5/st GLOBAL CONGRESS ON MIGS

December 1–4, 2022 | Gaylord Rockies Resort and Convention Center | Aurora, Colorado

SYLLABUS

GEN-608: Gender Affirmation Surgery

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The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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FACULTY DISCLOSURE

The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the "best available evidence" from medical literature (in alphabetical order by last name). Veronica Lerner,

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Cecile A. Ferrando, MD, MPH – Royalty: UpTpDate

Robert R. Pollard, MD*

Bobbie J. Rimel, MD – Advisory Board Participant: Merck, GSK, Immunogen, AstraZeneca; Consultant: Deep6A1

GEN-608: Gender Affirmation Surgery

Chair: Cecile A. Ferrando, MD, MPH

Faculty: Veronica Lerner, MD, Michelle Y. Morrill, MD, Rob R. Pollard, MD, and Bobbie J. Rimel, MD

Course Description

This course is meant for attendees interested in learning about perioperative considerations and management of the transmasculine patient seeking hysterectomy for gender affirmation. Attendees will learn about the assessment of patients, preoperative counseling, considerations about concurrent oophorectomy, vaginectomy and pre-surgical fertility options, as well as the role of vNOTES in performing these procedures. This course is meant for providers already performing gender affirmation surgery as well as those who are interested in learning more about this patient population and their surgical needs.

Learning Objectives

At the conclusion of this course, the participants will be able to: 1) Perform perioperative management of patients seeking hysterectomy for gender affirmation; 2) Recognize that the vNOTES approach to minimally invasive hysterectomy is an option for providers performing hysterectomy for transgender patients; and 3) Identify the role of concurrent vaginectomy at the time of gender affirming hysterectomy.

Course Outline

9:45 am	Welcome, Introduction and Course Overview	C.A. Ferrando
9:50 am	Overview of Gender Affirming Care	B.J. Rimel
10:15 am	Considerations for the Transgender Patient Seeking Hysterectomy	C.A. Ferrando
10:40 am	Transmasculine Hysterectomy: Surgical Technique, Complications and Outcomes	R.R. Pollard
11:05 am	Role of vNOTES for Gender Affirming Hysterectomy	V. Lerner
11:30 am	Vaginectomy at the Time of Gender Affirming Hysterectomy	M.Y. Morrill
11:55 am	Questions & Answers	All Faculty
12:15 pm	Adjourn	

Overview of Gender Affirming care

BJ Rimel MD Cedars-Sinai Medical Center Los Angeles, CA @bjrimelmd

Disclosures

- Advisory Board participant : Merck, GSK, Immunogen, AstraZeneca
- Consultant: Deep6AI



Learning Objectives

- Sexual and gender minority (SGM) definitions
- Gender dysphoria
- Gender affirmation
- Strategies for inclusion

What is a "sexual and/or gender minority"?

- SGM
 - Two things!!
- Sexual minority = non heterosexual
- Gender minority = non cisgender

NIH definition:

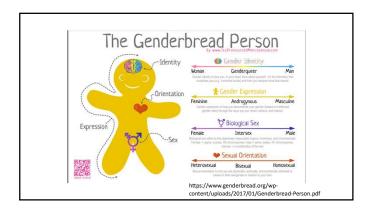
Sexual and gender minority (SGM) populations include, but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, transgender, Two-Spirit, queer, and/or intersex. Individuals with samesex or -gender attractions or behaviors and those with a difference in sex development are also included.

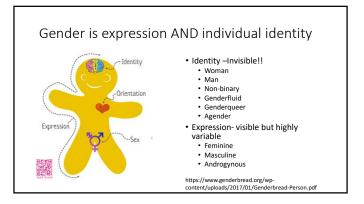
https://dpcpsi.nih.gov/sgmro

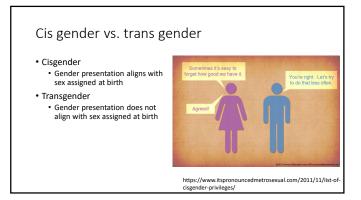
Sexual history taking is required

- Sexual minority status is Nonvisible
- Can't tell by looking
- Knowledge of sexual Behaviors can help determine appropriate care.
 - STI risk
 - HPV screening (not just the cervix)
 - Pregnancy risk













"Gender dysphoria describes the distress experienced by those whose gender identity feels at odds with aspects of their body and/or the social gender role assigned to them at birth. This can be experienced as physical discomfort, and psychological and emotional distress." Gender Dysphoria. Gender Identity Clinic, NHS. Available from: https://gic.nhs.uk/info-support/gender-dysphoria



• Social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity"
when it conflicts with the gender they were assigned at birth.



