Surgery: A Guide For F.T.M.s Part 2

Hysterectomy, Oophorectomy, Metoidioplasty and Phalloplasty

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Hysterectomy and Oophorectomy

Hysterectomy refers to the removal of the uterus, including its lining (endometrium). Total hysterectomy involves removal of the uterus and the cervix (the cone-shaped neck of the uterus that sticks out into the vagina).

Oophorectomy refers to the removal of the ovaries. The fallopian tubes, which carry eggs released by the ovaries into the uterus, are usually removed at the same time as the ovaries (salpingo-oophorectomy). Both surgeries can be done by a gynaecologist or reproductive endocrinologist.

Why get Hysterectomy/Oophorectomy?

There are various reasons F.T.M.s have for wanting to have their uterus and/or ovaries removed. Like any other type of S.R.S., there is no right or wrong answer in terms of whether to have a hysterectomy or oophorectomy: it is a personal decision. You might want to consider it if you:

a. **Feel dysphoric about having "female" organs or having periods.** Even though the uterus and ovaries are not visible, for some F.T.M.s it is uncomfortable to know they are there. For F.T.M.s in this situation, having the ovaries and uterus removed can help reduce the dysphoria. Testosterone stops menstrual periods, but some F.T.M.s don't want to take testosterone, experience bad side-effects from it, or can't take it for health reasons. Removal of the uterus guarantees no more periods. Endometrial ablation - removal of the lining of the uterus by surgically burning it away or vaporizing it - is a possible alternative to getting your uterus removed if your main reason for hysterectomy is wanting to stop periods.
b. **Are having gynaecological problems.** Your doctor may suggest hysterectomy if you have fibroids, endometriosis, abnormal uterine bleeding, very painful menstrual periods, or another gynaecological problem relating to the uterus, and may suggest oophorectomy if you have ovarian cysts or other problems with your ovaries. Usually surgery is considered a last resort for gynaecological problems, but for F.T.M.s surgery may be considered as treatment early on if you were planning to have a hysterectomy or oophorectomy in the future anyway.
c. **Are at risk for cancer of the uterus, ovaries, or cervix.** Risk of cancer depends on variables that are different for each person, including genetics and exposure to environmental agents known to cause cancer (carcinogens). As discussed in Trans People and Cancer (available from the Transgender Health program), F.T.M.s may be at increased risk of cancer of the uterus, ovaries, and cervix whether or not they take testosterone. There is also some evidence that testosterone may increase the risks of uterine and ovarian cancer. For these reasons, some doctors recommend that F.T.M.s who are taking testosterone over a long period of time should get their ovaries, uterus, and cervix removed. Other health professionals feel the evidence is not conclusive at this point and that these surgeries are only necessary if there are other risk factors for reproductive tract cancer.
d. **Find it traumatic to get Pap smears and pelvic exams.** The Pap smear is the main screening tool for cervical cancer. It involves gently spreading the vagina open (with a speculum) and taking a sample of cells from the cervix to look for changes that can indicate early stages of cervical cancer. Pelvic exam, which involves the health professional putting 1 – 2 fingers inside your vagina, is done to help feel the size, shape, and position of your ovaries, uterus, and fallopian tubes, and to check for pain or growths. It is the main screening tool for ovarian and uterine health. For F.T.M.s who feel dysphoric about their genitals or have been sexually assaulted or abused, having anyone look at or put something inside their vagina can feel traumatic or humiliating. Some F.T.M.s refuse to get Pap smears or pelvic exams. This increases the risk of ovarian, uterine, and cervical disease (including cancer) not being caught until it has advanced beyond the point where it can be treated. Removing your ovaries, uterus, and cervix is one way to prevent cancer. If you have had cervical cancer or high-grade abnormal Pap smears (cervical dysplasia) in the past, even after your cervix is removed you will still need to get samples of the cells of the top of your vagina (vaginal cuff) to check for cancer. It is recommended that you get vaginal cuff smears done every year until you have three normal tests in a row, then they can be done every two years.

e. **Want to lower your testosterone dose.** The ovaries are the main source of oestrogen. Having them removed lowers your oestrogen and therefore the amount of testosterone you need to overcome the effects of oestrogen. The health risks of long-term use of relatively high doses of testosterone are not known, and some doctors and trans people believe that lower doses are lower risk. If your combined oestrogen and testosterone are too low you are at risk for loss of bone density (see booklet on osteoporosis), so if you have your ovaries removed you will have to take some type of medication to protect your bones (if you have bad side-effects from testosterone, there are other options).

