

Gender Reassignment Surgery - Male to Female

Transsexuals do not actually have a choice. It is the way they are born. Something goes wrong when they are developing in the womb that ultimately leads to them feeling that they are a woman. For one in 10,000 of the population, a hormonal imbalance in the uterus about six to nine weeks after conception is where it all starts. However, this is discovered only when puberty kicks in and the body starts to head off down a route that is diametrically opposed to the lifestyle that the person wants to lead.

Many transsexuals go through periods when they attempt to suppress or deny their condition. Some choose hobbies or jobs that are hyper-masculine in order to try to prove that they are not transsexual. On the other hand, a few recognize their condition, come to terms with it and take steps to rectify their situation through GRS.

The decision to change their gender through surgery is a monumental one and cannot be easily made or implemented. All males cannot change their Gender to female and vice versa. When a person has a few features of a male body, e.g. penis while most of the other features such as breasts, lack of testes etc. are female, then depending on a case to case basis, the option of MtF GRS can be considered. In the old days, this was practiced through castration (see page.....) , where the penis was severed and no vagina was created. The person lived like a girl but she never had penetrative sex. There's more to a male to female gender change operation than simply snipping off the penis. Present day MtF GRS primarily involves psychological changes, hormone therapy, the surgical procedure of creating a vagina in the place of the penis, facial feminization surgeries, such as rhinoplasty, breast augmentation and other procedures.

A complete transition from male to female (including GRS) takes at least two or three years and often longer. The transsexual transitioning process begins with guidance and counselling, peer support and then the initiation of hormonal feminization. A broad

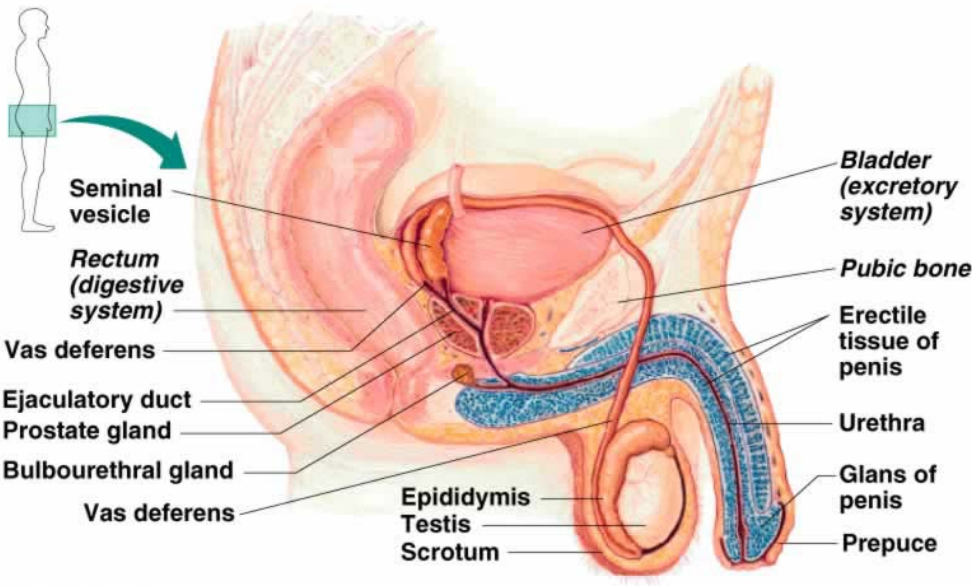
outline of this process has been given from a layman's perspective, purely for academic interest.

Many TS women evaluate surgeons from all over the world before deciding on where to go for critical procedures such as GRS. Due to differences in the cost of quality medical care, especially the cost of surgeries, many people in expensive countries such as USA / Japan go to countries such as Thailand for treatment.