World Health Organization

https://www.who.int/europe/health-topics/gender#tab=tab_1

Limitations of access to gender affirming care

 As of March 2022, 15 states have restricted access to gender-affirming care or are currently considering laws that would do so.



https://williamsinstitute.law.ucla.edu/publ cations/bans-trans-youth-health-care/

Movement Advancement Project. "Equality Maps: Snapshot: LGBTQ Equality By State." https://www.lgbtmap.org/equality-maps/. Accesse 08/26/2022

Gender affirming care

- · Care provided affirms the patient's gender identity
 - Medical treatment
 - · Surgical treatment
 - Fertility management

Transition

- The process of living as one's gender identity
- Highly variable
- May include just a social transition (e.g. clothing) or some or all surgical/medical options
- · Make no assumptions



Transmasculine

- Assigned female at birth (AFAB)
- · Medical treatment
 - Testosterone IM or transdermal
 - Dosing and potential side effects
 - Polycythemia • HTN



Gender Affirmation Surgery-Transmasculine

- Options:
 - Hysterectomy, bilateral salpingoophorectomy, vaginectomy

 - Chest surgery ("top surgery")
 Liposuction of the breast through incisions in the areola
 - Mastectomy
 - Metoidioplasty
 - Phalloplasty
 - Several options

Transfeminine

- Assigned male at birth (AMAB)
- Medical treatment
 - Estrogen therapy and/or antiandrogen therapy
 - Dosing and potential side effects
 Increase LDL cholesterol
 Decrease hemoglobin

Gender Affirmation surgery - Transfeminine

- Options:
 - Breast augmentation
 - Orchiectomy
 - Vaginoplasty
 - · Complex options

Fertility Management

- AFAB
 - If a uterus and tubes and ovaries and having male partners who make sperm—need to discuss contraception
 - If considering future genetic children -

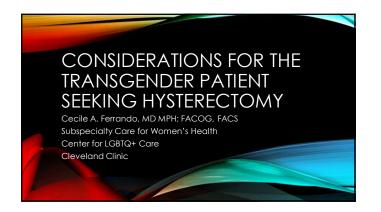
 - Discussion of options:
 Holding on surgery until fertility complete
 - · Oocyte preservation
- AMAB
 - If having partners who have a uterus tubes and ovaries –and patient is making sperm – need to discuss contraception
 - If considering future genetic children-
 - Sperm banking (Ideally done prior to starting hormone therapy)

How can I avoid causing dysphoria to my transgender AFAB patient?

- By gender-affirmation
 - Use of preferred name/pronouns
 - · Use of preferred name for
 - dysphoric body parts
 Ex. Instead of vagina:
 "front hole"



Pelvic examination Allow patients to have a distraction; phone, headphones, tell jokes, hold hand of partner etc. Ask about prior Have very small speculae. Listen to the patient. If it is not tolerable,



INDICATIONS FOR HYSTERECTOMY

- Gender dysphoria vs GYN etiology or is this a mix?
- How do you work-up GYN etiology this is different than the cisgender female population
 - · Breakthrough bleeding on testosterone is a real thing
- Do you need a preoperative pelvic examination? Ultrasound?
- Assessment of pelvic floor dysfunction/high tone PFM

Indication: GYN etiology "Hysterectomy is an option for the freatment of XXX. While XXX is still of reproductive age, he/they have been counseled about their fertility preservation." "Hysterectomy is medically indicated in the setting of gender dysphoria and XXX meets criteria for the procedure; he/they understand the consequences and risks associated with hysterectomy and he/they have been counseled about their fertility goals and options and have been offered fertility goals and options and have been offered fertility preservation."

INDICATIONS FOR HYSTERECTOMY

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INDICATIONS FOR HYSTERECTOMY Gender dysphoria vs GYN etiology – or is this a mix? Hov Original Research ajog.org GYNECOLOGY Uterine pathology in transmasculine persons on testosterone: a retrospective multicenter case series France W. Girmand, MD; tylia G. Fower, MD, MS; Erika P. Now, MD, MPH; Cockid, A. Fornardo, MD, MPH; Robert R. Pokard, MD; Crahum Chapman, MD; Verenica Gomez-Lobo, MD; Meredith Gray, MD How do you document need for hysterectomy?

INDICATIONS FOR HYSTERECTOMY

- Gender dysphoria vs GYN etiology or is this a mix?
- How do you work-up GYN etiology this is different than the cisgender female population
 - Breakthrough bleeding on testosterone is a real thing
- Do you need a preoperative pelvic examination?
 Ultrasound?
- Shared decision-making important during this discussion
- Assessment of pelvic floor dysfunction/high tone PFM

WPATH SOC7

- · Formal diagnosis of gender dysphoria
- 12 months of continuous GAHT
- Lives experience for > 12 months
- Good control of comorbid mental health conditions
- Two letters of referral from mental health providers (one from PhD or MD)

GATEKEEPING???

WPATH SOC8

- · Meets diagnostic criteria for gender incongruence
- Understands the effect of gender-affirming surgical intervention on reproduction
- Good control of mental health conditions
- At least 6 months of GAHT or longer to achieve the desired surgical result
- If written documentation or a letter is required to recommend gender affirming medical and surgical treatment (GAMST), only one letter of assessment from a health care professional who has competencies in the assessment of TGD people is needed

WPATH GUIDELINES -**IMPLICATIONS**

- · Less gatekeeping, increasing theoretic access, a victory for
- · Lag with insurance companies may lead to a gray zone which will temporarily reduce access
- Provides institutions with the ability to create SOPs and Carepaths - highly recommend to remain consistent and transparent speaks to the need for multidisciplinary approach/assessment

FERTILITY PRESERVATION

- Important part of counseling avoids risk of regret
- Will soon be required criteria so important to
- Provide patients with written materials to review after
- · Have an affirming fertility specialist designated to
- Acknowledge the challenges of fertility preservation for patients but provide space for them to make an autonomous decision



