

Hysterectomy/Oophorectomy

Most (but not all) trans men will have at least one surgical procedure in his lifetime related to gender transition, if not several of them. However, it is important to note that many trans men do not avail themselves of the surgeries listed below due to cost considerations, health reasons, or personal reasons. Currently, most surgeries related to gender transition are not covered by insurance companies, so costs can be prohibitive for many trans men of lower or fixed incomes.

FTM SURGERY IS GENERALLY DIVIDED INTO THREE MAIN GROUPS:

1. Chest reconstruction surgeries (also referred to as "top" surgery or male chest contouring);
2. Hysterectomy and oophorectomy (removal of the uterus and ovaries, respectively); and
3. Genital reconstruction surgeries (also referred to as "lower" or "bottom" surgery or GRS).

Within these three main groupings are different types of procedures and surgical methods that will be further described herein. This section describes the main types of hysterectomy and oophorectomy procedures that are currently available to trans men. Chest surgery and genital reconstruction surgeries (GRS) are detailed in their own separate sections. The descriptions of the FTM surgeries listed below are generalized. It is important to note that there are different methods for performing a hysterectomy/oophorectomy (sometimes referred to as "hysto" and "oopho" in FTM circles); the procedure chosen will depend on the physical characteristics of the patient as well as the expertise of the surgeon performing the procedure. If you are considering any of these procedures, it is important to research your options thoroughly and speak candidly with the surgeons you are considering.

WHY HAVE A HYSTERECTOMY/OOPHORECTOMY?

Some physicians recommend hysterectomy and oophorectomy within the first 5 years of starting testosterone therapy. There are two reasons for this. First, there is some concern that long-term testosterone treatment may cause the ovaries to develop similar symptoms as those seen in polycystic ovarian syndrome (PCOS). PCOS has been linked to increased risk of endometrial hyperplasia (a condition that occurs when the lining of the uterus (endometrium) grows too much) and thus endometrial cancer, as well as ovarian cancer.

It should be noted that it is difficult to prove whether the risk for such cancers is increased by testosterone therapy in trans men. Female-to-male transsexuals are a small population to begin with, and many undergo hysterectomy/oophorectomy early on in their hormonal treatment, thus making the study of long-term effects of testosterone on the uterus and ovaries difficult. Also, some trans men may have suffered from PCOS before beginning testosterone treatment.

Because the relationship between long-term androgen use and gynecological health is not yet fully understood, and because many trans men experience embarrassment and/or access issues over obtaining ongoing gynecological care, some may feel it is appropriate to pursue such surgeries as a preventative measure. For more information on PCOS, endometrial cancer, and ovarian cancer see the resources section.

The second reason why it may be considered beneficial to undergo a hysto/oopho is that after the removal of the ovaries, testosterone doses can often be decreased because the ovaries are no longer producing estrogen.

If a trans man chooses not to have a hysto/oopho procedure, he should continue to have regular Pap smears (to screen for cervical cancer) and should seek out the care of a doctor if he experiences any irregular vaginal bleeding (including spotting), cramping, or pain. It is not uncommon for trans men who are pre-hysterectomy to experience a buildup of endometrial tissue, especially during the first few years of testosterone therapy. Endometrial tissue is normally shed during menstruation, but since this process is usually stopped a few months into testosterone therapy, additional tissue may continue to build up and may eventually begin to shed in the form of spotting.

Because irregular bleeding can be a sign of cancer (though this is often not the case), trans men who experience any bleeding/spotting should see a doctor who will perform tests to determine the cause of the spotting. These tests may include an endometrial biopsy and/or an ultrasound. The doctor may advise a short course of progesterone to cause the uterus to shed the excess endometrial tissue-- this is much like inducing a period. While this may be unpleasant, it should be understood as a preventative measure, since the unusual buildup of endometrial tissue has been linked to endometrial cancer.



