Gynaecological care for trans men and women

IUSTI Conference
Auckland 9-9.30am
November 3rd 2018
Princes Ballroom B

Ladies first

Not to forget that not all transwomen have had surgery and therefore remain physically effectively oestrogenised males. It remains then that they will not have any 'gynaecological issues'

The majority of transwomen will have had some form of surgery. Their options are:

- Simple castration and a bare perineum
- Castration and a neovulva
- Penile inversion type neovagina
- Neovagina with colonic augmentation
- Neovulva with neovagina and uterine transplant with or without transplanted ovaries

The bare perineum with a neovulva gives rise to few problems except

- she is unable to make a conventional sexual relationship
- anal intercourse is often quite acceptable
- the external appearance is not remarkable to a casual sex partner and a social/sexual relationship is more possible thereby permitting a return to being more accepted in society as a woman

Ciswoman or transwoman-which is which?

Once the individual undergoes vaginoplasty the situation becomes more complex in both the immediate postoperative phase and in the longer term

We now have a physically feminised cismale in whom some gynaecological problems may present

Dilation can continue with care and in the knowledge that there may be bleeding. I'm not in favour of using topical steroids unless there is significant pain and irritation.

....but he can become a she⇒

Rosie at the Porchester Ball in 1962 aged 24~ the 'young doctor'

Early development

- The newly formed neovagina requires meticulous attention as it heals. The common problem is that of healing by granulation and the granulomas ('proud flesh') can be sore and may bleed.

- Repeated treatment by cautery is required and antibiotics may be needed to combat secondary infection.
- It's usually too soon to use douches but a mainstay should be that of salt baths that are comforting and assist in healing
- these can be used as frequently as the woman chooses and there is no such thing as too many baths.

Later development

- dilation can and usually does start immediately postoperatively but has to be employed with care maintaining a balance between causing further trauma but with the aim of maintaining optimum dimensions
- There are important anatomical distinctions to be made between the cisvagina and the neovagina

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- The cisvagina has an underlying and investing sling of pelvic fascia that supports the organ and retains it's shape
- the fascia is attached by ligamentous support to the bony pelvis
- it is analogous to a tent where the canvas is supported by poles that are strained into shape by the tension of guy ropes
- the cisvagina has none of this unless constructed laparoscopically- it is held up by a wing and a prayer
- hence the need to persistently maintain shape by dilation

- the best dilator is the penis or preferably a strap on dildo that is more firm
- if you don't use it you may lose it
- dilation can be used frequently (x2-3 per week) depending on the woman's availability
- it's best to introduce the smallest dilator slowly and carefully and then increase the size one by one- the angle of entry is important
- Vaginal strictures as, a cause of pain, are not uncommon and mostly yield to topical oestrogen and dilation

standard medical dilators are blunt ended and have a less slippery surface

the best dilators are commercially available steel vibrators in two sizes, are also cheap and have the vibrator

Microbiology of the neovagina

- it is generally held that the colonisation of the neovagina is by skin and intestinal flora
- candida is remarkable by it's rarity and that may relate to inadequate oestrogen
- in all women it is true that adequate systemic oestrogen does not guarantee effective vaginal oestrogen
- all other vaginal pathogens may find a home in the neovagina

Molecular detection of *Lactobacillus* species in the neovagina of male-to-female transsexual women
Scientific Reports volume 4, Article number: 3746 (2014)

Lubricants and hormonal support

- although the oestrogen receptivity is unconfirmed, topical oestrogen probably has some advantages. It can be used twice week with Aci Jel or as a lubricant in dilation
- Aci Jel maintains acidity and resistance to infection
- it may be worthwhile using a probiotic capsule into the neovagina- it can be conveniently inserted into the Aci Jel applicator

Persistent vaginal discharge in the trans women?

- the neovagina is a blind pouch in which secretions and other discarded rubbish may accumulate.
- Some of this can be removed by douching with plain water or saline but not too frequently
- the colon augmented vagina presents it's own problems with copious mucous discharge and the whole range of colonic conditions available
- the hairy vagina- impossible to treat with revision surgery

Persistent vaginal discharge in the trans women?

- the neovagina almost certainly has no oestrogen receptors and the skin remains squamous rather than stratified in contrast to the cisvagina
- it also lacks the presence of the mucous producing cervix. It has therefore no capacity to produce mucous and no lactobacilli (at least at first) to maintain a healthy acid environment to resist infection
- nonetheless topical oestrogen may improve the morphology of the vaginal skin in softening the skin
- Whether the skin develops oestrogen receptivity is unknown but remains a possibility.

