Reassignment Surgery

Extract from Dr. Peter Haertsch's Patient Information Booklet

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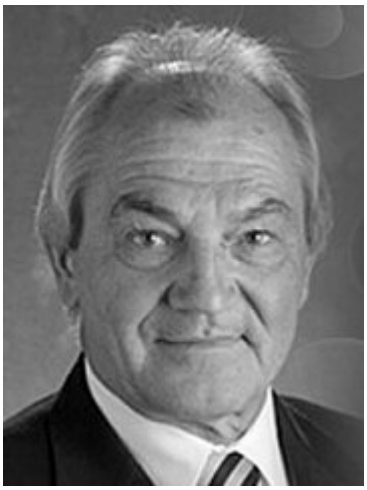

Dr. Peter Haertsch

Outcomes and Expectations

The object of the exercise in male-to-female reassignment surgery is to give you the external genitalia which have the appearance of being female and to give you a functioning vagina. Because of the differing amounts of tissue available to reconstruct the external genitalia, there will be a spectrum of appearances ranging from being similar to biological genitalia and quite convincing, to being obviously a surgical result. This appearance will be related not only to the availability of skin tissue, but also healing without complication. The two stage procedure which will be discussed with you, is able to achieve a more pleasing appearance. You will be shown a series of photographs depicting the varying appearances. Labia minora (the inner lips above the entrance to the vagina) are the most difficult to reconstruct and no guarantee can be given as to the final result.

The aim of vaginal reconstruction is to give you a functioning vagina which is somewhere in the vicinity of 13cms in depth and in circumference. Again, the given anatomy of the individual who has a narrow pelvis, will compromise the ability to construct a vagina with the above circumference and in those who have a lower pelvic floor, achieving adequate length will be difficult. Both these problems will not really be apparent until the time of surgery and there is no investigation, radiological or otherwise, which can be carried out to determine this. Given the physical constraints, i.e. the availability of suitable tissue and suitable quantity of tissue, the end result also depends on the healing process. As with any reconstructive process, healing is directly affected by blood supply which can be compromised and result in the death of some of the body's tissues around the surgical site. As a direct consequence of this there will be delayed healing, more scarring and possibly an inferior result.

Potential Surgical Problems

The clitoris

This is made from a small portion of the glans penis which during surgery is isolated only on it's blood supply and nerves. This portion of the head of the penis is orientated in an anterior/posterior position and buried to some extent to simulate a female clitoris in appearance. It will never be exactly the same as a female clitoris. According to whether or not there are problems with the blood supply, the clitoris may in fact die altogether, or end up hyposensitive. This is a rare occurrence. If there is to be a problem with sensitivity, it is most likely that the clitoris will be hypersensitive initially but this, in our experience, usually settles down over a period of several months. Manual stimulation of the clitoris or surrounding area normally will allow you to achieve orgasm and in doing so, there will be some ejaculate emanate from the urethra. The ability to climax is a complex process and no guarantee can be given in this respect. For more information on this please see the section in this booklet titled "Sexual Function".

The urethra

During surgery the purpose of repositioning the urethra is to allow for a straight stream and allow you to sit down to pass urine as a female would normally do. This result is sometimes not achieved because of various problems. The first problem is a caruncle, which is a small fleshy projection developing somewhere on the urethral opening. This is easily treated by surgical excision. Because the urethral opening is circular, occasionally there can be some stenosis, or narrowing of the opening when the scar matures. This can result in some difficulties passing urine. It will mean that you will have to strain to some extent to empty your bladder and you may feel that you are not emptying your bladder completely. This situation will lead to the development of urinary infection. The most common way of dealing with this problem, is to dilate the urethral opening and the most practical way to do this is to use a shortened golf tee. Secondary surgery for urethral stenosis is a rare event and stenosis effectively treated by dilation with a golf tee usually settles down as the scar totally matures. (This procedure should not be attempted without first receiving instruction and direction from the surgeon). Because the urethra goes through the urethral bulb which is erectile tissue (the tissue in a penis that swells during erection), it is not always possible to remove sufficient erectile tissue without destroying the blood supply to the urethra. Loss of blood supply to the urethra would result in the death of this tissue, therefore erectile tissue cannot be completely removed. This remaining erectile tissue can, in some instances when you are stimulated, become quite turgid and form an uncomfortable ball in the anterior vaginal wall. Secondary surgery can reduce this at a later date. The risk of this problem occurring is less than 10%. When a two stage procedure is

used, there is no urethral scar. Problems with urinary retention after surgery because of swelling and later scar contracture are vastly reduced.