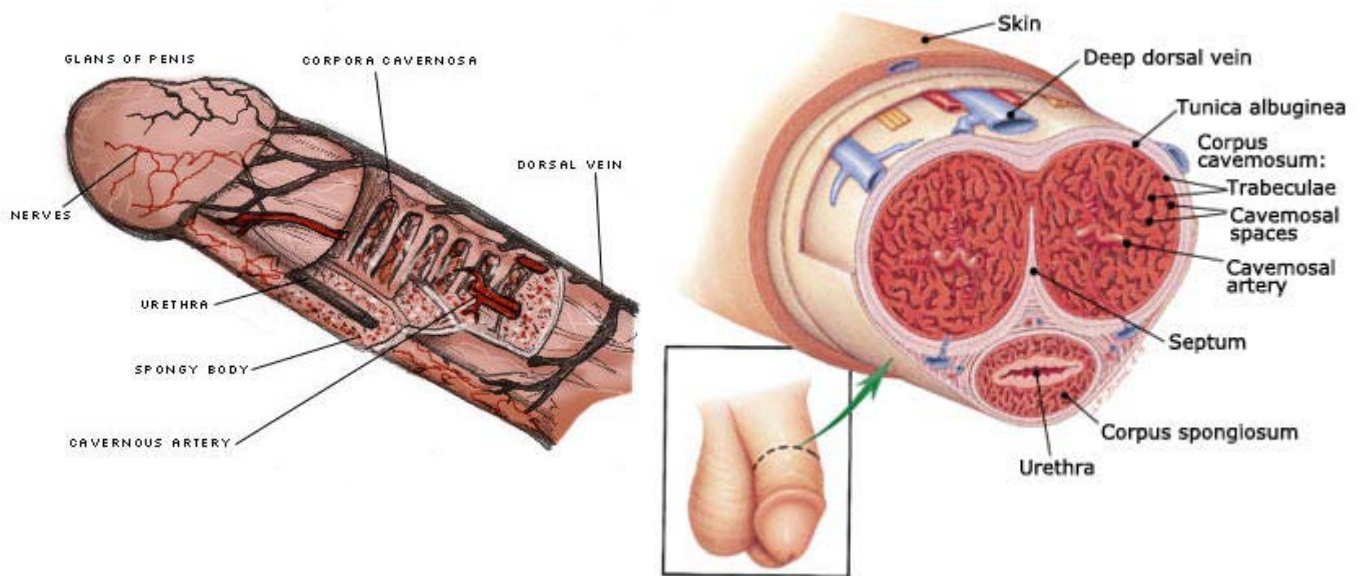
The Development of Modern GRS

With rapid advances in the knowledge of sex hormones and plastic surgery following World War II, it finally became possible to contemplate complete medical and surgical solutions for transsexualism. Initially, transsexual women began to benefit enormously from the newly available female sex hormones, which enable the development of breasts, soften the skin and over time produce female body contours. Later, a few surgeons began exploratory surgeries to construct vaginas in MtF transsexuals by using skin grafts taken from the thighs or buttocks. For this, they relied upon recently developed techniques for constructing vaginas in intersexed girls.

The modern form of penile inversion for MtF GRS uses the male genitalia as source of skin and sensitive erotic tissue to create the new female genitalia, including the vagina. Variations of this technique have been used ever since.



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Among the keys to the success of these surgeries were (i) the use of the skin of the penis and scrotum to form the new labia and a sexually functional vagina (thus avoiding the source area disfigurement caused in earlier operations by the use of large, deep skin grafts) and (ii) the careful dissection and placement of the terminated corpora cavernosa and the saving and relocation of some of the sensitive nerves and a small amount of erectile tissue. If done properly, the post-operative patient can have powerful feelings of sexual arousal (erection of the corpora stumps remaining inside her body)

and can easily be orgasmic (the prostate is left intact and can spasm during orgasm just as before GRS - while the nerve tissues throughout the corpora, the clitoris and the vulva spasm, throb and release at the same time, just as in any other woman).

The Necessity of GRS

Contrary to popular myth, total external emasculation after puberty does not necessarily 'de-sex' the person. Complete castration after puberty leaves the young eunuch and TG/TS with her newfound feelings of sexual arousal and her newfound orgasmic capabilities. While the psychological impact of such surgery would usually cripple the libido of a normal male, the effect on a young transsexual girl is usually just the opposite. The surgery can be liberating and can enable a fuller expression of her sensuality and her female libidinous feelings. Just as in the case of modern post-operative transsexual women, many eunuchs can have strong feelings of sexual arousal in the inner remnants of their genitalia (even though they lack the external nerve tissue left by modern GRS, they retain the internal portions of the erectile corpora cavernosa and of course the prostate, with its spasmodic orgasmic capabilities). Although eunuchs lack vaginas, many greatly enjoy (to orgasm) penetrative (anal) sexual activities with men. Because of their complete external emasculation, eunuch genitalia and pelvic regions look very 'girly' and many men in India greatly enjoy lovemaking with them.

What is the Right Age for GRS?

A good number of parents having children of ambiguous genitalia feel the urgent need for a surgery to partially correct the issue. They feel this need so that the wounds heal at younger age and by the time, the child reaches puberty, s/he has normal gender. Therefore, a number of parents seek information and guidance concerning 'gender reassignment' surgery in their children. It may be appreciated that parents are motivated by the desire to minimize any psychological trauma in their child associated with having atypical genitalia and by the earnest concern that their child should 'fit in' with his or her peers. Psychological counseling and peer support from other intersex individuals in childhood and early adulthood are absolutely critical to achieving a positive outcome.

However, the same assurance cannot be given regarding surgical intervention in infancy/childhood.

The practice, advocated by some clinicians, of performing vaginoplasty in infants/children will not yield the expected results for the most part. Vaginal surgery, like that of gonadectomy in infancy/childhood, has more to do with parents (and clinicians in some cases) not wanting to face telling a teenager the truth about her diagnosis, than with obtaining the best possible psychosexual outcome for the patient.

Evaluation of the intersexed child should preferably be performed by a gynaecologist, a pediatrician, a urologist and a plastic surgeon before a GRS is done on a child.

Embryology of a Foetus

During foetal development in females, the Mullerian ducts mature into the Fallopian tubes, uterus, cervix and upper third of the vagina (the so-called 'Mullerian organs'). The lower part of the vagina is derived from a primitive structure called the urogenital sinus, which comes from the perineum. In males, the Mullerian ducts regress under the influence of a hormone, Mullerian Inhibitory Factor or MIF, secreted by the developing testes.

In AIS, although the testes fail to cause masculinization of the external genitalia, they do produce sufficient MIF to suppress development of Fallopian tubes, uterus and upper vagina. The upper third of the vagina is invariably missing but the lower two-thirds may be fully developed and sufficient for intercourse. The reason is not clear but in some cases the vagina may be even shorter, perhaps only a few centimeters or even just a 'dimple'.

What is a Normal Vagina?

It should be noted that because of the vagina's natural elasticity and its tendency to expand with arousal, the unstretched length of the vagina is usually less than the length it achieves with penetration. A survey revealed average quoted lengths ranging from 9 to 11 cm for the longest (posterior) wall in normal women with XX chromosomes. Indian

doctors give the minimum length as equal to 7 cm below which patients and their partners had problems in achieving intercourse (see page _____).

