Editorial

Gender affirmation surgery and the younger patient

Stan J. Monstrey[1], Karel Claes[1], Griet De Cuypere[2]

[1]Department of Plastic Surgery, [2]Center for Gender Identity and Sexology, Ghent University Hospital, Gent, Belgium

Correspondence to: Stan J. Monstrey, MD, PhD. Department of Plastic Surgery, University Hospital Gent, Corn. Heymanslaan 10, 2K12C, B-9000 Gent, Belgium. Email: Stan.Monstrey@UGent.be.

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Transgender people, often called trans people (or even simply 'trans') are a diverse population of individuals who experience a degree of *gender incongruence* which is a disparity between the personal sense of their own gender (= gender identity) and the sex they were assigned at birth (= birth assigned sex) (1,2). The term (trans)gender identity refers to what degree a person experiences him or herself as a male or female, as a mixture of the two, as none of the two or even as a gender beyond male or female (3,4). This should not be confused with sexual orientation which is about to whom a person is sexually attracted (1,2). In the past ten years there has been a worldwide increase in the number of individuals presenting for care in relation to their gender identity. In that same period, public awareness and media attention of nonconformity in gender identity and expression has reached unprecedented heights especially among children and adolescents (2-4). Traditionally, transgender individuals have always been diagnosed by the western psychiatry as 'mentally disordered' (1). The previous edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV-R) published by the American Psychiatric Association (APA) used the term 'Gender Identity Disorder' (GID). Such an official diagnosis might have facilitated the provision and (eventual) reimbursement of health care services for transgender people but of course the denomination 'Disorder' also aggravated the multiple challenges and problems that transgender individuals have to face. The more recently published DSM-5 retained the mental disorder diagnosis but focused on 'Gender Dysphoria' (GD) which is defined as the discomfort or distress that is generated by the disparity or incongruence between one's own gender identity and the sex assigned at birth. In ICD-10 (the tenth revision of the International Statistical Classification of Diseases and Related Health Problems) published by the World Health Organization (WHO) the diagnosis 'Transsexualism' is used for an individual who displays *"a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with one's preferred sex"* (5-7). WHO has recently announced the final version of its diagnostic manual ICD-11 wherein "Gender Incongruence" and all the categories related to gender identity are to be taken out of the Mental and Behavioural Disorders chapter and placed in a chapter called: 'Conditions related to Sexual Health". Nowadays, transgender is more considered as an identity and no longer as a disorder (7).

As clearly described by Winter, there are two aspects of gender dysphoria. One component is *social*, and results from the non-acceptance of the transgender person's gender by other people or by society in general. This disapproval adds to stigma, prejudice, harassment and possibly even violence which can result in social isolation and economic depreciation. The second aspect of gender dysphoria is the *physical* whereby an anatomical component is causing discomfort or distress (also called bodily dysphoria).

When a transgender individual starts to live in his or her own experienced gender this process is called *gender transition*. Also for this transition, there is a social and physical aspect. For many trans people, the social element may include a new first name, changes in clothing or hair dress and also a new identity card. The physical elements of the transition may include medical interventions such

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as hormonal and/or surgical therapy. Gender confirming healthcare can represent a real medical necessity for many trans people, however not for all individuals with gender dysphoria (1-7).

It is important to realize that over the past decade a major paradigm shift has taken place related to transgender health from a dichotomic or binary conceptualization of gender (male *vs.* female) towards a recognition and discovery of a broad spectrum of gender identities and expressions. This so-called "gender fluidum" covers all varieties of transgender individuals including the more recently named gender queer and non-binary individuals. This paradigm shift has important consequences as to the treatment options for individuals with gender dysphoria. Indeed, on one hand there are many trans people who want to undergo medical interventions making their physical appearance more consistent with their experienced gender, while for other transgender individuals medical treatment is not a medical necessity at all. Bockting *et al.* coined the construct of 'Gender Affirmation' which has replaced the concept of 'sex reassignment' throughout the field, the former referring to the affirmation of a range of gender identities and expressions, including transgender, genderqueer and non-binary identities (5,6,8,9).

The treatment of Gender Dysphoria may consist of mental health care, cross-sex hormones and various kinds of surgical interventions (called Gender Affirmation Surgery or GAS). Some individuals only experience a mild degree of distress (or no distress at all) between their own gender and that assigned at birth and therefore might opt for limited treatment (mental health care and/or hormonal therapy, but no surgery or even no therapy at all). Many gender dysphoric individuals might opt to undergo only some of the currently available surgical procedures while others insist on receiving the entire collection of treatments (5-10).

Worldwide, the Standards of Care (SOC) from the World Professional Association for Transgender Health (WPATH) are followed as the therapeutic guidelines for managing gender dysphoria or transgender health in general. The most recent, 2011 revision (version 7) consisted of a complete overhaul of these Standards after an extensive review of scientific evidence and multiple consultations with experts as well as transgender community advisors from around the world. The next revision of the WPATH Standards of Care is already in progress and will further affirm the individualized therapeutic approaches according to this wide spectrum of gender identities.

Gender Affirmation Surgery has become a highly specialized field with participation of various specialties such as plastic surgery, urology, gynaecology, as well as ear, nose and throat (ENT) and maxillofacial surgeons.