PERIOP CONSIDERATIONS

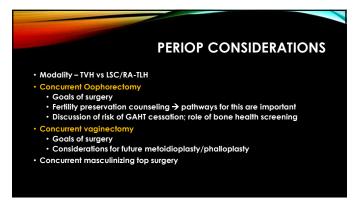
- Modality TVH vs LSC/RA-TLH
- · Concurrent Oophorectomy
 - Goals of surgery
 - Fertility preservation counseling \Rightarrow pathways for this are important
 - · Discussion of risk of GAHT cessation; role of bone health screening
- Concurrent vaginectomy
 - Goals of surgery
 - Considerations for future metoidioplasty/phalloplasty
- · Concurrent masculinizing top surgery

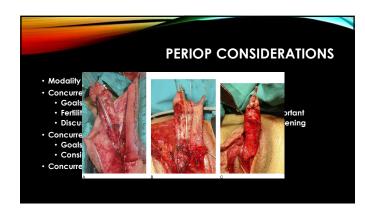
PERIOP CONSIDERATIONS

- Modality TVH vs LSC/RA-TLH

Feasibility of Vaginal Hysterectomy for Female-to-Male Transgender Men

- Juno Obedin-Maliver, MD, MPH, Alexis Light, MD, MPH, Gene de Haan, MD, and Rebecca A. Jackson, MD Considerations for future metoidioplasty/phalloplasty
- · Concurrent masculinizing top surgery





PERIOP CONSIDERATIONS

- Modality TVH vs LSC/RA-TLH
- · Concurrent Oophorectomy

 - Goals of surgery
 Fertility preservation counseling → pathways for this are important
 - Discussion of risk of GAHT cessation; role of bone health screening
- Concurrent vaginectomy

Need for

Preopero

Careful h

Shared

Goals of surgery
 Considerations for future metoidioplasty/phalloplasty

Shannon S. Wu, BA; Charles A. Raymer, MD; Bram R. Kaufman, MD; Raymond Isakov, MD; and Cecile A. Ferrando, MD, MPH

Concurrent masculinizing top surgery

PERIOP CONSIDERATIONS

- Perioperative use of testosterone therapy
- Need for PAP smear
- Preoperative pelvic examination vs pelvic US
 - Shared decision-making important during this discussion

Careful history taking and suspicion for endometriosis

PERIOP CONSIDERATIONS Perioperative use of testosterone therapy The Effect of Preoperative Gender-Affirming Hormone Therapy Use on Perioperative Adverse Events in Transmasculine Individuals Undergoing Masculinizing Chest Surgery for Gender Affirmation

OXFORD

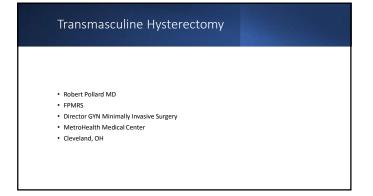
PERIOP CONSIDERATIONS

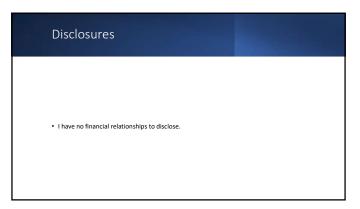
- Perioperative use of testosterone therapy
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- Preoperative pelvic examination vs pelvic US
- Careful history taking and suspicion for endometriosis

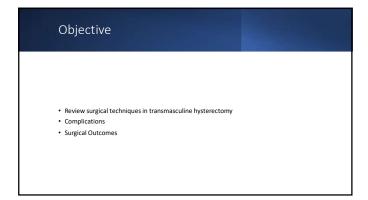
PERIOP CONSIDERATIONS

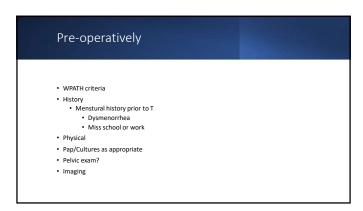
- Planning overnight stay vs SDD (ERAS protocols are <u>great</u> for these patients)
- Foley removal in the OR discussing this ahead of time
- Counseling about need for preop HCG
- Expectations about postoperative bleeding and risk of dysphoria

We are not gatekeepers to care – we are facilitators – but our job is to make sure we take into consideration the unique nuances that are associated with TGD individuals, and accommodate these factors and engage in shared decision-making with our patients.













Indications for surgery

- Gender Affirmation/Confirmation Surgery
- Abnormal Uterine Bleeding
- Pelvic Pain
- Dysmenorrhea
- Avoid future Gyn visits
- · Cancer Risk Reduction
- Decrease Testosterone Dose

- Preoperative Pain Symptoms and the Incidence of Endometriosis in Transgender Men Undergoing Hysterectomy for Gender Affirmation
- <u>Cecile A Ferrando</u> 1, <u>Graham Chapman</u> 2, <u>Robert Pollard</u> 3 J Minim Invasive Gynecol
- 2021 Sep

Pelvic pain

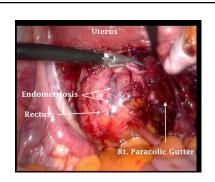
- 67 patients between 2010-19 retrospective review
- 1 patient desired to keep ovaries-remaining TLH BSO
- 90% patients on T for mean of 36 months
- 60% amenorrheic, 43% c/o dysmenorrhea, 50.7% c/o pelvic pain

- 33% reported pelvic pain and 22% did not
- NO difference in patients with/without endo except those with endo 67% reported h/o HMB and 21% reported irregular menses

