

Male to Female Surgery Kit



The Gender Centre Inc.

Services for People With Gender Issues

7 Bent Street Petersham N.S.W. 2049

Phone: (02) 9569 2366

Fax: (02) 9569 1176

Website: www.gendercentre.org.au

Supported by the New South Wales Health Department through the AIDS and Infectious Diseases Branch.



The Gender Centre Inc. Fact Sheet
Service Brochure
Of the Gender Centre Inc.

Reviewed July 1st 2008

The Gender Centre is committed to developing and providing services and activities which enhance the ability of people with gender issues to make informed choices.

The Gender Centre is also committed to educating the public and providers about the needs of people with gender issues.

We offer a wide range of services to people with gender issues, their partners, families and friends in N.S.W.. We also act as an education, support, training and referral/resource Centre to other organisations and service providers.

We specifically aim to provide a high quality service which acknowledges human rights and ensures respect and confidentiality.

Counselling Service

Provides counselling to residents, clients and partners, families and friends of people with gender issues. Also provides education, support and referrals to a range of specialist counselling. For an appointment please contact the Counsellor.

For Service Providers and Others

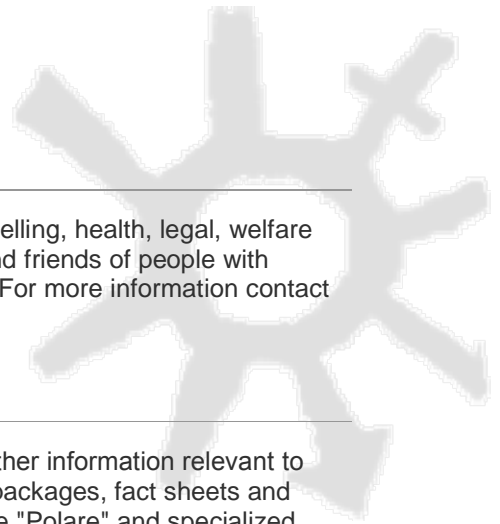
Training, support and workshops are available to employers, service providers, students and other people interested in gender issues. Topics covered include implications for staff and clients in relation to anti-discrimination legislation, E.E.O. issues, workplace harassment and provision of goods and services as well as many personal aspects of the transgender process. For more information contact the Coordinator of The Gender Centre.

Social & Support Service

Provides social and support groups and outings. Also provides referrals for medical, H.I.V./AIDS, education, training, employment, legal, welfare, housing and other community services to residents and clients living in the community. For more information, contact the Community Worker or the Outreach Worker.

Outreach Service

Available to clients in the inner city areas on Thursdays from 10:00am – 5:00pm and Tuesday nights from 6:00pm – 2:00am. Also available to clients confined to home, hospital or gaol (by appointment only). For an appointment contact the Outreach Worker.



For Partners, Family & Friends

Support, education and referrals to a wide range of specialist counselling, health, legal, welfare and other community services are available for partners, families and friends of people with gender issues. There are also social and support groups available. For more information contact the Community Worker, or the Counsellor.

Resource Development Service

Produces a range of print resources on H.I.V./AIDS medical and other information relevant to people with gender issues and their service providers. Information packages, fact sheets and other printed materials, including a free quality bi-monthly magazine "Polare" and specialized advertising supplements. For more information contact the Resource Development Worker.

Residential Service

Provides semi-supported share accommodation for up to 11 residents of age 16 and above. Residents can stay up to twelve months and are supported to move towards independent living. During their stay they are also encouraged to consider a range of options available to meet their needs. A weekly fee is charged to cover household expenses. Assessments for residency are by appointment only and can be arranged by contacting the Residential Program Worker or the Counsellor.

Drug & Alcohol Service

Provides support, education and referrals to a broad range of services by appointment only. For an appointment contact the Outreach Worker.

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The Gender Centre Inc. Fact Sheet

Choosing a Surgeon

For Male to Female Transgenders

Reviewed July 1st 2008

An important factor to consider ensuring the success of your Sex Reassignment Surgery is the surgeon you choose. Some surgeons have Internet websites and some don't. The Gender Centre has made contact with all Surgeons who have Websites, and has obtained permission to pass on their webpage information from some. The Gender Centre can provide this webpage information in print form for those without internet access and unable to access the Gender Centre, though the Gender Centre doesn't recommend any Surgeon over another, and cannot provide prospective patients with anything other than available resources to enable you to make an informed decision. Should you not have Internet access, you are more than welcome to contact the Gender Centre, to arrange an appointment to access this information from the Internet.

When Choosing a Surgeon

When choosing a surgeon there are several things worth considering. Once you've received the list of Surgeons, you can start checking their credentials. While good credentials can't guarantee you a successful outcome, they can significantly increase the odds. You can obtain the following information from hospitals and professional societies, and the surgeon's office.

Training

More important than where your surgeon went to school is the type of training he or she received. Who the Surgeon trained under, the experience of that person, what procedures the surgeon specializes in, and how long has he or she been practicing. While a Surgeon may choose to concentrate on a limited number of procedures, this comprehensive background gives a solid foundation to his or her skills.

Experience

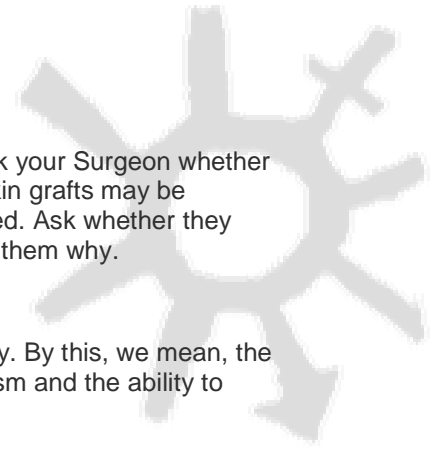
Although there's no magic number (of years or procedures) that defines "experience," you should feel comfortable that the surgeon you choose is well versed and up-to-date in the procedure you're considering. You can ask the surgeons on your list if they perform the procedure frequently or only occasionally, and when they last performed that procedure. You can also ask how many Sex Reassignment Surgery procedures they've performed, and state that you mean actual Sex Reassignment Surgery and not associated facial surgery or other feminizing cosmetic surgery.

Requirements

Most Surgeons operate under the Harry Benjamin International Gender Dysphoria Associations Standards of Care, and will need documentation from you to ensure that you meet their criteria for Sex Reassignment Surgery. Often you'll need two letters of recommendation from Psychiatrists and have lived in a female role (fulltime) for a period of two years. Other requirements, blood tests etc. vary slightly from Surgeon to Surgeon, ask your preferred Surgeon what documents he or she requires from you.

Technique

Ask your Surgeon which technique he or she prefers to use and why. Ask them why they use a certain technique as opposed to other techniques, and ask them to explain the benefits and disadvantages of using the technique they prefer. (For further information regarding different



techniques, see the Technique Information Sheet included in this kit). Ask your Surgeon whether they use skin grafts, how often and under what specific circumstances skin grafts may be required, where they are taken from, and whether scrotal skin can be used. Ask whether they insist on patients undergoing genital electrolysis before surgery, and ask them why.

Functionality

Ask your surgeon just how functional your results will be following surgery. By this, we mean, the depth of the vagina, the sensitivity of the clitoris, the ability to reach orgasm and the ability to urinate cleanly and without any difficulty.

Appearance

The appearance of your result is obviously an important part of any cosmetic procedure. Ask your surgeon to show you photographic examples of their work, the more the better. If your chosen Surgeon is overseas, interstate or not able to be reached easily for a consultation, ask him or her to send you photographs or direct you to Internet websites where they appear. (See also "Photographic Vaginoplasty Results" in this kit).

