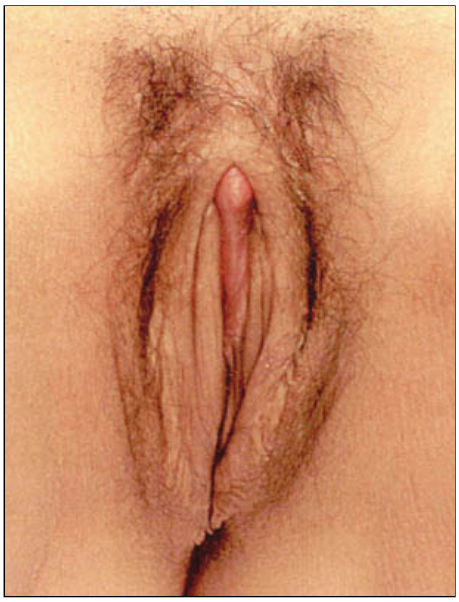
Search

LynnConway.com Web

Vaginoplasty: Male to Female Sex Reassignment Surgery

Historical notes, descriptions, photos, references and links.

by Lynn Conway



Right: Photo of the details of the genitalia of a TS woman (with her legs spread in stirrups and her labia partially opened) after undergoing vaginoplasty (SRS) and labiaplasty performed by Eugene Schrang, M.D. of Neenah, WI.

Deutsch, Espa&#65533;ol, Fran&#65533;ais, Portugu&#65533;s, Русский עברית (Hebrew), Nederlands (in progress), Bahasa Malaysia (in progress)

This page sketches the historical development and surgical details of vaginoplasty surgery (also often called 'sex reassignment surgery' (SRS) or 'gender reassignment surgery' (GRS)). Before reading this page, please read the introduction to the concepts of gender identity, transgenderism and transexualism elsewhere in this website, so that you'll understand why transsexual women undergo these operations. This page clarifies that post-operative MtF transsexual women really do have female genitalia, and will also help readers visualize some of the ordeals trans women endure to achieve their new physical gender status.

IMPORTANT NOTE: This page contains graphic visual material and other medical information that might shock or be very disturbing to some readers.

DO NOT READ ANY FURTHER if you are squeamish about surgeries, or if you have any anxieties about your own genitalia.

Access to this medical information is NOT AUTHORIZED for those UNDER THE AGE OF 18. By entering this page, you hereby certify that you are 18 or over.

Contents

Historical Background

Transsexualism is not a "modern discovery". Instead it is a not-uncommon, naturally-occurring variation in human gendering that has been observed and documented since antiquity. In many cultures, including native tribes in North America, transsexual individuals have long had the choice to cross-dress and live their lives as women, including taking husbands. The surgical alteration of genitalia to relieve intense cross-gender feelings was also not "invented in the twentieth century". In some cultures, even ancient ones, many transsexuals have voluntarily undergone surgeries to modify their bodies in such a way as to "change their sex".

The surgical methods and the effects of castration were everywhere for the ancients' to see. It's use in the domestication of animals quickly taught ancient people that removal of a human male's testicles at a young enough age would prevent his masculinization too. Such a person would forever be childlike - or "girly". These surgeries were also often forcibly done upon captive adult male slaves in order to "domesticate them" as "eunuchs". Performing such surgeries on normal post-pubertal males does not change their gender feelings or gender identity, although is lessens their sexual drives somewhat and sharply reduces their ability to develop male musculature.

The accumulating knowledge about the effects of castration was further extended to help MtF transsexuals: Untold millions of transsexuals over thousands of years have voluntarily sought and undergone surgeries vastly riskier and more dramatic in effect than mere castration. In these surgeries transsexuals are completely emasculated by total removal of the testes, penis and scrotum. In addition, the external pubic area is often roughly shaped to look like a girl's vulva. No one knows precisely how it started, but such transsexual surgeries were well known by the time of ancient Greece and especially in sexually-permissive ancient Rome, and were often traditionalized in various "religious rituals" that provided the resulting "women" with a place in society.

By undergoing these surgeries, young MtF transsexuals (if they survived) not only avoided becoming men, but also gained genitalia that looked somewhat like those of a woman. Although lacking vaginas and lacking the powerfully feminizing effects of female sex hormones, young transsexuals in the past could nevertheless live life better as women after undergoing such surgery.

Even today, very large numbers of desperate young transsexuals in India and Bangladesh run away from home to join the "Hijra" caste. To become Hijra, these teens voluntarily undergo fully emasculating surgeries under primitive conditions, just as they would have in ancient times, with only opium as an anesthetic. Most undergo the surgery in their teens shortly after the onset of puberty, with results as seen in photo below. By being castrated just early enough, many avoid the development of male secondary sex characteristics (except for the breaking and lowering of the voice), and their bodies can remain permanently soft, childlike and girly.

Contrary to popular myth, total external emasculation after puberty does not necessarily "de-sex" the person. Complete castration after puberty leaves the young Hijra with her newfound feelings of sexual arousal and her newfound orgasmic capabilities. While the psychological impact of such surgery would usually cripple the libido of a normal male, the effect on a young transsexual girl is usually just the opposite: The surgery can be liberating and can enable a fuller expression of her sensuality and her female libidinous feelings. Just as in the case of modern post-operative transsexual women, many Hijra can have strong feelings of sexual arousal in the inner remnants of their genitalia (even though they lack the external nerve tissue left by modern SRS, they retain the internal portions of the erectile corpora cavernosa and of course the prostate, with its spasmodic orgasmic capabilities). Although Hijra lack vaginas, many greatly enjoy (to orgasm) penetrative (anal) sexual activities with men. Because of their complete external emasculation, Hijra genitalia and pelvic regions look very "girly", and many men in India greatly enjoy lovemaking with them. The Hijra in turn accept their fate and their limited, but real, possibilities for finding at least a little bit of love as a woman in this life.

A young Hijra in India, showing her genitalia

a photo from the book
Hijra-The Third Gender in India
by
Takeshi Ishikawa

Most Hijra live out their lives as women with other Hijra in "family groups", earning an existance by performing in traditional ceremonies at weddings and childbirths. Many also work as prostitutes and beggars in this lowly but traditional Indian caste. Some Hijra today are fortunate to have access to female hormones, and can feminize their bodies by growing breasts and developing natural female body contours. The combination of emasculation as teenagers combined with use of estrogen enables some Hijra now to become very beautiful - even though, sadly, they do not have female genitalia (vaginas) and are not socially accepted as women.

The origins of the Hijra caste goes back hundreds of years in Indian history. This widespread practice enables transsexuals to escape the angst and fate of masculinization as teenagers, and provides a safe though lowly place in society for them. The agonizing extremes to which these transsexual youngsters will go in order to "approximately have a female gender", with full knowledge that they will never see their families again and will face social degradation for the rest of their lives, is a testament to the reality and extremity of the gender conflict that they face within themselves.

There are several million Hijra in India and Bangladesh today. For more information see the Kinnar (Hijra) website at http://www.kinnar.com/ and the BBC story on Hijra in Bangladesh. Many wonderful photos of Hijra can be found in the book *Hijra-The Third Gender in India* , by Takeshi Ishikawa. Although shrouded in caste secrecy and mystery for centuries, the underlying condition that compels young teenagers to become Hijra is clearly transsexualism: Says Dhanam, the leader of a Hijra family (a Hijra 'Guru'):

"We are born with a gender identity crisis. It is not an imitated or learnt one, but a natural instinct that urges us to be women." - Dhanam

It is not uncommon even in the modern western world for truly desperate young transsexual girls to "commit Hijra" upon themselves. By fully emasculating themselves, and then falling upon the medical system for "patching up", they can thus achieve a "low-cost SRS early in life". A number of girls in the U.S. have done this to themselves, and then feminized themselves with estrogen to quickly become very passable and pretty as girls (unfortunately, the loss of penile and scrotal skin makes later vaginal construction by SRS much more difficult). Even larger numbers of young TS girls in the U.S. have resorted to self-castration in order to avoid masculinization, especially during the '50s and early '60s when there were severe restrictions on doing SRS on "intact males" in U.S. hospitals (see below).

The long history of traditional 'Hijra-style' surgeries extends from ancient times right up to today, continuing onward in countries such as India and Bangladesh. The detailed knowledge of the postoperative effects of the Hijra-type emasculations provided an important empirical background for the development of modern transsexual surgeries.

The Development of Modern Sex Reassignment Surgery (SRS)

[To be added here later: Discussion of advances in plastic surgery after WW I, and a discussion of the pioneering of vaginoplasty in TS women around 1930 by F. Abraham, M.D., in Germany - - - see http://www.symposion.com/ijt/ijtc0302.htm#Case%201 - - -]

With the rapid advances in knowledge of sex hormones and plastic surgery following World War II, it finally became possible to contemplate complete medical and surgical solutions for transsexualism. During the 1950's, transsexual women began to benefit enormously from the newly available female sex hormones, which enable the development of breast, soften the skin and over time produce female body contours. Also during the 1950's, a few surgeons began exploratory surgeries to construct vaginas in MtF transsexuals by using skin grafts taken from the thighs or buttocks, drawing upon then recently developed techniques for constructing vaginas in intersexed girls.

Christine Jorgensen, a U.S. citizen, was among the first small group of transsexuals to undergo such a surgical "change of sex". She was "outed" in 1952 by U.S. print media shortly after her initial surgery, and her story became a national sensation. Through her story, many transsexuals for the first time learned of the existence of the new hormonal and surgical treatments. However, access to this new, experimental surgery was limited to a tiny handful of patients in Europe.

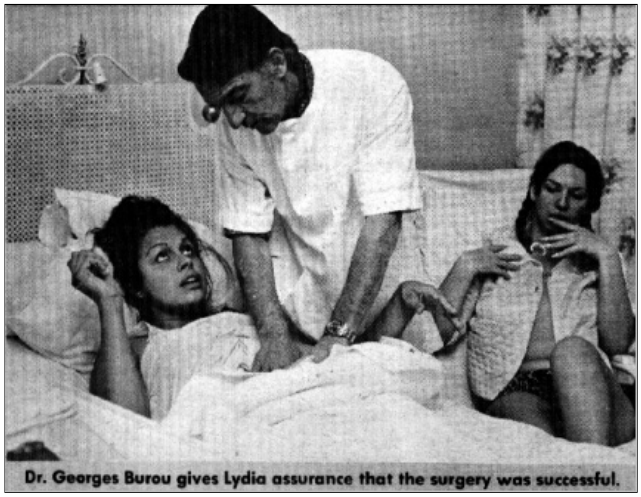
At the time of Christine's surgery in the '50's, doctors first removed the transsexual's male organs in one or more surgeries. The patient then waited through an extended period for healing. Then, in a surgery similar to those done to create vaginas for intersexed patients, surgeons constructed the patient's vagina by using skin grafts taken from her thighs or buttocks (Christine's vaginoplasty surgery was in 1954).

Transsexual pioneer Christine Jorgensen,
who underwent an early for of SRS in 1952-54

Although patients were extremely pleased with the results (especially when compared to their previous situations), there were major problems with this early method. The skin grafts were unreliable, and sometimes partially failed to "take". The use of extensive grafts also left large disfiguring scars at the donor sites. In addition, a lot of sensitive genital tissue was forever lost in the first step, affecting patients' feelings of sexual arousal and capacity for orgasm.

During the late 50's and into the 60's, several hundred transsexuals in the United States came under the care of Harry Benjamin, M.D, a compassionate physician and endocrinologist who had offices in New York, N.Y. and San Francisco, CA. Dr. Benjamin was the first physician/researcher to sort out the distinction between cross-gender identity and homosexuality. Instead of viewing transsexuals as mentally ill deviants as did most psychiatrists of the day, he began to visualize transsexuals as truly suffering from a genuine mis-gendering condition of unknown origins. In efforts to ease their suffering, he began prescribing estrogen to selected patients in response their profound pleas for medical feminization. He also maintained close watch on the results of transsexual surgeries being performed, and began to refer his most intensely transsexual patients to those surgeons who were obtaining the best results.

Then, in the late 50's, a french plastic surgeon named Georges Burou, M.D. invented the modern form of penile inversion MtF sex reassignment surgery for MtF transsexuals. Variations of Dr. Burou's technique have been used ever since. Dr. Burou's classic innovation was to use the male genitalia as source of skin and sensitive erotic tissue to create the new female genitalia, including the vagina.



Thanks to Pascale from France for finding these photos of Dr. Burou.
[They are from a July 1970 "National Police Gazette" article (a U.S. men's magazine).]

Dr. Burou performed these surgeries in his clinic in Casablanca, Morocco. In 1958-60, several famous and very beautiful young "female impersonators" from the club Le Carrousel in Paris, France, including Coccinelle (more info), Bambi and April Ashley, were successfully transformed into women by Dr. Burou. Many of the young Le Carrousel girls had received female hormones as a side-benefit of working at the club, and as a result had become incredibly beautiful, feminine and sexy. Several returned to perform at the club after their genital surgery. Their successful "sex changes" became widely known about, and they became sought after as love objects by many prominent, wealthy men. Some very wealthy men (including Aristotle Onassis) would occasionally "sponsor" the sex change surgery of a Le Carrousel girl, who would then became their mistress for a while.

