

tion was ultrasound (80%), followed by an MRI (60%), and finally, CT (30%). Pharmaceutical hormonal suppression prior to definitive treatment consisted of GnRH agonist/antagonists (60%), oral progestin (30%), and continuous OCP's (10%). For undiagnosed patients, surgical management primarily occurred via a two-step process, though 22% of the patients underwent a one-step technique. Definitive surgical management of the obstruction occurred 23 months (± 12) after initial diagnosis. The procedure took 7.8 hours (± 4.2) to complete and most commonly required three surgeons from pediatric and adolescent gynecology, pediatric surgery, and pediatric urology. Average postoperative hospitalization was 7 days (± 3). The most common postoperative complications were restenosis (33%), vaginal infection (11%), and fistula (11%). The cohort underwent an average of three total surgeries and were followed for about 3.4 years (± 3.1) after definitive surgery.

Comments: Our case series provides new information regarding the diagnosis and definitive management of 10 girls with complex obstructive Müllerian anomalies. Management of this type of anomaly requires hormonal suppression, multiple prolonged surgeries, and multidisciplinary care. Further elucidation regarding the presentation and care for this population will aid in swift diagnosis and a stepwise standardization of management.

Supporting Figures or Tables

<https://www.abstractscorecard.com/uploads/Tasks/upload/19245/RGXGDRUQ-1372492-1-ANY.pdf>

<https://www.abstractscorecard.com/uploads/Tasks/upload/19245/RGXGDRUQ-1372492-2-ANY.pdf>

18. Non-healing vulvar ulcer in a toddler

Olga Kciuk, MD, MSc¹, Nichole Tyson, MD²

¹Stanford Medicine Children's Health

²Stanford University

Background: Although most vulvar ulcers represent an acute process, persistent vulvar ulcers require the pediatric and adolescent gynecologist (PAG) to consider systemic and neoplastic processes. The objective of this case report is to describe workup of non-healing vulvar ulcers in the prepubertal patient.

Case: The patient was referred to a tertiary care PAG clinic at the age of 16 months for evaluation of vulvar lesions. She was born at 40w1d gestation by emergent cesarean section for fetal bradycardia. During labor, her mother had an oral lesion and positive herpes simplex virus (HSV) IgG, with otherwise normal serology. Maternal history was negative for vulvo-vaginal lesions as was physical exam at the time of labor. At birth, the patient had a vulvar lesion noted and was treated with acyclovir until one month of age for suspicion of congenital HSV infection. At 12 months of age, the vulvar lesion persisted and was further characterized by an infectious disease specialist as bilateral, raised, and rubbery with demarcated margins and fungating surface, and diagnosed as a congenital anomaly. HSV swab was negative. At 16 months of age in PAG clinic, the patient's mother described yellowish exudate from the lesion. There was no bleeding and the patient was easily consolable after wiping. No change in size had been noted over time. No other gastrointestinal or systemic symptoms were present. The patient had been seen by otolaryngology for enlarged adenoids, treated with Flonase. Family history was otherwise unremarkable with no known autoimmune disease. On physical examination, the sexual maturity rating was Stage 1. At 5 and 7 o'clock on the labia majora, symmetric bilateral ulcerations were seen measuring approximately 1cm each, with white exudate at the bases, no bleeding and no surrounding erythema (see Figure 1). Workup of non-healing ulcers present from birth requires biopsy (which for this patient has been delayed due to family circumstances) to rule out neoplastic processes such as granular cell tumor or nodular fasciitis. Other etiologies under consideration include infectious (eg. herpes simplex virus, syphilis, Epstein-Barr virus, cytomegalovirus, mycoplasma, bacterial and fungal cultures), autoimmune (eg. Crohn's) and nutritional deficiencies (eg. vitamins A, B12, C, D, folate, zinc, copper).