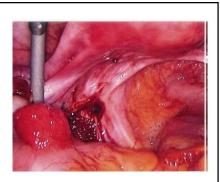


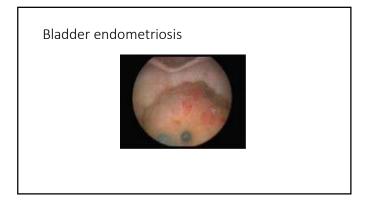


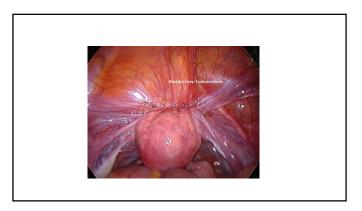




Infiltrating Lesions

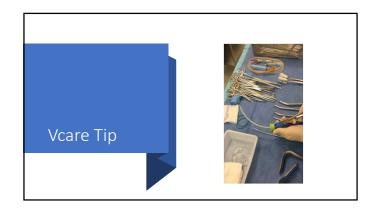






Uterine Manipulator Challenges

- Small introitus
- Atrophic vagina



TM Hysterectomy

Small uterus with relatively normal anatomy
Small pedicles
Typically easy, straight-forward cases

Post op spotting/bleeding

Postoperative vaginal bleeding concerns after gender-affirming hysterectomy in transgender adolescents and young adults on testosterone

Danielle T. Cipres 1, Jessica Y. Shim 2, Frances W. Grimstad 2

1 Pediatr Adolesc Gymecol
2022 Sep 8,51083-3188(22)00291-1.



Cuff Closure Take Home Points - Colpotomy - Cutting current - Limit coagulation for hemostasis - Adequate bites - Interrupted, Figure of 8's, running - Barbed vs standard suture

Decreased Incidence of Vaginal Cuff Dehiscence after Laparoscopic Closure with Bidirectional Barbed Suture

Matthew T. Siedhoff, MD*, Amanda C. Yunker, DO, MSCR, and John F. Steege, MD

Trum the University of Steeth Continue at Chapet Bill. Steepel Bill.

Cuff Closure Route

• Do what YOU do Best!

TM Hysterectomy

• Always check vagina for lacerations at completion
• Foley not necessary post operatively
• Easy case- don't mess it up!!

Obstet Gynecol

2018 Nov;132(5):1265-1273.

doi: 10.1097/AOG.000000000000002936.

Complication Rates and Outcomes After Hysterectomy in Transgender Men

Cemi Bretschneider ¹, David Sheyn, Robert Pollard, Cecile A Ferrando

Affiliations expand

PMID: 30303922

DOI: 10.1097/AOG.00000000000002936



- . 2020 Jan;42(1):25-30.
- doi: 10.1016/j.jogc.2019.05.009.Epub 2019 Oct 31.
- Surgical Outcomes for Transgender Men Undergoing Hysterectomy
- Innie Chen ³, Vincent Nguyen ², Meryl Hodge ³, Ranjeeta Mallick ³, Hélène Gagné ⁴, Sukhbir S Singh ⁴, Abdul Jamil Choudhry ³, Rihua Xie ⁵, Yan Liao ³, Shi-Wu Wen ⁶

- Successful management of ureteral injury after gender-affirming laparoscopic hysterectomy: A case report
- <u>Gaku Nakamura ¹, Akinori Nukui ², Issei Suzuki ³, Kohei Takei ⁴, Toshiki Kijima ⁵, Takao Kamai ⁶</u>

Combined Surgery

- Combining total laparoscopic hysterectomy and bilateral salpingooophorectomy with subcutaneous mastectomy in trans men: The effect on safety outcomes
- Lian Elfering¹², Tim C van de Grift¹²³, Mark-Bram Bouman¹², Norah M van Mello⁴, Freek A Groenman⁴, Judith A Huirne⁴, Ivo Y W Budiman¹, Linde D J Goijen¹, Dorothea K G van Loenen⁵, Margriet G Mullender¹²
- Int J Transgend Health
- 2020 Apr 25;21(2):138-146.

Feasibility, Safety, and Satisfaction of Combined Hysterectomy with Bilateral Salpingo-Oophorectomy and Chest Surgery in Transgender and Gender Non-Conforming Individuals

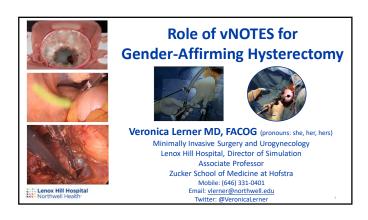
- Ilaria Mancini ¹², Davide Tarditi ¹², Giulia Gava ¹², Stefania Alvisi ¹², Luca Contu ¹³, Paolo Giovanni Morselli ¹³, Giulia Giacomelli ¹², Alessandra Lami ¹², Renato Seracchioli ¹², Maria Cristina Meriggiola ¹²
- Int J Environ Res Public Health
- . 2021 Jul 3;18(13):7133.

