Current options for male-to-female gender confirmation surgery focus on available in addressing gender dysphoria. Uterus transplantation has the potential to expand capacity and quality of care to be personalized to each patient. No uniform clinical course or set of goals of The experience of gender dysphoria is individualized and requires goals of female function: gestation.

As this is a departure from previous treatment paradigms it is important to consider the ethical implications for all stakeholders involved:

- **Patient Autonomy**
  - Risks of immunosuppressive therapy
  - Risks of gestational state
  - Childrearing as gender identity

- **Offspring Consent**
  - Potential risk to psychological health
  - Unpredictable hormonal interactions
  - Predetermined asent

- **Society and Culture**
  - Acceptance of transgender individuals
  - Reconstructive transplants growing in popularity
  - Paradigm shift in healthcare policy

- **Professional Virtues**
  - Ability to treat hinges on public trust
  - Duty to treat for public’s best interest
  - Transparency to be critical

**Medical Team**

A procedure of this complexity requires an interdisciplinary medical team with combined experience in transplantation, reconstructive surgery, and transgender care. Members might include plastic surgeons, reconstructive gynecologists and urologists, endocrinologists, psychiatrists, social workers, pharmacologists and immunologists.

**Medical Center**

A medical center that has an established culture of providing transgender care is an appropriate environment for this procedure. A supportive staff throughout all phases of care affirms the institution’s commitment to this patient population.

**Patient & Community**

Futuristous patient selection is crucial to the success of any operation. This procedure is as unique as the individual and can only succeed in a supportive community where transgender patients are given honest informed consent of risks, benefits, and realistic expectations of undergoing this experimental operation.

This patient selection framework was adapted for transgender patients.6

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Role of Uterus Transplantation in Transgender Care

Surgical options for patients with gender dysphoria aim to reduce associated psychosocial stress by aligning the patients’ phenotypic preferences with their genotypic expression to aid with integration into society. Patients have the opportunity to undergo a variety of procedures altering facial, body and genital structures.

Uterus transplantation would be unique in large part due to its potential for gestation. Such did Lili Elbe desire the experience of gestating that she became the first transgender recipient of UTx;1 albeit, it led to her untimely death. Almost 90 years later, UTx has successfully been performed and has led to multiple live births.2 A gender transition plan must consider known risks in cisgender females and patient preferences for other gender confirmation surgery.

It is critical that providers distinguish reproductive desire in transgender patients exploring surgical options. Recommendations for bottom surgery could follow two treatment paths based on the goals of care discussions. Patients unsure of their future gestational preferences may choose to delay bottom surgery until their decisions have solidified.

Adoption
Currently, no laws explicitly prohibit the adoption of children by transgender women. Protection is scarce as only 5 states, Guam and Washington D.C. have laws which explicitly prohibit discrimination against prospective adoptive parents based on gender identity; meanwhile, 42 states and 3 territories are silent on the issue. Notably, 10 states allow child welfare agencies to refuse prospective parents on the basis of religious beliefs.

In Vitro Fertilization
No explicit legal barriers exist for transgender individuals seeking to become parents via in vitro fertilization and surrogacy. Only 11 states and Washington D.C. recognize non-gestational parents as legal guardians regardless of marital status. This limits access for transgender women that transitioned and cannot contribute genetic material to gestation;3 and, may prohibit legal recognition as parents should they chose to have a child through IVF.

Anatomical and Physiological Considerations
Differences between gynecoid and non-gynecoid pelvic anatomy have been discussed. Propositions have included adapting vasculature anastomosis and structural support sites. The complex interactions of transgender hormone therapy and reconstructive transplantation could conflate viability assessments and increase risks to mother and child. Adoption of novel techniques and further research could increase safety and likelihood of success of UTx in a non-gynecoid pelvis.


Political & Legal Considerations for Childrearing in Transgender Women

Surgical Technique
• Adoption of laparoscopic procurement could improve allograft quality and increase living donor organ pool4

Imaging Technique
• Advances in preoperative computerized surgical planning, 3D printing technologies, and intraoperative navigation have been used in face transplant5

Immunosuppressive Technique
• Minimize graft time and risks by optimizing immunosuppression to facilitate earlier embryo transfer6

Transplantation Technique
• Creation of optimized gestational environment with an en bloc utero-vaginal allograft7