Cost

The cost of Sex Reassignment Surgery varies between Surgeons, and is usually an important factor in choosing a Surgeon. Ask your Surgeon how much he or she charges, and what their charges include. Some include hospital, surgery fee, anesthetist, airport pick up and return (for overseas and interstate patients), a Surgery Care Kit including aftercare items, and post surgery consultations. Make sure you know what you're paying for! If traveling overseas, check likely exchange rates, airline ticket prices, and possible accommodation and living expenses. Some Surgeons provide accommodation, most don't.

Aftercare

Ask your Surgeon how long your hospital stay will be, and how long you should remain close to his or her practice for follow-up consultations. Ask what aftercare product you'll need to buy, and which ones will be provided. Ask your Surgeon for his or her recommended post-operative dilation and aftercare you'll be expected to uphold once you've returned home. Ask your Surgeon how long you'll be required to rest before you return to work or other activities. Ask your Surgeon how long he or she recommends before having intercourse.

Testimonials

Ask your preferred Surgeon for names of previous patients you can contact. Ask them the same questions you asked the Surgeon. If you know someone who has seen your chosen Surgeon, ask them the same questions you've asked your Surgeon, compare their responses to those given by your Surgeon. Try and make contact with as many previous patients as possible, either in person or by email.

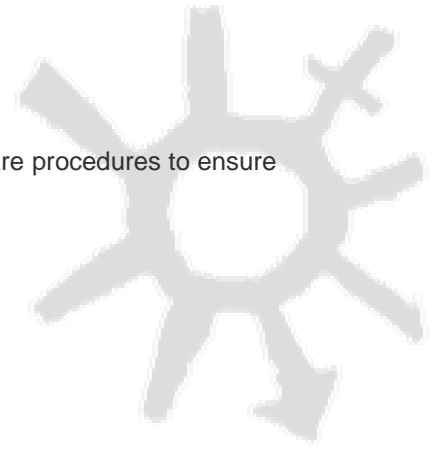
Other Relevant Information

If traveling overseas for surgery, ask your Surgeon to write a letter to your airline requesting that a wheelchair be made available for you. You may not feel you need this, though you will be first on the plane and last off, avoiding unnecessary crowds. At your destination you'll be assisted in collecting your luggage and through customs. This is extremely helpful.

If traveling overseas, you'll be able to gain a female passport before you depart. This passport is valid for one year only.

Expect to be recovering and unable to work for a period of about four weeks following surgery. Plan for this financially when considering your surgery costs.

It is your responsibility to uphold diligent dilation and other related aftercare procedures to ensure a quick and safe recovery.



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Vaginoplasty Techniques

Courtesy Benjamin's Syndrome Information website

Reviewed July 1st 2008

Overview

Genital Reconstruction Surgery (G.R.S.) corrects the most drastic physical symptom of Benjamin's Syndrome by removing the testicles and constructing a vagina and vulva from the existing genital tissue. The techniques are very sophisticated (though not perfect and not without risk) and a good surgeon can create a result virtually indistinguishable from the natural version. It does not create a uterus or ovaries, so H.R.T. is still desirable after surgery, and there is of course no menstrual cycle. The outcome is essentially equivalent to that for women who have undergone total hysterectomies. G.R.S. is often referred to as Sex Reassignment Surgery (S.R.S.), or sometimes Gender Reassignment Surgery (inappropriately since the surgery doesn't change gender at all) or other variations.

Penile Inversion

The most common form of G.R.S. is penile inversion. This involves removing the spongy tissue from inside the penis, and inverting the skin. An opening is made between the rectum and the urethra, and lined with the penile skin. Skin grafts can be used to provide additional depth; in recent years, the scrotum has become the preferred source. This requires scrotal electrolysis beforehand to avoid hair inside the vagina – electrolysis around the base of the penis is also highly recommended. Some hair can be removed at the time of surgery, but it helps to get rid of as much as possible beforehand. The remainder of the scrotum is reshaped to form the labia. The urethra is trimmed to the appropriate length, and a clitoris is usually created from the glans of the penis or other sensitive tissue.

After the operation, it is necessary to dilate regularly to prevent the new vagina from shrinking. That means inserting a dilator or dildo into the vagina, and holding it in place with steady pressure for an extended period. For the first few weeks several dilations a day are required, but the need diminishes over time to once every few days, or potentially less if sexually active. The vagina does not produce a significant amount of natural lubrication, though fluid may be produced from the urethra during arousal, and some form of lubricant is usually essential for sexual intercourse.

Colon Surgery

An alternative form of G.R.S. uses a segment of the colon to form the vagina, which has both advantages and disadvantages. The colon segment provides an odourless (if properly cared for), self-lubricating vagina of appropriate dimensions, with little need for dilation to maintain it. The colon segment is rotated within the body, but retains its original blood supply. More external tissue is left from which to form the vulva, requiring less stretching and compromising of nerves and blood supply. Construction of the clitoris is the same as with the penile inversion technique.

The main downside is that the surgery is much more invasive than penile inversion. Chopping a piece out of the colon and stitching the loose ends together to close the gap is a bigger shock to the system than surgery restricted to the genital region. Some surgeons use laparoscopic instruments to carry out the operation without having to cut open the abdomen to access the

colon, which eliminates scarring but does not greatly reduce the risks. Also, the colon segment produces lubrication constantly, not in response to arousal, and excessive mucus production may be a problem in some cases. Some dilation may be needed to prevent the entrance of the vagina from shrinking. Colon G.R.S. is generally more expensive than penile inversion.

Labiaplasty

Some surgeons carry out G.R.S. in two stages, a vaginoplasty and a Labiaplasty. Patients of other surgeons may also request a Labiaplasty later to improve the cosmetic or functional result. At the time of the vaginoplasty, the whole genital area becomes very swollen and generally messy. This, along with individual variations in healing, makes it virtually impossible for the surgeon to accurately predict the appearance of the eventual outcome. A more aesthetically pleasing result can be obtained by leaving the finer detailing of the vulva to a later date, after it has healed and the swelling gone down. The two-stage procedure also helps to preserve blood supply and nerve connections, by allowing some to heal before messing around with others. The Labiaplasty typically involves bringing the tops of the labia together and providing hooding to the clitoris, along with refinement of the labia minora. Other problems, most commonly involving the urethra, can also be resolved at the same time.

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The Gender Centre Inc. Fact Sheet
Genital Electrolysis
Courtesy of the Looking Glass Society Website

Reviewed July 1st 2008

No discussion of electrolysis in the male-to-female transsexual would be complete without some notes on the removal of hair from genital skin prior to gender reassignment surgery (G.R.S.).

The precise method of surgery used depends upon the surgeon performing the procedure; but all methods of G.R.S. place potentially hair-bearing tissue from the penis and/or scrotum in locations where hair would be undesirable and problematical (inside the vagina, under the clitoral hood, and perhaps inside the labia). For this reason, patients are well advised to seek the advice of their chosen surgeon as to which parts must be depilated, and then to obtain the necessary electrolysis well in advance of surgery (to allow the skin to recover).

Genital electrolysis can be exceedingly painful, and in addition to pain control methods used for facial electrolysis, it must be emphasised that hygiene before and after treatment is paramount, as there is a high risk of skin infections from genital electrolysis. Some patients report using Betadine liquid to good effect, before and after genital electrolysis.

Some patients have found genital electrolysis unbearably painful even with topical anaesthetic cream and analgesics/sedatives, and for this group subcutaneous local anaesthesia may be the only solution. Good results have been obtained with use of Xylocaine 2% with Adrenaline 1 in 200,000. The vasoconstrictor action of the adrenaline not only extends the duration of the pain block but effects a substantial reduction in the oedema which often results from electrolysis on genital tissue. It will be necessary for the patient to have the area to be treated clearly marked, so that multiple insertions of the needle can be used to ensure that the entire area is anaesthetised – as a guide, 5–10nl of solution will be required for the lower scrotal flap used in peno-scrotal inversion vaginoplasty, and the pain block can be expected to remain adequate for up to three hours. In many cases this is long enough for the Electrolysisist to clear the entire area in one session. When this technique is used on scrotal tissue, a healing period of several weeks must be allowed prior to gender reassignment surgery to allow complete healing: not only does the electrolysis itself cause localised tissue damage that may take 2–3 weeks to heal, but the subcutaneous injection may result in small haematomata which, while generally harmless, must be allowed to heal prior to surgery.

