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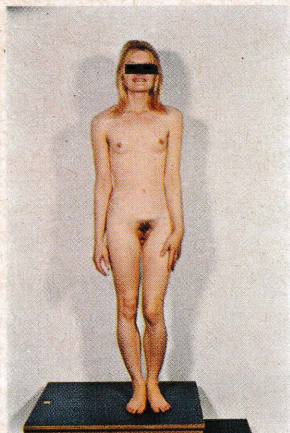


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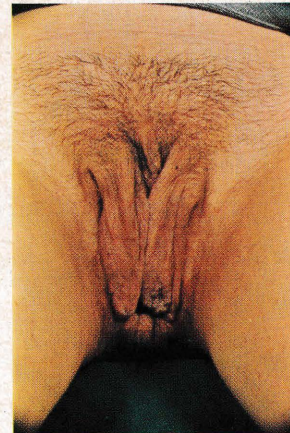
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Full face after operation



Six months post operative vagina admits two fingers to full length of fingers



THE SURGICAL TREATMENT OF TRANSSEXUALISM

*by Dr Grant Williams,
Consultant Urologist and Transplant Surgeon,
Charing Cross Hospital, London.*

The surgical treatment of transsexualism only makes the patients more able to live with their problem. It is not a sex change. Sex is objectively measured by chromosome analysis, and most transsexual patients are XY configuration in male bodies, or XX configuration in female bodies, no matter how much the patient may protest to the contrary.

Because most transsexuals are already taking oestrogens or androgens before seeking the advice of a gender clinic, it has been difficult to evaluate the normal peripheral and central hormone status of these patients. The few studies on "virginal" cases have failed to find any underlying organic abnormality in these patients. There are one or two patients who are Klinefelter anomalies but these are an excessive rarity in the large, and expanding group of transsexuals.

From this, it must be stressed that transsexualism is totally different from intersex, which consists of variations on the pseudohermaphrodite theme, but it does appear to be a psychological phenomenon.

Now this conclusion should not be despised, any more than other psychological anomalies, but, in the same way that biochemical lesions are being uncovered in other areas of psychiatric disturbance, so may such a lesion be found in transsexuals.

Incidence and epidemiology

The story is astonishingly constant. The patient develops these feminine feelings at pre-pubertal age. If I refer to men who wish to be women, this is because they

outnumber the opposite by 20:1.

We have been impressed by the high incidence of Malaysian patients with this problem, and we also see numerous patients who have never experienced any homo- or heterosexual encounter, but are overwhelmed by their problem. The oft-stated theory that the problem begins from an adolescent homosexual seduction, is seldom substantiated. We not infrequently find patients whose parents have considerable insight into the problem of their offspring, and who allow them to develop in dress and toys in the role their children wish.

Counselling

Although many attempts have been made to redirect the patient to the organic role decreed by the body form, the success rate of this psychotherapy is very low. However, detailed psychiatric care is vital for about two years before resorting to surgical gender re-assignment. During this time, it is found that about 90 per cent of such patients are not suitable for operative treatment.

Problems of the patient

Although these patients can rarely become suicidal, despite what they threaten, some have resorted to self-castration, which makes future reconstructive surgery difficult.

When patients become this desperate, they are probably more at peace when making the big step, when they start wearing the appropriate dress of their chosen role. Some "camp-up" this outrageously, and mince into

I dislike operating on male-to-female transsexuals who are not regarded by an XX female as a female. It almost takes a woman to recognise a woman.

your consulting room in a way which no normal female does.

The male-to-female transsexuals have fears that they will be knocked over in the street and admitted to a female ward where they will be discovered to be males. They may be bothered by the police unjustly, but, at the same time, they do appear to have a higher incidence of minor criminal activity than normal groups.

They are worried about birth certificates (which cannot be changed) and of National Insurance cards, or passports, which will "give the patient away". While many transsexuals do not know that these latter things can be changed, many doctors do not know either.

These would-be women have beards which can be treated safely by electrolysis, and have the lack of a bosom, which they may despise. They can resort to all sorts of things to develop bosoms. For this, most male-to-female transsexuals take oestrogens, with the thromboembolic sequelae seen in some girls on contraceptive pills, or men with prostatic carcinoma treated with oestrogens. Others, though, resort to silicone injections to bulk up their breasts, which are hard, ugly, sometimes unequal, and may even develop malignancy. The more natural-looking, Silastic bag implants are softer, and look better.

Female-to-male transsexuals have fewer problems, but usually would like to be able to stand up to urinate from a penis. Breasts are a nuisance to them and are suppressed by tight binders, until a surgeon removes them, when they will soon want a hysterectomy and oophorectomy.

This raises the whole question of surgery in these patients, who are

usually most importunate and often wanting something removed or realigned or bulked up.

As to who should receive operative treatment is nigh on an impossible question to answer. But I will not operate on any patient with any other organic illness, such as chronic pyelonephritis, or hypertension.

I also dislike operating on male-to-female transsexuals who are not regarded by an XX female as a female. It almost takes a woman to recognise a woman. I similarly dislike constructing a vagina for a patient who will never use it sexually, and I will not operate on patients who threaten to injure themselves if surgery is denied.

The operation in the male-to-female transsexual

The skin of the posterior two-thirds of the scrotum is reflected posteriorly and the testes removed by dividing the spermatic cords and gubernacula. A mid-line ventral incision along the scrotum passes to the tip of the penis; the skin of the penis is reflected dorsally, giving a dorsal pedicle flap of penile skin and a dorsal pedicle of scrotal skin.

The corpora cavernosa are separated from the corpus spongiosus, and are divided flush with the ischia, leaving their crura intact. A tunnel is then made behind the bulb of the spongy urethra in the plane through the fascia of Denovilliers, as used in excision of the rectum. This tunnel extends to behind the prostate and the tunnel is lined with the dorsal scrotal flap and the anterior penile flap. The spongy urethra is brought through the anterior skin flap in the midline.

The "vagina" is packed with gauze roll, soaked in flavine

emulsion. This keeps the vagina in situ, and is removed on the fifth post-operative day. The bladder is drained by a urethral catheter which is also removed on the fifth day, when the patient can also be put in a bath and taught to pass a vaginal dilator. This vaginal dilatation is done three times a day until the vagina is healed.

Recently, we have been using Dexon sutures, so we do not have to remove them and this shortens the stay in hospital.

It is important to place the vagina high up between the levators so that the patient can grasp the penis at subsequent intercourse. The patient can leave hospital after ten days.

Complications

The skin flaps always look swollen and deformed at first and do not resolve for about three months. Failure to use a vaginal dilator vigorously leads to a shortening of the vagina. Sometimes the scrotal flap is too big posteriorly, giving an ugly posterior redundant flap. Recto-vaginal fistula has occasionally happened, as has pulmonary embolism, so this surgery is not to be undertaken lightly. For this reason we always stop oestrogens for four weeks pre-operatively, not restarting them until four weeks after the operation.

The female-to-male operation is most unsatisfactory. Bilateral mastectomy and hysterectomy is a major undertaking. We are beginning to try phalloplasty by straightening out the physiological chordee of a clitoris, and then doing a hypospadias-type repair to bring the urethra to the tip of the penis. But the results are not as encouraging as are the results of plastic implants.