canadian provinces/territories offer health coverage for FGAS.

Materials and Methods: A systematic review of online databases was conducted according to PRISMA guidelines. Screening and quality assessment was conducted by two independent blinded reviewers. For statistical analysis, data from different Likert-scale-like questionnaires were extracted and coalesced into three-point scales on a data table of seven QoL domains; "Pre-" and "Postoperative femininity," "Psychological satisfaction," "Social Integration and Functioning," "Aesthetic Satisfaction," "Physical Health," and "Satisfaction with Surgical Results."

Results: From 2000-2022, 1837 patients and 3886 procedures from 19 studies were included. Weighted averages across all QoL domains reflected statistically significant improvement compared to neutral following FGAS ($p<0.001$). Three studies used the same questionnaire, which showed that out of all eight questions regarding facial appearance, FGAS patients most strongly agreed the surgery was important to their ability to live as a woman (mean=4.56/5, n=137). Secondary outcomes showed the most common complications were hardware palpability (3.45%, n=145) and aberrant scarring (2.17%, n=423) with an overall revision rate of 2.17% (n=423). The most common procedure was fronto-orbital remodeling.

Conclusion: FGAS significantly improves QoL with minimal risk to life and supports the literature in defining FGAS as a medically necessary procedure comparable to other TRSs.

Friday, November 3, 2023

9:45am - 11:00am

Mini Symp: Mental Health Across the Lifespan

FRI-E1-M: PSYCHEDELIC THERAPY FOR TRANSGENDER & GENDER EXPANSIVE PEOPLE

Angela Carter[1], Rachel Golden[1], Jae Sevelius[2], Syre Saniyah[3], Rixt Luikenaar[1]
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Presented by: Angela Carter, Rachel Golden, Jae Sevelius, Syre Saniyah, Rixt Luikenaar

Statement of Significance:
Psychedelic-assisted therapy (PAT) is a breakthrough innovation that has the potential to change the field of mental health and the options we have to offer transgender and gender expansive (TGE) people who are suffering. Promising evidence is building for successfully treating conditions including anxiety and depression, substance abuse disorder, and post-traumatic stress disorder. Access to ketamine-assisted therapy is rapidly growing, and the United States Food and Drug Administration (FDA) has granted breakthrough therapy status to PAT using psilocybin for treatment-resistant depression and major depressive disorder, and MDMA for post-traumatic stress disorder. While these early studies are extremely promising, the populations included in these studies have been homogeneous (e.g., primarily white, heterosexual, and cisgender – when that data is collected). Further, few training programs in PAT for therapists address working with TGE communities. There is much work to be done to ensure that underserved communities, including TGE people, BIPOC, and neurodiverse people, have safe access. In this panel, we will describe current approaches to PAT (e.g., set and setting, importance of preparation and integration) and potential applications to working with diverse TGE populations. We will offer ideas about next steps in research and therapeutic approaches to increase inclusion and accessibility for TGE

communities. Panelists will share their clinical experiences providing PAT to TGE patients, uplifting the voices of patients themselves and providing examples of clinical applications in practice. We will discuss innovative research designs that may help address some of the challenges that we face when conducting clinical trials of PAT with TGE communities, such as small sample size. Finally, we will include resources for audience members who want to learn more about PAT and its applications for working with diverse TGE people.

Learning Objective 1: Describe the therapeutic utility of psychedelic-assisted therapy for addressing common mental health concerns in transgender and non-binary communities

Learning Objective 2: Discuss the current legal, policy, and cultural milieu as well as accessibility of psychedelic-assisted therapy for transgender and non-binary people

Learning Objective 3: Review the available data and praxis of culturally-specific applications of psychedelic-assisted therapy for transgender and non-binary people

Method to Achieve Learning Objectives: We will present innovative information in powerpoint, video and spoken presentation with Q&A opportunities throughout.

Mini Symp: Community Engagement

FRI-F1-M: FANDOM CULTURE AND TGD COMMUNITY ENGAGEMENT: WHAT CLINICIANS NEED TO KNOW

Kaela Joseph[1,2], Tanya Cook[3], Jame Agapoff[1]
[1]San Francisco VA Health Care System, San Francisco, CA, USA, [2]Palo Alto University, Palo Alto, CA, USA, [3]Community College of Aurora, Aurora, CO, USA

Presented by: Kaela Joseph, Tanya Cook, Jame Agapoff

Statement of Significance: Fandom subcultures, unique communities of people who identify as fans of a particular person or thing, are quickly becoming indistinguishable from culture more broadly. This is due, in part, to the rise of online socialization, which has the potential to bring people together, across physical distances. Fandoms, especially those with online components and those engaged in transformative works such as fan art and fan fiction, have a particular appeal for transgender and gender diverse (TGD) people in that they allow for safer exploration of self and the development of queer and trans community that may be inaccessible otherwise (Duggan and Fazekas, 2023). Research suggests that LGBTQ+ youth who participate in fandom reach identity milestones earlier and quicker, as well as use a broader variety of sexual and gender identity labels (Mclnroy and Craig, 2018). Fandoms also function like social movements, and have mobilized to address social inequities, TGD representation in media, and anti-trans legislation in the US and abroad (Cook and Joseph, 2023; Mclnroy, Zapcic, and Beer, 2021; Fandom Forward, 2023; Random Acts, 2021). Fandom and online culture impact multiple hot topics important to TGD people, from participation in sports to global tactical communication used to access gender affirming care (Flores et al., 2020; Edenfield, Colton, and Holmes, 2019). Despite this, most clinicians know very little about fandom culture, and often mislabel it as pathological or less socially valuable behavior, further stigmatizing those whose TGD identities are interconnected with fandom. Increased clinician understanding of fandoms would improve gender affirming care by broadening cross-cultural competence to better utilize within-group norms and practices such as transformative narratives, as well as address the rise of medical fandoms which can contribute to misinformation about interdisciplinary approaches to care.

Learning Objective 1: Identify at least 3 ways participation in fandom culture can impact gender identity development

Learning Objective 2: Identify at least 3 ways in which fandoms act as social movements to mobilize positive, community engagement and change

Learning Objective 3: Identify at least 3 ways clinicians across disciplines can adapt care with consideration of fandom cultures

Method to Achieve Learning Objectives: Learning objectives will be achieved through a combination of didactic learning, case examples, and audience participation in discussion questions.
(5min) Overview of fandom culture broadly
(20min) Overview of literature on fandom culture and gender identity development with case examples of clinicians incorporating fandom culture into multidisciplinary care
(20min) Discussion of fandoms as social movements with case examples related to TGD community engagement
(10min) Discussion of medical fandoms, the spread of misinformation online, and what clinicians can do to address questions about care in culturally responsive and respectful ways
(10min) Overview of ways clinicians across disciplines can adapt care with consideration of fandom cultures
(10min) Questions

11:15am - 12:30pm

Mini Symp: Physical Medicine/Physical Therapy

FRI-A2-M: UTILIZING YOGA TO IMPROVE OUTCOMES IN GENDER AFFIRMING CARE

Kaela Joseph[1,2], Laura Hoge[3], Naomi Leong[4]
[1]San Francisco VA Health Care System, San Francisco, CA, USA, [2]Palo Alto University, Palo Alto, CA, USA, [3]Spectrum Health and Wellness, LLC, Montclair, NJ, USA, [4]Brownes Addition Wellness Center, Spokane, WA, USA

Presented by: Kaela Joseph, Laura Hoge, Naomi Leong

Statement of Significance: Yoga and similar embodied practices are increasingly being utilized in health care, under the Whole Health model. Yoga has been shown to improve flexibility and balance, increase strength, decrease pain and inflammation, lower blood pressure, and improve cardiovascular and respiratory function (Kamraju, 2023a). Mental health benefits include reduction in stress, anxiety, depression, and symptoms of PTSD (Kamraju, 2023b). One study involving transgender participants found even a single session of yoga positively impacted cardiovascular parameters among participants with hypertension, as well as reparatory and psychiatric conditions (Bhavanani, Ramanathan, and Madanmohan, 2013). An advantage of utilizing yoga is its ability to be adapted cross-culturally to address different needs, however, few referring providers are trained in ways yoga can specifically benefit transgender and gender diverse patients. For example, we think of speech therapists as important parts of care teams but rarely consider ways a yoga instructor, through chanting, may also assist in changing pitch, articulation, vocal loudness, and vocal quality. We readily discuss ways to mitigate health risks of prosthetics like binders and gaffs through proper hygiene and limited use, but we don't often consider ways specific yoga poses can relieve pain and pressure associated with these devises. From a health and fitness standpoint, poor body image, stigma, and fear have been associated with barriers to exercise among transgender people, especially related to accessing gyms (Teti, Bauerband, Rolbiecki, and Younga, 2020). Yoga can be practiced anywhere, and through social justice framing and interdisciplinary, community-based partnerships, can be made to be more inclusive of all bodies, including transgender and gender diverse bodies (Webb, Rogers, and Thomas, 2020). Yoga can also increase interoceptive awareness, which could assist patients in better understanding emotional states and bodily changes related to gender affirmation (Finkelstein-Fox, Sacco, Braun, and Lazar, 2020). Having a better understanding of ways in which yoga could be utilized to improve health outcomes, especially those which impact gender affirming hormone therapies and surgeries, would improve clinicians' abilities to address patients' needs.

Learning Objective 1: 1) Describe at least 3 physical and mental health benefits of yoga, broadly

Learning Objective 2: 2) Describe at least 3 specific benefits of yoga related to gender affirming care

Learning Objective 3: 3) Identify ways yoga can be adapted, through interdisciplinary partnerships, to specifically address needs of transgender and gender diverse patients

Method to Achieve Learning Objectives: This symposium will utilize didactic learning and demonstrations, with optional opportunities for experiential learning/audience participation.
(5 min) Optional opening movement exercise that can be done standing or seated in a conference style room.
(20 min) Didactic overview of the literature on the benefits of yoga, broadly and specifically as it relates to gender affirming care.
(20 min) Demos conducted by certified yoga instructors on the following:
1. Yoga poses for relieving pain/pressure related to binding and tucking, with explanation of the physiologic reasons
2. Mindfulness exercise that can be utilized as a tool by non-yoga practitioners
3. Chanting exercise with explanation of speech benefits
(20 min) Discussion of cases in which interdisciplinary approach that involved yoga was used.
(10 min) Questions

Oral: Mental Health Across the Lifespan

FRI-B2-T1: EXPLORING GENDER EUPHORIA AMONG TNB ADULTS USING PHOTOELICITATION METHODS

Ashley Austin, Ryan Papciak
Barry University, Miami Shores, FL, USA

Presented by: Ashley Austin

Introduction/Background: Gender euphoria is an increasingly important concept for members of the transgender and nonbinary (TNB) community. Despite its relevance to the mental health and well-being of TNB clients, experiences of gender euphoria have been overlooked in academic research and clinical practice.

Specific Aim: The primary aim of this study is to improve understanding about experiences of gender euphoria among TNB adults in order to inform mental health practice and policies that impact the lives of TNB individuals.

Materials and Methods: This study utilized grounded theory combined with photo-elicitation methodologies to collect and analyze data. Photo elicitation interviewing centers the experiences of TNB participants by allowing participant generated photos to drive the interview process. The use of photo-elicitation methods offers a rich understanding of participants' experiences, thoughts, feelings, and ideas, introducing dimensions to a study which go beyond those conceived of by researchers. This aspect of photo-elicitation methodology is relevant for under researched topics and populations. This is particularly important for TNB participants, who may suffer from the erasure and invalidation of their experiences in research rooted in a cisnormative worldview. Recruitment efforts consisted of outreach, as well as paid advertising via social media and digital marketing (e.g., Facebook, Instagram). Digital images and narrative data were collected from TNB adults though photo-elicitation interviews conducted via Zoom from 2019-2020. Researchers obtained informed consent for use of digital images and narrative data.

Results: Participants were TNB adults (n = 30) aged 18- 62 who identified with the following non-mutually exclusive gender identity categories (trans man 27%, trans woman 23%, nonbinary 13%, woman 13%, genderqueer 7%, man 10%, other 7%) and endorsed the following racial/ethnic identities (White 63%,

Hispanic/Latinx 17%, Black/African American 13%, Asian American 3%, Native American 3%). Narrative and visual data revealed the importance of gender euphoria as a core concept and experience within the lives of TNB adults. The term gender euphoria, as well as detailed descriptions of experiences of gender euphoria emerged organically from participants across the course of the study. I Specifically, visual and narrative findings yield four themes which highlight key processes that may contribute to experiences of gender euphoria: 1. Being exposed to a gender affirming antecedent, 2. Having an affirming thought, 3. Feeling a positive emotion, and 4. Experiencing enhanced quality of life. In particular, participants' self-selected images and corresponding narrative discussions elucidate the critical role gender affirmation, in its various forms (e.g., internal and external sources of affirmation), on subsequent experiences of gender euphoria. (note--data includes visual images that correspond with each theme). Importantly, gender affirming experiences seem to be the catalyst for thoughts and feelings that contribute to experiences of gender euphoria and eventual long-term positive changes in well-being among participants. This presentation will discuss specific considerations for skillfully integrating study findings into mental health practice to enhance experiences of gender affirmation and euphoria.

Conclusion: Findings contribute to a growing body of research highlighting the importance of gender affirmation which can help challenge the onslaught of anti-transgender legislation across the U.S. that include restrictions to gender affirming care for TNB individuals.

FRI-B2-T2: A Qualitative Exploration of Preliminary Effectiveness of A Mindful Self Compassion Expressive Arts Group For Trans and Nonbinary Adults

Ryan Papciak, Ashley Austin
Barry University, Miami Shores, FL, USA

Presented by: Ryan Papciak

Introduction/Background: A growing body of research explores identity-specific stressors impacting the mental and behavioral health of transgender and nonbinary (TNB) individuals. Research increasingly demonstrates the negative impact of gender minority stressors including gender dysphoria and the protective role of gender affirmation on the health and wellbeing of TNB adults. Moreover, emerging research suggests that gender affirming experiences not only mitigate gender dysphoria but may also contribute to experiences of gender euphoria for members of the TNB community. Increased attention has been given to the utility of trauma informed intervention approaches such as mindfulness, self-compassion, and expressive arts. To date very few explicitly aim to cultivate gender affirming experiences as part of the intervention process. To address this need, emerging evidence across three areas: Mindful Self Compassion, Expressive Arts, and TNB Affirmative Practice was used to inform the development of "Colors of Trans Expression", A Mindful Self-Compassion (MSC) Expressive Arts (EA) Group designed specifically for TNB participants. Weekly themes integrated Kristen Neff's Self-Compassion work with gender affirming concepts: 1. Introducing Self Compassion, 2. Self-Compassion and Authentic Self, 3. Self-Compassion in the Face of Stigma and Oppression, 4. Self-Compassion and Embracing Gender Affirmation. Expressive arts activities were an integral element of engaging in each session.

Specific Aim: The primary aims of this study were to use qualitative narrative and visual data to explore the perceptions and experiences of TNB participants participating in a pilot study of a 4-session virtual MSC-EA Group.

Materials and Methods: The four-session virtual Colors of Trans Expression group took place in South Florida during the fall of 2022. All participants received art supplies via mail prior to the start of the group. Eleven (11) individuals attended the group. Eight participants were retained for all sessions. Five of the participants identified as BIPOC and all identified as TNB. Sessions were co-facilitated by a TNB MSW-level facilitator and a cisgender Doctoral-level facilitator. Informed consent to collect narrative and visual data via SurveyMonkey after each of the 4 sessions was obtained from participants.

Results: The group had an encouraging retention rate of 73%, which may be attributed to the virtual delivery method, incentives for participation, and positive affirming experiences during each session.

Narrative and visual data highlight the impact of the intervention across five key domains of healing: 1. a sense of belonging, 2. self-awareness, 3. healthy self-expression, 4. self-compassion, and 5. confidence. Moreover, participants described the group itself as “a very safe and loving space”, where they could “bond and share my stories without any fear of judgement”.

Conclusion: Given the mounting anti-transgender sentiment and laws across the US, and in Florida where this intervention was delivered, positive findings associated with accessibility, within-group experiences, and perceptions of therapeutic growth are encouraging. The need for innovative, accessible mental health interventions for TNB individuals is growing and findings suggest that a MSC-EA group such as the Colors of Trans Expression intervention represents a feasible and impactful option for supporting the well-being TNB individuals.

FRI-B2-T3: NARRATIVE EXPOSURE THERAPY REDUCES POST-TRAUMATIC STRESS SYMPTOMS AMONG TRANSGENDER AND GENDER DIVERSE ADOLESCENTS AND YOUNG ADULTS

Jamie Julian[1], Bridgid Conn[1,2], Marisol Chavez[1], Nadezda Zubareva[1], Elizabeth Wages[1]
[1]Children's Hospital Los Angeles, Los Angeles, CA, USA, [2]University of Southern California, Los Angeles, CA, USA

Presented by: Jamie Julian

Introduction/Background: Transgender and gender-diverse (TGD) adolescents and young adults (AYA) are an under-served and marginalized community who experience significantly higher rates of interpersonal violence, gender-based discrimination, and bullying (Grossman & D'Augelli, 2007; Reisner et al., 2016), leading to estimated rates of post-traumatic stress disorder (PTSD) as high as 42% (Valentine et al., 2019). In a recent U.S. sample of gender minority adults, experiencing transphobia and trauma was positively associated with PTSD (Keating & Muller, 2020). Among TGD youth who experience post-traumatic stress symptoms (PTSS), there is a clear burden and a need for interventions that aim to address their symptoms within a gender-affirming approach and support their growth and resilience. While there are numerous evidence-based interventions to address PTSS, there is a lack of research focused on addressing this gap for the TGD community (McCormick et al., 2018; Valentine et al., 2019). Currently, there are no tailored interventions for TGD AYA experiencing PTSS, notwithstanding the clear established connection between receiving responsive timely care and better outcomes for those who experience post-traumatic stress (Wang et al., 2005). Research clearly indicates that TGD AYA are in need of a targeted intervention specifically designed to address their complex, nuanced experiences of traumatic events (McCormick et al., 2018). Initial examination of Narrative Exposure Therapy (NET) with TGD AYA through case studies has shown promise in the reduction of reported PTSS (Julian et al., 2023). Building upon this initial evidence, the current study presents an initial pilot investigation of the effectiveness of NET in reducing PTSS among TGD AYA.

Specific Aim: 1. We describe a tailored intervention to provide gender-affirming, trauma-focused brief treatment for TGD youth who have experience trauma, including gender-based violence, rejection, and discrimination.
2. We present findings from an initial pilot study of 41 TGD adolescents and adolescents who presented with PTS symptoms and who received NET, including changes in their self-reported symptomatology and resilience.

Materials and Methods: We conducted descriptive analysis and paired pre-post t-tests using the clinical data from 41 TGD participants who participated in a pilot study of NET for PTS symptoms. This study was approved by the institutional IRB and all participants provided consent or parental consent/youth assent.

Results: 41 participants completed NET, a brief, trauma-focused treatment with sessions ranging from x to x. Participants reported significantly fewer PTSD symptoms following treatment, as well as significant increases in self-perceived resiliency and positive well-being. Youth noted most significant decreases in their negative mood and cognitions, hyperarousal and reactivity, and intrusion symptoms.

Conclusion: These findings provide initial support for the use of NET with TGD youth experiencing PTS symptoms arising from a range of complex childhood traumatic experiences, including abuse, neglect, and gender-based experiences of rejection and discrimination. While NET has not been as well-established in this U.S., this brief, client-centered trauma treatment shows promise as an effective, adaptable intervention for TGD youth.

FRI-B2-T4: Utilizing Photo Elicitation Inquiry Methods to Elucidate Multifaceted Presentations of Gender Dysphoria Among Trans and Nonbinary Adults

Ashley Austin[1], Ryan Papciak[1], Veronica Timbers[2]
[1]Barry University, Miami Shores, FL, USA, [2]University of Utah, Salt Lake City, UT, USA

Presented by: Ashley Austin

Introduction/Background: There is a growing body of research demonstrating severe impact of gender dysphoria (GD) on the well-being of trans and nonbinary (TNB) youth and adults. Historically research of GD has been rooted in binary perspectives of dysphoria. Likewise, measures of GD symptomology often overemphasize primary sex characteristics, failing to capture the complexity of GD. To improve assessment and intervention to relieve the suffering associated with GD, novel research rooted in the perspectives of TNB individuals is needed to expand understanding about the unique and varied ways in which GD may be experienced across TNB individuals.

Specific Aim: To advance clinical knowledge and address gaps in the research, we explored qualitative, photo elicitation data from (N = 31) TNB adults. The primary aim of this study was to offer a more accurate understanding of the range of ways GD presents across TNB individuals.

Materials and Methods: Participants (n=31) selected the following non-mutually exclusive gender identities: nonbinary (n=7), trans man (n=9), trans woman (n=10), demiboy (n=1), genderfluid (n=1). Participants ranged in age from 18-62 (M = 26.9). The sample was a majority white (n=20), Hispanic (n=5), other/mixed race (n=6). A phenomenological, thematic analysis approach was used to analyze the visual and narrative data of the participants' lived experienced with GD which was collected via photo-elicitation interviews.

Results: Analyses revealed important themes regarding the range of ways that GD presented among a sample of (n=31) TNB individuals. Visual and narrative data yielded the following 6 GD specific themes which elucidate the specificity and intensity of GD across different dimensions of the embodied self: 1. Size of the body and body parts, 2. Shape of specific body parts, 3. Facial features, 4. Haircut/style, 5. Body and facial hair, and 6. Tone and pitch of voice.
Findings revealed that experiences of GD were nuanced and multifaceted, extending beyond current diagnostic criteria and a one-dimensional narrative. Instead, salient presentations of GD among participants' were associated with many distinct aspects of the embodied self. Findings challenge the myth that GD is binary experience; rather participants with both binary and nonbinary identities experienced a range of GD presentations as well corresponding GD related distress and suffering. Findings reveal serious consequences associated with unmitigated GD related distress. For example, some participants described developing disordered eating as way to cope with GD associated with body shape. In addition, participants experiencing voice dysphoria described how they avoided speaking in social groups and academic settings to mitigate GD related distress.

Conclusion: This presentation shares narrative and visual data from participants' to promote a more in-depth understanding of the range of ways that GD is experienced among TNB individuals. Findings can be used to guide mental health assessment and intervention recommendations which attend to the realities of GD. Furthermore, study findings elucidate the negative consequences of current anti-trans legislation which denies access to treatments for GD for both youth and adults.
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FRI-B2-T5: USE OF PHARMACOGENOMICS IN GENDER-DIVERSE PATIENTS WITH OR WITHOUT GENDER-AFFIRMING CARE AND ITS IMPACT ON MENTAL HEALTH OUTCOME MEASURES

Serena Mitaly, Fiona Fonseca, Cesar Gonzalez, Jessica Wright
Mayo Clinic, Rochester, MN, USA

Presented by: Serena Mitaly

Introduction/Background: Although the data surrounding gender-affirming care is promising, the use of psychotropic medications in the management of mental health disorders is challenging, and fewer than 50% of patients receive effective therapy. Current strategies for psychotropic medications include slow titrations to achieve a standard dose thought to provide clinical efficacy. However, not all patients will reach clinical efficacy upon reaching a standard dose. One potential strategy for overcoming this issue is by using pharmacogenomics (PGx). PGx is the study of how an individual's genes impact response to medications. To our knowledge, research regarding the use of PGx testing in the transgender and nonbinary population has not been conducted. Therefore, the potential of pharmacogenomics to identify actionable gene-drug pairs and optimize psychotropic use in conjunction with gender-affirming therapy may show substantial benefit in improving mental health outcomes in this historically underrepresented and at-risk population.

Specific Aim: To determine whether pharmacogenomics testing improves mental health outcome scores when used prior to or after gender affirming care (GAC) in gender diverse patient populations.

Materials and Methods: An institutional review board (IRB)-approved retrospective, enterprise-wide study for gender diverse patients (n=773) patients who received pharmacogenomics testing (n=39) with and/or without hormonal or surgical gender affirming care.

Results: PHQ-9 and GAD-7 scores improved at both 8-12 weeks (-4.4 points vs -2.3 points, respectively) and at 12 weeks – 6 months (-4.8 points vs -4 points, respectively) in patients who identified as nonbinary. Patients who received pharmacogenomics testing prior to gender-affirming care (GAC) had modest improvements in PHQ-9 scores at 12 weeks – 6 months (-2 points) and GAD-7 scores at 8 – 12 weeks (-1 points. For patients with GAC prior to pharmacogenomics, there was a significant increase in baseline PHQ-9 (+5 points) and GAD-7 (+6 points) scores 8-12 weeks after pharmacogenomic testing, and modest improvement at 12 weeks (-3 points) for PHQ-9 but not for GAD-7 (+2 points).

Conclusion: Pharmacogenomics testing may be beneficial in nonbinary patients with mental health disorders. There may be more benefit in using pharmacogenomics testing prior to receiving GAC. However, more data is needed to better understand the role of pharmacogenomics testing in transgender patients. This presentation will review the basics of pharmacogenomic testing, indications for pharmacogenomic testing, and how such testing may impact care for transgender and gender diverse patients.

Oral: Non-surgical Body Modifications (e.g., hair removal, binding, tucking)

FRI-B2-T6: THE IMPORTANCE OF HAIR REMOVAL BEYOND ESTHETIC VALUES

Yuki Arai
New York Electrolysis Office, New York, NY, USA

Presented by: Yuki Arai

Introduction/Background: Removing hair permanently is an essential adjunct prior to Gender Affirmation Surgery for both transfeminine and transmasculine individuals. It also enhances authenticity for most transfeminine people. However, there is much misunderstanding about the importance of the process. This systematic review will provide a thorough awareness of the situation and how to best avoid negative outcomes.

Specific Aim: I will focus specifically on the crucial importance of permanent hair removal as a part of Gender Affirming Surgery and why this process should be combined properly into the transitional process. It must be perceived beyond purely esthetic values, as when this is not performed adequately, the negative outcome impacts self-esteem, genital health, and an individual's ability to fully integrate into their authentic gender.

Materials and Methods: Clinical data was compiled using a rich qualitative dataset derived from over 10,000 client-visits at my private clinic, including over 50 additional client surveys and semi-structured interviews compiled since 2010. The data are mainly highlighted by transfeminine, transmasculine, and transqueer profiles, and will be shown using data charts plus photographic evidence of 'before' and 'after' cases.

Results: Compiled data show that overall satisfaction with Gender Affirmation Surgery has a direct correlation with the degree of genital hair removal prior to surgery. A key factor is that if hair removal is not effectively performed and permanent prior to Affirmation Surgery – for both transfeminine and transmasculine individuals – then the regrowth in the neo-vagina and neo-urethra is essentially untreatable. For those whom electrolysis had started sufficiently in advance of surgery, overall satisfaction reached over 90%. However, for individuals where hair removal was not robust or comprehensive enough (usually by not starting the process early enough prior to surgery) their overall surgical satisfaction dropped to below 20%. I will also show the differing success levels comparing electrolysis and laser methodology using compiled data from past clients. Again, the inability to treat hair within the neo-urethra or vaginal canal post-surgery is not only a concern medically but usually increases an individual's gender dysphoria, their body-image insecurity, and impacts their wellbeing. I will also highlight that such negative effects are entirely preventable.

Conclusion: In over 20 years of practicing electrolysis in the New York City area I have found a concerning lack of information about the importance of permanent hair removal prior to affirmation surgery. To their credit the transgender community is becoming increasingly aware of this fact, however many falsehoods prevail and continue to be spread in professional circles. These include that electrolysis will make the skin less malleable, skin cauterization during the surgical process will prevent all hair regrowth, or even that just a few treatment sessions prior to surgery will be effective. These have all been proven to be incorrect, and I have seen too many individuals desperately unhappy with their surgery results simply because the information on hair removal they were given prior to surgery was wrong. As a professional electrologist specializing in transgender clients, I hope to increase knowledge and awareness of these facts for the betterment of the LGBTQI+ community.

Mini Symp: Pubertal Suppression/Hormone Therapy – Adolescent

FRI-C2-M: Developmental Trajectories and Medical Decisions; Transitions in Childhood vs. Adolescence and Young Adulthood

Johanna Olson-Kennedy[1,2], Darlene Tando[3], Jessica Lee[1,2]
[1]Children's Hospital Los Angeles, Los Angeles, CA, USA, [2]University of Southern California, Los Angeles, CA, USA, [3]Darlene Tando, Owner, San Diego, CA, USA

Presented by: Johanna Olson-Kennedy, Darlene Tando, Jessica Lee

Statement of Significance: The decision-making process for transgender and non-binary (TNB) youth and their parents/guardians is complex and is influenced by chronologic age and developmental stage at time of disclosure. The developmental trajectories of TNB individuals who disclose their gender and subsequently socially transition in childhood versus those who disclose in adolescence or early adulthood differ across multiple domains including but not limited to their relationship to the broader TNB community, disclosure patterns, psychological challenges, identity integration, medical timelines and surgical needs. Despite these differences, there are very little existing data discussing these differential developmental trajectories. This workshop will present perspectives from the professional domains of mental health, medical and surgical care regarding the challenges that face these two distinct cohorts of

young people. Specifically, this team will discuss how gender dysphoria is experienced differently among these two groups, the differences in timelines for medical interventions, the different relationship with the larger TNB community of each group and the necessity for augmenting surgical approaches, particularly for trans feminine youth seeking vaginoplasty. Jo Olson-Kennedy is an Adolescent Medicine specialist and has been providing medical care for transgender and non-binary youth and young adults at Children's Hospital Los Angeles for the past 17 years. Darlene Tando is an LCSW practicing in the San Diego area who has provided mental health services for gender diverse, transgender and non-binary children, adolescents and adults for 18 years. Jessica Lee is a surgeon who has been providing surgical interventions for transgender adolescents and young adults for the past 4 years. Together this team will present critical information for other professionals to incorporate into practice across these three specialties.

Learning Objective 1: Recognize how gender dysphoria presents in childhood vs. adolescence

Learning Objective 2: Identify the differential patterns of intervention among childhood vs. adolescent presenters

Learning Objective 3: Describe the surgical options for transfeminine individuals who had endogenous puberty blocked

Method to Achieve Learning Objectives: Presenters will utilize didactic teaching methods with Power Point presentation slides to discuss concepts. Additionally, case reports will be presented to promote critical thinking and facilitate appreciation for the ideas presented in the didactic portion of the session. Finally, this team will attempt to have two patients with two parents from each of these trajectories of development to discuss personal perspectives as consumers of services and a parent of a transgender young person to highlight some of the differences in the two developmental pathways.

Oral: Health Professional Education

FRI-D2-T1: EDUCATION ON TRANS-INCLUSIVE CHEST CANCER SCREENING PRACTICES FOR IMAGING PROFESSIONALS

Arielle Martinez[1], Shanna Stryker[1], Jonah Yokoyama[2], Jules Madzia[1], Delia Sosa[1], Carson Hartlage[1], Harsimran Makkad[1], Madeline Schumacher[1], Catherine Xu[1], Elizabeth Kelly[1], Rahul Patel[1], Shalini Roy[1], Adam Conway[1], Jasmine Haraburda[1], Sarah Whitton[3], Sarah Pickle[1]
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Presented by: Arielle Martinez

Introduction/Background: The risk of breast/chest cancer (BCC) in transgender patients is insufficiently investigated in scientific research. There are many social and systemic barriers that impact a transgender patient's access to preventative and curative medical care. Furthermore, many healthcare professionals do not receive adequate training in how to provide care for LGBTQIA2+ patients. These factors combine to create space for negative experiences to occur, with up to one-third of transgender patients reporting events such as verbal harassment and refusal of care. Despite guidelines on breast/chest imaging for cancer screening being released by the American College of Radiology in 2021, many patients in whom screening is recommended currently remain unscreened, likely in part due to expectations of poor encounters.

Specific Aim: This pilot study aims to create and evaluate the impact of a replicable training model for healthcare staff involved in providing imaging for chest cancer screenings. The greater purpose of this project is to foster a more inclusive healthcare environment for LGBTQIA2+ patients, particularly transgender and gender non-conforming patients, by educating healthcare professionals who directly interact with transgender patients during imaging encounters for BCC screening.

Materials and Methods: We developed a 45-minute virtual educational session for the University of Cincinnati Health's Department of Radiology staff. The training covered terminology relevant to the LGBTQIA2+ community, inclusive screening techniques, current guidelines for BCC screening specific to the transgender community, and feasible steps to increase inclusivity and diversity in clinical spaces. Pre- and post-training surveys were developed in REDCap and included questions assessing demographics, prior exposure to the LGBTQIA2+ community, and self-reported knowledge. A gender attitudes scale (GAS) and direct knowledge assessment questions were also included. Data from the self-reported knowledge scale and GAS were analyzed with the Wilcoxon signed-rank test to measure significant differences between pre- and post-survey responses; the McNemar test was used to determine the training's impact on directly-assessed knowledge.

Results: The training session had 28 attendees. Seventeen individuals participated in the pre-survey and 12-14 in the post-survey. Most participants were mammography or ultrasound technicians (53% and 12%, respectively). No participants were a part of the LGBTQIA2+ community, but most (n=17, 77%) reported sometimes or often interacting with nonbinary patients and sometimes, often, or very often with transgender patients. After the training, there were significant increases in self-reported understanding of multiple LGBTQIA2+-related topics. There were no significant changes to directly-assessed knowledge or GAS scores. There will be more training sessions hosted in summer 2023 with updated results to reflect new data.

Conclusion: This training improved our group of imaging staff's self-reported understanding of gender-inclusive techniques for BCC screening imaging encounters, but did not change gender attitudes or directly-assessed knowledge. This pilot study demonstrated the feasibility and potential efficacy of gender inclusivity training for imaging staff and provided valuable insights for future research and educational endeavors. The next steps for this project include training a wider audience and assessing the impact of training on patients' experiences.

FRI-D2-T2: ONLINE LEARNING MODULES IMPROVE CONFIDENCE AND BEHAVIORS IN PROVIDING GENDER AFFIRMING CARE FOR YOUTH

Juanita Hodax, Nicole Kahn, Julia Crouch, Janis Sethness, Kevin Bocek, Catherine Sumerwell, Gina Sequiera
Seattle Children's Hospital, Seattle, WA, USA

Presented by: Juanita Hodax

Introduction/Background: Gender diverse youth are disproportionately burdened by poor health outcomes, yet healthcare providers often lack training and education in caring for this population.

Specific Aim: We aimed to explore change in provider confidence and behaviors following the implementation of an online learning course focused on gender affirming care provision for youth.

Materials and Methods: We created an asynchronous, online learning course to educate healthcare providers about gender affirming care for adolescents (https://cardea.matrixlms.com/visitor_catalog_class/show/595436). This consisted of 2 modules and was made available in October 2021. Participants were asked to complete 3 surveys for each module they completed: a pre-survey, a post-survey immediately after completing the module, and a follow-up survey that was emailed 3 months after the module was completed. Surveys included demographic data and items adapted from the Trans-Inclusive Provider Scale, a previously validated 27-item Likert Scale measure developed to assess providers regarding their inclusivity toward transgender and gender diverse adult patients. Paired sample t-tests were used to compare participant confidence in pre-, post-, and 3-month follow-up surveys. Behavior items for Module 1 and prescriber confidence items for Module 2 were measured and compared at pre- and 3-month follow-up.

Results: In 15 months, 487 participants completed at least one survey and spanned 37 states, Washington DC, Canada, and Mexico. There was notable diversity in provider types, the most common of

which were mental health providers (n=86, 17.7%), community health workers (n=71, 14.6%), and medical students or health professionals (n=61, 12.5%). Participants were significantly more confident in all aspects of care provision when comparing pre-surveys and post-surveys. This change in confidence was sustained at 3-month follow-up surveys in their ability to “support a gender diverse patient in talking with their parent or caregiver about their gender identity” (mean difference: 0.38, t=2.61, p=0.01), “explain to a parent or caregiver who is refusing to use a gender diverse patient's name and pronouns the negative impact this has on mental health (with patient’s consent)” (mean difference: 0.38, t=1.79, p=0.04), “provide information to a patient about local, gender-affirming resources youth can access confidentially (i.e., without parental involvement)” (mean difference=0.48, t=2.12, p=0.02), and “provide information to a patient or family about local, gender-affirming resources or supports for parents or caregivers of gender diverse youth” (mean difference: 0.48, t=2.35, p=0.01). However, these modules did not result in behavior change among medical providers regarding provision of gender affirming hormone therapy or puberty blockers.

Conclusion: Online learning modules may be an effective means of educating a large number of healthcare providers in a variety of settings and across disciplines about caring for gender diverse youth. While online learning modules may help increase provider confidence, additional educational opportunities may be needed to change provider behaviors related to providing gender affirming medical care.

FRI-D2-T3: BUILDING AND MAINTAINING EXCELLENCE: A GENDER AFFIRMATON EDUCATION PROGRAM AT A LARGE COMMUNITY HEALTH CENTER

Steph deNormand
Fenway Health, Boston, MA, USA

Presented by: Steph deNormand

Introduction/Background: Fenway Health is a federally qualified community health center (FQHC) in Boston, Massachusetts, with a mission to center LGBTQIA+ people, BIPOC individuals, and other underserved communities. For Fenway’s 5000+ trans and gender diverse (TGD) patients, Gender-affirming care (GAC) is provided through an integrated model within primary care and is expected of all pediatricians, family medicine, and internal medicine providers. While this expectation entails a detailed onboarding process, a gap in ongoing engagement and education in GAC was identified as a barrier to providing innovative, affirming, and accessible care to TGD patients. As seasoned providers depart and new providers join, maintaining an ad hoc training program has become insufficient and difficult to administrate.

Specific Aim: This project aims to develop a sustainable ongoing gender affirmation education program, requiring regular engagement with identified core competencies by primary care medical providers.

Materials and Methods: During each training year, a curated list of training opportunities was made available including publications, webinars, didactics, conferences, and independent study opportunities. A set of “core competencies” based on TGD community input were modified by a working group and used as the basis for determining content areas. Providers were expected to engage in one activity in each content area during the year. A variety of methods of engagement were made available; some content areas were incorporated into existing platforms and others were made available during opt-in meetings or as recorded webinars. Live training attendance and use of pre-established platforms were tracked automatically, while independent engagement required the completion of an online form.
Prior to the initiation of the pilot for the ongoing GAC education program, providers were anonymously surveyed regarding their comfort level providing GAC, self-rated competency, knowledge of existing resources, and level/types of engagement with ongoing education. This survey was reissued after the pilot year and following training year to assess comfort levels in providing GAC, self-rated competency, knowledge of existing resources, level/types of engagement with ongoing education, and program feedback.

Results: An assessment of pre- and post-survey data was used to assess effectiveness at addressing provider comfort with GAC, program engagement, and areas of improvement. Training completion data measured by provider, content area, site, and specialty were used to assess engagement levels and areas for improvement. Easy access to training and education, including in-house engagement during existing meetings, proved more successful in engaging providers than providing access to alternative training opportunities.

Conclusion: This program, and lessons learned, can serve as a model for health centers looking to build, maintain, and advance their providers' level of education in GAC. The administrative load presents a significant barrier, highlighting the need for a cohesive training platform. Providing access to training opportunities cannot be the only nor main mechanism for ongoing education. Continued low barrier access to training and education alongside institutional support for the importance of a comprehensive approach to GAC are essential to the advancement and maintenance of high-quality gender-affirming care within an integrated primary care setting.

FRI-D2-T4: INCREASING PCP LIKELIHOOD TO PRESCRIBE GENDER-AFFIRMING HORMONE THERAPY: AN RCT COMPARISON OF TWO EDUCATIONAL STRATEGIES

Helene Hedian[1], Aliza Norwood[2], Jenny Siegel[3], Danielle Loeb[4], Christopher Terndrup[5], Megan McNamara[6], Carl Streed, Jr.[7], Elijah LaSota[8], Mary Catherine Beach[1], Marielle Bugayong[1], Amanda Bertram[1], Sean Tackett[1]
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Presented by: Helene Hedian

Introduction/Background: Although gender-affirming hormone therapy (GAHT) can be safely prescribed in the primary care setting, many primary care providers (PCPs) feel unprepared to care for transgender and gender diverse (TGD) patients. We sought to measure the influence of brief educational interventions on PCPs' willingness to prescribe GAHT.

Specific Aim: (1) To compare the effect of a clinical knowledge training versus one showcasing TGD lived experiences, and (2) to assess the impact of a pocket resource for GAHT on PCP willingness to prescribe GAHT.

Materials and Methods: Internal medicine residents with a primary care clinic were enrolled at 12 study sites in California, Colorado, Maryland, New York, Ohio, Oregon, Pennsylvania, Tennessee, and Texas. Residents were randomized prior to enrollment and received an email invitation with links to a pre-test, two 1-hour webinars, and a post-test. The first webinar, which was on trauma-informed care for TGD patients, was assigned to all residents. The second webinar was determined by randomization. Half of the residents watched a lecture on TGD primary care ("clinical arm"), and half watched a panel of TGD people of color discussing healthcare experiences ("cultural arm"). There was a $100 incentive for completing all aspects of the study. All measures were the same on pre- and post-test. Attitudes were measured with a modified Transphobia scale for Healthcare Practitioners, measured as aggregated item-means of 10 items on a 7-point Likert scale (possible range 1-7); lower numbers indicate less transphobia. The knowledge measure combined a previously published scale with original questions: possible scores ranged from 0-20; higher numbers indicate greater knowledge. Residents rated their likelihood of starting GAHT and continuing GAHT on a 7-point Likert scale on pre and post-surveys. On the post-survey, residents reviewed a 1-page "Quick Guide for GAHT" and rated their likelihood of starting or continuing GAHT if they had access to this resource.

Results: Of 1602 eligible residents, 629 (39.3%) responded to the survey and were included in the analysis. Transphobia scores were low at baseline (Mean=2.09, SD=0.90). Transphobia decreased in both the clinical and cultural arms from 2.07 to 1.78 ($p<0.001$) and from 2.11 to 1.81 ($p<0.001$), respectively. At baseline, residents were likely to continue a patient's GAHT prescription (Mean=5.26, SD=1.68), but unlikely to start a patient on GAHT (Mean=3.55, SD=1.71). After watching the webinars, both arms were likely to continue GAHT (Mean=5.66, SD=1.48) and start GAHT (Mean=4.29, SD=1.73). After reviewing a pocket resource on GAHT, residents in both arms were even more likely to continue GAHT (Mean=6.17, SD=1.13) and start GAHT (Mean=5.45, SD=1.49).

Conclusion: We found that brief interventions had a measurable effect on attitudes and likelihood to prescribe GAHT in resident PCPs. Watching TGD people share life experiences was as effective at reducing transphobia as watching a lecture on clinical care of TGD patients. The results of this study demonstrate that brief, online educational interventions are effective at reducing transphobia and increasing the likelihood that PCPs will prescribe GAHT. Pairing trainings with a high-yield pocket resource on GAHT led to even greater willingness to prescribe GAHT.