Assessment and Counseling

In pubertal girls with AIS, contrary to GRS the issue of vaginal hypoplasia should not be ignored or deferred until a girl is considered old enough to begin her sex life. Some discover a short vagina through self-examination and can live in fear and isolation with this secret for many years. Others have experienced the trauma of a failed attempt at intercourse. If a girl perceives that she is unable to have penetrative sex due to a short or absent vagina, her conclusion may be that she will be forever ineligible to be anyone's sex partner. This can lead to depression and prevent normal social development.

Counseling, with the goal of preventing such occurrences by providing information, should be given near the age of puberty. The girl should be informed truthfully of her anatomical situation and concurrently told what treatment is available.

Before advice is given, an examination should be made to assess vaginal length. The author met girls who were caused needless anguish by being mistakenly told that they would require surgery to have intercourse, when they actually required no treatment at all or vaginal dilation at maximum.

Patients who are suitable for Gender Reassignment must meet the following specifications:

1. Must be HIV negative.
2. Have been living for at least one year full-time in the new gender role. Living in this role should be complete and successful.
3. Live with desire for being the other gender for more than 2 years.
4. Take hormone therapy for at least 6 months.
5. Obtain a recommendation from a psychiatrist or therapist.
6. Have a negative attitude towards your current sexual organs.
7. No psychiatric illness.

STEP One: Counselling

Counselling is essential, not only to enable an improved understanding of the issues that the transsexual is born with but also his/her 'quality of life' plus the smooth and successful management of all issues pertaining to the transition. It enables transsexuals to understand the birth condition that they suffer, its origins and as a result, for them to be able to live as comfortably as possible, without low self esteem, guilt, confusion and the knowledge that it is a birth condition - not deviant behaviour. They understand that gender diversity is not a traditionally thought of mental illness, but is a birth condition which can nurture depression, anxiety and stress related mental health conditions, which can arise directly from it.

A program of individualized counselling and assessment is very essential to get advice and support for the patient wishing to explore identity issues, hormone regimes, surgical procedure, letters of recommendation and other issues involved in the GRS.

Clients undergo many hours of counselling to determine that they are really transsexual and to rule out other psychiatric problems. The client is then referred to a psychiatrist for further evaluation.

STEP Two: Hormone Treatment

Hormone therapy brings transsexuals closer to their felt sexual identity psychologically as well as physically. Therefore, the patients must be on hormone therapy for 6 months before surgery. Male to female transsexuals use the hormone oestrogen to feminize their voices, faces and body characteristics. This hormone changes their fat distribution, increases their breast size, decreases the waist size and body hair. They will see more fat on their hips and smoother skins along with reduction of body hair and loss of libido. Oestrogen also shrinks the penis and testicles. One thing that this hormone does not do, however, is to eliminate facial hair. Hormones do not alter voice pitch either, although speech therapy can help in that respect.

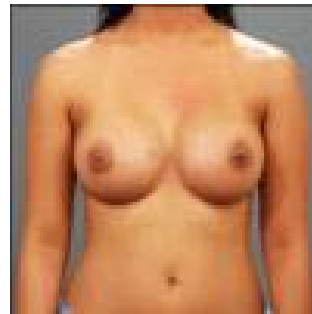
Breast Augmentation

Breasts are universally recognized as a symbol of nourishment, love, femininity and sexuality. Breast augmentation is the second most popular cosmetic procedure performed, following liposuction.

It can be done either by use of hormones or prostheses. Breast enlargement hormones consist of oestrogen and progesterone. These hormones are produced in the female body and are responsible for the gender related physical changes which occur in a woman's body as she ages. Hormone therapy is one non-surgical method of increasing breast size and density (for details, see page _____).



Before hormone therapy



After hormone therapy

STEP Three: Electrolysis

Electrolysis is adopted to remove facial hair and conspicuous body hair which is not removed through hormone treatment. It is a very painful, expensive, time-consuming process in which little needles are inserted into the hair follicles and then heated to kill them. It often takes 75 to 100 hours of electrolysis costing about Rs 200 per hour to remove just the male facial hair. The process causes many logistical and time-management problems for transitioners, because the facial hair must be allowed to grow out for a day in order to treat it. The treated areas are often red and irritated for a day or two afterwards. However, unless all dark facial hair is removed, the new woman has no chance of 'passing', because those hairs show beneath the skin even when fully shaved and covered with foundation.

STEP Four: Changing gender role

The MtF transitioner must completely and permanently change their social gender. In addition to learning how to dress and make up and be pretty as a woman, she must also readjust a phenomenal range of mannerisms and gestures and learn a whole new set of social protocols. Although there are no specific rules or guidelines regarding patients undergoing GRS in India, in Western countries, patients should preferably live in their new gender role for about 1 to 2 years before an operation can be performed. During this time, all documents relating to the patient are changed – driving license, insurance papers, voter's identity card, everything except birth certificate. The patient also needs to continue working throughout the transition period.

Friends become former friends!

A transsexual gender transition is a very major, socially disrupting, emotionally traumatic undertaking and is indeed one of the most difficult things someone can do. Travelling this path can be a very lonely journey, because all the physical, emotional and social challenges along the way must usually be faced alone, without much help from family and friends. However, escape from a body and the daily entrapment of a gender role that feels totally alien to you is very much like escape from bondage. Any TS girl who can see a path to full gender transition, no matter how painful or difficult that path is, will usually make her run for freedom.

Once she starts this journey and her appearance begins to change in noticeable ways, many people will be afraid to associate with her or even be seen with her, until she gets far enough along to 'pass' for a female.