These operative procedures are often divided in three groups: (I) n*on-genital*, *non-breast* surgical interventions: such as facial feminizing surgery or various aesthetic procedure (e.g., liposuction, lipofilling, hair surgery…); (II) *breast ('top')* surgery: augmentation mammoplasty or subcutaneous mastectomy; and (III) *genital ('bottom')* surgery: castration ± vaginoplasty and hysterectomy/oophorectomy and metaidoio/phalloplasty ± implantation of an erectile prosthesis. An Increase in advocacy efforts and extended insurance coverage have enhanced access to health care for trans people resulting in a substantial rise in the numbers of patients wishing to undergo gender affirmation surgery. The requests for these procedures have exceeded the number of surgeons with adequate qualification or experience. At the present moment, only limited formal training or GAS fellowships are available for surgical specialists or residents who are motivated to gain experience with these surgical procedures (3,9,11,12).

For many surgeons, especially for those who are not that familiar with trans issues, the wide variation in clinical presentation of gender dysphoria nowadays makes it more difficult to delineate the indications for specific surgical procedures and even (much) more so in transgender adolescents.

As a general rule, the SOC do recommend that mental health professionals provide letters of referral to surgeons for patients wishing to undergo gender affirmation surgery: one referral letter is recommended for subcutaneous mastectomy and/or breast augmentation while two referrals are required for genital operations. In the ideal situation, the surgeon should have a good working relationship with the general practitioner, the endocrinologist and/or the mental health professional and an evaluation of the transgender patient within a multidisciplinary team is always preferred (9,11,12).

Although gender identity can fluctuate during childhood, it has been shown that most adolescents who strongly and consistently identify as transgender also become transgender in adulthood eventually requesting some form of medical therapy (13). Ideally, the treatment of adolescents with GD should prevent the development of the secondary sex characteristics of their birth assigned gender making it more easy for them to go through life conform their experienced gender identity. Treatment to suppress puberty with gonadotropin-releasing hormone analogues is in large

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part reversible and provides the adolescents extra time to explore the nature of their gender dysphoria and gender identity (13,14). It is recommended to start the therapy with gonadotropin-releasing hormone analogues not before (and not after) Tanner stage II. It is to be expected that with social transitioning at a young age and with the administration of puberty blocking hormones, trans adolescents will request surgical intervention at a younger age (13).

Version 7 of the WPATH Standards of Care presents criteria for transitioning adolescents in which irreversible interventions (especially genital operations) are not recommended until the adolescent has reached the legal age of majority which can vary from country to country (9). The SOC mention that age should not be the sole criterion to decide whether or not to operate a patient (also emotional maturity) and it also recommends some flexibility in the minimum age requirement specifically the for subcutaneous mastectomy (SCM) or male chest contouring (which could be considered as only partly irreversible) in male affirmed adolescents. Many surgeons nowadays have no reservation to perform a SCM before the age of 18 years in FTM adolescents with well documented gender dysphoria and the capacity of a fully informed consent (13,14).

It is specifically this group of patients who has demonstrated the most substantial increase in referrals over the past 5–10 years. Luckily, after their breast reconstructive surgery, the majority of these young male transgenders do not feel an urgent need to immediately go on with a hysterectomy/oophorectomy and definitely not with the more complex phalloplasty procedure. The dilemma whether or not to perform (the truly irreversible) genital surgery at a young age is more often requested for the young female transgender.

As an increasing number of gender dysphoric girls and boys take puberty blockers and subsequently cross sex hormones, many of them live fulltime as an early teen in the experienced gender which can be kept completely private. As long as the gender status is not disclosed to their peers, the chances of being bullied, harassed and victimized are minimal (13,14). On the other hand, retaining the genitals of birth can be very confusing for the adolescent and will block a normal (puberty-appropriate) emotional development by avoiding any romantic or physical exploration (13-16).

Unfortunately, in the literature there are no guidelines or ethical standards to assist the surgeon in the decision whether or not to perform genital surgery in a transgender adolescent under 18 years of age. One of the premises of the Hippocratic Oath is: "First, do no harm". For most surgeons this means to absolutely avoid all possible risk of postoperative regret in these young patients even in case of adequate recommendation by mental health professionals and a competently given informed consent. Actually, nowhere in the world, this kind of surgery is advocated or legally permitted and with the surgeon ultimately being responsible, a postsurgical regret could always carry the risk of lawsuit (14).

On the other hand, as clearly described by Christine Milrod, it is important to realize that 'harm reduction' can also be a justification for treatment (including genital surgery) since delaying medical intervention during early puberty could also prolong and/or worsen the gender dysphoria and the psychological suffering of the trans adolescent. It is not correct to suppose that refusing to treat e.g., an emotionally impacted teenaged girl is by definition a morally neutral option (14-16).

In conclusion, no clear or evidence-based answers as to the indications for surgery in these young patients are available nowadays. More research is needed in this field as demonstrated by the authors of the article "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults." published in this edition (17). In the meanwhile, the following factors should be considered in decision making: adequate assessment of gender dysphoria and psychological maturity of the adolescent, a longer follow-up within a multidisciplinary gender team and a competently given and fully informed consent also by parents or guardians.

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aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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