FRI-D2-T5: DEVELOPMENT OF A NOVEL EDUCATIONAL PROGRAM TO IMPROVE HEALTHCARE EXPERIENCES FOR LGBTQ INDIVIDUALS: LGBTQ INTEGRATIVE TEAM EDUCATION (LITE) STUDY

Matthew Loria[1,2], Rachel Waitzman[2], Elad Fraiman[1,2], Ruthy Amkraut[2], Salvatore Caradonna[2], Celine Rajoulh[2], Allison Mo[2], Kelly Chambers[1,2], Alyson Auriemma[2], Megan McNamara[3], Shubham Gupta[1,2]
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Presented by: Matthew Loria

Introduction/Background: While LGBTQ Americans experience numerous health disparities, including disproportionate rates of suicide, substance abuse and depression, 18% of LGBTQ adults avoid seeking healthcare due to anticipated discrimination. Negative interactions with healthcare professionals, both clinical and nonclinical, can contribute to persistent disparities in LGBTQ health care. There is a general lack of education about LGBTQ patient needs, with 79% of nurses stating that they have no LGBTQ sensitivity training, despite often having the most patient-facing time. While many similar projects across the nation focus on training medical students and physicians, this training is designed to increase knowledge, engender positive attitudes, and foster constructive behavioral change among physicians, nurses, advanced practice providers, clerical staff, and other patient-facing positions.

Specific Aim: The long term goal of this project is to create an LGBTQ inclusive health care environment. We aim to do this by designing and implementing a non-traditional, highly interactive training for clinical and nonclinical employees at a regional hospital. Specific aims of this training include: 1) increasing healthcare workers' confidence in interacting with LGBTQ patients and 2) improving communication among healthcare workers and LGBTQ patients.

Materials and Methods: University Hospitals' center for LGBTQ+ & Gender Care Services is newly located at their Parma Medical Center. At this site, 200 employees will undergo this training. UH contacted Case Medical School Pride Association who has spear-headed the development of this project. We first conducted a literature review to identify common concerns of LGBTQ patients in the healthcare environment and learn about current educational methods to train staff on LGBTQ sensitive care. While most LGBTQ cultural competency training occurs through lectures or online modules, we are creating an in-person interactive 3 hour training. The entire design and implementation of this training program will be led by medical students. Participants will first work in small groups through a series of cases-based modules designed to address key concepts for LGBTQ care. Then, they will practice with standardized patients (SP) with immediate feedback from trained facilitators. Participants will take a pre- and post-test to determine the effectiveness of this intervention.

Results: The curriculum culminated in the development of two separate training sessions designed for clinical and non-clinical personnel. Overall, 12 modules and 7 SP cases were created. Modules focus on topics such as: understanding LGBTQ experiences, LGBTQ history and current events, fostering a welcoming environment, pronoun usage, LGBTQ health disparities, creating an environment of accountability, and specific trans-health needs. SP cases were designed to highlight concepts from these modules and how they translate to real-life interactions. The training sessions are expected to begin in July 2023.

Conclusion: Interactive team-based learning and live practice with standardized patients are novel methods of LGBTQ sensitivity training in hospitals. Furthermore, these trainings are unique as they will be entirely led by medical students. Overall, our aim is to create a training methodology that leads to actionable changes in communication by employees and serves as a model for training at other healthcare institutions looking to promote institutional culture change towards increased inclusivity of LGBTQ patients.

FRI-D2-T6: CORE COMPETENCIES FOR HEALTHCARE PROVIDERS AND CLINICS PROVIDING GENDER-AFFIRMING CARE FROM THE PATIENT PERSPECTIVE: AN INTERNATIONAL QUALITATIVE STUDY

Manraj Kaur[1], Shane Morrison[2], Shelby Deibert[3], Tim van de Grift[4], Astrid Hojgaard[5], Amalie Jacobsen[6], Natasha Johnson[3], Margriet Mullender[4], Lotte Poulsen[6], Thomas Satterwhite[7], Richard Santucci[8], John Semple[9], Tannon Topple[2], Kinusan Savard[10], Jens Soensen[6], Andrea Pusic[1], Anne Klassen[3]
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Presented by: Manraj Kaur

Introduction/Background: The lack of knowledgeable, culturally competent healthcare providers (HCPs) combined with structural barriers to gender-affirming care has been recognized as an area of concern by the World Professional Association for Transgender Health Standards of Care for the Health of TGD People version 8 (WPATH SOC8). Subsequently, the WPATH SOC8 recommends that institutions involved in training health professionals develop competencies for TGD health within their subspecialties. While core competencies have been defined by the jurisdiction-specific accreditation bodies for medical and surgical education councils, specific guidance related to what high-quality gender-affirming care looks like is lacking.

Specific Aim: The objectives of this study were to understand patient experiences related to seeking and receiving gender-affirming care and subsequently, to establish patient-derived core competencies for HCPs and clinics (outpatient or in hospital settings) providing gender-affirming care.

Materials and Methods: Transgender or gender-diverse (TGD) individuals who were 16 years or older and who had or were seeking gender-affirming care at four outpatient or tertiary care centers in the United States, Canada, Denmark or the Netherlands, and were able to provide informed consent were invited to participate in a semi-structured interview conducted in-person or over the telephone. Participants were asked to describe in detail their experience of care, including satisfaction with healthcare professionals and clinic administrative staff. All interviews were recorded and transcribed verbatim. Interviews conducted in Denmark and the Netherlands were translated into English prior to data analysis. The interviews were analyzed using the content analysis approach. Inductive, line-by-line coding was used to generate codes from the data. Constant comparison was used to develop the conceptual framework with top-level domains and subdomains.

Results: A total of 84 interviews were conducted (mean age, 34 ± 14 years); 56% of the participants were seeking or had masculinizing procedures. The core competencies of the health professionals and the

clinic administrative staff were described in terms of generic traits, gender-affirming care-specific cultural competencies, patient-centred care and care organization and delivery. All participants expected their provider and clinic staff to demonstrate professionalism, interpersonal communication, openness, and a non-judgmental attitude and be aware of and consider gate-keeping practices and discourses in their respective jurisdictions. Knowledge and competence regarding working with TGD clients were crucial to quality care, especially trauma-informed care. Participants expected a collaborative, person-focused communication style from their provider that was (a) evidence-informed, (b) thorough and responsive to their preferences for information, (c) incorporated their goals, preferences, and values, and (d) made them feel heard were central to patient-centred decision-making. Participants expected the provider, clinic, and clinic environment to signal allyship with TGD individuals, be gender-affirming, safe, proficient with paperwork related to care access and organized with respect to care delivery, including multidisciplinary post-operative care. HCPs or clinic staff who were members of the TGD community was identified as a key indicator of high quality care.

Conclusion: The patient-centered core competencies may be used as a framework to train HCPs and clinic staff in providing high-quality care and enhance the patient experience of receiving gender-affirming care.

Mini Symp: Health Services and Systems

FRI-E2-M: Interdisciplinary Approaches to Capacity Assessment for Medical Decision Making in Gender-Affirming Care

Kathleen Alto[1,2], Allison Myers[1,2], Kirtishri Mishra[1,2,3], Caitlin McCann[1], Sarah Benuska[1,2]
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Presented by: Kathleen Alto, Allison Myers, Kirtishri Mishra, Caitlin McCann, Sarah Benuska

Statement of Significance: Transgender health experts increasingly reject paternalistic model of care in which clinicians drive decisions, instead favoring patients as the primary decision-makers (Gerritse et al., 2021). In an informed consent model, the clinician's role shifts from determining medical necessity towards guidance about risks and benefits. Newest WPATH Soc8 guidelines identify capacity to engage in informed consent as key to assessment of adults seeking gender-affirming care. Capacity for medical decisions is broadly described as the ability to understand and appreciate risks and benefits of treatment, express a choice, and explain the reasoning behind that choice (Applebaum, 2007). While age of majority is used as proxy for capacity to consent (Grootens-Wiegers et al., 2017), intellectual or developmental disability, severe psychiatric symptoms, or cognitive impairments may temporarily or permanently impair an adult's capacity to make medical decisions about gender-affirming care (Moye et al., 2007).

A comprehensive assessment focused on the specific decision faced by the patient is indicated when concerns about capacity are raised. Clinicians assessing capacity must thoroughly understand the medical interventions, including patient-specific risks, benefits, and alternative treatments. Since individual judgments of capacity can be inaccurate and unreliable (Moye et al, 2007), a multidisciplinary approach to assessment is strongly recommended. At the MetroHealth Pride clinic, a capacity assessment includes a clinical interview with a psychologist that focuses on psychiatric and cognitive symptoms relevant to capacity. Vignette based assessments, structured interview tools, and collateral reports from caregivers may be used. Interdisciplinary team meetings with primary care clinician, psychologist, surgeon, social worker, patient, and caregiver as appropriate, can facilitate more nuanced conceptualizations of the patient's abilities and needs. Depending on the nature and degree of impairment in capacity, recommendations may include: psychiatric treatment, involvement of trusted caregivers in decision-making, additional support for education, and/or additional expert assessment.

People with disabilities are over-represented among gender minorities and face unique barriers to gender-affirming care (Mulcahy et al., 2022). Recent research highlights higher prevalence of autism

spectrum disorder and autistic traits in the gender minority population (Warrier et al., 2020). Capacity may be impaired in cases of developmental disability, especially when cognitive and communication deficits are severe (Strang et al., 2016). Patients with impaired capacity may present with formal and informal proxy decision makers (e.g., payees, caregivers), and informed consent process should be adjusted appropriately. Dewey (2013) raises valid concern that the ambiguity of informed consent may lay groundwork for gatekeeping when clinicians hold exacting standards for appreciation of medical transition. If clinicians overly focus on prevention of treatment regret, they ultimately risk impeding disabled patient's right to access care (Exposito-Campos, 2021). We propose interdisciplinary approaches to capacity assessment engender a person-centered approach that prioritizes access to care.

Learning Objective 1: Define role of capacity assessment in an informed consent model of gender-affirming care

Learning Objective 2: Describe tools for assessing capacity for medical decision making in gender-affirming care

Learning Objective 3: Identify potential recommendations when capacity for informed consent is impaired

Method to Achieve Learning Objectives: Interdisciplinary team including a psychologist, psychologist-in-training, primary care clinician, and surgeon will use literature, case examples, and visual aids to stimulate audience discussion

Mini Symp: Social Determinants of Health/Health Equity

FRI-F2-M: PRACTICAL RESISTANCE TO FORMAL AND INFORMAL CRIMINALIZATION OF GENDER EXPANSIVE COMMUNITIES TO IMPROVE SAFETY AND HEALTH OUTCOMES IN DIVERSE SOCIOPOLITICAL ENVIRNOMENTS IN THE US

Laura Mintz[1,2], LJ Johnson[3], Kathleen Alto[1,2], Maya Simek[2], Jessica Kant[4,5]
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Presented by: Laura Mintz, LJ Johnson, Kathleen Alto, Maya Simek, Jessica Kant

Statement of Significance: The rising tide of violent political actions and rhetoric aimed at gender expansive communities has mobiliized a broad range of trans* people and allies to oppose the legal restriction of standard of care medicine and to eliminate gender expansive people's existence alongside their families, loved ones, and healthcare providers. This new tide of violent rhetoric has overshadowed the longstanding reality that trans and gender expansive communities have been and are currently criminalized in multiple contexts, driving poorer outcomes and disproportionate burden of the structural determinants of health in comparison to cisgender peers.
This criminalization is not only formal involvement with the criminal legal system (policing, mass incarceration, prosecution, surveillance) but importantly the enormous range of informal criminalizing practices within healthcare (police in healthcare spaces, formal and informal surveillance of gender expansive persons, coercive psychiatric care, facilitation of involvement with the family regulation system, etc). Healthcare providers and workers across health systems participate and collude in these practices with the ultimate impact of decreasing gender expansive peoples' access to healthcare and additional toxic stress for gender expansive people and communities already navigating violence and stress on multiple fronts.
This symposium brings together a diverse group of activists, scientists, advocates, and clinicians to challenge themselves and participants to look deeply at the breadth of criminalization in care and to offer practical and concrete strategies to resist criminalization of gender expansive persons and communities.

Learning Objective 1: Describe the impact of formal criminalization (police and legal structures) and informal criminalization (coercion, state systems, in-clinic violence) on the health outcomes of gender expansive communities.

Learning Objective 2: Discuss successful interventions that coalitions of people involved in care have used to reduce the harm of criminalization in diverse political environments

Learning Objective 3: Discuss individual, group, and system strategies persons working in health systems (administrative, social work, case management, psychology, medicine) can use to resist the criminalization of gender expansive communities in order for participants to identify specific strategies to bring back to their own contexts.

Method to Achieve Learning Objectives: Facilitated conversation with a physician, two social workers, a psychologist, and a lawyer with diverse backgrounds working in diverse sociopolitical contexts in different locations in the US to decrease criminalization in care with question and answers from symposium participants

3:00pm - 4:15pm

FRI-A3-M: PRIDE IN ALL WHO SERVED: OVERVIEW OF A HEALTH PROMOTION GROUP TO ADDRESS SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUITIES IN LGBTQIA+ VETERANS

Michelle Wilcox[1], Teddy Bishop[2], Heather Sperry[3], Guneet Jasuja[4]
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Presented by: Michelle Wilcox, Teddy Bishop, Heather Sperry, Guneet Jasuja

Statement of Significance: PRIDE in All Who Served (PRIDE) is a health promotion group established in 2016 by Veterans Health Administration (VHA) to serve LGBTQIA+ Veterans. This 10-week health promotion group focuses on identity development, health promotion, and social connectedness and is shown to reduce suicide attempt likelihood, suicidal behavior, depression, and anxiety. This symposium will (a) examine the social determinants of health (SDOH) that impact the intersection of LGBTQIA+ Veterans with a focus on transgender and gender diverse (TGD) Veterans, (b) provide an overview of the development and implementation of PRIDE as a solution to a critical care gap and rapid scaling of the group, (c) discuss the PRIDE curriculum and training program, which address SDOH and health inequities, and (d) highlight a novel method for identifying LGBTQIA+ Veterans who completed the PRIDE group and report descriptive data for TGD Veterans who participated in PRIDE.

Learning Objective 1: After attending this symposium, participants will be able to describe 3 unique health inequities faced by TGD Veterans.

Learning Objective 2: After attending this symposium, participants will be able to provide an overview of the PRIDE curriculum and 3 Veteran-reported outcomes.

Learning Objective 3: After attending this symposium, participants will be able to consider different data elements in electronic health records to conduct program evaluation analyses.

Method to Achieve Learning Objectives: Speaker #1: Michelle Wilcox will provide an overview of the particular needs of LGBTQIA+ Veterans with a focus on TGD Veterans. SDOH and contextual factors that contribute to worse outcomes for TGD Veterans, with compounded outcomes for racial/ethnic minorities, will be discussed. Given that stigma, discrimination, and prejudice are likely contributors to suicide and worse health outcomes, TGD Veterans would benefit from tailored interventions such as PRIDE to

address SDOH and health inequities.

Speaker #2: Teddy Bishop will provide an overview of PRIDE's development and implementation across VHA. Development of the PRIDE group will be discussed, including its human-centered design and inclusion of feedback from LGBTQIA+ Veterans and facilitators. Pilot outcomes include increased protective factors (i.e., resilience) and decreased suicidal ideation and symptoms of distress (i.e., stigma, depression, anxiety). Further, this presentation will provide an overview of the PRIDE team's organization and growth.

Speaker #3: Heather Sperry will provide an overview of PRIDE's manualized group and training program targeted to address SDOH and health inequities among LGBTQIA+ Veterans. Discussion will include the 10-week curriculum (e.g., Identity Development, Military Culture, Affirmative Care) and the iterative process utilized for updating the curriculum, with particular focus on intersections of identity. Additionally, the PRIDE Training Program will be discussed, including the implementation and sustainment of PRIDE across VHA.

Speaker #4: Guneet Jasuja will discuss ongoing identification of a PRIDE cohort using VHA administrative data. Using an iterative process, a working cohort of 429 LGBTQIA+ Veteran PRIDE participants, of whom 204 are TGD, has been identified. This presentation will focus on the novel methods in identifying a cohort of LGBTQIA+ Veterans in the EHR who participated in a clinical program; describe the TGD PRIDE cohort in terms of demographics, suicide risk, chronic conditions, healthcare utilization; and summarize key next steps.

Oral: Engaging Family and Caregivers

FRI-B3-T1: EFFICACY OF AN EDUCATIONAL SEMINAR ON IMPROVING PATIENT AND CARE PERSON UNDERSTANDING OF AND PREPAREDNESS FOR VAGINOPLASTY

Darren Ha[1], Micol Rothman[2,3], Rita Lee[2,3], Christina New[3,4]
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Presented by: Darren Ha

Introduction/Background: Gender-affirming surgery (GAS) is medically necessary and beneficial for transgender and gender diverse (TGD) individuals who experience gender dysphoria and desire surgical interventions. Long wait times often limit access to GAS and hinder the ability to ask questions of surgical providers. Patients often rely on internet resources for information on GAS, however the accuracy and quality of these resources may not be appropriate and could add to potential anxiety regarding surgical consultation and interventions. Additionally, the amount of information given at the initial consultation can be overwhelming, and patients may benefit from hearing about the procedures over time. To date, there has been limited data on best strategies to educate patients and care persons on vaginoplasty.

Specific Aim: The aim of this quality improvement initiative was to evaluate the feasibility and efficacy of a pilot preoperative educational presentation on patient and care person understanding and preparedness for vaginoplasty.

Materials and Methods: Patients at least 18 years of age with an upcoming vaginoplasty consultation in the Department of Plastic Surgery on or before April 2023 and their care persons were invited to attend. Content of the presentation was in concordance with WPATH Standards of Care version 7 and encompassed pre-, intra-, and post-operative requirements and expectations. Pre- and post-session surveys were administered to participants and assessed awareness of preoperative assessments, understanding of vaginoplasty and recovery, and self-reported preparedness for surgery. Survey

responses were analyzed using paired t-test; qualitative data from Likert scale questions were aggregated and analyzed using descriptive statistics.

Results: 17 participants were in attendance. Eight pre- and eight post-session patient surveys were received and six could be matched. Five pre- and five post-session care person surveys were received and three could be matched. There was a significant improvement in understanding of all elements assessed for both patients and care persons who could be matched. Aggregate responses for each group demonstrated similar improvements in understanding and self-reported preparedness (3.5 vs 4.7, pre vs post, patients; 2.9 vs 4.5, pre vs post, care persons; $p< 0.0001$ for both). Participant feedback included expanding presentations to other forms of GAS and allocating more time for participant questions.

Conclusion: The educational seminar on vaginoplasty was effective in improving understanding and preparedness for vaginoplasty for both patients and care persons. Future iterations of this presentation will aim to streamline delivery of content and allow more time for questions.

FRI-B3-T2: HISTORY OF FAMILY NEGATIVITY ASSOCIATED WITH SIGNIFICANT REDUCTIONS IN THE EMOTIONAL WELLBEING OF TRANSGENDER YOUTH

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Presented by: John McKenna

Introduction/Background: There is a growing body of research demonstrating that family support can have substantial benefits for the emotional well-being of transgender youth. However, there is less research demonstrating the relative impacts of positive and negative familial behaviors on youth well-being.

Specific Aim: The purpose of this study was to understand the relative effects of positive- and negative-aspects of family support on key psychological measures in transgender youth seeking gender affirming care.

Materials and Methods: The study population consisted of 175 transgender youth between the ages of 13 and 18 who were seeking gender affirming hormones. Part of their assessment included screening with the Family Environment Scale – Adolescent, a tool designed to look at family experiences related to gender identity and expression. The tool contains 7 subscales. Three are positive: open communication, advocacy/resources, and explicit care and support for gender. Three are negative: exclusion and abuse, viewing gender and expression as moral wrong, and trying to change the TGD individual’s gender expression. The measure also yields an overall support score. Youth well-being was assessed using the Youth Self Report (YSR), a validated, and nationally normed tool that is widely used to understand various aspects of young people’s mental health.

Results: Subscales associated with negative support were associated with significant increases in internalizing problems, externalizing problems, and total problems, as well significantly increased odds of thinking about suicide. Overall family support, in contrast, was associated with improvement across all four areas of child well-being. Interestingly, the only positive family support subscale associated with changes in well-being was Explicit Care and Support, which was associated with significantly fewer externalizing problems and total problems, but no changes in internalizing problems or thoughts of suicidality. There were no significant changes in these associations when adjusted for affirmed gender identity.

Conclusion: This work adds to the growing research emphasizing that the family environment has significant impact on the well-being of transgender youth. Even in a well-supported population – where parents were willing to support a consultation for gender affirming care – negative familial interactions had a profound impact on the mental health of transgender youth. There is a need for consistent parental education on the need for families to avoid engaging in behaviors that could be seen as blaming,

stigmatizing, or attempts at conversion. In this population, explicit care and support for a young person's gender was beneficial, but negative behaviors had a greater impact – even though they occurred in a smaller percentage of the population.

FRI-B3-T3: Stigma Experiences and Management Among Trans Youth and their Siblings in the Northeastern US

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Presented by: Eli Godwin

Introduction/Background: Stigma and discrimination targeting transgender and/or nonbinary (trans) people, particularly youth (TNY), is virulent at this time in the US. While a growing body of research demonstrates the effects of anti-trans stigma on trans adults and youth, few studies have examined the effects of "courtesy" anti-trans stigma among family members of TNY, particularly siblings. Most research also focuses on negative ramifications of stigma, rather than how TNY and siblings exhibit resilience through stigma management strategies.

Specific Aim: 1. Describe how TNY and their siblings conceptualize, experience, manage, and resist anti-trans stigma in various forms
2. Examine how TNY and their siblings' experiences and management of anti-trans stigma change over multiple timelines: adolescent development, gender affirmation trajectories, and structural/sociopolitical developments

Materials and Methods: We conducted a secondary analysis of interview data from 10 TNY/sibling dyads from the Trans Teen and Family Narratives Project (PI: Sabra Katz-Wise), a longitudinal study conducted from 2016-2019 (spanning the election of Donald Trump as President) among TNY and family members in the New England region of the US. At baseline, TNY ages ranged from 13-17 years and sibling ages ranged from 14-24 years. Using conceptual frameworks of stigma and its management (Goffman, 1963; Hannem & Bruckert, 2012), the Health Stigma and Discrimination Framework (Earnshaw & Chaudoir), and Ecological Systems Theory (Bronfenbrenner, 1979), we conducted reflexive thematic analysis (Braun and Clarke, 2022) of 92 semi-structured interviews conducted with 10 TNY/sibling dyads who completed at least 4 of the 5 waves of data collection.

Results: TNY and siblings experienced and anticipated multiple types of anti-trans stigma, including interpersonal stigma, structural stigma, courtesy stigma (for siblings), and internalized stigma (for TNY). Both TNY and their siblings employed various strategies to manage anti-trans stigma, such as selective disclosure of their/their sibling's gender modality, reducing contact with unsupportive peers or family members, and performing educational labor about trans people. Participants engaged in meaning-making about anti-trans stigma, frequently attributing stigmatizing beliefs (or lack thereof) to certain religious and political affiliations, regional cultures, and lack of accurate information about trans people. Schools were a common setting in which stigma was both enacted and resisted. Despite the dyads living in relatively "trans-friendly" states and/or communities, concerns about the shifting sociopolitical climate throughout the US were salient for both TNY and siblings.

Conclusion: Even while living in a relatively supportive area of the US for trans people, TNY and their siblings anticipated, encountered, and managed multiple forms of anti-trans stigma. Participants' concerns about shifting sociopolitical currents at both federal and state levels with respect to trans people indicate that the current rash of anti-trans laws and policies can have negative impacts for TNY and their families beyond the borders of states in which they are debated and enacted.

FRI-B3-T4: “GIVING AGENCY OVER THEIR HEALTH:" A CONTENT ANALYSIS OF RESPONSES TO A PATIENT AND FAMILY SATISFACTION SURVEY REGARDING GENDER INCLUSIVITY IN A LARGE PEDIATRIC ACADEMIC CENTER

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Presented by: Scott Jelinek

Introduction/Background: Many hospital systems seek to provide inclusive and affirming care to all patients, recognizing the importance of respecting patients' identities as a key aspect of quality healthcare. However, there has been limited research on the lived experiences of families seeking care at our institution, particularly those with transgender and gender expansive children and adolescents.

Specific Aim: This study aimed to explore the care experiences of families to develop better understandings of perceptions of inclusivity and affirmation in our health system’s community and hospital settings, with particular attention given to interactions with healthcare providers and staff. The findings of this study are intended to help inform best practices and further improvements in care delivery, develop recommendations for enhancing patient-centered care and ensuring a supportive healthcare environment for all individuals, regardless of gender identity.

Materials and Methods: A patient and family satisfaction survey was distributed through Press Ganey to families of children and adolescents who received medical care at our institution. Researchers culled responses from July 1, 2021 to March 17, 2023 using key words gender, identity, pronoun, binary, and orientation. Responses (n = 71) were qualitatively analyzed by means of an inductive content analysis, extracting emergent themes by classifying the arising phenomena into conceptually meaningful categories.

Results: Seven themes emerged from the analysis: 1) Respect for Pronouns and Names, with many positive comments about staff's respect for the child's identity; 2) Welcoming Environment, a critical aspect highlighted in the patient experience; 3) Positive reception of staff displaying pronouns on name badges, promoting an inclusive atmosphere; 4) Use of Sexual Orientation and Gender Identity (SOGI) Assessment Tools, where most participants preferred electronic responses; 5) Struggle with Pronouns, showcasing challenges among the staff in correctly using preferred pronouns; 6) Misgendering and Deadnaming, a noteworthy area of concern for patients and their families; and 7) Caregivers being Misgendered, demonstrating a broader issue that extends to family members as well as patients.

Conclusion: This study highlights progress in establishing a patient-centric, inclusive care environment, while also illuminating areas requiring further improvement in a large pediatric academic health system. This study underscores the need for continued staff training on these aspects of patient care. The findings affirm the importance of using correct pronouns and names in fostering a positive patient experience and creating a welcoming environment for all. Future research should focus on investigating and developing innovative strategies to enhance these crucial domains, aligned with best practices to provide inclusive and affirming care in pediatric health care settings. Harnessing the power of this patient and family-centered feedback serves as a vital benchmark, offering a robust method for evaluating the effectiveness and impact of diverse quality improvement strategies and interventions, thereby continuously improving the care experience.

FRI-B3-T5: DEVELOPMENT OF THE FAMILIES IN TRANSITION THERAPEUTIC GROUP FOR GENDER-DIVERSE YOUTH AND THEIR CAREGIVERS

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Presented by: Richard Brandon-Friedman

Introduction/Background: Gender-diverse youth (GDY) experience elevated levels of psychosocial concerns due to the variety of negative experiences many GDY encounter in their daily lives (e.g., bias, discrimination, isolation, marginalization, and rejection). Alternatively, many GDY exhibit high levels of resiliency. A primary source of resiliency is a supportive relationship between GDY and their caregivers, but caregivers often need a space and time to learn about gender diversity, process the youths' gender identity, examine their own beliefs, and develop skills to support the youth. GDY have identified caregivers' efforts to learn about gender diversity, ability to discuss gender diversity, provision of emotional security, and acting as advocates as primary sources of support, but caregivers often need support to develop these skills.

Specific Aim: The described project used community-based participatory research to develop a therapeutic group for GDY and their caregivers. Group-based services are beneficial for members of marginalized communities as they allow for destigmatization, conjoint learning, and community connectedness. The conjoint curriculum is the first known that addresses GDYs' and caregivers' needs simultaneously and one of few focused on GDY.

Materials and Methods: During the fall of 2022 and early spring 2023 a team of social workers, caregivers of GDY, community-based service providers who work with GDY and their families, representatives of two community partner agencies that work with GDY and their families, gender-diverse community members, and a research team of masters and doctoral level social work students and a social work faculty member developed an 8-week curriculum for GDY and their caregivers. The curriculum was built on a previously developed 8-week group developed for GDY only. The initial draft curriculums were then reviewed by an additional caregiver of a GDY and a GDY; their feedback was incorporated into the final curriculum.

Results: The resultant curriculum consisted of the following one and a half hour sessions for caregivers: Exploring Gender; Minority Stress and Resilience; Community, Othering, and Coming Out; Advocacy and Microaggressions; Family and Outside Relationships; Grief, Religion, and Spirituality; Body Positivity, Dysphoria, and Gender Euphoria; and Curriculum Review, Reflection, and Moving Forward. The youth sessions were: Exploring Your Gender; Minority Stress and Resilience; Coming Out and Building Community; Self-Advocacy and Confronting Microaggressions; Evaluating Environments and Enhancing Assertiveness; Relationships with Family; Body Image, Body Positivity, and Gender Euphoria; and Curriculum Review, Reflection, and Moving Forward. Three sessions included a 30-minute conjoint discussion during which youth and caregivers discussed topics that are often difficult for families. The topics covered conjointly were: Completing an ecomap showing who the youth is out to and who they desire to be out to, developing assertiveness skills when addressing concerns related to gender identity, and the final overview and discussion of building gender euphoria.

Conclusion: Families in Transition is an 8-week curriculum for GDY and their caregivers developed within the community and designed to enhance communication related to gender, improve conjoint understanding of gender, develop advocacy skills, improve mental health, enhance community connectedness, and further build caregiver support.

Mini Symp: Health Professional Education

FRI-C3-M: A LITERATURE ANALYSIS ON EDUCATION OF GRADUATE STUDENTS AND HEALTH PROFESSIONALS IN GENDER IDENTITY AND GENDER AFFIRMING CARE: A USPATH EDUCATION COMMITTEE INITIATIVE

Kelly Ducheny[1], Danielle Moyer[2], AC Noël Rakotoniaina[3], Gaya Chelvakumar[4], Alicyn Simpson[5]
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Presented by: Kelly Ducheny, Danielle Moyer, AC Noël Rakotoniaina, Gaya Chelvakumar, Alicyn Simpson

Statement of Significance: Transgender and gender diverse (TGD) people experience persistent and numerous health disparities, with research highlighting a wide range of medical and behavioral health disparities. In addition, it is often difficult for TGD people to locate affirmative and knowledgeable medical, behavioral health, vocal and surgical care. Despite the consistently demonstrated health need, few systems intentionally train their students or care providers to provide gender affirming care. Clinicians, residents, fellows, trainees and students across disciplines report a lack of preparation to provide gender affirming care while expressing a desire to receive this training. USPATH, as an organizational leader in TGD health and wellness, is uniquely positioned to develop strategies and resources to address these training gaps across disciplines and to support its membership in training the next generation of gender affirmative care providers.

In 2022, USPATH created its Education Committee. Committee members include graduate students, and early/mid/late career professionals across a range of disciplines. As its first initiative, the Education Committee is titrating the existing literature across disciplines on curriculum development and education of graduate students and health professionals on gender identity/gender presentation and the provision of gender affirmative care. The Committee is conducting a comprehensive literature review across disciplines on curriculum development and health professional education methods to identify best practice and knowledge/resource gaps in graduate and health professional education in this area. Literature is being assembled through a university library assisted literature search. Literature will be summarized/coded. Extracted data will be analyzed and synthesized, with the analysis used to inform future Committee activities and available for dissemination. The initial search resulted in 182 articles. Following removal of duplicates and preliminary abstract review, 77 articles were excluded and 105 articles underwent full-text review. Full-text articles ranged across 3 categories: (1) curriculum development and/or evaluation, (2) education-related survey, and (3) education-related literature review and/or recommendations. The Committee will present on the results of the data analysis, including a discussion on identified best practices, patterns within and across disciplines, and evidence gaps. The Committee will also gather feedback from USPATH members on future initiatives/offerings and initiatives/educational products would be most useful for USPATH members.

Learning Objective 1: Identify gaps in health professional education on gender affirming care in the United States.

Learning Objective 2: Describe the critical value of integrating TGD lived experience into professional education on gender affirmative care.

Learning Objective 3: Discuss the role of USPATH and the Education Committee in addressing these educational gaps.

Method to Achieve Learning Objectives: Presenters will discuss the creation and purpose of the Education Committee, describe the pressing need for a comprehensive literature review of education best practices, including the importance of seeking resources across disciplines, discuss the results of the data analysis, including a discussion on identified best practices, patterns within and across disciplines, and evidence gaps. Presenters will invite audience members to offer feedback on the data analysis and findings of the comprehensive literature review, types of resources that would be be most helpful resulting from the literature review and additional educational initiatives or resources the Committee could pursue that would be helpful for USPATH members.

Oral: COVID-19/Pandemic Impacts

FRI-D3-T1: Gender, Sex Assigned at Birth and Legal Sex on Estimated Risk of Covid-19 Complications

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Presented by: Johanna Back

Introduction/Background: Sex assigned at birth (SAB) and gender affect the risk of acute complications from Covid-19 infection, as indicated in studies among cisgender persons. Estimated Covid-19 risk scores have factored in variable definitions of sex but not gender. No studies have examined the risk of acute complications in transgender and gender diverse (TGD) persons receiving gender affirming hormone therapy (GAHT). This presents a gap in 1) understanding the role of hormones in Covid-19 infection, 2) Covid-19 risks faced by the transgender population and 3) the effect of social, legal, and medical conflations of sex and gender in healthcare measures.

Specific Aim: To examine the impact of SAB, gender identity, legal gender marker change, and duration of GAHT on the estimated COVID risk (MASSBP) score, number of Covid tests and infections, and vaccination status in a sample of TGD adults receiving GAHT.

To assess the consistency among legal sex, SAB, and gender identity data in a sample of TGD adults within a healthcare system's EHR, and its potential impact on Covid related healthcare measures.

Materials and Methods: Methods: Retrospective chart review, with data extraction from EHR database and free-text extraction from visit notes
Sample: 619 TGD adults receiving GAHT from 1/2012 to 9/2021 at the Institute for Sexual and Gender Health, University of Minnesota.
Variables: Demographics, number of Covid tests, number of positive tests, Covid related hospitalizations/symptoms, vaccination rates, legal sex, SAB, Gender marker change, Gender identity, duration of GAHT, MASSBP score.
Analysis: Descriptive and comparative statistical analysis among variables, using Excel

Results: Legal sex and SAB were inconsistent, with 48.2% having had legal gender marker change, 5% during pandemic. EHR SOGI data collection was limited, with 19% of SAB data and 21% of gender identity data was missing, compared documentation in visit notes. Over 40% of patients were asymptomatic at time of Covid testing, and positive test rates were similar to state rates at the time. Transfeminine persons had similar vaccination rates to the state overall, while transmasculine and nonbinary persons had lower rates. Only 10 patients had ED visits or hospitalizations, most among unvaccinated persons. Transfeminine persons were more likely to have high MASSBP scores, but those with moderate and low risk categories showed no difference for gender or SAB. Long duration GAHT (>16 years) and transfeminine gender were associated with higher MASSBP scores, likely a function of age.

Conclusion: Legal sex is poor marker of SAB or of patient physiology. EHR databases are erratic as sources of SOGI data, while determination by a two step, standardized and systemic process remain improved markers for "sex" in measures. Among a Midwestern sample of transgender persons on hormone therapy, Covid infections rates were similar to overall population, but full vaccination rates differed by gender identity. One estimated risk of Covid complications (MASSBP) is affected by the interaction of legal sex versus SAB, gender identity, age and duration of hormone therapy. The Covid-19 pandemic presents an opportunity to examine concepts of sex and gender and how these interact with health systems, and research methods in a marginalized population.

Oral: Health Services and Systems

FRI-D3-T2: PATIENT EMPOWERMENT AMONG TRANSGENDER AND GENDER DIVERSE YOUTH: THE GENDER EMPOWER STUDY

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Presented by: Chaya Pflugeisen

Introduction/Background: Patient empowerment (PE) – broadly understood as the enhancement of healthcare knowledge, control, and decision-making engagement – is becoming increasingly important as healthcare becomes more collaborative. PE has been shown to positively associate with several measures, including quality-of-life, self-esteem, self-efficacy, and mental health. Patient empowerment amongst TGD youth has not been studied but may illuminate pathways to alleviating healthcare-related stressors in this population and improving care access and experience for youth.

Specific Aim: The primary objectives of this study were to assess domain-specific and overall patient empowerment and to then evaluate the relationship between PE and perceived parental support and sociodemographic variables in a sample of TGD youth.

Materials and Methods: We adapted a validated, five-domain (knowledge, control, identity, decision-making, supporting others) PE scale for use with TGD youth ages 14-24 who had engaged in discussion with healthcare providers around gender-affirming care. The confidential, online survey was distributed widely throughout our healthcare organization, to gender clinics across North America, to organizations that serve queer youth in our region, and through professional and personal networks. The survey was open for eight weeks in Spring 2022.

Results: 177 youth completed the survey. Mean age was 18.4 ± 3.0 years, the sample was 39.5% gender-diverse/nonbinary, 16.4% transfeminine, 44.1% transmasculine, and 16.9% Black, Indigenous and/or People of Color. On a 4-point Likert-type scale, average empowerment was 0.22 points higher in youth with supportive parents than those without (99% CI 0.06–3.46, $p < 0.001$) and 0.20 points higher in youth who had accessed gender-affirming mental health support (99% CI 0.06–3.30, $p = 0.001$). Parental support increased youth's sense of control over their health and healthcare by 0.29 points (99% CI 0.09–0.50, $p < 0.001$), and mental health support increased youth decision-making agency by 0.30 points (99% CI 0.06–0.53, $p = 0.001$). Significant marginal associations between empowerment measures and sociodemographic variables had medium to large effect sizes (Cohen's |d| ranging from 0.48-0.84).

A majority (71%) of our sample reported that their caregivers were supportive or very supportive of them accessing gender-affirming care. Youth sense of control over gender-affirming medical care decreased linearly with decreasing parental support ($p < 0.001$). With respect to healthcare knowledge, decision-making capability, and the ability to support peers, youth with the most *unsupportive* parents reported patient empowerment comparable to those with the most *supportive* parents ($p > 0.05$). Youth with somewhat unsupportive parents consistently reported the lowest PE.

Conclusion: This is the first study to assess patient empowerment in TGD youth. Several sociodemographic factors were significantly associated with overall and domain-specific empowerment. This study adds to a body of work that suggests that high parental supportiveness for TGD youth yields positive outcomes and suggests that additional support may be needed for youth with somewhat unsupportive parents, who experience the lowest empowerment. Further work in this area is needed to better understand patient empowerment in TGD youth. Future studies with larger samples, longitudinal designs, and a more nuanced parental support instrument will greatly benefit our understanding of PE in TGD youth.

FRI-D3-T3: A Survey of Provider Strategies for Gender-Affirming Surgical Referral

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Presented by: Essie Ghafoor

Introduction/Background: Mental health provider assessment prior to gender-affirming surgery (GAS) is recommended by the World Professional Association of Transgender Health Standard of Care 8 (WPATH

SOC v8). The most recent Standards of Care recommend behavioral health assessment before gender-affirming surgery, either by an interdisciplinary team or a qualified provider. There needs more data informing the evaluation approach for the readiness assessment. We conducted a cross-sectional study to characterize the decision-making process of mental health providers (MHPs) to assess behavioral health readiness prior to GAS.

Specific Aim: The goal of this study was to characterize current strategies in assessing readiness for gender-affirming surgery, in a local cohort of mental health professionals.

Materials and Methods: MHPs who provided care to transgender and non-binary (TGNB) individuals in Baltimore and the District of Columbia were identified through Psychology Today and surveyed via email to investigate their approach and assessment of psychosocial domains during pre-surgical referral for GAS. MHPs were grouped by method of training in TGNB care, number of evaluations completed per year, and gender identity of the provider. Descriptive statistics were calculated. Chi-square/Fisher's exact tests were used to compare the assessment methods used, psychosocial domains prioritized, and potential barriers for referral between the groups. One-way ANOVA were used to compare the number of sessions required and assessment outcomes between groups.

Results: A total of n=490 MHPs were identified. Of n=98 /490 (20%) MHPs who responded, n=22/98 (22.4%) identified as TGNB. TGNB MHPs were more likely to consider unrealistic expectations as a contraindication to referral compared to cisgender MHPs (n=16 [88.9%], n=29 [51.8%]; P=.005). Evaluations resulted in surgical referral for a median of 95% of clients (IQR [85.0% – 100.0%]) and did not significantly differ based on volume of evaluations or gender identity of the evaluating provider. On average 3.1 ± 2.9 sessions were required between letter request and referral. Cisgender MHPs with a low-volume practice required more sessions (4.3 ± 3.4) before referral compared to cisgender high-volume (1.5 ± 0.4), TGNB high-volume (1.9 ± 1.3), and TGNB low-volume MHPs (1.8 ± 1.1; *P*=.006).

Conclusion: The approach to MHP assessments of behavioral health readiness prior to GAS is variable, though most evaluations result in referral. This inconsistency is demonstrated in varying session requirements and contraindications to referral.

FRI-D3-T4: PATIENT AND PROVIDER EXPERIENCES ON MISGENDERING IN HEALTHCARE

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Presented by: Kyle Okamuro

Introduction/Background: Misgendering of transgender and gender nonbinary (TGNB) individuals in healthcare settings can lead to worse mental and physical health outcomes, as well as decreased utilization of care. While the negative impacts of misgendering are well documented, few studies have investigated the factors that contribute to this phenomenon.

Specific Aim: In this study, we aimed to identify factors that contribute to the misgendering of TGNB individuals in the healthcare setting. We also aimed to identify solutions that future research and system engineering approaches can explore. We hypothesized that misgendering occurs due to a constellation of factors, from individual to system levels.

Materials and Methods: Twenty-three in-person and Zoom interviews with TGNB patients, gender-affirming care providers, and transgender health care workers were performed. Interviews were conducted individually using an open-ended topical guide and recorded. Audio files were transcribed verbatim. Analysis was performed by two independent study personnel who hand coded the transcripts using Constructivist Grounded Theory qualitative methods.

Results: Analysis revealed several preliminary misgendering themes and subthemes that describe various sources, risk factors, modifying factors, as well as implications of misgendering on patient

engagement with healthcare (Table 1). Preliminary solution themes included developing systems to provide continual training and feedback to patient-facing staff, provider self-practice, inclusive naming, and resolving issues with the EHR. Additionally, a four-step provider response to misgendering a patient was recommended with the following steps: 1) acknowledge 2) apologize 3) advance (past the incident) 4) act (to prevent recurrence) (Table 2).

Conclusion: Our data suggest that misgendering is ubiquitous and perpetuated by numerous sources operating at multiple levels within the healthcare system. Any potential solution to reduce this non-inconsequential phenomenon will require a multifaceted approach targeting behavioral, technological, and implementation domains. Future research should employ human factors, improvement science, risk management, and biopsychosociotechnical systems approaches.