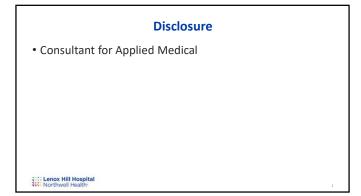
Post-OP

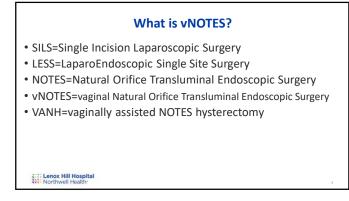
- 23 hour stay/Same Day Discharge
- Foley
- Pelvic Rest?
- Vaginal Spotting
- Communication/Education
- Follow up

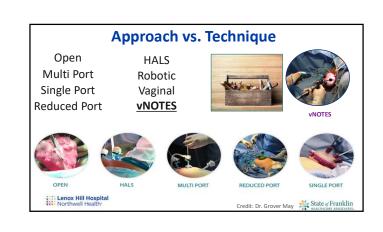


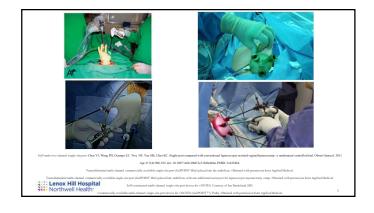


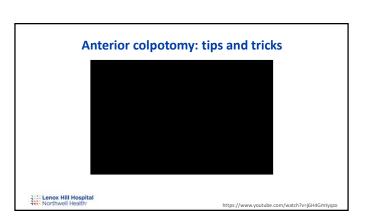


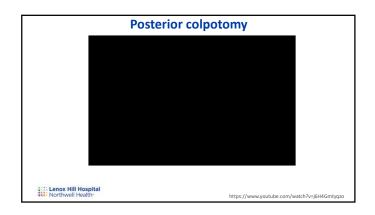




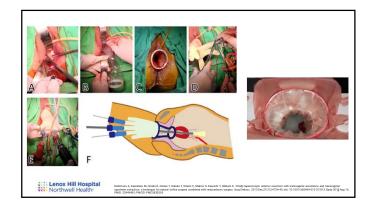






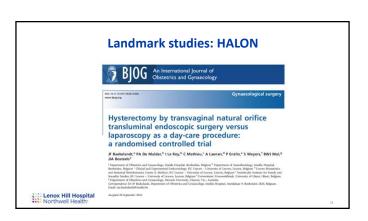


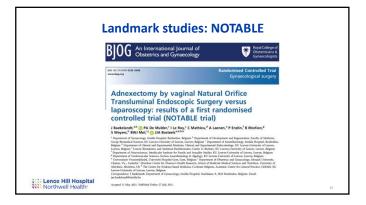












Indications

- Practice setting:
- 15 years post-fellowship
- Routes: vaginal and laparoscopic
- Added robotics post-fellowship
- Large urban academic center (residents, fellows)
- Referral center
- Focus on surgical training and simulation

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Northwell Health

Month Day, Yea

Goals

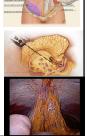
- Convert laparoscopic cases to vNOTES
- Teach the next generation of surgeons
- Convert uterosacral ligament suspensions to vNOTES
- Contained tissue extraction
- Postop pain
- Ergonomics
- Dissemination
- Research
- Innovation

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Convert laparoscopic cases to vaginal

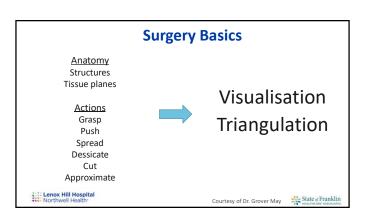
- Avoid abdominal wall
- · Post-op pain
- · Injury at entry
- · Nerve injury
- Risk of hernia (esp. with tissue extraction)
- Adhesiolysis
- Mesh from prior surgery
- Rigid abdomen (abdominoplasty, nulliparous)
- Cosmesis (gender-affirming as a subcategory)
- Obesity
- · Limited vaginal access

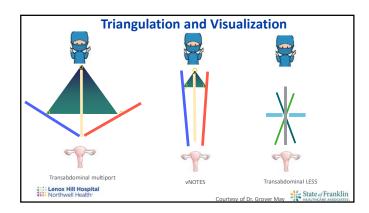
Lenox Hill Hospital



Indications: who is not a candidate?

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Indications: who is not a candidate?

- Access for visualization and triangulation
- Need "from above" vs. "bottom-up" view:
- Endometriosis
- Cul-de-sac obliteration (radiation, colorectal surgery)
- Procedures:
 - Myomectomy
 - · Lymph node sampling
 - Sacrocolpopexy

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Indications: who is a candidate?

- Hysterectomy
 - Large uteri
 - Obesity
- Nulliparity
- Adhesions
- Gender-affirming (Testosterone, Leuprolide)
- USLS (uterosacral ligament suspension)
- Adnexal (salpingectomy, BSO)
 - Prior hysterectomy
- Repeat vNOTES

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Technique: Tips and Tricks

· Efficiency and safety in vNOTES

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Getting started

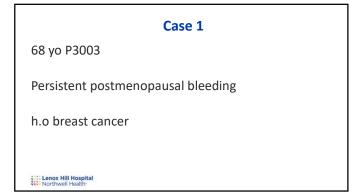
- Take a hands-on vNOTES course
- Engage with a colleague (proctors available)
- Chose low- or moderate complexity case as your first case
- Watch vNOTES videos to prepare for your first case
- SurgeryU, Facebook (vNOTES USA, vNOTES global)
- If you are not confident with colpotomy, consider asking a colleague who performs vaginal hysterectomies to assist
- Record your cases, engage with a mentor to do a video review
- A low threshold to place the umbilical port to visualize the pelvis