Fistula as a cause of vaginal discharge

- Vesicovaginal fistula
- Ureterovaginal fistula
- Rectovaginal fistula
- Colovaginal fistula (colon augmented vaginas only)

Rupture of neovagina

- Neovagina may lack elasticity- as in the post menopausal woman
- Vigorous penetrative sex and a corresponding female arousal allowing ballooning of the neovaginal vault
- Tight seal of penis in vagina
- Very high pressure from hydraulic pressure

Residual corpus cavernosum

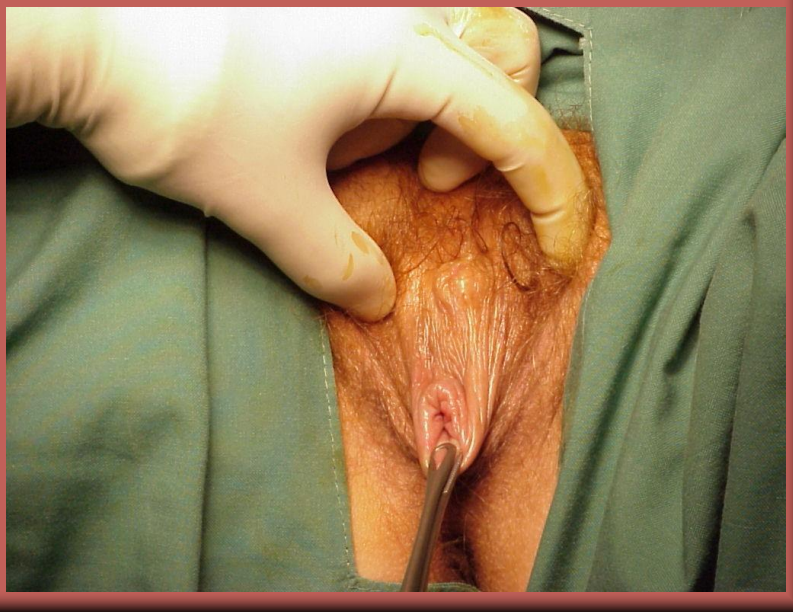
- it is possible to inadequately excise the corpus cavernosum in the penile inversion technique
- this may result in a bulge at the introitus when sexually aroused obstructing penetration
- simple excision is an exacting dissection with regard to the integrity of the bladder base and urethra
- in addition, excision of the surplus tissue may damage erotic response (G spot)

Residual corpus cavernosum

- preop

- postop

Neovaginal prolapse



Neovaginal prolapse

- The neovagina lacking the essential supports of the cisvagina but without the disruptive trauma of childbirth may still prolapse infrequently
- The usual form of prolapse is vault prolapse
- I have treated one case of complete vault prolapse by laparoscopic resuspension with great success

Uterine/ ovarian transplants

- The possibility of a transplant should be included in counselling despite this being expensive and a remote eventuality

Living the life

- How many transwomen have ever asked me about motherhood?
- not to mention the washing and cooking and looking after a man?

The transman

- Presents the problem of female organs that are dormant under the suppression of testosterone (T). If the T dose becomes inadequate or if aromatisation of T to E, occurs then the ovarian axis will start to reassert itself.
- Episodes of break through bleeding mostly respond to an increase in T dosage but if the bleeding continues there is the need to evaluate the uterus and ovaries by hysteroscopy, a smear test and an ultrasound.
- Continued bleeding may call for surgery but this is a rare event at least in the Antipodes.

- quite rarely the transman may undergo pelvic extirpation surgery including the vagina and the construction of a neophallus

  this solves all the gynaecological issues but may raise mainly urological problems.

  the neophallus may be erected by means of a pump concealed as a testis in the neoscrotum. The organ however will lack any kind of rewarding sensation.

Gynaecological diseases

- Endometriosis should be suppressed and with that most of the pain
- Fibroids and adenomyosis should shrivel and effectively disappear
- Ovarian cystic activity should be suppressed
- The question of cancer remains a possibility except for endometrial cancer that should be suppressed

The neophallus

- Dr Nim in UK- £14,000 in private or free on the NHS
- Dr Miroslav Djordjevic Belgrade (now working in New York)

Pain in the neophallus

- Pain may occur at the base of the neophallus
- Junctional fistula at anastomosis of neourethra and the membranous urethra

Routine care

- cervical smear tests should be done but now at a five year interval
- HPV immunisation may render this unnecessary and should be given even if patient is an adult
- pelvic examination still required to check the ovarian morphology
- may be preferable to undertake ultrasound every 4-5 years
- Mammography is less certain if testosterone reduces the risk of cancer

"When you conclude the war in your own head,
you are free to make peace with the rest of the world."