FRI-D3-T5: UTILIZING TELEMEDICINE TO MAINTAIN ACCESS TO GENDER EXPRESSION CARE, A NOVEL PROGRAM FOR SOCIAL TRANSITION, AFTER THE COVID-19 PANDEMIC

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Presented by: Sai-Wing Chan

Introduction/Background: While many transgender and gender-diverse (TGD) individuals have access to gender-affirming hormone therapy, surgeries, and mental health care, support with aspects of social gender expression are not often provided, being viewed as “cosmetic” and non-essential. This lack of professional guidance can lead patients to unvetted lay resources that may reinforce stereotypes, resulting in suboptimal outcomes during transition. The Kaiser Permanente Northern California Gender Expression Care (GEC) Pilot Program, established in 2019, provides holistic and practical support to patients in a small-group format, creating a safe space for exploring and refining each patient's unique social gender expression.
During the COVID-19 pandemic, in-person workshops were discontinued. To maintain access to this program, workshops were adapted to an online, video-based format, allowing patients to continue participating from the safety of their homes. Several unique benefits emerged from the successful transition to a telemedicine format, rendering this change permanent.

Specific Aim: 1. Understand the value of GEC as an adjunct to traditional medical services
2. Explore how telemedicine provides equitable patient access, regardless of geography
3. Discuss the strengths and weaknesses of video-based workshops in providing social support and practical skills for non-pharmaceutical, non-surgical treatment of gender dysphoria

Materials and Methods: Following adaptation to a telemedicine platform, patients in the GEC program participated in a biweekly six-session online-based virtual workshop series. Each group was composed of 12-20 participants who identified as TGD. Topics included professionally guided free-form exploration of authentic gender expression, transition timeline planning, gender-affirming speech therapy, movement and exercise, wardrobe, hairstyling, and cosmetics. Discussion topics during each workshop were tailored to the individualized needs of participants.

Results: To date, more than 300 transmasculine, transfeminine, and gender-diverse individuals within 13 cohorts have participated in the GEC program. While initial in-person workshops were limited to 6-10 patients who were able to travel to the San Francisco Bay Area, the telemedicine format has allowed larger cohorts of patients across Northern California to participate from any internet-connected device, increasing the geographic reach and diversity of each cohort.
After completing the workshop, most participants rated the virtual format as good, very good, or excellent (88.8% [95%CI: 82.5%—95.0%]). They reported that GEC filled a critical gap in their care (82.7% [95% CI: 73.7%—89.6%]) and should be available to all TGD patients (94.9% [95% CI: 88.5%—98.3%]).

Conclusion: We found telemedicine to be an ideal format for delivering GEC, as participants can build social connections, learn practical skills from a variety of experts, and explore ways to express their gender identity in a safe and comfortable environment. In addition, the virtual format was endorsed by a large majority of participants. This provides more equitable access by removing barriers and reducing costs (both to providers and patients), while mitigating fears of discrimination and safety concerns inherent to in-person encounters. In this way, the GEC program offers professional guidance to help patients express their most authentic selves during social transition and is primed to expand beyond traditional geographic boundaries.

FRI-D3-T6: THE TRANSGENDER LATINÉ ASYLUM PROCESS EXPERIENCE: A QUALITATIVE ANALYSIS

Gabriela Gonzalez[1], Melissa Suarez[2], Kyle Okamuro[2], Jamie Finegan[2], Yahir Santiago-Lastra[2], Tara Cohen[3], Alan Card[2], Jennifer Anger[2]
[1]University of California, Davis, Davis, CA, USA, [2]University of California, San Diego, San Diego, CA, USA, [3]Cedars-Sinai, Los Angeles, CA, USA

Presented by: Jamie Finegan

Introduction/Background: The documented experiences of transgender and gender non-binary (TGNB) individuals from Latin America have demonstrated the marginalization experienced by community members. There continues to be scarce data about the refugee transgender Latiné experience and their experiences accessing gender-affirming care services.

Specific Aim: This analysis aimed to capture the transgender Latiné patient asylum and gender-affirming care experiences.

Materials and Methods: Participants were recruited via 1) TransFronteras, a community organization that advocates and provides shelter for TGNB people recently seeking asylum in the United States, and 2) urology clinics in San Diego where transgender Latiné patients sought gender affirming pelvic or “bottom” surgery. Ten semi-structured individual phone interviews were conducted using a topical question guide about their asylum process and gender-affirming care experience. The interviews were de-identified, recorded, transcribed verbatim, and translated. Qualitative analysis was performed using Grounded Theory methods, as described by Charmaz. An iterative line-by-line, open-coding approach was used until thematic saturation was achieved. Initial codes were combined and grouped into thematic categories and subcategories.

Results: Our qualitative analysis yielded several themes (Table 1) related to the transition process, as well as discrimination that made participants’ gender transitions more challenging. Factors unique to refugee transgender individuals were also characterized, such as the asylum process and physical violence abroad. Differences in accessibility abroad versus in the United States (US) were also identified.

Conclusion: This qualitative analysis captures the asylum process experiences of Latiné refugee TGNB patients. The findings of this analysis highlight how intersectionality affects patient access to and experience within the US healthcare system.

Mini Symp: Reproductive and Sexual Health Sciences

FRI-E3-M: BODILY AUTONOMY AND JUSTICE: EXPLORING THE INTERSECTIONS OF ABORTION AND GENDER AFFIRMING CARE

Jen Hastings[1,2], Mai Fleming[1,3], Sachiko Ragosta[4], Rafa Kidvai[5]
[1]UCSF Department of Family and Community Medicine, San Francisco, CA, USA, [2]Aria Medical Group, Wichita, KS, USA, [3]Folx Health, Oakland, CA, USA, [4]Ibis Reproductive Health, Oakland, CA, USA, [5]If/When/How, Brooklyn, NY, USA

Presented by: Jen Hastings, Mai Fleming, Sachiko Ragosta, Rafa Kidvai

Statement of Significance: The recent onslaught of anti-trans legislation comes alongside a wave of anti-abortion legislation, together constituting a calculated effort to strip individuals of their bodily autonomy. This symposium brings together researchers, clinicians, and advocates at the intersections of transgender and abortion justice to provide context to these coordinated attacks on bodily autonomy, discuss the unique challenges transgender, nonbinary, and gender-expansive (TGE) people face in accessing abortion care and present recommendations and solutions.
Researchers from Ibis Reproductive Health will present data and conclusions from a 2019 study and subsequent articles on the experiences of and barriers to abortion care already faced by TGE people before the Dobbs decision to give a sense of the inequities already present even when abortion was a constitutional right.
Building on the justice frameworks of the advocacy groups If/When/How and Forward Together, Rafa Kidvai, Esq will then expand the context to help us understand how the Dobbs decision has shaped the current abortion landscape and how those changes uniquely affect different communities.
Dr. Jen Hastings and Dr. Mai Fleming, abortion and trans care providers and clinical faculty at the UCSF Department of Family and Community Medicine (full bios below), will present clinical perspectives and guidance for providers at the intersection of transgender and abortion care, including Self Managed Abortion (SMA). They will discuss the impacts and realities of providing abortion and gender affirming care in the post-Dobbs era, lessons learned from providing abortion care in restrictive environments as legislators borrow familiar tactics in drafting anti-trans bills, and best practices and resources (Euki app, abortion funds and mutual aid groups, trans inclusive RH websites) to support TGE patients.
Finally, panelists will present on the implementation of novel projects to support TGE people during this time. Sachiko Ragosta from Ibis Reproductive Health will highlight key points and lessons learned from a collaborative training on Self Managed Abortion as well as visions for a broader sexual and reproductive health hotline run by and for TGE people.
In grounding the symposium in contexts and perspectives from researchers, advocates, and clinicians, and sharing solutions by and for TGE people, we hope attendees can take away 1) an understanding of how transgender and abortion justice are at their core the same fight for liberation and bodily autonomy, 2) an understanding of the unique challenges transgender and nonbinary individuals face in seeking abortion care, and 3) ways to provide and support transgender and nonbinary access to affirming abortion care both with clinician guidance and through self-management.

Learning Objective 1: Participants will be able to identify the similarities in lack of access to gender affirming care and to abortion care.

Learning Objective 2: Participants will be able to recognize the challenges that transgender and nonbinary individuals face in seeking abortion care.

Learning Objective 3: Participants will be able to describe the basics of Self Managed Abortion and how to support access to self managed and clinically based abortion for trans and gender expansive individuals.

Method to Achieve Learning Objectives: Presentations by and discussion between panelists followed by Q and A.

Mini Symp: Law, Policy, and Ethics

FRI-F3-M: TRANSGENDER AND INCARCERATED: THE REALITIES OF TRANSGENDER EXPERIENCE IN THE UNITED STATES PRISON INDUSTRIAL COMPLEX

Rachel Golden[1], Shéár Avory[1], Kennedy Carter[1], julie graham[1], Mik Kinkead[1], Trisha Wallis[2]
[1]None, None, NY, USA, [2]University of California, Davis, Davis, CA, USA

Presented by: Rachel Golden, Shéár Avory, Kennedy Carter, julie graham, Mik Kinkead

Statement of Significance: The United States currently holds over 2 million people in its jails, prisons, and other "correctional" facilities. This includes approximately 5,000 known transgender people. These Transgender and Gender Expansive individuals are disproportionately BIPOC Transgender Women. In prison, Transgender people are at exceedingly high risk for violence, victimization, and abuse. They are isolated and dehumanized, not permitted access to affirming doctors or supportive community. Indeed, incarcerated Transgender individuals report higher rates of sexual victimization, assault, segregation, and serious psychological distress compared to their cisgender peers. Those responsible for their abuses are rarely identified or reprimanded. Meanwhile, providers within the system who wish to advocate for gender-affirming care are met with barriers to the provision of that care to their patients.

In this symposium we present three intertwined topics: the legal landscape impacting the rights of transgender people who are detained; the lived experiences of these transgender individuals; and the challenges facing providers who are trying to improve gender affirmation in prison environments.

First, we focus on the legal landscape. Most prisoner rights cases in the United States can be traced back to the work of one Black Transgender Woman, Dee Farmer, whose initial 1994 case shifted the legal landscape and created a foundational legal concept about care of transgender people in prisons. On the basis of Ms. Farmer's work, over 190 similar cases have been filed by transgender individuals on the "deliberate indifference" of prison and jail conditions. Despite this landmark decision – unanimously upheld by the US Supreme Court - courts across the United States cannot agree where transgender people should be housed, and what, if any, medical care, they should have access to. Nationwide, departments of correction issue guidance on housing, treatment, and access. Meanwhile the majority of these departments offer no policy supporting their guidance. Every individual who gains necessary access through court order -- to healthcare, a transfer to affirming housing, or affirming legal aid in the form of name or gender marker change -- faces an uphill battle.

Second, we focus on the stories of individuals who have faced the effects of criminalization and incarceration. We detail the dehumanizing and dangerous experiences of these individuals and elevate voices of those directly impacted by the criminalization of Transgender bodies and lives.

Third, we focus on changing existing carceral environments. Advocates and activists have identified how to provide equitable treatment for Transgender and Gender Diverse people. Research demonstrates appropriate and necessary care, yet the majority of carceral settings struggle with providing those basic needs. We will describe optimal care in prison settings. We will describe the points of disjuncture and difficulties implementing court rulings and legislative initiatives.

Learning Objective 1: To learn about the legal landscape shaping transgender experiences in U.S. prisons and jails.

Learning Objective 2: To learn about the lived experiences of Transgender people detained in U.S. prisons and jails.

Learning Objective 3: To learn about the essential ways carceral settings need to change to be gender-affirming.

Method to Achieve Learning Objectives: We will present innovative information in powerpoint, video and spoken presentation with Q&A opportunities throughout.

Saturday, November 4, 2023

9:45am - 11:00am

Mini Symp: Social Determinants of Health/Health Equity

SAT-A1-M: ALL THE COLORS OF THE RAINBOW: INTERSECTIONAL AND CULTURAL CONSIDERATIONS OF TRANSGENDER AND NONBINARY YOUTH OF COLOR

A. Ning Zhou[1,2], Kai Huang[3], Terence Howard[2], Aza Frias[4]
[1]San Francisco Department of Public Health, San Francisco, CA, USA, [2]University of California, San Francisco Department of Psychiatry and Behavioral Sciences, San Francisco, CA, USA, [3]University of California, San Francisco School of Medicine, Program in Medical Education - Urban Underserved, San Francisco, CA, USA, [4]Self-employed, Oakland, CA, USA

Presented by: A. Ning Zhou, Kai Huang, Terence Howard, Aza Frias

Statement of Significance: For transgender and nonbinary youth of color (TNBYOC), their various social identities may intersect in ways that may lead to multiple marginalization. For example, youth may experience transphobia within racial communities, and racism within lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities. The resulting minority stress can lead to adverse mental health outcomes, such as increased rates of depression, anxiety, and suicidal behavior. It is important for health care providers to understand the intersections of race/ethnicity and gender diversity. We will begin with an overview and provide frameworks for intersectionality and ethnic-racial identity. We will then discuss the challenges, disparities, strengths, and resilience of specific ethnic-racial groups including Black, Latinx, and Asian American Pacific Islander transgender and nonbinary youth. We will conclude with practical tips and clinical pearls to consider when working with these populations.

Learning Objective 1: Describe a framework for conceptualizing intersectionality and ethnic-racial identity

Learning Objective 2: Discuss challenges, disparities, strengths, and resilience of Black, Latinx, and Asian American Pacific Islander trans and nonbinary youth

Learning Objective 3: Apply clinical pearls to clinical care with trans and nonbinary youth of color

Method to Achieve Learning Objectives: A. Ning Zhou will provide an overview of intersectionality and ethnic-racial identity (ERI). ERI is a multidimensional construct that has content (i.e. affirmation, centrality, and public regard) and process components (i.e. exploration and resolution), varies depending on social context, and intersects with other social identities to impact mental health.

Terence L. Howard will discuss the intersectionality of Black trans and nonbinary youth, highlighting the various challenges these youth encounter due to the convergence of their racial and gender identities which increase the risk of psychiatric concerns including substance use and suicidality. He will also touch upon the cultural importance of Christianity and voguing culture specifically to this community.

Aza Frias will discuss the intersectionality of Latinx trans and nonbinary youth. Aza will provide a summary describing the marginalization and oppression faced by Latinx communities in the US, such as immigration status, poverty, and experiences of racism. Aza will discuss aspects of Latinx culture that can affect a person's experience of gender, such as strict gender roles, religion, and the importance of the family unit. Aza will then discuss factors that increase resiliency among trans and nonbinary Latinxs, such as family acceptance, affirming both ERI and gender identity, building supportive networks outside of the family, and celebrating cultural histories of gender variance.

Kai J. Huang will discuss the intersectionality of AAPI trans and nonbinary youth. Kai will discuss research that explores how cultural values, the model minority myth, and anti-Asian racism can affect the mental health of AAPI trans and nonbinary youth. They will then discuss how AAPI trans and nonbinary youth may navigate expressing their gender in family and cultural spaces. Finally, Kai will present data regarding health disparities among AAPI trans and nonbinary youth, resilience factors, and considerations for care.

A. Ning Zhou will share practical clinical pearls when working with TNBYOC.

We will incorporate audience-response software, powerpoint slides, and interactive discussion in our presentation. We will have time for questions and discussion.

Oral: Health Services and Systems

SAT-B1-T1: "I WAS THE TRAINER AT MY PRACTICUM SITE!": GAPS IN TRAINING AND SUPPORT FOR TRANS* MENTAL HEALTH TRAINEES, AND RECOMMENDATIONS FOR SYSTEMIC CHANGE

Chelse Song
New Mexico State University, Las Cruces, NM, USA

Presented by: Chelse Song

Introduction/Background: Using semi-structured interviews to explore clinicians' (n = 13) experiences working with survivors of Queer Intimate Partner Violence, the researchers found over half of participants identified as TGNC (transgender, gender non-conforming, or otherwise genderqueer). When asked about their training experiences, these providers frequently reported gaps in knowledge, understanding, and acceptance of the TGNC community, and that their supervisors, staff, and professors expected them as trainees to be the educator, despite their role as a student/supervisee.

Specific Aim: The study originally sought to explore how providers describe the experience of clinical work with survivors of Queer IPV. Grounded theory research follows the themes which emerge, and one theme was "I was the trainer at my site": Gaps in training and support for trans* mental health trainees.

Materials and Methods: Thirteen mental health providers - six cisgender, seven TGNC - engaged in semi-structured interviews. Interview data was interpreted through a combination of queer theory and feminist theory framework, using a grounded theory iterative coding process. Training and Supervision emerged as an overarching theme, with noted disparities/inequity across gender and sexuality.

Results: Providers across disciplines (e.g., Ph.D., Psy.D., LCSW, LPC) reported dissatisfaction with the *lack of attention* their schools and practicum sites paid to addressing the mental health needs of the LGBT community. All but one participant (n = 12) told of how their programs either offered "no training, none at all" on transgender mental health issues. Participants often attributed this gap to a "checkbox" approach to diversity.
TGNC-identified providers reported that they were often seen as the "expert by default" or shoehorned into this teaching role, whether they have the training or even wanted to do this work. All but one Queer-identified participant shared that they were viewed as the expert at their training site. Some voiced dismay that no other provider at their site was capable or willing to assume this role, and others voiced passion and enthusiasm for sharing their lived experiences. "River" described the following: "it bothered me so much so I went to H.R. and said "I will do a training! – *I will do whatever we need to do*." Several providers echoed this mixed reaction, both irritation that no training existed as well as passion to "make it happen." SL recalled: "I have been popped in that position, of… "you work well with these folks; let's make 70 percent of your caseload this." And I loved it and at the same time I felt, we've got to make sure that I *actually do know* what I'm doing."

Conclusion: Providers across gender identities sought to fill the gaps; however, gender minority providers were more likely to be outright asked or implicitly assumed to perform this role. This suggests a clear need for didactic training, continuing education, and self-reflection on the part of clinical supervisors and training directors, particularly those who are cisgender. If mental health providers wish to adopt a trauma-informed, trans-affirming approach to training and clinical work, we have to take the onus off of trainees and shoulder that labor ourselves.

SAT-B1-T2: Insurance as a Barrier to Gender-Affirming Surgery

Caitlin McCann, Kathleen Alto, Sarah Benuska
MetroHealth System, Cleveland, OH, USA

Presented by: Caitlin McCann

Introduction/Background: Insurance companies regularly deny coverage for gender-affirming surgery, leading to costs for patients that are unsustainable and often unaffordable (Ngaage et al., 2020). Higher costs lead to poorer overall health outcomes and significantly reduced quality of life for patients who are unable to access affirming medical care (Padula & Baker, 2017). Insurance companies may cover some gender-affirming procedures but not others due to determinations of "medically necessity." The arbitrary designations of medical necessity are often inconsistent with WPATH standards of care or existing research (Cohen et al., 2019). These inconsistencies are confusing for patients, especially as out-of-pocket costs may vary significantly depending on differences in procedure (e.g., an insurance company may cover a vaginoplasty but not a vulvoplasty) (Cohen et al., 2019). Out-of-pocket cost estimation understandably plays a significant role in a patient's decision-making process regarding the type of affirming intervention chosen.

Navigating pre-authorizations is time intensive and costly for health care systems (Hu et al. 2021). However, healthcare providers have a responsibility to advocate for patients' access to medically necessary care. The knowledge to navigate common insurance barriers (e.g. policy requirements, pre-authorization, appeals) is critical to continued access to care, however, many patients and providers lack the required skills. Increased understanding of advocacy strategies for health care systems, providers, and patients is needed. Understanding the experiences of patients in our own hospital is the foundation to building better care-navigation systems.

Specific Aim: 1. Review insurance outcomes among patients seeking surgical support letters from MetroHealth System (MHS) psychologists for MHS surgeons in a 12 month period to better understand patient's experiences in using insurance to navigate care.
2. Provide accessible and clear information about insurance coverage navigation for gender-affirming surgery, including strategies to address common barriers.
3. Educate providers about how to assist patients with self-directed advocacy related to insurance.

Materials and Methods: Data will be presented on insurance company outcomes for patients seeking psychological letters of support for surgical procedures at MHS from psychologists in the system over 12 months. Patients present to MHS with interest in facial feminization, hysterectomy, masculinizing top surgery, breast augmentation, orchiectomy, phalloplasty, and vaginoplasty surgeries. Data will be collected using chart review and is scheduled to be finished in August of 2023.

Results: Data will be collected on the outcome of pre-authorizations for any patients who submitted during the 12 months (e.g. accepted, rejected, appealed). Results will be compared based on type of surgical procedure and types of insurance (e.g. commercial or federal/state funded). Data analysis is planned to be completed in September of 2023.

Conclusion: Results from data collection and analysis, including trends found across types of surgical procedures and insurance companies, will be presented and discussed. Practical tips and resources on how to navigate insurance denials, appeals, and pre-authorizations for both patients and providers will be provided.

SAT-B1-T3: EVALUATING AN ELECTRONIC CONSULTATION PLATFORM TO SUPPORT PEDIATRIC PRIMARY CARE PROVIDERS IN CARING FOR TRANSGENDER AND NONBINARY ADOLESCENTS

Gina Sequeira[1,2], Peter Asante[1], Kevin Bocek[2], Nicole Kahn[1,2], Janis Sethness[1], Juanita Hodax[1], Kacie Kidd[3], Wanda Pratt[1], Dimitri Christakis[1,2], Laura Richardson[1,2]
[1]University of Washington, Seattle, WA, USA, [2]Seattle Children's Research Institute, Seattle, WA, USA, [3]West Virginia University, Morgantown, WV, USA

Presented by: Gina Sequeira

Introduction/Background: Gender-affirming medical care has been shown to improve mental health outcomes for transgender and nonbinary (TNB) adolescents, however many are unable to access this care due to the limited number of clinicians providing it. Electronic consultation (e-consult) has shown great promise in providing PCPs with timely, patient-specific consultative support, and has been used to support care provision for TNB adults but not adolescents. We implemented an e-consult platform to support PCPs in caring for TNB adolescents. Following its implementation, we conducted a study to 1) explore how access to the e-consult platform impacted PCP confidence and specialty referral patterns, 2) describe the content of clinical questions submitted, and 3) evaluate PCP's perspectives regarding platform usability.

Specific Aim: Following its implementation, we conducted a study to 1) explore how access to the e-consult platform impacted PCP confidence and specialty referral patterns, 2) describe the content of clinical questions submitted, and 3) evaluate PCP's perspectives regarding platform usability.

Materials and Methods: The e-consult platform was designed in partnership with PCP stakeholders using EpicCare Link. PCPs submitted consult questions which were addressed by a multidisciplinary pediatric gender clinic team within 3 business days. Following each e-consult submission, providers were emailed a 17-item follow up survey to evaluate the impact of e-consult use on patient management, referral patterns, and overall platform usability using the validated 10-item system usability scale (SUS). Survey data were analyzed descriptively. Submitted consult questions were individually coded to identify key content areas based on a pre-determined codebook and analyzed using inductive thematic analysis methods.

Results: Providers submitted 38 e-consults and completed 26 follow up surveys between October 1, 2021 and December 31, 2022. Question content was most frequently related to initiating puberty blockers (26%) or gender-affirming hormones (26%), followed by determining whether to initiate puberty blockers or hormones (18%; Table 1). Survey responses indicated a high overall value of the e-consult, both to PCPs themselves (mean: 5 out of 5) and the patient for whom the consult was submitted (adjusted mean: 4.8/5). All providers (100%) reported that having access to the e-consult platform made them feel more confident caring for other TNB adolescents in their practice (Table 2). A majority of providers (81%) felt they 'got new advice for a new or additional course of action' and for 19% a referral was originally contemplated but was able to be avoided because of the e-consult. The mean usability score on the SUS was 78.2, indicating good overall usability.

Conclusion: This e-consult platform shows great promise in increasing pediatric PCP confidence providing gender-affirming care to TNB adolescents in pediatric primary care. Access to this platform may decrease referrals to pediatric gender clinics as PCPs become more comfortable providing this care. More widespread access to such platforms could improve health outcomes by making gender-affirming care more accessible for TNB adolescents, especially those who currently experience barriers to receiving specialty care in pediatric gender clinics.

SAT-B1-T4: Artificial Intelligence Knowledge of Evidence-Based Recommendations in Gender Affirmation Surgery and Gender Identity: Is ChatGPT Aware of WPATH Recommendations?

Daniel Najafali[1], Chandler Hinson[2], Justin Camacho[3], Logan Galbraith[4], Tannon Tople[5], Danielle Eble[6], Brielle Weinstein[7], Loren Schechter[7], Amir Dorafshar[7], Shane Morrison[6,8]
[1]Carle Illinois College of Medicine, University of Illinois Urbana-Champaign, Urbana, IL, USA, [2]Frederick P. Whiddon College of Medicine, University of South Alabama, Mobile, AL, USA, [3]Drexel University College of Medicine, Philadelphia, PA, USA, [4]Northeast Ohio Medical University College of Medicine, Rootstown, OH, USA, [5]University of Minnesota Medical School, Minneapolis, MN, USA, [6]University of Washington School of Medicine, Seattle, WA, USA, [7]Rush University Medical Center, Chicago, IL, USA, [8]University of Washington at Harborview Medical Center, Seattle, WA, USA

Presented by: Chandler Hinson

Introduction/Background: Artificial intelligence (AI) is rapidly evolving, as are its uses in healthcare and scientific literature. ChatGPT has already excelled at notoriously challenging medical examinations, demonstrating its ability to provide pertinent medical information. However, there are concerns about whether AI platforms, like ChatGPT, have implicit biases when it comes to certain topics. It is important to ensure the spread of misinformation is halted and AI follows evidence-based recommendations when sharing information to questioning users. Currently, there is minimal understanding of how AI could potentially skew or hinder healthcare delivery. This study explores ChatGPT's ability to reference evidence-based recommendations related to gender-affirming surgery (GAS).

Specific Aim: We aimed to capture the accuracy and breadth of ChatGPT's knowledge on gender-affirming medicine and surgery as well as relevant concepts surrounding gender identity.

Materials and Methods: ChatGPT was prompted using open-ended questions based on frequently asked questions on gender affirmation surgery and gender identify. These questions were solicited from resources like the Cleveland Clinic and the World Health Organization. Answers were extracted and analyzed by comparing outputs to published literature on these topics. ChatGPT was also prompted on the World Professional Association for Transgender Health Standards of Care (WPATH SOC) for the Health of Transgender and Gender Diverse People, Version 8's statements of recommendations. The recommendations were reworded to be open ended questions and then inputted into ChatGPT. Responses were analyzed based on agreement to and reference of WPATH SOC recommendations. In total, 125 questions were prompted in ChatGPT.

Results: ChatGPT was successful in accurately describing the concept of being gender diverse along with gender identity based on a spectrum approach. ChatGPT also demonstrated a general knowledge of GAS, including breath of specialized procedures used in GAS. Additionally, ChatGPT was able to describe treatment options for gender dysphoria. When asked to explain the political controversy in GAS, ChatGPT only provided specific examples from the argument against GAS without providing examples of support for GAS. Memorable outputs from ChatGPT included:

"It is important to note that gender identity is a deeply personal and individual experience, and there is no one 'right' way to be transgender."
"[GAS] can help improve their quality of life, reduce their distress, and allow them to live more authentically."

In analyzing WPATH statements, a total of 95 statements of recommendations were given to the chatbot. There were 70 (74%) agreements, 0 (0%) disagreements, and 25 (26%) neutral responses to the prompts. WPATH was directly referenced in 12 (13%) responses.

Conclusion: We found that ChatGPT's outputs were largely accurate and comprehensive when prompted to discuss nuanced concepts of gender and gender-affirming care. The platform successfully described definitions of biological sex, gender, gender expression, and gender identity on a linear spectrum, rather than as binary concepts. While often using neutral language, ChatGPT does intermittently reference WPATH and its evidence-based recommendations. As AI evolves, so can the spread of misinformation if it is not rooted in evidence-based recommendations. Further, AI may serve as a viable tool for patient education on GAS.

SAT-B1-T5: A NATIONAL E-CONSULTATION SERVICE TO IMPROVE PATIENT-CENTERED CARE FOR TRANSGENDER AND GENDER DIVERSE VETERANS

Susan Mejia-Flores[1], Alex McConnell[1], Wyatt Meriwether[1], Dawnelle Paldino[1], Michael Kauth[1,2], Jillian Shipherd[1,3,4]
[1]LGBTQ+ Health Program, Office of Patient Care Services, Veterans Health Administration, Washington, DC, USA, [2]Baylor College of Medicine, Houston, TX, USA, [3]Women's Health Sciences Division, National Center for PTSD, VA Boston Healthcare System, Boston, MA, USA, [4]Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA

Presented by: Dawnelle Paldino

Introduction/Background: Transgender and gender diverse (TGD) Veterans have unique health care needs that are often not included in professional training. The Veterans Health Administration (VHA) has taken steps to support health care providers and the Veterans they treat through its National TGD E-Consultation service. The service, launched in 2014, allows care team members at any VHA facility nationwide to receive individualized consultation on patient care from an interdisciplinary team of transgender health specialists. Previous evaluations of the program showed early uptake of the e-consultation service (Shipherd, Kauth, & Matza, 2016) and usefulness of the program to providers (Blosnich et al., 2019). Nearly 10 years on from the launch of the service, the current analysis provides an update on its utilization.

Specific Aim: The specific aims of the current study are to: 1) evaluate the utilization and spread of the e-consultation service by VHA providers; and 2) describe characteristics of the TGD Veterans served through e-consultation as compared with TGD Veterans without e-consultation.

Materials and Methods: Descriptive statistics related to program utilization are reported from program data. Characteristics of TGD Veterans served through e-consultation (n = 1,552) were extracted from the Corporate Data Warehouse (CDW), a national VHA database containing data from the electronic medical records of all Veterans served in VHA, and compared to the cohort of TGD Veterans for whom an e-consultation has not been placed (n = 7,747).

Results: From 2014-2023, 2,181 e-consultations were submitted by 1,372 unique providers across VHA. Number of e-consultations per provider ranged from 1-25 (M = 1.59, SD = 1.67). More than a quarter (27.14%) of e-consultations were placed by repeat users. E-consults have originated from all 50 states, D.C., and Puerto Rico, including 35.20% of e-consultations which originated from rural facilities. The modal primary consultation question related to medications (42.60%), followed by primary care (31.89%), mental health assessment (22.01%), and psychotherapy (3.50%).

Among Veterans for whom an e-consult was placed and for whom gender identity was recorded in the medical record, 70.37% identified as women/transgender women, 23.53% as men/transgender men, 5.23% as non-binary, and 0.87% as another gender. Chi-square analysis revealed that relative to TGD Veterans for whom an e-consult has not been placed, those with e-consultation were significantly more likely to be service-connected for a disability ($\chi^2(1) = 4.29$, $p = .04$), live in a rural or highly rural area ($\chi^2(1) = 52.90$, $p < .001$), identify as White ($\chi^2(1) = 177.37$, $p < .001$), and identify as LGBQ ($\chi^2(1) = 124.05$, $p < .001$).

Conclusion: The National TGD E-Consultation service has been utilized across VHA, sometimes multiple times per provider, suggesting utility of the service. Questions addressed ranged from medication management to psychotherapy. E-consults are more likely to be placed to support treatment plans of Veterans with multiple minoritized identities, including those with a disability, living in a rural area, or who identify as sexual minorities. However, Veterans for whom an e-consult was placed were more likely than expected to identify their race as White, suggesting a possible gap in coverage for TGD Veterans with marginalized racial/ethnic identities.

SAT-B1-T6: PREOPERATIVE HAIR REMOVAL AND GENITAL SURGERY COVERAGE: AN ANALYSIS OF INSURANCE DISPARITIES FOR GENDER-DIVERSE PEOPLE

Tannon Tople[1], Bhagvat Maheta[2], Peaches Dozier[3], Victoria Stoffel[4], Justin Camacho[4], Daniel Najafali[5], Alexander Skokan[6], Deepti Gupta[7], Russell Ettinger[8], Shane Morrison[8]
[1]University of Minnesota Twin Cities Medical School, Minneapolis, MN, USA, [2]California Northstate University College of Medicine, Elk Grove, CA, USA, [3]Southern Illinois University School of Medicine, Springfield, IL, USA, [4]Drexel University College of Medicine, Philadelphia, PA, USA, [5]Carle Illinois College of Medicine, University of Illinois Urbana-Champaign, Urbana, IL, USA, [6]University of Washington Medical Center, Seattle, WA, USA, [7]Seattle Children's Hospital, Seattle, WA, USA, [8]University of Washington at Harborview Medical Center, Seattle, WA, USA

Presented by: Tannon Tople

Introduction/Background: Permanent hair removal is required for transgender and gender-diverse (TGD) people planning to undergo some forms of gender-affirming genital surgeries. As hair growth within the urethra or vagina following genital surgery can lead to medical complications, it is crucial that hair removal is covered as a medical necessity for patients. By highlighting current gaps in coverage for both procedures, this research emphasizes the need for new policy changes to prioritize equal insurance coverage.

Specific Aim: This cross-sectional review of Out2Enroll was conducted to understand the prevalence of health insurance policy coverage for both gender-affirming hair removal and genital surgery and assess whether state protections for TGD people influence coverage.

Materials and Methods: Private and state-sponsored standard-silver insurance plans on the website "Out2Enroll" were reviewed in a cross-sectional study conducted between March 2023 and April 2023. Out2Enroll is an online platform created to connect TGD people to health insurance plans covering gender-affirming care. Plans were assessed for evidence of coverage for gender-affirming genital surgery, hair removal procedures (e.g. electrolysis and laser), and total out-of-pocket and deductible costs. Descriptive statistics were used to describe the dataset, and a Chi-Square test and Fisher's exact test were used to compare coverage of private and state-based Medicaid policies between states with and without bans on transgender exclusions in private health insurance plans, respectively.

Results: 170 insurance plans were reviewed, including 145 (85.3%) state-specific private and 25 (14.7%) state-based Medicaid policies from 33 states. Of these policies, 116 (68.2%) fully covered genital gender-affirming surgeries, while some plans did not cover (N= 13, 7.1%), partially covered (N= 21, 12.4%), or were silent about coverage for these procedures (N = 20, 11.8%). For plans fully covering genital surgery (N= 116), 88 (75.8%) fully covered hair removal, but 21(18.1%) did not cover these procedures, 2 (1.7%) plans partially covered, and 5 (4.3%) were silent about coverage. There was no difference in coverage for hair removal in states with or without mandated bans on transgender exclusions for private ($X2 = 0.43$, $P = 0.51$) and state-based Medicaid ($P = 0.6$) health insurance plans. Potential financial costs of hair removal were high for plans covering genital surgery but not hair removal, with average total deductibles and out-of-pocket expenses totaling $4,067 (SD = 2,435) and $8,154 (SD = 1,802), respectively. Plans not covering genital surgery had a deductible and out-of-pocket cost of $4,285 and $8,125, respectively.

Conclusion: Disparities in equal coverage for gender-affirming hair removal and genital surgery act as financial barriers to care and further decrease access to genital surgery for TGD people. As state protections for TGD people inadequately address gaps in coverage, more must be done to ensure that this discrepancy in insurance coverage is accounted for.

Mini Symp: Non-surgical Body Modifications (e.g., hair removal, binding, tucking)

SAT-C1-M: ADVANCES IN ADULT AND PEDIATRIC GENDER EXPRESSION CARE IN SUPPORT OF SOCIAL TRANSITION FOR TRANSGENDER AND NON-BINARY INDIVIDUALS

Monica Prata[1,2], Grace Firtch[1,2], Jennifer Slovis[2,3], Carlos Morales[2,4], Alice Turner[2,5]
[1]Kaiser Permanente RWC, Redwood City, CA, USA, [2]The Permanente Medical Group, Oakland, CA, USA, [3]Kaiser Permanente OAK, Oakland, CA, USA, [4]Kaiser Permanente SF, San Francisco, CA, USA, [5]Kaiser Permanente WCR, Walnut Creek, CA, USA

Presented by: Monica Prata, Grace Firtch, Jennifer Slovis, Carlos Morales, Alice Turner

Statement of Significance: At a time when transgender care is under attack, the need for holistic, non-invasive transition care is more critical than ever.

This symposium is designed to provide a review of Gender Expression Care and to explore the experiences of one healthcare system including accomplishments and obstacles during the past two

years.

A formal pilot program in Gender Expression Care (GEC) was implemented in Kaiser Permanente Northern California in 2019. GEC is defined as professional guidance and practical support of social transition, offering immediate non-invasive interventions to optimize transition-related medical and surgical care. At the 2021 USPATH conference, we presented early outcomes data from this pilot. Since that time, more than 200 patients have participated in the adult GEC workshop series; in addition, we have designed and launched a pediatric workshop series. In the current symposium, we will review our learnings from the implementation of the adult GEC workshops, share initial promising findings from the pediatric workshops, and describe the advances in this field since 2021.

Topics include the following:
- Meeting the needs of specific subgroups of the population (e.g. non-binary, neurodiverse, racially minoritized, etc…)
- Migrating to a fully virtual program
- Identifying obstacles to implementation
- Refining the program for a pediatric audience
- Implementing our new measurement tool (GEMT)

Learning Objective 1: Explain the value of Gender Expression Care.

Learning Objective 2: Identify components of Gender Expression Care that can be implemented within your system in the short-term and long-term.

Learning Objective 3: Understand how GEC can help overcome some of the political obstacles we face in the US today.

Method to Achieve Learning Objectives: A combination of brief lecture, case studies, visual examples, patient and caregiver testimonials, and audience participation will be utilized to describe and illustrate the material presented. Updated results from our expanded cohort will also be reviewed.

Oral: Health Professional Education

SAT-D1-T1: Filling the Gap: Medical Educators Collaborate to Improve Access to Gender Affirming Primary Care Training

Erika Sullivan[1], Shanna Stryker[2], Marie Forgie[3], Ryan Spielvogel[4], Rachel Nixon[5,6], Dylan Sabb[7], Lisa MacVane[8], Julie Blaszczak[9]
[1]University of Utah, Salt Lake City, UT, USA, [2]University of Cincinnati, Cincinnati, OH, USA, [3]Advocate Aurora Healthcare, Milwaukee, WI, USA, [4]Sutter Health, Sacramento, CA, USA, [5]Michigan State University, East Lansing, MI, USA, [6]Ascension Heatlh, Warren, MI, USA, [7]University of California Davis Health, Sacramento, CA, USA, [8]UMass Chan, Fitchburg, MA, USA, [9]University of Michigan, Chelsea, MI, USA

Presented by: Erika Sullivan

Introduction/Background: Access to gender affirming care (GAC) remains limited for many transgender/gender diverse (TGD) individuals, despite the World Professional Association for Transgender Health (WPATH) Standards of Care describing the importance of robust care delivered in the primary care setting by trained providers. Many primary care providers are increasingly open to providing primary and preventative care for TGD individuals but report insufficient training to comprehensively and independently initiate transition-related GAC. In speaking with medical educators of residencies across the United States, there are numerous isolated efforts to create GAC curricula and teaching materials for their individual programs. Currently, no standard competencies exist around which to design longitudinal educational initiatives, despite evidence that this is the most effective way to train clinicians.

Specific Aim: To bolster the workforce of physicians trained in providing GAC, the Gender-Affirming Primary Care Residency Research Collaborative (GAPCRRC) formed a community of medical educators dedicated to training resident physicians on GAC to ultimately improve access to gender-affirming primary and transition-related care for TGD individuals.

Materials and Methods: A call for collaboration was shared at the 2022 WPATH Scientific Symposium and through several professional listservs, including the Society for Teachers of Family Medicine. Educators joined GAPCRRC by filling out a Google Form that gathered demographic information and assessed interested in offering and/or obtaining resources. No prior experience in GAC was necessary to join the group. Medical educators or residents of all specialties with a passion for GAC were invited to join. Members self-nominated to be a part of the leadership team to clarify GAPCRRC mission and goals.

Results: The GAPCRRC includes over 200 residents or residency faculty members across the United States who are interested in furthering gender-affirming training of primary care physicians within their residency's curriculum. The leadership team is working on three initiatives: 1) developing an online implementation guide that includes resources contributed by GAPCRRC members 2) developing competencies in GAC which could be utilized by residency training programs across the country to evaluate the effectiveness of their training and 3) developing a primary care practice-based research network which could pool data to answer new and enduring clinical questions.

Conclusion: Primary care physicians in medical education understand the importance of providing quality training in GAC and strongly desire to expand the training for residents. The challenge lies in harnessing that enthusiasm to collaboratively create a curriculum that can be used across institutions rather than each institute re-creating their own. GAPCRRC aims to fill that "gap". Given the lack of standardized primary care training in this area as well as variation in available resources for different programs, GAPCRRC's goal is to collaboratively create a readily available high-quality GAC curriculum as well as competencies for assessment for residency programs.

SAT-D1-T2: ASSESSING MEDICAL STUDENTS' INTEREST IN ABORTION CURRICULUM AND TRANSGENDER CARE IN UNDERGRADUATE MEDICAL EDUCATION AT A COMMUNITY BASED MEDICAL SCHOOL

Frankie Perry, Anna Nichols, Carmen Abbe, Jessica McAllister, Emma Stucki, Shell Tokko, Jaime Bowman, Dawn Kopp
Washington State University Elson S. Floyd College of Medicine, Spokane, WA, USA

Presented by: Frankie Perry

Introduction/Background: Fair access to reproductive healthcare is an important and necessary component of health equity for transgender individuals. Transgender people have less clinical support when trying to end a pregnancy compared to their cis-gendered counterparts, and limited curriculum focused on transgender care contributes to this inequity. For future efforts to expand abortion access, it is necessary to consider how medical education can facilitate equitable access to comprehensive reproductive healthcare.

Specific Aim: In the effort to expand access to both abortion and transgender medical care, it is important to consider these topics that have not been comprehensively taught in medical school education. It is unknown if medical students prior to choosing a specialty desire to learn this in their curriculum. This study aimed to understand current medical students' perspectives on and interest in medical education on transgender reproductive health and abortion care in order to modify case-based learning curricula to include reproductive heath care issues.

Materials and Methods: An IRB-approved, voluntary survey developed from national resources was administered to students at the community-based Washington State University Elson S. Floyd College of Medicine. Statistics were analyzed through SPSSv28.