Dr. Burou became both famous and notorious as news spread of his work. His "Clinique du Parc" at 13 Rue La Pebie in Casablanca, Morocco eventually became besieged by transssexual patients from all over the world. Dr. Burou began performing many hundreds of these operations every year. In 1973, Dr. Burou gave his first formal public presentation on his innovative surgical technique at a major interdiciplinary conference on transsexualism held at the Stanford University Medical School. By the time of that 1973 conference, he had performed over 3000 MtF surgical sex reassignments. By that time many other surgeons around the world had inferred and adapted Dr. Burou's technique, and were applying it in similar SRS surgeries.

Transsexual pioneers Coccinelle (l), Bambi and April Ashley (r)
were among the very first of Dr. Burou's SRS patients (in 1958-1960)



Among the keys to the success of these surgeries were (i) the use of the skin of the penis and scrotum to form the new labia and a sexually functional vagina (thus avoiding the source area disfigurement caused in earlier operations by the use of large, deep skin grafts), and (ii) the careful dissection and placement of the terminated corpora cavernosa and the saving and relocation of some of the sensitive nerves and a small amount of erectile tissue. If done properly, the post-operative patient can have powerful feelings of sexual arousal (erection of the corpora stumps remaining inside her body) and can easily be orgasmic (the prostate is left intact, and can spasm during orgasm just as before SRS - while the nerve tissues throughout the corpora, the clitoris and the vulva spasm, throb and release at the same time, just as in any other woman).

Dr. Benjamin's practice grew rapidly as more and more transsexuals learned that they could obtain compassionate treatment from him. He began referring ever larger numbers of patients to surgeons, especially to Dr. Burou in Casablanca. By the mid 60's, several other top surgeons abroad began performing SRS surgeries on transsexuals using Dr. Burou's techniques, and Dr. Benjamin referred patients to these surgeons too. The most notable of these was Jose Jesus Barbosa, M.D., a prominent plastic surgeon in Mexico (Dr. Barbosa was Lynn's SRS surgeon, and had performed over 300 SRS's by 1973).

However, such surgeries were still virtually unheard in the U.S. even in the mid-to-late 60's. Under intense pressure from religious groups following the publicity of the Jorgensen case in 1952, most U. S. hospitals installed policies that explicitly forbade such operations, and religious strictures were frequently drawn upon to support the witholding of any hormonal or surgical treatments of transsexuals. Then too, the U.S. medical community in the 60's thought of transsexuals as "severely psychotic" rather than biologically mis-gendered. Instead of receiving help for gender-transition from medical professionals, many transsexuals were forced into mental institutions, where psychiatrists tried to "cure them of their mental illness" by electroshock therapy and aversion therapy.

During the late 50's and into the early 60's, a number of intensely transsexual girls in the U.S. resorted to castrating themselves in order to become more feminine and to bypass hospital restrictions on removal of testicles from "intact males" during SRS. Once no longer intact, the girl might hope to obtain complete SRS in some hospitals here - if she had the money to pay for it. See for example, the story of transsexual pioneer Aleshia Brevard. At a young age and feminized on estrogen, Aleshia became a star performer at Finocchio's, the world famous "female impersonator" nightclub in San Francisco. After a self-castration to further feminize herself, Aleshia was able to undergo SRS in the U.S. in 1962 with the help of Dr. Benjamin. As did so many postop transsexual women in the 1960's (including Lynn) Aleshia left her past life behind and entered stealth mode. She went on to become a showgirl, a "Playboy Bunny" (a hostess at one of the famous "Playboy" clubs), a widely recognized actress in movies, on stage and on TV, and got married three times! Aleshia only recently came out to tell her story in a wonderful book about her amazing life.

Aleshia (pre-op) as the star "Lee Shaw" at Finocchio's in 1961

Aleshia Brevard, shortly after her SRS in 1962

Aleshia as an actress in stealth mode, in the early 1980's

Early Sex Reassignment Surgeries in the U. S.

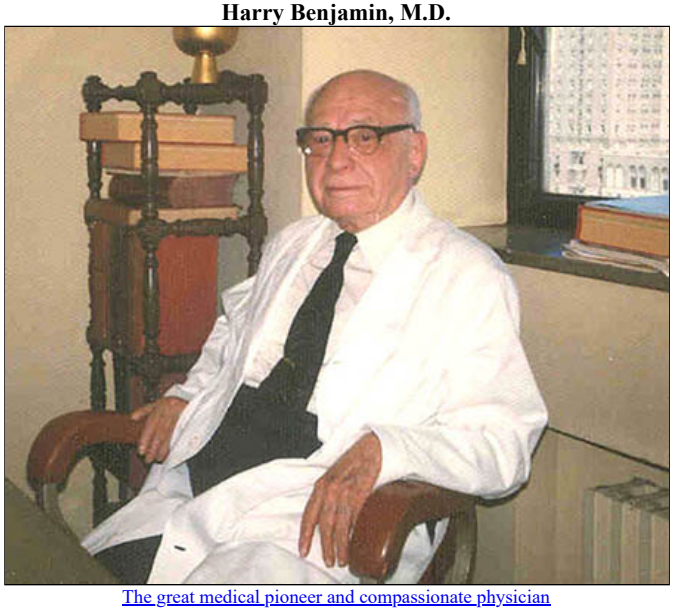
Finally, in 1966, surgeons at the John Hopkins Medical Center began performing a limited number of MtF SRS operations in effort to help some intensely transsexual patients under care of Hopkins' new gender identity clinic. The Hopkin's staff believed that transsexuals were mentally ill, but they also believed that there was no psychological method for reversing the "incorrectly formed gender identity". In an experimental program they began to explore the possibility of helping patients via surgery, as was being recommended by Dr. Benjamin. The Hopkins' Surgeons used a variant of Dr. Burou's method.

In the fall of 1966, newspapers around the country propagated the following item from a column in the New York Daily News:

"Making the rounds of Manhattan clubs these nights is a stunning girl who admits she was a male less than one year ago and that she underwent a sex change operation at, of all places, Johns Hopkins Hospital in Baltimore. Surprisingly, the hospital confirms the case, saying surgery followed psychotherapy. Such operations, although rare in this country, are neither illegal nor unethical, according to a Johns Hopkins spokesman. Officials at a number of major hospitals here agreed with Johns Hopkins on the legality and ethics of the operations but none could recall such an operation ever having been performed in New York."

Then, on November 21, 1966, the New York Times published an extensive front-page article on transsexualism. The Times article provided extensive information on the surgical and hormonal treatments then being done abroad, and on the new program at John's Hopkins University Medical Center, where several surgeries had recently been done. The article also identified Dr. Benjamin as being the world's leading authority on transsexualism, and as author of a new textbook on the subject entitled The Transsexual Phenomenon (see this link for an online version of the original text).

Harry Benjamin, M.D.



The great medical pioneer and compassionate physician
[photo taken by Lynn Conway in 1973]

Dr. Benjamin was the pioneer of the whole new area of medical knowledge of transsexualism. His paradigm-shifting medical text described his experiences with many patients over several decades. He was the first researcher to recognize how gender identity and sexual orientation are two independent dimensions of each person's human nature. Dr. Benjamin recommend how "intense transsexuals" could and really should be treated, in order to enable them to live in the gender they sought. His book documented the results of the new, innovative surgical and hormonal treatments and put those treatments into a rational context as therapy for transsexualism. This book gave fresh hope to many transsexuals, and opened the door for the modern medical approaches that we now take for granted. At the same time, the fact that Johns Hopkins was actually doing transsexual surgeries greatly enhanced the visibility of Dr. Benjamin's theories and the attention that his research results received from the medical community.

Diagrams of the early John's Hopkins MtF SRS Procedure

Following are illustrations that sketch the basic steps in the early Hopkins surgical method, which is a variation on Georges Burou's method. These figures are taken from Chapter 22, by Howard W. Jones, Jr., M.D. in *Transsexualism and Sex Reassignment*, Richard Green, M.D. and John Money, Ph.D., Editors; Johns-Hopkins Press, 1969. By this time it was common to refer to this type of surgery as "sex reassignment surgery" (SRS). The illustrations were reproduced from an original article by Howard W. Jones, Jr., Horst K. A. Schirmer, and John E. Hoopes, " A Sex Conversion Operation for Males with Transsexualism", *American Journal of Obstetrics and Gynecology* 100 (1968): 101-9. (Note: See comments following the diagrams regarding the anatomically misleading/incorrect sketching in the final sketch, Figure 10.)

Figure 1. A sketch of the perineum showing the line of primary incision.

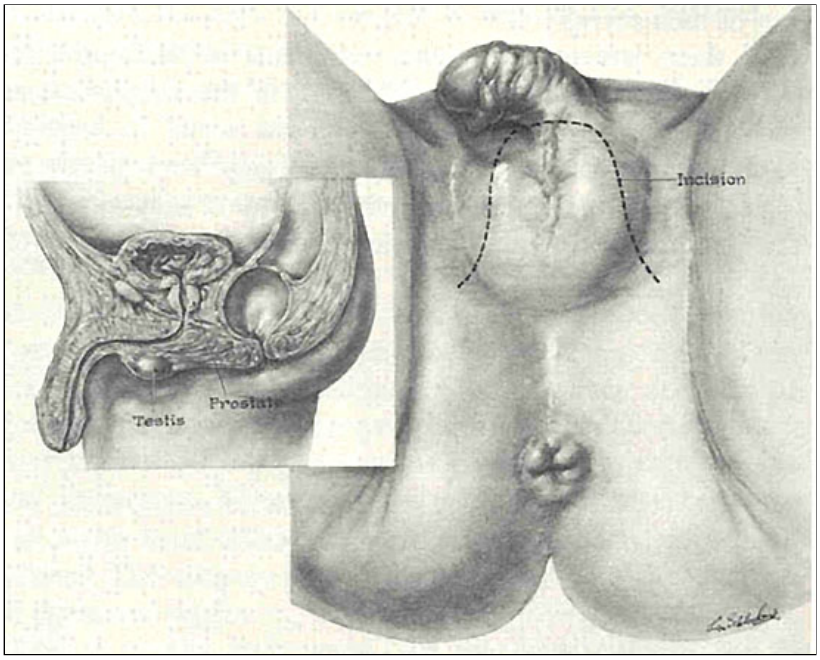


Figure 2. The right spermatic cord is clamped and ligated.

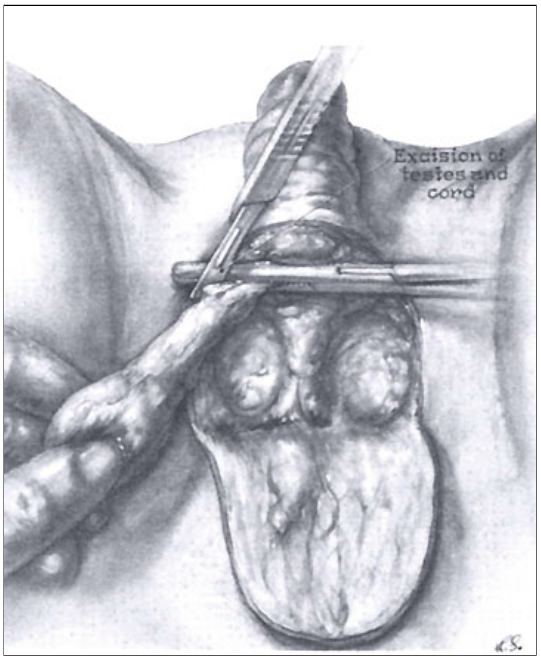


Figure 3. The primary incision is continued up the ventral side of the shaft of the penis.

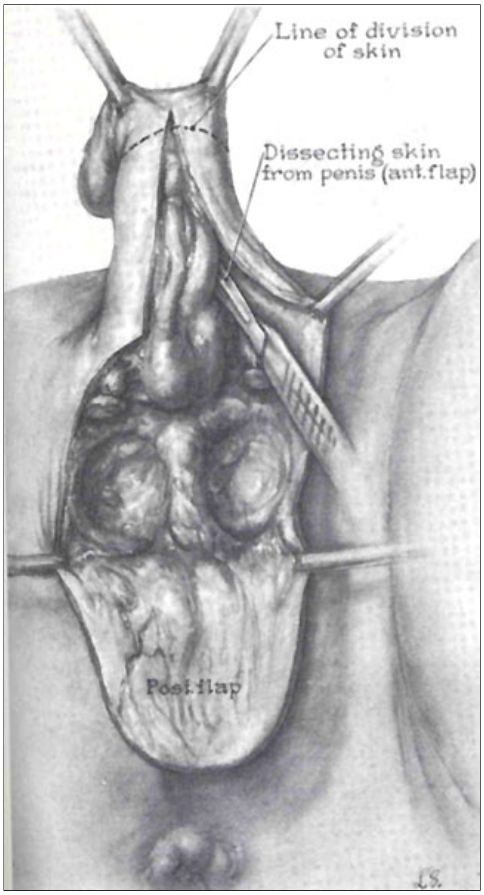


Figure 4. The anterior flap is developed from the skin of the penis.