Surgical techniques for Hysterectomy/Oophorectomy

Hysterectomy

In the past the only option for hysterectomy was a large cut across the abdominal muscles. This was a major surgery that involved prolonged recovery time. It is usually done differently now to spare the abdominal muscles. Several small cuts are made in the bellybutton/abdomen and a tiny telescopic camera (laparoscope) and other surgical instruments are passed into the pelvis. The camera is used by the surgeon to see the uterus and other pelvic organs, and the surgical instruments are used to snip the tissues holding the uterus and cervix in place. The uterus (and possibly cervix) is removed through a cut in the vagina (vaginal hysterectomy) or alongside the abdominal muscles (abdominal hysterectomy), and the top of the vagina is sewn shut.

It is up to you and your surgeon to decide together whether to do abdominal or vaginal hysterectomy. Abdominal hysterectomy involves a larger incision than with vaginal hysterectomy, so can take longer to heal. However, a vaginal hysterectomy can be difficult to do if you have never had penetrative vaginal sex or have a small vagina (especially if your vagina has atrophied from taking testosterone over a long period of time), or if your uterus has become attached to other organs due to adhesions from endometriosis or another gynaecological condition.

Oophorectomy

This is usually done at the same time as hysterectomy and usually involves removal of ovaries and fallopian tubes on both sides (bilateral salpingo-oophorectomy). It is usually done through laparoscopic abdominal incisions as described above for hysterectomy.

When can I have hysterectomy/oophorectomy?

If you are having hysterectomy/oophorectomy to treat pre-existing medical problems (pain, bleeding, etc.) you will go through the same process as women who are having the same surgery for similar conditions.

The wait for surgery depends on how much of an emergency the condition is; if it's considered serious you will have surgery sooner than if it is considered a minor health problem. Mental health assessment is generally not required to have hysterectomy/oophorectomy for a physical health problem unless the surgeon has concerns about your ability to provide informed consent or doesn't think you are psychologically prepared for surgery.

If you are wanting hysterectomy/oophorectomy to reduce dysphoria, to change your legal sex, or for other reasons that are considered part of gender transition, your surgeon will likely treat the surgery differently. Most surgeons follow the World Professional Association for Transgender Health (W.P.A.T.H.)'s Standards of Care, which state that hysterectomy/oophorectomy should only be done after one year "real life experience" and evaluation by two trans-experienced mental health professionals.

Because there is a risk every time you go under general anaesthetic, in S.R.S. programs where there is a team of surgeons working together, hysterectomy/oophorectomy is often done at the same time as chest reconstruction or genital surgery.

At the hospital

You will be admitted the same day as your surgery. You may be asked to come to the hospital the day before surgery to go over information about the surgery and to have a last-minute physical check-up. You may be prescribed antibiotics to help reduce the risk of infection, or laxatives to clean out your bowels. You will be told not to eat or drink after midnight the night before you have surgery.

You will be monitored by hospital staff as you come out of the anaesthetic and will stay in hospital for 2 – 5 days to recover (depending on the type of surgery you've had and your progress in healing). You will likely have a tube in your bladder (catheter) to collect urine for the first 48 hours after surgery, as it's often difficult to urinate at first. There may also be tubes from your abdomen to help drain fluids from the operation site.

As with any surgery, you will not be able to drive afterwards so you will need someone to help you get home. You will likely be given antibiotics in the hospital to help reduce the risk of infection as your wounds are healing, and also will be given pain medication. You may be given medication that you put inside your anus (anal suppositories) to help with pain, constipation, bloating, and gas.