The vagina

The preferred method of lining the vagina is inverted penile skin and there is usually sufficient skin if you have not been circumcised. The vaginal introitus (entrance) has to be between the urethra and the anus and if the inverted penile skin flap cannot be repositioned sufficiently, then to avoid an introitus that is too far anterior, a small posterior mostly hair bearing flap from the front of the anus will have to be used. This will allow the vaginal introitus to be situated where it should normally be. This flap gives a rather squarish appearance to the introitus and is occasionally bulky, however at secondary surgery the flap can be debulked without risk of interfering with its blood supply. If you don't have enough penile skin to adequately line the neo vagina, then the surgeon will have to resort to either a skin graft which can be split thickness graft or a full thickness graft, or else a colovaginoplasty. With split skin grafts there are problems associated with a painful donor site on the back of the thigh which may even become hypertrophic, that is raised and red, but this is a low risk, especially if your heritage is Caucasian. Skin tissue that is grafted can never be guaranteed to always take whether it is a full thickness or a split skin graft. The complication rate for grafts used during this surgery is approximately 30%. Of this about a third require re-operation to form another vagina because of vaginal shrinking related to graft failure or the inability to dilate. For this reason, Dr. Haertsch will not perform this surgery unless it is specifically demanded by the patient. Full thickness grafts are obtained by doing an abdominoplasty at the same operation and using the skin of the lower abdomen. The removal of skin for a full thickness graft will leave an extensive permanent scar and there is a risk that it may keloid. There can sometimes be concerns as to the exact repositioning of the umbilicus or navel. Because these grafts are extremely thick and are therefore associated with poor take, Dr. Haertsch will not perform this operation unless specifically requested. A full thickness graft using scrotal skin appears to be the desired method of skin grafting the neo vagina. It can only be used if there is sufficient laxity of the scrotal skin and, quite often, because it is hairy, patients will be asked to have the area depilated by way of electrolysis or laser prior to surgery. Any remaining hair follicles may be removed at the time of surgery by diathermy, however there can be no guarantee that there will be no remaining hair follicles and therefore some hair growth. Colovaginoplasty is also available if insufficient penile skin tissue is available to create the vagina. This involves using the right side of the colon (large bowel) with an associated appendectomy if not already done. Colovaginoplasty has no problems in direct relation to the depth of the vagina, however because of the nature of the surgery and the precarious blood supply of the colon, the risk of necrosis (death of some bodily tissue) is there, albeit not high. Associated with a colovaginoplasty is the fact that you will have an abdominal scar, which will vary in it's length depending on your physical condition. Any abdominal operation carries with it the risk of further problems later on, in relation to adhesions. The right side of the colon is used because there are less problems after full healing has occurred with discharge when dilating or after having intercourse, than if other parts of the bowel are used. However there may still be some problems associated with discharge and hygiene pads are recommended as the appropriate way to manage this problem should it occur. Remember whilst the aim of this surgery is to give you a functioning vagina, there can be no guarantees and at worst you could end up with a non-functioning vagina.

Labia minora

There is never in any patient, sufficient quantities of thin skin to form the inner lips of the vagina, which are the mirror image of those of a biological female. The labia minora of a reassigned patient are always thicker and shorter. The main problem with the labia minora is healing at the attachment to the entrance to the vagina and this will leave ulceration on one or either side of the opening. This will slowly heal and the end result will not be really any better or worse than if this complication had not occurred. Scrupulous hygiene is necessary to ensure healing, should this problem occur and daily salt baths must continue. The most satisfactory and convincing labia minora can be constructed by way of a second procedure involving extra cost, separated from the first by a period of three months. You will be shown photographs which will demonstrate a range of appearances that can be achieved.

Labia majora

These are the outer lips of the vagina and are mostly responsible for the external appearance of the genitalia. After the primary surgery most patients have external genitalia that looks for all intents and purposes female. Occasionally because of the cleft produced by pulling the inverted penile skin backwards, secondary surgery is required on the labia major, to reduce the cleft and make it more feminine. This can simply be done under a local anaesthetic in the rooms at Epping and is by no means major surgery. Less than 5% of patients have required this revisional procedure.

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