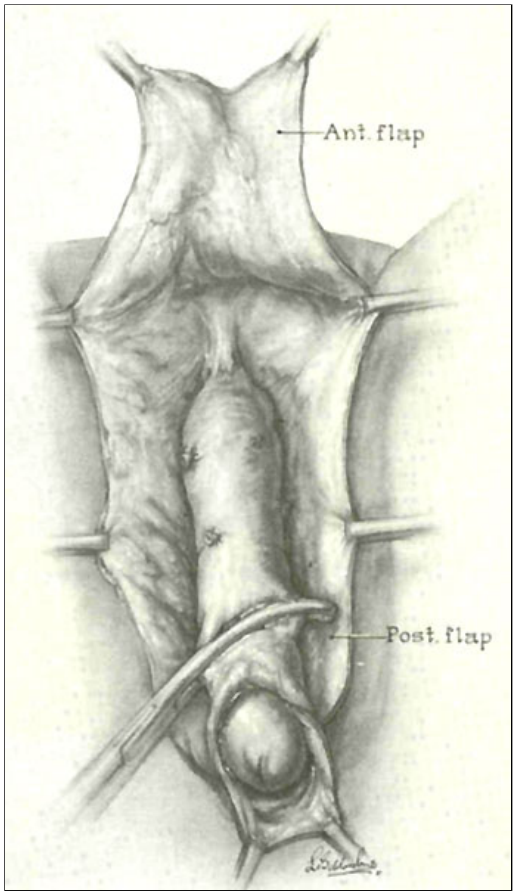


Figure 5. The urethra is dissected from the shaft of the penis.

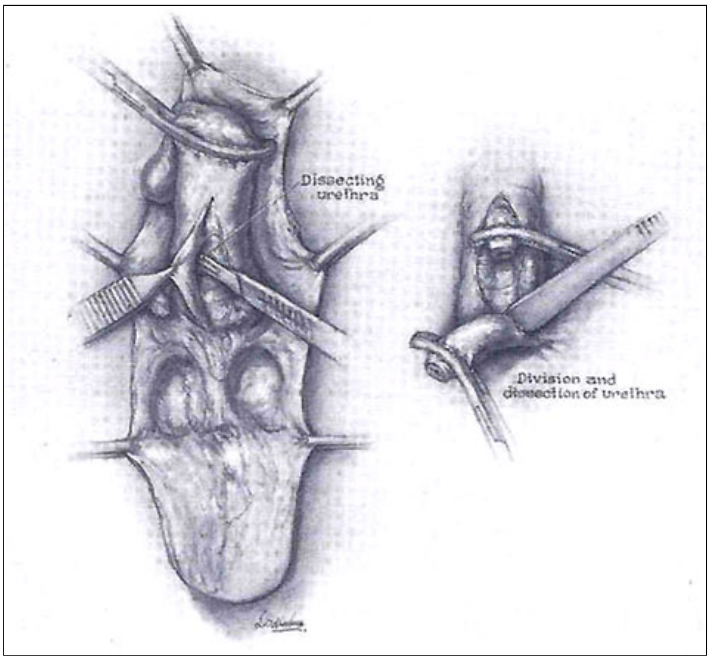


Figure 6. The corpora cavernosa are separated to assure a minimal stump.

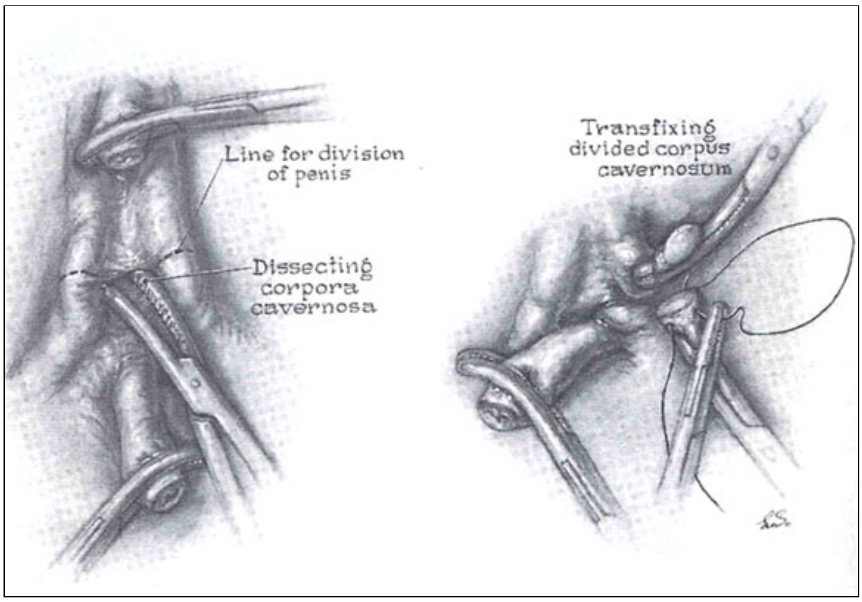


Figure 7. The perineal dissection.

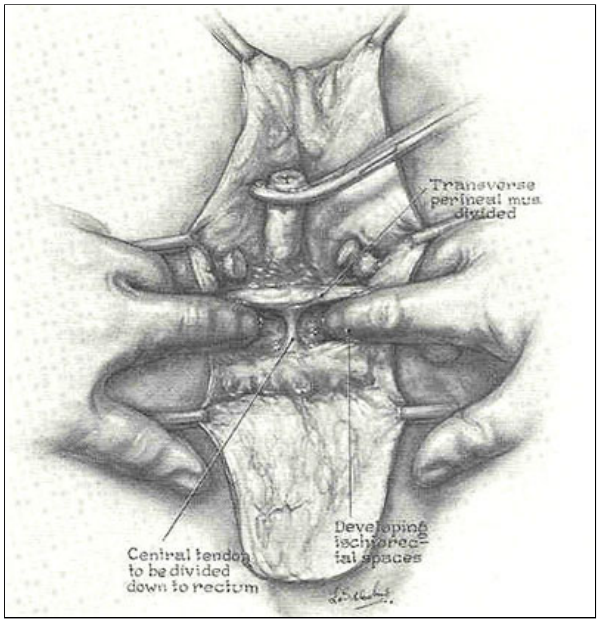


Figure 8. The perineal dissection has been completed and the anterior flap perforated to position the urethral meatus.

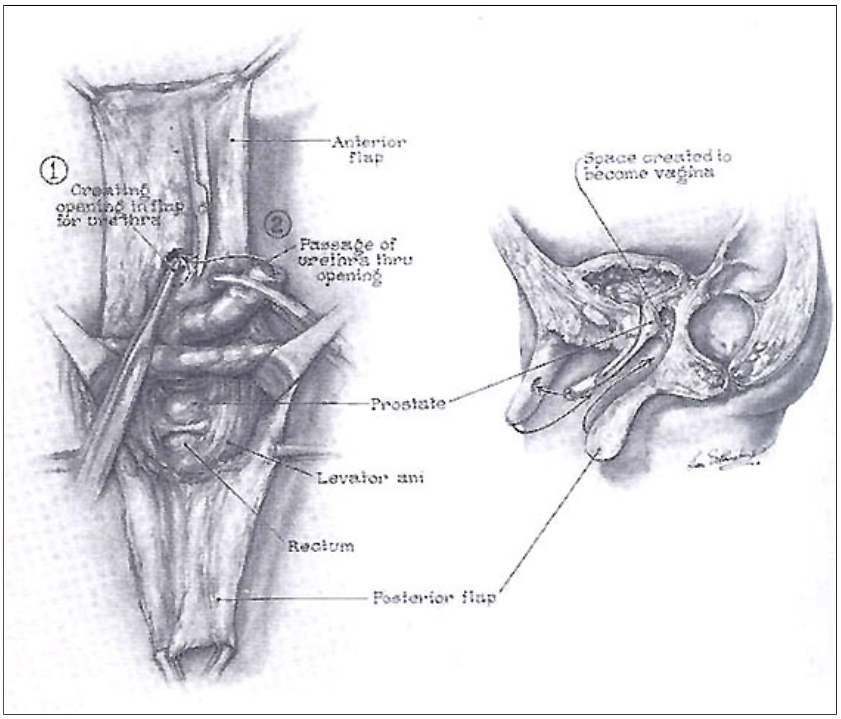


Figure 9. The skin flaps are sutured and placed in position in the vaginal cavity.

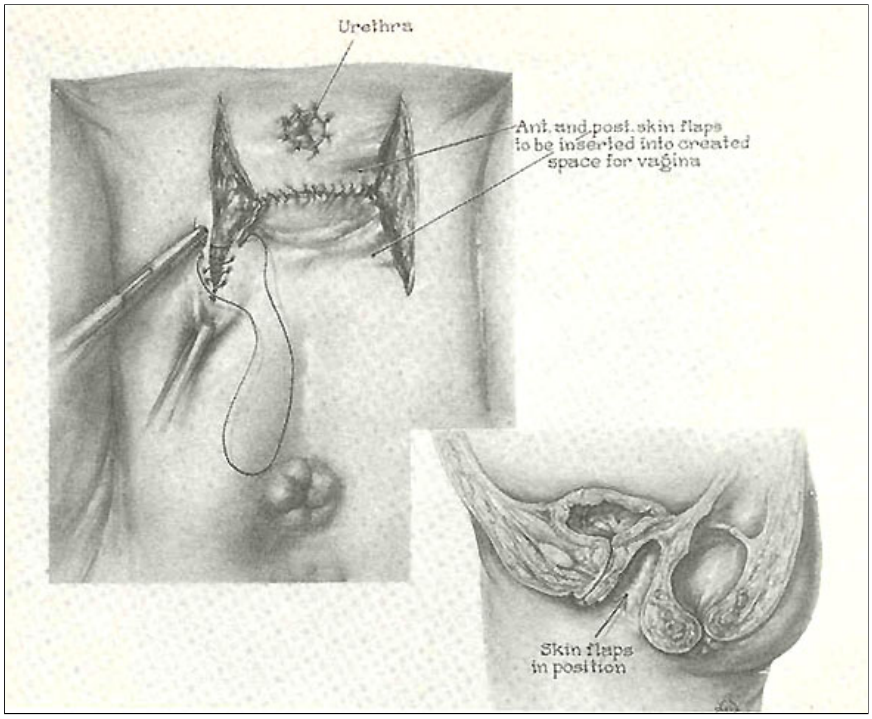
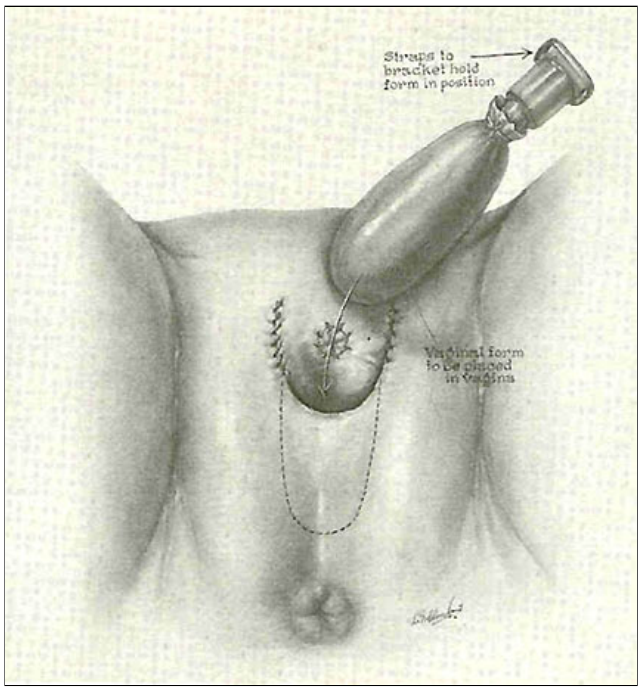


Figure 10. The preservation of the vaginal cavity is assured by use of a suitable vaginal form.



*Note 1: Figure 10 is **quite misleading** and **does not correspond to the anatomy the should result from this procedure**. In figure 10, the vaginal opening is way too far forward from the anal opening, and the vaginal entry is shown going first in horizontally and then turning upwards after passing a large web of skin in front of the anus. (Compare this sketch with the later photos of the details of modern SRS results, especially the one showing the entry of a vaginal stent into a postop's vagina). This very poorly conceived sketch has likely been the source of many botched surgeries in the early days, as surgeons copying the Hopkins procedure may have thought that a thick web of skin was needed in order to prevent tears into the rectum. Such webs of skin often prevented easy dilations and intercourse for patients after SRS, leading to vaginal stenosis (loss of depth and/or width).*

Note 2: Over the years, the techniques for doing SRS have been steadily refined. It has also became common for post-op MtF's to have additional genital surgery called "labiaplasty" that construct further details of the external female genitalia. For more information on modern SRS surgeries, see the links and the "Photo Details of Modern SRS Results" below.

SRS Becomes an Accepted Treatment for Transsexualism in the U.S.

The early Johns Hopkins announcement and publications coincided with the publication of *The Transsexual Phenomenon*, by Harry Benjamin, M.D. in late 1966. The result of many years of research observations and clinical practice by Dr. Benjamin became the seminal text on transsexualism. The book finally identified transsexualism as a distinct, major medical affliction in which patients have an innate gender identity opposite to the genital sex of their bodies. These theories and results obtained considerable attention within the U.S. medical community over the next several years - but most of it was highly skeptical.

