From dysphoria to dignity: A case report on bilateral double incisional mastectomy with free nipple-areola graft in a transgender male

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ABSTRACT

Gender-affirming chest surgery is one of the procedures in the management of transgender male with gender dysphoria. Bilateral double-incision mastectomy with free nipple–areola complex (NAC) grafting is commonly indicated in individuals with large or ptotic breasts to achieve better outcome. We report a case of a transgender male who underwent bilateral double-incision mastectomy. Preoperative assessment was performed using World Professional Association for Transgender Health (WPATH) Standards of Care Version 8 (SOC-8). The procedure involved excision of breast tissue via inframammary incisions, contouring of the chest wall, and harvesting and grafting of the NAC as full-thickness grafts at anatomically appropriate positions. The postoperative period was uneventful, with satisfactory graft uptake and good patient satisfaction.

This procedure is a safe and effective technique for chest masculinization in transgender men with moderate to large breasts. It provides reliable aesthetic results with acceptable complications, when performed with appropriate patient selection and surgical expertise.

Keywords: Chest masculinization, double-incision mastectomy, free nipple–areola graft, gender-affirming surgery, transgender male.

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INTRODUCTION

Gender incongruence is defined as marked and persistent incongruence between an individual's experienced gender and their gender assigned at birth.[1] A transgender male is a person who was assigned female at birth (AFAB) but identifies himself as a male. Gender dysphoria refers to the distress or impairment that may occur when a person's gender identity is incongruent with their sex assigned at birth or primary/secondary sex characteristics.[2] Gender-affirming surgery (GAS) is a medically necessary intervention for transgender individuals, significantly improving psychological well-being and quality of life.[3] In low- and middle-income countries (LMICs), access to GAS remains limited due to resource constraints, lack of trained professionals, and social stigma.[4] Nepal, despite legal recognition of gender diversity since 2007, had no structured surgical pathway for transgender care until 2025 when the first gender affirming surgery was performed at Tribhuvan University Teaching Hospital.

CASE REPORT

A 28-year-old transgender male, assigned female at birth, presented

with a 5-year history of gender dysphoria. He had not undergone hormone therapy. He was experiencing repeated distress from using a chest binder to achieve masculine chest contour. Preoperative chest assessment revealed bilateral cup size D breasts with moderate ptosis and poor skin elasticity. The patient was referred to the psychiatrist for the evaluation and hence diagnosed with gender incongruence. After explaining in detail about the procedures, complications and other treatment option, the patient provided written informed consent. The patient opted for chest masculinization via bilateral double-incision mastectomy with free nipple-areola grafting.

SURGICAL TECHNIQUE

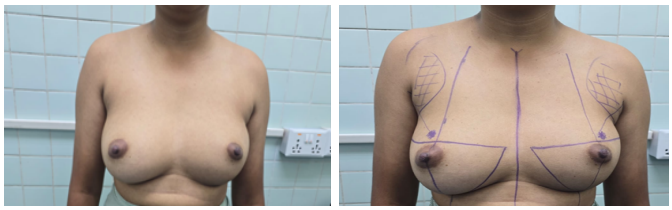

Figure 1: Preoperative views with and without surgical markings

Under general bilateral horizontal incisions were placed along each inframammary fold independently, preserving a midline skin bridge between the two incisions. Breast tissue was excised, and the NAC was harvested as a full-thickness graft. The harvested NAC grafts were trimmed to a circular diameter of 2.5 cm to achieve standard masculine nipple-areola dimensions. After achieving hemostasis, the grafts were resized and repositioned at 2.5 cm superior to the inferior border of the pectoralis muscle and 2.0 cm medial to the lateral border of the muscle. Drains were placed bilaterally, incisions were closed in layers and skin was closed in subcuticular absorbable suture. The total duration of surgery was three hours with estimated blood loss of 200 ml.