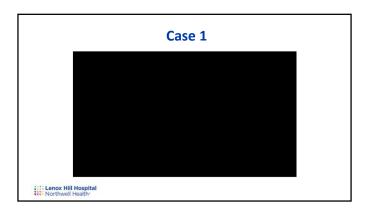
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Getting started

Be patient with yourself

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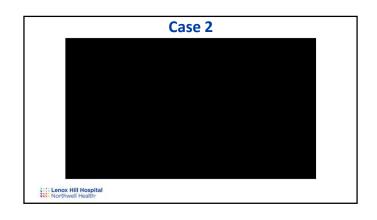
Case 2

43 yo P2002

Csx2, appendectomy, abdominoplasty, failed UAE

BMI 32

10 x 8 x 6 cm uterus, fibroids (211 g)

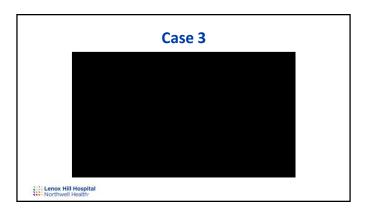


Case 3
41 yo P1

BMI=35

h/o LSC LSO and right salpingectomy for follicular cyst

POP, cervical elongation, C=+1



Step of the procedure	Suggestions on technique	Rationale
Setup		
Draping/Positioning	Use a drape similar to what is being used for LAVH or TLH Patient positioning: -one arm tucked (to allow tower to be closer) -dorsal lithotomy (same as for VH)	Allows easy placement of umbilical port in case need to visualize pelvis from above, or in case conversion from vNOTES to the laparoscopic route is needed
Preparation	Abdominal and vaginal anti-septic solution (most commonly chlorhexidine), same as what is used for LAVH or TLH	No change in the standard of care in comparison to LAVH or TLH
Antibiotics	Same as LAVH or TLH, most commonly cephalosporin and metronidazole	No change in the standard of care in comparison to LAVH or TLH
Vaginal hysterectomy instruments	Include a long retractor of choice (right angle, Briesky, Dolen)	Long retractor is used to guide the introducer for the ring
Laparoscopic instrumentation	Grasper (atraumatic, "wavy" or a bipolar grasper) A bipolar sealing device with cutting blade Avoid ultrasonic energy devices (ex. Harmonic)	
Laparoscopic instrumentation	Laparoscopic suction irrigation is not needed	If suction is needed, use Yankhauer inserted into one of the ports or disassemble LESS port and suction pelvis with ring in place

procedure	Suggestions on teeminque	Partionale
Vaginal entry and ring placement		
Anterior colpotomy	Place an interrupted suture from anterior peritoneum to anterior vaginal mucosa	Assures that ring fits into an anterior cul-de-sac with ease and peritoneum "curtain" is not hanging anteriorly, obstructing the view
	Stretch anterior perineum after sharp entry with index fingers	Assures enough space for the ring to sit properly in the anterior cul-de-sac
Posterior colpotomy	Place an interrupted suture from the posterior peritoneum to the posterior vaginal mucosa	Assures easy ring placement and decreases chanc of it "popping out"
Uterosacral ligament ligation	Suture ligate ligaments with double or triple fixation; tag ligaments	Assures secure suture placement, less likely to have to secure ligaments again at the end of the case
After ring placement, prior to port assembly	Place a large laparotomy pad or a 4x4 into a posterior cul-de-sac prior to ring assembly ("Stockwell sponge")	Retracts sigmoid during the case; Aids with sigmoid retraction during uterosacral ligament suspension; Serves as a "backdrop" during adnexectomy to ai with depth perception when looking toward the pelvic brim, decreasing the risk of small and large bowel coming too close to the surgical field.
Complications	Same approach to management as in vaginal surgery	No change in the standard of care in comparison with vaginal surgery

Step of the	ouggestions on teeninque	Nationale
procedure		
Laparoscopy		
Trandelengerg during laparoscopy	Case-dependent, less than with transabdominal laparoscopy In case of morbid obesity, can tolerate less Trandelengerg and still get adequate exposure	Less Trandelenberg improves physiologic parameters and decreases risk
Insufflation pressure	Lower than during laparoscopy	Adequate visualization is easier to achieve than in transabdominal laparoscopy
Flow rate	Lower than during laparoscopy	Adequate visualization is easier to achieve than in transabdominal laparoscopy
Angle of laparoscope	30-degree angled laparoscope	Less internal instrument and camera collisions
Length of laparoscope/instruments	Bariatric (scope, energy device)	Less external instrument and camera collisions
Right angle adapter for light source		Less external instrument and camera collisions
Complications	If vaginal or vNOTES repair is not possible, have a low threshold to convert to laparoscopy	

Jan Baekeland's 30 Little Tips for Safe and Efficient vNOTES

- 1. Be extremely meticulous about case planning and standardization
- 2. Check OR set up yourself
- 4. See that the patient's buttocks sit on the edge of the table.
- 5. Ensure that the patient cannot slide cephalad.
- 6. Disinfect and drape for both vNOTES and laparoscopy
- 7. Administer antibiotics before, during, and after surgery.
- 8. Always perform a rectovaginal examination.
- 9. Infiltrate the vaginal mucosa surrounding the cervix.
- 10. Master the 3-phase, 10-step approach in easy cases, and it will be your lifeline in the difficult cases.