Then, following interactions with Dr. Benjamin and some of his patients, physicians at the Stanford Medical Center started a exploratory gender clinic in 1969, led by Norman Fisk, M.D. and Donald Laub, M.D. SRS operations were undertaken on selected MtF patients, and the Stanford clinical and surgical results further validated the concept of SRS as treatment for those suffering from intense transsexualism. Acceptance of SRS as a serious and valid treatment for transsexualism began to slowly spread among thought leaders in the U.S. medical community. Hospitals around the country began gradually lifting their bans on transsexual surgeries, and surgeons at various locations began performing these surgeries on small numbers of selected patients in the U.S.

In 1969 Stanley Biber, M.D. (1924-2006*), a surgeon in Trinidad, Colorado, began performing MtF SRS vaginoplasty operations using information he obtained from the surgical team at Johns Hopkins. The excellent successes of his surgeries became widely known, and patients streamed to him. For a detailed report from one of Dr. Biber's surgeries, see this 1984 Operative Report.

For many years Dr. Biber performed over 150 MtF SRS's per year, and by the year 2000 had performed over 4500 of them. A *USA Today* article told Dr. Biber's story, as follows:

4A -WEDNESDAY MAY 24, 2000 - USA TODAY

Sex-Change nickname makes Colo. town cringe: 'Nobody cares'

Transformation via surgery has become common in community

By Pauline Arrillaga
The Associated Press

TRINIDAD, Colo. - The young waitress examined her customers as she refilled their coffee and haltingly asked whether anyone wanted more tea.

There was Elise, a buxom brunette in a crop top and hip-huggers. Kate, a Harvard graduate writer in khakis, hand-knit sweater and pearl earrings. Thea, a graphics designer sporting chic suede boots. And Jackie, a towering figure in trousers and blazer.

In the lunchtime crowd of merchants, housewives and farmers at the Main Street Bakery and Cafe, the four stuck out like fashion models on a pig farm.

Retreating to the kitchen, the waitress pulled her boss aside and stammered, "Those women I'm waiting on? They're men!"

Hardly anyone else gave the foursome a second glance. Not in the so-called "Sex-Change Capital of the World."

Repeat that phrase to, almost any of the town's 9,500 people and one would likely get a lecture on what the southern Colorado hamlet should be known for - its idyllic scenery, comfortable climate and friendly people.

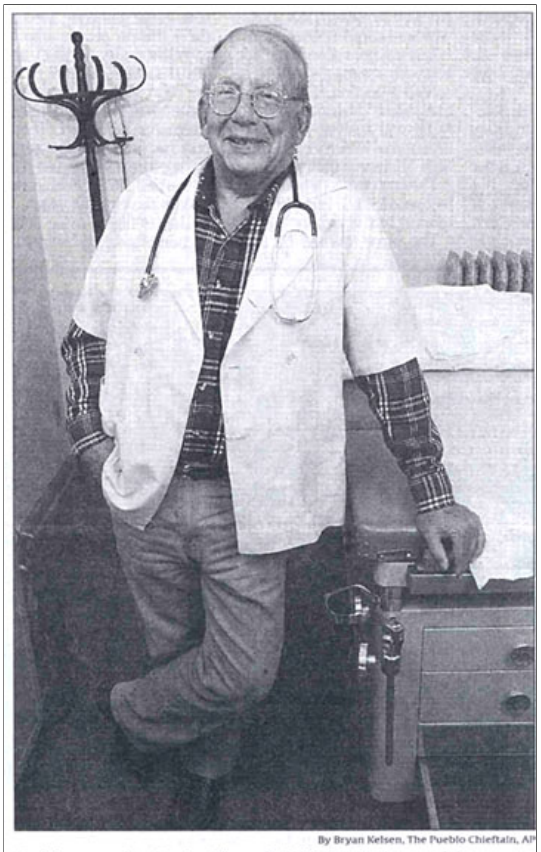
Most don't mind that more sex-change operations have been done in their town than anywhere else (about 4,500 to date); they just hate that nickname.

"Nobody cares," says Monica Violante, owner of the Main Street Bakery. "It's just a part of Trinidad."

Town in transition

Although no formal statistics are kept on the number of sex reassignment surgeries, experts in the field agree that Trinidad's Stanley Biber - because of the year he began and his age - has performed more than anyone.

The International Foundation for Gender Education lists 14 surgeons in the USA and Canada that do the procedure, and, as spokeswoman Sara Herwig points out, "Biber's been doing it longer than most."



By Bryan Kelsen, The Pueblo Chieftain, AP

Thriving practice: Stanley Biber of Trinidad, Colo., is one of the country's leading practitioners of sex-change operations.

What makes Trinidad unique is not that it's the sex-change capital of the world, but the fact that this former mining town has come to accept its destiny, depend on it and even embrace it.

In 1969, Trinidad was a town in transition. Coal had been king in these parts since the turn of the century, but after World War II, the mines began closing. By the late '60s, only a few remained.

Families left, and Main Street, once a bustling collection of. department stores, car dealerships and restaurants, became a lifeless shell of shuttered storefronts.

Yet Biber was thriving from his fourth-floor office inside the First National Bank building.

As Trinidad's-s only general surgeon, Biber did it all - from delivering babies and removing appendixes to reconstructing the cleft palates of poor children.

Biber moved here in 1954 after serving as a MASH surgeon in Korea and finishing a stint at Camp Carson in Colorado Springs.

In those first 15 years, Biber built a comfortable life around a practice he loved and a town he adored. In 1969, he encountered the patient who would forever change both.

A social Worker Biber had met asked him to perform her surgery. "Well, of course," he told her. "What do you want done?"

"I'm a transsexual," she replied. And Biber asked, "What is that?"

After consulting a New York physician who had done sex reassignment operations and obtaining hand-drawn sketches from Johns Hopkins University, Biber agreed to do the surgery. "She was very happy," he recalls. "And then it started spreading all over."

With less than a handful of doctors performing the procedure, Trinidad became THE place to come for a sex-change operation, and Biber was THE man to do it.

The town's sole hospital, Mt. San Rafael, was run by Catholic nuns, and Biber hid the charts of his first transsexual patients. But he knew he'd eventually need the approval of the hospital board and his neighbors. Biber explained his Work to the sisters and local ministers.

I went through the psychology of it all. They decided as long as we were doing a service and it was a good service, that there was no reason we couldn't continue doing them," he says.

Soon, Biber was lecturing to the hospital staff and the public.

"We figured that's his way of making a living; more power to him," says Linda Martinez, 54, a lifelong patient of Biber's.

Lucrative operations

Not all agree. The Rev. Verlyn Hanson, pastor of the First Baptist Church for the past three years says the town turned a blind eye to Biber's work because of the economic boost it provided. "The love of money is the root of all evil, and people will overlook a lot of evil to have a stronger economy," he says .

At one point, Biber's operations brought about $1 million a year to the hospital, according to his estimates. The basic procedure costs about $11,000, with the hospital taking in a little more than half.

At the height of his practice, Biber performed about 150 transsexual operations a year. His patients brought families and friends who remained in town during their loved ones' eight-day hospital stay.

Whether or not people liked what Biber did, they liked the squat, balding doctor who wore jeans and flannel shirts to work and always said hello.

At 77, Biber has scaled back his transsexual business to about 100 surgeries a year. The majority of his practice remains tending to the ills of Trinidad's citizens. He knows retirement may not be far off, and he's in search of a surgeon who will continue his work. "it started here, and I want the hospital to continue with it," he says.

[end of AP article on Dr. Biber]

*Stanley Biber, M.D.

Dr. Biber was one of the pioneering surgeons of the 20th century. Over a 35 year period beginning in 1969, he performed over 5000 sex reassignment surgeries, almost single-handedly establishing SRS as an acknowledged and accepted treatment for transsexualism in the U.S. Much beloved by the trans community, Dr. Biber passed away on Monday January, 16, 2006 at the age of 82.

The Current Protocol for Referring Transsexuals for Vaginoplasty (SRS)

Vaginoplasty (sex reassignment surgery) is a dramatic and irrevocable final step in male to female gender transition. This step is usually taken only after the deepest introspection and counselling regarding all the options. For those needing complete gender correction, this surgery is a life saving and life enhancing miracle, and can enable them to live a full and joyous life afterwards. However, carrying out of a mistaken urge for such a complete transformation could lead to permanent and terrifying emotional and psychological consequences. The background for this process is discussed in the introduction to the concepts of gender identity, transgenderism and transexualism found elsewhere in Lynn's website.

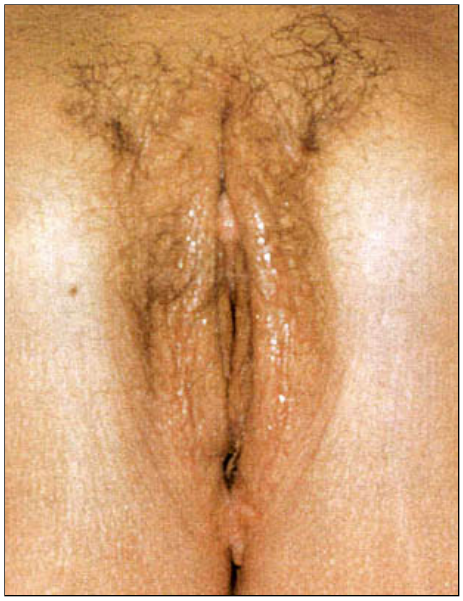
The Standards of Care of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) defines the currently accepted protocols for the medical treatment of transsexual women. These Standards cover all aspects of medical treatment, including the requirements for Real Life Experience (aka, Real Life Test), and other requirements that must be met before a trans woman is recommended for SRS. Most surgeons who perform vaginoplasty will only operate on transsexual women who have been treated under these Standards and who present the corresponding letters of recommendation for surgery from their case-counsellors.

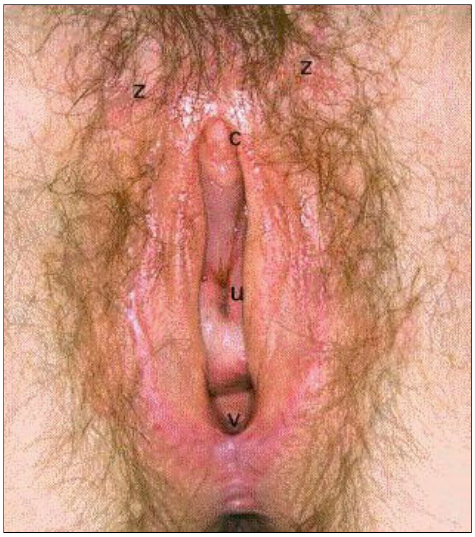
For more information on the overall TS treatment and transition procedures, see Andrea James' TS Roadmap website, which contains outstanding planning information for anyone contemplating MtF gender transition. For more details on Vaginoplasty, see Andrea's Vaginoplasty page and follow the many links there.

Some Photos of Modern Vaginoplasty (SRS) Results

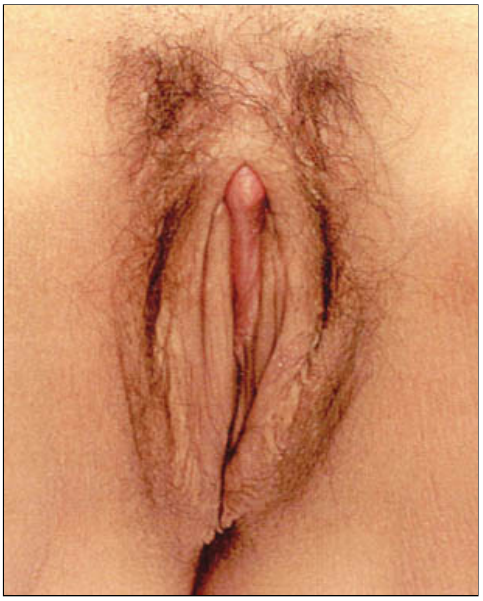
During the 80's and especially during the 90's, there were steady advances in vaginoplasty (SRS) techniques. When performed by the most experienced surgeons, the SRS results are much more predictable than in earlier years, both in appearance and function, and there are far fewer incidents of complications. (Note: We now often use the alternative term Vaginoplasty to refer to SRS. This term better communicates that the surgical goal is the construction of functional female genitalia - i.e., a vagina). The vaginoplasty surgery is often followed several months later by labiaplasty surgery to refine the external female genitalia (labia).