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Post Operative Maintenance For Male to Female Transsexuals

Reviewed July 1st 2008

So, you are planning your surgery. You have your reservations, your tickets, your suitcase, etc, etc. But what about when you get home? This information was gathered primarily to help get you through the rough times after surgery. What you are going through will not be easy, but you have made it this far, and we hope to help make the rest of your journey a little easier.

One of the first things you should do is get your yellow pages and locate a surgical supply store near you (Look under the Surgical or Pharmacy headings). They will stock many of the items you will need, including some that may be difficult to find anywhere else, and often at prices lower than your local pharmacy.

You are going to need quite a few thin Maxi Pads and panty liners. You will need the thin Maxis for about 4 weeks after surgery, and you may be able to switch to panty liners after that time. You will need to change the pad after each dilation and before you go to bed, so plan on a minimum of 6 pads per day. It is a good idea to stock up during sales in the months prior to your surgery.

For immediate use following surgery, it's easier to purchase and use the disposable douche applicators of the type recommended by your surgeon (usually vinegar and water, or Betadine). After surgery, these can get expensive, so the best alternative is to purchase a bulb type douche, consisting of a rubber or soft plastic squeeze bulb and a removable pipe, and make your own vinegar and water solution (one tablespoon of white vinegar per quart of water). If you prefer Betadine® douche, mix one teaspoon of Betadine in 6 ounces of water.

You may wish to purchase one or two packages of pre-moistened personal wipes. These provide effective yet gentle cleansing of the surgical site, and with a little Betadine also provide disinfecting of the surgical and anal area after a bowel movement. One alternative is pre-moistened baby wipes, but many, if not all, of the baby wipes have "Do Not Flush" printed on the container.

For dilation, you are going to need a large quantity of lubricant, such as K.Y. Jelly®. Surgilube®, a sterile lubricant, is available at the Surgical Supply store for about one-third of the cost of K.Y. You may be able to cooperate with several friends and purchase larger quantities, such as a full case at a substantial discount. Plan on having a minimum of 24 tubes (two boxes) before you leave for surgery. Do not use liquid lubricants such as Astroglide® for three months. Some surgeons are reporting that they interfere with proper healing of the vaginal lining.

During dilation, simply applying the lubricant to the dilator and then inserting it often does not provide adequate internal lubrication, which can lead to excessive pain and irritation. One solution to this problem is to use the applicator that is supplied with product such as Gyne-Moistrin® (a vaginal moisturizing jelly) or other lubricant or spermicidal product that provides a re-usable vaginal applicator.

You are going to be doing a lot of cleaning and wiping during your recovery, especially after dilating. While paper towels and toilet paper will work, they will leave a lot of paper residue behind. As an alternative, you may wish to purchase about 2 dozen cotton washcloths, provided that you have the facilities to launder them at home. You are also going to need several towels or waterproof pads to place under you while dilating.

You should have a bottle of 400 I.U. Vitamin E capsules. Medical studies have shown that the application of Vitamin E to wounds or incisions increases the healing rate and reduces the amount of scar tissue formation. Keep in mind that this is very dependent on you, as not all people respond the same to this treatment. To apply, wash your hands and puncture the capsule with a sterile needle or knife. Squeeze the contents onto your finger(s) and apply to the external incisions. Repeat the application after washing the area. Do Not apply to the interior of the vagina. Some lotions are advertised as containing vitamin E, but they contain very little actual vitamin E, and may contain ingredients you neither want nor need.

Your surgeon may recommend that you use Bacitracin® or Neomycin®, also sold as Triple Antibiotic ointment under store names. Some brands are available with Lidocaine, a topical anesthetic. Apply it along with the Vitamin E.

Please make sure that you have your soon-to-be constant companion, the inflatable rubber doughnut (really, it's called an invalid ring). You can put it in a pillowcase if you wish.

For good healing and recovery, you are going to need good nutrition. You are not going to feel like doing much cooking for several weeks, so if you are living by yourself, stock up with nutritious foods that are easy to prepare, such as soup, or prepare dinners before you leave and freeze them.

Post-Surgical Responses

After you return home, it is important that you get all the rest that your body requires as it diverts energy to the healing process. Listen to your body. If you feel tired, take a nap. Don't push yourself and don't even think about resuming your normal workload. Heavy Lifting is right out! Failure to heed these warnings can adversely affect your healing, and therefore the overall results of the surgery. Take six weeks to recover if you can, but don't take less than four.

After two or three weeks, you will probably feel your strength starting to return and be tempted to resume some of your normal activities. For example, you may feel strong enough to go shopping at the mall only to find yourself totally exhausted after 30 minutes.

Although every person will respond and heal at different rates following surgery, there are many physical responses that are quite common. For example, you will experience some degree of bruising and discoloration around the surgical area. This may range from a few small bruises on the thighs and buttocks, to extensive bruising from the navel down. One woman, upon observing the degree of bruising, asked her surgeon if his assistant had been beating her with a stick while he worked. Most of the discoloration will fade in a short time, but some may remain for several weeks.

General swelling of the entire surgical site is a typical response, and this will usually last longer than the discoloration. It may take 6 weeks or even longer in some cases for all of the swelling to completely subside.

If you experience an increase in localized swelling, especially along a suture line combined with localized pain, redness, warmth, or a discharge from a suture line, seek medical help immediately.

Some women experience a minor problem with a few sutures in the labia that do not dissolve by themselves. Your local doctor should remove any labial sutures that have not dissolved after three weeks.

Another problem may occur with sutures that dissolve too early. This usually occurs in the area between the vagina and the anus and results in the incision opening slightly. Keep it clean and covered with antibiotic ointment, and it should heal by itself.

One of the results of the swelling is that you may not be able to urinate in a stream until the swelling subsides. The result is that you may "spray" urine in a variety of directions, including all over yourself. Messy, but not harmful. As the swelling subsides this problem will usually disappear.

Everyone has a different tolerance to pain, so we cannot tell you how much pain you will experience. Over-the-counter analgesics will usually handle the pain, but if you feel that the pain is severe, contact your doctor. You will probably find that the pain is least severe when you are lying down, so go with the feeling. During the early phases of your recovery, you will find that changing position from lying down to standing up will cause a sharp increase in pain in the surgical area. This is caused by blood accumulating in the lower part of your body due to gravity. This sensation will decrease as healing progresses.

You should expect a variety of fluid discharges during the first few weeks of recovery. You will see small amounts of blood and plasma (a clear yellowish fluid) on your pads. These discharges will decrease as you heal. If you experience continued bleeding in small amounts (heavily stained pads) for more than 2 weeks, or if you experience a large amount of bleeding, seek medical help immediately.

Another discharge that is quite common is dead tissue from various areas in the surgical site. When the surgeon rearranges the tissues, some parts, such as a piece of skin or other tissue, no longer have any use in its new position, and your body will gradually remove it. This process is called "sloughing". The sloughed tissues will show up as small clumps or spots of white or whitish-ellow mushy stuff, both externally and from within the vagina. The amount depends on you and the surgical technique, and will vary from a very tiny amount to very large clumps in some cases. This will typically last two to three weeks. If you experience any signs of infection (localized swelling, pain, redness, and/or warmth), or you notice a foul odour, seek medical help immediately.

If you have ever experienced haemorrhoids, surgery and subsequent dilation may cause them to flare up. Not everyone will suffer this problem, but you should be aware that it could happen. Over the counter preparations may help alleviate the symptoms, but prescription strength products may be preferable if the haemorrhoids cause dilating to be more difficult. Consult your regular doctor if this should occur.