Jan's 30 Little Tips for Safe and Efficient vNOTES

- 11.Let the peritoneal fold SMILE at you.
- 12.Don't make hesitation cuts.
- 13. Feel the Foley balloon.
- 14. Take your time to place the inner ring perfectly.
- 15.Don't overtighten the Alexis retractor.
- 16.Inspect the uterus anteriorly, posteriorly and cranially.
- 17.Lift all the bowels out of the pelvis.
- 18. Push medially and cranially.
- 19. Hemostasis makes you faster.
- 20. Don't completely release the first side of the uterus.
- 21. Avoid using a suction device.

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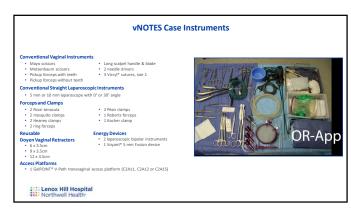
Jan's 30 Little Tips for Safe and Efficient vNOTES

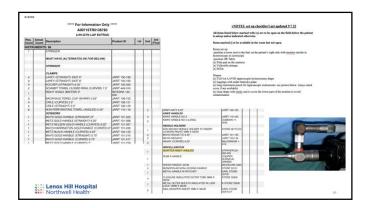
- 22.Use two bipolar instruments and advanced energy.
- 23. Give the assistant only one task: to see that the laparoscope sits between the hand instruments.
- 24. Remember: Slow + less = FAST.
- 25.Remain courteous (this is expected of all OR personnel at all times).
- 26.The less significant the indication, the greater the complication.
- 27. Know your limitations, and slowly move beyond them.
- 28. When encountering problems, go slower, add "please" and "thank you," and follow routine steps.
- 29. Remember, conversion is a great save, not a failure.
- 30.Follow up no later than six weeks after surgery.

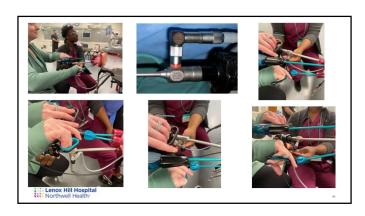
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Goals

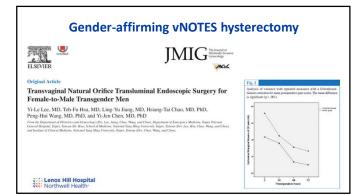
- Convert laparoscopic cases to vNOTES
- Teach the next generation of surgeons
- Convert uterosacral ligament suspensions to vNOTES
- Contained tissue extraction
- Ergonomics
- Dissemination
- Research
- Innovation

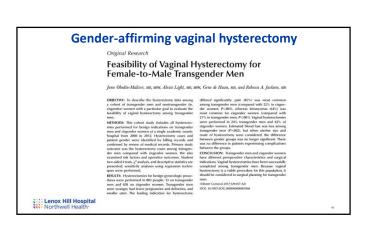
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Gender-affirming vNOTES hysterectomy Challenges Nulliparous No scar (preference, stigma, dysphoria) Narrow introitus/vaginal caliper Limited descent Less pain Reconstruction Testosterone: small, non-compliant, atrophic vagina Prior c-section/prior pelvic surgery less likely Puberty suppression: android pelvis Pathology less likely Desire for BSO Cuff dehiscence risk Lenox Hill Hospital Northwell Health









Gender-affirming hysterectomy

ACOG

ACOG COMMITTEE OPINION

Committee on Gynecologic Practice and Committee on Health Care for Underserved Warners
This Committee Options was Analoged by the Innexes Salige of Observation and Consulagin' Committee on Consulagin Practice and

Health Care for Transgender and Gender Diverse Individuals

gender dysphoria who desire this procedure. The route of hysterectomy should be based on clinical findings as well as surgeon and patient preference. Although vaginal hysterectomy will allow for recovery without abdominal scarring, some surgeons may find it to be technically difficult given likely lack of uterine descent and severe vaginal atrophy with a narrow introitus; however, it can be accomplished if desired (24).

Gender-affirming hysterectomy: traditional thinking

- Pain as the leading indication
- Does not correlate with pathology (musculoskeletal changes, inflammation)
- Possibly helps with insurance coverage
- Androgen therapy
- "small, non-compliant, atrophic vaginal walls"



Practical considerations

Testosterone

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- Similar to nulliparous post-menopausal women
- No testosterone/no puberty suppression
 - Same approach as for cis-gender

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Innovation: TVNH





Instruments and Techniques

Total Vaginal NOTES Hysterectomy: A New Approach to Hysterectomy

Jan Baekelandt, MD*



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Total Vaginal Notes Hysterectomy (TVNH)



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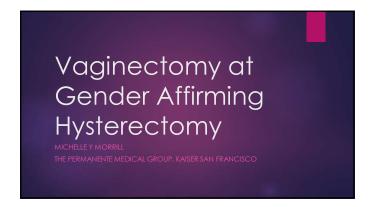
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Resources

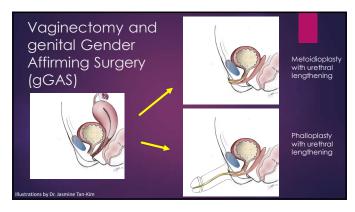


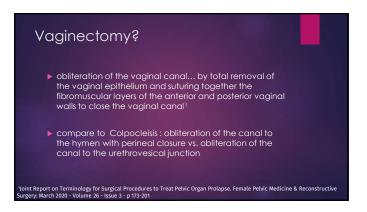
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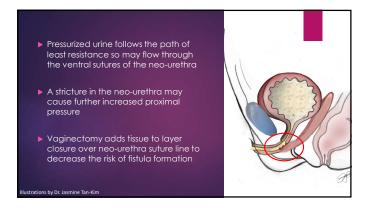