Comments: For non-healing vulvar ulcers in a toddler, the differential diagnosis should be widened from infectious causes to include autoimmune conditions, nutritional deficiencies, and neoplastic processes. If the biopsy for this patient is consistent with granular cell tumor or nodular fasciitis, it will be the first described case of congenital presentation of these vulvar neoplasms.

Supporting Figures or Tables



19. Affirmative medical treatment and contraception choice in a cohort of gender diverse adolescents assigned female at birth

Andreanne Jodoin, MD¹, Janie Kelley, BSN¹, Ingrid Stoyanova Brunet¹, Nicholas Chadi, MD, MPH², Lyne N. Chiniara, MD, MA², Afnan Al-Saleh²

¹Université du Québec à Montréal

²CHU Sainte-Justine, Université de Montréal

Background: In the past two decades, there has been a rapid increase in the number of referrals at gender diversity clinics. Youth and their families may be presented with a wide range of cosmetic, medical, and surgical treatments. Little is known about the specific needs of gender diverse youth assigned female at birth (AFAB) receiving care in these clinics. Our goal was to describe treatment provided to this specific population and assess clinical outcomes.

Methods: We conducted a retrospective cohort study in a large tertiary care gender diversity clinic located in Quebec, Canada. All patients assigned female at birth seen at the clinic between November 2016 and May 2021 were included. We analyzed patients from 10 and 18 years-old at the time of the initial consultation. A retrospective chart review was completed regarding population characteristics, medical and surgical treatments with their respective outcomes according to clinical and biochemical criteria. Local IRB approval was obtained.

Results: A total of 187 patients were included, with a mean age of 14,9 years-old at first consultation. Duration of follow-up varied from 0 to 1 499 days (Mdn=504 days). 80% of our population identified as binary male gender at first and for 82,9%, identity did not change over the follow-up time. 88% had their menarche before or during the follow-up. Regarding medical treatment, 15% received no treatment at all, 42,8% received GnRH agonist, and 48,1% received testosterone at one point in their follow-up. Binary transmale were more likely to receive testosterone (55,3%) but less likely to receive GnRH agonists (44%) compared to non-binary gender individuals (20% and 63,6%). The mean age at initiation of GnRH agonists was 14,3 (9,8-17,9) years-old. 89,5% of patients receiving GnRH agonists has a monotherapy experienced amenorrhea as opposed to 56,6% of patients who received testosterone only. Levels of LH showed significant decrease (6,29 to 0,61 U/L) 3 months after initiation of GnRH agonists but almost no change 3 months after testosterone initiation. Estrogen levels showed similar patterns. Regarding surgical treatment, 1,1% of our population did not express desire to have a mastectomy while 5,9% went through the surgery during the study period.

Conclusions: Young AFAB in gender diversity clinics have complex gynecological needs which may vary with fluidity of gender identity. Patient goals and gender affirming-approach have to be at the center of our care and discussions. There is a need for additional studies to better understand the clinical outcomes of affirmative medical treatments and the impact on the well-being of young AFAB.

20. Reproductive health counseling and contraceptive use in adolescents with sickle cell disease

Angie Hamouie, MD, MPH

Baylor College of Medicine, Texas Children's Hospital

Background: Sickle Cell Disease (SCD) is a group of inherited red blood cell disorders characterized by microvascular ischemic injury and vasoocclusive pain crises. SCD has a number of impacts on the adolescent period. Menstruation can trigger pain crises and those with SCD have heavier than average menstrual bleeding. Patients with SCD are also more likely to use teratogenic medications (especially hydroxyurea) and face poorer maternal health outcomes during pregnancy and delivery. All of this highlights the need to understand the rate at which adolescents with SCD are being screened for menstrual issues and sexual activity and whether they are being adequately counseled on menstrual suppression and/or contraception.

Methods: This is an IRB- approved retrospective chart review of patients with a diagnosis of SCD seen in the hematology department at Texas Children's Hospital between September 1st, 2011 through September 30th, 2021. Descriptive statistics were used.