Due to the nature of the surgery, it is unavoidable that some nerves will be injured or severed. This can lead to areas of numbness and/or tingling in and around the surgical site. The vast majority of these areas will regain normal feeling as the nerves regrow, but the process may take up to a year, so don't panic.

An interesting little side effect of the healing process is the occurrence of "electrical shocks" in the surgical area. These are caused by the regrowth of the nerves in the area, and it does indeed feel like a rather sharp electrical shock. They can feel strong enough to make you jump, and while they can be uncomfortable, they are harmless and should decrease over several weeks.

Another thing about nerves is the occurrence of "phantom pain" or "phantom itches". Your brain has built a three dimensional "map" of the nerve endings throughout your body. For example, a nerve ending located 5 feet 8 inches down and 8 inches in front of your brain, and on the right side, is in the area corresponding to your right toes. So if you drop something on your foot, your brain gets the signal from the nerve endings, looks up the location in its map, and tells the conscious part of your brain that your foot needs attention.

During surgery, tissue with its associated nerve endings gets moved around quite considerably. Because your brain has not had sufficient time to update its map, it may be telling you that you are experiencing an excruciating itch somewhere in your groin, when in fact that particular nerve ending is now deep inside you. You may automatically reach for the spot and be surprised when you find that you can't scratch it. This will disappear quickly as your brain adjusts.

You will be experiencing a sudden change in hormone levels, and for some individuals this can result in sudden and unpredictable mood swings and/or feelings of depression. You may find yourself suddenly crying uncontrollably for no apparent reason. This is usually temporary and should resolve itself when you start taking hormones again. If these feelings seem overwhelming, contact your doctor about your hormones.

Hygiene

Good hygiene is critical to successful recovery. This means keeping the surgical site absolutely clean. This is critically important after a bowel movement. Always wipe yourself from front to back! A baby wipe will probably be more comfortable and provide more thorough cleansing than toilet paper. After the area has been thoroughly cleansed, apply Betadine® to another baby wipe and wipe the entire area, starting with the surgical site. Remember, always wipe from front to back to avoid contaminating the surgical site. Thorough cleansing after dilating is also important. After cleansing, apply the Vitamin E and antibiotic ointment.

If your surgeon does not recommend the use of Betadine®, but he does not recommend against it, we would advise you to purchase and use the Betadine®. It is a powerful disinfectant, and we feel it is better to be over-enthusiastic when cleansing, than take chances with developing an infection.

Dilating

Now we get to the part that seems to worry everyone the most: the dreaded dilation. Let's be honest here. It is time consuming, generally uncomfortable, and sometimes painful. But next to hygiene, it is the single most important thing you can do to insure the success of your surgery. Failure to dilate properly can result in serious injury, or failure to achieve adequate depth and width of the vagina.

Now that you are properly frightened, let me reassure you that with a little guidance from us and some dedication on your part, you can get through this.

Follow your surgeon's instructions regarding the frequency of dilation. The goal is to be able to reach full vaginal depth (this varies according to the individual) without excessive discomfort. As you progress you will be able to judge for yourself when you can reduce the number of daily sessions. Remember, it's better to dilate more frequently than less.

First, gather all of your materials together. You will need your dilators, lubricant jelly, waterproof pad or towel, and a small towel or washcloth. Wash your hands thoroughly. Place your pad or towel on the bed, lie down and get comfortable. Sometimes, a small pillow under your hips will help. You want to be able to relax, especially the muscles in the groin and lower abdomen. Relaxing music can be helpful, as can meditation.

You need to be as relaxed as possible to minimize discomfort. A common mistake is to spread your knees as wide as possible. This actually makes insertion more difficult because it tenses the muscles in the thighs and lower abdomen.

Place your feet about the width of your hips apart and bend your knees at about a 45 degree angle. Move your knees apart only enough to get your hand between them.

If you have trouble reaching your vagina, do not pull yourself up with your abdominal muscles. Instead, place pillows behind your shoulders and neck for support.

Now lubricate the dilator you will be starting with. However, when inserting the dilator, much of the lubricant will be scraped off of the dilator as it passes through the vaginal opening. Therefore it is useful to insert some of the lubricant into the vagina prior to inserting the dilator. The lubricant

can be applied by finger, or by means of an applicator such as the applicator supplied with product such as Gyne-Moistrin (a vaginal moisturizing jelly) or other lubricant or spermicidal product that provides a re-usable vaginal applicator. Fill the applicator with lubricant (K.Y. or Surgilube), insert the applicator into the vagina, and push the plunger to place the lubricant into the vagina. This will provide extremely good lubrication exactly where you need it. Relax and open your legs to a comfortable position. Insert the nose of the dilator into the vaginal opening. The dilator must be inserted at the proper angle to avoid damaging the vaginal wall.

Never insert the dilator at a downward angle.

Always insert at a flat or slightly upward angle, as if pointing toward the navel.

It may be necessary to put your thumb or finger on the top of the dilator shaft and apply slight pressure so that the nose of the dilator passes under the pubic bone.

Never insert the dilator at a downward angle to get it under the pubic bone!

If you are using straight dilators, begin rotating the dilator back and forth about a quarter to a half turn in each direction while applying gentle pressure to ease the dilator into the vagina. Alternatively, you can rotate the dilator in one direction while applying pressure. The rotation will make insertion easier. As the dilator enters the vagina, you may feel the dilator become more difficult to insert or rotate. You are either not far enough below the pubic bone or you are encountering the P.C. muscle. When the surgeon created the vaginal cavity, he had to make an opening in this muscle for the vagina to pass through. This muscle is not used to having anything poked at or through it, and it may start spasming or cramping. This makes it feel like you cannot get the dilator in. Relaxation will help a lot, but you may want to try massaging the P.C. muscle to help it relax. Reach into your vagina with a clean finger and locate the area where it feels like the dilator stopped. Gently massage the surrounding tissues and try the dilator again. The P.C. muscle will quickly be "trained" to accept this, and should stop giving you problems relatively quickly. Continue rotating and insert the dilator again, until full vaginal depth is reached. Although the sensation is difficult to describe, you will be able to feel when you have reached full depth. Once at full vaginal depth, continue rotating the dilator and apply gentle inward pressure. The slight friction as the dilator rotates will help stretch the tissues. If rotation becomes difficult, remove the dilator and apply additional lubricant to the nose of the dilator, or use the applicator to apply additional lubrication internally.

Once the dilator is inserted, relax your legs by bringing your knees together and straightening them as much as you can. You may roll over on your side with your knees slightly bent if you wish.

An accurate measurement of vaginal depth can be made immediately following dilation. Remove the dilator and wipe off any remaining lubricant. Insert the dilator to full vaginal depth and rotate it in one direction for 3 or 4 turns. There will be adequate lubricant remaining in the vagina for this. Remove the dilator and measure the part of the dilator that is covered by the lubricant.

After dilating, thoroughly clean the area as described previously. Clean the dilators and applicator with antibacterial dishwashing liquid and water. To relieve post-dilating discomfort, try a warm bath, or apply moist heat to your groin.

One problem that many people encounter is how to maintain the required dilating frequency when they return to work. Some people have made arrangements to use the Infirmary. Others have successfully dilated in a stall in the lady's room. This is a situation that you will have to explore for yourself before surgery, and depends upon your work situation.

Sexual Response

This is an area that is very dependent on you, and all we can do is provide some information about what has happened to others. Some people recover sensation quickly, for others, the process can take many months. The best thing to do is to wait, and not worry about it. When it happens, you will know.

One thing that people worry about is whether or not they will have self-lubrication. The surgeons that we know of will tell you that there will be very little, and for some people, this is true. On the other hand, others find that they can produce adequate lubrication for intercourse. The lubrication reportedly comes from two sources: The urethra and the vagina. The urethral secretions probably originate from the remaining glands such as the cowpers gland and the prostate gland. The origin of the vaginal secretions is more of a mystery, but it has been reported. The only way you will find out is to wait and see how you respond. Remember that there are no guarantees about this.

