

consider additional avenues like social media to perform additional outreach to potential applicants.⁵ These and related interventions may help to optimize applicant-program fit.

Study limitations include small sample size, limiting comparison between websites. Future directions of this work may include assessing whether improved content quality on these websites increases application numbers or affects applicant attitudes toward a given program. Our findings suggest that increased usage of program websites with comprehensive information may benefit both transgender fellowship training programs by increasing their visibility, as well as prospective applicants by informing their decision-making.

Ethical approval

Not required.

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Declaration of Competing Interest

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Comments on: “Immediate vaginal and perineal reconstruction after abdominoperineal excision using the Inferior Gluteal Artery Perforator Flap (V-IGAP)”



Dear Sir,

We read with interest the study by Johal et al., reporting a case series of 22 patients who underwent to Abdominoperineal Excision (APE) and immediate reconstruction using the Inferior Gluteal Artery Perforator (IGAP) flap for perineal and vaginal reconstruction¹. We agree that this study is very interesting and may be useful in the plastic surgeon's therapeutic arsenal.

There are many flap choices for perineal and vaginal reconstruction after APE, each one having advantages and drawbacks. According to vast literature, one of the most used and studied fasciocutaneous flaps for this purpose is the Internal Pudendal Artery Perforator (IPAP) flap (also called “lotus petal” or “gluteal fold” flaps), with hundreds of patients reported in cohorts and case series²⁻⁴.

We would like to highlight some advantages related to the IPAP flap for the perineal and vaginal reconstruction, compared to others such as the IGAP flap. The cutaneous sensibility of IPAP flap is preserved in perineal reconstruction after APE, according to what we previously published in 2015. This is because its source of innervation (given by branches from the pudendal nerve and the posterior femoral cutaneous nerve) can be preserved during the harvesting of the flap⁵. Maintenance of the flap sensation is important in these cases because the flap will be located in an area of support during the act of sitting, and it has other benefits for the simultaneous reconstruction of vulva and vagina. These and other advantages associated with IPAP flap reinforce the idea that it is reliable and versatile. Besides, the scar from its donor area can be hidden on the gluteal fold, and the flap can be harvested in the prone or supine positions.

In 2017, we published the biggest consecutive series of patients (to our knowledge) using IPAP flap only for perineal reconstruction after APE, presenting the outcomes with 122 immediate IPAP flap reconstructions for 73 irradiated APE defects⁴. Based on its reliability and versatility, we have proposed that IPAP flap can be considered as the first choice for perineal and vulvovaginal reconstruction in patients with moderate and some large defects after APE⁴. We agree that the IGAP flap (as proposed by Johal et al.) is another option for plastic surgeons and should be adopted mainly regarding larger perineal defects, situations in which the IPAP flap may not offer enough tissue volume for reconstructive surgery.

Abbreviations: COP26, The 26th UN Climate Change Conference; WALANT, Wide-awake local anaesthetic no tourniquet.

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