

# Transforming Lives: A Gastric Bypass That Enabled a Gender Confirmation

Matthew Wynn, MD, Benjamin Clapp, MD

Department of Surgery, Texas Tech HSC Paul Foster School of Medicine, El Paso, TX, USA (Drs Wynn and Clapp)

## ABSTRACT

**Background:** In the past, hormonal therapy was the primary treatment option for patients with gender dysphoria, but it has been supplemented in recent years by surgical treatments, termed sex reassignment surgery (SRS).

**Case Report:** A 41-year-old male-to-female patient presented with morbid obesity, hypertension, hyperlipidemia, obstructive sleep apnea, fibromyalgia, and osteoarthritis. She identified as a woman and planned to undergo gender confirmation surgery. She had already undergone bilateral orchiectomies and was enrolled in hormonal therapy. The patient underwent a laparoscopic Roux-en-Y gastric bypass without complication. At 1 year postoperation, the patient has experienced a 65% extra body weight loss, her body dissatisfaction has resolved, and she has undergone bilateral breast augmentation. She is now planning to finish her transition.

**Discussion:** This patient highlights an important consequence of weight loss surgery in an underserved segment of society that suffers from morbid obesity as well as gender identity issues. One study from 2016 found that up to 61% of the lesbian, gay, bisexual and transgender (LGBT) respondents were obese or overweight, and transgender individuals had the highest prevalence of obesity among the different groups of the LGBT community. With government insurances now funding SRS surgeries, bariatric surgeons will likely encounter patients undergoing gender confirmation surgeries more often.

**Conclusions:** Bariatric surgery can assist transgender patients with confirming their gender, without the risks associated with primary eating disorders. The transgender population remains an underserved sector of the morbidly obese population, and bariatric surgeons are more likely to see patients undergoing gender confirmation surgery.

**Key Words:** Bariatric Surgery, Gender Confirmation, Gastric Bypass.

**Citation** Wynn M, Clapp B. Transforming lives: a gastric bypass that enabled a gender confirmation. CRSLS e2018.00097. DOI: 10.4293/CRSLS.2018.00097.

**Copyright** © 2019 by SLS, Society of Laparoendoscopic Surgeons. This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 Unported license, which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Dr. Wynn contributed to the paper equally with Dr. Clapp.

Disclaimer: This was presented in a poster format at the Minimally Invasive Surgery Symposium in Las Vegas, NV in March 2017. There has been no prior publication.

Disclosures: none.

Conflicts of Interest: All authors declare no conflict of interest regarding the publication of this article.

Informed consent: Dr. Clapp declares that written informed consent was obtained from the patient for publication of this study/report and any accompanying images.

Funding: There was no funding from any source for this paper.

Address correspondence to: Benjamin Clapp, MD, Department of Surgery, TX Tech HSC Paul Foster School of Medicine, 1700 N. Mesa, El Paso, TX 79902. Telephone: 915-351-6020, Fax: 915-351-6048. E-mail: benjamin.clapp@ttuhsc.edu

## INTRODUCTION

It has been well established that patients with gender dysphoria have body dissatisfaction. In the past, hormonal therapy was the primary treatment option, but it has been supplemented in recent years by surgical treatments,

termed sex reassignment surgery (SRS). Some of these surgeries include genital reconstruction, chest reconstruction, breast augmentation, glottoplasty, facial feminization surgery, and hair transplantation. In the past, transgender patients had experienced multiple barriers to SRS, which included employment issues, cost, access of care, and fear of

the procedure itself.<sup>1</sup> The cost of SRS can be very expensive, which can add to the stress of gender dysphoria.

To cope with this stress and body dissatisfaction, some patients develop eating disorders in order to suppress unwanted features of their natal gender and accentuate features of their gender identity.<sup>2</sup> This can be a very dangerous practice, and safer alternatives to reaching their identity goals must be explored.

Bariatric or weight-loss surgery is the only proven method of affecting significant, long-lasting weight loss.<sup>3</sup> Bariatric surgery also has the added benefits of improving or resolving obesity-related comorbidities such as diabetes mellitus, hypertension, and sleep apnea, among many. This case highlights the use of bariatric surgery to assist transgender persons express their gender identity. Case reports are exempt from the institutional review board but the guidelines of the Declaration of Helsinki were followed nonetheless.