After surgery

The aftercare instructions are different for different types of surgery and depend on the specific technique used. Talk with your surgeon before surgery to make sure you understand what to expect and what you need to do after you've been discharged from the hospital, and to talk about pain management options.

Your surgeon will give you information about wound healing and the dressings over your wounds, and a home care nurse will visit you once a day after you are discharged from hospital until the wounds have healed enough for you to take care of them yourself. If you

have had surgery done by laparoscopy, the wounds will be very small; if you have had abdominal hysterectomy you will have a larger incision. Do not have a bath or otherwise soak the incisions until they have completely healed.

During the first two weeks, you will need to rest and avoid lifting or other movements that cause pain. After this, you can try slowly working in more daily tasks that do not involve too much physical activity. People describe having a feeling of abdominal pressure; pain when trying to urinate, pass gas, or defecate, or sometimes vaginal bleeding. Once this has stopped, you can go back to most of your normal activities, being careful to not overdo it and to rest when you need to. Complete recovery usually takes 4 – 6 weeks for vaginal hysterectomy and 6 – 8 weeks for abdominal hysterectomy. Whichever type you've had, don't have vaginal sex until six weeks after surgery, and avoid heavy physical exercise for at least three months after surgery. The surgeon will want to see you approximately six weeks after surgery to check your healing.

Risks and possible complications of hysterectomy/oophorectomy.

Every surgery involves possible risk of infection, bleeding, pain, and scarring. Antibiotics are usually given at the hospital to reduce the risk of infection, and hospital staff and the home care nurse assigned to you after you are discharged will be checking for signs of infection. It is normal for there to be swelling and bruising, but if the skin is very tender or warm and you don't feel well, see a doctor to check whether you have an infection. Also see a doctor if your incisions are red more than 1 to 2cm beyond the end of the incision line.

All surgery that involves general anaesthetic is a serious medical procedure. With general anaesthetic there is a risk of a negative reaction to the anaesthesia or, if you are lying flat for a long period of time, a risk of blood clots (which can be fatal). Surgeons, anaesthetists, and surgical nurses are experienced in preventing problems and responding to any emergencies that happen during surgery. After you're discharged from the hospital, to prevent blood clots move around as much as feels comfortable, and drink plenty of water. Get emergency medical help (call 000) if you have sudden shortness of breath, chest pain, dizziness, or tender, warm, and swollen legs - these can be signs of a blood clot and you may need emergency help.

Possible complications specific to hysterectomy include:

- accidental damage to the bladder, rectum, or other internal organs;
- bladder or urinary tract infection;
- sinking of the top of the vagina (vaginal vault prolapse) due to decreased support from other organs, this needs surgical repair;
- changes in sexual sensation or decreased intensity of orgasm.

Possible complications specific to oophorectomy include:

- accidental damage to the bladder, rectum, or other internal organs;
- bladder or urinary tract infection;
- menopausal symptoms and loss of bone density related to decreased oestrogen (if you're not taking testosterone);
- pain and menstrual bleeding if some ovarian tissue is left behind (see below)

Call your doctor or go directly to hospital if you have:

- severe pain;
- nausea or vomiting;
- heavy vaginal bleeding (more than a typical menstrual period would be)
- fever of 38°C/101°F or higher;
- pain when you urinate, or problems controlling your bladder (incontinence);
- a swollen abdomen or inability to pass gas.

Whether or not you have vaginal sex, you may find that the removal of your uterus and cervix affects the sensations you experience during orgasm. The uterus changes shape during sexual arousal and contracts with orgasm, so its removal can change what you feel when you have an orgasm. If you enjoy vaginal penetration as part of sex, you may find that having your cervix removed makes it harder to have an orgasm or that orgasm is less intense. The loss of the cervix can also impact vaginal lubrication, so you may need more lube after a hysterectomy.