Following are photographs of the details of the female genitalia created by modern vaginoplasty *and* labiaplasty. These photos clarify the remarkably advanced state of modern MtF sex reassignment surgery. In these cases, the surgeries were performed in 1999-2000 by Eugene Schrang, M.D., of Neenah, WI. The patients are in the same orientation as in Figure 10 above (i.e., in stirrups with legs spread and labia separated). The middle photo shows the inner and outer labia spread apart and is labelled to identify the clitoris (c), the urethral opening (u) and the vaginal opening (v). The (z's) note locations of faint z-plasty scar-lines where incisions were made during labiaplasty to construct the clitoral hood. Note the normal anatomical proximity of the vaginal and anal openings. (See the web-links at the end of this page for more photos of SRS and labiaplasty results):

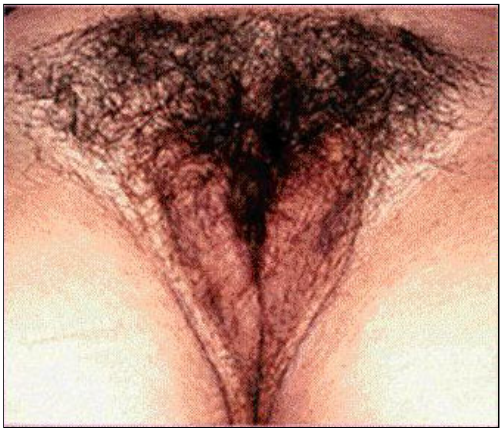




Results of modern SRS surgeries performed by Eugene Schrang, M.D., of Neenah, WI



Here is a photo of the appearance of the external genitalia of a TS patient one year after SRS (vaginoplasty only) was performed on her in Montreal, Canada at the Clinic of Yvon Menard, M.D. and Pierre Brassard, M.D. **(en espa&#65533;ol)**. In this case the patient is shown with her legs close together and we are looking upwards from the direction of her knees. Therefore the outer labia are pressed together, and the inner details of her genitalia are not visible. This photo is fairly typical of the normal-looking external appearance of TS women's genitalia after basic SRS. Note that electrolysis can be applied to the genital area so as to remove unwanted hair from the labial areas, if needed to produce a natural final appearance.



Postoperative Care Following Vaginoplasty (SRS)

During the immediate postop period, the woman will be under the good care of her surgeon and hospital recovery environment. During this time, she will learn whether her surgery was fully successful, or whether some complications have occurred and have to be dealt with. Later, after leaving the hospital, she will have to take a lot of responsibility for long-term ongoing aftercare, and the long-term outcome of the surgery will depend on how consistently she performs that aftercare.

A high percentage of modern SRS surgeries done by the top surgeons are fully successful, aesthetically and functionally, without any major complications. However, when done by less experienced surgeons various complications can and do occur, and even the top surgeons will very occasionally encounter difficulties. Complications can include minor infections, bleeding, a sloughing-off and loss of some of the grafted skin. Most of these minor complications can easily be managed and will be under control before the woman leaves the hospital.

However, there is some risk of more serious complications. Anyone contemplating SRS should understand these risks, and should be sure to go to only the very TOP surgeons here or abroad who have track records of very low frequencies of serious complications. The more serious complications include major infection or bleeding, and damage to the bladder, prostate or major nerves during the dissection to form the vagina. These complications can be difficult to control and correct, may require major extension of the hospital stay, and can lead to permanent uncorrectable damage.

One of the most feared complications of all is the formation of a vaginal-rectal fistula. This can occur during the dissection of the vaginal cavity by accidentally cutting through the rectal wall, or it can occur due to vaginal-rectal tissue death from pressure of the packing during the immediate postop period. A fistula enables excrement to bypass the anal stricture and exude from the vagina. The excrement prevents proper healing of the fistula and an

ongoing danger of infection. The only way to correct the damage is to perform a colostomy, and then wear a bag for many months while the fistula heals. Proper dilation of the neovagina may not be possible during this periond, often leading to closure of the neovagina. The patient may thus later need a complete redo of the SRS using skin grafts.

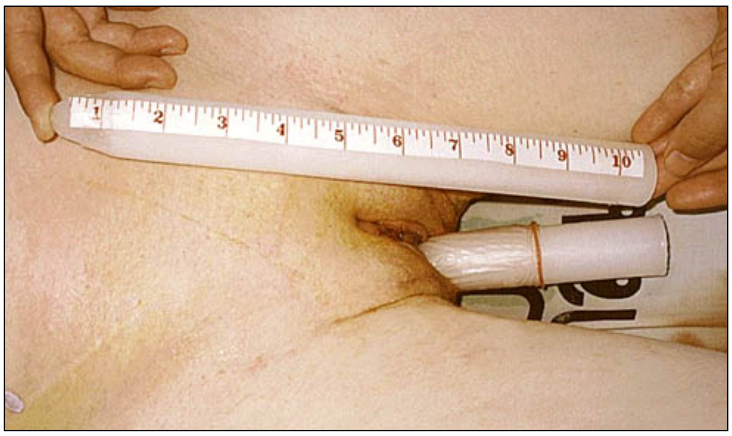
[Note: This terrible type of complication often goes unreported because the patient is dependent of the surgeon to correct the damage, and won't want to alienate him by publicly revealing that the complication has occurred. She is also usually devastated emotionally and won't want to reveal the horror she is going through. Be sure to go to one of the TOP surgeons if you want to minimize the risk of such awful complications.]

Once released from the hospital, the main concern facing the newly postop woman is to insure that her neovagina heals properly, and maintains its size and remains functional. In order to do this, the patient must dilate frequently using a vaginal stent for an extended period following surgery. There are a number of sources for such stents, and your surgeon will most likely recommend a source to you. One current internet source for stents is Duratek Plastics of Canada.

Vaginal stents typically range in size from about 1-1/8 to 1-1/2 inches or more in diameter (28 to 38 mm), and must be inserted to full depth (4 to 6 inches or more) into the woman's vagina for 30-40 minutes several times per day for many months after the surgery. Increasing sizes are used to gradually widen and maintain the vaginal opening during the postop recovery period. Later-on, especially during any prolonged periods of sexual inactivity, basic dilation must be done at least once or twice a week to insure maintenance of vaginal width and depth. Even after many years, if the woman notices any tightening or constrictions from one week to the next, the frequency of dilation must be increased until that tightening episode has passed.

For more detailed information about dilation techniques and immediate postop care, carefully study the article Zen and the Art of Postop Maintenance. We cannot over-emphasize how essential it is to rigorously perform dilations according to the schedule provided by your surgeon. Many of the cases where surgical outcomes seem to be poor are actually the result of women not rigorously dilating, especially during the critical months immediately following SRS.

Following is a photo of a newly-postop transsexual woman, whose pubic hair is still shaven, undergoing one of her initial vaginal dilations (after SRS at Dr. Suporn clinic in Thailand). Note that the depth obtainable during SRS is a function of surgical technique, available penile and scrotal tissue for skin grafts and the patient's pelvic anatomy. Typical SRS depths for most patients of the better surgeons are in the range of 4" to 6". Here you see an above average result of SRS: a vaginal depth of about 6 to 6-1/2 inches. The stent in this photo is 30mm in diameter. As you can see the stent enters the body at the base of the vulva, and in a normal angle in line with the main torso. Thus this patient's overall genital geometry is now the same as for any female, and will accomodate all the usual positions for sexual intercourse and lovemaking.



Lynn highly recommends that all women having SRS find a friendly, trustworthy, competent family practitioner or gynecologist beforehand. Tell them what you are about to do, so that they can help you with any minor complications that may be present or may arise once you return from your surgery. Unfortunately, few physicians have any clue about SRS. Therefore, if you suddenly have a complication at home after surgery, you may find it very difficult to get medical help. Many physicians will be afraid of helping for fear that lack of knowledge may lead them into malpractice problems, etc. It would be better if more of the top surgeons would write-up some aftercare information that included a section for general practitioners and gynecologists regarding postop care. This might help ease the concerns among local physicians about how to help a postop woman after SRS.

Note: Lack of local medical care was a huge problem for postop women in past decades. Many women returning from abroad with major complications in the 1960's and 1970's were unable to find any medical help here in the U.S. Some were even ejected from ER's they had gone to with life-threatening complications. Some died for lack of access to basic postop medical care in the U.S. Fortunately, things aren't this bad anymore in most places. But to be absolutely safe, be SURE to line up access to local medical care BEFORE going for SRS.

All postop patients should be very careful not to let fears and worries and embarrassments interfere with proper aftercare. If you are having any medical problems and are in doubt about your condition, go see a doctor! Don't let a minor infection or bleeding or pain stop you from doing your scheduled dilations! If there is any problem at all, seek local medical help and also get back in contact with your primary surgeon. You must not let ANYTHING interfere with your dilations, or else you risk the loss of your neovagina.

After a couple of months have passed, healing will begin to be complete and you can relax a bit. The frequency of scheduled dilations will ease a bit, and you will begin to feel your new form of sexual arousals. At this point you are ready to fully begin your new sex life as a woman.

Some Practical Matters:

Dilations require lubrication, and many postop gals use the water-soluble lubes such as K-Y for this purpose. However, if you need to lube "on the run" in rest room or similar situation, K-Y is rather messy because you need to wash with water to clean it off. Mineral oil is an inexpensive alternative lubricant for dilation that works well, and it cleans up without necessarily requiring washing it off. It can be almost completely removed with paper towels without water, and really isn't very "oily" after all. The only problem with mineral oil is when travelling you have to pack your bottle of it inside a zip-lock bag lest it sneak out into your luggage.

Lubrication is also usually required during sex play and intercourse using your new vagina. Here too there is a good alternative to the ubiquitous K-Y. Astroglide is a much better lube. It takes less of it, and it feels much more "slimy" like natural mucous secretions do. It lasts well and is water soluble too. The only problem with it is that the Astroglide bottles have a little pop-up nozzle that it very sharp at the end - so do be careful when applying it in the heat of passion to yourself and especially to your lover!

The postop woman may need to douche occasionally, especially after intercourse, in order to keep her neovagina clean and odor-free. There are many over-the-counter preprepared douches that work fine for this. They come in various scents and concentrations. Lynn prefers the "extra cleansing vinegar and water" mixtures, but all the mixtures work fine and will leave you feeling clean and fresh inside. The easiest way to use the douche is to stand in a bathtub or shower and relax and carefully insert it vertically in line with your vagina. Once it is in all the way (the tips are about 4" long), squeeze the bottle empty and let the fluid simply run down your legs. Wipe off with a wet washcloth, and you're done.

Most of these prepared douches, such as the Massengill brand, have a tip that tapers down to a fairly fine end, almost to a point. These tapered tips can be a bit painful to insert, especially during the first months after SRS. Since the shafts get larger as you insert further, you can sometime feel the rather sharp flutes along the shaft (slot where the fluid will be ejected from the bottle). Therefore, you'll need to use quite a bit of lube all along those shafts in order to insert those tips, and the sensation may still be unpleasant.

However, there is one brand of douche, "Summers Eve" which uses a wider, hemispherical tip the size of a small finger, and the shaft behind the tip is smaller in diameter than the tip. Summers Eve douches insert very easily and painlessly with only a small amount of lube on the tip.

Initially, when newly postop, the girl may have difficulty with her urine unpredictably "spraying" all over the place when she sits to pee. However, as her urethral opening heals, she will gradually be able to direct her urine into a more predictable stream. This may take some learning on exactly how to sit and how to position the urethral opening when peeing - learning some things that all GG's had to do when they were little girls.

Many newly postop gals at some point suddenly become overly concerned about whether their new genitalia are going to look perfectly normal and whether they are "deep enough" for intercourse. These concerns can be very disabling and prevent the woman from relaxing, having fun, learning her body well, and then going out and dating and becoming open to sexual activities with a partner. This can become a kind of panic as the possibility of sexual intercourse as a woman begins to present itself. Newly postop women need to know that as long as they have at least 4" of depth, they will be able to have fun sex with most average-sized men. More than 4" is defintely better, but 4" is just enough. Many postops have about that much depth and do just fine in relationships with men. Also, most men find female genitalia a bit scary and just don't look all that closely. If you are a fun sexual partner and your genitalia are sexually functional, then you should have no concerns about "looking perfect".

By the way, quite a few GG women have confusions and concerns about "how they look". A recent controversy in Australia clarifies this issue: Most GG women have not seen the details of many other women's vulvas, but nowadays they may often see photos of other women in their boyfriends or husbands' porno magazines. In Australia the men's magazines such as Playboy and Penthouse are forced to digitally "pretty-up" and simplify the appearance of women's genitals in their photos in order to be sold without plastic-wrap covers. As a result of seeing these modified photos, many women in Australia have now gotten a very unrealistic notion of what most women's vulvas look like, and this has led to many women there to seek out plastic surgeons to make their genitals "look normal"! This story should help more postop TS women to relax a bit and not worry so much about "how they look". There is a very wide range of vulvar appearances, and most postops these days fit somewhere within the rather "normal-looking" part of that spectrum.

It also turns out that most men find postop women quite wonderful feeling during intercourse, because postops are usually "tighter" than other girls those men have made love to. Postop women can also "snatch" their lovers' penises and apply pressure by tightening their abdominal muscles, just as GG's do, and thus make themselves even tighter. However, you must be sure to regularly dilate to at least 35mm in width (1-3/8 inch) in order to take in an average-sized male, and 38mm is even better (1-1/2 inch). Remember, your vagina is not as elastic in diameter as a GG's vagina. It will stretch out only to the maximum size you've dilated to, and will then go no further. If you are in doubt about someone's size, be sure to carefully "feel the width" of your date before indicating a desire for intercourse. That way you can see if he's likely fit into you. If he's definitely too wide, you can decide that you are "too tired" that night. Then find someone else to date.