Some of the surgeons have been using a section of urethral tissue as a way to provide additional lubrication. The urethral tissue is mucosal in nature, and will continue to secrete mucous and provide lubrication.

Whether or not they will regain orgasmic function is an important question for many people. As with lubrication, this is very dependent on you, and there are no guarantees. It does happen for many people, so keep a positive attitude and after you are healed, start experimenting. Things are different now and you will have to learn some new tricks, but during the learning process, the practice can be so much fun.

For men, orgasm – usually occurring fairly quickly – is almost a sure thing whenever sexual stimulation is undertaken. For a woman, this may not always happen so it may be more effective to approach the session with the idea that you simply want to experience pleasure without specifically seeking orgasm. Holding out orgasm as the specific goal may create a sort of performance anxiety that leads to further frustration and a cycle of failure.

The physical surroundings may be rather unimportant to men, but for many women it is extremely helpful to find a quiet and relaxing place where you won't be disturbed. "Getting in the mood" with sensual things like music, soft fabrics, a warm bath, muted lighting, etc., can be beneficial. Some discover a heightened sensitivity to fragrances and tactile stimuli like the gentle breeze from a ceiling fan. Anecdotally, it has been suggested that men tend to have a more strongly visual/cognitive component to sexual arousal, while women may find tactile and olfactory stimuli more persuasive.

In your former life, you may have been accustomed to very focal stimulation but now you may want to get your whole body more involved in the process, breasts, abdomen, legs, face, everything.

Some have suggested there is an erotic component to feminization and feminization fantasies that may dissipate for a while or even permanently after vaginoplasty. The extent to which this phenomenon may occur is obviously variable. In some instances, however, an individual may find that her old core fantasies need to be redeveloped, replaced or just discarded.

Genital surgery remaps tissue and nerves, so take some time to gently but thoroughly explore your anatomy. There might be all kinds of stuff going on there you didn't expect.

Another factor in sexual function is your endocrine system. A proper hormone balance is often critical to proper sexual functioning. Both women and men require testosterone for libido and orgasmic ability. After surgery, some women find that their adrenal glands (the other source of testosterone) do not produce enough to provide adequate libido to orgasm. You may require a small amount of supplemental testosterone to regain functioning. The amount required is typically far below the amount that will cause any other unwanted side effects, such as hair growth. Not everyone requires this, but keep in mind that some do.

It is important to be patient and learn about your new body in a playful and joyous way. Don't put expectations on yourself – just revel in who you are. Take your time, and let every part of your body and your mind and your spirit have a role in the experience. Give yourself the freedom to truly love yourself and appreciate your own beauty and unique sensuality. Crummy sex is probably worse than none at all, but good sex, well...

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The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
Female Genital Anatomy
Courtesy TSRoadmap.com

Reviewed July 1st 2008

I wrote this page after all five of my close early-transitioning friends told me they had no idea what a woman's vagina looked like. They basically had no idea what to say to the surgeon to express concerns. One friend wrote about her labiaplasty:

As they prepared to give me the general, and Dr. Schrang walked into the operating room, he asked me if I had any special requests, to which I responded quite truthfully, "Uh, I don't know." He then asked me if my clitoris was too large, and I kind of stared at him, and answered, "I have no idea." It was very amusing, and I think the anesthesiologist had to bite his tongue to keep from laughing.

Luckily, she trusted the surgeon to make everything look right, but it would have been better if she had common points of reference for a discussion of cosmetic and functional outcomes. I was very surprised how badly my friends wanted a vagina, but really didn't know what exactly it was they wanted. It seems to me that they were more interested in not having a penis than in what they'd end up with.

Turns out it's not just younger Transsexuals, either. The day after I put up this page, a friend who is older than I am sent me this note:

You can add me to the group who had no idea what I would end up with, I just knew it was a lot better than what I had. I will be quite honest with you here, please don't post this with my name or spread knowledge of my ignorance around. I had very little idea of what I would end up with. I knew I would have Labia and a vaginal cavity, but I had no idea what the urethra was or where it would be located. I knew very little about the clitoris or its position or function. The mons pubis was a total mystery to me until I bumped it too hard!

I feel that awareness and understanding of your genitalia is fundamental to ownership and control of your own body. Not just in a sexual sense, either. You need to be aware of all the parts and attendant joys and difficulties.

Keep in mind that while almost every woman's anatomy is basically the same, each person is also different. Differences in size, color and shape are completely normal. Like penises, women's external genitalia vary quite significantly. If you have aesthetic or functional concerns either before or after surgery, contact your health care provider.

So, without further ado, let's look at what's inside first.

Male Anatomy

The bladder, which holds urine, is found right behind your pubic bone. When you have to urinate, you empty your bladder through your urethra. In male genitalia, the urethra is longer and goes through the penis and out the end. In Sex Reassignment Surgery (S.R.S.), the surgeon shortens the urethra so it's more like the female urethra.

The colon is where solid waste is held until you expel it from the anus.

The bone behind the colon is your spine. The bone in front of your bladder is your pubic bone. Attached to the pubic bone are your abdominal muscles.

Areas removed during S.R.S. include the testicles or testes, where most male hormones (testosterone), sperm, and some semen are produced. Once the testicles are removed, your production of male hormones is virtually eliminated, and you are no longer able to produce sperm. Also removed is most of the spongy erectile tissue inside the penis. (Trivia buffs: This tissue is called the corpus spongiosum.)

In S.R.S., the skin from the penis and scrotum is usually used for making the lining of your vagina, as well as making the features of your vulva or external genitalia (discussed below).

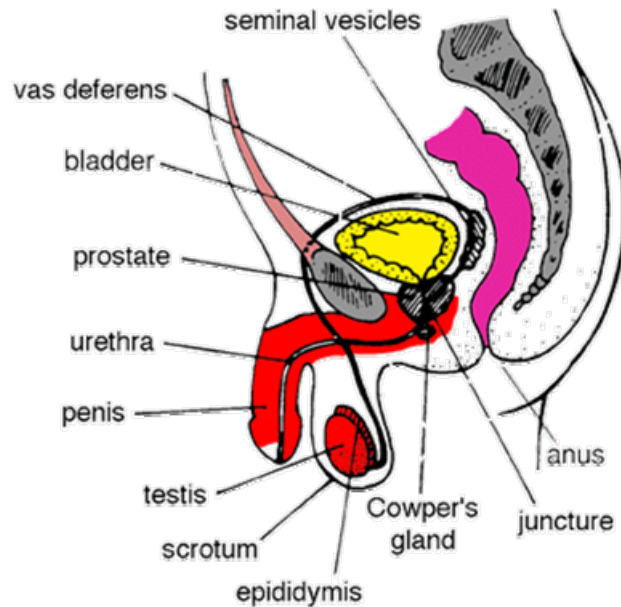
A small amount of tissue at the tip of the penis is used to make your clitoris (see below).

Now, you may think this paragraph is gross or unimportant, but you need to understand how semen is produced. Please read this! Semen is the white milky fluid that males ejaculate when they have an orgasm. Semen has only a tiny amount of sperm, which can fertilize a female egg and produce a baby. The rest is a mixture of other fluids: nutrients for the sperm from the seminal vesicles, mucus from the Cowper's gland, and an alkaline secretion from the prostate (this alkaline offsets the acids found inside the vagina, so the sperm aren't killed as they travel into the uterus). The prostate is a gland that is at the base of the bladder. If you look at the diagram above, you'll see that semen travels from the testes through a tube called the vas deferens. The vas deferens eventually connects with the urethra at a juncture near the prostate. When males ejaculate (come), muscles around the prostate and other glands contract and shoot the semen and sperm out the end of the penis.