POST-OPERATIVE PERIOD

The patient was monitored on general ward for 5 days. Drains were removed on the fourth post-operative day. The first dressing of free NAC was done on the fifth post operative day and patient was discharged on same day. He was advised to follow up on at 2 weeks, 1 month, 3 months, 6 months and 1 year. Graft viability was satisfactory with aesthetically masculine chest contour. During follow up patient was assessed for complications like hematoma, seroma. Up to 3 months of follow up, no complications were identified and patient reported high satisfaction with both physical appearance and psychological outcomes. Although patient did not receive hormone therapy, postoperative outcome was not adversely affected.

Figure 2: Post-operative chest appearance at three-month follow-up

DISCUSSION

Gender-affirming surgery plays a crucial role in alleviating gender dysphoria and improving the quality of life among transgender individuals. Chest masculinization is the most commonly chosen procedure by transgender male, as it significantly contributes to the external appearance consistent with gender identity.[5] Various surgical techniques have been described for chest masculinization like peri areolar, keyhole, and double-incision mastectomy. The choice of procedure depends on breast size, skin elasticity, and degree of ptosis. The double-incision mastectomy with free NAC grafting is a procedure of choice for patients with large breasts, excess skin, and poor skin elasticity. This technique allows for adequate removal of glandular tissue and redundant skin, as well as precise repositioning of the NAC to achieve a more masculine chest contour.[6]

Pre-operative assessment of our case was done using WPATH SOC-8, including psychosocial readiness, informed consent, and surgical planning.[3] Surgical technique used in our case was double-incision technique. Although this technique is associated with complications like graft loss, altered pigmentation, and reduced nipple sensation, our case demonstrated satisfactory graft uptake and acceptable cosmetic results without any complication.

The outcomes in our case are consistent with published literature on double-incision mastectomy with free nipple–areola grafting. A study of 72 cases reported low overall complication rates, with major complications such as hematoma and infection occurring infrequently and most patients achieving satisfactory chest contour.[7]Similarly, large cohort data involving over 400 patients demonstrated that the double-incision technique has lower complication rates (around 18–21%) and fewer reoperations compared to peri areolar approaches, supporting its role as the preferred technique in patients with large or ptotic breasts.[8] In addition, studies comparing techniques have shown lower revision rates and better aesthetic outcomes

with free nipple grafting compared to other methods. Our case aligns with these findings, demonstrating excellent graft uptake, absence of complications, and high patient satisfaction, thereby reinforcing the safety and effectiveness of this technique even in resource-limited settings.

Notably, the absence of hormone therapy did not adversely affect surgical outcomes in our case, challenging the assumption that testosterone therapy is essential prior to chest masculinization. This observation aligns with the evolution of the World Professional Association for Transgender Health (WPATH) Standards of Care. Earlier versions, particularly SOC-6, placed greater emphasis on hormone therapy as part of the transition process, although it was not an absolute prerequisite for chest surgery. In contrast, SOC-7 and the more recent SOC-8 have adopted a more flexible, patient-centered approach, clearly stating that hormone therapy is not mandatory for chest masculinization surgery.[3] This shift reflects growing evidence that satisfactory surgical and psychosocial outcomes can be achieved without prior hormonal treatment, especially in patients who either decline or have contraindications to hormone therapy.[9]

This case demonstrates the feasibility of gender-affirming chest surgery in a resource-limited setting. Institutional support, multidisciplinary collaboration, and adherence to SOC-8 principles were critical to success. Significant challenges remains, including stigma, lack of national guidelines, and limited long-term follow-up data. Expanding GAS services in LMICs will require investment in training, public funding, and community engagement.

LIMITATIONS

This case report is limited by its single-patient design and short follow-up period, precluding assessment of long-term outcomes such as scar maturation and NAC sensation recovery. Psychosocial outcomes were not evaluated using validated objective measures.

CONCLUSIONS

Bilateral double-incision mastectomy with free NAC grafting is a safe and effective technique for chest masculinization in transgender men with moderate to large breasts. This case suggests the feasibility of performing gender-affirming chest surgery in a resource-limited public healthcare setting. Wider implementation will depend on policy support, workforce development, and culturally sensitive care models.

Written informed consent was obtained from the patient for the publication of this case report, including clinical photographs and all identifying clinical details, in accordance with the ethical standards of Tribhuvan University Teaching Hospital.

CONFLICTS OF INTEREST: None declared

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