Results: A total of 103 students of the 311 enrolled, spanning all four years, participated in the survey. The students surveyed intended to practice in a wide range of specialties, with 10.7% interested in choosing Ob/Gyn as their specialty. Topics that students wanted to remain or be enhanced in the curriculum included abortion (56.3%), sexual assault/rape (53.4%), pregnancy options and counseling (51.5%), and cultural competency around sexual/reproductive health issues (50.5%). A majority of students expressed belief that “abortion should be available to all who seek it” and would be willing to provide abortion services if trained to do so. 71.8% of respondents said they would provide referrals to patients for abortion services. While only 13% of respondents identify as LGBTQIA+, 53% of respondents were interested in taking elective time to target their learning towards transgender care, and 44% of respondents desired to be taught about transgender care.

Conclusion: While current learning opportunities exist and inform student opinions on abortion, medical students with a variety of specialty interests want to expand their learning about abortion and transgender reproductive health services. These results identify gaps in education, establish an interest in transgender-inclusive reproductive education during early medical training, and can inform future efforts to modify curricula to include topics that ensure physicians have the necessary tools to support future patients.

SAT-D1-T3: Exploring Routes to Providing Gender Affirmation Surgery

Anna Nichols, Roxanna Stapleton, Jess Domingo, Nicholas McDonald, Jaime Bowman
Washington State University Elson S. Floyd College of Medicine, Spokane, WA, USA

Presented by: Jess Domingo

Introduction/Background: Gender affirmation surgery (GAS) seeks to utilize surgical methods to align physical characteristics with a patient's gender identity. Although transgender individuals have long existed, GAS is an evolving field of surgical care with opportunities through multiple specialties. Given the various paths to providing GAS as well as the myriad of procedures used in GAS, doctors and students interested in joining this field may be unsure of the route to take. This research analyzes existing provider training and how that relates to procedures offered by surgeons, and outlines opportunities to enhance and expand the number of physicians offering GAS in the U.S..

Specific Aim: 1. Identify patterns of training among current surgeons offering GAS
2. Establish regional availability of surgeons offering GAS
3. Outline opportunities for enhanced training of physicians interested in offering GAS

Materials and Methods: The database of GAS doctors from transhealthcare.org was utilized to track U.S.-based physicians, their residency and fellowship training, board certifications, procedures offered and location of practice. Physician credentials and procedures offered were then verified through secondary online sources, including hospital affiliated websites. Procedures offered across board specialties, training, and location were compared and then grouped based on regions: West, Midwest, Northeast, Southeast, and Southwest. The relationships between physician speciality, procedures offered, and region were analyzed on SPSSv2.

Results:
Of the 173 GAS surgeons identified, 38.8% were located in the West, 21.8% Southeast, 20% in Northeast, 11.5% in Midwest, and 7.9% in Southwest. The state with the greatest number of reported surgeons offering GAS was California (42), followed by Florida (19), New York (13), Pennsylvania (12), Washington (9), Oregon (8), and North Carolina (8). The remaining states had less than 5 reported surgeons offering GAS, with 19 states having zero reported gender affirmation surgeons.
Only 83 physicians were included in training analysis due to limited available online data. Gender affirmation surgeons have an array of board certifications including Plastic and Reconstructive Surgery (57.1%), General Surgery (19.3%), Urology (18.1%), and Obstetrics/Gynecology (6%). A majority of surgeons (68.7%) offering GAS received additional training through fellowships. Reported fellowships

included plastic surgery, craniomaxillofacial, hand and microvascular, cosmetic, reconstructive urology, urogynecology, and gender affirmation. Plastic Surgeons accounted for the majority of physicians who did not obtain additional training. The most frequently offered procedures included Top Surgery (68.2%), Vaginoplasty (59.5%), and Breast Augmentation (52.6%).

Conclusion: The path for physicians to practice gender affirmation surgery is actively being built. It is important for future physicians to anticipate the training and fellowship necessary to perform GAS. Despite the variety of board certified surgeons offering GAS, there continue to be a limited number of fellowships specifically aimed at GAS. Of the Gender Surgery fellowships that do exist, these programs are limited to physicians trained in Plastic Surgery or Urology. Considering the demonstrated ability and interest of general surgeons in performing GAS, existing GAS Fellowships should consider offering positions to General Surgery trained physicians. Finally, although GAS fellowships have grown in number over recent years, efforts should continue to establish more of these focused training programs across the country.

SAT-D1-T4: GYNECOLOGIC PRACTICE PATTERNS IN THE MANAGEMENT OF TRANSGENDER AND GENDER DIVERSE INDIVIDUALS IN CANADA: RESULTS FROM A NATIONAL CROSS-SECTIONAL SURVEY

Anna-Lisa Nguyen[1,2], Sandy Zhang[2,3], Nicole Thompson[3], Smita Mukherjee[2,3], Richard Wassersug[2,3], Nicole Todd[3], Krista Genoway[2,3], Alex Kavanagh[2,3]
[1]Schulich School of Medicine and Dentistry, London, ON, Canada, [2]Gender Surgery Research Program, Vancouver, BC, Canada, [3]University of British Columbia, Vancouver, BC, Canada

Presented by: Anna-Lisa Nguyen

Introduction/Background: The American College of Obstetrics and Gynecology recognizes the importance of providing a safe and inclusive space for transgender and gender-diverse (TGD) patients who need gynecologic care. Gynecologists are commonly involved in the care of TGD patients for a variety of indications, both those who have undergone lower gender-affirming (GA) surgery and those who are surgery naïve. However, there are currently no published recommendations or guidelines for GA gynecologic care in Canada.

Specific Aim: Our aim was to survey Canadian gynecologic surgeons to evaluate training and practice patterns in GA gynecologic care.

Materials and Methods: A survey was developed to characterize training, and practice patterns in TGD care (with approval from the University of British Ethics Board). The survey was translated into French for francophone practitioners and forwarded to all members of the Society of Obstetricians and Gynaecologists of Canada. Descriptive statistics were used to summarize respondent demographics and the provision of care to patients seeking hysterectomies and genital reconstruction procedures.

Results: A total of 85 responses were received and 65 responses were included in the final analysis. Most respondents (75%) had provided care to TGD patients, and the majority (75%) of those physicians had performed at least one GA hysterectomy. None of the respondents performed lower GA reconstruction surgery. Fifty-nine percent of OBGYNs in our survey have not received any TGD care training during residency, despite most having seen TGD patients in their practice.

Of those that performed GA hysterectomies (n=30), a total laparoscopic approach is preferred in both TGD and cisgender patients and all 30 performed opportunistic bilateral salpingectomies. Twenty-four of the 30 OBGYNs provided opportunistic bilateral oophorectomies. In terms of post-vulvoplasty or vaginoplasty patients, 44% have provided gynecologic care to this population, though most felt that they had little to no knowledge of the anatomical changes from the surgery nor did they feel comfortable with providing care to those patients. Even fewer OBGYNs have provided care to post-metoidioplasty or phalloplasty patients, and ever higher rates of discomfort and lack of knowledge were reported.

Conclusion: Overall, although our sample size is small, we found that Canadian OBGYN respondents are centralized to urban areas and provide GA care to TGD patients distributed across the country. While none performed lower GA reconstructions, OBGYNs provide both GA hysterectomies and care following lower GA surgery. Despite providing gynecologic care, they have minimal training and do not feel comfortable nor knowledgeable about caring for patients following lower GA reconstruction. This survey population is likely biased towards those already engaged in TGD care or have an interest in TGD health; however, even in this subset, there is minimal training, knowledge, and comfort. Further research is warranted to assess surgeon desire for continuing education in postoperative GA medical care.

SAT-D1-T5: CREATING AN EXPERIENCE-BASED CO-DESIGN EDUCATIONAL MODULE CONSIDERING LIVED EXPERIENCE FROM NON-BINARY IDENTIFIED PROFESSIONALS AND PATIENTS

Edgar Vargas, Barbara Warren, Diane Tider
Mount Sinai Health System, New York, NY, USA

Presented by: Barbara Warren

Introduction/Background: In the past decade education for mental health and medical providers has had an increasing focus on clinical and cultural competency with transgender adults and adolescents. More recently the need for healthcare providers to effectively address the needs and concerns of gender diverse and specifically non-binary patients has become more evident. To this end the Mount Sinai Office for Diversity and Inclusion and the Mount Sinai Institute for Advanced Medicine collaborated on developing an experienced based co-design project to develop and implement an educational module in best practices with non-binary patients that would utilize lived experiences of both non-binary patients and providers in creating the content, in delivering the education module and then in refining it.

Specific Aim:
To establish and then be able to replicate a collaborative, experience-based design process that utilized lived experiences of non-binary identified patients and providers, in creating a cultural competency training module for health system staff and clinicians. To pilot the module with a group of multi-stakeholders and gather qualitative data to assess and refine the training module. To then pilot the module with a larger group; of staff and clinicians from the Institute for Advanced Medicine and collect post training feedback through surveys.

Materials and Methods: The initial pilot development included recording the module which was presented virtually and then the documented audio and the chat box comments and questions from the project team were used to refine the draft version. A quantitative anonymous survey from staff members at the Institute for Advanced Medicine clinics who see a high volume of TGD patients, took the second refined training and they were administered the evaluation survey.

Results: The development team felt that the following aspects of the original version that were highly effective included the presenting speaker who is a non-binary diversity trainer with a background in healthcare education; the inclusion of video snippets from a diverse group of non-binary folks speaking about both good and bad patient experiences illustrating the training points as extremely valuable; and the inclusion of tips and skills that would be relevant to patient facing healthcare employees from the front desk to physicians, was also deemed very valuable. There were some discussions on limiting didactic lists of pronouns and too much research on health disparities and increasing time on case studies, which was added to the second pilot. In the revised second pilot, survey evaluation results included: 94% of participants felt that the educational intervention helped them better understand non-binary terms, identities and patient experiences. In addition, 94% of participants reported having a better understanding of and being able to implement best practices in creating a safe and welcoming environment for non-binary patients.

Conclusion: In conclusion, it is evident that utilizing an experienced based approach to creating content and delivery of LGBTQ+ education that is useful to healthcare staff and clinicians and inclusive of the

lived experiences of patients, with a chance to practice skills through case studies results in a resource that is well received and is more effective than a more didactic approach.

SAT-D1-T6: EXAMINING STIGMA AMONG RESIDENCY APPLICANTS PURSUING CAREERS IN GENDER AFFIRMING SURGERY

R. Sineath, Jr., Blair Peters, Geolani Dy, Casey Seideman
Oregon Health and Science University, Portland, OR, USA

Presented by: R. Sineath

Introduction/Background: Access to gender-affirming surgery remains limited in the United States, and there is an urgent need to train more surgeons. Transphobia has a long-standing history in medicine and has shaped the current state of gender-affirming care, including the relative paucity of TGD providers. TGD people experience widespread stigma, including when accessing healthcare, and such stigma and transphobia in healthcare settings may shape perceptions of residency applicants interested in gender-affirming surgical training. The impact of this stigma on applicants pursuing a career in gender-affirming care has not been previously explored.

Specific Aim: This study aims to capture and describe the stigma perceived and experienced by urology and plastic surgery residency applicants who are interested in pursuing a career in gender-affirming surgery during medical school and residency application cycles.

Materials and Methods: Participants were recruited June to July 2022 through social media postings linked to a web-based survey. Eligible participants applied for urology or plastic surgery residency from 2018 to 2022 and had an established interest in gender affirming surgery as a career. Participants provided information on age, race, sex assigned at birth, gender, sexual orientation, success in the match, US Medical Licensing Examination scores, and questions related to experienced and perceived stigma against pursuing a career in gender affirming surgery during medical school and the residency application process.

Results: Our final cohort included 17 recent plastic surgery applicants and 27 urology applicants. Twenty three percent identified as TGD. Forty-four percent identified as heterosexual. Twenty-six percent were not successful in the match. Thirty eight percent of respondents indicated their family was not supportive of them pursuing a career in gender affirming surgery. Twenty four percent experienced stigma in medical school, and one-third reported experiencing stigma during residency interviews. Only one person stated that experiencing this stigma made them rethink their career choice in gender affirming surgery. The majority (90%) stated they had supportive mentors, and all participants had supportive medical school classmates. Two-thirds were worried about being transparent about pursuing a career in gender-affirming surgery on their residency application. Forty three percent felt the need to hide this in their application, and over half (57%) felt the need to hide this during interviews.

Conclusion: With the increasing need for gender affirming surgeons, we must understand barriers to training this critical workforce. This study identifies experiences of stigma during medical school and during the residency application cycle that may dissuade surgeons from pursing this field. Unfortunately, many students hide their academic interest in gender-affirming care, and may not feel their application is as desirable as those of their peers. It is important for these applicants to have supportive mentorship. Interviewing institutions should ensure all interviewers have received appropriate cultural sensitivity training as this field continues to grow and has become a mainstay in the fields of urology and plastic surgery. Lastly, there is a clear demonstration of TGD applicants wanting to provide this care. Supporting and mentoring this group will greatly contribute to the needed improvement of diversity, representation, and community leadership within these two fields.

Mini Symp: Law, Policy, and Ethics

SAT-E1-M: Gender Affirming Care Under Assault: How Clinicians Can Respond

Dan Karasic[1], Alex Koren[2], AJ Eckert[3]
[1]UC San Francisco, San Francisco, CA, USA, [2]Percussion Strategic, Seattle, WA, USA, [3]Anchor Health, Hamden, CT, USA

Presented by: Dan Karasic, Alex Koren, AJ Eckert

Statement of Significance: As of the writing of this abstract 18 states have fully or partially banned gender affirming care for adolescents, with Louisiana poised to become the 19th in the coming weeks. Florida has also heavily restricted these treatments for adults by legislating that hormone replacement therapy cannot be prescribed by nurse practitioners and/or via telehealth.
Opponents of gender affirming care have supported these measures with a highly effective propaganda campaign to claim that their position is supported by science. They have been highly effective at persuading both legislators and media that these treatments are dangerous.
Clinicians across disciplines can play a crucial role in opposing these state bans and ensuring access to appropriate and evidence-based healthcare. Our mini-symposium will offer a two-fold approach to how clinicians can respond to these new laws. The first part addresses how to educate lay people through the media, courts, and legislative bodies. The second part draws on cutting edge research to address how to best train other clinicians to provide gender affirming care in a safe, welcoming, and culturally sensitive environment for trans patients.

Learning Objective 1: Participants will learn about the process of testifying in policymaking settings, such as a legislative committee or board of medicine, and in judicial settings, such as a deposition. We will cover how to prepare testimony, what they can expect the day of, and how to present with confidence.

Learning Objective 2: Participants will learn how to educate reporters and editorial boards as expert sources on gender affirming care. We will cover how to identify journalists in your state that are writing about gender affirming care, how to set up educational meetings with reporters and editorial boards, and how to talk to reporters both on the record and on background.

Learning Objective 3: Participants will learn how to train other clinicians on gender affirming care and best practices for working with trans patients and clients. We will cover how clinicians can set up a training program in their own practice, how to give presentations on gender affirming care for clinicians who are interested but have no experience, and how to address harmful pre-conceived notions that clinicians may have about trans people.

Method to Achieve Learning Objectives: Each of the three speakers will present for 15-20 minutes providing both detailed how-to instruction and case studies from our professional experiences. Hand-outs will be provided to help guide the sessions. Following all three presentations there will be 20 minutes of open discussion and Q&A with the audience. We have decided to save this part for last, since presenters have overlapping areas of expertise and more than one of us will likely have useful insights to audience questions.

Mini Symp: Reproductive and Sexual Health Sciences

SAT-F1-M: LIFE-LONG CARE CONSIDERATIONS IN PATIENTS FOLLOWING VULVOVAGINOPLASTY: ADDRESSING COMPLICATIONS AND ROUTINE SURVEILLANCE.

Frances Grimstad[1,2], Cecile Ferrando[3,4], Jessica Kant[1,5], Chance Krempasky[6], Meredith Gray[7]
[1]Boston Children's Hospital, Boston, MA, USA, [2]Harvard Medical School, Boston, MA, USA, [3]Cleveland Clinic Foundation, Cleveland, OH, USA, [4]Case Western University, Cleveland, OH, USA, [5]Boston University, Boston, MA, USA, [6]Callen-Lorde Community Health Center, New York, NY, USA, [7]University of Kansas Medical Center, Kansas City, KS, USA

Presented by: Frances Grimstad, Cecile Ferrando, Jessica Kant, Chance Krempasky, Meredith Gray

Statement of Significance: One of the fastest growing components of transgender health is gender affirmation surgery, as more surgeons are being formally trained in these surgeries. Vulvovaginoplasty is one the many feminizing surgeries available to transgender women, and transfeminine and nonbinary people. Variations to this procedure include vulvoplasty and different graft options to line the vagina. There is also a diversity in the types of surgeons who perform these surgeries; the current specialties include plastic surgery, gynecology, urology and general surgery. Despite the increasing number of surgeons, many patients struggle to find competent long term pelvic health care following vulvovaginoplasty. This becomes ever necessary with the expanding population of patients who have undergone gender-affirming vulvovaginoplasty or vulvoplasty. In this workshop we will provide clinicians with the skills and knowledge necessary for providing long-term, interdiscliplinary, post-vulvovaginoplasty and post-vulvoplasty care for this patient population. Relevant providers include, but are not limited to, primary care, sexual health behavioral and medical clinicians, surgeons, and pelvic floor specialists.

Learning Objective 1: Compare the long-term care of penile inversion vulvovaginoplasty, peritoneal vulvovaginoplasty, and a vulvoplasty

Learning Objective 2: List three causes of discharge in a patient following vulvovaginoplasty and describe how this differential may vary depending on the graft used

Learning Objective 3: Describe the workup for a patient who presents with new pain with dilation 3 years after a vulvovaginoplasty

Method to Achieve Learning Objectives: In this workshop we will review the approaches to surgery and discuss how these approaches may alter postoperative care. We will also review the evidence that currently exists on neovaginal infectious and neoplastic conditions that may occur after surgery and provide recommendations and approaches to surveillance for common postoperative and long-term care pelvic health concerns that may be encountered by patients. We will also discuss the role of long-term pelvic health in patients who have undergone vulvoplasty (zero depth/no depth vaginoplasty) alone.

11:15am - 12:30pm

Mini Symp: Health Professional Education

SAT-A2-M: NEURODIVERSITY-AFFIRMING SUPPORTS IN MEDICAL AND SURGICAL ENVIRONMENTS

Finn Gratton[1], Sarah Dobro[2], Jaxyn R Brown[3,4], Rixt Luikenaar[5,6,7]
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Presented by: Finn Gratton, Jaxyn R Brown, Rixt Luikenaar

Statement of Significance: This presentation will identify shared perspectives from an interdisciplinary lens as presenters review how to best support neurodivergent individuals in medical settings, including the pre- and post-operative surgical environment. Healthcare professionals often feel ill-prepared to meet the needs of neurodivergent patients, and neurodivergent individuals often express discomfort with medical care. The misalignments in the environment, communication, and protocols between a neuronormative-based healthcare delivery system and neurodivergent patients can contribute to reduced access to care and poorer outcomes for treatment. Given the data highlighting the overlap in autistic and transgender or gender-expansive experiences, it is critical that medical professionals and mental health professionals collaborate to improve practices around communication and care protocols that improve access and best meet the needs of neurodivergent individuals.

With a focus on the experience of autistic individuals and ADHD, presenters will use an anti-ableist framework to review best practices and propose practice changes to support neurodivergent individuals in healthcare settings and in accessing gender-affirming healthcare and surgery. Presenters will use an interdisciplinary approach by sharing their perspectives from different positions in gender care: a medical social worker providing pre- and post-operative surgical support and coordination, hormone prescribing primary care physician, a somatic psychotherapist providing guidance for preparation and recovery, and an OB/GYN offering surgery and hormone therapy. All presenters have lived experience at the intersection of neurodivergence and transgender and non-binary identities, and will speak to the practice of trauma-informed and identity-based services that effectively meets the intersectional needs of neurodivergent and transgender or gender expansive individuals.
Presenters will review medical environment stressors and relevant supports to provide a trauma-informed and inclusive approach relevant to all individuals. Each medical and mental health professional presenting will review aspects of a neurodiversity-affirming clinic experience, as well as pre-and post-surgery support relevant to gender-affirming healthcare, including complex and/or nontypical bottom surgeries. Presenters will identify best practices and review interventions to support individuals in medical environments, in preparation for surgical consultation, and in preoperative and postoperative environments and recovery period. They will also review decision-making models in complex and/or nontypical surgery requests. Presenters will identify how to prepare medical professionals and surgeons on specific supports relevant to providing affirming and patient-centered care experiences. By identifying neurodiversity-affirming supports for clients in medical settings, presenters will provide healthcare professionals and attendees the opportunity to empower neurodivergent individuals.

Learning Objective 1: Presenters will provide an overview of neurodivergence, history, and meaning, particularly as it relates to the current presentation and overview of neurodiversity-affirming supports in healthcare environments.

Learning Objective 2: Presenters will identify best practices to support neurodivergent individuals in preparation for medical appointments, consultation, and surgery.

Learning Objective 3: Presenters will review how to prepare neurodivergent individuals and their healthcare surgeons for the postoperative recovery time period.

Method to Achieve Learning Objectives: Identity-based, interdisciplinary presentation by powerpoint media provided in person

Oral: Hormone Therapy – Adult

SAT-B2-T1: CHARACTERIZING THE RISK OF VENOUS THROMBOEMBOLISM IN TRANS FEMININE AND TRANS MASCULINE INDIVIDUALS - IT IS NOT ALL ABOUT THE HORMONE THERAPY

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Presented by: Daniel Slack

Introduction/Background: Use of exogenous estradiol (E2) has been associated with an increased risk of venous thromboembolism (VTE) in cisgender women and trans feminine individuals. Testosterone (T) products have been scrutinized for their possible association with VTE in cisgender males, an association that has not been demonstrated in trans masculine users. VTE is estimated to affect 1-2 individuals per 1,000 person-years in Europe and the USA, suggesting a prevalence of 0.1-0.2%. VTE risk rises exponentially with age and has sparsely been studied in young people.

Specific Aim: We sought to determine the prevalence of VTE in a cohort of individuals using feminizing or masculinizing gender-affirming hormone therapy (GAHT) and to examine whether there are variables that may modify one’s risk of VTE.

Materials and Methods: We conducted a chart review of trans feminine and trans masculine patients actively engaged in care in the Mount Sinai Health System (*n = 4030*) and identified 23 individuals (0.5% of the cohort) with a history of VTE. 17 were using E2 (0.8% of E2 users), 3 were using T (0.3% of T users) and the remaining 3 were not on GAHT (0.4% of those not on GAHT). We compared the +VTE group to the remainder of the cohort by examining the proportion of individuals in each group with specific comorbidities and demographic variables.

Results: We identified a higher proportion of VTE in Black individuals compared to white (*1.3% vs 0.5%, p < 0.*05) and in those with public insurance compared to private (*0.9% vs 0.4%, p < 0.*05). The mean age of the +VTE group was higher than the -VTE group (*46.8 vs 31.4 years, p < 0.05*). A greater proportion of individuals in the +VTE group had hyperlipidemia (HLD), HIV, and hypercoaguable conditions (HC) compared to the -VTE group (*p < 0.05*). Compared to those using T, a greater proportion of E2 users had hypertension (HTN), HLD, HIV, and HC (*p < 0.05*). Higher proportions of VTE were observed amongst E2 users with either HTN, HLD, diabetes mellitus (DM), or HC when compared to their counterparts on E2 without the respective comorbidity (*p < 0.05*). In T users, HC was the only comorbidity associated with an increased proportion of VTE (*p < 0.05*). A multivariate regression analysis of all variables that were associated with an increase in proportion of VTE in univariate analysis found that age, Black race/ethnicity, HLD, and HC remained significant (*p < 0.05*). Notably, neither the route of administration of GAHT nor serum levels of E2/T were associated with VTE risk on multivariate regression.

Conclusion: While the prevalence of VTE in our cohort was higher than that of the general population, the risk remains quite small and may be modified by factors unrelated to GAHT. VTE was associated with known VTE risk factors and potential surrogates for social determinants of health rather than exogenous hormone therapy. Black individuals, those who are of advanced age, and those who have HLD or HC may benefit from increased surveillance and efforts aimed at mitigating other modifiable risk factors.

SAT-B2-T2: Not all transfeminine individuals on estradiol can reach both target testosterone and target estradiol levels— time to revisit treatment guidelines?

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Presented by: Nithya Krishnamurthy

Introduction/Background: Both the WPATH SOC 8 and the Endocrine Society recommend targeting serum estradiol (E2) and testosterone (T) levels for feminizing gender-affirming hormone therapy (GAHT) to T < 50 ng/dL and E2 100 - 200 pg/mL to mirror the physiologic range for premenopausal cisgender females.

Specific Aim: We aimed to determine whether optimal T suppression in transfeminine individuals on E2 requires maintenance of E2 levels in the range noted in the reference guidelines. We conducted a comprehensive analysis of patients actively engaged in GAHT in the Mount Sinai Health System and with Plume, a nationwide gender-affirming hormone prescribing service.

Materials and Methods: Individuals who had an active prescription for feminizing GAHT and both T and E2 laboratory results were included (n = 9,921). We stratified the cohort by those with T levels at target <50 ng/dL (n = 5064) and those with T >= 50 ng/dL (n = 4857). We compared the proportion of people in each group with E2 below target < 100 pg/mL (n = 3881), at target 100 - 200 pg/mL (n= 2811), and above target > 200 pg/mL (n = 3229).

Results: Those in the T < 50 ng/dL group had a higher mean E2 than those in the T >= 50 ng/dL group (283.9 vs 131.9 pg/mL, p < 0.001). Of people with E2 levels at target (100-200 pg/mL), 58.3% had T < 50

ng/dL. Additionally, 77% of people with E2 > 200 pg/mL had T < 50 ng/dL, while 24.1% of people with E2 < 100 pg/mL had T < 50 ng/dL. In the T < 50 ng/dL group compared to the T >= 50 ng/dL group, there was a higher proportion of individuals with E2 > 200 pg/mL (49.2% versus 15.2%, p <0.001) and E2 in the 100 - 200 pg/mL range (32.4% versus 24.1%, p < 0.001) and a lower proportion of people with E2 < 100 pg/mL (18.5% versus 60.6%, p < 0.001). Our results indicate that 81.5% of those with T < 50 ng/dL had E2 levels above 100 pg/mL.

Conclusion: Our findings suggest that not all transfeminine patients on GAHT will achieve both T and E2 targets. In order to achieve the desired level of feminization while minimizing risk of adverse events, it may be appropriate to concentrate on achieving one target rather than both. The total testosterone level represents an integrated bioassay reflecting how the patient's body is reading treatment. In our study, 82% of people with T < 50 ng/dL had an E2 level at or above target but nearly 20% achieved a T at goal with a lower E2 level. If avoiding risk associated with higher E2 levels is prioritized, a laboratory goal could be a total testosterone at a preferred level (e.g., < 50 ng/dL), while the estradiol assay would serve as a confirmatory test. Future research should include prospective surveys to assess patient satisfaction at different E2 and T levels. Furthermore, stratification by route of estradiol administration, LH and FSH levels, and use of androgen blockers could help inform treatment guidelines.

SAT-B2-T3: EPIDEMIOLOGICAL INSIGHTS INTO CHRONIC PAIN AMONG TRANSGENDER INDIVIDUALS: EVALUATING ASSOCIATIONS WITH HORMONE THERAPY USE

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Presented by: Tomasz Tabernacki

Introduction/Background: Transgender individuals frequently undergo gender-affirming hormone therapy (GAHT) as part of their gender transition. Though GAHT is crucial for many in affirming their gender, its health implications are incompletely understood. Chronic pain, a leading cause of disability with a multifaceted etiology, has been associated with hormonal changes in previous studies, though mostly in the context of perimenopause. Leveraging the TriNetX database, this study compares the rates of chronic pain in trans patients undergoing GAHT with those who are not, while controlling for many known confounders.

Specific Aim: Our aim is to explore the potential association between GAHT and chronic pain, improving our understanding of the unique healthcare needs within the transgender community and facilitating informed clinical decision-making.

Materials and Methods: From the TriNetX database, encompassing over 120 million patients across 82 hospital systems, we identified four cohorts: trans women either receiving estrogen HT or no intervention (TWHT, TWNI) and trans men receiving testosterone therapy or no intervention (TMHT, TMNI). Inclusion criteria were based on ICD-10 codes indicating transgender status excluding individuals with prior chronic pain diagnoses. Using 1:1 nearest neighbor propensity score matching (PSM) with a caliper of 0.1 standard deviations of the propensity score, cohorts were matched on 24 chronic pain-associated covariates including age, race, preexisting mental health conditions, and lifestyle factors identified after literature review. The primary outcome was the rate of new chronic pain diagnoses determined by ICD-10 codes highly likely to represent chronic pain, compared between hormone therapy and non-hormone therapy groups post-matching. The analysis window began 6 months after start of GAHT or 6 months after first trans ICD-10 code for the HT and NI groups, respectively. Statistical significance was assessed using Kaplan-Meier survival curves and Cox Hazard Analysis.

Results: We identified 40,275 trans men (18,308 HT, 21,967NI) and 33,474 (18,050 HT, 15,424 NI) trans women. Following PSM, cohort sizes were 16,869 (TMHT, TMNI) and 13,806 (TWHT, TWNI) with standardized mean differences between groups of below 0.035 for all covariates.

We observed that groups who received GAHT were more likely to be diagnosed with chronic pain than those who did not. Cox proportional hazards models revealed a 21.4% (HR 1.214, 95% CI: 1.093, 1.348) increased hazard for TMHT vs TMNI and 14.0% (HR:1.140, 95% CI: 1.009, 1.289) for the TWHT vs TWNI groups. (Table 1, Fig. 1)

Conclusion: Our study indicates a significant association between GAHT and the likelihood of chronic pain diagnosis in transgender individuals, both in patients receiving testosterone and those receiving estrogen. It should be noted that our propensity score matching cannot fully eliminate unmeasured or residual confounding. Additional limitations include potential undercounting of both trans patients and chronic pain due to the lower sensitivity, high specificity ICD-10 codes we chose, and potential access-related disparities in healthcare for transgender populations resulting in undercounting in measured covariates. Further research is required to better understand causal mechanisms and to improve screening and management of chronic pain in trans populations. Our next step will be to further characterize the full range of factors contributing to chronic pain in transgender patients.

SAT-B2-T4: BICALUTAMIDE USE AS ANTIANDROGEN IN TRANS FEMININE ADULTS - A SAFETY PROFILE

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Presented by: Kristen Vierregger

Introduction/Background: Bicalutamide is a non-steroidal anti-androgen (NSAA) approved for use for treatment of metastatic prostate cancer (MPC) by the FDA in 1995. An antagonist at the androgen receptor (AR), it binds to cytosolic ARs, inhibiting androgenic effects in target tissues. Androgen deprivation is a clinical goal in trans feminine (TF) gender-affirming hormone therapy (GAHT), though bicalutamide use has been limited in this clinical setting by lack of data substantiating its safety in this patient population.

In 2019, Neyman et al., reported a small study of TF adolescents (n=23), in which oral bicalutamide 50 mg daily was shown to be safe, effective, and a more affordable option for patients unable to access GnRH agonists for androgen suppression. Citing specific concern for bicalutamide's hepatotoxicity risk, including fulminant liver failure leading to death, and the lack of literature investigating its use in TF patients, the World Professional Association (WPATH) Standards of Care v8 (2022), "do not recommend [bicalutamide's] routine use."

Bicalutamide is currently used off-label to treat other androgen-dependent disorders, with 13 published case reports of its use in male precocious puberty, 7 in hirsutism in cisgender women with PCOS, 4 in female pattern hair loss, and 2 in minoxidil-induced hypertrichosis in female pattern hair loss. Though authors of each of these studies were aware of its hepatotoxic potential, none observed it in their cohorts.

There are 9 published case reports of bicalutamide-induced liver injury since 1995, each occurring within 6 months of starting the drug; 7 patients survived upon drug withdrawal and 2 died. Despite this, bicalutamide is considered "generally safe" by the WHO and remained the standard of care for MPC until it achieved generic status in 2011 and newer generation AAs became available.

Specific Aim: We present our findings to specifically address WPATH's concerns that insufficient data exists to consider bicalutamide's inclusion in TF GAHT. We hope to pool our data with clinics using bicalutamide for TF GAHT to lend power to the study and increase confidence in inclusion/exclusion determination.

Materials and Methods: Approval was obtained from University of California Irvine's IRB for a retrospective chart analysis of the electronic health records from one gender-affirming clinic to compare transaminase levels (AST and ALT) over time in TF patients prescribed oral bicalutamide 25 mg daily as part of TF GAHT from 2016-2022. Data was deidentified and imported into Python for analysis.

Results: We report 231 patients with AST and ALT serum levels taken within 6 months of oral bicalutamide 25 mg daily initiation and at specific intervals thereafter, with 143 followed to 24 months. No elevation in AST or ALT, defined as 3x the laboratory's upper reference limit, were reported in any patient in any interval up to 24 months follow up.

Conclusion: Our results support broader evidence acknowledging bicalutamide-induced liver injury as a rare adverse event — but one that should not preclude its use. With adherence to recommended precautions - careful patient selection, education regarding early signs of liver toxicity, and laboratory monitoring - this clinic's data favorably support bicalutamide's consideration for inclusion in TF GAHT.

SAT-B2-T5: TESTOSTERONE'S IMPACT ON CERVICAL CANCER SCREENING, BY THE NUMBERS

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Presented by: Derek Chen

Introduction/Background: The Papanicolaou (Pap) test, also called cervical cytology, is an effective and widely used screening procedure for detection of cervical cancer (CC). Although CC screening is recommended for all patients with a cervix between the ages of 21-65, current approaches for CC screening have not accounted for the unique circumstances of transgender individuals. Three studies, to date, have found that transgender individuals on testosterone therapy are more likely to have unsatisfactory cervical cytology results due to atrophic changes of the cervix in the setting of suppressed estrogen (a side effect of testosterone therapy). Additional evidence is needed to demonstrate the need for revised guidelines and approaches for CC screening among transgender patients using testosterone for gender affirming therapy.

Specific Aim: To assess the frequency of inadequate and/or atrophic cervical cytology specimens among transgender patients undergoing testosterone therapy and determine the frequency of need for repeated specimen collection to render a cytologic result.

Materials and Methods: Design and Analysis: Retrospective chart review. Number of available Pap results varied by patient, so all Pap results were pooled. Chi-square and t-tests were used to compare results between testosterone-associated Pap specimens (TAPS) and non-testosterone specimens (NTS). Setting: Primary care clinics from the Oregon Health and Science University system. Population: Medical chart reviews of 213 patients identified as transgender patients with a cervix between 2012 and 2019 at one of the primary care clinics. Transgender individuals were identified using sex at birth, legal sex, gender identify, organ inventory, and gender dysphoria diagnostic codes. Outcome Measures: Primary outcome was quality of specimen (transformation zone present, transformation zone absent, atrophic specimen, scant cellularity). Secondary measures include presence of inflammation (yes/no) and Pap results (normal/abnormal). Testosterone therapy status prior to Pap test was noted in chart. CC screening results between January 2012 and December 31 2022 were collected.

Results: Results: 304 unique Paps were included. Average age of patients with TAPS and NTS results was 30 years old. TAPS (n=132) were more likely to lack cells from the cervical transformation zone, demonstrate scant cellularity, or be described as atrophic than NTS (56.1% vs 32.6%; $p<.001$, respectively). Among TAPS 5.3% had scant cellularity and 27.3% had atrophic characteristics; none of the NTS had these characteristics. TAPS were also more likely to show signs of inflammation (12.1% vs 3.5%; $p<.01$), even when atrophic or scant-cellularity specimens were excluded (11.2% vs 3.5% $p<.05$).

Conclusion: Conclusions: Cervical cancer screening is a critical service for early detection of cervical cancer. This study's results will serve as evidence of the unique limitations and scenarios that must be considered when formulating cervical cancer screening guidelines for transgender individuals.

Mini Symp: Health Services and Systems

SAT-C2-M: In the clinic and in the community: wraparound services for gender diverse youth

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Presented by: Lisa Melady, Katie Appelbe, Logan Pierce, Nicolas Meade, Jenna Rudo-Stern

Statement of Significance: Transgender and gender expansive (TGE) youth are experiencing increased political scrutiny and distress. Much attention has been focused on gender-affirming medical care; less attention has been spent on other aspects of TGE youth's experiences and ways to support their wellbeing.

Pediatric gender health clinics serve as a hub for information and support. In addition to medical interventions, youth are curious to learn about a wide range of gender-affirming services and practices and are often eager to meet TGE peers. TGE youth are looking to speak freely about gender and feel acknowledged and validated. Providers in these clinics are well-positioned to expand services to meet these needs.

At the same time, many TGE youth face barriers to accessing care through clinics and rely on other community supports, most notably schools. It is imperative to work across systems to get resources to the larger population of TGE youth without access to clinic services.

We will present innovative, interdisciplinary services offered by pediatric gender programs from across the country that aim to increase TGE youth's sense of confidence and safety across settings.

At Phoenix Children's, an occupational therapist and speech therapist co-lead a group intervention that targets client-centered communication and daily living goals. Participants report improved self-confidence and set more specific goals for voice therapy.

A team of educators at Lurie Children's has developed multiple programs in collaboration with schools. They provide adults with tools to create a gender inclusive environment and work with schools around implementing inclusive procedures. Additionally, the team offers a sexual health education program for K-9th grade students that presents medically accurate, LGBTQIA-affirming, developmentally appropriate, trauma informed, culturally responsive content. They also facilitate sessions during Gender Sexuality Alliance club meetings to provide content designed by and for LGBTQ+ youth, and trained youth leaders often co-facilitate. They have served 36 schools and around 5,000 students per year for the past 3 years.

The Yale Pediatric Gender Program has implemented programs to celebrate TGE youth's self-expression. At the start of the Covid pandemic, they supported youth in creating an e-zine and later coordinated an exhibit of youth art at a public library. More recently, they organized a Day of Gender Joy, providing gender-affirming family portraits with the assistance of professional stylists, a barber, and photographer.

These innovative programs bring together professionals across disciplines and institutional settings to work with TGE youth and their families to support them in a holistic way. Presenters will describe the development and implementation of these programs, share pre/post outcome data, and offer attendees informational resources to pass along to the communities they serve.

Learning Objective 1: Identify two advantages of addressing speech and occupational therapy goals in an adolescent group setting.

Learning Objective 2: Identify qualities of gender inclusive sexual health education and classrooms.

Learning Objective 3: Identify three innovative ways to support the social and emotional wellbeing of TGE youth and their families outside of the context of medical interventions.

Method to Achieve Learning Objectives: Presenters will offer 15-20-minute talks supported by use of slides and videos, concluding with a summary presented by the moderator, followed by open discussion.

Oral: Surgery

SAT-D2-T1: MANAGEMENT AND CONSIDERATIONS IN GENDER AFFIRMING BREAST RECONSTRUCTION

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Presented by: Charles Raymer

Introduction/Background: Breast cancer in transgender women is an uncommon occurrence, though likely to increase as more transgender women receive gender affirming care with endocrine hormone therapy. Evidence is sparse but suggests that gender affirming hormone therapy increases overall lifetime risk for development of breast cancer in transgender women above that of cisgender men, but less than overall lifetime risk for cisgender women. Breast cancer screening protocols for transgender women currently follow those for cisgender women. There are relatively few resources that discuss management of breast cancer and breast cancer reconstruction in transgender women.

Specific Aim: The authors hope that this case report will be useful as a reference for providers who are presented with similar clinical scenarios involving breast cancer and breast cancer reconstruction for transgender women in the future.

Materials and Methods: A case report is presented with the patient's consent to discuss the diagnosis and management of breast cancer in a transgender woman who had previously medically transitioned with gender affirming hormone therapy for over a decade. A review of the literature shows few previous cases reported of management of breast cancer in a transgender woman on gender affirming hormone therapy.

Results: 56-year-old transgender woman (T.S.) on gender affirming hormone therapy (daily estrogen and progesterone since 2007), an active smoker, with a BMI of 31 kg/m2 presented to Plastic and Reconstructive Surgery Clinic for breast reconstruction consultation after receiving right breast cancer diagnosis. Oncologic work-up revealed multicentric right breast grade 2 invasive ductal carcinoma (IDC) and high-grade ductal carcinoma in situ (DCIS). The tumor showed strong estrogen receptor (ER) and progesterone receptor (PR) positivity and negative human epidermal growth factor receptor 2 (HER2) staining.
Multidisciplinary Breast Tumor Board recommended she undergo oncologic right breast mastectomy with sentinel lymph node biopsy, axillary radiation therapy, adjuvant chemoradiation therapy, daily tamoxifen therapy for 5 years post-treatment, and to permanently discontinue all exogenous hormone therapy. T.S. ultimately underwent therapeutic right mastectomy with sentinel lymph node biopsy and prophylactic left mastectomy with immediate bilateral sub-pectoral tissue expander reconstruction. Final surgical pathology revealed negative margins of the right breast tumor, with 2 of 2 sentinel nodes harboring metastatic disease. Final pathologic stage was pT2m pN1a.
Her tissue expansion was completed at a total fill volume of 600 mL in each breast and these were exchanged for Natrelle silicone implants SSX-800. Her postoperative course was complicated by delayed wound healing of her right breast and ultimately wound dehiscence and partial mastectomy skin flap

necrosis. She was treated with debridement and a course of oral antibiotics and eventually underwent right chest debridement and right breast reconstruction with right pedicled latissimus myocutaneous flap and implant exchange.

Conclusion: Treatment requires a multidisciplinary approach to achieve appropriate patient-centered care. Hormone positive tumors will necessitate the cessation of gender affirming hormone therapy to reduce the risk for cancer recurrence. This decision may cause significant distress and needs to be made in collaboration with patients for optimal outcomes. Long-term follow up with both medical and surgical teams should address mental health related quality of life in addition to survivorship.

SAT-D2-T2: INCIDENCE AND LONG-TERM OUTCOMES OF GENDER-AFFIRMING PHALLOPLASTY: ANALYSIS OF A LARGE STATEWIDE POPULATION-BASED DATASET

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Presented by: Tenny Zhang

Introduction/Background: A growing number of transgender individuals undergo gender-affirming surgery, including phalloplasty. Though phalloplasty is a highly complex procedure associated with high complication rates, existing outcomes data are sparse and derived from small single-center studies, limiting generalizability.

Specific Aim: To evaluate the incidence of gender-affirming phalloplasty, complications, and associated re-presentation to healthcare facilities including inpatient hospitals, emergency departments (EDs), and ambulatory surgery (AS) centers in a large population-based dataset.

Materials and Methods: We performed a retrospective cohort study using the California Department of Health Care Access and Information datasets which include patient-level data from all licensed hospitals, EDs, and AS facilities in California. Adult patients 18 years or older undergoing gender-affirming phalloplasty in California from January 1, 2009 to December 31, 2019 were included. We examined phalloplasty-related complications using International Classification of Disease diagnosis and procedure codes and Current Procedural Terminology codes. Unique Record Linkage Number (RLN) identifiers were used to follow patients longitudinally. Statistical analysis included Kaplan-Meier survival analysis and Cox proportional hazards analysis.