Important note: Surgeons do not remove the prostate gland and Cowper's gland in the current techniques.

This means you will have some secretions when aroused from these glands. This will usually not be enough for lubrication during sex, but you will have some.

Also, for this reason, it's important to have a prostate exam whenever you have a gynaecological exam. Prostate cancer is a major killer, although the likelihood in transsexual women is probably significantly reduced. Still, you should have it checked regularly along with your breasts and vagina, especially after age 35.

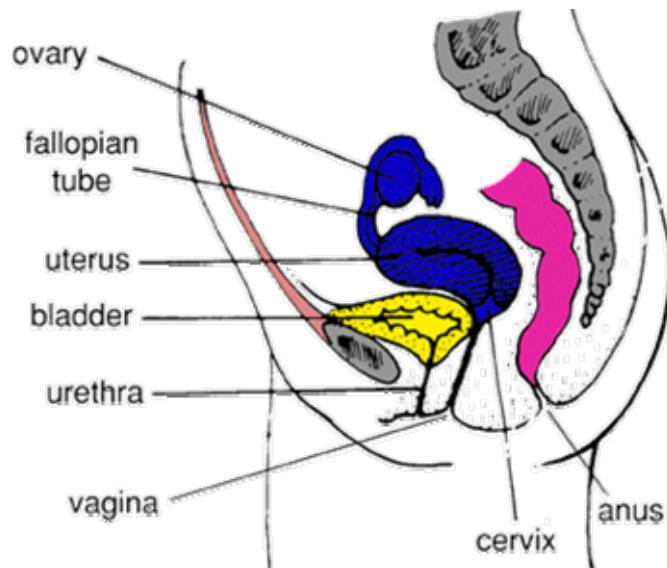


Female Anatomy

The bladder, which holds urine, is found right behind your pubic bone. When you have to urinate, you empty your bladder through your urethra. In female genitalia, the urethra is shorter. It's located between the clitoris and the vagina. You'll notice there tends to be a general difference in the size and placement of the bladder between males and females.

The colon. This is where solid waste is held until you expel it.

The bone behind the colon is your spine. The bone in front of your bladder is your pubic bone. Attached to the pubic bone are your abdominal muscles. Generally, the male pubic bone is a bit more prominent and larger.

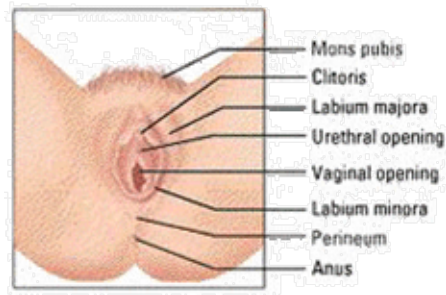


Areas not constructed as part of current S.R.S. techniques are reproductive organs in natal females. They are the organs that allow egg production, ovulation, pregnancy and childbirth, menstruation, etc. These include:

- Cervix – The base of the uterus which extends into the vaginal canal. In its center is a small opening into the uterus, called the cervical or (mouth).
- Uterus (womb) – The pear-shaped muscular organ situated in the pelvic cavity that receives and holds the fertilized ovum (egg). This is where it grows for about nine months until it is born.
- Ovaries – The two small organs located on either side of the uterus, in which ova (eggs) are stored and grow to maturation. The ovaries are the female equivalent of the testes in males. They are the place where female hormones (estrogen and progesterone) are produced. That's why you have to take female hormones even after S.R.S.. The ovaries are also where eggs are produced.
- Fallopian tubes (oviducts) – The two small tubes which extend from the ovaries to the uterus, through which eggs travel. About once a month, a mature egg travels down the fallopian tube (the equivalent of the vas deferens in males). If the egg is fertilized with sperm as it travels down the fallopian tube, it becomes a foetus.

Important note: One thing I want to emphasize is that not having female reproductive organs doesn't mean you aren't a real woman. Many females are born without some or all of these parts, or their parts have some condition so that they are not able to have children. The ability to bear children is by no means the essence of womanhood.

As you can see, there isn't a huge difference physiologically. Basically, the surgeon simply removes the inside of the penis and testicles, and then uses the skin to make a vagina, clitoris, labia, and a shorter urethra. All of this is discussed in detail below.



Glossary

Vulva (vul–vuh) – The vulva is a collective term used to describe the visible external genital organs, extending from the mons pubis to the perineum. The external genitalia consist of the clitoris and clitoral hood, and the labia majora and labia minora.

Mons pubis (Mahns pew–bis) – The soft fatty tissue covered with pubic hair which lies on top of the pubic bone. You have this before surgery. After surgery, your clitoris will be on the lower part of the mons pubis.

Labia majora (lay–be–uh muh–jo–ruh) – Labia majora means "large lips" in Latin. The labia majora are the large, outer lips of the vulva that extend from the mons pubis down either side of the vulva. They are covered by pubic hair and contain fatty tissue under the skin. The soft folds of skin which form flaps on the outer part of the vulva. In sex–reassignment surgery, these are fashioned from scrotal tissue.

Labia minora (lay –be–uh–My–nor–uh) – Labia minora means "small lips" in Latin. The labia minora are the smaller, fleshy inner lips of the vulva that are inside the labia majora and closer to the vaginal opening. The folds within the labia majora which surround and cover the openings of the urethra and the vagina. They are not covered by pubic hair. The size, color, and shape of the labia minora varies a great deal. Some natal women even have larger inner lips than outer. These tend to be not as pronounced in transsexual women, especially in those who opt for a one–stage S.R.S. with no labiaplasty follow–up.

Clitoris (clit–or–is) – The clitoris is a small, firm, rounded organ at the top of the vulva within the labia majora, just above the urethra, that measures about 1/4 of an inch – that's just about the size of a pencil eraser. The clitoris is an important organ for female sexual responsiveness. It is composed of erectile tissue and blood vessels. The clitoris is formed from the head of the penis during surgery.

The external part of the clitoris, called the glans, is covered by a hood of skin. It is connected to a shaft which extends upwards internally toward the pubic bone. During surgery, the same shaft of nerves that extends through the penis is used to form a shaft that you can feel around the clitoris and sometimes on the upper side of the vagina.

When the clitoris is aroused, it fills with blood, becoming harder and more sensitive. The sole purpose of the clitoris is sexual sensation and if sufficiently stimulated it will produce orgasm. Many Transsexuals focus on vaginal orgasms (stimulation caused by penetration), but for most Transsexuals and genetic women, it's much easier to have an orgasm through direct clitoral stimulation with a finger, vibrator, partner's tongue, or a partner rubbing or bumping their mons pubis against yours.

Size and position of clitoris during surgery is an important aesthetic and functional consideration. While natal women vary greatly in clitoral size, it's not unusual for transsexual women to have a larger than average clitoris. Sometimes, it's well outside normal female range. Most surgeons are well aware of this potential outcome and take steps to avoid it. It's also not unusual for the clitoris

to be in a slightly unusual position. This is especially true when a surgeon attempts to accommodate a patient's request for a lot of depth.

Urethra (You-ree-thruh) – The urethra is a short tube connected to the bladder that transports urine to the urethral opening. This opening can be seen as a very small, v-shaped dimple below the clitoris. During surgery, the surgeon removes the spongy penile tissue that surrounds the urethra and uses the urethral tube itself for your new urethra.

It's not uncommon in transsexual women to have a slightly more pronounced and wider urethra. It's also fairly common for the urine stream to go in a more forward direction than in natal women. This might mean you have to sit back on the toilet a bit more and lean forward some. No biggie.

Vagina – The muscular canal that leads from the vaginal opening. It is a narrow tunnel that usually measures between three and six inches in length. The vaginal opening is called the introitus, through which flows vaginal discharge. A certain degree of vaginal discharge is normal, and may change in consistency depending on the hormones present. Because a constructed vagina will not have the same glandular secretions, you may experience dryness, irritation or even infection.

