Material and Methods: For the period of 5 years in the clinic of pediatric urology in the University Hospital Pirogov 12 feminizing reconstructions of the external genitalia were performed in children at the age between 1 and 14. We offer our method of feminizing reconstruction, which consists of:
- resection of the clitoris
- opening of introitus vaginae
- plastic reconstruction of the external genitalia – labii minoris and preputium clitoridis.

According to the size of the clitoris we performed:
- resection with termino-terminal anastomosis of the cavernous body of the clitoris, preserving the neurovascular body in the cases with smaller clitoris
- resection of the body of the clitoris, preserving part of glans clitoridis on a neurovascular body.

Results: we follow up the early and late results by means physical examination and photo documentation. The late results in all operated children are with good cosmetic result and preserved sensitivity of glans clitoridis.
Conclusions: we recommend our organ sparing method of choice for operation and tactic of treatment for the feminizing reconstruction in children.

S123
One stage metoidioplasty in female to male transgender patients: the role of genital flaps for urethral reconstruction

M. Bizic*, M. Majstorovic, V. Kojovic, D. Stanojevic, G. Korac, B. Stojanovic, M.L. Djordjevic. *Belgrade Gender Dysphoria Team, Dept. of Urology, Belgrade, Serbia*

Introduction and Objectives: Urethral reconstruction presents one of the most complex surgical procedures in metoidioplasty. We appraised the role of local vascularized genital flaps (vaginal wall, clitoral and labial skin) in urethral reconstruction as a part of one stage metoidioplasty.
Material and Methods: Total of 112 patients underwent metoidioplasty from August 2003 to February 2009. Urethral reconstruction consists of two parts: (I) creation of proximal part of the neourethra by joining of the flap formed from anterior vaginal wall and proximal part of divided urethral plate, (II) reconstruction of distal part of neourethra using different genital local flaps; in 21 cases longitudinal island clitoral skin flap was button-holed ventrally and tubularized (group 1); combined buccal mucosa graft and dorsal island skin flap was used in 33 patients (group 2), while in remaining 58 patients combined buccal mucosa graft and labia minora skin flap was used for urethral reconstruction (group 3). One stage metoidioplasty was done as previously reported.
Results: The mean follow up was 37.5 months (range 4–71 months). All patients reported voiding while standing. Comparing these different types of urethral reconstruction, better results are achieved in groups with combined buccal mucosa graft and vascularized genital flaps, especially labia minora flap, where success rate was 92%. In this group of patients fistula occured in 4 patients and was resolved three months later by minor surgical procedure. One patient had distal urethral stricture which was resolved by simple dialation.
Conclusions: Urethral reconstruction in female to male transsexuals, undergoing metoidioplasty as one stage surgical procedure, relies on appropriate and versatile use of different genital flaps. Permanent improvement in technique and results are needed for minimal complication rate. Combination of buccal mucosa graft and labia minora skin flap presents the most successful alternative for urethral reconstruction in these patients.

S124
Combined total phalloplasty and metoidioplasty as a single stage procedure in female to male gender reassignment surgery

V. Kojovic*, M. Bizic, M. Majstorovic, S. Kojic, D. Stanojevic, G. Korac, M. Djordjevic. *University of Belgrade, School of Medicine, Belgrade, Serbia*

Introduction and Objectives: Total phalloplasty includes creation of neophallus from an extragenital tissue, large enough to enable insertion of penile prosthesis and penetration during sexual intercourse. Urethroplasty, which enables voiding in standing position, is performed later on, in separate stages. Metoidioplasty presents creation of small phallus, from hormonally enlarged clitoris, which enables voiding in standing position, but without possibility for sexual intercourse. We evaluated advantages of combining phalloplasty and metoidioplasty as one stage procedure.
Material and Methods: Between May 2007 and June 2008, five female transsexuals, aged 26–42 years (mean 35 years) underwent one stage phalloplasty combined with metoidioplasty. Surgery included: removal of internal/external female genitalia, creation of neophallus using microvascular latissimus dorsi free flap, clitoral incorporation into the neophallus, urethral lengthening and insertion of testicle prosthesis into the scrotum created from joined labia majora. Penile prosthesis insertion is planned for the next stage.
Results: Follow-up was from 11 to 21 months (mean 15 months). The length of neophallus ranged from 14–17 cm with circumference from 12–15 cm. There was no partial or total necrosis of the phallus. All patients obtained voiding in standing position. Urethral fistula occurred in one case and repaired 3 months later.
Conclusions: Combined total phalloplasty and metoidioplasty is feasible and safe surgical procedure. The main advantage is complete reconstruction of neophallus that avoids multi-staged gender reassignment procedures in female to male transsexuals. Our results confirmed successful outcome.

S125
Functional and esthetic reduction of hyperthrophied labia minora

M. Bizic*, V. Kojovic, M. Majstorovic, G. Korac, M.L. Djordjevic. *School of Medicine, University of Belgrade, Dept. of Urology, Belgrade, Serbia*

Introduction and Objectives: Hypertrophied labia minora can be functional or psychosexual problem. Local irritation, hygiene problems, difficulties during sexual intercourse as well as aesthetical appearance are generally accepted as indications for surgical correction. We present our results in the reconstruction of hypertrophied labia minora.
Material and Methods: Between May 2004 and January 2009, 19 women, aged 18 to 36 years (median 21) underwent surgical correction of hypertrophied labia minora. The majority of the patients (17/19) were dissatisfied with the appearance of their labia. Two patients presented pseudo incontinence due to urinary retention in vulvar and vaginal space. Excessive parts of both labia minora are removed including part of the clitoral hood to reach better esthetical appearance. The desired length of the labia minora is preoperatively discussed with the patient and the difference between the levels of the labia minora and labia majora is kept to be no less than 1 cm. The wound is sutured using running 6–0 resorbable suture. Compression dressing is applied for the first week to prevent swelling and haematoma.
Results: Follow-up ranged from 6–61 months (median 28 months). Good esthetic results with symmetrical reduced labia are achieved in all patients. In two patients with