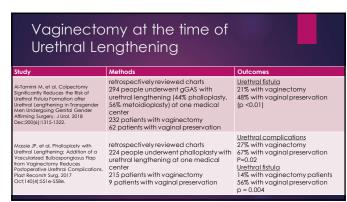






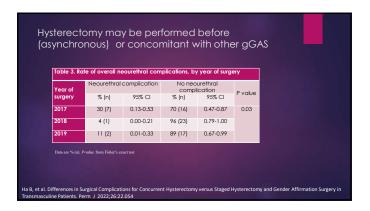






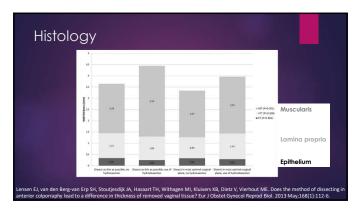


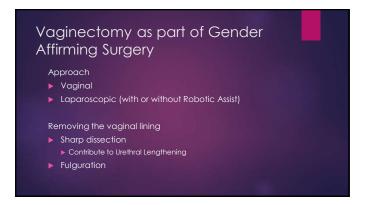
Hysterectomy may be performed before (asynchronous) or concomitant with other gGAS			
	Genital Gender Affirming Surgery with asynchronous hysterectomy (n=32)	Genital Gender Affirming Surgery with concurrent hysterectomy (n=34)	P value
Incision to close (min)	297 (257-335)	321 (275-347)	0.08
Estimated blood loss (mL)	254 (150-350)	224 (150-300)	0.45
Hospital length of stay (days)	4 (4-5)	4 (4-5)	0.84
Neourethral complications (fistula, stricture)	28 (9)	3 (1)	<0.01
Morphine equivalents during inpatient evaluation (mg)	125 (98-146)	121 (94-141)	0.70
Superficial SSI within 3 months	9 (3)	0	0.11
Deep incision SSI within 3 months	3 (1)	6 (2)	1.00
Organ space SSI within 3 months	0	0	-
Wound disruption SSI within 3 months	3 (1)	0	0.49

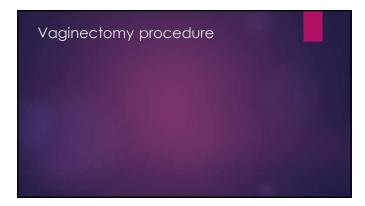


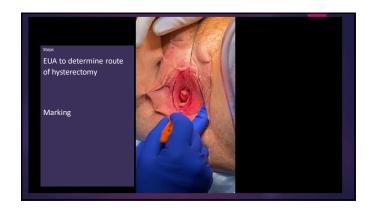


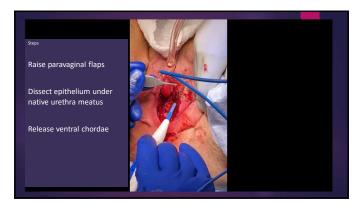






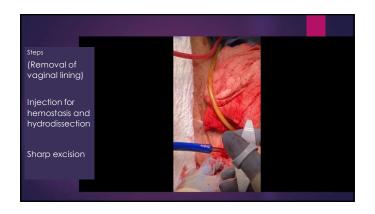


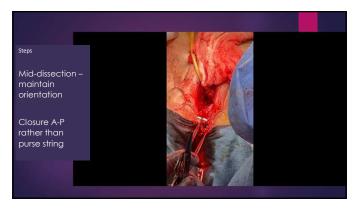






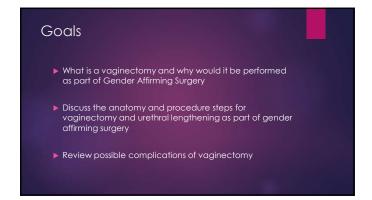


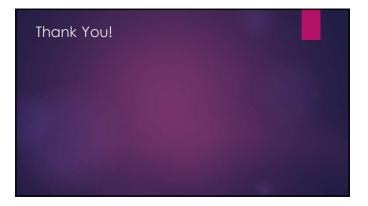












CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) announced new standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. <u>AAGL is ACCME-accredited and headquartered in California</u>.

CMA developed the standards in response to California legislation (<u>Business and Professions (B&P) Code Section 2190.1</u>), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations beginning January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the <u>CLC and IB standards page</u> on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.

Bill Text – AB-241 Implicit bias: continuing education: requirements.

Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)

Cultural Competence In Health and Human Services | NPIN (cdc.gov)

Cultural Competency – The Office of Minority Health (hhs.gov)

Implicit Bias, Microaggressions, and Stereotypes Resources | NEA

Unconscious Bias Resources | diversity.ucsf.edu

Act, Communicating, Implicit Bias (racialequitytools.org)

https://kirwaninstitute.osu.edu/implicit-bias-training

https://www.uptodate.com/contents/racial-and-ethnic-disparities-in-obstetric-and-gynecologic-care-and-role-of-implicitbiases

https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn

https://pubmed.ncbi.nlm.nih.gov/34016820/