In S.R.S., the vagina is formed by removing the spongy penile tissue and forming a pocket inside the body. This new pocket is then lined with skin from the penis and scrotum, which is inverted (turned inside out) and tucked into the pocket.

Generally, transsexual women seem to have stronger muscles in the vagina. For this reason, it's important to dilate, not just to avoid losing depth, but also width. In fact, width will probably play a greater role in comfort during penetrative sex.

Perineum (Pair-in-ee-um) – The perineum is the area between the vagina and the anus.

Anus – The anus is the outer opening to the rectum and bowels. After puberty, pubic hair may grow around the anus, and the skin may darken in color.

Hymen (not constructed during S.R.S.) – The hymen is a thin, delicate mucous membrane surrounding and partially covering the vaginal opening, which becomes stretched and/or broken when a finger, tampon, penis, or other object is inserted into the vagina. Despite myths to the contrary, it is not an indication of virginity.

Skene's ducts and Bartholin's glands (both not constructed during S.R.S.) both are somewhat mysterious. They're just under the skin and produce secretions believed to aid in lubrication and to ward off infection. You won't have either of 'em, so don't worry about 'em.

Photographs of variations

This page gets nearly four times the hits of any other page on my site, ranging from teenage girls seeking information to men seeking masturbatory material.

Because of the latter, there are very few free sites online that depict non-pornographic photos of women's genitalia. These sites get clogged with traffic, which can be very expensive. That's why there are no photos available on my site.

The-Clitoris.com (<http://www.the-clitoris.com/>) has a great site that discusses a variety of topics about women's sexuality. Due to the problems described above, the owner had to take the photo section offline and make it available by invitation only. However, it's worth joining the discussion list, which contains descriptions and photos of female genitalia in the incredible diversity of shapes, sizes and colours.

For an excellent published example of the variety, check out Joani Blank's *Femalia*. Published by Down There Press; 32 photos; I.S.B.N.0940208156.

Anne Lawrence's site (Transsexual Women's Resources <http://www.annelawrence.com/twr>) has an excellent collection of surgical photos of transsexual genitalia. As you will see, even with the same surgeon, there can be significant variation in outcome.

Depth

A lot of Transsexuals are obsessed about vaginal depth. Most natal women have between 3 to 6 inches of depth, which is plenty in the majority of sexual encounters with men. The largest dilator given out by most surgeons is larger than an average penis. If you can accommodate this dilator, you shouldn't have problems accommodating most men. If you find yourself with a man who has a larger than average penis, it's quite likely he has met many natal women who had difficulty accommodating him as well.

Most women I know who have had the penile inversion technique with a scrotal graft have had 5 to 6 inches of depth, with one a little past 7 inches.

After surgery

Besides not knowing (or wanting to know) what their surgical outcome should look like, many Transsexuals are squeamish about seeing what their outcome does look like. Even more are afraid to see what it feels like. Check things out every now and then – it's very important to be aware of your body. Having hang-ups or being disgusted by your own body can lead to serious mental and medical problems.

The following info is largely from the wonderful Kotex website (<http://www.kotex.com/na/index.asp>):

When it comes to your body, you're the biggest expert around. After all, you live there; you know its workings best. But no matter how young or old you are, your body's shape, hormones and capabilities are changing, in teeny, almost imperceptible ways, all the time. So you owe it to yourself to know what's going on, inside and out.

Outer genitals

The best way to become familiar with what's down there is the same way you learned about other parts of your body: by looking at them. However, these particular parts are rather inconveniently placed for direct staring-at-them purposes. Therefore, you might wish to consult an illustration, or better yet, use a mirror to hold between your legs. Most S.R.S. surgeons supply a hand mirror, but if not, go buy one or use one from a compact.

That whole area you're looking at is called the vulva, also known as. "external genitalia."

At the top of the genital region, where your pubic hair begins, you'll feel a round bone called the mons. Check out below. See the soft flaps of skin? These are the labia majora (outer lips). Inside the protective outer lips, you'll find another, more delicate pair of lips called the labia minora (inner lips). There's a lot of variation in appearance here: Some women's inner lips are bigger than their outer ones, some are more wrinkled or paler or darker or whatever.

Between your inner lips, high up, is a protective fold of skin. This is called the clitoral hood. If you pull it back gently, you'll expose a teeny, round bulge. This is your clitoris, which plays an important, positive role in a woman's sexuality. The clitoris is rich with nerve endings and extremely sensitive.

Just below your clitoris you'll see a small opening, the urethra. This is the opening through which you urinate. Continuing downward, below your urethra, you'll see a larger opening, which is your vagina.

Don't be squeamish about touching everything. It's really important to feel around and get a sense of what you have. A good place to feel around can be in the shower when you're washing the area.

Inner genitals

You should also put your fingers up into your vagina to see how it feels. Do it in the shower, or on the bed just prior to dilation.

Use a little lubrication. I can tell you from experience that it feels just like the inside of a natal woman's vagina.

Also, I recommend checking out my page on Dilating for more information on care and maintenance.

Similarities to non-Transsexual genitalia

In 2001, a reader sent along this good news after she and her non-transsexual female partner did some careful exploring of each other:

My partner and I ordered some toys from a wonderful shop in Seattle, and I noticed that for six dollars I could pick up a speculum. With the help of a pen light and a hand mirror, we explored one another and I made the most delightful discovery.

The only visible difference between our vaginas is that at the termination of hers is a tiny, round donut-shaped depression about the size of a pencil eraser (her cervix). I'd heard the results looked good to Obstetrician / Gynaecologist anecdotally, but seeing it myself made me irrationally happy. I think I'd imagined this would look different, that perhaps scar lines would be visible or the character of the tissues would be noticeably different. That six dollars is one of my best investments to date and, as I imply, assuaged some unarticulated trepidation I had.

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The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
HIV/AIDS Issues
For Transsexual People

Reviewed July 1st 2008

Who is at risk?

All people are at risk of contracting the H.I.V./AIDS virus regardless of their age, gender or sexuality. Anyone who has unprotected vaginal, anal or oral sex is at risk of contracting H.I.V. Infected needles and syringes or exposure to infected blood and blood products may also transmit H.I.V.

People with gender issues, however, face unique risks and it is most important to be aware of these. This Fact sheet is to help you and your sexual partners manage these risks.

How can I protect myself?

Hair Removal

If you shave or wax your body or pubic hair, be careful of cuts and scraping. Cover any cuts and abrasions before sex and never allow anyone's body fluids (blood, semen or vaginal fluids) on damaged skin. Be particularly careful if you shave your pubic hair, legs, chest or armpits and then engage in "trick sex" (having intercourse between closed thighs or under armpits etc.).

Needles

Some people may use syringes/needles for hormone injections. The H.I.V. and other dangerous viruses including hepatitis can hitch a ride in a shared needle or syringe. If you inject your own hormones or help friends with theirs, keep a clean supply and never share needles or syringes.

Needles and syringes are available from the Gender Centre exchange program. They stock correct size needles and syringes for the administration of hormones and for intravenous drug use.

Needles and syringes can also be obtained from many chemists as part of their exchange programs for a small fee. Many community health centres and agencies provide a needle exchange, or ring your local drug information service for their location.

Taping, Strapping and Tucking

If you are taping, strapping or tucking you could create a warm, moist area leading to skin disorders, chaffing and dermatitis. Removing tape roughly could result in damaged/broken skin. Any of these increase the risk of the virus penetrating your skin during sex, particularly if you get someone else's body fluids onto that region as might happen from unprotected "trick" sex.

So,

Always use condoms

Try to keep these areas as dry and clean as possible (unscented sterilised talcum powder may help) and let them breath a bit when you're in private

Remove tape carefully and remove any traces of adhesive with something gentle and soothing like eucalyptus oil.