Sexual Arousal, Lovemaking and Orgasm in Postoperative Transsexual Women

Many myths surround the effects of SRS on libido, sexuality and orgasm. Many preop TS women are understandably concerned about whether they will be able to fully enjoy and eagerly participate in lovemaking after SRS. Of special interests and concern is whether postop TS women can fully experience sexual arousal and orgasm. The ability to easily become aroused, to desire intimate and sensual contact, and to achieve sexual release through orgasm is a precious gift to bring into love relationships, especially when combined with a desire to give full and complete pleasure to one's love partner too. A loss of these capabilities could ruin the woman's chances of experiencing her full humanity after transition, especially for finding and enjoying a passionate, deeply-bonded love relationship. However, as we'll see, SRS can provide those for whom it is right the chance to fully experience the joys of sex and lovemaking - and thus to finally enjoy a full human life.

Myths vs Reality, and the decision to undergo SRS

Many people simply assume that the loss of the external male genitalia will result in a complete loss of sexuality. This very naive myth unnecessarily frightens many preop women, and it also furthers prejudice against postop TS women, who are often thought of by the general public as having "desexed themselves".

Certainly a typical male would suffer a catastrophic impact on body image and libido from the loss of his external genitalia. However, it has long been known that with counseling and practice, even males who have lost their genitalia to cancer can recover the capability for arousal and orgasm.

Furthermore, intensely TS women are not "regular guys". They do not suffer a negative impact on body image as a result of SRS, but instead find a greatly enhanced body image. The experiences of countless Hijra girls in India demonstrates that even primitive forms of SRS do not desex transsexual girls and in fact helps many of them. SRS has the opposite effect on intensely TS women as would the emasculation of a typical male. SRS usually releases and enhances the libidos of TS women, enabling them to frequently and fully "turn-on" and enjoy their physical sexuality and lovemaking, including achievement of orgasm during intercourse with a partner.

The myths and misunderstandings about the effects of SRS cause many preop TS women to remain in a state of indecision about having surgery. Although feeling an intense need to undergo SRS to achieve physical conformity with their gender identity, some preops may also feel extreme anxiety about whether or not they will still experience sexual arousal and orgasm after SRS.

This anxiety is enhanced by stories heard from many TS transition failures, including the cases of intense cross-dressers, drag queens and crossdressers who mistakenly underwent SRS for various sexual reasons and then found that their male libidos were greatly reduced and their male orgasmic capability eliminated. See the "WARNING " in Lynn's TS information pages, for clarification of what can happen when male-gendered crossdressers or drag queens become misguided and have SRS. There have been so many of these misguided cases that the urban myths about SRS have escalated over the years, and there is now a lot of confusion about what to expect after SRS.

SRS Warning

On the other hand, many other transsexual girls learn to visualize from their preop sexual experiences (as Lynn did) that they'll probably still "turn-on" sexually and be orgasmic as women after SRS: Many preop women hide their genitals by inserting the testicles up into the abdomen, and then tightly tucking the male organ back through the crotch (with tight underwear or taping). In this configuration, the penis cannot usually get enough blood supply for full external penile erection. Even though the external part of the penis cannot erect when tucked tightly, the girl nevetheless experiences the familiar female "glow" and warmth throughout her interior genital region when she is aroused, for example, by a man's warm attentions. In addition, the corpora cavernosa shafts inside her body can become erect once the girl is sexually aroused, and that arousal feels really wonderful - even though the external part of the penis is flaccid. Sexual stimulation by rubbing and caressing the genital area and the breasts can then lead to orgasm for a girl who is sufficiently aroused.

From experiences like this, preop women can visualize that after undergoing SRS the remaining internal stumps of her corpora will still engorge and become erect, and that she can experience similar feelings of sexual arousal when she is postop. In addition, the postop woman can now also experience wonderful sensations from caressing her clitoris, which, in contrast to the previously hidden penis, can now be openly played with without her experiencing angst about her body-image.

There are thus many dimensions to postop women's sexuality, and the actual postop effects of SRS on arousal and orgasm vary greatly from case to case. Those who are male-gendered, and who have male sexual urges focused in the external genitalia, are likely to experience great loss over time. Those who are "in between somewhere" will likely experience a mixture of losses and gains. Those who are female gendered and who have strong female sexual urges are likely to benefit greatly, as a whole new life of sensuality, sexuality and lovemaking opens up to them. All of this is of course contingent upon the person having a normal-level of libido, having no "hang-ups" about being sensual and sexual, and also upon a successful surgical result.

Thus the decision for SRS must be taken with great internal soul searching and introspection, and with complete honesty with oneself about one's own gender identity, body image and likely psychic reactions to the body changes of SRS. This is especially true if sexual arousal and orgasm are very important in one's life. However, for those for whom SRS is the right thing to do, that surgery can release them fully from the physical gender trap they had been living in, and free them to experience their full humanity in sexual and lovemaking relationships.

Initial sexual response of postoperative TS women: Entering a second puberty

There is a wide range of libidos in postop women, just as in natal women. Some women are very highly sexed, the majority are moderately sexed, and some are asexual and have little libido at all. This section is relevant for those postop women who have healthy libidos, who experience sexual arousals and who desire ongoing sexual fulfillment and orgasms.

Most postop women having healthy libidos begin to experience their first postop arousals within a month or two after surgery. After a initial period of low sensations and even numbness, they then experience "turning on" due to engorgement of remaining internal erectile tissue (corpora and spongiosum) that was left during SRS. The arousals produce a feeling of "erection", but one that is different than for guys, since it is inside their bodies.

For some postop women, it may take much longer for these arousals to begin, especially if they were inactive sexually and/or asexual prior to SRS due to their gender angst. However, even these postop women will eventually begin to experience genital arousals and the onset of sexual desires if they have active libidos.

Consider also these words from the webpage Zen and the Art of Post-Operative Maintenance: "*Another factor in sexual function is your endocrine system...After surgery, some women find that their adrenal glands (the other source of testosterone) do not produce enough to provide adequate libido or orgasm. You may require a small amount of supplemental testosterone to regain functioning. The amount required is typically **far** below the amount that will cause any other unwanted side effects, such as hair growth. Not everyone requires this, but keep in mind that some do.*"

Many natal women who are having difficulty in feeling turned-on and in achieving orgasms (especially post-menopausal women) are now taking Estratest tablets, which contain a combination of estrogen and small amounts of testosterone. Although Estratest is a somewhat controversial treatment, many natal women began taking it after it was featured in a story on Oprah Winfrey's hugely popular television show in the U.S. As a result of this news, and of advice like that on the Zen page, some post-op women who were experiencing difficulty in arousals and orgasms began using Estratest too, and some report that the therapy helps them. These tablets contain either 1.25 mg or 0.625 mg of estrogens (as in Premarin tablets), but also include a small amount of testosterone in each pill (for more information, see this link). There may be some kind of threshold effect involved here, whereby some women need a

small amount of testosterone to maintain orgasmic capability. On the other hand, many other postop (and post-menopausal) women enjoy strong orgasms even in the complete absence of testosterone.

In any event, once a postop woman begins experiencing arousals, the nerves in the clitoris and vulvar surfaces become highly sensitized, and sensual and sexy feeling permeate her body. Then, just as during pubertal sexual awakening, she will automatically feel urges to play with her body and to masturbate. The arousals will gradually intensify as her genital area fully heals from the SRS. Masturbation and sexual activity can likely play a role in helping neural regeneration and sensitivity during this period.

There are many ways to masturbate, but one favorite way for girls to do it is to "rub on a pillow". The girl does this by lying face down on her bed, with a firm pillow between her legs. This way she can rub her vulva and clitoris on the pillow while squeezing it, putting pressure on her clit and also being able to thrust and thrash around. At the same time she can play with her breasts and body with her hands. Alternatively, she can rub her clitoris with the fingers of one hand while squeezing her legs and thrashing around to stimulate her body. And there are many other ways to stimulate arousals and produce orgasms, including using vibrators and other women's sex toys. Girls discover these ways just as automatically as boys discover "jerking off", even though girls have been more secretive about it our society in the past.

While masturbating, the pubertal girl will suddenly begin to experience her first orgasms, and she is then on her way to developing her full sexuality as a woman. In just the same way, the postop woman needs to explore her new sexual anatomy and masturbate, and learn her new sexual responses and experience her first orgasms as a woman - learning what most girls do in their teens during puberty.

This ongoing pubertal aspect of immediate postop life can be very thrilling and exciting, but also very confusing and scary for the woman, much in the same way that the onset of sexual maturity is for any teenager.

For some insights into this process, I highly recommend that you read the very candid webpage by entitled "M -> F Transexual Post-Op Orgasms - A Personal Perspective", by Monica Stewart. Monica's site stresses the need to gain experience with your new sexual responses prior to having intercourse. It is also important to try to get over hang-ups about what's "OK" and what's "naughty". Then too, many woman enjoy experiencing playful anal stimulation, including using sex toys to overcome inhibitions and enhance arousals. Most women also learn to use fantasies to trigger and enhance arousals and orgasms. Those fantasies can be used during masturbation, and then later used to help heighten one's experiences during intercourse with a lover.

Thus we see that transition and SRS are just the very beginning: They enable the girl enter her new puberty. What she will make of herself as a woman is yet to be determined!

Some advice to postop women about finding the right lover and losing your virginity

This section is aimed at postop women who have gained some experience with their new bodies and new sexual responses, and for whom "losing your virginity" is now a "goal". This can be a good thing to get behind you, because you'll be much more comfortable in the knowledge that you can really "do it", and it'll be easier the next time when it might really count.

By doing this you can get over your fears of whether you will pass or "look OK" in the sack, and whether your body or scars or whatever will lead to comments or difficulties. It turns out that most guys won't notice a thing even in very problematic cases as long you are sexually functional. Most guys just don't look very close. And there is such a wide range of vulvar appearances among natal women that most postop women look OK anyways. So you'll soon be able to relax about all that, and feel comfortable "cutting loose" and enjoying lovemaking without being self-conscious.

However, it is important to avoid doing it with just "any guy", especially someone whose persona or approach doesn't turn you on, or who doesn't try to make you feel good. Instead try hard to find someone you have something in common with, and with whom you can test out if there is any "chemistry" in advance, before jumping into the sack. And of course, you really should try to figure out if the guy is a nice person who won't get violent with you if he somehow "finds out".

One mistake many girls make is to hope for too much and too quickly, and then becoming greatly disappointed with how sex feels. By expecting sex with "just any guy" to be fun, they can become extremely disappointed. They may mistakingly think that guys know how to turn them on, instead of needing to get aroused themselves. They may simply discover that they have little or no genital sensation when they are not turned on, even with the man penetrating them and ejaculating into them. This can erroneously lead them to believe that they "lack sensation", leading to all sorts of fears and worries.

However, not "feeling much" when having sex with a man while you are not turned on is pretty much the same for ALL women, TS or not! It is a common experience nowadays among young teenage girls who cave in under pressure to "have sex with someone". It's not even a lot different from the situation a guy who isn't turned on faces while being pressured to have sex by a girl. Touching, rubbing and attempting intercourse simply do not feel good and do not produce results, unless you are turned on! That's why "being in love" with someone really does mean something folks!

Only if your libido kicks-in and you get a feeling of "erection" or warm arousal, will all the external sensitive tissue begin to give really good sensation and will sex be fun and potentially lead to orgasm. Also, just as for any GG, postop women should not expect much sensation from inside the vagina. Most of the sensation when you are turned on will be from the external clitoral area and the outer vulva (for the TS woman there will also be strong sensations from the erect corpora and the prostate inside her).

So, the problem is how to find a guy whose presence and voice and warm touch makes you feel "melty", and who turns you on and makes you feel really comfortable and sensual and excited. You'll know it when it happens. Then definitely do jump into the sack and let your inhibitions go!

Many of these same issues arise for postop gals who seek women as love partners. They may feel even stronger concerns about whether their bodies and genitals look OK, and whether they will really be accepted as women. On the other hand, they may feel a lot less physical fear of their partners than do gals going out with men. Beyond this, the situations are similar: For lovemaking to work, you and your partner must both be aroused and be comfortable with each other, and you must find sweet and compatible ways to share and enjoy lovemaking together.

Even if you find a good loving partner who turns you on and who is a good lover, you may still need some advance practice in order to easily reach orgasm. Some of this depends upon the sexual positions you both like best, and upon how you have previously been masturbating. You may need to

modify your private masturbation habits, and migrate to positions and stimulations more similar to those you experience during intercourse with your partner. Also, be sure to TELL your partner what you like. If he or she enjoys being with you and wants to make you happy, they will try to help you feel good. But they can't do that if they don't know what you like.

Thinking about intercourse positions

Some intercourse positions make it easier for a woman to reach orgasm than others. Most guys will let YOU tell them or guide them towards what you like (i.e., what position sequence you like to use). However, if you don't tell them what you like, you may end up flat on your back in the "missionary position" and get nothing out of it even IF you are turned on!

Remember, you are no different from GG women in that most of your sexual sensations will come from your clitoral area and outer-areas of the vulva, and you won't feel much sensation from down inside your vagina unless you are highly aroused. Therefore, just like most other women, simple penile penetration alone is not going to do much for you (contrary to most guys' misconceptions about female sexual response). Thus you don't want to leave it up to your man to just do it his way. It's very important to have some ideas of positions and lovemaking moves that will make you feel really good too.