Results: From 2009 to 2019, we identified 766 patients who underwent gender-affirming phalloplasty in 23 facilities. Over one-third (36.6%) traveled from out-of-state to have surgery in California. Phalloplasty incidence has risen over time and increased four-fold from 2014 to 2019. Of 475 patients with RLNs, 253 (55.3%) developed phalloplasty-related complications leading to subsequent re-presentations to the inpatient, ED, and AS settings (see Table 1). Approximately one-third (33.9%) of patients developed fistula and/or stricture across all datasets. The most common reasons for re-presentation to the ED included lower urinary tract symptoms/catheter-related issues (47.3%), urinary tract infection (30.7%), and wound-related issues (20%). The most common subsequent ambulatory procedure was urethral revision and/or reconstruction (50.9%). Cox proportional hazards analysis demonstrated no evidence of statistically significant associations between age, payment category, income, or hospital type and likelihood of re-presentation (see Table 2). However, Asian/Pacific Islander patients were less likely to re-present (HR 0.43 with White as referent, p=0.02, 95%CI [0.21-0.88]), and patients who lived in California were more like to re-present (HR 1.98 with out-of-state as referent, p<0.01, 95%CI [1.42-2.75]). This latter observation may reflect our inability to detect out-of-state patients who develop complications and re-present to facilities in their home states, rather than returning to California. Finally, survival analysis indicated that half of patients re- presented by 1 year post-phalloplasty.

Conclusion: This population-based study confirms that gender-affirming phalloplasty has a high complication rate, and demonstrates for the first time an association with high rates of return to hospitals, EDs, and AS centers. These findings provide additional higher-level evidence that may aid patient counseling, shared surgical decision making, and institutional and government policy regarding GAS outcomes and quality metrics.

SAT-D2-T3: EXPLORING THE PREFERENCES OF NON-BINARY INDIVIDUALS REGARDING CHEST SURGERIES

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Presented by: Christian Lava

Introduction/Background: The number of gender affirmation surgeries (GAS) performed in the U.S. has increased in recent years, secondary to sociocultural acceptance of diverse gender identities. Chest surgeries, such as mastectomy (removal of breast tissue) or chest augmentation, are often sought by non-binary individuals to align their physical appearance with their gender identity. Despite its growth in popularity, little is known about the preferences of non-binary individuals regarding chest surgeries (e.g., chest masculinization vs. feminization, appearance of breast and/or areolas).

Specific Aim: This study aims to investigate the preferences of non-binary individuals regarding chest surgeries in order to optimize outcomes.

Materials and Methods: A 9-question online survey was developed by the senior authors using the Qualtrics Survey Tool, then advertised on the HER application from June to August 2022. The survey consisted of questions pertaining to demographic information, surgical history, and preferences regarding chest surgeries and outcomes. Respondents consisted of non-binary individuals aged 18 years and above.

Results: Between June and August 2022, a total of 37 individuals completed the survey. 4 (10.8%) respondents reported having already undergone top GAS, 9 (24.3%) would like to have top GAS, 13 (35.1%) are considering top GAS, and 9 (24.3) do not want top GAS. The most common chest and/or breast features the respondents would like to address via surgery were removal of breasts (n = 24, 64.9%), changing the size of breasts (n = 13, 35.1%), changing the appearance and/or size of areolas (n = 10, 27.0%), and changing the appearance of nipples (n = 4, 10.8%). Figure 1 illustrates the respondents' ideal location of their nipples on their chest. 45.9% (n = 17) of respondents identified an ideal nipple projection length of >1 to 3 mm. Figure 2 illustrates the respondents' ideal breast or chest size. 35.1% (n = 13) of respondents preferred to have a more flat-appearing chest. Most respondents preferred a keyhole incision scar (n = 16, 43.2%), followed by a double-incision scar along the inframammary fold (IMF) (n = 7, 18.9%) and double-incision scar along the IMF with periareolar incision (n = 5, 13.5%). The following aspects of these surgeries were most important to respondents: "I would like to be in public without a shirt on" (n = 24, 64.9%), "I would prefer not to wear a bra regularly (e.g., under a shirt)" (n = 23, 62.2%), "I hope to have normal nipple sensation after top surgery" (n = 19, 51.4%), and "I would like to stop wearing a binder" (n = 17, 45.9%).

Conclusion: Non-binary individuals preferred to have a flat-appearing chest, >1 to 3 mm nipple projection, and keyhole or double-incision scar along the IMF. This study provides valuable insights into the preferences of non-binary individuals regarding chest surgeries, which may further support plastic surgeons in optimizing outcomes.

SAT-D2-T4: PREOPERATIVE EXPECTATIONS AND POSTOPERATIVE SATISFACTION ASSOCIATED WITH GENDER-AFFIRMING BILATERAL ORCHIECTOMY: WHY THIS PROCEDURE IS IMPORTANT

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Presented by: Jenna Stelmar

Introduction/Background: Gender-affirming bilateral orchiectomy (GA-BO), defined here as either a standalone procedure and/or precursor to vaginoplasty, is associated with a decrease in dosage of gender-affirming hormone therapy (GAHT). In comparison to gender-affirming bilateral orchiectomy at time of gender-affirming vaginoplasty (GA-V), GA-BO is associated with shorter waitlist times, procedure duration, and outpatient recovery. While objective benefits of GA-BO have been described, there is limited qualitative data that assesses the preoperative goals and postoperative satisfaction of patients who elect GA-BO.

Specific Aim: We aim to assess the decision-guiding factors that led patients to select GA-BO, and to compare measures of patient satisfaction between GA-BO and GA-V patients.

Materials and Methods: A retrospective chart review identified 170 patients who underwent GA-BO alone (n=106; 62%) or with GA-V (n=64; 38%) at a single institution between 4/2017 and 12/2020. Patients were emailed a link to an anonymous, online questionnaire (Qualtrics™).

Results: The questionnaire was completed by 136/170 (80%) patients: 86/136 (63%) respondents were GA-BO patients and 50/136 GA-V (37%). 78/86 (91%) of GA-BO respondents had either subsequently undergone GA-V, or, planned to do so in the future. For patients who later underwent GA-V, the mean reported time interval between GA-BO and GA-V was 21.8 ± 29.11 months.

Respondents prioritized the following expectations in their decision to undergo GA-BO: potential to decrease GAHT medications and dosages (reported as important by 67%), low rates of complications (56.5%), short recovery time (51.6%), and low postoperative pain (46.2%).

GA-BO and GA-V patients reported high improvement in various indices of gender dysphoria and body image, with only 1/4 indices of gender dysphoria differing significantly between the two groups (Figure 1). Unsurprisingly, GA-V patients reported a significantly *greater* improvement in 3/3 body image indices.

Conclusion: GA-BO is a low-risk genital gender affirming surgery (gGAS) that provides a graded, but more immediately available, option to decrease gender dysphoria and improve QOL. All patients interested in feminizing gGAS should be made aware of the advantages of GA-BO and offered GA-BO alongside GA-V.

SAT-D2-T5: PERCEIVED MENTAL HEALTH IMPROVEMENTS AFTER PHALLOPLASTY AND METOIDIOPLASTY: RESULTS FROM A PATIENT-ORIENTED, COMMUNITY-BASED SURVEY.

Leo Rutherford[1], Logan Berrian[2], Noah Adams[3], Aeron Stark[1], Gaines Blasdel[4,5], Linden Jennings[1], Lucas Wilson[6]
[1]University of Victoria, Victoria, BC, Canada, [2]The Buncke Clinic/SF Transgender Institute, San Francisco, CA, USA, [3]University of Toronto, Toronto, ON, Canada, [4]NYU Langone Health, New York, NY, USA, [5]University of Michigan Medical School, Ann Arbor, MI, USA, [6]Trans Care BC, Vancouver, BC, Canada

Presented by: Leo Rutherford

Introduction/Background: Trans and nonbinary people experience mental health-related challenges such as depression and suicidality more often than cisgender peers due to transphobia and discrimination. Research has demonstrated that social support and accessing needed gender-affirming care have positive impacts on the mental health of trans people. For the gender-affirming surgeries of phalloplasty and metoidioplasty, little research exists which documents, from a patient perspective, whether mental health improves after undergoing one of these procedures.

Specific Aim: This aims of this research include understanding how undergoing phalloplasty and/or metoidioplasty impacted the mental health of our participants. In this presentation, we will describe overall positive mental health changes including dysphoria decreases and euphoria increases in our sample who underwent these surgeries.

Materials and Methods: Our data comes from a cross-sectional, patient-oriented, community-based survey entitled Patient-Reported Outcomes of Genital Reconstruction and Experiences of Surgical Satisfaction (PROGRESS). Responses to the survey were collected from April to June of 2022. Criteria for eligibility included living in the United States or Canada, having undergone phalloplasty and/or metoidioplasty and identifying as trans, non-binary or another related term. Analysis for the current presentation focused on whether participants self-reported perceived improvements in their mental health after undergoing surgery and what factors are related to likelihood of experiencing improvement.

Results: Our sample includes 215 participants from the United States and Canada. Over 90% of participants reported their mental health improved due to undergoing surgery; related, large proportions reported significantly less dysphoria and more euphoria after undergoing surgery. Results of chi square tests included significant associations between goals for surgery being met, feeling prepared for surgery, social support, surgical satisfaction, and mental health improvements (p<.05); no demographic factors were statistically significant. In a multivariable model, no demographics factors became statistically significant; high surgical satisfaction, feeling prepared for surgery and high amounts of social support were significantly related to self-reported, perceived mental health improvement.

Conclusion: In summary, data from this novel, community-based study indicate that for those who undergo phalloplasty and metoidioplasty mental health may overall improve while dysphoria decreases and euphoria increases. In order to promote improved mental health after gender-affirming surgeries, patients should be supported by their care teams before surgery to identify realistic surgical goals, get the information they need to feel prepared for surgery and develop social support networks. Our results can be utilized to help trans patients understand possible surgical outcomes while seeking access to these surgeries.

Mini Symp: Community Engagement

SAT-E2-M: Integrating Community into Clinical and Research Programs: Fundamentals of Starting a successful Community Advisory Board

Danielle (Dani) Loeb[1,2], Avery Hendrixon[3], Stephanie Roberts[4,5], Alexander Harris[6], Brad Morse[1]
[1]University of Colorado School of Medicine, Aurora, CO, USA, [2]Ichan School of Medicine at Mount Sinai, New York, NY, USA, [3]UC Health, Aurora, CO, USA, [4]Harvard Medical School, Boston, MA, USA, [5]Boston Children's Hospital, Boston, MA, USA, [6]Callen-Lorde, New York, NY, USA

Presented by: Danielle (Dani) Loeb, Avery Hendrixon, Stephanie Roberts, Alexander Harris, Brad Morse

Statement of Significance: Transgender and gender diverse (TGD) people need to have meaningful input into the development and management of clinical programs and research that directly affects their communities. The long history of pathologizing TGD people and prevalence of trauma within the medical setting increases the importance of community integration in all aspects of care for TGD people. Organizers face multiple challenges in establishing a community advisory board (CAB) with genuine engagement, which vary by setting and type of advisory board. Common challenges include recruitment and retention of CAB members, especially across racial, ethnic, and gender identities. Furthermore, all

CABs need to address methods of facilitation that encourage productive communication inclusive of all members. Research focused CAB members need adequate training in research methods to facilitate meaningful contribution to research agendas, methodology, and dissemination.
This panel will address processes essential in the development and management of TGD CABs and provide specific insight into research and clinical CABs. We will address cross cultural and intersectional approaches by focusing specifically on inclusivity in recruitment, retention and participation in CABs.

Learning Objective 1: Participants will: have 3 tools necessary to start a research or clinical CAB

Learning Objective 2: problem solve 3 potential barriers to setting up a CAB

Learning Objective 3: avoid 5 common mistakes in starting a CAB

Method to Achieve Learning Objectives: Presenters from four CABs with diverse goals and settings will engage with the audience to explore specific issues around the development and implementation of both research and clinical CABs.
1) Clinical Adult: Danielle (Dani) Loeb (CAB Lead) and Avery Hendrixon (CAB member) will represent the UChealth Interdisciplinary Transgender Program (ITP) CAB at the University of Colorado School of Medicine. Founded in 2019, this CAB is well-established and plays a vital role in clinical management decisions at the UCHealth ITP. The CAB largely clinical though also addresses research and educational projects.
2) Clinical Youth: The Boston Children's Hospital GeMS Advisory Board (GAB) was recently formed to improve community engagement in the realm of clinical care and research. GAB members include patients over the age of 18 or a parent/guardian of a patient who has been cared for in our program over the last two years.
3) Research Project: Brad Morse (CAB Research Team Lead) will represent Transgender Health Information Research (TGHIR) CAB. A research team and a Community Advisory Board co-designed a health information resource that provide credible health information for individuals who identify as transgender and/or gender diverse.
4) Community-Based Research Program: Alexander (Ali) Harris will represent the new Research CAB at the Callen-Lorde Community Health Center, currently undergoing a patient-driven process intended to create a sustainable, equitable working dynamic between research staff and patient-investigators.

Presenters will briefly describe their CAB; its phase of development; and essential features. (20 min) Then panelists will have a round table discussion on two questions: 1) essential processes and elements to starting a CAB and 2) biggest challenges faced in developing and managing the CAB and strategies for working with the challenges (30 min). We will then have a discussion with participants through a Q and A (30 min).

Mini Symp: Mental Health Across the Lifespan

SAT-F2-M: The Development of a Behavioral Health Assessment and Therapy Service within a Multidisciplinary Setting: The THRIVE Approach

Scott Leibowitz, Heather Thobe, Lourdes Hill, Tina Mason, Molly Green
Nationwide Children's Hospital, THRIVE Gender Development Program, Columbus, OH, USA

Presented by: Scott Leibowitz, Heather Thobe, Lourdes Hill, Tina Mason, Molly Green

Statement of Significance: Transgender and gender diverse (TGD) youth and their gender affirming care providers have increasingly become under political attack in recent times. In 2022, the Standard of Care 8th edition was published, providing specific guidance on how to deliver care to adolescents with an emphasis on ensuring a comprehensive assessment to ensure the totality of mental health needs, both gender and otherwise, are met. Considering access to mental health care can be challenging in different environments, there is variability among different multidisciplinary programs with respect to the inclusion of in-house mental health services. Yet now more than ever, in this political climate, appreciating the

impact that mental health entities have on adolescents' decision-making capacity is important.

This session will provide an overview of the unique comprehensive therapy program offered at Nationwide Children's Hospital's THRIVE Gender Development Program. The program is in central Ohio, where families have dealt with the constant threat that their care will be removed ever since late 2021. The therapy program consists of five full-time therapists, a clinical manager, a resource coordinator, and incorporates two child/adolescent psychiatrists and two medical social workers (who participate in Rounds and serve as linkage to the medical services of the program within Adolescent Medicine and Endocrinology). The program offers outpatient and community-based services (therapists can meet clients in their families or schools if needed). A track for youth requiring a higher level of care (more acuity) has also been developed, which provides services multiple times a week to those who need it. Additionally, a comprehensive group therapy program for young trans adolescents, older trans adolescents, transfeminine-specific youth, and parents have become invaluable services for the families of Central Ohio and beyond.

Families start with the resource coordinator who does an initial screening of families and their needs. A secondary screening may take place with the medical social worker team, particularly if a medical referral is needed for either Psychiatry or Adolescent Medicine services. For young people who do not have an outside therapist, they are linked with one of the THRIVE therapists. Multidisciplinary collaboration takes place on a weekly basis. On rotating weeks, rounds either consist of discussions about youth and families who have complex mental health issues and needs, while on the other weeks rounds focus on the youth being seen in the Adolescent Medicine and/or Endocrine clinics.

Learning Objective 1: Attendees will learn about a model of care that integrates gender affirming Behavioral Health therapy services into the delivery of care.

Learning Objective 2: Attendees will appreciate the successes and challenges of developing a comprehensive therapy program that offers different levels of care and different group components.

Learning Objective 3: Attendees will appreciate the impact of the polarized political environment on the youth and families in a Midwestern State and the ways that a gender affirming, comprehensive, multidisciplinary therapy-based service mitigate the deleterious effects of the legislative threats.

Method to Achieve Learning Objectives: In this presentation, details of the different components of the program will be taught through didactic presentation. Interactive audience discussion will be incorporated. Multidisciplinary perspectives of the team will be incorporated.

3:00pm - 4:15pm

Mini Symp: Reproductive and Sexual Health Sciences

SAT-A3-M: Sex Matters: Assessing and Supporting Sexual Health Needs in Transgender Patients

Elizabeth Boskey[1], Frances Grimstad[1], R. Featherstone[2], Erin Parish-Gibson[3]
[1]Boston Children's Hospital, Boston, MA, USA, [2]Eucalyptus Healthcare, Richmond, VA, USA, [3]University of Virginia, Charlottesville, VA, USA

Presented by: Elizabeth Boskey, Frances Grimstad, R. Featherstone, Erin Parish-Gibson

Statement of Significance: This symposium is designed to highlight interdisciplinary approaches to the sexual healthcare of transgender adolescents and adults. Sexual health is an important part of overall health and wellbeing, but many providers are uncomfortable discussing these topics with patients, a discomfort that is often compounded when working with transgender populations. Having a strong understanding of methods for taking a sexual history and considerations when talking about sexual health topics can reduce the difficulty of initiating these conversations and improve the ability to provide holistic

care for transgender patients that recognizes sexuality as an important part of whole-body health. This is a topic that historically has not been well addressed by WPATH or other healthcare training organizations, and there is a need for more regular education on sexuality and related subjects.

The panelists represent diverse professional backgrounds and personal histories, with a nurse midwife, a psychiatry and women's health nurse practitioner, a social worker and sex educator with training in sex therapy, and a pediatric and adolescent gynecologist with additional fellowship training in gender affirming surgery. They practice across several very different localities including Boston, rural Virginia, and Idaho and see transgender patients across a full range of ages and identities.

Learning Objective 1: Participants will be able to take a sexual history with their transgender patients, keeping in mind the ways that gender identity and evolution can complicate self-definition and terminology use around sexual orientation and function.

Learning Objective 2: Participants will be able to describe the effects of gender affirming hormones on sexual function.

Learning Objective 3: Participants will be able to describe the common types of gender affirming surgeries and how they affect sexual function.

Method to Achieve Learning Objectives:

Presentation will start by discussing ways to incorporate patient language about anatomy and sexuality into the visit and the importance of working from a trauma-informed care paradigm when discussing difficult and sensitive topics.

The panelists will then provide an overview of the domains included in a sexual history including orientation, attraction, and behavior, and when each of these factors are and are not relevant to a healthcare encounter.

This will be followed by an introduction to the ways that gender affirming hormones affect sexuality and an overview of the most common types of gender affirming surgery and how they affect sexual sensation and function.

Finally, this will lead into a discussion of multidisciplinary care for sexual health concerns including an overview of the different types of providers who offer sexual health care and their roles for addressing varied patient needs.

Oral: Community Engagement

SAT-B3-T1: RE-VISIONING HEALTHCARE: YOUTH, PARENT, AND PROVIDER PERSPECTIVES ON THE PATH TOWARDS TRANSGENDER HEALTH JUSTICE

Chaya Pflugeisen, Deana Williams
MultiCare Health System, Tacoma, WA, USA

Presented by: Chaya Pflugeisen

Introduction/Background: Incorporation of community voice is critical to disrupting power structures within research and ensuring that research for transgender and gender diverse (TGD) youth advances transgender health justice. Youth access to gender-affirming care is moderated by parents and healthcare professionals alike, amidst excessive barriers to care. Even supportive parents may be reluctant to authorize gender-affirming medical intervention, and providers report insufficient gender-health training, resources, and support at the institutional level. Research for this population frequently happens in absence of input from these three interrelated groups, and no known efforts have integrated their perspectives and priorities into research planning.

Specific Aim: This project aimed to bring youth, parent, and provider voice to the development and prioritization of a gender health research agenda. Working within a Transgender Health Justice Framework, participants defined gaps and opportunities in gender-affirming care access, delivery, and experience. We followed this with the development and prioritization of patient-centered research directions for cultivating a re-envisioned landscape of trans youth healthcare.

Materials and Methods: We held group-specific convening sessions with cohorts of 8-9 TGD youth, parents, and providers. Using thematic analysis with member checking, we then identified desires and ideas around re-visioning healthcare for this population, building a model that presents distinct and interconnected healthcare-change themes and priorities of each group in the care triad.

Results: Re-visioned healthcare unique to the youth perspective prioritized better support and clarity in the transition from pediatric to adult care. Parents and youth alike called for higher quality information about care pathways and affirming providers, the development of a system of healthcare advocates/mentors to support youth as they learn to navigate and advocate for themselves within healthcare infrastructures, and increasing the number of social workers supporting TGD healthcare. Parents and providers both prioritized the need for structured education and support for parents outside of youths' clinical encounters and the intentional hiring and visibility of TGD adults working in healthcare settings. Providers also prioritized the need to improve care access by both increasing the number of providers who offer gender-affirming care and normalizing the provision of gender-affirming care within the primary care setting. All participant groups advocated for increasing and improving education and TGD competency amongst healthcare staff and providers, particularly those working outside of gender health. Providers made an explicit call to healthcare leadership to increase resource allocation for this purpose as a concrete commitment to equitable healthcare.

Conclusion: Participants in our project clearly articulated collective and group-specific directions and priorities for improving TGD healthcare for youth. Healthcare systems and researchers can build upon these community-endorsed areas as they begin or continue to provide gender-affirming care for youth. Especially amidst the current US political climate, it is critical that researchers develop studies around these priority areas to demonstrate the impacts of justice-focused healthcare delivery on youth mental health and well-being, articulation and realization of embodiment goals, healthcare access and utilization, parental/familial cohesion, treatment continuation, and other measures that facilitate and promote the access and provision of high-quality healthcare to transgender and gender diverse youth.

Oral: Social Determinants of Health/Health Equity

SAT-B3-T3: WHO ARE WE MISSING? DEMOGRAPHIC DIFFERENCES IN DIAGNOSIS AND ACCESS TO GENDER-AFFIRMING CARE AMONG ADOLESCENTS

Nicole Kahn[1], Peter Asante[1], Tumaini Coker[1], Kacie Kidd[2], Dimitri Christakis[1], Laura Richardson[1], Gina Sequeira[1]
[1]University of Washington/Seattle Children's Hospital, Seattle, WA, USA, [2]West Virginia University School of Medicine, Morgantown, WV, USA

Presented by: Nicole Kahn

Introduction/Background: Most prior research on transgender and gender diverse youth (GDY) has been conducted with youth who are already receiving gender-affirming care (GAC). These convenience samples limit our understanding of the broader population of GDY and may further mask differences in access or need by race and ethnicity, language spoken, insurance type, and/or rurality.

Specific Aim: To identify demographic differences in receipt of a gender dysphoria (GD) diagnosis and GAC among adolescents whose gender identity and/or pronouns as documented in an electronic health record (EHR) differed from their sex assigned at birth.

Materials and Methods: This cross-sectional study is a secondary analysis of data from the Seattle Children's Hospital (SCH) EHR system (Epic). Patients were included if they 1) were 13-17 years old on the data extraction date, 2) were seen at SCH after the implementation of the Epic system in October 2020, and 3) had a documented gender identity or pronouns that did not align with their sex assigned at birth. Presence/absence of a GD diagnosis was identified using International Classification of Disease codes. Patients were considered to have accessed GAC if, on manual review of their EHR, they had completed an in-person or telemedicine encounter with a medical or mental health provider where provision of GAC was documented in the provider note.
Adjusted logistic regression models explored associations between demographic characteristics (i.e., age, sex assigned at birth, gender identity, race/ethnicity, language for care, insurance type, rural status) and presence of GD diagnosis and having accessed GAC.

Results: Of 2,444 patients who met inclusion criteria, the mean age was 15.2 years (SD=1.3). Most were assigned female at birth (AFAB; n=2,080, 85.1%) and identified as male/trans male (n=854, 34.9%) or nonbinary (n=833, 34.1%). For race and ethnicity, most were White (n=1,672, 68.4%), followed by Hispanic/Latine (n=315, 12.9%), multiracial (n=188, 7.7%), Asian (n=82, 3.4% and Black/African American (n=67, 2.7%). The majority used English for care (n=2,384, 97.6%) had commercial/private insurance (n=1,567, 64.1%), and lived in non-rural areas (n=2,241, 91.7%). Overall, 61.8% (n=1,511) of patients had received a GD diagnosis and 48.1% (n=1,176) had accessed GAC. Regression analyses (Figures 1 & 2) indicated that AMAB youth and those identifying as male/trans male were more likely to have received a GD diagnosis and accessed GAC. Black/African American youth were the least likely to have received a GD diagnosis and accessed GAC. Youth who used Spanish for care were also less likely to have received a GD diagnosis and accessed GAC. Although there were no significant differences in GD diagnosis by insurance type, youth using Medicaid, other government insurance, or self-pay/charity care were less likely to have accessed GAC compared to youth using commercial/private insurance. No differences emerged for rural status.

Conclusion: Our results indicate significant differences in both receipt of GD diagnosis and accessing GAC by various demographic characteristics, but particularly among Black/African American youth. Identification of these differences provides an opportunity to further understand potential barriers and promote more equitable access to GAC among GDY who desire this care.

SAT-B3-T4: Social Support, Affirmation of Gender Identity, and Social Well-being in Transgender Adults

ClaraGrace Pavelka, Amy McCurdy, Stephen Russell
University of Texas - Austin, Austin, TX, USA

Presented by: ClaraGrace Pavelka

Introduction/Background: Previous research shows higher incidence of mental health problems among transgender adults relative to their cisgender peers, which has been explained in terms of greater exposure to social stress (Valentine & Shipherd, 2018). Less studied, however, are the predictors of social well-being among transgender adults. There is some emerging evidence that access to affirming social structures enhance the psychological well-being of trans adults – and presumably, their social well-being. Gender affirmation may be a particularly important component of social support that helps explain the link between social support and social well-being.

Specific Aim: The present study explored: (1) direct and indirect pathways linking perceived social support, gender affirmation, and social well-being, and (2) whether the strength of the indirect pathway varied by gender identity for women, men, and non-binary adults.

Materials and Methods: Participants were 274 transgender adults between the ages of 18 and 81 (M = 39.4, SD = 17.13) who completed the TransPop Study, a nationally representative study of transgender individuals in the United States. There were 78 transgender men (28.5%), 120 transgender women (43.8%), and 76 non-binary individuals (27.7%). Participants reported on their social support, gender

affirmation, and social well-being. A mediation model was tested using structural equation modeling in R Studio with the lavaan package (Rosseel, 2012). We conducted a path assessment using bootstrapping run at 1,000 sub-samples. In an exploratory analysis, we conducted multiple group analysis to examine the presence of gender differences in the indirect pathway (i.e., the link between social support and gender affirmation) on social well-being.

Results: Social support was associated with gender affirmation (B = 0.127, p = 0.045) and gender affirmation was associated with social well-being (B = .250, p < .001; Figure 1). The direct relationship between social support and social well-being was statistically significant (B = .218, p < .001). Tests of indirect effects indicated that the effect of social support on social well-being was marginally significantly mediated by affirmation of gender identity (B = .032, p = .054). The exploratory multiple group analysis results indicated that constraining the indirect pathway from social support to social well-being resulted in significantly worse model fit relative to the unconstrained model ($\Delta\chi^2$= 68.36, Δdf = 4, p < .001). Follow-up pairwise tests indicated that the indirect pathway between social support and social well-being was strongest among women relative to men and non-binary participants (Table 1).

Conclusion: Results indicated that gender affirmation approached significance as a mediator between the main effect of social support and social well-being. We suggest that gender affirmation is a specific component of social support that helps explain the association between social support and well-being. A multiple group analysis by gender identity showed that the indirect pathway was statistically significant only for trans women, suggesting that gender affirmation as a source of social support is particularly relevant for women's social well-being. Our findings add to the collective body of evidence by revealing the importance of social support and gender affirmation to greater social well-being for transgender adults.

SAT-B3-T5: DERMATOLOGY INTEGRATION IN ACADEMIC CLINICAL GENDER PROGRAMS ACROSS THE UNITED STATES: A CROSS-SECTIONAL STUDY

Soumya Reddy[1], Caroline Fisher[1], Matthew Mansh[2], Klint Peebles[3]
[1]University of Virginia, Charlottesville, VA, USA, [2]University of Minnesota, Minneapolis, MN, USA, [3]Kaiser Permanente, Mid-Atlantic Permanente Medical Group, Rockville, MD, USA

Presented by: Soumya Reddy

Introduction/Background:
Introduction: Transgender and gender-diverse (TGD) individuals face significant disparities in both healthcare access and outcomes, resulting in delays in care or avoidance of the healthcare system for fear of discrimination. Multispecialty gender programs have been developed across a variety of healthcare systems in the United States to help meet the needs of TGD people in a safe, comprehensive, and affirming environment amid a growing demand for care from knowledgeable, culturally humble physicians. Dermatologists play a vital role in gender-affirming care, including, but not limited to, procedural gender affirmation, aesthetics, and management of complications related to hormonal therapy. However, the extent of dermatologic availability and integration within multispecialty gender programs remains unknown.

Specific Aim: Specific Aim: To assess the current representation of dermatology within academically affiliated gender programs in the U.S. to determine gaps in visibility and accessibility of dermatologic services for TGD individuals.

Materials and Methods: Materials and Methods: We conducted a cross-sectional review of 144 Accreditation Council for Graduate Medical Education (ACGME)-accredited dermatology residency programs in the U.S. A web-based search of the affiliated institutions of each residency program was conducted from December 2022 to May 2023 for the existence of organized gender programs and mention of dermatologists or dermatologic services available within those programs (Figure 1). Programs without institutional affiliations with gender-affirming healthcare programs or those affiliated with non-multispecialty gender programs (i.e. offering both medical and surgical services OR offering medical

services from at least 2 subspecialties) were excluded. 73 of 144 (50.7%) dermatology residency programs were institutionally affiliated with multispecialty gender programs.

Results: Results: Of the 73 dermatology residencies with affiliated multispecialty gender programs, only 20 were explicitly integrated into their respective gender programs. 17/20 (85%) listed one or more dermatologists by name and 3/20 (15%) either did not identify dermatologists by name or offered dermatology services through a non-physician clinician. The majority of programs specified only a single dermatologist offering gender-affirming dermatology services. The characteristics of the residencies with affiliated gender programs explicitly offering dermatology services are outlined in Table I.

Conclusion: Conclusions: This study highlights gaps in access to dermatologic care in organized gender programs at academic institutions in the U.S. Incorporation of dermatology into culturally humble, multidisciplinary care within multispecialty gender programs can improve and expand accessibility and quality of care for TGD people seeking gender-affirming care. Thus, dermatology departments and residency programs should prioritize collaboration with available institutionally affiliated gender programs and maximize transparency of such efforts to help address existing healthcare inequities for TGD individuals.

SAT-B3-T6: CULTURAL CONSIDERATIONS WHEN ASKING ABOUT SEXUAL ORIENTATION AND GENDER IDENTITY IN MANDARIN CHINESE: RESULTS FROM A QUALITATIVE STUDY OF CHINESE TRANSGENDER AND NONBINARY YOUNG ADULTS

A. Ning Zhou[1,2], Kai Huang[3]
[1]San Francisco Department of Public Health, San Francisco, CA, USA, [2]University of California, San Francisco Department of Psychiatry and Behavioral Sciences, San Francisco, CA, USA, [3]University of California, San Francisco School of Medicine, Program in Medical Education - Urban Underserved, San Francisco, CA, USA

Presented by: A. Ning Zhou

Introduction/Background: Given the demonstrated health inequities and increased mental health needs among sexual and gender diverse individuals, it is a public health priority to collect information about sexual orientation and gender identity (SOGI) in clinical settings. However, mental health providers serving monolingual Chinese-speaking immigrants and refugees seldom ask about SOGI and report discomfort and lack of knowledge regarding how to ask about SOGI in a culturally-attuned way. Further, there is a dearth of literature on accepted SOGI terminology in Mandarin Chinese.

Specific Aim: In this qualitative study with transgender and nonbinary bilingual Mandarin-speaking adults, we sought to develop best practices for asking about SOGI in Mandarin Chinese.

Materials and Methods: Chinese transgender and/or nonbinary adults (aged 18+ years), fluent in English and Mandarin Chinese, residing in the US, were recruited from local and international community-based organizations and social media groups to participate in a qualitative study. All interviews were conducted virtually using a semi-structured interview guide, which included questions about demographics, SOGI-related language, healthcare experiences, and recommendations for clinicians. Each interview was summarized and double-coded using thematic analysis; differences were discussed until consensus was reached. Participants were each given a $25 gift card for participation.

Results: Eight participants were interviewed, all self-identified as ethnically Chinese and were international students from China, Taiwan, and Southeast Asia. Age range 19-31 years. Transfeminine, transmasculine, and nonbinary identities were represented. Participants reported a cultural taboo with discussing gender and sexuality, so native terms are not yet developed in Chinese; many Chinese terms for SOGI (e.g. nonbinary: 非二元fēi èr yuán) are literal translations from English. Pronouns (gendered and nongendered) sound the same in spoken Chinese, so pronoun distinctions were described as less relevant in spoken Chinese and more relevant in written Chinese. Participants identified strategies and behaviors that providers could apply to discuss SOGI with patients in more supportive ways. For example,

the terms for gender and sex are the same (性别 xìngbié), so extra care should be taken to distinguish between gender identity (性别认同xìngbié rèntóng) and sex assigned at birth (出生时候的指派性别 chūshēng shíhòu de zhǐpài xìngbié).

Conclusion: Participants identified current language regarding SOGI in Mandarin Chinese and processes for asking about these sensitive topics. Based on the data, we developed best practices for how to ask about SOGI in Mandarin Chinese in a culturally and linguistically-attuned manner.

SAT-C3-M: BREAKING DOWN SYSTEMIC BARRIERS: A NOVEL COLLABORATION TO PROVIDE GENDER AFFIRMING SURGERY FOR INDIVIDUALS IN STATE PRISON

Amy Penkin, Mair Marsiglio, Kelly Jeske, Daniel Dugi, III, Dorian Scull
Oregon Health and Sciences University, Portland, OR, USA

Presented by: Amy Penkin, Mair Marsiglio, Kelly Jeske, Daniel Dugi, Dorian Scull

Statement of Significance: Transgender and gender diverse (TGD) individuals in state prison experience significant health disparities, trauma, and have historically been unable to access gender-affirming surgical care while in state prison. This presentation will detail the collaboration between several agencies and formally incarcerated TGD people to provide access to gender affirming surgeries for incarcerated TGD people in Oregon State prison.

The presentation details steps taken to establish the collaboration between Oregon State Department of Corrections (ODOC), the OHSU Transgender Health Program, and TGD community members who have formally experienced incarceration. Specifically, we will discuss defining referral processes between ODOC and OHSU, creating surgical pathways, engaging in care coordination, delivering staff medical and behavioral health education, and implementing direct patient support for incarcerated individuals. It will also include a report on both incarcerated patient experience in care as well as health service staff attitudes, skills, and knowledge both before and after initiating a comprehensive training series.

This multidisciplinary collaboration included behavioral health, medical, and peer support disciplines from the State Dept of Corrections, the OHSU Transgender Health Program, and community advocates and peer support service providers.

Learning Objective 1: Increase knowledge of health disparities for incarcerated transgender and gender diverse (TGD) people

Learning Objective 2: Increase understanding of challenges in accessing and receiving gender affirming care as an incarcerated transgender person

Learning Objective 3: Identify challenges and solutions for systemic collaboration between correction facilities and academic medical centers

Method to Achieve Learning Objectives: This presentation will provide an overview of the collaboration and then engage attendees in discussion, and Q/A. We also look forward to calling upon the knowledge, experience, and curiosity of attendees to participate in brainstorming to further identify potential solutions to both the barriers experienced by this type of collaboration as well as strategies to provide trauma informed gender affirming care to incarcerated TGD communities.

Oral: Mental Health Across the Lifespan

SAT-D3-T1: Elevated History of Attempted Suicide in Gender Minority Individuals Mediated by Experiences of Gender-Identity Based Discrimination

Elizabeth Boskey, Jessica Kant

Boston Children's Hospital, Boston, MA, USA

Presented by: Elizabeth Boskey

Introduction/Background: Research has demonstrated that adverse childhood experiences (ACEs) are strongly associated with both physical and mental health outcomes later in life. An increased burden of ACEs have been shown to be linked to outcomes ranging from suicidality to heart disease, but there remains limited data about the relative impact of ACEs and gender-based discrimination and stigma on the health of transgender and other gender diverse (TGD) individuals.

Specific Aim: The purpose of this study was to determine 1) whether the relationship between ACEs and suicidality is similar in TGD and cisgender adults, and 2) whether the excess burden of suicidality in TGD adults is better explained by exposure to gender minority stress, an elevated impact of ACEs in the TGD community, or both.

Materials and Methods: The TransPOP study is the first nationwide probability sample of transgender individuals in the United States. It includes a comparative cisgender sample, and data were made available for use by the Inter-University Consortium for Political and Social Research (ICPSR). The primary dependent variable of interest was a history of suicide attempt. Independent variables examined were TGD identity, a history of four or more ACEs, experiences of everyday discrimination, and the following TGD specific scales – feeling understood and accepted by others (non-affirmation) and avoiding disclosure of gender identity (non-disclosure). Univariate and multivariate weighted logistic regressions with imputed values were used to examine relationships between the variables of interest.

Results: Taken together, the combination of having 4 or more ACEs and everyday discrimination explained approximately 15% of the variability in suicide history seen in this population (R^2=14.8), while adding in TGD identity only explained an additional 0.5% (R^2=15.1). In that model, having four or more ACEs (aOR 3.6, p<.001), increased everyday discrimination score (aOR 2.8, p<001), and TGD identity (aOR 4.8, p<.001) were all associated with a significantly increased odds of having attempted suicide. Importantly, the association between transgender identity and suicide history ceased to be significant when non-affirmation and non-disclosure scales were added into the model. This suggests that the association between transgender identity and suicide risk is largely mediated by gender-based discrimination. Of note, the associations between history of attempted suicide and exposure to both four or more ACEs and everyday discrimination were similar in transgender and cisgender individuals (i.e. there were no significant interaction terms).

Conclusion: More of the suicide history of the TGD population was explained by a history of adverse childhood experiences and everyday discrimination than by gender minority identity, and the extent of these effects was similar in the cisgender population. While having a gender minority identity was associated with a history of attempted suicide in the simple model, this association ceased to be statistically significant when non-affirmation and non-disclosure were taken into account. This analysis supports our understanding the increased suicide risk seen in the TGD population compared to cisgender peers is related to experiences of discrimination and non-affirmation in an increasingly hostile world, rather than any inherent vulnerability.

SAT-D3-T2: Intersection of gender dysphoria and social anxiety in a sample of US transgender/non-binary adolescents

Kathryn Blew[1], Katha Desai[2], Kristen Russell[1], Alexandra Stonehill[2], Deanna Adkins[1]
[1]Duke University Health System, Durham, NC, USA, [2]Duke University School of Medicine, Durham, NC, USA

Presented by: Kathryn Blew

Introduction/Background: The prevalence of gender dysphoria is rising in the adolescent population, with increasing rates of pediatric gender-care referrals. Youth who identify as transgender or gender non-

binary (TGNB) have been shown to have high prevalence of multiple mood disorders. Social anxiety is associated with increased frequency and severity of depressive episodes, as well as increased risk for self-harm. Social anxiety rates have been shown to be higher in TGNB adolescents/adults (31.4%) vs the general US adult population (2-4%), but the role of gender dysphoria has not been previously explored.

Specific Aim: (1) Quantify social anxiety in a sample of US TGNB adolescents, (2) Describe the relationship between severity of gender dysphoria and social anxiety

Materials and Methods: Participants were recruited from a single US pediatric gender care clinic. Protocol was approved by the Duke University Institutional Review Board. Participants were aged 12-18 years old, and were recruited before initiating gender-affirming hormone therapy. Data was obtained from self-report questionnaires regarding social dysphoria (Utrecht Gender Dysphoria Scale), body dysphoria (Body Image Scale), social anxiety (PROMIS Social Anxiety Scale) and generalized anxiety (PROMIS anxiety). Bivariate analyses and multivariate linear regressions were utilized to evaluate the relationship between body dysphoria, social dysphoria and social anxiety. Covariates evaluated in multivariate analysis include age, sex assigned at birth, BMI, use of anxiolytics at time of intake visit, and generalized anxiety.

Results: Social anxiety was prevalent in our population, as 78% of sample had a positive screen for social anxiety. The mean PROMIS Social Anxiety score was 2.1 ± 1.1 (max 4). Body dysphoria ($R2= 0.199$, $p=0.0035$) and social dysphoria ($R2=0.131$, $p=0.0197$) were both found to be associated with social anxiety in bivariate analysis. Following multiple linear regression with model including generalized anxiety, the relationship between body and social dysphoria and social anxiety was no longer found to be statistically significant ($T=1.16$ with $p=0.25$ and $T=0.59$ with $p=0.56$ respectively). Social anxiety was instead found to be most closely related to generalized anxiety in each model ($T=5.82$ and $p <0.0001$ in model with body dysphoria, $T=6.29$ and $p<0.0001$ with social dysphoria). Demographic variables and the use of anxiolytics were not associated with social anxiety.

Conclusion: Severity of body and social dysphoria were both shown to be associated with social anxiety in a sample of US TGNB adolescents in bivariate analysis. Multivariate analysis suggests that the relationship is most likely mediated through the severity of generalized anxiety. This highlights the importance of screening for social anxiety and generalized anxiety in TGNB youth. TGNB youth who screen positive for either social or generalized anxiety would likely benefit from further diagnostic evaluation for both conditions given the varied therapeutic modalities with demonstrated efficacy.

SAT-D3-T3: Receipt of Gender-Affirming Healthcare and Mental Health Outcomes Among Transgender and Nonbinary Young People

Jonah DeChants, Myeshia Price, Ronita Nath
The Trevor Project, West Hollywood, CA, USA

Presented by: Jonah DeChants

Introduction/Background: A growing body of literature has demonstrated the positive mental health impacts of gender-affirming healthcare (GAHC), or procedures which allow transgender or nonbinary individuals to change their bodies to align with their gender identities. Despite this evidence, access to GAHC is increasingly restricted, particularly for young people under age 18. Seventeen U.S. states have passed legislation banning the provision of GAHC to transgender and nonbinary children. Using a large dataset of diverse young people ages 13-24, this study examines the prevalence of GAHC among transgender and nonbinary youth and relationships between receipt of GAHC and recent mental health symptoms and suicide risk.