Fortunately, the hormonal changes during transition tend to reinforce these inner emotional changes. But this can be scary too. At the beginning of transition, persons are often quite fragile. Many become much more emotional than before, with emotions and tears coming much more easily and they need to be reassured that this is a normal response. Often they are a lot more open, talkative and interactive too. Sometimes for

the first time in their lives transitioners are accepting and asserting themselves and not hiding their true self or their pain at having to play a false role in the past. This is a profound experience for the transitioner. These changes can be so pronounced that friends, family and loved ones may become 'lost' (confused by it) for a while.

Voice training

MtF transitioners need to gradually raise their voices until the fundamental tone is up to around 180 Hz, making it 'breathy' or 'smoky'. Between 175 Hz and 192 Hz the voice can pass as either male or female depending upon whether it is soft and breathy and uses female intonations or hard and monotone (male). The adjustment to female is then made by using intonation and a 'breathy' form of voice. Once the subjects have permanently transitioned, they try to raise their fundamental frequency further towards 262 Hz. It will be within a female range and a great asset to the patient.

The key test of success is whether the transitioners can always pass as female with strangers on the telephone (i.e, whether they are always called 'ma'am' by those who cannot see them and only hear their voices). If that always happens, then the voice is OK.

For details of voice training, see box below:

There are two steps to developing a female voice:

1. *Learn the techniques* 2. *Practice and More practice!* To learn the techniques, transsexual should find a voice coach in her area. If there are no voice coaches in vicinity then find someone who teaches singing and tell him or her you just want to work on the upper register.

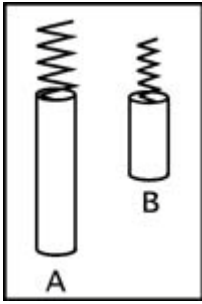
There are many nuances that make up the female voice and transsexual women can only hear them again and again. When a person hears his, or her, voice played back for the first time they're usually surprised at how different it sounds, because it's resonating in their head and will sound different from what others hear.

Warm ups

Actors are taught warm-ups to get them ready to read scripts and they are applicable to learning a female voice, such as saying the vowels (a-e-i-o-u) and *over-emphasizing* them by making exaggerated mouth movements. This will help relax her mouth and jaw muscles and achieve the clear enunciation and modulation of the female voice.

Pitch

The main difference between a male and female voice is pitch and this is the technique a transsexual should work on the most. Males have deeper voices due to longer and thicker vocal cords. If you picture your vocal cords as a pipe (diagram on left) pipe B will



make a higher pitched sound than pipe A, since pipe B is shorter. This is what you want to accomplish with your throat by *tightening your vocal cords*. You want to move the resonance out of your chest and lower throat and up into your nasal passages and head.

To master this technique place your index finger just above your Adam's apple and your middle finger just below it. Now speak in your normal voice. You should feel vibration under both your fingers. Now tighten your throat, raise your pitch and try to make your voice resonate from just your upper throat. You should now feel vibration mainly under your index finger. Don't be discouraged if your pitch doesn't sound natural at first—it'll rise over time with practice. If your voice cracks or breaks there's nothing wrong in it.-- your throat isn't accustomed to using the upper vocal cords exclusively. Practice will make you perfect!

Breathiness

Bollywood actor Rekha has the classic sexy, breathy voice . Breathiness begins by whispering. In other words, pretend you're whispering something into your best girlfriend's ear. You may be thinking, "No one will hear me if I whisper all the time!" That might be true in group situations or when speaking in front of an audience, but one-on-one you can speak with enough volume and still keep a whispering quality. Over time your volume will increase. In the beginning the you may sound funny but ignore it and keep on practicing.

Enunciation

Men tend to slur words and not speak as clearly as women; probably due to having louder voices, so they don't have to enunciate as clearly. However for a woman her voice should be clear to be audible and this can be achieved through enunciation only. A good way to learn to enunciate is to read something and over e-nun-ci-ate each word. This will sound overdone, but you're breaking the male pattern of slurring words. Find your pitch and read a few paragraphs from your reading material and *o-ver e-nun-ci-ate ev-er-y* word.

Phrasing and Modulation

Men tend to speak in a flat-footed or monotone way, not varying their tone much, saying as much as they can in one breath. Women modulate, or vary their tone, more. In other words, their pitch will go up and down during a sentence. For example, a woman would say: "Oh, my dear [pitch up]. How are you-u?" [pitch down]. Men have larger lungs and can speak longer without taking a breath, whereas women have less breath capacity and tend to take more breathe when speaking. A way to practice this is to read something and every time you see a comma, take a breath.

Pronunciation

Men and women pronounce words differently. The main differences are women often pronounce one syllable words as two and sometimes their voices go up at the end of sentences, like when asking a question. For example, a man would say: "*Hi*" while a woman will greet with "*HI-eee*".

Similarly Transsexual women must remember to make sentences according to their new gender, at least if when they are speaking an Indian language. For example, while going somewhere she must say, "Main jaa rahi hoon." Not "main jaa raha hoon" and so on. That means, when you think to yourself, *think in your female voice*.

Lisp

When women talk they make a hissing sound when they say words with the letter 'S' in them. You can do this by putting your tongue at the roof of your mouth just behind your front teeth. It's like talking with a lisp.

Real Life Experience

As a key step in the formal treatment protocol, the transsexual woman enters what is often called a 'Real Life Experience' (RLE). The woman usually enters RLE only after having worked very hard during her pre-transitional period to learn how to feminize her voice, facial appearance and presentation and after being on hormones and electrolysis long enough to feminize her features.