Thank you from the old Front Bench

Uterine transplantation

This is a recent development, at first on an experimental basis in Sweden with the indication being the Mayer-Rokitansky-Küster-Hauser syndrome (MRKH) and where they have had significant success.

In the first 11 transplant patients they had had seven successful pregnancies.

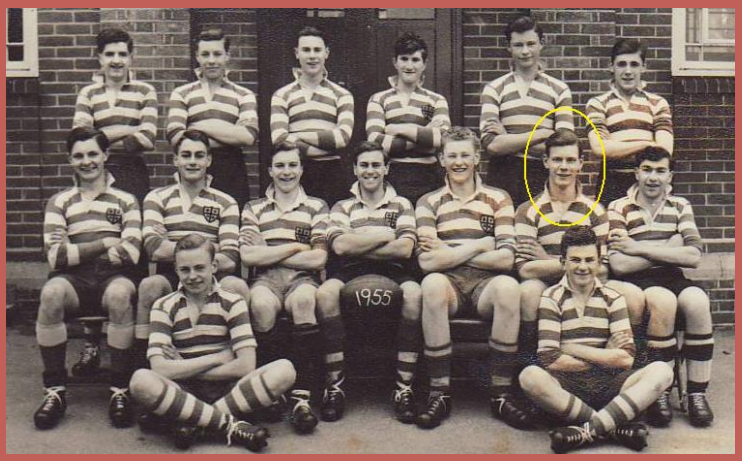
While this operation costs in the order of $200,000, I don't let the expense of it get in the way of informing my patients about the possibility at least.

...or he becomes she

Belize1989

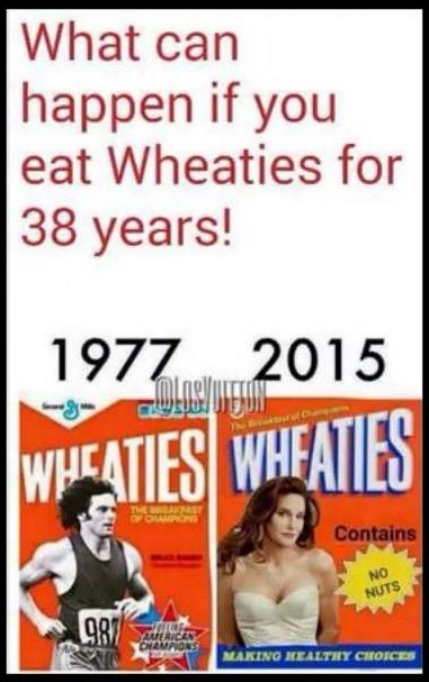
Adelaide 2003

Not exactly feminine...

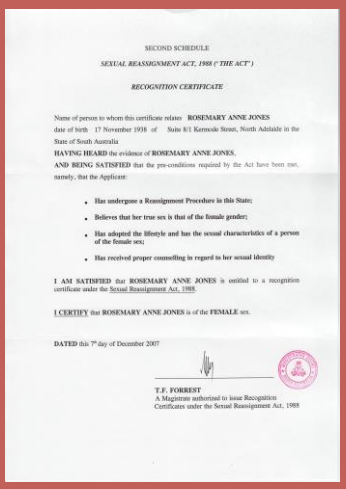


Rugby days in 1955

Bruce becomes Caitlyn Jenner- healthy choice and no nuts!



Post-op- the Recognition Certificate



SECOND SCHEDULE

SEXUAL REASSIGNMENT ACT, 1988 ("THE ACT")

RECOGNITION CERTIFICATE

Name of person to whom this certificate relates **ROSEMARY ANNE JONES**
date of birth 17 November 1938 of Suite 8/1 Kermode Street, North Adelaide in the State of South Australia
HAVING HEARD the evidence of **ROSEMARY ANNE JONES**,
AND BEING SATISFIED that the pre-conditions required by the Act have been met, namely, that the Applicant:

- **Has undergone a Reassignment Procedure in this State;**
- **Believes that her true sex is that of the female gender;**
- **Has adopted the lifestyle and has the sexual characteristics of a person of the female sex;**
- **Has received proper counselling in regard to her sexual identity**