Polycystic ovaries, endometriosis, infections, and other gynaecological problems can cause scar tissue (adhesions) that attaches your ovaries to your uterus or other organs. It can be hard to separate and pull the ovaries off the other organs. Bits of ovarian tissue may be left behind and grow, causing pain. This situation is called ovarian remnant syndrome. In rare cases enough tissue is left to produce eggs, or normal amounts of oestrogen - which can bring about a menstrual period if you still have a uterus and are taking low doses of testosterone. Further surgery is needed to remove the leftover pieces of ovarian tissue.

F.T.M. Genital Surgery

F.T.M. genital surgery can involve:

1. removal of the vagina (vaginectomy or colpectomy) or closure of the vagina (colpocleisis)
2. creation of a scrotum and testicular implants (scrotoplasty)
3. creation of a penis (two types of surgery - metoidioplasty or phalloplasty - with various techniques that can be done for each type):

both techniques can involve lengthening of the urethra - which carries urine from the bladder to outside the body - to allow you to urinate through your penis (urethroplasty)
    - phalloplasty can include placement of a device to make it stiff for sex, and also tattooing of the head to make its colour look more like a non-trans man's penis

Different surgeons do different parts of the surgery:

- vaginal closure, urethral lengthening, metoidioplasty: urologist (urinary tract specialist)
- removal of the vagina (if done with removal of ovaries/uterus): gynaecologist or reproductive endocrinologist
- phalloplasty: plastic surgeon
- scrotoplasty: urologist or plastic surgeon

Timing of F.T.M. genital surgery

There are various ways the surgeries can be grouped together, depending on the protocols used by the surgical team, your health, and your overall goals of genital surgery. Possible combinations include:

- vaginal closure/removal, urethral lengthening, scrotal construction, and metoidioplasty/phalloplasty done at the same time, along with removal of the ovaries and uterus if they have not already been removed
- vaginal closure/removal, urethral lengthening, and phalloplasty done at the same time, with scrotum construction and placement of a penile stiffening device done later (one year after phalloplasty)
- vaginal/closure removal at the same time as removal of the ovaries and uterus, if there are no plans for urethral lengthening in the future

If you have recently had your ovaries/uterus removed, you must wait at least 4 – 6 months before having genital surgery, to give your body time to fully recover from the first surgery.

F.T.M. genital surgery techniques

Creation of a penis

There are two options for creating a penis: metoidioplasty (sometimes spelled "metoidioplasty" or "metoidioplasty," or abbreviated as "met") and phalloplasty. Phalloplasty can be done on top of a metoidioplasty - in other words, you can have a metoidioplasty first, then have phalloplasty later.

Metoidioplasty

- **How is it done?** Testosterone makes your clitoris grow usually 1 – 3cm). Metoidioplasty involves cutting the ligament that holds your clitoris in place under the pubic bone, as well as some of the surrounding tissue. Your clitoris is then freed up so more of it is showing (this technique is sometimes called "clitoral free-up" or "clitoral release"). The surgical technique can include modifications to enhance the result:
    - fat can be removed from your pubic and the skin pulled upward to bring the new penis farther forward;
    - flaps from the inner-labia can be wrapped around the shaft to make it bigger
- **Vagina removed?** Optional - done if you get urethral lengthening
- **Result Size?** A very small penis
- **Sexual Function?** Sexual sensation is generally good, as the clitoris is not impacted much. The new penis will get erect on its own when you're sexually aroused, but won't be large enough to penetrate a partner with.
- **Urinate standing up?** Yes, if you have urethroplasty done (optional).
- **Visible scarring?** Minimal

Phalloplasty

- **How is it done?** There are various techniques, but the most common involves removing a flap of skin/blood vessels/nerves from the forearm (or another area), rolling this to make a "tube within a tube", and then using microsurgery to attach the new penis to your groin. (over the top of your clitoris). The end is surgically sculpted to look like the head of a penis. Tattooing of the head can be done six months later to help create a visible line between the head and the shaft. A skin graft is taken (usually from your thigh) to cover the graft area on your arm.
- **Vagina removed?** Yes
- **Result Size?** An Adult-male-size penis
- **Sexual Function** Pulling on the penis will stimulate the clitoris that is buried at its base. If the microsurgical nerve hook-up is successful you will also have sensation in the skin of the penis. At least one year after phalloplasty, a stiffening device can be inserted to create an erection firm enough for penetrative sex.
- **Urinate standing up?** Yes, as part of phalloplasty, urethroplasty is done.