TYPES OF HYSTERECTOMY AND OOPHORECTOMY PROCEDURES

There are three main ways in which the uterus can be removed from the body: either through an incision in the abdomen, vaginally through an incision in the top of the vagina (sometimes assisted laparoscopically through small incisions in the abdomen), or through a combination of tissue removal through small incisions in the abdomen as well as through the vagina. The type of surgery chosen will depend on the patient's physical limitations as well as the surgeon's expertise.

Some surgeons who perform genital reconstruction surgery (GRS) may wish to do a hysterectomy/oophorectomy at the same time as GRS. If you are considering GRS, you may wish to fully research such options.

TOTAL ABDOMINAL HYSTERECTOMY (TAH)

This is the removal of the uterus and the cervix via an incision in the abdomen. During the procedure, the surgeon will make an incision, either horizontally or vertically, in the abdominal wall. The abdominal muscles will be spread apart with retractors. The uterus and cervix are cut away from the surrounding ligaments and blood vessels, and then removed by cutting them off at the top of the vagina. The vagina is sewn closed at the top.

The surgical procedure lasts about 1 to 3 hours, and usually involves a hospital stay of 3 to 5 days. Recovery is usually a 6 to 8 week period of restricted activity. The procedure leaves a 4 to 6 inch scar on the abdomen, usually just above the pubic hair line.

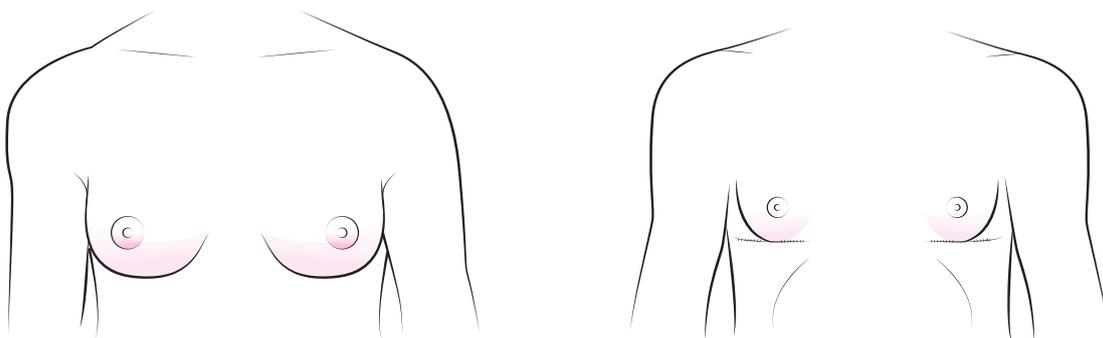
Because of the advances in laparoscopic surgical procedures, surgeons will often recommend less invasive procedures such as LAVH or TLH, listed below, if the patient is a good candidate. Laparoscopic procedures generally involve smaller incisions, less scarring, shorter recovery time, and shorter hospital stays than abdominal hysterectomy.

TOTAL VAGINAL HYSTERECTOMY (TVH)

This is the removal of the uterus and the cervix via an incision in the vagina; all operating procedures are performed through the vagina. The uterus and cervix are cut away from the surrounding ligaments and blood vessels, and then removed by cutting them off at the top of the vagina. The vagina is sewn closed at the top.

Because there are no incisions made in the abdomen during TVH, the surgeon cannot easily access the abdominal cavity. She/he cannot examine for and remove endometriosis, she/he cannot perform the procedure if adhesions are present, and certain complications may arise if also attempting to remove the ovaries. Additionally, because TVH is performed entirely through the vagina, it is best performed on individuals who have vaginal laxity (i.e. a wide enough and flexible enough vaginal canal, as often seen after childbirth).

The surgical procedure lasts about 1 to 3 hours, and usually involves a hospital stay of 1 to 3 days. Recovery is usually a 6 to 8 week period of restricted activity. This surgery is not recommended if your vaginal canal is restricted, as the surgeon will need space for instruments and for the removal of the organs. For a restricted vaginal canal, your surgeon may recommend TLH as an alternative option.