RLE is a time when, under the guidance of her gender counsellor, she 'socially transitions' into living and working full-time in her new gender role for at least one year. RLE is a time when all her social skills, grooming, dressing and personality presentation are enhanced and refined and confidence and self-esteem are developed in her new social role. Although the procedures and trans-community customs for the social changes, real life experience (RLE) and medical treatments are well established, transition is often an awkward and frightening time for the emerging woman. She must face many challenges in relating to others, maintaining employment and maintaining self-esteem and confidence in the face of public ridicule, family rejection and social stigmatization. There is always the risk of 'transition failure', where someone loses their employment, is unable to make steady progress through all the complex medical and social procedures and eventually becomes socially marginalized back into the world of the inner-city streets. Transition failures often have terrible consequences and the TS transitioner needs to plan and work carefully to avoid such a failure.

Finally, it is a time for deep introspection, during which she must make the ultimate decision of whether or not to undergo GRS. If the woman wants to go forward to GRS after successful completion of about one year of RLE and if she is otherwise in good health and good spirits, her gender counsellor will provide her with the needed documents so that she can go on for the surgery.

STEP Five: Counseling and Referral

Psychiatric examination follows more counselling to rule out delusion in the patient. After all, it is a one way journey and there will be no going back after the operation.

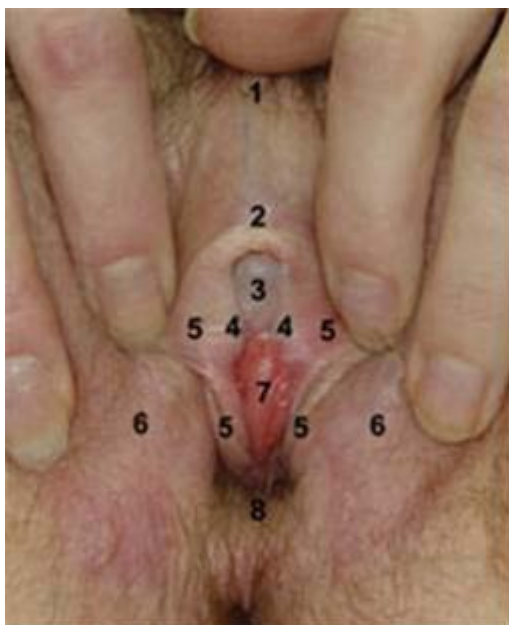
Preparation before operation

1. The patient should stop taking hormone pill for 2 weeks before operation.
2. The patient should stop taking Aspirin because this will cut down on the amount of bleeding during the procedure.
3. Two months before surgery, the patient should stop smoking, drinking, nicotine use etc. which may cause vaso-spasm, excessive scarring, tissue necrosis, damage to pulmonary membranes, impair wound healing and enhance aesthetic risks.
4. The patient should eat a soft diet for 2-3 days prior to surgery to prevent the problem of defecation after operation.
5. The patient should not drink and eat food for 6 hours before the operation.

STEP Six: Vaginoplasty

This is the final step in the MtF transition. It involves a surgical procedure to remove phallic tissue and fashion a vagina in its place.

Vaginoplasty is any surgical procedure the purpose of which is to address vaginal structural defects or aesthetic considerations or to partially or totally construct or reconstruct a vagina.



The vaginoplasty consists of the following important phases:

1. Mon Veneris/ Mon Pubic

Characteristic: The mons is sexually sensitive fatty tissue that covers the pubic bone.

Technique: The mound tissue is made from neurovasucular bundle of neoclitoris which carries a special sensation to the aboved skin.

2. Clitoral hood

Characteristic: Prepuce of the clitoris covers the clitoral body.

Technique: The clitoral hood is made from dorsal neurovascular prepuce flap attached to the neoclitoris.

3. Clitoris

Characteristic: The glans of the clitoris has many nerve endings which result in the clitoris being extremely sensitive.

Technique: This complex and specialized organ is made from dorsal part of glans penis with intact sensory nerves and vessels.

4. Clitoral frenulum

Characteristic: Each labia minora attaches to the base of the clitoral glans. The point at which they attach is called the Frenum or Frenulum.

Technique: This is junctional area of which the dorsal prepuce flap (clitoral hood) and the ventral prepuce flap (labia minora) merged with the lower part of neoclitoris.

5. Labia minora (inner labia)

Characteristic: The labia minora are the inner lips of the vulva, thin stretches of tissue within the labia majora that fold and protect the vagina, urethra, and clitoris.

Technique: The inner surface of labia minora is made from originally pink coloured tissue from the neurovasculized ventral prepuce flap while the outer surface of labia minora is made from the penile skin flaps. Entire surface of labia minora is hairless and sensitive to sexual stimulation.

6. Labia majora (Outer labia)

Characteristic: The labia majora are the outer lips of the vulva, pads of fatty tissue that wrap around the vulva from the mons to the perineum.

Technique: The labia majora is made from scrotal skin flaps. The copora cavernosa (shaft of penis) are removed up to their attachments to the pubic bones. The vasaline gauze is used to secure the skin graft inside neovagina for 4-5 days.

7. Vestibule of the vulva

Characteristic: The Vestibule is the triangle shaped area below the clitoris and above the vaginal introitus. The labia minora form the sides of the triangle. The urethral meatus is located within this area of the vulva.

Technique: This special sensate area is made from the combination of the two originally pinked coloured tissues which are the glans neurovascular island flap and the vascularized urethral flap.

8. Vaginal introitus

Characteristic: The entrance of vagina or vaginal opening.

Technique: This area is made from the combination of perineal flap and two sliding distal penile flaps.

9. Vagina

Characteristic: The internal genital female space extends from the vaginal opening

Technique: The wall of vagina is made from scrotal skin graft and/or abdominal skin graft. Entire surface of neovagina is hairless.