## CASE REPORT

A 41-year-old male-to-female patient presented with morbid obesity, hypertension, hyperlipidemia, obstructive sleep apnea, fibromyalgia, and osteoarthritis. She identified as a woman and planned to undergo gender confirmation surgery. She had already had bilateral orchiectomies and was currently undergoing hormonal therapy. She had consulted with a plastic surgeon but was told that her body mass index of 38 kg/m<sup>2</sup> was too high to undergo the body remodeling required and she would have to lose a significant amount of weight. She had tried and failed with multiple diet and exercise attempts on her own. She felt that the gastric bypass would allow her to lose the necessary weight so she could undergo the rest of her surgeries, which included breast augmentation and eventual penectomy with neovagina creation. The patient underwent a laparoscopic Roux-en-Y gastric bypass without complication.

At 1 year postsurgery, the patient has experienced a 65% extra body weight loss, and resolved her hypertension, hyperlipidemia, and obstructive sleep apnea while also proceeding with her gender confirmation surgeries. Her body dysmorphic syndrome has resolved and she has undergone bilateral breast augmentation since her gastric bypass. She is now planning to undergo a penectomy and neovagina creation.

The patient admits she would not have been able to undergo these surgical procedures if not for the gastric bypass. As she noticed the changes in her body postgas-

tric bypass, she realized she could take the next steps in achieving gender confirmation.

## DISCUSSION

This case highlights an important consequence of weight loss surgery in an underserved segment of society that suffers from morbid obesity as well as gender identity issues. With the impressive weight loss afforded by the gastric bypass, the plastic surgeon was able to help this patient in a safe manner, achieving the desired surgical results. One study from 2016 found that up to 61% of the LGBT respondents were obese or overweight, and transgender individuals had the highest prevalence of obesity among the different groups of the LGBT community.<sup>4</sup> Furthermore, a study from 2014 actually found that transgender older adults had a much higher risk of poor physical health and disability compared with nontransgender participants. This could be attributed to the fear of accessing health services due to perceived judgment by providers, lack of social support, and internalized stigma with victimization.<sup>5</sup> The general surgery literature is just now starting to address this issue.<sup>6</sup> In a study conducted in Colombia, they found many transgender patients sought body modification procedures outside the health care system due in part to societal stigma and social norms within the transgender community.<sup>7</sup>

The obesity epidemic continues to grow in the United States. The average body mass index in the United States is 31.4 kg/m<sup>2</sup>, and the percentage of obese patients is 39.8%.<sup>8</sup> Morbid obesity afflicts all groups of people in the United States, including the LGBT community. For transgender patients who want to undergo gender confirmation surgery, this poses unique challenges. Plastic and reconstructive surgeons encounter difficulties when evaluating and operating on patients with a body mass index of greater than 35 kg/m<sup>2</sup>. There is an increased risk of flap and donor site complications, as well as increased blood loss, surgical time, and risk of deep venous thrombosis, not to mention a more challenging surgical technique.<sup>9</sup> With this in mind, the morbidly obese transgender patient attempting to undergo gender confirmation surgery can benefit from weight loss surgery prior to SRS.

The benefits of bariatric surgery are well established. The gastric sleeve is the most common operation for weight loss with over 65,000 operations performed yearly in the United States. The gastric bypass is the second most common operation.<sup>10</sup> Both of these operations are performed with a minimally invasive technique (laparoscopically) and require only a 1–2-day hospital stay. There have been

recent, well-publicized results with regard to comorbidities such as diabetes mellitus and hypertension. Bariatric surgery plus intensive medical therapy was more effective than intensive medical therapy alone.<sup>11</sup> Patients who undergo surgical weight not only improve their medical conditions, but can also likely extend their lives.<sup>11</sup> There are also positive benefits regarding depression and night eating syndrome. Bariatric surgery has also been shown to improve evening hyperphagia, nocturnal ingestion, morning anorexia, and sleep problems.<sup>12</sup>

With the wider acceptance of gender identity in the United States, bariatric and general surgeons will likely encounter patients undergoing gender confirmation surgeries more often. There is no clearcut guideline for what body mass index reconstructive surgery can be performed on or whether it should be done before or after bariatric surgery, but many plastic surgeons prefer to perform body modification after massive weight loss, as this leads to superior results.<sup>13,14</sup> The surgeon should be aware of hormonal therapy at the time of bariatric surgery and modify venous thromboembolism prophylaxis accordingly, as this can increase the risk of a venous thrombotic event.<sup>15,16</sup> Furthermore, with proper preoperative medical management, bariatric surgery can be more safely performed.<sup>17</sup>

## CONCLUSIONS

Bariatric surgery can assist obese transgender patients in achieving a goal weight without the risks associated with primary eating disorders. The weight loss and resolution of body dissatisfaction can allow transgender patients to achieve a safer weight for gender confirmation surgeries. Transgender patients are an underserved segment of the morbidly obese population that should be offered bariatric surgery, not only for health reasons, but to also allow them to find their pathway to gender confirmation.