- **Visible scarring?** Large scar on the forearm (where the tissue was removed). Scars on the graft sites.

Metoidioplasty is a simpler and less invasive surgery, but the penis created is too small to have penetrative sex with. Phalloplasty is a more complex and invasive surgery, but the penis created is adult-male-sized and can be used for penetrative sex. Deciding which one to have depends on many factors, including your overall goals for surgery and the health risks of each.

It is highly recommended that you look at pictures of surgical results from both metoidioplasty and phalloplasty so you know what you can likely expect from each. There are many techniques that can be used in phalloplasty (pedicle, flaps from areas other than the forearm, etc.) and two metoidioplasty techniques (basic and Centurion), so make sure the photos you look at match the technique you are thinking about having.

There are various options for devices to make your penis erect after phalloplasty. Hydraulic erectile prosthesis (e.g., Dynaflex, CXM) involves a pump that moves liquid from a central reservoir (usually in the abdomen) into an inflatable chamber in the penis. Alternatively, a flexible rod can be inserted.

Vaginal removal or closure and urethral lengthening

F.T.M. vaginal surgery can involve removal of the vagina (colpectomy) or closure of the vagina (colpocleisis). In colpectomy, the entire vagina is removed, usually at the same time as removal of the uterus and cervix.

In colpocleisis, the lining of the vagina is removed and the muscles surrounding the vagina are stitched together to close it.

Closure/removal of the vagina and urethral lengthening are a necessary part of phalloplasty, but are optional in metoidioplasty. They are usually done together because the lining of the vagina is typically used to make the urethral extension. If you're not planning to have urethral lengthening, you can have colpectomy or colpocleisis done separately (usually at the same time as removal of the uterus/ovaries).

Scrotoplasty

Male testicles hang in a pouch of skin called the scrotum. The scrotum and testicles provides a significant part of the bulge when men wear underwear or swim trunks. F.T.M.s who identify as men may want a scrotum constructed to help with passing, and/or because having a scrotum is part of their self-image as a man.

Scrotoplasty can be done by a urologist or plastic surgeon at the same time as metoidioplasty/phalloplasty or as a later stage. Vaginal removal or closure must be done first. The outer labia are used to create two pouches, joined in the middle over the former opening of your vagina.

After the tissue is stable, silicone implants are placed inside the pouches to simulate testicles. At first the scrotal skin looks oddly tight, but over time the weight of the implants stretch out the scrotal skin to create a more natural appearance.

What to expect before and after F.T.M. genital surgery

Vaginal closure is a relatively simple surgery, but all other F.T.M. genital surgeries are major procedures that require more complex care before and after surgery. As most F.T.M.s have a group of genital surgeries done together, the information below describes what to expect in the typical groupings of genital surgeries.

At the hospital

If you are getting a metoidioplasty you will be admitted to hospital the same day as surgery. You may be asked to come in a day earlier to get blood work done and go over the instructions for surgery.

Special preparation for phalloplasty

If you are having phalloplasty, there are two special issues that need to be addressed months in advance of your surgery.

Removal of hair on graft sites

Ask your surgeon whether or not you need to have electrolysis to remove hair on any of the donor sites. Electrolysis is usually optional for the skin that will be used to form the shaft of the penis, but mandatory for skin that will be used to lengthen your urethra (as hairs can promote infections and urinary tract stones). Some surgeons require electrolysis to be completed at least three months before phalloplasty.

Quitting smoking

Smoking affects wound healing, skin quality, and other aspects of healing after surgery, so surgeons strongly encourage their patients to quit well in advance of surgery. With all types of surgery, the surgeon will ask you whether you smoke as part of the initial consultation. With phalloplasty, it is mandatory that you quit several months before surgery. You will not be considered for phalloplasty if you smoke or if your surgeon thinks it is likely you will start smoking soon after surgery, because the likelihood of your new penis dying is much higher if you smoke.

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