Specific Aim: This study examines associations between receipt of three forms of GAHC (puberty blockers, hormone replacement therapy, and gender-affirming surgery) and mental health symptoms and suicide risk among transgender and nonbinary youth ages 13 to 24.

Materials and Methods: Using data from the 2023 National Survey on the Mental Health of LGBTQ Young People, this study examines a subsample of 14,291 transgender and nonbinary respondents ages 13-24 living in the United States (U.S.). Data were collected via an online survey administered between September and December 2022. Multivariate logistic regression analysis was used to determine the adjusted odds of each mental health indicator and measure of suicide risk among those who received each form of GAHC compared to those who did not, controlling for age, Census Region, socio-economic status, gender identity, sexual orientation, and race or ethnicity.

Results:
A minority of transgender and nonbinary young people who wanted GAHC reported having received it: 4% of respondents who reported wanting puberty blockers had received them, 18% of respondents who reported wanting hormone replacement therapy had received it, and 4% of respondents who reported wanting gender-affirming surgery had received it. Receipt of puberty blockers was associated with 35% lower odds of recent anxiety (aOR = 0.65, [CI = 0.50-0.85, $p<0.001$), 46% lower odds of recent depression (aOR = 0.54, [CI = 0.42-0.70, $p<0.001$), and 34% lower odds of considering suicide in the past year (aOR = 0.67, [CI = 0.52-0.87, $p<0.01$) among transgender and nonbinary young people who wanted them compared to their peers who did not want them. Similar findings were observed with receipt of hormone replacement and associations with recent anxiety and recent depression. Receipt of gender-affirming surgery was associated with 24% lower odds of considering suicide in the past year (aOR = 0.76, [CI = 0.59-0.99, $p<0.05$) and 38% lower odds of attempting suicide in the past year (aOR = 0.62, [CI = 0.40-0.95, $p<0.05$) among transgender and nonbinary young people who wanted it compared to their peers who did not want it.

Conclusion: These findings suggest that receipt of desired GAHC is associated with better mental health and lower suicide risk among transgender and nonbinary young people living in the U.S.

Oral: Nonbinary and Genderqueer Identities

SAT-D3-T4: Exploring Facilitators & Barriers to Accessing Gender Affirming Medical Care in the Nonbinary and Genderqueer Community: Community Member and Medical Provider Perspectives

Katelyn Regan
Widener University, Chester, PA, USA

Presented by: Katelyn Regan

Introduction/Background: The nonbinary and genderqueer (NBGQ) community is heterogenous in its medical needs, where individuals often desire varying levels of medical supports/interventions (Conlin et al., 2019; Reisner & Hughto, 2019; Taylor et al., 2019). Most studies make little distinction between the needs of binary transgender individuals and NBGQ individuals. Little is documented about the specific medical desires of NBGQ individuals or their experiences in accessing gender-affirming medical care. Studies have shown that providers can struggle with creating care plans for NBGQ patients who desire body changes that fall outside of binary-focused medical protocols (Lykens et al., 2018; Paine, 2018). This has the potential to put medical providers in a position of having to choose between adhering to established protocols or departing from these protocols to co-create a care plan for their patient based on their patient's expressed desires for gender affirmation.

Specific Aim: The first study aim is to document NBGQ community members' desired medical interventions and their experiences attempting to access gender affirming medical care. The second aim was to explore knowledge, comfort, skills, and perceived facilitators/barriers of gender-affirming medical providers in providing desired care.

Materials and Methods: Phase I of this study utilized virtual semi-structured qualitative interviews with NBGQ participants. To qualify, participants must live in the United States, be between the ages of 18-29 years old, identify as NBGQ, and have previously accessed or desire future access to gender-affirming medical interventions either in a primary care or specialty care setting. Data was coded solely by the

researcher by using an inductive (Thomas, 2006) and constant comparative method (Corbin & Strauss, 2012) to analyze for themes pertaining to desired gender-affirming medical interventions and experiences in attempting to access desired interventions.
Phase II of this study utilized a mixed-methods survey created based on the information gathered from Phase I. To qualify, participants had to be a licensed medical provider in the US who has offered gender-affirming care to more than 20 transgender patients and who has received training in gender-affirming medicine. The final survey was created with the support of a Community Advisory Group and had four novel measures to assess the self-reported knowledge, comfort, and skills of medical providers in providing or recommending various medical interventions to NBGQ individuals.

Results: Data collection/analysis is ongoing. The emerging themes from NBGQ individuals include: a desire for medical interventions outside of established gender care protocols; barriers to accessing gender-affirming medical care (e.g., lack of finances, lack of insurance coverage); and perceived inconsistent provision of medical care by gender-affirming medical providers by patients. The emerging themes from medical providers include: lack of education for providers on caring for this population; lack of insurance coverage for desired interventions; positive and negative levels of institutional support in offering gender-affirming care; legal challenges posed by anti-trans medical care bans; expressed benefits of working with multidisciplinary teams; and geographic barriers to accessing resources.

Conclusion: The information gathered by this study will serve as a foundation for the creation of gender-affirming medical care protocols that promote the autonomy, health, and wellbeing of NBGQ individuals.

SAT-D3-T5: THE BINARY OF MODERN TRANSGENDER HEALTHCARE: A CASE REPORT HIGHLIGHTING THE NEED FOR NON-BINARY AFFIRMATIVE TREATMENT

Upasana Ravinder, Krishna Prasad Muliyala, Devvarta Kumar
National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, India

Presented by: Upasana Ravinder

Introduction/Background: While non-binary people comprise 25-50% of the transgender population, gender-affirmative treatment, and surgical options become tricky to access in various parts of India. Furthermore, mental health challenges, social, familial, cultural, environmental, legal, and other inter-sectional factors add to barriers to receiving adequate health support.

Specific Aim: To present a psycho-social context and highlight societal and mental health issues experienced, and challenges faced by a non-binary person in receiving gender-affirmative treatment in an Indian context.

Materials and Methods: This is a case of an 18-year-old non-binary person (they/them), bisexual in orientation, listed male at birth, currently residing in Bengaluru, India, diagnosed as having Social Anxiety Disorder with a history of Major Depressive Disorder and Deliberate Self Harm who presented to the OPD of a tertiary care center in Bengaluru, India in October 2022. Features of Obsessive-Compulsive Disorder are evident along with Borderline Personality traits which will be highlighted in the presentation. There is family discord and mental health issues in the mother. They experience dysphoria with respect to their assigned male genital organs.

Results: This presentation will highlight how various factors can potentially play a role in the mental health issues of a non-binary person, and, the subsequent challenges in seeking gender-affirmative treatment. Psychotherapeutic management will also be presented. These will be supplemented with an overview of current laws and guidelines in India. Possible suggestions to help with psycho-social, medical, surgical, and legal affirmation and treatment in an Indian context will also be presented.

In terms of trying to address their dysphoria, initially, they had believed that getting a penectomy or a nullification surgery would be most in line with their gender identity but subsequently went on to pursue the idea that a vagina would be more congruent and help reduce their dysphoria than having a penis,

hence wishing to get a vaginoplasty without any prior Hormone Replacement Therapy (HRT). They are now in the process of searching for affirmative surgeons who would also help them understand medical and psychological implications in detail.

They also find it hard to navigate through the guidelines which state that they have to first get HRT, which they do not wish to get prior to surgery. Moreover, they find the guideline of having to live for 12 continuous months in a gender role that is congruent with their gender identity problematic in a context that largely views gender in binary terms, because they believe they are already living a gender role congruent with their identity, and expressing/presenting themselves in their own “uniquely neutral” neither too masculine nor too feminine way.

Conclusion: Guidelines that are more aware of the lived reality of those who identify as non-binary are the need of the hour especially in an Indian context. We need a survey of the needs of non-binary individuals, concrete legal frameworks, guidelines for psychological well-being, awareness of healthcare professionals towards existing guidelines for addressing medical and surgical needs, need for appropriate contextual modification, and sensitivity of healthcare professionals towards persons who identify as non-binary in our context.

SAT-D3-T6: NONBINARY INDIVIDUALS AND THEIR PURSUIT, USE, AND GOALS OF GENDER AFFIRMING CARE, AS COMPARED TO BINARY TRANSGENDER INDIVIDUALS

Marie Piatski, Kara Connelly
Oregon Health & Science University, Portland, OR, USA

Presented by: Marie Piatski

Introduction/Background: Individuals with nonbinary gender identities (a wide umbrella term including nonbinary, genderqueer, genderfluid, and agender individuals) have been shown by various studies to pursue gender-affirming care at different rates and with different modalities of care (e.g. hormone therapy, masculinizing chest surgery, etc.) as compared to binary transgender individuals (people who identify predominantly as transgender men or women). There are few studies exploring the different goals of transition of nonbinary patients and some qualitative reports of frustration on the part of nonbinary patients facing barriers or misunderstandings while attempting to access gender-affirming care.

Specific Aim: This quantitative and qualitative chart review was aimed at quantifying the rates at which nonbinary vs binary transgender patients pursued and received gender-affirming treatment, with qualitative review of stated goals of treatment. Additional goals were to inform practitioners of possible goals and motivations of nonbinary patients to improve care and service to this already marginalized group.

Materials and Methods: A retrospective chart review was conducted based on patients (age 14-25) accessing any care at Oregon Health & Science University with non-cisgender identities listed in their chart: nonbinary (NB) (n = 138), transgender male (TM) (n = 80), and transgender female (TF) (n = 81). We assessed the types of gender-affirming care pursued, types of care received, and goals of care.

Results: Nonbinary individuals, who were disproportionately assigned female at birth (AFAB) (87%), pursued gender-affirming care at significantly lower rates than their binary transgender counterparts (72% NB, 97% binary, $p<0.001$). Of those who desired certain gender-affirming interventions, nonbinary individuals were less likely to receive this care than their binary counterparts (75% vs 95%, $p<0.001$). The most common intervention pursued by nonbinary individuals were gender-affirming hormones, masculinizing top surgery, and cycle suppression. Of these, nonbinary patients AFAB were less likely to receive these as compared to binary transgender men (hormones: 64% vs 90% $p<0.05$; top surgery: 33% vs 57% $p<0.05$; cycle suppression: 85% vs 96%). When assessed for goals of interventions sought, the most common theme for all genders was ‘to avoid dysphoria’. However, after that, the goals began to diverge depending on patient population – for nonbinary individuals the next most common goals were

‘deeper voice’ and ‘androgyny’, as compared to TM (deeper voice and facial hair), and TW (breast development and fat redistribution).

Conclusion: This chart review demonstrates that even when accounting for different rates of seeking gender-affirming care, nonbinary individuals are still significantly less likely than their binary transgender peers to receive desired gender-affirming interventions.

Mini Symp: Health Services and Systems

SAT-E3-M: IDENTIFYING BEST PRACTICES FOR INTERDISCIPLINARY COLLABORATION IN GENDER CARE PROGRAMS

Nic Ryder[1], Owen Karcher[2], Kellie Rusch[2], Kim Schneider[2], Callen Smith[3]
[1]Institute for Sexual and Gender Health, University of Minnesota Medical School, Minneapolis, MN, USA, [2]UM Physicians, M Health Fairview, Minneapolis, MN, USA, [3]UW Health Comprehensive Gender Services Program, Madison, WI, USA

Presented by: Owen Karcher, Kellie Rusch, Kim Schneider, Callen Smith

Statement of Significance: While the Standards of Care 8 describe the importance of interdisciplinary collaboration (Coleman et al., 2022), there are not uniform guidelines for how to create an effective system of care for transgender patients. Each program has a different approach to providing patient care, dictated by their resources, region, and organizational structure. Additionally, the current climate of intense transphobia has made information-sharing between programs and offering patients interdisciplinary support even more important.
The M Health Fairview Comprehensive Gender Care Program has worked to improve the program and align our practices with current standards of care. In 2017, our program started building an interdisciplinary approach. From 2020-2022, our program underwent significant changes due to the pandemic, the uprising following George Floyd’s murder in our city, and staff turnover. Previously, our program had one social worker to support patients. We now have a team of seven support staff. As we grew, we identified practices for ongoing evaluation of protocols, patient care, and organizational methods.
Historically, our program was siloed within an institutional health system. Today, we have communicative relationships across departments and community stakeholders including: nonprofit organizations, community clinics that serve BIPOC queer and trans youth, other gender care programs, and a transgender tattoo artist providing post-surgical nipple tattoos. We utilize regular meetings with providers from multiple disciplines to build off each other’s strengths, discuss shared decision-making with patients, and improve our model of care. This practice eases some of the burden on gender diverse patients to navigate complex systems. We use transparent communication and an historically accountable, intersectional framework to build trust with patients harmed by institutionalized racism, ableism, fatphobia, cissexism, and compulsory heteronormativity.
Our efforts resulted in reported improved patient experience and increased provider understanding of their experience. Our interdisciplinary approach has also resulted in cutting edge research. Providers within our interdisciplinary care teams have disseminated high-impact research that providers around the world access. Findings from studies are used in healthcare education and for decreasing barriers to care, improving surgical outcomes, and policy-related changes.
Given our program’s history and growth, our team is uniquely poised to discuss implementing interdisciplinary and intersectional approaches to gender care.

Learning Objective 1: Participants will be able to describe several different options for interdisciplinary collaboration to support transgender patients.

Learning Objective 2: Participants will be able to describe the practices needed for an ongoing evaluation of protocols, patient care, and organizational methods.

Learning Objective 3: Participants will be able to describe how to build trust with community stakeholders and patients using effective, transparent communication strategies.

Method to Achieve Learning Objectives: In this symposium, presenters will take turns covering the material described above. We will describe our practices for program evaluation, and share how we've built relationships that support collaborative patient care. The symposium will be interactive and conversational in order to foster community-building. We'll provide opportunities for attendees to share their program's approach, ask questions, and engage in discussion to identify best practices for interdisciplinary trans healthcare.

Mini Symp: Pubertal Suppression/Hormone Therapy – Adolescent

SAT-F3-M: CONDUCTING AN SOC8-INFORMED "COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENT" FOR ADOLESCENTS IN THE CURRENT POLITICIZED ENVIRONMENT: PERSPECTIVES FROM TNB2S AND ADJACENT CLINICIANS

Colt St. Amand[1], Amelia Brewer[2], Shawn Giammattei[3], Nic Rider[4], Adam Sauceda[5], Laura Kuper[6,7]
[1]Bassett Healthcare Network, Cooperstown, NY, USA, [2]Amelia Brewer LLC, Edmond, OK, USA, [3]Gender Health Training Institute, LLC, Santa Rosa, CA, USA, [4]University of Minnesota Medical School, Minnesota, TX, USA, [5]Synchronicity Counseling, PLLC, Dallas, TX, USA, [6]Children's Medical Center Dallas, Dallas, TX, USA, [7]University of Texas at Southwestern, Dallas, TX, USA

Presented by: Colt St. Amand, Amelia Brewer, Shawn Giammattei, Laura Kuper

Statement of Significance: Compared to previous versions, the SOC8 gives the most guidance on how to provide gender care to transgender, nonbinary, and two spirit (TNB2S) adolescents. A "comprehensive biopsychosocial assessment" is referenced prominently throughout the Adolescent chapter, which is described as including: informed assent/consent, assessing emotional/cognitive maturity, counseling regarding fertility implications, and discussing potential risk and benefits of interventions. The SOC8 also acknowledges that assessments need to be flexible, non-pathologizing, and tailored treatment type, developmental stage, and individual circumstances of youth. However, the specific content and process of such an assessment is not agreed upon and no guidance is provided on how to navigate the unprecedented attacks that are occurring in trans youth's access to care.

Following the SOC8 public draft release, a collective of 14 TNB2S and TNB2S adjacent (i.e., those with a TNB2S loved one in their day-to-day life) mental health and medical providers from diverse practice settings and U.S. geographic locations collaborated to create an assessment for adolescents aligning with SOC8 recommendations that is informed by our own lived experiences and professional knowledge. We outlined guiding principles (e.g., acknowledging historical harms, addressing biases), further specified assessment components (e.g., exploring/identifying embodiment goals and experiences of gender euphoria), and articulated how our concerns about weaknesses in the SOC8 could be addressed (e.g., incorporating cultural humility and reflexivity). The assessment framework we developed adopts a trauma-informed lens that centers youth voice and embodiment, is developmental in nature, and honors flexibility and fluidity as opposed to requiring certainty and conformity. The framework is also guided by a family centered model of care that is collaborative yet avoids prioritizing parents/caregivers over youth themselves.

TNB2S adolescents have the right to access individualized gender care from knowledgeable providers who practice cultural humility and reflexivity. With the turbulent political climate causing more roadblocks, providers in these areas face new challenges in providing affirming care for youth. It will be important to include this aspect into the assessment process to help youth and families navigate these difficulties.

This presentation will differ from the one presented at WPATH 2022 by focusing specifically on the content of the assessment and how to adapt it in the current politicized climate. The presentation will focus on "how-tos" versus conceptual considerations that incorporate SOC8 recommendations.

Learning Objective 1: Describe guiding principles for conducting assessments with adolescents in the setting of oppressive youth gender care bans.

Learning Objective 2: Identify components of a comprehensive biopsychosocial assessment for adolescents that adheres to the SOC8 and takes a trauma informed, developmental, family centered, and culturally humble approach.

Learning Objective 3: Discuss how the assessment framework presented can be applied to specific clinical cases and practice settings in the climate of youth gender care bans.

Method to Achieve Learning Objectives: Presenters will cover the material described, including how they adapt assessments to their specific practice setting. Case examples will be provided to demonstrate how the assessment framework can be applied. Time will be allotted for attendees to ask questions, share how their practice has been impacted by the bans, collaborate on strategies to increase access to care, and discuss case examples.

Sunday, November 5, 2023

9:45am - 11:00am

Mini Symp: Reproductive and Sexual Health Sciences

SUN-A1-M: Supporting the Lactation Goals of Transgender and Nonbinary Families

Lauren Abern[1], Elizabeth Collins[1], Karla Maguire[2], Kae Greenberg[3], Alicia Simpson[4]
[1]Emory University, Atlanta, GA, USA, [2]University of Texas at Austin, Austin, TX, USA, [3]Center for HIV Law and Policy, Brooklyn, NY, USA, [4]Pea Pod Nutrition, Atlanta, GA, USA

Presented by: Lauren Abern, Elizabeth Collins, Karla Maguire, Kae Greenberg, Alicia Simpson

Statement of Significance: Many transgender and nonbinary (TGNB) patients desire to feed their children expressed milk either by breast/chest feeding or through pumping/bottles, yet they face multiple barriers. On the other hand, there are parents that do not wish to feed their child expressed milk but who still desire support in infant feeding needs. Parents and caregivers should be supported in their choices around infant feeding. However, due to the cis-normative framework and rhetoric surrounding childbirth, discussions around infant feeding can be some of the most difficult for TGNB parents.
An important part of providing support is ensuring that expectant TGNB parents are given early access to information regarding the full panoply of infant feeding choices available to them, provided in a culturally competent manner. Infant feeding using expressed milk, especially when combined with skin-to-skin contact, can be an important foundation of both physical and emotional wellness for all parents and children. Members of marginalized communities, such as TGNB, low income, Black and Indigenous individuals, are less likely to engage in exclusive breast/chest feeding. This is often due to healthcare providers' failures to provide comprehensive information about options as well as culturally competent support so that decisions about infant feeding are truly a choice and not necessitated by circumstances caused by systemic oppression and historic neglect by medical providers and government support systems.
Concerns around being a TGNB parent, especially one living with HIV, are understandably heightened due to the flood of transphobic legislation being passed nationwide to "protect children," attacks on peoples' reproductive choices, and ongoing criminalization of people living with HIV in over two-thirds of the United States. TGNB people, especially Black and Brown individuals, have historically fraught relationships with not only the medical system, but also the criminal-legal and dependent systems as well. It is a necessity that healthcare providers be prepared to address these concerns during the postpartum period. Providing comprehensive, culturally competent, nonjudgmental information and support to TGNB parents can not only help alleviate these concerns, but also help heal or deepen the parents positive

relationship with their body, and make sure that the new family has the best chance to thrive.
This symposia will address the benefits of and barriers to human milk feeding in marginalized groups, explicitly including those with intersectional identities such as Black TGNB people, and offer strategies for improving access to human milk. The ultimate goal is to reduce birth parent and infant morbidity and mortality by increasing rates of human milk feeding in the United States.

Learning Objective 1: Discuss the options available to both gestational and non gestational TGNB parents to express milk for their child's consumption, including providing a comprehensive overview of available medical interventions and milk-induction techniques.

Learning Objective 2: Identify ways that a person's intersectional identity can impact their ability to successfully accomplish their infant feeding goals and provide suggestions on how healthcare providers can help counter obstacles placed in their way by systemic oppression.

Learning Objective 3: Review the new HHS guidelines about infant feeding for gestational parents living with HIV

Method to Achieve Learning Objectives: Lecture, case studies, and discussion

Oral: Pubertal Suppression/Hormone Therapy – Adolescent

SUN-B1-T1: CHANGES IN GENDER AND SEXUAL ORIENTATION AMONG TRANSGENDER YOUTH RECEIVING GENDER-AFFIRMING HORMONE THERAPY OVER THE COURSE OF 4 YEARS

Laura Kuper[1,2], Tyler Zapata[1], Bree Horrocks[1]
[1]University of Texas Southwestern, Dallas, TX, USA, [2]Childrens Medical Center, Dallas, TX, USA

Presented by: Laura Kuper

Introduction/Background: While experiences of regret associated with gender-affirming hormone therapy (GAHT) appear rare, little is known about how transgender and gender diverse (TGD) youth's experience of their gender evolves as they are receiving GAHT. Further, while exploring one's sexuality is a common developmental milestone associated with adolescence, little is known about how TGD youth's experience of their sexual orientation evolves during this time.

Specific Aim: The first aim of this study is to explore how TDG youth perceive changes in their gender identity, pronoun use, and sexual orientation over the course of four years of receiving GAHT. The second aim is to examine whether youth's experiences adjusting to GAHT differ by their perception of changes in their gender or sexual orientation.

Materials and Methods: Participants are transgender youth receiving care at a multidisciplinary gender-affirming clinic. Participants completed surveys one (n=267), two (n=194), three (n=154), and/or four (n=82) years after initiating care. Surveys asked youth to self-report their gender identity, sexual orientation, pronouns, and whether they experienced a change in their gender or sexual orientation (or change in how they think about these) during the past year. Those that reported a change were asked to describe the change. Youth's report of their experiences with GAHT was extracted from the physician note corresponding to when the survey was completed. Responses were iteratively coded into themes.

Results: Over the four-year period, the most common gender identities were female, male, nonbinary, and transgender/trans (often along with another identity). Most common sexual orientations were pansexual and bisexual. However, there were 40 unique gender identities and 30 unique sexual orientations.

Frequency of changes in gender were 19.1% from baseline to year one, 18.6% from year one to year two, 12.3% from year two to year three, and 18.3% from year three to year four. Frequency of changes in

pronouns were 15.7% from baseline to year one, 13.9% from year one to year two, 7.8% from year two to year three, and 11.0% from year thee to year four. Frequency of changes in sexual orientation were 26.1% from baseline to year one, 25.3% from year one to year two, 26.1% from year two to year three, and 20.7% from year three to year four.

Most youth who reported a change in their gender described a shift towards a more nonbinary gender identity and/or expression. The main themes associated with changes in gender were Increased clarity, confidence, and/or comfort towards one's gender, less pressure to conform, less need/strictness in labeling oneself, and more fluidity in gender.
For sexual orientation, themes included increased acceptance/embracing of one's own sexuality, increased comfort, clarity, and/or confidence, feeling like no one set sexuality/label fits, questioning one's sexuality, and increased openness to experimenting.

The main themes regarding adjustment to GAHT reflected satisfaction with treatment, improvement in mood, reduced dysphoria, and desire for further changes. No patients expressed regret, although some noted unwanted side effects (e.g., acne) and/or ongoing dysphoria.

Conclusion: Changes in gender and sexual orientation were fairly common and generally described positively.

SUN-B1-T2: The REAL Story: Preliminary findings on long-term satisfaction and rates of regret related to pediatric gender affirming healthcare

Luca Crabtree[1], Sarah Connor[2], Kara Connelly[2], Jess Guerriero[2], Eleanor Battison[2], Max Sutherland[3], Danielle Moyer[2]
[1]Outside In, Portland, OR, USA, [2]Oregon Health and Science University, Portland, OR, USA, [3]Washington State University, Pullman, WA, USA

Presented by: Luca Crabtree

Introduction/Background: Pediatric gender-affirming healthcare is currently under legislative attack in the United States and worldwide. These dangerous and misleading initiatives are not based on science and are often fueled by unhelpful, and irresponsible coverage of this topic in mainstream media, which tends to overemphasize risks of regret.

Specific Aim: The REAL Story project (Research-based, Ethical, Affirming, and Lifesaving) is a 3-part study of long-term satisfaction and regret among a large cohort of adolescents and adults who received pediatric gender-affirming healthcare. Additional aims of the overall project are to center community voices in the discourse around pediatric gender-affirming care and regret, and to ultimately inform and improve clinical practice.

Materials and Methods: The REAL Story project has three research arms: (1) an anonymous online survey, (2) a comprehensive, retrospective chart review, (3) focus groups and individual interviews. Final results of the anonymous survey (N = 150), as well as preliminary findings from the ongoing chart review (N = 1,123), and focus groups will be presented. The anonymous survey was distributed through MyChart (secure messaging system linked to the EHR) to 941 current and past patients of a clinic with over 80% MyChart usage.

Results: Survey respondents (ages 15 to 27) were disproportionately assigned female at birth (86%) and had been prescribed hormones (94%) compared to the distribution of patients who received the survey. This may be the result of individuals prescribed testosterone needing more frequent access to their health records system for ongoing prescription. Only 9 respondents have never been prescribed hormones, for which barriers to access were described. Of those who have ever taken hormones, 30 have ever stopped (21 have already restarted or plan to). Some repondents also reported past surgery (N = 72), predominantly top surgery/mastectomy. When asked about emotions associated with gender-affirming healthcare, the most common were satisfaction (88.6%), confidence (87.2%), and euphoria (75.8%),

followed by frustration (20.8%) and disappointment (8.1%). The least endorsed emotion was regret (2.0%). One respondent wishes they had not taken hormones (0.7%) or undergone surgery (1.4%). Preliminary chart review data are thus far consistent with survey results. In order to best supplement these findings, focus group and interview recruitment aims to include participants who have had diverse journeys and trajectories with gender identity and gender affirming healthcare, including those who have had experiences of dissatisfaction, and/or regret.

Conclusion: Preliminary results of this large, 3-part project demonstrate (1) a high level of satisfaction with pediatric gender-affirming healthcare, (2) low levels of regret consistent with research on adult populations, and (3) ongoing barriers to accessing and maintaining care. Methodology for conducting surveys and recruiting participants to discuss the topic of regret in a sensitive and responsible manner will be highlighted throughout the presentation.

SUN-B1-T3: FACTORS INFLUENCING DECISION-MAKING PROCESSES OF TRANS AND NONBINARY YOUTH SEEKING GENDER AFFIRMING MEDICAL CARE: RESULTS FROM PHASE 1 OF AN INTERNATIONAL LONGITUDINAL QUALITATIVE STUDY

Charles-Antoine Thibeault[1], Eli Godwin[2], Manvi Arora[1], Valeria Kirichenko[1], Max Davies[3], "Kork" Korkodilos[2], Patrick Schmitt[4], Damien Riggs[5], Sabra Katz-Wise[2], Anne-Emmanuelle Ambresin[4], Anna Carlile[3], Annie Pullen Sansfaçon[1]
[1]University of Montreal, Montreal, QC, Canada, [2]Boston's Children Hospital, Boston, MA, USA, [3]Goldsmiths, University of London, London, United Kingdom, [4]Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland, [5]Flinders University, Adélaïde, Australia

Presented by: Charles-Antoine Thibeault

Introduction/Background: Trans and/or nonbinary youth (TNBY) seeking access to gender affirming medical care (GAMC) typically face many barriers. These include, but are not limited to: lack of parental support (Clark et al., 2020), distance from providers, absence of social support, and medical professionals' lack of knowledge (Taylor et al., 2020). Whereas this paints a gloomy picture for access to GAMC for TNBY, little research has examined, from an international perspective, the aspects that may impact access to care for TNBY approaching puberty. To fill this gap, 39 interviews were conducted in six countries (Canada, Switzerland, England, Australia, India and the United States) with TNBY and their caregivers/siblings as part of a larger international prospective longitudinal study that aims to examine trajectories to seeking GAMC and its impact on TNBY wellbeing.

Specific Aim: This research project from has four main objectives:

1) To trace the trajectories that TNBY and their families take in their journeys to seek and access gender affirmation and GAMC,
2) To produce a nuanced and contextualized understanding of the factors that facilitate the process of TNBY obtaining GAMC or obstruct them from doing so,
3) To trace how their care trajectories affect their experiences of gender affirmation in various dimensions of their lives, and
4) To understand how their well-being evolves as a result.

Materials and Methods: An invitation to participate was circulated by partner organizations to recruit families in each of the 6 countries. Inclusion criteria were for the child to be at the onset of puberty (typically aged between 8 and 14 years old), a desire to receive GAMC care and have at least one parent or caregiver willing to participate. 39 families representing the 6 countries participated in the baseline interviews (N =101 participants). Interviews were conducted online or face to face depending on the location, were tape recorded and lasted approximatively 2 hours. Baseline interviews were transcribed and then analyzed by a multidisciplinary and intercultural team with research, clinical and service use backgrounds using reflective thematic analysis. The analysis unveiled 6 broad categories as well as several subcategories that served to develop the codebook.

Results: Factors such as family understanding of child's gender dysphoria, anticipation of puberty, ambivalence regarding treatment's side effects, knowledge, access and availability of GAMC, importance of fertility preservation, and parent's comfort with child's level of autonomy were found to affect decisions to seeking GAMC. While many of these factors appear to be found across contexts, some appear more specific to local contexts such as knowledge, access and availability of GAMC.

Conclusion: Baseline data collection provides an already solid ground to better understanding what may facilitate or prevent youth from accessing GAMC care while paying attention to cultural differences.

SUN-B1-T4: COMPARISONS OF BODY COMPOSITION AND MUSCLE STRENGTH BETWEEN TRANSGENDER ADOLESCENTS AND CISGENDER CONTROLS

Aaron Misakian, Jin Long, Kyla Kent, Mary Leonard, Tandy Aye
Stanford University, Palo Alto, CA, USA

Presented by: Aaron Misakian

Introduction/Background: Approximately 1.8% of US adolescents identify as transgender. As a result, more adolescents are seeking gender affirming hormone therapy (GAHT). While studies have examined changes in body composition and muscle strength *after* GAHT, few have characterized these elements in transgender youth *before* initiation of exogenous sex hormones. Knowing if transgender youth have different body compositions and strength at baseline compared to those who are cisgender is important given the physical changes that are likely to occur from GAHT. Additionally, body composition and muscle strength are associated with health outcomes later in life.

Specific Aim: To compare body composition and muscle strength between post-pubertal transgender adolescents and their cisgender controls before the start of GAHT.

Materials and Methods: Measurements of body composition were obtained using dual-energy X-ray absorptiometry (DXA, Hologic). Lean body mass index (LBMI), appendicular lean mass index (ALMI), and fat mass index (FMI) were converted to age-specific Z-scores using National Health and Nutrition Examination Survey normative data. Leg lean mass adjusted for leg length Z-scores were generated using the Bone Mineral Density in Childhood Study data. Hand grip (kg), leg flexion (ft-lbs) and knee extension (ft-lbs) strengths were measured using the grip (Takei) or the isokinetic (Biodex) dynamometry. To compare differences between the means of each cohort, p-values were generated use two-sample t-tests on STATA 17.0 with the exception for age and race, where p was determined using Wilcoxon rank sum and Fisher's exact tests, respectively.

Results: To date, we have enrolled 13 transgender females (TF), median age 16.3 years (interquartile range/IQR 15.7-17.7), and 19 transgender males (TM), median age 15.2 years (IQR 14.5-17.1). Controls were matched for age, Tanner stage, and sex designated at birth [e.g., TM matched with cisgender females (CF)] (see table). There were no significant differences in race between groups. There were no significant differences in body mass index (BMI), LBMI, or ALMI Z-scores and muscle strength between TM and CF controls. Although TF compared to cisgender male (CM) controls had lower BMI (-0.48 ± 1.02 vs 0.22 ± 0.71, p=0.03), LBMI (-1.34 ± 0.77 vs -0.36 ± 0.57, p = 0.003), and ALMI (-1.68 ± 0.80 vs -0.42 ± 0.65, p = <0.0001) Z-scores, there was no significant difference in their FMI Z-scores (-0.15 ± 0.78 vs -0.07 ± 0.69, p = 0.742). Handgrip, leg extension, and leg flexion strengths were all significantly lower in TF compared to CM (26.16 ± 4.81 vs 36.31 ± 6.70, p = 0.0001; 84.82 ± 26.14 vs 131.12 ± 40.88, p = 0.001; and 41.47 ± 10.36 vs 60.42 ± 19.10, p = 0.003, respectively).

Conclusion: Unlike TM, TF have lower measurements of lean body mass and muscle strength compared to cisgender controls before starting GAHT. These initial analyses are limited by small sample size. Additional participants and longitudinal measurements will potentially provide differences in body composition and muscle strength between transgender youth and their cisgender controls once GAHT is started.

SUN-B1-T5: SAFETY OF BICALUTAMIDE AS ANTI-ANDROGENIC THERAPY IN GENDER AFFIRMING CARE FOR ADOLESCENTS AND YOUNG ADULTS: A RETROSPECTIVE CHART REVIEW

Jonathan Warus, Marianela Gomez Rincon, Bianca Salvetti, Johanna Olson-Kennedy
Children's Hospital Los Angeles, Los Angeles, CA, USA

Presented by: Jonathan Warus

Introduction/Background: Gender-affirming medical intervention for adolescents and young adults with functioning testes and a transfeminine gender identity often involves the use of both a testosterone-blocking medication and feminizing hormone. The most commonly used testosterone-blocking medications in the United States are gonadotropin releasing hormone (GnRH) agonists and spironolactone. While GnRH agonists are frequently preferred in younger patients, they are not widely available in oral preparations and their use is often limited by variable insurance coverage and high out-of-pocket costs. Spironolactone is a low-cost alternative that is available to be taken by mouth, however, its side effects (particularly hyperkalemia, polyuria, and hypotension) can be bothersome or unacceptable for some patients.

Bicalutamide is a potent nonsteroidal peripheral androgen receptor blocker that is FDA-approved for the treatment of prostate cancer and is available for oral administration. Bicalutamide has also been used off-label in younger patients for the treatment of some forms of precocious puberty in cisgender males and for hirsutism in patients with polycystic ovarian syndrome. Increases in liver enzymes with bicalutamide use in the treatment of prostate cancer are uncommon and are usually transient and asymptomatic. Two small retrospective chart review studies involving transgender youth (N=23 and N=5) have shown clinical efficacy of bicalutamide with no adverse effects. However, many practitioners have been hesitant to use this medication given the potential side effect of liver toxicity and the lack of larger studies providing safety data.

Specific Aim: AIM 1: Describe the demographics of adolescents and young adults who were prescribed bicalutamide for the treatment of gender dysphoria at a large gender-affirming care specialty clinic during the study period.
AIM 2: Assess the incidence of hepatotoxicity and other side effects in patients taking bicalutamide for the treatment of gender dysphoria.

Materials and Methods: A retrospective chart review was conducted for patients prescribed bicalutamide within a large academic gender-affirming care clinic from January 2018 through April 2023. Data collected includes demographic information, age of initial prescription of bicalutamide, stage of pubertal development at initiation, duration of bicalutamide use, liver function testing before and during treatment, side effects including reported liver toxicity.

Results: During the study period, 426 adolescents and young adults were prescribed bicalutamide for the purposes of androgen blockade in the treatment of gender dysphoria. Results of the chart review are currently pending, but per provider report, increased liver enzymes have only been known to occur in one patient during this time and resolved after medication discontinuation with no lasting sequelae.

Conclusion: Healthcare providers within one large academic gender-affirming care clinic have used bicalutamide for testosterone blockade in 426 adolescent and young adult patients since 2018 with no major complications. This study will add significant evidence for the safety of this medication as an alternative approach to anti-androgenic therapy in the treatment of gender dysphoria.

Mini Symp: Community Engagement

SUN-C1-M: GROWING WHAT YOU SOW: GENDER AFFIRMING COMPETENT CARE WITHOUT SILOS IN FRESNO, CALIFORNIA

Julie Nicole[1], Crow Fitzpatrick[2], Jess Fitzpatrick[3], Drew Harbaugh[4]
[1]UCSF Fresno, Fresno, CA, USA, [2]California State University, Fresno Campus, Fresno, CA, USA, [3]Fresno Economic Opportunity Commission, Fresno, CA, USA, [4]PFLAG, Fresno, CA, USA

Presented by: Julie Nicole, Crow Fitzpatrick, Jess Fitzpatrick, Drew Harbaugh

Statement of Significance:

The goal of our symposium is to present a follow up from our 2021 presentation where we showed that through education and community support, small projects, across many disciplines, have a big impact in communities that are struggling for gender affirming services. This year, we will demonstrate the impact that our projects have had while presenting new data on mental health access and socio demographics along with recent other projects and collaborations.

Centrally located in California, Fresno is a city with some of the highest rates of economic disparity in the state and across the country. Since the last conference, we are proud to have added three WPATH GEI trained physicians to the community, two of them being family medicine physicians who have completed an elective rotation in gender affirming healthcare. We have continued our outreach to other historically erased communities, partnering with groups representing the Black community to extend our intersectionality in events such as the Transgender Day of Remembrance. We have completed a retrospective chart review to help us fine tune the delivery of our services. We added to our previously presented reports on housing and access to healthcare with the recent completion of a master's thesis by Crow Fitzpatrick, which highlights barriers to accessing gender affirming mental health care, biopsychosocial experiences of trans and nonbinary individuals in the Central Valley and identifying 12 recommendations to expand gender affirming mental health services. Our local PFLAG chapter has been taking the outreach further with advocacy groups including culturally appropriate training for those caring for LGBTQ+ children in foster care. Finally, in our continuing efforts to break down silos and foster community collaboration, we are anchoring our work within a local nonprofit organization, the Fresno Economic Opportunity Commission's LGBTQ+ Resource Center.

These lessons demonstrate how a more rural, economically and socially stressed, and conservative-leaning community can rise to the challenge and create a foundation of equity for a population that often finds itself further marginalized and isolated when away from larger urban centers. Our symposia will present the results of two research projects, demonstrate our outreach to other historically erased communities and will introduce other members of our transgender and gender expansive leadership team which include a nurse, a physician, a college professor, several therapists, social workers, community organizers and activists.

Learning Objective 1: Update symposium attendees of our newest research data, current and upcoming community projects and its impacts for our community.

Learning Objective 2: Expand the network of resources between communities which will serve as building blocks for interdisciplinary, intersectional collaboration.

Learning Objective 3: Continue to connect with other communities in order to share ideas, build bridges and capital.

Method to Achieve Learning Objectives:
Presentation and updates on the approaches taken in order to address transgender health care barriers in Fresno including new data obtained through local research projects.
Storytelling from presenters with lived experience, on how to enact community projects from idea to execution.
Q & A discussion session to address barriers/challenges and share knowledge.

Oral: Voice and Communication

SUN-D1-T1: Vocal Congruence and Safety: The Medical Necessity of Gender-Affirming Vocal Therapy

Shanna Stryker[1], Jules Madzia[1,2], Sarah Pickle[1], Ishita Dubey[1], Gregory Dion[1], Victoria McKenna[3]
[1]University of Cincinnati College of Medicine, Cincinnati, OH, USA, [2]University of Cincinnati College of Arts & Sciences, Cincinnati, OH, USA, [3]University of Cincinnati College of Allied Health Sciences, Cincinnati, OH, USA

Presented by: Shanna Stryker

Introduction/Background: Voice is considered a gender signifier, and incongruence between a person's gender identity and the perceived gender of their voice by others can trigger vocal dysphoria in transgender/gender diverse (TGD) individuals. Vocal incongruence can also divulge one's TGD identity, which may be unsafe given the prevalence of discrimination and victimization experienced by TGD persons. Gender-affirming vocal therapy (GAVT) can improve vocal congruence but is often unavailable or non-covered by medical insurance companies in the United States.

Specific Aim: To investigate the relationship between vocal congruence, wellness, and safety in a large group of TGD individuals. We hypothesize that patients who self-report vocal congruence will present with higher quality of life and safety, and reduced perceived stress compared to those who do not self-report vocal congruence.

Materials and Methods: A cross-sectional electronic survey was developed in REDCap which included standardized questionnaires: the Quality-of-Life Scale [QOLS], Transgender Self-Evaluation Questionnaire [TSEQ], and Perceived Stress Scale [PSS]. The research team developed additional questions assessing vocal congruence, safety, and experiences of discrimination and gender affirmation. Differences in safety and wellness measures between participants with and without self-reported vocal congruence were assessed using t-tests for continuous variables and chi-squared tests for categorical variables. Linear and logistic regression analyses were conducted to examine the relationships between vocal congruence (as measured by the TSEQ) and safety and wellness measures. All regression models were adjusted for age, race, gender identity, history of gender-affirming hormones, and history of voice therapy.

Results: Of the 187 TGD participants who responded to all questions relevant to this analysis, age 18-79 (M=31.3, SD=11.2), 35.4% were men, 33.3% women, and 26.2% non-binary/genderqueer adults. Sixty (32%) agreed with the statement "I think my voice aligns with my gender." Participants who self-reported vocal congruence had significantly higher scores on the QOLS ($p=.02$) and were significantly less likely to have been misgendered based on their voice in the past year ($p<.001$). There was no difference in PSS scores based on self-reported vocal congruence ($p=0.13$). In adjusted linear regression models, higher TSEQ scores (indicating lower vocal congruence) were associated with higher PSS scores ($p<.001$) and lower QOLS scores ($p<.001$). In adjusted logistic regression models, TSEQ scores indicating lower congruence were associated with greater likelihood of having experienced public discrimination ($p<.001$), medical discrimination ($p<.001$), and verbal harassment ($p<.001$) but not physical harm ($p=0.05$). Lower vocal congruence was also associated with greater frequency of being misgendered based on physical appearance ($p=.01$) and voice ($p<.001$).

Conclusion: Vocal incongruence is associated with lower quality of life, higher stress, and experiences of discrimination and verbal harassment for TGD individuals. Therefore, GAVT is medically necessary healthcare.