For many women it may be easiest to control your erotic sensations during penetrative intercourse if you are "kneeling on top". Thus the "woman on top" position (see photo of Jenny Hildouaki below) is considered by some women to be the easiest way to reach orgasm through intercourse alone, even without extra manual clitoral stimulation.

Kneeling on top of her partner, the woman can control the speed, rhythm and angle of penetration in a way that arouses her most. She can move her pelvis against her partner's so that her clitoris rubs against his pubic bone (and pressure can be applied to her aroused corpora stumps, inside her and just behind the clitoris), which is an effective way to trigger an orgasm in many cases. At the same time, either the woman or her man can play with her breasts, adding to the erotic sensations she feels. If kneeling all the way down doesn't quite work, the woman can raise her torso slightly so that either she or her man can play with her clitoris by hand even while he is still inside her. In order to develop some insight into these possibilities, watch how "Leticia" (Halle Berry) reaches for her orgasm in the final lovemaking session of her academy award-winning performance in the movie "Monster's Ball".

Instead of trying to "both come at once", as if that were some sort of ideal goal, it is usually best for the woman to come first. That way she can be sure to come even if it takes some time. Playfully and lovingly swapping back and forth between penetration and then manual or oral stimulation of the girl's clitoris and vulva can help her get really hot and reach orgasm. Whatever works, works. Then, once the woman has had her orgasm, she can flip over and wrap her legs firmly around her man's back, and let him enjoy mounting her from above and thrusting hard into her while he approaches his orgasm and ejaculation.

Note: If the man has difficulty "staying up" long enough for the woman to reach orgasm, the solution is simple: Viagra! With Viagra almost any man can get good firm erections, and many healthy men can easily "stay up" for an hour or more by using it. Women should not hesitate to suggest Viagra to their men, because it can be a wonderful lovemaking enhancer. Since Viagra helps their men stay excited longer and takes pressure off their men, it can help women reach orgasms who otherwise can't reach orgasm soon enough - by giving them plenty of time to reach a climax.

These same concerns arise if your partner is a woman. There is a need to explore for positions and methods that work, and for signaling about things such as shifting positions, who should come first this time, etc. The shared experiences of developing really satisfying lovemaking skills together is an important part of falling deeply in love and fully emotionally bonding with your partner.

Once you are comfortable making love and reaching orgasm in basic sex-positions, you and your partner may want to explore more advanced techniques in order to keep your love-life fun and exciting. There is a wide variety of excellent books and videos available to help you in this. For starters, you could check out books like How to Be a Great Lover: Girlfriend-to-Girlfriend Time-Tested Techniques That Will Blow His Mind and *The Good Girl's Guide to Bad Girl Sex*. Also, take a look at videos like *The Guide to Advanced Sexual Positions*. Such books and videos can also help a woman get over various hang-ups and become more comfortable thinking about and then enjoying lovemaking.

Some differences between earlier male vs later female genital experiences, arousals and orgasms

The results of SRS are made immediately obvious to the postop woman by one important effect: She now has to "sit down to pee". Peeing isn't as easy as before, and every time you pee you are reminded that you are now a girl, reminded in the same way that all the other girls are.

On the other hand, there is a really great advantage to having female genitals that soon becomes obvious too: Your sexual arousals are no longer "visible to others". Just as for any other woman, the postop woman does not have to constantly suppress her arousals like men do. She can let herself get aroused any time she wants to, and can stay aroused for long periods of time without others "seeing anything", just as many other women do (this is another reason so many women smile a lot!).

It's great to be able to engage in fantasies and visualizations and get aroused at any time you want to. This freedom can help a woman create and firmly establish a healthy libido. She can hook-up her brain with her genitals without much "censorship" going on. Even though her libido is not as heavily stimulated by the large doses of testosterone that men have, neither does she have to tame and control her libido like men do theirs. Therefore, on balance, a woman can generally feel "sexy" much more of the time than a man can.

Lynn speculates that a lot of men have problems with getting erections simply because they have to constantly avoid having erections. In other words, they get much more practice in avoiding erections than they do in getting them! Women do not need to "censor" their arousals in that way. If they have no religious or other types of hang-ups about sex and lovemaking, they can easily practice and enjoy getting aroused as much as they like, and can develop very healthy libidos as a result. This advantage can help the postop woman get into her sexuality fairly quickly and help her learn a lot in just the first year or two postop.

Once she begins experiencing arousals and engaging in sexual activities, one major thing becomes immediately obvious. Orgasm feels really different as a woman. It may not be quite as easy to achieve and may take longer to achieve, but it can be a much more powerful sensation than any she ever experienced before as a boy.

Following SRS, the perfunctory feeling of male ejaculation during orgasm is gone forever. Instead, you can build up your sexual arousal to a much higher level without ejaculation bringing things to a halt. It may take more time to reach it, but you can now experience a more powerful orgasm - with the old male ejaculation feeling now replaced by an intense neural discharge and spasm throughout the entire genital area during orgasm. It feels kind of like you are being gently stimulated with electricity inside and throughout your entire genital region. The experience can vary a lot from orgasm to orgasm in the way in which the "neural halo and spasmodic colors" of the orgasm develop, spread, and feel. It seems almost as if most men so easily and quickly reach ejaculation that they never manage to get "high enough" sexually to trigger this more powerful form of orgasm.

In addition, there are real differences in "body feelings" during lovemaking between the male and female experience (although many of these feelings will be "female" in form for preop TS women too). Most males are usually stimulated visually by their partner's body-appearance. Once aroused, they usually feel a growing "tightness inside" and a desire to "grab and hold and thrust and penetrate". This desire comes on suddenly, and quickly becomes quite overpowering, with most of the sexual sensations coming only from within the penis itself. However, when the release of orgasm occurs, it is usually much more perfunctory than for a woman, being accompanied by a few spurts of semen and a few grunts and that's it. The ejaculation is then followed by quite a sudden letdown and loss of any interest in sexual activity.

The sexual experience for the postop woman is much more "internal" within and throughout her whole body than for a male. The arousal may start in her genitals, but then can spread all through her lower body, especially inside the muscles, and her skin all over her body becomes more sensitized to caressing and touching. Instead of sexual arousal being just in the genitals as in a male, the estrogen seems to also enable a powerful "heat" to fill the woman's whole body once she is aroused - and especially once she is being penetrated. Having this heat come over her in the absence of a partner, and without any satisfaction, can make her feel like "climbing the walls" or "thrashing around in her bed".

Since her whole body becomes much more sensitive to touch as she get fully aroused, she is not stimulated so much by her partner's appearance as by the way he (or she) touches her and manipulates her body and the way his (or her) voice sounds. She doesn't feel the hard focused drive to quickly achieve orgasm as do males, but instead feels a desire to let go and thrash around and be "handled" and gradually heighten her erotic feelings. It isn't what she is seeing that counts as much as what she is feeling and hearing and how her body is being manipulated by her partner, as she yields to the wonders of sexual heat and lovemaking. And usually she'll like to take some time to do this and enjoy this, instead of just "rushing for ejaculation" like most guys do.

Finally, she will get up on a "plateau" and realize that an orgasm is going to come. This is a truly wonderful feeling. At some point, the orgasm starts and spreads throughout her genital area, with the genital nerves becoming tremendously sensitized as it spreads. The sensation of the orgasm will vary a lot from orgasm to orgasm (more variably than in the male). Sometimes it will be weak, but sometimes it can be amazingly intense, and the feeling varies a lot in form and "color" from orgasm to orgasm.

Just like natal women, trans women often experience a strong urge to "vocalize" just before and during orgasm - moaning, squealing, screaming and making other loud noises while they come. The sound and internal body sensation of these vocalizations can greatly heighten the intensity of the orgasmic experience for many women. Postop women shouldn't be afraid to let out loud moans or screams when they come. It is perfectly natural, and can help transform ordinary orgasms into ecstatic ones. In contrast, very few men vocalize when they ejaculate, other than making a few grunts. Perhaps the difference is hormonal, with testosterone blocking these emotional vocalizations, just as it blocks emotions such as "crying" in males.

After climax the trans woman feels a sudden relaxing and calming effect that is somewhat similar to what it is like for boys. But unlike when she was a boy, she may often feel aroused and sexy again rather soon after having sex, often getting firm internal erections again soon after her orgasms. Even though it may be difficult for her to achieve orgasm again until some time has passed (a few hours to a day or so), she may feel a desire for sex again right away anyways. These re-arousals are a really wonderful feeling, and can enable sweet sessions of touching and snuggling with a loving partner after intercourse.

Measuring and documenting postop orgasmic response in TS women

As part of an effort to better measure and document postop women's sexual capabilities, Lynn participated in first scientific physiologic study of orgasm in postop TS women, in June 1999. This research was conducted by Rom Birnbaum, as part of her Ph.D. studies at the Institute for the Advanced Study of Human Sexuality in San Francisco, CA. Space was provided space for Rom's equipment and for conducting the research studies by Club Eros, a gay men's club in San Francisco. Although seemingly a strange place to conduct research studies on women, this "sex-friendly" site in the Castro Area was a good place for accommodating a wide range of research subjects and control subjects, during daytime "off-hours" at the club.

Research subjects were instrumented with electronic sensors (using measurement techniques evolved from the pioneering work of Masters and Johnson in their early studies of orgasm), and then engaged in masturbation in a comfortable, private environment in an effort to achieve orgasm. A number of the postop TS women, including Lynn, achieved orgasm as measured directly by Rom's instrumentation. Lynn's case was particularly important, since she demonstrated that the capacity for very intense orgasms can endure for many decades after SRS (Lynn was 31 years postop at the time of this research). Dr. Birnbaum's work demonstrated scientifically for the first time what many postop women and their lovers have known all along, namely that strong orgasms can be fully enjoyed by many TS women. Rom published her Ph.D. thesis results in 2000 (see following abstract).

Abstract: First physiologic study of orgasm in postoperative male-to-female transsexuals. Birnbaum, R.

Ph.D. dissertation, The Institute for Advanced Study of Human Sexuality, San Francisco (Oct. 18, 2000).
Contact: poststudy@aol.com

Objective: To determine whether data generated by a physiological sex research study would support the hypothesis that orgasmic capacity can be retained and/or gained after sex reassignment surgery in the postoperative male-to-female transsexual. Design: Controlled laboratory-based analysis of responses to masturbation to orgasm(s). Setting: A mobile sex research laboratory setup predominately in two central San Francisco locations. Participants: A volunteer sample of eleven postoperative male-to-female transsexuals as well as twenty-nine control group participants divided into five groups: eleven nontranssexual males, nine nontranssexual females, five preoperative male-to-female transsexuals, two intersexual people and two female-to-male transsexuals. These totals include one participant who joined the study first as a preoperative male-to-female participant, and returned again later as

a postoperative male-to-female participant. Intervention: One protocol including measurements of preorgasmic, orgasmic, and postorgasmic responses; response time determined per individual. Dependent variables: Pressure waveform patterns produced by involuntary contractions of the anal musculature, heart rate, and blood pressure. Results: Of the eleven postoperative male-to-female study group participants, eight self-reported orgasm and three of these eight produced orgasmic contraction episodes similar to those produced by control group participants in this study and subjects in previous physiological studies of orgasm. Furthermore, no statistically significant differences were found between contraction patterns produced by study and control groups in terms of duration of orgasmic contractions, intraorgasmic amplitude changes, number of orgasmic contractions per series, mean intervals between the first four contractions, mean intervals between all contractions, or orgasmic heart rates. Conclusions: Data from this study strongly support the hypothesis that orgasmic capacity can be retained and/or gained after sex reassignment surgery in the postoperative male-to-female transsexual. However, given the limited sample sizes, projected percentages of orgasmic capacity in the postoperative male-to-female transsexual population are unavailable.

Lynn Conway and Rom Birnbaum at Club Eros in San Francisco, where Rom made the first scientific physiologic measurements of orgasm in postop TS women, in 1999.

The range of experiences of many postop women - - effects on sexual orientation and the moderate unpredictability of postop sexual orientation - - long-term effects - - some of Lynn's own experiences - - [to be completed] - -

Who are the most active, prominent surgeons doing vaginoplasty (SRS) now?

The most prominent SRS surgeons in the U.S. today are Toby Meltzer, M. D. of Scottsdale, Arizona and Eugene Schrang, M.D. of Neenah, Wisconsin. These surgeons are in their prime, are performing hundreds of SRS each year, and are achieving outstanding results in appearance, function and sensitivity. Marci Bowers, M.D., a surgeon who has worked closely with Dr. Biber, has recently taken over his practice in Trinidad, Colorado and is reported to be doing excellent SRS surgeries there (Dr. Biber is now retired). There are also other expert surgeons performing high-quality SRS's in various other countries around the world, most notably Yvon Ménard, M.D. and Pierre Brassard, M.D. **(en espa****ol)** in Montreal, Canada, and Suporn Watanyusakul, M.D. ("Dr. Suporn") in Chornburi, Thailand.

Marci Bowers, M.D.

Toby Meltzer, M.D.

Eugene Schrang, M.D.