It's not only the end results that are good, there are also very few complications following the 4-5 hour long operation. The patient is out of hospital in ten days and can be back at work in three months. The risk of prolapse is small and usually occurs only if patients have sex too soon after surgery or if the surgery is poor. Satisfaction rates with good surgery are 100%.

Photos of recent vaginoplasty (GRS) results

Penile Inversion Vaginoplasty

This is widely regarded as the preferred method of male-to-female GRS, is widely performed, and when performed by an accomplished surgeon, can produce very satisfactory results.

The basic method involves turning the penile skin 'inside out' and using it to line a vaginal cavity created by blunt dissection through the muscles of the perineal area. The penis and testes are removed. Many surgeons use variants of the technique: a pure penile inversion limits the size of the vagina that can be created, depending on the

amount of penile skin available. In many patients it is necessary to supplement this material with scrotal skin or by means of a skin graft, often taken from the thigh or abdomen.

Early vaginoplasty techniques often used split skin grafts; these were invariably unsatisfactory and very prone to scar tissue formation and shrinkage, leading in many cases to vaginal stenosis (narrowing of the vagina, often with accompanying tissue changes such as dryness, loss of elasticity and resilience, and scar tissue). Some surgeons still use free, full-thickness skin grafts to supplement the penile skin, but the disadvantages of these include visible scarring of the donor site, lack of sensation of the grafted tissue, and possible problems with obtaining enough material in very slim patients.

A more modern method involves the use of scrotal tissue, and is sometimes termed 'peno-scrotal inversion'. This is widely regarded as the preferred method. In this technique, the penile skin is usually divided, part being used to form the floor of the vulva, and part being used to form the anterior wall of the vagina, with a flap of scrotal tissue being used to form the posterior wall and apex of the vagina. This has the considerable advantage that a satisfactory vagina can usually be formed even in circumcised or mildly-intersexed patients where penile tissue may be very limited. The corresponding disadvantage is that the risk of vaginal prolapse increases with the proportion of scrotal tissue used, as scrotal tissue adheres less well to the muscles than penile tissue.

Labia are constructed from scrotal tissue, and the urethra is shortened and everted to correspond to normal female anatomy. A good surgeon will re-site the urethral meatus to an appropriate female position, and will ensure that the erectile material of the penis is removed to the maximum possible extent, so as not to leave an unsightly and possibly painful 'stump'. The remnant of the prostate gland (long-term hormone therapy causes it to atrophy and shrink) is left in place, and provides sexual sensation through the anterior wall of the vagina, analogous to the so-called 'G spot' of natural-born females.

After this operation, the patient will have a pack (usually of surgical gauze) placed in the vagina, to retain the tissues in their proper locations for about five days while healing proceeds. During this time she will be on bed rest, and a clear-fluid-only diet to avoid the possibility of a bowel movement which could damage the vagina or disturb the pack. The patient will also be catheterised, typically for seven days, to allow the urethra to heal.



In some cases where the penile skin is very short the Surgeon may need to perform "Colon-Vaginoplasty" in a second step after 6 months. In the meantime, the Surgeon constructs a clitoris by retaining a small section of the glans penis with its blood supply and nerves intact, and position this into an appropriate position above the urethral meatus. Since the nerves of the glans in phenotypic male are analogous to the nerves of the clitoris in a female. The surgeon also constructs labia majora and labia minora so that patients can have natural feelings of erotic sensation like a normal female. This is a special technique which makes patients very satisfied. They will have the most natural looking and aesthetically pleasing female genitalia with very good functional and cosmetic appearance.

Chart

Postoperative Care Following Vaginoplasty

During the immediate post operation period, the woman will be under the good care of her surgeon and hospital recovery environment. During this time, she will learn whether her surgery was fully successful or whether some complications have occurred and have to be dealt with. Later, after leaving the hospital, she will have to take a lot of responsibility for long-term ongoing aftercare and the outcome of the surgery will depend on how consistently she performs that aftercare.

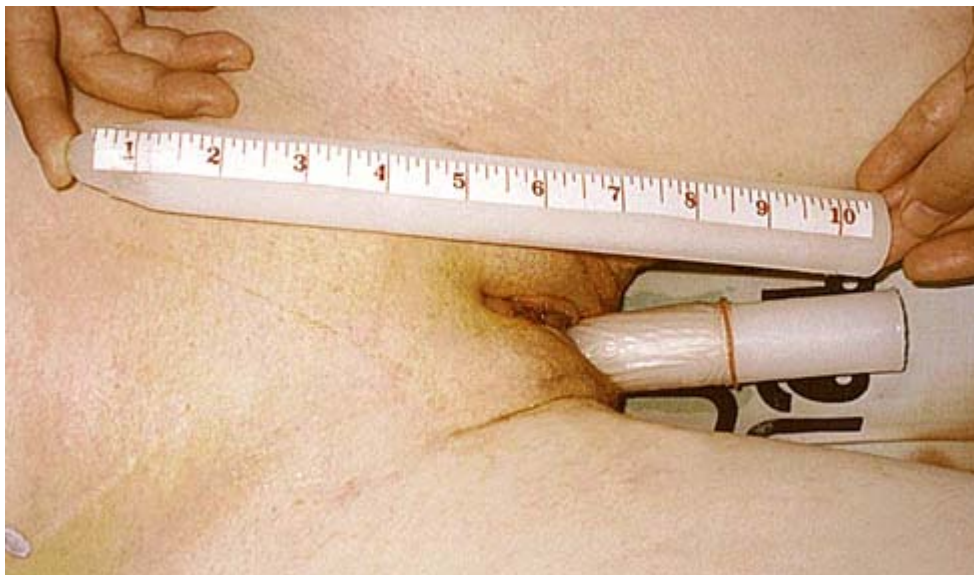
Once released from the hospital, the main concern facing the newly postoperation woman is to insure that her neovagina heals properly and maintains its size and remains functional. In order to do this, the patient must dilate frequently using a vaginal stent for an extended period following surgery. The neovagina is an artificially created opening into the body. The tissues surrounding the neovagina, including the PC muscle, were pushed aside during the dissection of neovaginal cavity. Because their genetic code has no plan for an opening there, the MtF transitioner's body will simply heal what it considers to be a gaping wound and close the neovagina completely and permanently. So in order to keep it open, something must be inserted into the neovagina on a regular and frequent basis. Such a device is called a stent or dilator.