SUN-D1-T2: The impact of gender minority stress on voice-related life impact: Differences among trans men, trans women, and non-binary adults

Benjamin Parchem[1], Stephanie Misono[2], Taymy Caso[3], Daniel Weinstein[2], Lisa Butcher[2], Anna Sombrio[2], G. Nic Rider[1]
[1]Institute for Sexual and Gender Health, Minneapolis, MN, USA, [2]University of Minnesota Medical School, Minneapolis, MN, USA, [3]University of Alberta, Edmonton, AB, Canada

Presented by: Benjamin Parchem

Introduction/Background: Trans and gender diverse (TGD) adults face interpersonal, structural, and systemic oppression that shape negative health outcomes. Minority stressors, such as misgendering, can impact one's comfort (e.g., vocal dysphoria) and sense of safety when expressing their gender through voice and result in or exacerbate voice-related symptoms or concerns. There is limited information on the interaction between gender minority stress and voice-related life impact (or voice handicap) and how this may differ by gender identity.

Specific Aim: 1. Examine differences in voice-related life impact by gender minority stressors among TGD adults.
2. Assess whether gender identity (i.e., trans man, trans woman, and non-binary) moderates the relation between gender minority stressors and voice-related life impact among TGD adults.

Materials and Methods: TGD adults (N=313) completed an online survey of their voice-related experiences. Gender minority stressors were measured with the Gender Minority Stress and Resilience Measure (GMSR); voice-related life impact was measured with the Voice Handicap Index-10 (VHI-10); gender identity was measured with a self-report item and categorized into trans man (N=72), trans woman (N=88), and non-binary (N=165); 69 respondents selected more than one category.

Results: Most negatively-valenced GMSR subscales (discrimination, rejection, victimization, non-affirmation, internalized transphobia, negative expectations, and non-disclosure) (r's 0.19 to 0.39) and the community connection subscale (r=0.13) were positively associated with VHI-10 (in which high scores reflect worse voice-related life impact). The pride subscale did not predict VHI-10. The relationships between non-affirmation and VHI-10 (β=-0.74) as well as negative expectancy (for those not living in their affirmed gender) and VHI-10 (β=-0.26) were stronger in trans men than in the other respondents. The relationship between minority stressors and VHI-10 was not moderated by trans woman or non-binary identities.

Conclusion: Gender minority stressors were associated with worse voice-related life impact among TGD adults, suggesting that experiences of oppression may be connected to experiences with voice. As voice can be an integral aspect of one's gender expression and embodiment, gender-affirming voice care offers a point of intervention to achieve voice-related goals and also counteract oppressive societal messaging that contributes to voice symptoms. Individualized supports may be necessary for trans men whose voice quality was particularly linked to gender minority stress.

SUN-D1-T3: Individualized Voice Recipes: Selecting Ingredients for Person-Centered Goals in Gender-Affirming Care

Brett Myers, Jenny Pierce, Pamela Mathy
University of Utah, Salt Lake City, UT, USA

Presented by: Brett Myers

Introduction/Background: Gender-affirming voice therapy is a common intervention for individuals seeking to modify communication attributes to be congruent with their gender identity. Goals in therapy should be centered on patient perspective, which is especially informative in transgender and gender-diverse voice care. Patient-reported outcome (PRO) measures in this area have largely focused on transfeminine voice characteristics and very few have been inclusive of transmasculine and non-binary individuals. We created a novel PRO measure that assesses an individual's self-perception of voice parameters, which is accessible to all individuals on the gender spectrum. We conducted focus group meetings across the United States to aid the development of this PRO measure. Based on focus group discussions and survey data collected, we demonstrate the importance of self-ratings for measuring progress, as well as a wide variability in goals, when working with diverse populations.

Specific Aim: To validate a novel PRO measure (the Utah Gender Presentation Scale) by comparing data across diverse groups and over the course of gender-affirming voice and communication therapy.

Materials and Methods: Data were gathered from survey responses of individuals with diverse gender identities, including transgender female and male, non-binary/genderqueer, and cisgender female and male. Participants were asked to rate their own voices in a series of attributes related to verbal (e.g., pitch, intonation, resonance) and non-verbal communication (e.g., gesture, posture). Operational definitions were provided for these terms, and participants rated their self-perceptions for each parameter on a scale from 1 to 10, where 1 is very masculine and 10 is very feminine. For individuals receiving gender-affirming voice and communication therapy, pre and post data are reported.

Results: Data were collected from a diverse group of over 200 participants. Linear mixed-effects models compared variability of self-ratings across gender identity groups. We found high variability in the goals of gender-diverse populations, which was representative of focus group discussions. The PRO measure demonstrated significant change over time that was indicative of higher gender congruence at the end of therapy.

Conclusion: Gendered ratings of voice and communication parameters appear to exist on a continuum rather than a binary framework. Individuals among diverse gender identities showed variability in ratings of congruence and which parameters contributed to that congruence. Furthermore, these data support the use of the novel PRO measure for gender diverse populations.

Mini Symp: Health Services and Systems

SUN-F1-M: INTERDISCIPLINARY APPROACH TO THE GENITAL MASCULINIZATION & FEMINIZATION SURGICAL JOURNEY

Nora Dixon[1], Kelsie Kaiser[2], Lisa Semro[1], April Spina[2], Emily Moon[2]
[1]University of Southern California Herman Ostrow School of Dentistry - Mrs. T.H. Chan Division of Occupational Science and Occupational Therapy, Los Angeles, CA, USA, [2]University of Southern California Herman Ostrow School of Dentistry - Division of Biokinesiology and Physical Therapy, Los Angeles, CA, USA

Presented by: Nora Dixon, Kelsie Kaiser, Lisa Semro, April Spina, Emily Moon

Statement of Significance: The journey through feminization or masculinization bottom surgeries can be daunting for any individual, especially with various medical practitioners' involvement. Development of an interdisciplinary team creates an environment that is efficient and effective. Creation of pre-operative and post-operative screening tools for physical therapy and occupational therapy services, as well as a rehabilitation plan of care are essential for optimal outcomes. This symposium aligns best with the "interdisciplinary approaches" category.

Learning Objective 1: Understand the distinct value of interdisciplinary approaches across the continuum of care for patients undergoing bottom gender confirmation surgery.

Learning Objective 2: Define pre-surgical expectations and timelines to facilitate optimal health outcomes for patients undergoing gender confirming bottom surgery.

Learning Objective 3: Identify best practices to support patients post-gender confirming bottom surgery.

Method to Achieve Learning Objectives: Learning objectives will be achieved through a combination of approaches:

Knowledge checks
Self-analysis and self-reflection

Case studies
Question and answer portion

11:15am - 12:30pm

Oral: Mental Health Across the Lifespan

SUN-B2-T1: SCREENING FOR SUSPECTED AUTISM AMONG TRANSGENDER YOUTH USING THE BASC-3

Danielle Moyer[1], Marni Axelrod[2], Lisa Buckloh[3], Jonathon Poquiz[4], Alora Rando[5], Anthony Alioto[5]
[1]Oregon Health & Science University, Portland, OR, USA, [2]Baylor College of Medicine, Houston, TX, USA, [3]Nemours Children's Health-Florida, Jacksonville, FL, USA, [4]University of Minnesota, Minneapolis, MN, USA, [5]Nemours Children's Health-Delaware, Willmington, DE, USA

Presented by: Danielle Moyer

Introduction/Background: Autism spectrum disorder appears to be more common among transgender and gender diverse (TGD) youth than their cisgender peers. There is limited evidence on the utility and accuracy of commonly used psychological screening measures among TGD youth. Research in the broader population of children has identified the following subscales of the Behavior Assessment Schedule for Children, Third Edition (BASC-3) to be helpful in distinguishing children diagnosed with ASD from their peers: Parent- and Self-Report Atypicality, as well as Parent-Report Withdrawal, Developmental and Social Disorders, and Autism Probability.

Specific Aim: The current study aimed to explore Parent- and Self-Report BASC-3 scales for TGD youth across three groups: youth with an established diagnosis of autism spectrum disorder (Diagnosis), youth without a diagnosis for whom the youth or parent expressed a concern for potential autism (Concern), and youth without a diagnosis or expressed concern (None).

Materials and Methods: Data were collected as part of a retrospective chart review of standard of care measures used in a comprehensive gender wellness program housed in a pediatric healthcare system. Youth (N = 189) and their parents completed the BASC-3 as part of their psychological evaluation.

Results: One-Way ANOVAs were significant across groups for self-reported Atypicality ($F = 8.375$, $p < .001$), as well as parent-reported Atypicality ($F = 7.227$, $p < .001$), Withdrawal ($F = 11.987$, $p < .001$), Adaptive Functioning ($F = 6.054$, $p = .003$), Developmental and Social Disorders ($F = 17.307$, $p < .001$), and Autism Probability ($F = 17.086$, $p < .001$). Self-Report Atypicality was more elevated in the Concern group than the Diagnosis group. Mean Atypicality scores in the Concern group were significantly higher than the None group and marginally higher than the Diagnosis group. Parent-Report scales followed the expected pattern of being most elevated in the Diagnosis group, followed by the Concern group. Withdrawal, Developmental and Social Disorders, and Autism Probability demonstrated the most significant distinctions, including significantly higher scores in the Diagnosis group compared to all others, but the difference between the Concern and Diagnosis groups was not significant for any scale.

Conclusion: These results suggest that BASC-3 Parent-Report scales, and the Withdrawal, Developmental and Social Disorders, and Autism Probability scales in particular, may be better indicators of potential autism spectrum disorder than Atypicality scales and especially the Self-Report Atypicality scale. No scales explored in this study distinguished the Diagnosis and Concern groups, suggesting that other screeners such as the Social Communication Questionnaire may be needed if a higher level of specificity is desired.

SUN-B2-T2: CLINICIAN PERSPECTIVES IN THE GENDER AND AUTISM PROGRAM - A NOVEL CLINICAL SERVICE FOR TRANSGENDER AUTISTIC YOUTH

Sarah Bernstein, Abigail Fischbach, John Strang
Children's National Hospital, Washington, DC, USA

Presented by: Sarah Bernstein

Introduction/Background: The intersection of autism and gender diversity is common: Autism Spectrum Disorder (ASD) is 3-6.4 times more prevalent in transgender compared to cisgender individuals. The co-occurrence rate is estimated at 11%. The World Professional Association for Transgender Health (WPATH) Standards of Care call for autism specialists to collaborate with gender specialists to provide attuned care when serving this population. Autistic transgender youth describe specific barriers to pursuing gender-related needs, which arise from challenges with executive functioning skills, social awareness, and self-advocacy. These ASD-related gender barriers are strongly associated with increased internalizing symptoms and suicidality. Co-occurring autism and gender-diversity is associated with significantly increased mental health risks, above and beyond mental health risks in autistic or gender-diverse populations independently. The Gender and Autism Program (GAP) at Children's National Hospital in Washington D.C., founded in 2017, is the first clinical service specifically designed for youth who are both transgender and autistic; more than 110 patients have participated in the program. The GAP provides evaluation services for autism and gender needs as well as support group programs for youth and their parents/caregivers.

Specific Aim: Examine clinical considerations and challenges of expert providers in the subspecialty clinic.

Materials and Methods: The five clinicians providing direct assessment services for the GAP, uniquely expert given their work with the novel GAP service as psychologists/neuropsychologists, participated in a multi-stage Delphi study to identify overarching challenges and clinical needs of this population. The providers responded to the initial prompt asynchronously and anonymously, then evaluated the resulting statements, with 80% agreement set as the threshold for inclusion of a response.

Results: Of the 12 clinical statements submitted and reviewed by the clinicians, 11 were accepted unanimously. Several highlights include: this is a high risk group; ASD social differences can lead youth to avoid connecting with LGBTQ+ peer supports; there is limited information about the impact of gender-affirming medical care on the developing neuro-divergent brain; a subset of youth are at the margin of ASD diagnosis (subclinical traits) for whom diagnostic assessment requires greater nuance; a subset of parents enter the process with the intention that the evaluation will validate that their child is not truly transgender because the child is autistic; and family education on the intersection of autism and gender takes time.

Conclusion: Clinicians emphasized how autism-related differences (executive functioning, social awareness, self-advocacy) can impact the gender-affirmation process. Accommodations must be made (i.e., visual supports, concrete language, structured visits) and extended clinical time is often necessary. Providers described the importance of balancing the time needed for adequate support/gender-discernment without gatekeeping the timeline for gender-affirming medical care. Future research is needed to investigate perspectives of providers from other disciplines (i.e. endocrinologists, adolescent health specialists, pediatricians, speech-language pathologists) who interface with this intersectional population.

SUN-B2-T3: SOCIAL, COGNITIVE, AND EMOTIONAL FUNCTIONING AMONG TRANSGENDER YOUTH EVALUTED FOR AUTISM SPECTRUM DISORDER

Tara Rutter[1], Randi Phelps[2], Rachel Greene[1], Danielle Moyer[1], Emily Olsen[1], Raquel Harmon[1]
[1]Oregon Health and Science University, Portland, OR, USA, [2]Phoenix Children's Hospital, Phoenix, AZ, USA

Presented by: Tara Rutter

Introduction/Background: A higher incidence of autism spectrum disorder and associated traits have been shown among transgender and gender diverse (TGD) youth, and the number of TGD youth requesting evaluation for autism is increasing. More research is needed regarding the specific profile of social, cognitive, and emotional functioning among TGD youth diagnosed with autism.

Specific Aim: This study aimed to explore the social, cognitive, and emotional functioning of TGD youth who receive an autism diagnosis compared to those who do not, and compared to their cisgender peers.

Materials and Methods: Autism evaluation results for 41 TGD youth aged 5-18 years and 70 cisgender matched controls were included in the study. TGD participants were identified through retrospective chart review and 25% (*n* = 11) were not yet out as TGD at the time of evaluation. The control group was matched on age, whether or not autism was diagnosed, and approximate IQ, with both male and female sex assignment for every TGD participant.

Results: At the time of analysis, TGD participants were female (*n* = 8), male (*n* = 19), nonbinary (*n* = 12), and questioning/unknown (*n* = 2). Approximately half were diagnosed with autism (TGD+ group; *n* = 19) versus not (TGD- group; *n* = 22). Average Full-Scale IQ was 103 (range: 70-126), and did not significantly differ between TGD+ and TGD- groups. Meeting criteria for autism did not significantly differ across sex assigned at birth (c^2 = 1.856, *p* = .173) or gender identity (c^2 = 1.784, *p* = .618), but those who did not yet identify as TGD were more likely to be diagnosed (c^2 = 4.209, *p* = .04). The most common co-occuring mental health diagnosis across TGD groups was anxiety (*n* = 34), and TGD- youth were slightly more likely to receive an ADHD diagnosis (72.7% versus 47.4%). Parent-reported adaptive functioning was significantly lower among TGD+ youth (*t* = -3.396, *p* = .002). While IQ was matched as closely as possible, IQ was nonetheless signifcantly higher among TGD youth compared to controls (*t* = -2.579, *p* = .009), although less than one standard deviation (*M* = 7 points). In contrast to TGD youth, adaptive functioning did not differentiate whether or not autism was diagnosed among matched controls (interaction *F* = 5.014, *p* = .027).

Conclusion: Compared to TGD youth without autism, those who receive a diagnosis do not differ based on sex assignment, gender identity, age, or IQ score, but parents report significantly lower adaptive functioning. TGD youth seeking evaluation for autism may have higher IQ scores than their cisgender peers, and parent-reported adaptive functioning may be more relevant to this group. Some youth seeking evaluation for autism may not yet identify as gender diverse, and asking questions about gender during autism evaluations for all youth is recommended.

SUN-B2-T4: Mental Health Practice with Transgender and Gender Expansive Clients in Appalachia

Veronica Timbers
University of Utah, Salt Lake City, UT, USA

Presented by: Veronica Timbers

Introduction/Background: It is estimated that one in six transgender and gender expansive (TGE) people live in rural areas. TGE people in these rural spaces have unique strengths and stressors related to visibility, community, and access to care. Rural communities in the US also tend to hold binary conceptualizations of gender and have higher religiosity than urban areas. Little research has been done around the specific cultural needs and dynamics of mental health services for TGE clients in rural locations.

Specific Aim: The current qualitative study explores how trans and gender non binary mental health clinicians in Appalachia are addressing the unique intersectional needs and experiences of TGE people in this rural location. The goal is to provide initial understanding of what contextual factors, interventions, clinician-client dynamics, and training is guiding current practice at these intersections of identity and location to expand research and evidenced-based practice.

Materials and Methods: This study used a grounded theory, qualitative approach to analyze interviews with six (*N*=6) transgender or non binary clinicians serving TGE clients in Appalachia. Eligible participants were recruited through snowball sampling. Participants had to be practicing in the region historically known as Appalachia, held a clinical license, and had seen at least one TGE client. Two independent coders analyzed the data and member checking was used to increase rigor.

Results: Results showed that clinicians' lived experiences impacted their decision to specialize in work with TGE clients and was perceived as providing a sense of safety to clients. Lived experience also impacted how cultural factors and religion was integrated into therapy with TGE clients. Practice interventions were most frequently based in behavioral modalities such as CBT, DBT, and MI along side of using conflict theory perspectives to increase client awareness and resilience related to oppression. All six clinicians reported formal training related to practice with TGE clients but none of the clinicians had formal training in integrating Appalachian cultural factors or RS topics with TGE clients. The results suggest that there are unique cultural factors to be considered in practice with TGE clients in Appalachia.

Conclusion: This research shows current trends in mental health practice with Appalachian-located TGE clients so that more specific training and skills can be developed to improve quality care in this region. This grounded theory study also adds foundational knowledge to the unique needs of rurally-located TGE clients and to research on the appropriate use of self in the therapeutic process. More research is needed to advance specific practice models for trans-affirming care in rural areas.

SUN-B2-T5: GENDER TRANSGRESSED: FELT PRESSURE TO CONFORM TO GENDER STEREOTYPES, GENDER TYPICALITY, AND MENTAL HEALTH IN TRANSGENDER VS. CISGENDER ADULTS

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Presented by: Kiran Sundar

Introduction/Background: Access to gender-affirming healthcare provides life-saving support and improves quality of life for transgender and nonbinary people. However, many people in these communities may perceive clinicians as gatekeepers of the gender-affirming medical services that become available through a clinical diagnosis of gender dysphoria. Previous studies have found that treatment-seeking transgender patients may feel pressure to only report experiences that closely align with this diagnostic criteria. Thus, they may feel the need to conform to gender expectations to prevent invalidation of their identities and exclusion from access to medical transition. Pressure to conform to gender expectations may also impact mental health negatively—studies in cisgender people have found that increased pressure to conform to gender stereotypes and increased other-gender typicality is associated with lower self-esteem and worse mental health overall. However, there is limited research on whether felt pressure to conform to gender stereotypes and other-gender typicality are associated with worse mental health in transgender and nonbinary populations.

Specific Aim: My study aims to fill this gap by comparing felt pressure, gender typicality, and mental health—as indexed by self-esteem and psychological distress—in cisgender vs. transgender adults.

Materials and Methods: We surveyed cisgender men (n = 231), cisgender women (n = 202), transgender men (n = 50), transgender women (n = 53), and nonbinary people (n = 66) of ages ranging from 18 to 64. The survey collected information on experiences of felt pressure to conform to gender stereotypes (feminine and masculine), gender typicality (same-gender and other-gender), self-esteem, and psychological distress.

Results: A series of ANOVAs and Tukey post hoc tests revealed that only cisgender men felt pressure to avoid feminine stereotypes; all other groups felt pressure to conform to feminine stereotypes. Cisgender women felt the least pressure to conform to or avoid masculine stereotypes, whereas all other groups felt pressure to conform to them. Transgender men, transgender women, and nonbinary people felt pressure

to conform to both feminine stereotypes and masculine stereotypes. Cisgender men reported higher same-gender typicality than cisgender women and nonbinary people. Transgender women reported higher other-gender typicality than cisgender men, cisgender women, and nonbinary people. Transgender men reported higher other-gender typicality than cisgender men and cisgender women. Transgender men, transgender women, and nonbinary people all had lower mean self-esteem scores than both cisgender men and cisgender women. Transgender men, transgender women, and nonbinary people all had higher mean psychological distress scores than both cisgender men and cisgender women.

Conclusion: These results suggest that previous findings in cisgender children—that higher pressure to conform to gender stereotypes combined with higher other-gender typicality is associated with worse mental health—may hold true in transgender and nonbinary adults as well. Consistent with prior research, transgender and nonbinary people reported worse mental health than cisgender people. These results highlight the need for researchers and clinicians to consider felt pressure to conform to gender expectations and gender typicality when providing healthcare services to transgender and nonbinary patients.

SUN-B2-T6: PAST-YEAR SEXUAL ASSAULT VICTIMIZATION VARIES OVER THE COURSE OF SOCIAL AND MEDICAL AFFIRMATION AND DIFFERS BY GENDER

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Presented by: Sarah Peitzmeier

Introduction/Background: Qualitative studies suggest that “early transition,” i.e. in the first 1-2 years following medical or social gender affirmation, may be a high-risk period for sexual assault and other forms of violence in transgender/nonbinary individuals. However, there has been little quantitative exploration of how sexual violence victimization risk changes over the course of gender affirmation, and how this trajectory might differ by gender identity.

Specific Aim: Quantify the past-year prevalence of sexual violence victimization by gender identity and time since socially or medically affirming gender.

Materials and Methods: This study used data from the 2015 U.S. Transgender Survey (USTS) to examine past-year sexual violence victimization by any partner by years since socially affirming gender, years since medically affirming gender, and years since any social or medical gender affirmation. Past-year prevalence of victimization was examined separately for trans women (n=3,239), nonbinary individuals assigned male at birth (AMAB; n=763), trans men (n=4,075), and nonbinary individuals assigned female at birth (AFAB; n=4,483).

Results: Lifetime risk of sexual assault was highest in individuals assigned a female sex at birth, including trans men (51.4%) and nonbinary AFAB individuals (57.3%), as compared to individuals assigned a male sex at birth, including trans women (35.2%) and nonbinary AMAB individuals (39.8%). However, past-year prevalence of sexual assault trajectories differed by gender. Past-year victimization was quite similar across gender groups among individuals who had not socially or medically affirmed their gender, but past-year prevalence initially increases sharply among AMAB individuals (both trans women and nonbinary AMAB individuals) after social or medical gender affirmation, while past-year prevalence trends downward after socially or medically affirming gender in AFAB individuals, especially trans men. This pattern is clearest when using medical affirmation, rather than social or any affirmation, as a timeline. Past-year prevalence of sexual violence is higher for trans women than for trans men for at least 10 years after pursuing medical or social affirmation, after which prevalence appears to converge again.

Conclusion: Congruent with qualitative research, “early transition” is a high-risk period for victimization among trans women and nonbinary AMAB individuals. For trans men, medical affirmation, in particular, may actually reduce the risk of sexual violence; in nonbinary AFAB individuals, however, this protective effect is less clear. Though more research should be conducted, these findings are congruent with

sociological theories that as individuals present as more feminine or more genderqueer they may be at higher risk of sexual violence, while those who present as more masculine may be at reduced risk of sexual violence. Trans men still face an elevated risk of sexual assault throughout all parts of the transition timeline as compared to cisgender men.

Mini Symp: Reproductive and Sexual Health Sciences

SUN-C2-M: KEY TOPICS IN REPRODUCTIVE HEALTH FOR TRANSGENDER AND GENDER DIVERSE PEOPLE

Chance Krempasky[1], b.a. goodrum[2], Miles Harris[3], Lauren Abern[4], Frances Grimstad[5]
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Presented by: Chance Krempasky, b.a. goodrum, Miles Harris, Lauren Abern, Frances Grimstad

Statement of Significance: Gynecologic and obstetric care of transgender and gender diverse (TGD) patients is multifaceted and often includes addressing multiple domains of pelvic health needs. It is vital that clinicians both understand these individual entities of pelvic health, the existing evidence regarding them, how they interact with one another, and how therapies and approaches to managing them may be both shared and distinctive. Until recent years, research and care guidelines were sparse in these domains, however newer data is emerging to help inform clinical approaches. For example, many patients and healthcare providers have misconceptions regarding pregnancy risk for TGD individuals assigned female at birth using testosterone as gender-affirming hormone therapy and wonder about appropriate contraceptive options and considerations. Patients may also experience concerns with breakthrough bleeding and/or pelvic pain on testosterone. Various abortion options may uniquely impact TGD patients, as well as the challenges and barriers faced in accessing those services. Finally, perinatal care quality for TGD individuals and families may be improved by applying insights from trauma research and psychoneuroendocrinology. Co-creating a sense of cultural and physiologic safety with individuals seeking care can support self-regulation, physiologic birth, recovery, and social connection.

This symposia integrates cutting edge research with multi-specialty practice perspectives from primary care, gynecology, surgery, and midwifery, with a significant focus on cultural safety.

Learning Objective 1: Recall 3 key contraceptive counseling points for TGD people using gender-affirming hormone therapy.

Learning Objective 2: Name 3 therapeutic options for managing breakthrough bleeding.

Learning Objective 3: Describe techniques for establishing cultural and physiologic safety with pregnant TGD people.

Method to Achieve Learning Objectives: In this workshop, each presenter will focus on one of the following topics: contraception, breakthrough bleeding, abortion, perinatal care. We will present relevant data as well as clinical and theoretical approaches, and we will utilize case studies to exemplify how these concerns may arise for clinicians in various settings.

SUN-D2-T2: EVALUATION OF AN EDUCATIONAL VIDEO ASSESSING KNOWLEDGE AND ATTITUDES OF TRANSGENDER YOUTH ON FERTILITY PRESERVATION

Florence Grégoire-Briard[1,2], Andie Chernoff[3], Ken Tang[4], Jenna Gale[5,6], Margaret Lawson[7], Maria Kielly[8]
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Ottawa, ON, Canada, [7]Children's Hospital of Eastern Ontario (CHEO) Research Institute,, Ottawa, ON, Canada, [8]Department of Obstetrics and Gynecology, Memorial University, Saint-Johns', NL, Canada

Presented by: Florence Grégoire-Briard

Introduction/Background: While hormone therapy and surgery can be used to help alleviate gender dysphoria in transgender individuals, such treatments may negatively impact fertility. Multiple organizations have highlighted the importance of counselling on infertility risk, as well as offering fertility preservation (FP) prior to therapy. Previous studies have shown low rates of FP utilization by transgender youth however a similar desire to have children compared to the cis-gender population. To supplement fertility discussions, a whiteboard video was created to explain FP and to provide an additional educational tool for transgender youth and their families.

Specific Aim: The current study assessed: (1) The understandability, actionability, and readability of the FP educational video; (2) Patient perceptions, knowledge, barriers, and interest in FP; and (3) Overall satisfaction with a patient education video on FP.

Materials and Methods: Participants (age 12 to 18) were enrolled at the Gender Diversity Clinic of our tertiary care paediatric centre. Patients had to complete a short online baseline survey (pre-video survey) assessing their knowledge, perceptions and overall thoughts on FP. They were then sent a link to an online educational video on FP (based on sex assigned at birth). Finally, participants had to complete a short post-video survey assessing their knowledge and thoughts on FP as well as to attain their feedback on the educational video presented. Descriptive statistics were used.

Results: Twenty participants (20) were enrolled in the study. Fourteen participants (14) completed the pre-video survey, twelve (12) completed the post-video survey, and ten (10) completed the post-video feedback survey (completion rate of 70% for the pre-video survey, 60% for the post video survey, and 50% for video feedback). The mean age of participants was 15.50 (SD = 1.34), with the majority being in high school (12/14; 85.7%). Of those that completed the pre-video survey, 10/14 (71.4%) considered their FP knowledge to be "fair". Eleven participants (11/14; 78.6%) were "not interested" or "not at all" interested in pursuing FP, only 1/14 (7.1%) was "very interested" and the remaining participants (2/14; 14.3%) were unsure. Of those that completed the post-video survey, 9/12 participants (75.0%) considered their FP knowledge to be "good" or "very good". Feedback regarding the videos was overwhelmingly positive: 8/10 (80.0%) participants found the video to be helpful, 9/10 (90.0%) were satisfied with the video, 9/10 (90.0%) understood the video, and 10/10 (100.0%) reported FP to be an important topic.

Conclusion: Preliminary results suggest that targeted patient education aids, such as our whiteboard educational video, may be a meaningful resource for supplementing fertility discussions in gender diverse pediatric populations.

SUN-D2-T3: MACRONUTRIENT-RICH LACTATION INDUCTION IN A TRANSGENDER WOMAN: OUTCOMES AND SAFETY ANALYSIS

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Presented by: Danit Ariel

Introduction/Background: Successful non-puerperal lactation induction for women has mostly involved adoptive parents or cases of surrogacy. Transgender women are actively interested and engaged in lactation induction, but only two formal case reports have been published. Less than 10% of healthcare providers experienced in transgender health report direct experience in lactation induction protocols. The nutritional composition of breast milk in lactation induction in transgender women is unknown.

Specific Aim: To induce lactation in a transgender woman and detail the associated hormonal changes, safety profile, and nutritional breast milk composition.

Materials and Methods: A 39-year-old transgender woman (she/her) on feminizing gender affirming hormone therapy for 13 years presented for support to induce lactation with her fourth child. She noted that inducing lactation and breastfeeding her child was an important part of her identity. She had a cisgender woman partner who planned to breastfeed the infant on cue, and the patient's breastfeeding would be supplemental. Lactation induction was started three months prior to expected delivery with a combination of increased doses of transdermal estradiol, micronized progesterone, domperidone (a non-FDA-approved galactagogue obtained by patient), and mechanical nipple stimulation. She followed the protocol under the guidance of two gender-affirming care physicians and a lactation consultant. Regularly scheduled laboratory studies (including hormonal levels), electrocardiograms, breast milk macronutrient composition, and domperidone concentrations were evaluated.

Results: The patient was able to express breast milk within one month from start of protocol. Production steadily increased to 5-6 ounces daily prior to delivery with a maximum of 20-24 ounces daily; no changes to the lactation induction plan were needed. More than 19 months after the infant's birth, breast milk production continues with ~6-8 ounces daily. Infant growth and development have been normal.

Breast milk macronutrient composition was evaluated for protein, fat, carbohydrates, and total energy and found to be comparable to the cisgender lactating woman partner and met standards for milk donation. The relative infant dose of domperidone in the breast milk (*i.e.*, estimation of infant drug exposure) was 0.049% (considered acceptable when <10%).

There were no abnormalities in the patient's blood counts, serum chemistries, hepatic transaminases, or coagulation studies during lactation induction. There was no significant evidence of QT segment prolongation. No adverse effects commonly associated with domperidone (*e.g.*, dyspepsia, nausea, vomiting, xerostomia, seizure, extrapyramidal symptoms, neuroleptic malignant syndrome) were experienced.

The patient reported complete satisfaction and fulfillment with the process; she was able to achieve her gender identity goals.

Conclusion: We were able to successfully induce macronutrient-rich lactation in a transgender woman without adverse events. This detailed protocol that includes regularly scheduled safety monitoring, hormonal tracking, breast milk macronutrient evaluation, and infant outcomes is the first known report of its kind. This case report can serve as a guide to providers to support lactation induction for adoptive/non-birthing parents, including transgender women.

SUN-D2-T4: Sexual Satisfaction and Function of Transgender Women and Gender Diverse Individuals Post Vaginoplasty

Amine Sahmoud[1], Rebekah Russell[2], Erika Kelley[1], Kirtishri Mishra[1], Shubham Gupta[1], Elad Fraiman[2], Carly Goldblatt[2], Matthew Loria[2], Rachel Pope[1]
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Presented by: Amine Sahmoud

Introduction/Background: Among the many functional outcomes desired post-vaginoplasty, sexual function and satisfaction has not been studied using systematic methods designed for transgender women and gender diverse individuals post vaginoplasty. In cisgender women, systematic evaluation can be achieved using one of several validated surveys. Only one survey, Operated Male to Female Sexual Function Index (oMtFSFI), has been validated for transgender women post vaginoplasty. However, it has not been validated in English. This study aims to address this gap in the literature and develop and

validate a tool to assess sexual function and satisfaction in transgender women and gender diverse individuals post vaginoplasty.

Specific Aim:
Aim 1: Determine aspects of sexual health, function, satisfaction, distress, and genital self-image for trans women and gender diverse individuals after gender affirming vaginoplasty.
1a. Identify the effect of surgical or hormonal interventions on the above aspects on sexual function and experience.
1b. Identify specific anatomical aspects that are implicated in sexual function and satisfaction post vaginoplasty.

Materials and Methods: We developed a sexual satisfaction survey using previously validated measures including oMtFSFI, Sexual Health Inventory for Men Questionnaire, The Female Sexual Distress Scale, Male Genital Self-Image Scale, The Index of Male Genital Image, and novel questions using peer reviewed journal publications. We developed a 26 question survey with 8 sections (self image, desire, arousal, lubrication, orgasm, satisfaction, pain, anatomical sensitivity). We then identified eligible participants at our home institution from patient visits at the urology institute or through EMR screening and chart confirmation. Next, we sent emails and called patients to recruit and enroll participants. After enrollment, participants were sent the sexual satisfaction survey as well as a PHQ9 to complete prior to their interview. During the one on one interview, we asked open ended questions pertaining to the participants' sexual journey and asked their thoughts on the survey to determine any gaps or deficits.

Results:
16 individuals were interviewed and gave the following feedback:
There need to be questions surrounding what type of vaginoplasty was performed to differentiate from shallow depth/vulvoplasty and those with a canal. The PHQ-9 should not be included as it brings up unrelated mental health issues. The instructions should include dilator use to the other described sexual activities. A question regarding the level of gender dysphoria in relation to genital self image should be included. Issues around the time frame of 4 weeks were brought up as limiting. Finally the addition of a comment section at the end of the survey could prove to be beneficial.

Conclusion:
Community-based participatory research is essential when creating validated surveys. Our participants gave valuable insight to each question and recommended what questions are missing and what needs to be asked differently. Our next step is to continue the iterative process of finalizing the survey with our team of experts and patients. Once finalized, we will survey a larger sample with the goal to validate the tool for ongoing use as a metric to measure postoperative milestones and possible need for interventions as well as a foundation to facilitate conversation between patient and provider.

SUN-D2-T5: EXPERIENCES OF TRANSMASCULINE YOUTH AND YOUNG ADULTS WHO SELF-ADMINISTER DEPOT MEDROXYPROGESTERONE: A QUALITATIVE STUDY CENTERING TRANS AND GENDER DIVERSE VOICES

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Presented by: Nicholas Cleland

Introduction/Background: Due to structural inequities transgender and gender diverse (TGD) youth continue to face unmet health care needs. Professional medical organizations, including WPATH, AAP, and ACOG, have recommended specific counseling for TGD youth and adolescents when pertaining to contraception and reproductive health. Despite this, national surveys of OBGYNs indicate that most providers feel uncomfortable caring for TGD patients assigned female at birth (AFAB) and 50% of TGD people report having to educate providers about their own reproductive health needs. AFAB TGD people use contraceptives for many, diverse reasons including contraception, menstrual suppression, abnormal

bleeding, or other gynecologic needs. There is currently a paucity of literature addressing the unique experiences of TGD people, especially when pertaining to reproductive and sexual health. To meet this need, we center the voices of TGD youth and investigate their views, experiences, language preferences, and desires about communication regarding contraceptive use. We also provide the novel opportunity for self-administered DMPA and explore this as an alternative to clinic-administered DMPA.

Specific Aim: Understand what drives interest in, and initiation/discontinuation of DMPA among transmasculine youth and young adults;
Understand why transmasculine youth and young adults choose in office or self- administrated DMPA;

Materials and Methods: We recruited 25 transmasculine individuals from 2 clinical sites in the Denver metro area that provide gender-affirming care for this qualitative study. Inclusion criteria included fluency in English, age 15-21, AFAB, TGD, and interest in or already using DMPA. Data was collected from 4 focus groups of 5-6 participants using clinic-administered DMPA-IM, as well as structured interviews with participants who initiated self-administered DMPA-SC or change from clinic- to self-administered. Focus groups and interviews were analyzed using rapid thematic analysis.

Results:
We recruited 25 participants (1 lost to follow-up), with a median age of 18 years (range 15-21). While most participants identified as man/boy (88%) and used he/him pronouns (88%), we had representation from across the gender spectrum. We had a variety of sexual orientations represented in our sample. 16 participants (67%) used DMPA prior to participating in this study. 22 participants (92%) had never used puberty blockers, and 15 (65%) were currently using testosterone injections.
Several participants initiated DMPA to suppress menstrual cycles and accompanying dysphoria. However, some participants also cited reasons for DMPA initiation like “pregnancy prevention”, “cramps”, “debilitating pain”, or as an estrogen-free contraceptive. For self- versus in-office administration, many participants preferred home administration due to ease of access and eliminating travel time. This also provided flexibility with adjusting their injection schedule. However, there were still participants who preferred in-office administered DMPA due to fear of needles, presence of a nurse to ask questions, or preferring DMPA-IM over DMPA-SC.

Conclusion: While DMPA was commonly used for menstrual suppression, there were additional reasons unrelated to menses for DMPA use in TGD people. Further, we demonstrate self-administration of DMPA-SC as a viable option, with the benefit of reducing travel time, allowing for flexibility with injection schedule, and less injection-associated pain for some. Our study builds on extant literature, emphasizing individual unique experiences and how they shape contraceptive desires and choices.

SUN-D2-T6: SEXUAL PRACTICES AND BARRIERS TO SEXUAL HEALTH INTERVENTIONS IN TRANSGENDER AND GENDER-DIVERSE INDIVIDUALS

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Presented by: Melyssa Wilde

Introduction/Background: There are limited data regarding sexual practices, sexual satisfaction, and goals of sexual function in transgender and gender diverse (TGD) individuals. Existing studies do not examine barriers to accessing sexual health interventions.

Specific Aim: (1) To elucidate sexual activities and function in TGD individuals. (2) To identify sexual health concerns and barriers to accessing sexual health interventions in TGD individuals.

Materials and Methods: The study team developed a gender inclusive survey based on two validated sexual function surveys. We piloted and revised the survey with a Transgender Community Advisory Board (CAB). The final survey consisted of close-ended and open-ended questions assessing demographics, history of gender-affirming health interventions, sexual activities, and sexual interests.

Transmasculine, transfeminine, or non-binary individuals were recruited from a gender-affirming care clinic at a tertiary hospital and via the program's CAB. Categorical variables were analyzed using Pearson Chi-square and ANOVA tests. Qualitative data were analyzed for thematic content.

Results: Seventy-two participants met inclusion criteria (N=72). Table 1 presents demographic and self-reported clinical intervention history data. Most participants reported undergoing gender-affirming medical interventions (90.0%); though significant differences exist according to gender identity (p=0.003) with 100% of transmasculine individuals reporting intervention compared to 94.7% of transfeminine and 71.4% of nonbinary individuals. Self-reported complications of gender-affirming surgery that precluded sexual activity occurred in 12.5% of individuals. Table 2 reports sexual activity. Over half of participants endorsed sex partners across multiple genders and 47% reported non-monogamous relationships. Participants most often engaged in non-penetrative sexual activities; penetrative sexual activities occurred less than once a week on average. Over 90% of participants reported experiencing a satisfying orgasm in the past 30 days. However, participants reported ceasing or avoiding sexual activities because of pain—physical (46.9%) and/or emotional (66.0%). Common causes of distress across genders included current level of sexual activity or satisfaction, changes in libido after hormone therapy, inability to engage in desired sexual activities, and pressure to use natal genitalia with a partner. Less than half of participants reported discussing sexual concerns with a medical provider in the last year; of those, 76% talked with their primary care provider and 58% talked with a specialist providing transgender care (Table 1). Barriers to discussing sexual health included LGBTQ-competent provider availability, concerns regarding loss of access to gender-affirming care, and embarrassment.

Conclusion: Sexual function and activities are varied in gender diverse individuals. Despite high rates of ability to experience orgasm, many individuals across all genders reported that physical or emotional pain influenced their ability to engage in sexual activities, causing distress. Most participants did not discuss these concerns with a provider. To best serve gender-diverse patients, it is important that providers are aware of barriers this population faces in discussing sexual health. To mitigate embarrassment and increase providers' LGBTQ competent care, providers should initiate discussions of patients' actual and desired types of sexual activity, and any sources of emotional and physical distress.

Mini Symp: Physical Medicine/Physical Therapy

SUN-E2-M: PHYSICAL AND OCCUPATIONAL THERAPY FOR MASCULINIZING BOTTOM SURGERIES: INTERDISCIPLINARY TREATMENT ACROSS THE CARE CONTINUUM

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University of Utah Health, Salt Lake City, UT, USA

Presented by: Allison Yarborough, Kathryn Woolf, Kaysen Walker, Nicole Wilkinson

Statement of Significance: Physical and occupational therapists are key members of the healthcare team serving patients undergoing feminizing surgeries and other pelvic conditions requiring surgery. While published literature supports the role of rehabilitation professionals in the treatment of patients undergoing feminizing surgeries, literature support guiding treatment of patients after masculinizing surgeries is non-existent. Standard care for cis-gendered individuals with pelvic pain, pelvic floor tension, bowel dysfunction, urinary dysfunction, and sexual dysfunction includes physical and occupational therapy. Rehabilitation evidence and clinical expertise concerning these conditions can be useful in establishing practices for the treatment of patients undergoing masculinizing bottom surgeries. Individuals undergoing phalloplasty, in particular, experience dramatic alteration of their pelvic floor function as well as upper extremity function in those with a radial forearm flap procedure. Physical and occupational therapists at the University of Utah have a well-established clinical pathway for individuals undergoing phalloplasty that encompasses pre-operative, inpatient, and follow-up outpatient care.

At the University of Utah Health, there is an interdisciplinary practice that includes integrative care between the surgeons, midlevel providers, rehabilitation specialists, mental health providers, primary care providers, and patient care advocates. The interdisciplinary approach offered at the University of Utah is

invaluable, and allows for communication between providers from all aspects of a patient's care, from their decision to undergo surgery, through discharge. Physical and occupational therapists make up valuable members of this team, throughout the timeline of surgical transition.

At the University of Utah, patients undergo pre-operative pelvic physical therapy to screen for pre-existing dysfunction to address bowel, bladder, and sexual dysfunction prior to surgery. Patients then receive physical and occupational therapy in the hospital post-surgically to assist with ADLs, including learning to shower with their radial forearm flap, holding the neophallus, supporting the neophallus in the appropriate positioning for flap survival, and general mobility necessary for community ambulation and home function. After discharge, patients receive outpatient hand therapy to address the needs of their radial forearm flap and are fit with a splint. Patients also receive outpatient pelvic physical therapy to address pain management, swelling and scar management, urination after catheter removal, positioning for bowel/bladder function, and to address return to work/physical activity and physical requirements for daily life. We are unaware of an established transdisciplinary rehabilitation standard of care for individuals undergoing masculinizing bottom surgery. This symposia will describe our clinical pathway and suggest ways to collaborate on future care and research.