Results: A total of 611 charts met our inclusion criteria. Patients were excluded if they were younger than age nine at the time of their first hematology outpatient visit and if they had less than two visits total. Of all patients, 67% were asked about menstrual status. Two thirds were asked about sexual activity, 30% of whom reported sexual activity. Only 40% of those sexually active were counseled on pregnancy risk with SCD and offered contraceptive options. 71% of patients were started on hydroxyurea, but only 20% of those were counseled on its teratogenicity. 42% of patients were referred to gynecology however only 24% presented for a first visit. A total of 33% of patients were on contraception, with the top two indications being sexual activity and menstrual disorders. Of those on contraception, 50% took up the medroxyprogesterone acetate injection. Only 19% had a long-acting reversible contraceptive in place at some point during their care (levonorgestrel IUD or etonogestrel implant).

Conclusions: This research demonstrates that patients with SCD are not consistently screened for menstrual status or sexual activity, nor are they consistently counseled on adverse outcomes of pregnancy while on teratogenic medications, such as hydroxyurea, or as a result of SCD itself. However, for the minority of patients who are referred to gynecology, they do receive adequate counseling regarding options for menstrual suppression and pregnancy prevention. But even after counseling, patients with SCD take up long-acting reversible contraceptive options at lower rates than they do high failure methods, placing them at increased risk of unintended pregnancy.

21. Barriers to Healthcare Access for Adolescents and Young Adults Formerly in Foster Care and Impact on Reproductive Health

Julia C. Durante, MD¹, Kimberly Stone, MD, MPH¹, Anubha Sood, PhD², Parker Brady³, Amy Six-Means, MLIS⁴

¹ University of Texas Southwestern Medical Center, Children's Medical Center

² Peter O'Donnell Jr. School of Public Health, University of Texas Southwestern Medical Center

³ University of Texas Southwestern Medical Center

⁴ Children's Medical Center

Background: Adolescents in foster care and young adults formerly in foster care (AYAFC) face unique challenges in accessing medical care during the transition out of foster care into adulthood. How AYAFC and stakeholders perceive the material and psychological barriers to healthcare access is poorly understood, as is the impact of these barriers on sexual and reproductive health (SRH). This study aimed to identify critical barriers to healthcare access for AYAFC transitioning out of foster care.

Methods: This qualitative study recruited AYAFC and stakeholders involved in supporting foster care transition in North Texas to participate in focus groups. Recruitment of AYAFC participants occurred through community agencies serving transition-age youth. Stakeholders, including foster parents, caseworkers, healthcare professionals, and representatives of a wide range of organizations involved in the foster care transition process were recruited using convenience sampling. The focus group guide addressed domains of experiences accessing healthcare, existing health resources, and transition needs. Focus groups were recorded, transcribed, and analyzed with NVivo software to identify themes emerging from the discussions. This study was approved by the Institutional Review Board.

Results: Five focus groups of AYAFC and stakeholders were conducted, comprised of 2-6 participants each (N=22), with two participants electing to complete an individual interview. Five major categories of barriers to healthcare emerged: psychological barriers, cognitive barriers, logistic barriers, organizational barriers, and financial/insurance barriers. These primary healthcare access barriers were seen to secondarily impact SRH. Focus group participants discussed barriers such as trauma-based fear of making or keeping gynecologist appointments, lack of perceived autonomy, dependence on caregivers to pick up contraceptive prescriptions, transportation challenges, and lack of school-based sexual education.

Conclusions: AYAFC face multifactorial barriers in accessing healthcare that consequently impact access to SRH care. Qualitative methods can empower partnering with AYAFC and stakeholders to identify these challenges and create solutions to improving healthcare access. An improved understanding of these access barriers may help the SRH of AYAFC by addressing gaps in contraceptive care, supporting trauma-informed care, and advocating for autonomy and reproductive justice. Future studies should examine interventions to reduce logistic and organizational barriers, promote resilience, and improve access to quality healthcare for young adults transitioning out of foster care.