The Doctor will ask the patient to visit the hospital again within 2 weeks after the operation for the propose follow-up medication and advise. The most important thing is the effort to dilate the neo-vagina (for details, see page _____). Because of fear of pain sometime patients will not dilate the neo-vagina and this will make the vaginal canal suffer stenosis and obliteration which will be very difficult to repair afterward. The dilation should be done continuously for 2-6 months to increase the depth of the vagina as well as avoid stenosis. After being discharged from the hospital, the neo-vagina should be dilated by initially using small size vaginal dilator and gradually increasing its width and length 3-4 times a day. Patients have to retain the dilator in the cavity for half an hour every day. Also the patient can dilate the cavity by inserting two fingers in jelly

lubricated condom. Showering with soap is allowed to keep the wound clean. Use vaginal douche twice a day for 3 weeks. Apply the antibiotics ointment over the surgical wound, urethra and clitoris every time after showering. Stitches should be removed by 10-14 days after surgery. Sexual intercourse may be performed at least two months after surgery. The external appearance of the vagina will look natural after 2-6 months.

A high percentage of modern GRS surgeries done by the top surgeons are fully successful, aesthetically and functionally, without any major complications. However, when done by less experienced surgeons various complications can and do occur and even the top surgeons will very occasionally encounter difficulties. Complications can include minor infections, bleeding, a sloughing-off and loss of some of the grafted skin. The more serious complications include major infection or bleeding and damage to the bladder, prostate or major nerves during the dissection to form the vagina. These complications can be difficult to control and correct, may require major extension of the hospital stay and can lead to permanent uncorrectable damage.

Vaginal stent or dilator



Vaginal stents typically range in size from about 1-1/8 to 1-1/2 inches or more in diameter (28 to 38 mm) and must be inserted to full depth (4 to 6 inches or more) into the

woman's vagina for 30-40 minutes several times every day for many months after the surgery. Increasing sizes are used to gradually widen and maintain the vaginal opening

during the postoperation recovery period. Later-on, especially during any prolonged periods of sexual inactivity, basic dilation must be done at least once or twice a week to ensure the maintenance of vaginal width and depth. Even after many years, if the woman notices any tightening or constrictions from one week to the next, the frequency of dilation must be increased until that tightening episode has passed.

It cannot be over emphasized how essential it is to rigorously perform dilations according to the schedule provided by your surgeon. Many of the cases where surgical outcomes seem to be poor are actually the result of women not rigorously dilating, especially during the critical months immediately following GRS.

Modern Dilator



In around 1997, dilator appliances that are designed to be used in a seated position but on an ordinary chair were developed. They have a design that allows adjustment of their length in very small increments, which helps make the process less uncomfortable. There are two versions of the dilator kit, one for use after surgery, to maintain vaginal length and one for use when starting from scratch to form a vagina by pressure dilation alone.

Conclusion:

In terms of a child with AIS, it makes sense for a parent to wait on surgical treatment for vaginal hypoplasia until the girl herself can explore the matter, ideally by talking to a

psycho-sexual therapist and take an active and positive role in dealing with her natural inclinations and physical characteristics. What seems to be, in our experience, more important than early 'correction' of vaginal hypoplasia is having an opportunity to talk about the issues involved, both psychological as well as physical, when the girl reaches an age where she can understand about her condition.

Such surgeries are not common even abroad. It is because of the high costs and high risks involved. A GRS costs Rs. 50 lakhs to Rs. 1 crore abroad. It is a year long procedure. About half of the people undergoing this surgery feel happy with the results. The rest are not so lucky.

In India GRS are extremely rare. Two super specialty hospitals in Mumbai undertake such cases. They have the necessary departments such as specialized surgery, endocrinology, cosmetology, psychiatry etc. to deal with GRS. They have categories of patients. A,B,C,E,F. Based on category charges for every surgery are decided. I give a list of charges so that you have an idea of the costs involved. The procedures are very risky. They involve pampering of sex-stimulating nerves. A slight error causes the sexual sensitivity to come down drastically.

Some other Gender Rectification Surgical Procedures

All surgical procedures, however, are not carried out only in the case of GRS. There are numerous instances of children being born with defective genitalia such as enlarged clitoris, presence of testes etc. In these cases, the gender of the child is not in doubt but the presence of such blemishes is psychologically distressing, to say the least. Hence, in such cases, there are some procedures that are carried out to transform such defective genitalia in more conformity with normal ones.

Abbe-McIndoe Method

This is the most common surgical technique used. A newly created (neovaginal) cavity lined with split-thickness skin graft held in place with mould (stent). The main problem is

the strong tendency of the graft to contract, thus closing up the cavity, prevention of which requires conscientious use of dilators postoperatively.