## References:

1. Sineath RC, Woodyatt C, Sanchez T, et al. Determinants of and barriers to hormonal and surgical treatment receipt among transgender people. *Transgend Healthb*. 2016;1(1):129–136.
2. Jones BA, Haycraft E, Murjan S, Arcelus J. Body dissatisfaction and disordered eating in trans people: A systematic review of the literature. *Int Rev Psychiatry*. 2016;28(1):81–94.
3. English WJ, DeMaria EJ, Brethauer SA, Mattar SG, Rosenthal RJ, Morton JM. American Society for Metabolic and Bariatric Surgery estimation of metabolic and bariatric procedures performed in the United States in 2016. *Surg Obes Relat Dis*. 2018;14(3):259–263.
4. Warren JC, Smalley KB, Barefoot KN. Differences in psychosocial predictors of obesity among LGBT subgroups. *LGBT Healthb*. 2016;3(4):283–291.
5. Fredriksen-Goldsen KI, Cook-Daniels L, Kim HJ, et al. Physical and mental health of transgender older adults: An at-risk and underserved population. *Gerontologist*. 2014;54(3):488–500.
6. Shields R, Lau B, Haider AH. Emergency General surgery needs for lesbian, gay, bisexual, and transgender patients: Are we prepared? *JAMA Surg*. 2017;152(7):617–618.
7. Aguayo-Romero RA, Reisen CA, Zea MC, Bianchi FT, Poppen PJ. Gender affirmation and body modification among transgender persons in Bogotá, Colombia. *Int J Transgend*. 2015;16(2):103–115.
8. The prevalence of obesity was 39.8% and affected about 93.3 million of U.S. adults in 2015–2016. Available from: <https://www.cdc.gov/obesity/data/adult.html>. Accessed August 7, 2018.
9. de la Parra Marquez M, Fernandez-Riera R. Medial Arm Flap: An Unexplored Option for Autologous Breast Reconstruction in the Setting of Morbid Obesity. *Ann Plast Surg*. 2019;82(2):190–192.
10. Khorgami Z, Shoar S, Andalib A, Aminian A, Brethauer SA, Schauer PR. Trends in utilization of bariatric surgery, 2010–2014: Sleeve gastrectomy dominates. *Surg Obes Relat Dis*. 2017;13(5):774–778.
11. Schauer PR, Bhatt DL, Kirwan JP, et al. Bariatric Surgery versus intensive medical therapy for diabetes—5-year outcomes. *N Engl J Med*. 2017;376(7):641–651.
12. Ferreira Pinto T, Carvalhedo de Bruin PF, Sales de Bruin VM, Ney Lemos F, Azevedo Lopes FH, Marcos Lopes P. Effects of bariatric surgery on night eating and depressive symptoms: A prospective study. *Surg Obes Relat Dis*. 2017;13(6):1057–1062.
13. Carloni R, De Runz A, Chaput B, et al. Circumferential contouring of the lower trunk: Indications, operative techniques, and outcomes—A systematic review. *Aesthetic Plast Surg*. 2016;40(5):652–668.
14. Song P, Patel NB, Gunther S, et al. Body image & quality of life: Changes with gastric bypass and body contouring. *Ann Plast Surg*. 2016;76(Suppl 3):S216–S221.
15. Chan W, Drummond A, Kelly M. Deep vein thrombosis in a transgender woman. *CMAJ*. 2017;189(13):E502–E504.
16. Mohammed K, Abu Dabrh AM, Benkhadra K, et al. Oral vs transdermal estrogen therapy and vascular events: A Systematic review and meta-analysis. *J Clin Endocrinol Metab*. 2015;100(11):4012–4020.
17. Kumar SB, Hamilton BC, Wood SG, Rogers SJ, Carter JT, Lin MY. Is laparoscopic sleeve gastrectomy safer than laparoscopic gastric bypass? A comparison of 30-day complications using the MBSAQIP data registry. *Surg Obes Relat Dis*. 2018;14(3):264–269.