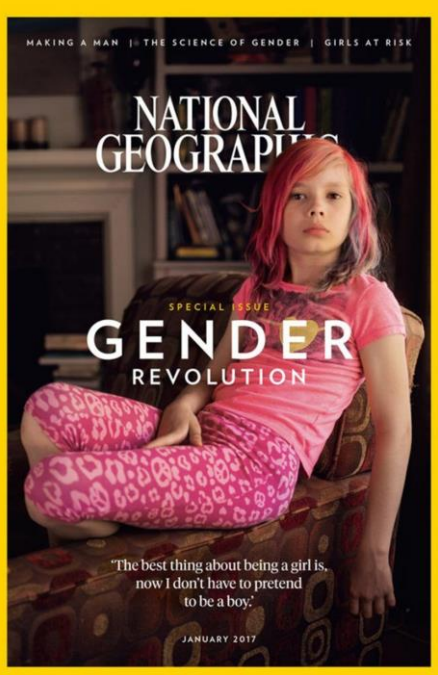
I AM SATISFIED that **ROSEMARY ANNE JONES** is entitled to a recognition certificate under the Sexual Reassignment Act, 1988.

I CERTIFY that **ROSEMARY ANNE JONES** is of the **FEMALE** sex.

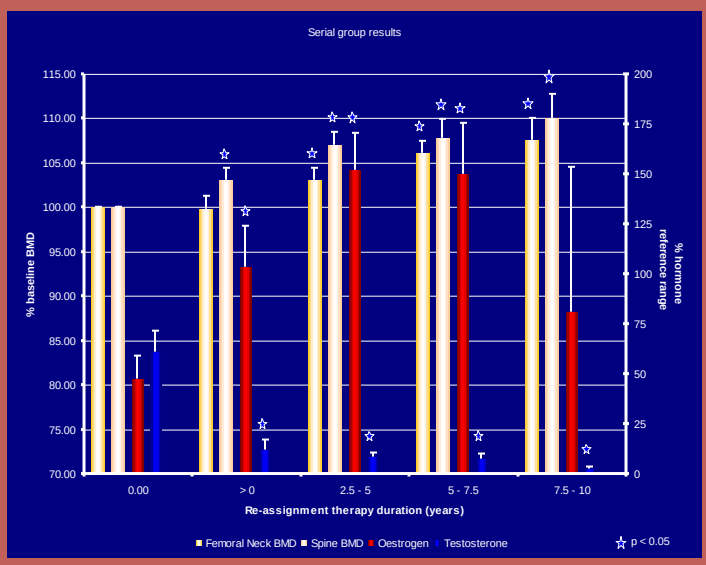
DATED this 7th day of December 2007

T.F. FORREST
A Magistrate authorised to issue Recognition Certificates under the Sexual Reassignment Act, 1988

9-year-old transgender girl Avery Jackson of Kansas City, Missouri January 2017



M2F Bone Densities over 10 years



Children and teenagers- puberty blockade

- nobody has great experience with children in this country but this is the 'cutting edge' of optimal gender affirmation
- deferred puberty allows the child to avoid feminisation/masculinisation and makes their subsequent lives less complicated and less expensive
- at the moment these clinical decisions are subject to Family Court rulings

Referrals to the RCH Melbourne

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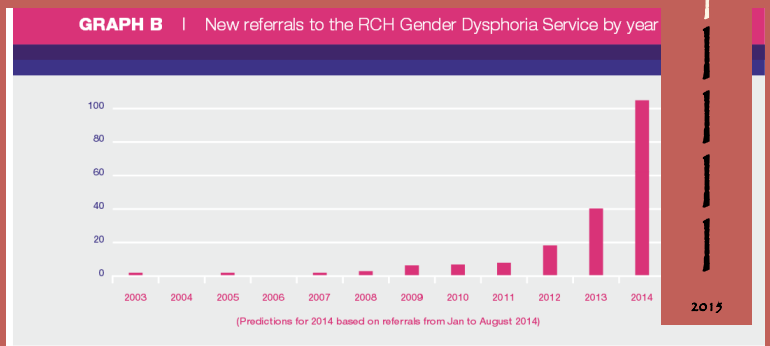

Clinical specialists submitted evidence of the benefits of early intervention hormone treatment. Further, they submitted that removing the requirement for the Family Court of Australia to approve treatment using oestrogen and testosterone in people under the age of 18 years is of paramount importance.[126]

Our son began puberty suppressants just after the court situation was changed therefore we did not need court permission to access these drugs. We are, aware though of the trauma and angst families