Pressure Dilation Techniques – Intermittent Pressure (Frank Method)

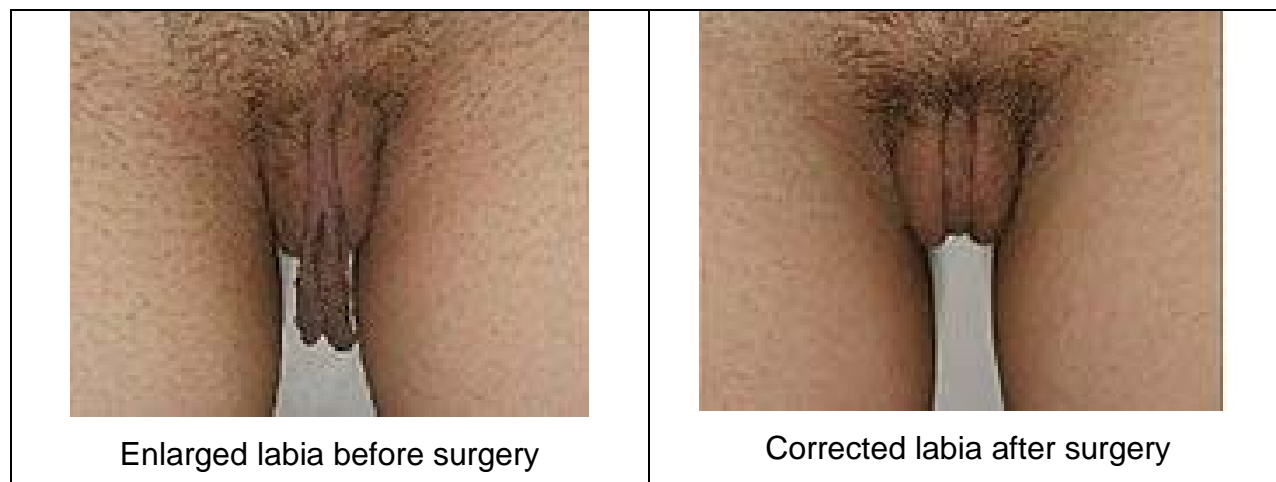
To a girl with no experience of surgery, the effort required to create a vaginal cavity by dilation may seem daunting. She should be aware that the inconvenience and discomfort imposed are usually far less than that experienced after conventional surgical vaginoplasty. Some who had been leaning towards preferring surgical vaginoplasty change their minds after speaking with adult AIS women who had undergone surgery.

This procedure is carried out by the girl herself at home. Rounded rod-shaped appliances are placed at the vaginal introitus (entrance) and gentle pressure (enough to cause mild discomfort) is applied. This is typically done once or twice per day for 20 to 30 minutes. The time to completion of treatment can vary from less than one month to over a year. An adequate dosage of oral oestrogen, plus local application of vaginal oestrogen cream may be helpful.

Pressure dilation requires that the patient be motivated to persist in carrying out the procedure daily and that she is able to overcome whatever inhibitions she may have about contact with her own genitalia. The patient-to-patient confidence and motivation thus engendered appears to be of a substantially higher degree than that provided by the gynaecologist alone.

One more method of dilation, practiced since ancient times, especially in Northern India is to insert a piece of dry sola stem in the vagina and make the girl sit in a trough of water. As the sola stem absorbs water, it expands and dilates the vagina. This practice was primarily followed by brothel owners to force girls into prostitution at an early age.

Vaginal Hypoplasia (Labiaplasty)



Labiaplasty (Labia Minora Reduction) is offered to women with excessive, redundant labia who suffer from unsightly contour lines and physical discomfort. Such women report pinching or chafing when sitting or walking, hindrance during intromission and difficulty maintaining hygiene during menses or after defecation.

Overly pigmented and unattractive labia can be reduced with a V-plasty technique that converges freshened margins in a neat concealable line. Delicate, minimally reactive, self absorbing plastic surgery suture is employed. Surgery can be performed on an outpatient basis. Sexual activity may be resumed in 6 weeks. Excessive clitoral hood tissue may also be trimmed during this procedure.

Reassurance regarding normal variation is provided. Areas of intended excision are delineated for patient approval with hand held mirror.

Recent developments

These include easier and earlier access to female hormones and anti-androgens. Easier access to hormones and surgery have made it much easier for young transsexual girls to feminize themselves while young and to achieve complete gender transition while in their twenties.

There has been a tradition of doing what superficial 'eunuch-style' GRSs which do not create a full vagina. The cost is around Rs 50,000. If someone does not need a full GRS, such surgery might be an option to consider. As a less expensive alternative, transsexuals can now take advantage of fairly easy access to orchiectomy. After orchiectomy (castration) a T-girl's body will not be further maimed by testosterone and the feminizing effect of female sex hormones is much more rapid and more pronounced (especially in younger girls). This option can enable younger T-girls to rapidly become feminized and passable and to buy some time to save money for GRS without feeling such desperate urgency. Results in such case are not so good.

The joys and wonders of complete gender correction

The joys and wonders of being able to resolve the transsexual condition and to then live a full life as a warm, loving woman in the resulting female body are manifold.

It is now possible for many postoperative women to feel totally gender-congruent in their transformed bodies and to be able to very comfortably and passionately enter into loving relationships (either heterosexual or lesbian, as the case may be) as sensual, sexually responsive women.

However, regardless of their sexual orientation, some of these women will overcome their fears and go on to find partners, often by seeking someone interested in a love-relationship involving deep emotional sharing and intimacy, instead of focusing simply on sexual relationships (as younger couples so often do). Such partners exist and their own quest for a life-partner may be as long and as uncertain as the one of transsexual women. However, in order to be successful in finding love, the transsexual woman must have found enough peace, joy and self esteem in herself so as to be able to fully partner in a loving relationship.