Learning Objective 1: Learners will be able to explain the purpose of and describe the interdisciplinary pre-operative rehabilitation and pelvic floor function screening in individuals undergoing masculinizing bottom surgery.

Learning Objective 2: Learners will be able to describe how physical and occupational therapists address masculinizing bottom surgery specific ADL and mobility function in the acute care setting.

Learning Objective 3: Learners will recognize the need for interdisciplinary post-operative pain, edema and scar management, splinting, bowel and bladder function, and return to work and physical activity in individuals undergoing masculinizing bottom surgery.

Method to Achieve Learning Objectives: -Lecture
-Case examples with critical thinking questions
-Group discussion with reflection
-Q & A

Mini Symp: Non-surgical Body Modifications (e.g., hair removal, binding, tucking)

SUN-F2-M: TUCKING & MUFFING IN THE CONTEXT OF GENDER-PLEASURE

Catherine Casey[1], Lucie Fielding[2], Nicholas Kidd[1]
[1]University of Virginia, Charlottesville, VA, USA, [2]Antioch University, Culver City, CA, USA

Presented by: Catherine Casey, Lucie Fielding, Nicholas Kidd

Statement of Significance: Although genital tucking and muffing are practices engaged in by many transfeminine people who have not pursued bottom surgeries, there has been, to date, little published data to guide discussion and recommendations for patients. During this interdisciplinary symposium, two physicians and a sex therapist with lived experience will share new research on tucking as well as insights on muffing, a pleasure practice that involves palpating the inguinal canals through invaginating the excess skin of the external gonads. In addition to giving providers tools and language to help them better support patients in navigating both the benefits and the potential risks of muffing and tucking, this symposium will promote a framework for practice that centers gender-affirmative care around "gender-pleasure".

Learning Objective 1: Define tucking and muffing.

Learning Objective 2: Describe how medical and mental health providers can use language to take discussions of gender affirmation out of a framework centering treatment of pathology, and into a framework centering gender-pleasure.

Learning Objective 3: Gain increased knowledge of and comfort with discussing tucking and muffing with patients and clients.

Method to Achieve Learning Objectives: Learning objectives will be achieved via didactics, group discussion, a video clip, and role-playing.

3:00pm - 4:15pm

Mini Symp: Mental Health Across the Lifespan

SUN-A3-M: REVISING THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER DIVERSE PEOPLE

Kelly Ducheny[1], Laura Kuper[2], Elliot Marrow[3], Jay Bettergarcia[4]
[1]Howard Brown Health, Chicago, IL, USA, [2]University of Texas Southwestern, Children's Medical Center Dallas, Dallas, TX, USA, [3]University of Massachusetts Boston, Boston, MA, USA, [4]California Polytechnic State University, San Luis Obispo, San Luis Obispo, CA, USA

Presented by: Kelly Ducheny, Laura Kuper, Elliot Marrow, Jay Bettergarcia

Statement of Significance: In 2015, the American Psychological Association (APA) published the Guidelines for the Professional Practice with Transgender and Gender Nonconforming People. The Guidelines were designed to support behavioral health professionals in providing culturally competent, developmentally appropriate, and gender-affirming services for transgender and gender diverse (TGD) people. The Guidelines have been used across disciplines, by behavioral health professionals and others, to improve the lives of TGD people and the quality of behavioral health care TGD people receive. The Guidelines will expire soon. A Task Force of 11 psychologists from across the United States has been assembled to revise them. Since the initial publication of the Guidelines in 2015, research, theory and practice in gender-affirming care has grown exponentially. In addition, extreme barriers to care have developed for both TGD youth, adults and families. The revised Guidelines will reflect advancements in the field and offer evidence-based guidance for psychological professional practice. The Guidelines will be informed by cutting edge research, with intersectionality and the impact of minority stress centered as guiding frameworks. The presenters for this Mini-Symposium are all members of the Guidelines revision Task Force. Presenters will a) discuss the existing Guidelines and their application, b) describe the Guidelines revision process, including areas of needed improvement that have been identified, efforts to center intersectionality and the impact of minority stress as guiding frameworks, and plans to collect/integrate professional and TGD community feedback, and c) gather feedback from the audience on how to improve the Guidelines in the upcoming revision. This Mini-Symposium will provide an excellent opportunity for national leaders and professionals in TGD health to learn about the current Guidelines and to provide feedback on how to improve them in the upcoming revision to inform the Task Force's continued work.

Learning Objective 1: Describe the domains of the Guidelines for Professional Practice with Transgender and Gender Nonconforming (TGNC) People.

Learning Objective 2: List two ways the Guidelines can be applied to improve behavioral health care provided to transgender and gender diverse people.

Learning Objective 3:
Identify two areas in participants' lived experience and/or work with transgender and gender diverse people that could be better addressed in a future version of the guidelines.

Method to Achieve Learning Objectives: he three learning objectives will be achieved in several ways. For the first 25 minutes, presenters will a) discuss the existing Guidelines and their application, and b) describe the Guidelines revision process, including areas of needed improvement that have been identified, efforts to center intersectionality and the impact of minority stress as guiding frameworks, cutting edge content that is being considered, and plans to collect/integrate professional and TGD community feedback. For the remainder of the time, presenters will invite audience members to offer feedback on a) gaps in the current Guidelines, b) important areas of guidance to include in the revision, c) critical resources to inform the revision, and d) any other suggestion to improve the Guidelines in the upcoming revision.

Oral: Community Engagement

SUN-B3-T1: USING COMMUNITY ENGAGEMENT TO DESIGN A CURRICULUM FOR AND BY TRANSGENDER/GENDER-DIVERSE PEOPLE OF COLOR

Tayon Swafford[1], Richard Brandon-Friedman[1,2]
[1]Indiana University School of Social Work, Indianapolis, IN, USA, [2]Indiana University School of Medicine, Indianapolis, IN, USA

Presented by: Tayon Swafford

Introduction/Background: Experiences and feelings of prejudice, discrimination, oppression, and violence are often compounded for TGD People of Color (PoC), resulting in feelings of isolation and distrust. As a result, some TGD PoC are hesitant to find and work with service providers during times of need and form social networks and communities with other TGD people. A Black, trans-owned and operated social service agency hosted a community event and invited community members and a research team to discuss how best to meet the community's needs. The goal was to use the narratives shared and lessons learned during the event as building blocks for a curriculum designed for TGD PoC by TGD PoC.

Specific Aim: This research analyzed the transcripts from the focus group to identify themes related to curricular topics and to ensuring community-focused facilitation. By using dialogue from a discussion held with transgender PoC, the themes center the experiences of a community who has often remained on the periphery.

Materials and Methods: The community event occurred in April 2023. While the event contained many instances of "KiKing" or informal dialogue, the researchers were asked to analyze the group interview to learn the needs of TGD PoC and the topics they felt should be included in an upcoming curriculum and what they felt is important for facilitators to know. The researchers transcribed the interviews and conducted a thematic analysis following the methods of Braun and Clarke (2006).

Results: Five facilitation themes and five topic themes were identified. The following facilitation themes were identified: *Not Just Your Judy* (you need to serve everyone equally and not just your friends); *I Wanna Know How It's Gonna Benefit Me* (we need to know there will be clear tangible outcomes such as a bank account or resume); *You Need Somebody That's on the Same Playing Field* (we need mentors who are part of our community); *They're Gonna Need a Way to Get Here* (transportation is the biggest barrier in our community); and *If They Don't Have…* , *They Probably Don't Want to be Here* (the program needs to be attuned to meeting immediate needs before longer-term goals). Facilitation themes represented ways participants felt the curriculum should be designed to help participants feel safe and supported during the program.
The topical themes represented areas participants felt the curriculum needed to cover. The following topical themes were identified: *Educational Achievement*; *Financial/Money Management*; *Accessing Community Resources*; *Mental Health Services*; and *Addressing Past Actions*. Each facilitation and topical theme contained an overview, applicable quotes, and practice implications to help provide guidance for structuring the curriculum.

Conclusion: The curriculum developed will give TGD PoC an opportunity to foster their own strengths while creating opportunities for building and sustaining the collective community. By being grounded in the experiences of TGD PoC, the material will be attuned to their needs. This presentation will provide guidance to agencies as they develop programming to meet the needs of TGD PoC.

Oral: Research Methods (e.g., CBPR, measurement, epidemiology)

SUN-B3-T2: "BECAUSE I GOT TO PICK MY GENDER": A QUALITATIVE ANALYSIS OF GENDER IDENTITY MEASURES IN A GENDER DIVERSE SAMPLE OF 5-8-YEAR-OLDS

Catherine Schaefer[1], Mary O'Brien McAdaragh[1], Transforming Families MN[2], Niko Blando[1], Arthi Jegraj[1], Toli Reigada[1], Dianne Berg[1], G. Nic Rider[1]
[1]National Center for Gender Spectrum Health, Institute for Sexual and Gender Health, University of Minnesota Medical School, Minneapolis, MN, USA, [2]Transforming Families Minnesota, Minneapolis, MN, USA

Presented by: Catherine Schaefer

Introduction/Background: Current pediatric gender identity measures in research and clinical use may be developmentally inappropriate, use language unfamiliar to children, or be non-inclusive of nonbinary identities. Increasingly, children are sharing that their genders are different from those assigned to them at birth (Olson et al., 2016), therefore it is important to have accurate, inclusive measures of gender identity that children are able to understand in order to self-report their own identity.

Specific Aim: This community-engaged qualitative study seeks to characterize how children self-report their gender identities and perceive a common set of gender identity measures. The ultimate goal is to use this information to guide development of inclusive and appropriate measures for young children relevant for clinical, research, and demographic use.

Materials and Methods: Our current sample includes 48 participants ages 5-8 (M= 7.22) recruited from a) community groups with the assistance of our community partner, b) a university participant pool, and c) both primary care and gender-specific clinics within a Midwest metropolitan area. Recruitment is ongoing until 100 participants have been enrolled. Each participant completes a battery of gender identification measures, including one randomly assigned longer measure used in gender-specific clinical and research settings and three shorter, one- or two-question measures similar to those on demographic forms. The longer measures include the Label/Self Concordance Measure (Schaefer & Signorella, 2018), the Gender Development Scale (Strang, 2017), and the Gender Identity Interview-Gender Spectrum (Berg et al., 2019). The shorter measures include one question from the Gender Preference Interview-Gender Spectrum (adapted from Cohen-Kettenis and Pfafflin, 2003), a two question method (adapted from Tate et al., 2012), and a question from the NIH recommended list of gender measures. Participants respond to four summary questions that evaluate difficulty, feelings toward the measure, and improved options for asking the question.

Results: Caregiver report indicated that nine children were trans/gender diverse and 37 were cisgender (two did not respond). Sixteen children's responses indicated their gender was not exclusively "boy" or "girl," suggesting that there may be greater diversity in how children think about their gender than caregivers expect. Our sample is 2% American Indian and Alaska Native, 17% Asian, 8.5% Black, 8.5% Multiracial and 64% White. Average measure difficulty ratings were 2.4-3.4 out of 5. Most commonly, children responded with positive emotion when asked how they felt about questions, saying things like, "in the middle between happy and excited." Children seemed to prefer questions with open-ended, inclusive responses. For example, when asked why the open-ended question was their favorite, one said, "Because I got to pick my gender."

Conclusion: This study shows the importance of including children themselves in the research process and honoring the wisdom that young children bring to the understanding of measures. Children provide a unique perspective on how to construct measures that will work best for them. In general, preliminary

findings seem to indicate that open-ended or expanded child-friendly gender response options, even with young children, are unlikely to limit a child's ability to self-identify.

SUN-B3-T3: PARTICIPANT-REPORTED CONFIDENCE IN EXPRESSING GENDER IN SOCIAL SETTINGS BEFORE AND AFTER PARTICIPATION IN GENDER EXPRESSION CARE PROGRAM

Alice Pressman[1,2], Sai-Wing Chan[1,3], Monica Prata[1,3], Grace Firtch[1,3], Douglas Balster[1,3], Andy Avins[2,3,4]
[1]Kaiser Permanente, Redwood City, CA, USA, [2]University of California, San Francisco, San Francisco, CA, USA, [3]The Permanente Medical Group, Oakland, CA, USA, [4]Kaiser Permanente Division of Research, Oakland, CA, USA

Presented by: Alice Pressman

Introduction/Background: Social challenges facing transgender and non-binary (TGNB) individuals may be ameliorated by Gender Expression Care (GEC). GEC augments traditional models of mental health care, hormone therapy and surgery to bridge common gaps in gender dysphoria care. Kaiser Permanente Redwood City Medical Center in Northern California created and piloted a novel 12-week GEC program, consisting of 6 2-hour group sessions augmented by individual as-needed sessions. The program has provided care to more than 300 individuals since 2019.

Specific Aim: To measure internal consistency of the GEMT measurement tool
To assess the bias of the GEC participants who complete the outcome questionnaire
To assess the change in confidence of gender expression in various social settings after participation in the GEC program

Materials and Methods: The team developed a Gender Expression Measurement Tool (GEMT) to measure confidence in gender expression before and after participation in the GEC program. Participants were asked to rate their confidence in 6 specific types of gender expression (Name, Pronouns, Voice, Movement, Wardrobe, and Hair/Cosmetics) and one Overall item across 5 settings (friends, family, work, healthcare, and strangers) on a 1-to-5 ordinal scale (5=most confident). We present results for baseline and changes in confidence from baseline to post-workshop for the first three cohorts of participants who completed the GEMT.

Results: Among 69 participants who completed the baseline GEMT, reliability was high with excellent internal consistency (Cronbach alpha = 0.95); 48 (70.0%) also completed the outcome questionnaire. Compared to participants with missing follow up, those with complete outcomes expressed similar confidence in gender expression at baseline (differences across all questions: median=0.18, IQR – 0.09-0.27), however, they were more likely to use She/Her pronouns (72.9% vs 42.9%).
At baseline, 58.0% self-identified as Non-Hispanic (NH) White, 15.9% NH Asian, 8.7% Hispanic, 2.9% NH Black, 2.9% NH Pacific Islander, 1.4% NH other, and 10.1% declined to state. The majority self-reported pronouns She/Her or She/They (63.7%) with even numbers reporting He/Him or He/They, They/Them, and multiple/undecided (10.1% each), and the remainder declining to report (5.8%).
Among those with complete outcomes, baseline confidence was highest for asserting name across all settings (range 3.79-4.48), and lowest for using gender-aligned voice (range: 2.71-3.31). (Fig 1)
Significant improvements in confidence were observed for expression at work for all expressions except name and movement (change in scores ranged from 0.49 – 0.79). In the overall category, significant improvements were observed across all settings (range: 0.44 – 0.79). The average confidence for all types of expression across all settings improved, though not all were statistically significant. (Fig 2)

Conclusion: Baseline confidence was highest for expressing names and lowest for gender-aligned voice. Expression at work tended to be low at baseline and improved after participation in the program. Overall gender expression significantly improved across all settings. Early results from this pre/post analysis are promising, however, more study is necessary to control for outside factors and regression to the mean. In addition, we plan to further validate the GEMT, and measure long-term improvement in confidence in gender expression with an appropriate control group.

SUN-B3-T4: A CONTENT AND READABILITY ANALYSIS OF GENITOURINARY AND SEXUAL HEALTH-RELATED PATIENT-REPORTED OUTCOME MEASURES IN GENTIAL GENDER AFFIRMING CARE

Meg Quint[1], Nkiruka Odeluga[2], William Boysen[1], Geolani Dy[3], Tracy Beck[2], Devin O'Brien Coon[1], Sophia Hu[4], Andrea Pusic[1], Manraj Kaur[1]
[1]Brigham and Women's Hospital, Boston, MA, USA, [2]Cook County Health, Chicago, IL, USA, [3]Oregon Health & Science University, Portland, OR, USA, [4]University of Pennsylvania, Philadelphia, PA, USA

Presented by: Meg Quint

Introduction/Background: Patient-reported outcome measures (PROMs) are questionnaires designed to measure how patients feel and function. The value of PROMs in clinical care, research, and quality improvement initiatives to evaluate treatment outcomes from a patient perspective has been well-established. To be useful in clinical care and research, PROMs should be understood by the individual completing the PROM and be comprehensive and relevant. Several PROMs assessing genitourinary function and sexual well-being have been used in individuals seeking genital gender-affirming care. However, no previous research has tried to map the concepts assessed by the PROMs used in the literature or assessed their readability.

Specific Aim: To map the concepts measured by the genitourinary and sexual health-related PROMs used in gender-affirming care literature and evaluate their readability.

Materials and Methods: A list of commonly used PROMs that measure genitourinary and sexual health-related concepts in gender-affirming care literature was identified from five recent systematic reviews on this topic. Individual items from available PROMs were extracted and the concepts measured were evaluated independently by two authors. The analysis was reviewed by the investigator team and conceptual gaps in the measurement of outcomes were identified. If the items used outdated terminology or were applicable across the gender spectrum was also assessed. Readability assessment was performed at the level of instructions, items, and full PROM using established readability assessment criteria of Flesch Kincaid Grade Level (FKGL), Gunning Fog Score, Coleman Liau Index, SMOG Index ("gold standard" for health-related material). Readability results were summarized descriptively.

Results: Of 27 identified PROMs, 21 were accessible to the authors (genitourinary (n=14), sexual (n=4), overall outcome (n=3). The 14 PROMs measuring genitourinary outcomes included 227 items that assessed urinary incontinence-related symptoms (37%), the impact of urinary issues on quality of life (12.3%), bowel incontinence-related symptoms (9.3%), prolapse (7.9%), erections (7.9%), pain (10.1%) and other symptoms. The 4 PROMs on sexual well-being included 101 items that included desire (17.8%), frequency of sexual behaviour (12.9%), arousal (11.9%), orgasm (10.9%), satisfaction/pleasure (7.9%), pain (5.9%), lubrication, (4.9%), and others (27%). The median reading grade level for the identified PROMs was 9 (range, 4-13). Multiple issues were identified that may impact the engagement of patients with PROMs including outdated terminology (e.g., "homosexual behaviour"), conflation of sex and gender and overt assumptions regarding stereotypical sexual behaviours. Further, several PROMs included items that were double-barrelled, included medical jargon and were incomprehensible.

Conclusion: The PROMs that are currently used in the genital gender-affirming literature were not developed using international guidelines for PROM development and were intended for use in cisgender individuals. The PROMs capture a wide range of symptoms collectively, but no comprehensive PROM currently exists. Further, most of the PROMs used in the genital gender-affirming care literature failed to meet the readability recommendations (i.e., Grade 6 or less) and were culturally unfit for use in transgender and gender-diverse individuals. Validated gender-affirming care-specific PROMs that are comprehensible, comprehensive, and relevant, such as the GENDER-Q, are urgently needed.

SUN-B3-T5: MULTIPLE RECRUITMENT APPROACHES AND LESSONS LEARNED IN A NATIONAL RANDOMIZED CONTROLLED TRIAL OF LIFESKILLS MOBILE ON HIV INCIDENCE AMONG YOUNG TRANSGENDER WOMEN

Keyanna Taylor[1], Matthew Mimiaga[1], Julie McAvoy-Banerjea[2], Kacey Draine[2], Jesse Holzman[3], Eun Kwak[1], Myah Brown[3], Zaya Meija[2], Marvin Belzer[2], Katie Biello[4], Amy Johnson[3], Sari Reisner[5], Rob Garafolo[3], Lisa Kuhns[3]
[1]University of California, Los Angeles, Los Angeles, CA, USA, [2]Children's Hospital Los Angeles, Los Angeles, CA, USA, [3]Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, IL, USA, [4]Brown University, Providence, RI, USA, [5]Harvard University, Boston, MA, USA

Presented by: Keyanna Taylor

Introduction/Background: Despite research documenting high rates of sexual risk behaviors and HIV infection among transgender women, only a small number of non-randomized interventions have attempted to reduce HIV risk in YTW, and none have been powered to examine HIV incidence. Digital and limited interaction approaches hold promise to reach a large number of individuals across geographic boundaries, as well as those in rural and underserved areas where access to comprehensive HIV prevention is lacking.

Specific Aim: LifeSkills Mobile is a psychoeducational and skills-building app to promote sexual health for young transgender and trans femme individuals, ages 16-29 (N = 5,000), that is currently being tested in a national randomized controlled efficacy trial with an HIV sero-incidence endpoint and employs a digital, limited-interaction approach to intervention delivery and data collection. The app is based on and adapted from Project LifeSkills, an evidence-based group-level HIV prevention intervention informed by both empowerment and social cognitive theories.

Materials and Methods: In this study, we focused recruitment nationally with special emphasis to the CDC's 57 *Ending the Epidemic* jurisdictions, which include 50 local areas that account for more than half of new HIV diagnoses and 7 states with substantial rural burden. Given the large sample size needed to examine an HIV incidence primary outcome, multiple recruitment approaches are being used in combination, including posts and paid advertisements on social media and online dating and sexual "hook-up" platforms; as well as collaborations with social media "influencers" and community-based organizations that serve trans femme individuals. To inform on-going recruitment in this study, we analyzed data on the success of each approach to date and compared the ratio of screened to eligible individuals and eligible to enrolled participants for each recruitment method.

Results: We found that paid advertisements on far-reaching dating and sexual "hook-up" platforms frequented by sexual and gender minorities had the greatest number of screening cases, while posts on sites frequented by transgender or trans femmes specifically and/or by trans femme influencers had the highest ratio of eligible individuals among those screened. In addition, the collaboration with community-based organizations had the highest ratio of enrolled among those eligible, although small in terms of absolute number of enrollees.

Conclusion: We conclude that continuing to focus on dating apps for absolute numbers of enrolled individuals will be important for continued success, while also increasing collaborations with social media influencers and community-based organizations serving this diverse population.

Oral: Chronic Conditions, including HIV

SUN-D3-T1: Chronic Pelvic Pain among Transgender Men and Gender Diverse Adults Assigned Female at Birth

Diana Tordoff[1], Mitchell Lunn[1], Bertha Chen[1], Annesa Flentje[2], Zubin Dastur[1], Micah Lubensky[2], Matthew Capriotti[3], Juno Obedin-Maliver[1]
[1]Stanford University School of Medicine, Palo Alto, CA, USA, [2]University of California San Francisco, San Francisco, CA, USA, [3]San Jose State University, San Jose, CA, USA

Presented by: Diana Tordoff

Introduction/Background: There are extremely limited data regarding pelvic pain among transgender individuals using testosterone and the etiology of chronic pelvic pain is poorly understood. It has been hypothesized that pain associated with endometriosis is expected to decrease with testosterone initiation due to ovulation suppression. At the same time, many transgender men experience new onset pelvic pain after initiating testosterone (with a median time until onset of 1 year) and commonly cite pelvic pain as a reason for seeking a hysterectomy.

Specific Aim: We aimed to characterize the prevalence and correlates of chronic pelvic pain among transgender men and gender-diverse people assigned female at birth.

Materials and Methods: We conducted a cross-sectional analysis of 2020-2021 data from The PRIDE Study, an online, prospective, longitudinal, cohort study of sexual and/or gender minority people in the US. Our analysis included adult transgender men and gender-diverse participants assigned female at birth (AFAB) who responded to questions about chronic pain. Chronic pain was defined as self-reported persistent or recurrent pain present for the last 3 months or longer in specific areas of the body. We defined chronic pelvic pain to include participants who reported pain in their pelvis, groin, and/or genitals. We used univariate and multivariable Poisson regression with robust standard errors to estimate prevalence ratios (PR) and identify correlates of chronic pelvic pain.

Results: This analysis included 2,048 transgender men and gender-diverse participants AFAB aged 18-80 years old (median age 27.5, IQR 23-34), among whom 347 (17%) reported chronic pelvic pain. Chronic pain was most commonly reported in the pelvis (77%), followed by the groin (40%) and genitals (22%). Nearly all (95%) participants who reported chronic pelvic pain also reported chronic pain at another location, most commonly in the neck, back, abdomen, wrist, and knee. Participants aged 30-49 (20%) and age 65+ (24%) as well as among participants who were Native American/Alaska Native (28%) or Asian (20%) were the most likely to report chronic pelvic pain. There were 884 (43%) participants who had never used testosterone, 1037 (51%) currently using testosterone, and 115 (6%) who formerly used testosterone. The median duration of use was 3.9 years (range 19 days to >30 years). In addition, 254 (12%) participants had a hysterectomy. The following self-reported diagnoses and risk factors were all significantly associated with chronic pelvic pain in unadjusted models: pelvic inflammatory disease, inflammatory bowel disease, irritable bowel syndrome, kidney stones, polycystic ovary syndrome, uterine fibroids, having a prior pregnancy, and currently having an intrauterine device. Current testosterone use was associated with a lower prevalence of chronic pelvic pain compared to participants who never used testosterone in unadjusted analyses (15% v. 19%, $p<0.03$) as well as in multivariable models (aPR 0.78, 95% CI: 0.63-0.98) that adjusted for age and the risk factors listed above. Prior hysterectomy was not associated with currently reporting chronic pelvic pain in any regression models.

Conclusion: Chronic pelvic pain is common among transgender men and gender diverse people AFAB and current testosterone use was associated with a 22% lower prevalence of chronic pain.

Oral: Surgery

SUN-D3-T3: GENDER AFFIRMING SURGERY COMPLICATION CARE IN THE EMERGENCY ROOM: A CROSS-SECTIONAL SURVEY OF EMERGENCY PHYSICIANS

Cassidy Bowen[1], Tori Gleason[1], Elizabeth Ablah[1], Hayrettin Okut[1], Adrienne Malik[2]
[1]University of Kansas School of Medicine- Wichita, Wichita, KS, USA, [2]University of Kansas Medical Center, Kansas City, KS, USA

Presented by: Cassidy Bowen

Introduction/Background: Transgender and gender diverse (TGD) populations experience worse health outcomes. Lack of medical training, provider bias, discrimination, and abuse contribute to this health inequity. Surgical complications of gender affirming surgeries (GAS) are diverse and often urgent, with many patients presenting to an emergency department for care. The extent of emergency physician (EP)

knowledge and/or competency in GAS complication (GASC) care remains unknown. This research sought to better understand EPs knowledge of and confidence in GASC management.

Specific Aim: To better understand emergency physician knowledge of and confidence in gender affirming surgery complication management.

Materials and Methods: We utilized an electronic, cross-sectional survey of EPs within 50 miles of the Kansas City metro area, as there is a large transgender population and surgeons that perform GAS procedures in the region. Our survey included questions on management of common GASCs, provider confidence in their ability to treat complications and data on GASC education received by respondents. The survey instrument was piloted with 5 EPs and revised based on feedback. Following the pilot, EPs in the Kansas City Metro area were approached for enrollment via peer-to-peer efforts. We received 57 completed responses of 600 contacts (9.5% response rate) during the survey period. Data were analyzed using SAS v9.4.

Results: Responses included 31 academic EPs, 13 community, 12 with both appointments and 5 unspecified. 43% of attendings and 32% of residents reported treating GASCs. Vaginoplasty complications were the most encountered (26%, n=15) and 64% of respondents disagreed that they were confident in its treatment. 20% and 24% of respondents disagreed they were confident in treating hysterectomy and chest augmentation complications respectively in TGD patients. There was no significant difference in the number of GASC's encountered by EPs based on practice setting (p=0.92). No respondent reported being "very aware," of standards of care for any GASC. Attending EPs were the majority reporting, "not at all aware" (66% n=14). For most of the questions, there was no significant response difference based on practice type, years practicing, or training level. Most respondents (84%, n=47) agreed more GASC education would be beneficial.

Conclusion: This study indicates that practice setting, years practiced, and training level alone do not adequately prepare EPs to confidently and competently care for transgender and gender diverse patients as it relates to GAS complications. Lack of confidence in care that mirrors non-TGD patient management emphasizes need for additional education. This population disparity is consistent with previous studies.[1]

This study is limited by small numbers and its mid-west metropolitan focus. The high number of TGD patients receiving gender affirming surgeries in this area highlights the significant need for updated EP training. The small and specific sample of this novel study adds to the literature a necessary and important perspective on transgender and gender diverse surgical populations.

Confidence in treating GAS complications was overall low and not influenced by EP years of experience. Our study highlights the need for EP specific training on managing GASCs as our data shows these patients are encountered in all practice settings by EPs at all training levels.

SUN-D3-T4: THE IMPACT OF OBESITY ON GENDER-AFFIRMING SURGERY: AN ACS-NSQIP STUDY

Sai Cherukuri, Solene Nooli, Samyd Bustos-Hermer, Nho Tran, Jorys Martinez-Jorge, Vahe Fahradyan
Mayo Clinic, Rochester, MN, USA

Presented by: Vahe Fahradyan

Introduction/Background: Obesity is associated with increased risk of perioperative complications. However, in transgender population, some surgeons may decide not to impose strict BMI criteria due to concerns about the potential adverse consequences associated with delaying gender-affirming care.

Specific Aim: We utilized ACS-NSQIP database to evaluate surgical outcomes associated with gender affirmation surgery in obese patients.

Materials and Methods: We analyzed data from the ACS-NSQIP database of 30-day complications of gender-affirming surgeries from 2012-2021. All patients with ICD code for gender dysphoria and CPT code for gender-affirming surgery were included in the study. Patients were excluded if the CPT code did not specify top or bottom surgery or had simultaneous top and bottom surgery. Patients were classified into normal weight (BMI18.5 - 25 kg/m2), overweight (BMI 25-29.9 kg/m2), class 1 obesity (BMI 30-34.9 kg/m2), class 2 obesity (BMI 30-34.9 kg/m2), or class 3 obesity (BMI>40 kg/m2) per World Health Organization (WHO) classification. Complications were defined by combining several NSQIP endpoint variables into major surgical complications, medical complications and wound complications. Major surgical complications included deep wound infection, graft or prosthetic loss, or an unplanned return to the operating room. Medical complications were defined as pneumonia, pulmonary embolism, postoperative renal insufficiency, urinary tract infection, stroke, myocardial infarction, symptomatic deep venous thromboembolism, or sepsis. Wound complications were defined as superficial surgical site infection, deep wound infection, organ space infection, or wound dehiscence. Statistical analysis was done using analysis of variance (ANOVA) with post-hoc tests when appropriate.

Results: A total of 6,682 patients were included in the analysis. A total of 3,088 (46.2%) underwent transmale gender-affirming top procedures, 1,297 (19.4%) underwent transmale gender-affirming bottom surgery, 1,018 (15.2%) underwent transfemale gender-affirming top procedures, 866(13.0%) underwent transfemale gender-affirming bottom surgery and 413 (6.2%) patients underwent facial feminization procedures. The prevalence of obesity was 32.9%, of which 18.4% were Class 1, 8.3% were Class 2, and 6.2% were Class 3. In the cohort of transmale top surgery, medical complications were found to be higher in overweight (0.33%), Class 2 (0.34%), and Class 3 obese patients (0.90%) ($p<0.05$), and wound complications were found to be higher in Class 2 (3.07%) and 3 obese patients (3.14%) when compared to patients of normal weight ($p<0.001$). In the cohort of transfemale bottom surgery, class 2 (7.84%) and class 3 (13.12%) obese patients had borderline higher rates of major surgical complications compared to the other groups ($p<0.1$). In the cohorts of transfemale top and transmale bottom surgery, there were no significant differences found in medical, major surgical, and wound complications between the BMI cohorts. In the cohort of facial feminization surgery, medical complications were found to be significantly higher in Class 2 obese patients (5.55%) compared to normal-weight patients ($p<0.001$), and wound complications were found to be significantly higher in class 2 patients (11.11%) when compared to normal weight patients($p<0.05$).

Conclusion: Class 2 and Class 3 obesity at the time of surgery appears to be associated with higher rates of major surgical and wound complications in transmale top surgery and increased wound and medical complications in facial feminization surgery.

SUN-D3-T5: Anaerobic Bacterial Predominance of the Neovaginal Microbiome in Transgender Women After Vaginoplasty

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Presented by: Lydia Fein

Introduction/Background: In cisgender women, acidification of the vagina by *Lactobacillus* is crucial to preventing the growth of anaerobic bacteria and the development of bacterial vaginosis (BV), the most common vaginal state that predisposes cisgender women to HIV and sexually transmitted infections (STIs). Transgender women (TW) are undergoing gender-affirming vaginoplasty (GAV) at increasing rates. However, the TW neovaginal microbial environment has not been well studied. Given the importance of GAV for TW, understanding the microenvironment of the neovagina is crucial to HIV and STI prevention in this vulnerable population.

Specific Aim: This study was designed to characterize the neovaginal microbiome in a cohort of TW after penile-inversion GAV.

Materials and Methods: Adult HIV negative TW who underwent penile inversion GAV were recruited in Miami and completed a sociodemographic, history of STI, and sexual practices survey. They then underwent neovaginal sample collection. Blood samples were collected to measure estradiol levels. Nugent scoring of >7 were used to determine the presence of BV. The neovaginal microbiome was assessed with 16S rRNA gene sequencing. Descriptive statistics were used for survey data. Alpha and beta diversity metrics were used to quantify microbiome diversity, and differential abundance testing was done to identify specific bacteria.

Results: Ten participants completed the study, with nine samples being adequate for microbiome analysis. Participants' mean age was 41; 9(89%) were White, 1(10%) Black; and 1(10%) Other Race. Mean number of partners (vaginal intercourse) in past month was 4; 3(30%) reported multiple past STI diagnoses. Mean serum estradiol level was 198 pmol/L. BV was diagnosed in 9(90%) of samples. All participants tested negative for *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, and *Trichomonas vaginalis.*

All neovaginal samples were comprised of predominantly anaerobic bacterial species, including *Prevotella, Peptostreptococcus, Morganella*. The relative abundance of *Lactobacillus* was very low (0.004%) in all samples. Sample evenness was significantly greater in participants who had receptive condomless vaginal intercourse two or more times in the past month (p=0.02). Beta diversity was significantly different for individuals whose estradiol levels were within range compared to those above or below (p=0.01). *Peptostreptococcus* (p=0.03), *Fusobacterium*(p=0.04), and *Gemella* genera (p<0.01) were found to be significantly higher in samples that are above the mean of 4 sexual partners within the last month, and *Porphyromonas* (p=0.01) and *Corynebacterium* genera (p=0.04) were found to be significantly higher in samples that were below the target estrogen level range (100-200 pg/mL) compared to the within range samples.

Conclusion: In this pilot study of TW neovaginal microbiome, we found it was composed of anaerobic species, and lacking the ideal vaginal bacteria species *Lactobacillus*. The predominance of anaerobic bacteria potentially compromises the neovaginal vaginal integrity and may increases the risk for HIV and STI acquisition. Decreased numbers of receptive condomless vaginal sex and fluctuations in estradiol levels contribute to increased biodiversity in the neovagina, which is not optimal in the vaginal microbiome. These results suggest further study is critical to characterize the microenvironment of the neovagina, its relationship with sexual practices and hormone levels, and its implications for HIV and STI risk in TW.

SUN-D3-T6: THE TRANSGENDER LATINÈ GENDER AFFIRMING SURGERY EXPERIENCE: A QUALITATIVE ANALYSIS

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Presented by: Kyle Okamuro

Introduction/Background: The experiences of transgender and gender non-binary (TGNB) individuals in the United States pursuing gender-affirming surgeries have been well described. However, there is a paucity of data addressing gender-affirming surgical knowledge and access to care for refugee TGNB individuals from Latin America.

Specific Aim: The aim of this analysis was to identify inequities and barriers in surgical and gender-affirming care through qualitative analysis.

Materials and Methods: Participants were recruited via 1) TransFronteras, a community organization that advocates and provides shelter for TGNB people recently seeking asylum in the United States, and 2) urology clinics in San Diego where transgender Latiné patients sought gender affirming pelvic or

“bottom” surgery. Ten semi-structured individual phone interviews were conducted using a topical question guide about medical experiences, gender-affirming care, and surgeries. The interviews were de-identified, recorded, transcribed verbatim, and translated. Qualitative analysis was performed using Grounded Theory methods, as described by Charmaz. An iterative line-by-line, open-coding approach was used until thematic saturation was achieved. Initial codes were combined and grouped into thematic categories and subcategories.

Results: Our qualitative analysis yielded several themes (Table 1) related to gender affirming surgeries. Factors that affected pursuit of gender-affirming surgical care were a lack of awareness, concerns about cost, and misconceptions about procedures and their risks. Participants reported a lack of reliable sources for surgical decision making. Overall, there was variability in the comprehension of options for pelvic surgery versus “top surgery.”

Conclusion: This qualitative analysis explores the distinct surgical perspectives of Latiné refugee TGNB patients. We captured areas of opportunity to enhance equity and accessibility to gender-affirming pelvic surgeries.

Mini Symp: Health Services and Systems

SUN-E3-M: A STRATEGIC APPROACH TO EMPOWERING YOUR WORKFORCE TO DELIVER HOLISTIC AND AFFIRMING TRANSGENDER CARE THROUGH TRAINING AND EDUCATION

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University of California, Los Angeles, Los Angeles, CA, USA

Presented by: Rebecca Rada, Maliha Khan, Allison Clement, George Yen, Emery Chang

Statement of Significance: Delivering holistic, affirming care to the gender diverse community and their families is an ongoing challenge. Addressing every touchpoint of a patient's journey in healthcare is essential to providing comprehensive care. Each visit involves multiple workgroups, from ancillary services, billing, and clinicians. These interactions, when negative, can be detrimental and further increase the distrust and marginalization of this population. Providing foundational education and skills are necessary for each staff member. Past efforts often began as individual efforts, lacking scale and sustainability. Further, the approach had a pathological problem-based focus, neglecting root cause and whole person perspectives. Our holistic approach of caring for gender diverse patients and their families considers the whole person including their background, life situation, and goals.

Our strategy is built on four pillars: Clinical Care, Advocacy, Research & Education. Through the lens of health equity, diversity and inclusion, coordinated efforts improve transgender focused services, community outreach, and forming new infrastructures for educational programming throughout the system.

Clinical Care
Created LGBTQ+ leadership fellowship focusing on gender health, HIV treatment/prevention, mental health and medical education
Expanded clinical services including resiliency skills workshops for gender diverse adults & laser hair removal
Dedicated services for gender health with coordinated, multidisciplinary approaches across the age spectrum

Advocacy
Intersecting CI-CARE Principles and policies
Creation of LGBTQ+ and Gender Health medical directorships in the Office Health EDI
Strategic marketing to promote awareness and inclusivity
Expanding accessibility by collaboration with insurance companies and government-funded programs

Research
Established LGBTQ+ Health Initiatives Fund
Piloting QI Projects

Education
Produced LGBTQ+ Health Film Series
Implemented LGBTQ+ curriculum for medical students
Created directorships for LGBTQ+ education
Created LGBTQ+ Health Lecture Series
EDI Education Series Modules

The four pillars provide a comprehensive and empowering approach to transgender education within broader health systems. By equipping all interactions in the UCLA Health system with knowledge, skills, and resources to provide an inclusive and supportive environment for all gender diverse individuals, we hope to work towards building a healthcare system that serves the needs of all.

Learning Objective 1: Address key barriers to accessing quality healthcare transgender patients face.

Learning Objective 2: Describe and develop tools and educational resources to foster delivery of comprehensive, holistic care to transgender patients.

Learning Objective 3: Advocate for integrated transgender-focused education and training for the health system and future clinicians.

Method to Achieve Learning Objectives:
Background presentation including vision, our four pillars of LGBTQ+ health, and SWOT analysis of clinical, administrative, research and educational resources.

Breakout groups based on organization (FQHC/AIDS service organization, academic institution/integrated health system, private/group practice) to create strategies for delivering affirming care
What available resources do you currently have to build an organizational strategy to provide holistic care to transgender patients?
Who are your current experts or interested stakeholders?
What specialized programs and expertise currently exist?
What current educational and/or networking efforts are in place?
What potential barriers is your organization facing & how to overcome them?
Brainstorm pillars to organize LGBTQ+ activities within your organization.
What are your first steps? What are achievable goals for short and long term?

Mini Symp: Health Professional Education

SUN-F3-M: GUIDELINES FOR A STEPWISE MODEL OF INFORMED CONSENT IN GENDER-AFFIRMING SURGERY

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Presented by: Rey Daigle, Elijah Castle, Andres Cazares

Statement of Significance:
Informed consent is a central component of what is generally considered to be ethical healthcare. However, when we discuss consent for gender-affirming healthcare, what we often mean is providing overarching consent for a particular intervention, such as informed consent models for initiating hormone therapy. Beyond that, consent is assumed for procedures or examinations that fall within the scope of these interventions. For example, if a patient consents to vaginoplasty, at clinical follow-up visits, it is

assumed the patient has consented to undergo assisted dilation and speculum exams. Assumed consent is, in part, a product of utilitarian medical education and a lack of patient-centered, trauma-informed care, resulting in unintentional harm and medical trauma for patients.

This symposium will provide guidelines for a trauma-informed stepwise model of informed consent, which involves (1) overarching consent, (2) clinician-specific consent, and (3) per-action consent. In this model, the responsibility of seeking consent and upholding patient autonomy and agency is placed on physicians. Any and each kind of procedure, physical exam, or anything which involves physically touching the patient should first be consented to by the patient, which the clinician should take care to solicit. While we believe that this model is helpful in all cases of healthcare, we will apply it specifically to gender-affirming settings. We will use case studies to illustrate how these guidelines can be implemented in clinical care to inform ethical and competent treatment of patients and ultimately improve clinical care.

The stepwise informed consent model takes intersectional identities, trauma histories, and experiences accessing care into account, and has been developed based on the input of individuals who work in research, public health, bioethics, nursing, social work, and surgical care. The stepwise model of informed consent requires interdisciplinary care to address all facets of clinical care for patients undergoing gender-affirming surgery.

Learning Objective 1: Provide information on the theoretical framework and background for informed consent and trauma-informed care, and how these apply specifically to gender-affirming care.

Learning Objective 2: Discuss the stepwise model of informed consent and how it can specifically apply to gender-affirming surgical care.

Learning Objective 3: Use case studies to give examples for strategies regarding implementation of the stepwise model of informed consent in clinical gender-affirming care.

Method to Achieve Learning Objectives: This symposium will address the theoretical framework for a trauma-informed, stepwise model of informed consent, and present strategies for how to implement such a model through case studies. This will be achieved through a presentation with 3 presenters with a variety of backgrounds which, together, provide a strong base of knowledge for this model. Attendees will be engaged throughout the presentation for discussion and Q&A.

Ultimately, the goal of this symposium is to provide concrete information and strategies so that clinicians will understand how to mitigate and prevent re-traumatization and unintentional harm when caring for trans patients undergoing genital gender-affirming surgery. We hope that the outcome of this symposia will be, in part, a call to action for empirical data to solicit information from patients' and clinicians' experiences which can further inform best practices.