For information on many surgeons performing excellent vaginoplasty (SRS) operations both here and abroad, see Andrea's Vaginoplasty page and follow the many links there. See also the SRS section of TS Women's Support Site and The New Sex Change Indigo Pages for information and links to SRS

surgeons in many countries. The new European TS Information pages provide information about many excellent European surgeons. There are also a number of surgeons in Thailand who are now performing good quality SRS's, and the costs of surgery there are much lower than for comparable work elsewhere in the world.

Important note: In past years, few surgeons would operate on girls who were HIV+. This compounded the tragedy of being TS for the small minority of women who had been forced to live "on the streets" and had contracted this dread disease. However, surgical techniques have improved to where SRS can now be done without risk to expert surgical teams, although extra procedures are required that may raise costs. For information about surgeons who accept HIV+ patients, contact Christine Beatty (christine@glamazon.net). Christine herself survived life on the streets, and went on to become a successful postop woman. She reports that the following expert surgeons now accept otherwise healthy HIV+ patients: Toby Meltzer, M.D.: Same price as HIV- ; Sanguan Kunaporn, M.D.: 30% price increase for HIV+ ; Preecha Tiewtranon, M.D.: $1000 extra from HIV+ ; Eugene Schrang, M.D.: Unspecified extra change.

Sites containing photos of many vaginoplasty (SRS) results from many surgeons

[VIEW WITH CAUTION! The photo sequences listed here are definitely NOT FOR THE SQUEAMISH!]

The TS women's support site contains links to many photographs of SRS surgical results of many surgeons. One link contains a series of 25 photographs of an SRS performed by Toby Meltzer, M. D. of Scottsdale, AZ. Another link contains a detailed sequence of photos of a labiaplasty performed by Dr. Meltzer.

Spanish actress Carla Antonelli's website also contains a very detailed "still-frame-video" sequence of SRS. Another site contains a photo sequence of SRS performed in the UK.

And here is a link to a photo of an early surgery done by Dr. Biber in Trinidad, Colorado in 1976. Dr. Biber became justifiably famous among T-girls in the U.S. for such results, and they've flocked to him ever since. The early surgical technique and results are very similar to Lynn's sex reassignment surgery, which was performed by the famous Mexican plastic surgeon J. J. Barbosa, M.D. way back in 1968.

Lynn had follow-up surgery for vaginal deepening and labiaplasty performed by Dr. Schrang (in November 2000), in order to bring her results up to modern standards. Dr. Schrang also has extensive experience in successfully correcting SRS complications surgeries done elsewhere. Gwendolyn Ann Smith has created a webpage, "Transsexual's Guide to Neenah", that provides a lot of practical information about undergoing SRS by Dr. Schrang at Theda Clark Regional Medical Center in Neenah, WI.

Options that can reduce costs and enable feminization and transition earlier in life

One of the greatest difficulties faced by young, intense transsexuals who are very certain of their need to undergo complete gender correction is the high cost of transition and the long time-period (several years) to get everything approved. The overall costs of counselling, hormones, electrolysis and surgeries is typically $30K to $40K in the U.S. Because of their gender condition, many younger transsexuals are unable to obtain good enough employment to save money fast enough to achieve a timely transition. Meantime, they are often doomed to watch as their bodies continue to masculinize (even if taking estrogen) which makes a successful and complete transition seem further and further out of reach.

Recent developments, including easier and earlier access to female hormones and antiandrogens (ordered from overseas pharmacy sites via the web). There are also several new sex-change surgery clinics in Thailand , where SRS costs only about $6000 to $8000 (see New York Times article of May 6, 2001). Easier access to hormones and surgery have made it much easier for young transsexual girls to feminize themselves while young and to achieve complete gender transition while in their twenties. The Thai surgeons do not insist on the full HBIGDA protocol (and instead make their own informed decision whether a patient is suitable for SRS), thus greatly reducing the financial burden and logistical complexities of having to go to two counselors or psychiatrists for several years in order to get the letters of approval for SRS required here in the U.S.

For more information about the Thai surgeons, see the TS Womens' Resources SRS page. See also Dr. Suporn Watanyusakul's website and photos of recent SRS at his clinic. For another recent example of Dr. Suporn's work (May 2002), see the webpage of a girl from Finland describing her SRS experiences and showing photos of her SRS results (in English).

Photos of recent vaginoplasty (SRS) results by Dr. Suporn on a girl from Finland (at 5 months postop)



Also see the websites for the Preecha Aesthetic Institute (Dr. Preecha Tiewtranon), the Aesthetic Plastic Surgery center in Bangkok (Dr. Pichet Rodchareon), and the Plastic Surgery Center in Phuket (Dr. Sanguan Kunaporn), including a sequence of photos of SRS surgery by Dr.Sanguan Kunaporn.

However, anyone going to Thailand for SRS should make very certain that they are going to one of the handful of reputable surgeons there who are doing high-quality SRS's using modern surgical techniques in the best hospitals. There has long been a tradition in Thailand of doing what superficial "Hijra-style" SRS's which do not create a full vagina. These are inexpensive surgeries (on the order of $1000 to $1500). Many Katheoy "working girls" undergo these surgeries, not being able to afford the full SRS surgeries (if someone does not need a full SRS, a Kathoey-type surgery might be an option to consider). Bottom line is that anyone going to Thailand should carefully research the latest information on Thai surgeons, and avoid going to the "lowest bidder" for such an important and life-changing surgery .

As an even less expensive alternative, transsexuals in the U.S. can now take advantage of fairly easy access to orchiectomy. After orchiectomy (castration) a T-girl's body will not be further maimed by testosterone, and the feminizing effect of female sex hormones is much more rapid and more pronounced (especially in younger girls). This option can enable younger T-girls to rapidly become feminized and passable, and to buy some time to save money for SRS without feeling such desperate urgency. For more information on this type of surgery, see this Orchiectomy page.

In the past, many T-girls went to Dr. Robert Barham in Portland Oregon for orchiectomies, who charged about $1000 for the surgery. Although Dr. Barham is no longer doing these surgeries, his protocols are worth documenting as being what you might expect elsewhere: Dr. Barham required that you had transgender counseling for one year and been on hormone replacement therapy for one year and had passed a recent HIV status test. His protocol involved seeing you at least one day before the procedure to discuss the procedure, the implications and the risks. The procedure was then generally done on the following day in his office. He used bilateral spermatic cord blocks for anesthesia. The procedure itself took approximately one hour. Following the procedure it was best if you can remained in bed with ice packs for 12 to 24 hours. He also asked that you stay in town for 48 hours, to take care of any problems that might arise, and also to give you a chance to begin healing before returning home.

For more detailed information about orchiectomy, see Sherry's website. Sherry is a transgender girl who underwent orchiectomy in 1999 as part of her preparation for gender transition. In her website she describes her own experiences and provides a lot of up to date information about orchiectomy, including a list of surgeons. See in particular her pages entitled "Questions I am Often Asked About My Castration" and "Orchiectomy for Transsexuals". See also Andrea James' new Orchiectomy page. (Ahora este pagina esta disponible en Espa&#65533;ol)

Completion of transsexual body feminization by cosmetic surgeries

Many transsexual women also undergo breast augmentation surgery, facial feminization surgery and various cosmetic surgeries to further feminize their bodies. Anne Lawrence's site contains photos of recent breast augmentation surgery on transsexual women, and Lynn's FFS site contains information on facial feminization. To give you an idea of the wonderful results now achievable, here are some photos of breast augmentations performed on hormonally-feminized transsexual women (these were done by Dr. Suporn, in Thailand):



However, it is important to note that many TS women achieve very satisfactory breast development without augmentation, especially if they started their transitions while in their teens. For a discussion of breast development in TS women, along with many photos of unaugmented development, see this Breast Development webpage.

The decision of whether to augment or not is very similar for a TS women as for any other woman - a complex one with many tradeoffs of appearance vs sensation vs risks of complications. In many cases of small development, augmentation can bring a lot of satisfaction, but in many other cases it may be quite unnecessary and carry unwanted risks. For a discussion of breast augmentation with many photos, see this Breast Augmentation webpage.

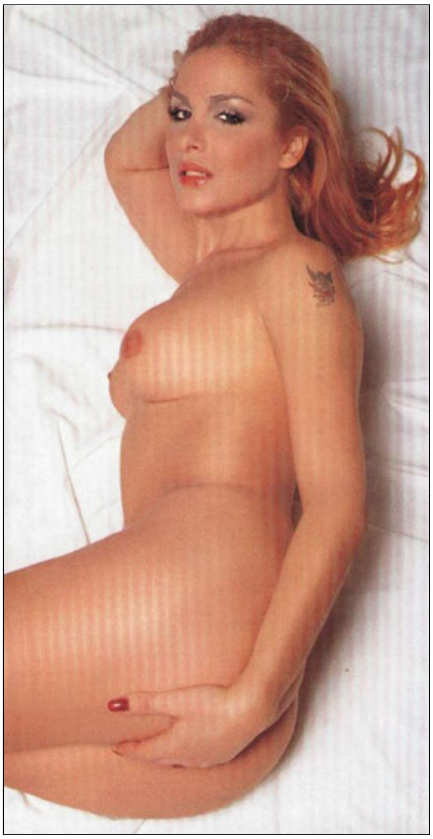
Carla Antonelli's website contains a page of photos of pretty T-girls where you can see even more results of breast augmentation surgery. Perhaps even more importantly, her page conveys images of the wonderful results that these young women obtained from feminization early in their lives. The ongoing moral to the story is this: If a T-girl knows for sure that she inevitably must become a woman, she should immediately seek medical help to stop any further masculinization and begin her feminization as early in her life as possible - in her mid-teens if she can. Courage and decisiveness in seeking gender correction while still young will dramatically improve her chances for a full and complete life.

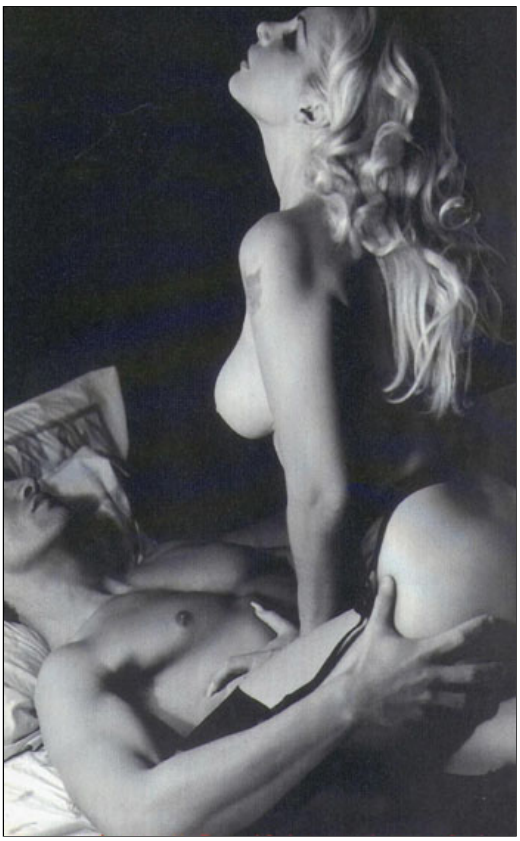
The joys and wonders of complete gender correction

Modern medical advances have brought us a long way from the ancient methods used in traditional "Hijra-style" surgical treatments of transsexualism. Modern sex hormone therapy, vaginoplasty (SRS) surgery, facial feminization surgery and cosmetic surgeries can substantially modify an MtF transsexual's body to properly match her innate gender, especially if treatment is started early enough in life. It is now possible for many postop women to feel totally gender-congruent in their transformed bodies, and to be able to very comfortably and passionately enter into loving relationships (either heterosexual or lesbian, as the case may be) as sensual, sexually responsive women.

The extent of body modification and feminization now possible by early medical intervention and lots of effort can be seen in many photos of young transsexual women (such as those of Amanda Lear (France), Roberta Close (Brazil), Carolyn Cossey (U.S.) and Julia Sommers (Australia)).

The joys and wonders of being able to resolve the transsexual condition and to then live a full life as a warm, loving woman in the resulting female body are suggested by the following beautiful photographs of Jenny Hiloudaki (Greece). Jenny started on female sex hormones at the age of 13 and underwent vaginoplasty (SRS) at the age of 20:





For more information, see:

Lynn's homepage:
http://www.lynnconway.com
http://ai.eecs.umich.edu/people/conway/conway-Arabic.html

TS information pages:
http://ai.eecs.umich.edu/people/conway/TS/TS.html

TS Successes page:
http://ai.eecs.umich.edu/people/conway/TSsuccesses/TSsuccesses.html
http://ai.eecs.umich.edu/people/conway/TSsuccesses/TSsuccesses-Arabic.html

Andrea James TS Roadmap (the internet "bible of MtF transition"):
http://www.tsroadmap.com/

Andrea James SRS (vaginoplasty) page, which includes an international list of surgeons:
http://www.tsroadmap.com/physical/vaginoplasty/index.html

The WPATH international Standards of Care for transsexualism:
http://www.wpath.org/
http://www.wpath.org/publications_standards.cfm
http://wpath.org/Documents2/socv6.pdf **(ES)**
http://www.symposion.com/ijt/soc_2001/index.htm

Reset on 6-03-00
V-1-05-05 + update of 10-14-05
LC update of 8-01-09 re Biber op report