Surgery

If you have recently undergone any surgery that has involved any areas of your body that may be exposed to body fluids during sex, then be sure to cover the area until your skins has completely healed.

Douching

If you have, a neo-vagina (created through surgery) a natural vagina or engage in receptive anal intercourse you may practice douching to keep these passages clean. Douching weakens the lining of the anal passage or vagina and removes friendly bacteria and mucous, exposing the porous membranes (surface skin lining) and increasing the risk of H.I.V. transmission and the risk of contracting general infections.

The practice of frequent douching is generally discouraged by health workers. If you feel you must douche for personal comfort, then it should only be practiced 2–3 times a week at most.

If you have a vagina then it is best to try and keep it slightly acidic as this will minimise the damage to friendly bacteria, while discouraging infections. This can be achieved by using a product called aci-gel that can be bought at the chemist. Use about 1 third to a quarter of an applicator 2 times a week. If you continue to douche, try to maintain the acidity by using a mixture of warm water and vinegar (one part vinegar to 10 parts water).

Remember douching and gels are not an alternative for safe sex. Only condoms can protect you during intercourse from the H.I.V. virus and other sexually transmissible infections.

Douche equipment should never be shared without thorough cleaning between uses.

If you are concerned about vaginal odours, see a doctor rather than douching. Doctors who work in women's health, for example through Family Planning N.S.W. have experience in vaginal care.

Sexual Activity

If you have a neo-vagina and engage in unsafe sex (unprotected) then you not only face the same risk of contracting the H.I.V. virus as biological women from receptive intercourse, you may also face risks that are specific to your situation.

The AIDS virus (H.I.V.) is found in an infected persons body tissues, and in blood, semen, vaginal fluid and breast milk.

Although a neo-vagina may produce some lubrication during intercourse it may not be enough for comfortable sexual activity. If you have sex without extra lubrication (Wet Stuff, K.Y. Jelly) small undetectable breaks or tears in the vaginal lining can occur. These breaks and tears increase the risk of the virus being transmitted from the partner's body fluids. This could also happen if you have a vagina that isn't wide enough to comfortably accommodate your partner's penis.

The AIDS virus (H.I.V.) can be passed on through receptive or insertive anal sex.

Infected semen can enter the blood stream through the lining of the back passage (rectum).

The H.I.V. virus may be present in the lining of the rectum and come into contact with the penis and get in through tiny skin tears or through the opening of the penis.

Always ensure that the "giver" wears a condom.

You have a right to protect yourself. Remember a partner can carry the H.I.V. virus whether they identify as gay, lesbian, bisexual or heterosexual. H.I.V. does not discriminate.

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The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet

Hepatitis C Brochure

Description, Infection, Treatment

Reviewed July 1st 2008

What is Hepatitis?

Hepatitis simply means inflammation of the liver. It can be caused by alcohol, chemicals, drugs or viral infections. Hepatitis infections caused by different viruses can produce similar symptoms but their prevention, treatment and control may differ because the viruses are quite different organisms – ask your doctor for more information.

What is Hepatitis C?

It is liver inflammation caused by the hepatitis C virus (H.C.V.). Before the virus was identified in 1989, hepatitis C was known as non–A non–B hepatitis. There is no vaccine to prevent hepatitis C infection.

How do you catch Hepatitis C?

H.C.V. is nearly always caught through blood to blood contact with someone who is already infected. This involves sharing drug–injecting equipment, tattooing, skin piercing, receiving blood transfusions prior to 1990, needle stick injuries or renal dialysis. Since February 1990, Australian blood banks have screened donated blood for H.C.V.

Is there a test for Hepatitis C?

An antibody blood test showing presence of antibodies to the virus is evidence of present or past infection. If you test positive for the antibodies, it is likely you have hepatitis C and are infectious.

Other blood tests (called liver function tests), may suggest if there is any liver damage.

A liver biopsy (studying a piece of liver) is an accurate way of telling whether the liver is damaged.

How might it affect me?

When people catch H.C.V., usually there is no sign of infection. Over a long period of time though, H.C.V. infection affects people to varying degrees. Of 100 people exposed to H.C.V., approximately 20 will clear the virus themselves within 4–6 weeks of infection. This means their infection is ongoing and long term.

Of these 80 people:

- around 20 people will not develop symptoms and will remain well;
- around 40 people may develop some liver damage and will eventually experience symptoms (the classic hepatitis symptom is tiredness);

- over 20 years, around 20 people will develop cirrhosis (scarred liver tissue); and
- after a further 5–10 years, 10 of these people will develop liver cancer or liver failure (liver failure often means a liver transplant is done).

Is there any treatment?

One proven treatment (called Interferon) leads to a good long-term response for around 15–40% of people who try it. Interferon helps the body fight the virus from multiplying. The drug does have side effects and treatment needs to be carefully monitored.

Some herbal and other natural therapy treatments may reduce liver damage and improve overall health.

If you seek treatment from a natural therapist you may want to consider:

- making sure they have proven experience in working with hepatitis C;
- ensuring they are properly qualified and belong to a recognised membership organisation;
- how much the treatment will cost you; and
- how they have measured the health outcomes of their therapy.

It would be to your benefit if you can find practitioners who will work together.

What can I do myself?

If you drink alcohol, try to limit yourself to 7 standard drinks a week or less. Consider drinking low-alcohol drinks and alternating non-alcoholic and alcoholic drinks. Try avoiding situations where there is pressure to drink heavily and avoid binge drinking.

Eat a well balanced diet that is low in animal fats (buy lean meats & low fat dairy products).

Avoid stress as much as you can and rest when you feel unwell.

Will my partner or kids catch it?

Hepatitis C cannot be caught by hugging, or sharing plates, cutlery, toilets etc. Although H.C.V. is rarely passed on sexually, all sexually active people need to consider safe sex due to the range of sexually transmitted diseases.

There is a small chance the virus will be passed on to a baby during pregnancy or at birth. The risk is increased if the mother has only just become infected (or re-infected) or if she has serious liver damage. H.C.V. does not seem to be passed on via breast milk.

How can we stop H.C.V. spreading?

In general, try to prevent transmission of H.C.V.:

- do not donate blood, sperm or body organs if you have hepatitis C;
- don't share any injecting equipment, including needles and syringes, spoons, filters, water, swabs & tourniquets. Wash your hands thoroughly. Avoid getting blood on your fingers and hands. Ideally, use a new fit for every hit;

- wipe up blood spills with household bleach;
- cover cuts and wounds with waterproof dressings (band-aids etc);
- have body piercing and tattooing done at shops that use good methods of sterilisation.
- don't share razors, toothbrushes or nail scissors; and
- Avoid sex that involves blood to blood contact.

Hepatitis C & injecting drug use

Hepatitis C has become a major problem for people who inject drugs. Most people who "use" have hepatitis C so those users who don't have hepatitis C must be seen as being at great risk of infection.

It doesn't matter what is injected – heroin, methadone, pills, speed or steroids – it is how the drugs are injected that is the important thing.

H.I.V. prevention strategies (harm reduction) should prevent H.C.V. transmission in most circumstances. Users should adopt these practices to prevent passing on the virus and to avoid infection or being re-infected with a different strain of H.C.V.

Users need adequate medical follow-up after an H.C.V. diagnosis is made. Awareness of injecting practice and recommended lifestyle changes.

Users can obtain specific and accurate information on injecting drug use, harm minimisation and hepatitis C from N.U.A.A. and the Hepatitis C Council of N.S.W.

Where can I get more information?

- N.S.W. Hepatitis C Info & Support Phone Line Sydney (02) 9332 1599 or N.S.W. 1800 803 990
- Hepatitis C Council of N.S.W., Sydney (02) 9332 1853
- Speak to your doctor. If necessary he or she can also refer you to a liver specialist
- N.U.A.A., Sydney (02) 9369 3455
- your local needle exchange worker.

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