Illustrations by the Gender Centre

LAPAROSCOPICALLY ASSISTED VAGINAL HYSTERECTOMY (LAVH)

This is similar to TVH above, but performed with the aid of laparoscopy. During the procedure, the surgeon makes several small cuts in the abdominal wall to provide access for a laparoscope (a tiny telescopic camera) and other small surgical instruments. The laparoscope is used by the surgeon to see inside the abdomen during the procedure. The surgeon may perform some of the cutting procedures by working through the abdominal incisions, but other surgical procedures will still be performed through the vagina. The uterus and cervix will be mainly removed through a cut at the top of the vagina, and then the vagina is sewn closed.

The surgical procedure lasts about 1 to 3 hours, and usually involves a hospital stay of 1 to 2 days. Recovery is usually a 4 to 6 week period of restricted activity. This surgery is not recommended if your vaginal canal is very restricted, as the surgeon will need space for instruments and for the removal of the organs. For a restricted vaginal canal, your surgeon may recommend TLH as an alternative option.

TOTAL LAPAROSCOPIC HYSTERECTOMY (TLH)

Is the removal of the uterus and the cervix by operating through several small cuts in the abdominal wall that provide access for a laparoscope (a tiny telescopic camera) and other small surgical instruments. The uterus is removed by passing the tissue out through the vagina or through one of the small abdominal incisions. Because there is no operating performed through the vagina (though small pieces of tissue can be passed down through it), there is no requirement for a wide vaginal passage, and there are fewer problems with increased urinary incontinence at a later date.

The surgical procedure lasts about 1 to 3 hours, and usually involves a hospital stay of 1 to 2 days. Recovery is usually a 2 to 4 week period of restricted activity. Because there is no requirement for a wide vaginal passage and because this procedure involves less blood loss, lowered risk of urinary incontinence, shorter hospital stay, and shorter recovery time for most patients, TLH can be an excellent choice if it is available. Because TLH is a relatively new procedure, not all surgeons are necessarily skilled in its practice. Be sure to inquire as to your surgeon's direct experience with TLH, or with any type of surgical procedure you are considering.

BILATERAL SALPINGO OOPHORECTOMY (BSO)

This involves the removal of both ovaries and of both fallopian tubes (bilateral=both sides, salpingo=fallopian tubes, oophor=ovaries, ectomy=removal). For trans men, this procedure will usually be performed at the same time as your hysterectomy. Because the risk of ovarian cancer remains if the fallopian tubes are left behind, both the ovaries and fallopian tubes are usually removed during this procedure.

RISKS & COST

As with any surgical procedure, there are some risks that may occur. These include bleeding, infection, problems from anesthesia, blood clots, or death (rare). Some other problems that have been reported after hysterectomy include irritable bowel syndrome, incontinence, damage to the urethra or bowel, prolapse of the vagina, back pain, or loss of sexual feeling or function. Depending on the type of procedure you undergo, these risks may be more or less common-- speak directly with your surgeon about the risks of the specific procedures you are considering.

The cost of hysterectomy/oophorectomy will vary, but in general will run between \$7,000 and \$20,00 in the United States (including surgery fees and related hospital/staff fees). Because there is usually a hospital stay after the procedure, and since hospitals charge by the day, this will effect the overall price depending on the duration of the stay.

Hysterectomy is one of the few surgeries that trans men may be able to have covered by insurance, if the procedure is shown to be health-related. If you are experiencing pain or irregular bleeding, or if you have a history of abnormal Pap smears, fibroids, or polyps, you may wish speak with your doctor about the possibility of hysterectomy as a necessary procedure for insurance purposes.

Ph: (02) 9519 7599

www.gendercentre.org.au

SOURCES OF FURTHER INFORMATION:

The Gender Centre Inc.

41/43 Parramatta Road

Annandale N.S.W. 2038

Phone (02) 9519 7599

Fax (02) 9519 8200

Anti-Discrimination Board

Level 4, 175-183 Castlereagh Street

Sydney N.S.W. 2000

Phone (02) 9268 5544

Fax (02) 9268 5500



Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only.

The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

*The Gender Centre Inc Ph: (02) 9569 2366 Fax: (02) 9569 1176
Web: www.gendercentre.org.au Email: reception@gendercentre.org.au*