Male to female sex reassignment surgery – Guide to MtF SRS Vaginoplasty

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Introduction to the vaginoplasty surgery for transgender patients

Sex reassignment surgery (SRS), also known as gender reassignment surgery or bottom surgery, is a **set of plastic and reconstructive surgical procedures with the aim of making the genitalia of the patient congruent with their gender identity**.

In the MtF case this means transforming the male genitalia with which the patient was born into an aesthetically accurate and functional vagina; under the care of an expert surgeon, normal urination, minimal scarring and the preservation of erogenous sensitivity can all be achieved.

Male to female sex reassignment surgery is a set of complex operations such as the orchiectomy, clitoris reconstruction, labia majora and minora reconstruction, mons pubis creation and vaginoplasty which are often bundled together in what is known as sex reassignment surgery or **primary vaginoplasty**; in some cases, the labiaplasty and mons pubis creation might happen some months after the vaginoplasty procedure as well as the orchiectomy might be executed some months in advance.

As per other surgical procedures, the adjective primary means that it is the first reconstructive surgery of its kind on that patient, while secondary vaginoplasty would mean we are talking about a revision surgery to correct defects arisen after the first surgery, or to perform further procedures that weren't possible during the primary surgery, or to improve functionality or the aesthetics after the first surgery.

History of sex reassignment surgery

Since ancient eras we have documentation about radical procedures on male genitals, obviously far from being modern surgeries, and about the role that these persons, known as eunuchs, had among the different societies throughout history.

The first modern surgery of this kind was performed in Germany in 1931, along with the transplant of the uterus and one ovary, but it ended with the death of the patient 3 months post-op.

In 1952, Danish surgeon Paul Fogh-Andersen became the pioneer of modern era sex reassignment surgery by performing gender reassignment surgery on a WWII veteran and US citizen: George Jorgensen (later Christine Jorgensen). The news was widely reported by the media and Christine Jorgensen became world famous and an activist and advocate for transgender rights; thanks to her, many transgender individuals became aware of the medical and surgical options available to them, giving hope to those suffering from gender dysphoria (https://www.medtravel.asia/what-is-gender-dysphoria-signs-and-symptoms-diagnosis-and-treatment) and propagating the knowledge in the field of transgender medicine and surgery.

As a result, the demand for this type of surgery increased steeply. A great number of people from all over the world started traveling to Denmark to undergo sex reassignment surgery until the Danish government, unable to cope with all the requests, had to limit access to this surgery to the Danish citizens only.

Meanwhile, the interest in the procedure grew also among US doctors and the John Hopkins University became the tertiary referral center for transgender surgeries in the United States in the 1960s. Patient selection criteria were very strict though and of the over 2000 requests received during the first 3 years of operation, only 24 were accepted. By the end of the 1970s this clinic closed its doors to the patients, but in the next 10 years over 1000 patients underwent sex reassignment surgery in the over 40 different university hospitals in the United States specialized in transgender medicine and surgery.

On the other side of the world, in Thailand, Dr. Preecha Tiewtranon (https://www.medtravel.asia/listing/dr-preecha-tiewtranon-md-bangkok) and Dr. Prakob Thongpaew performed the first male to female sex reassignment surgery at Chulalongkorn University Hospital in 1975. In this country, transgender therapies became a subject of research and development, with the invention of novel surgical techniques and the improvement of aesthetic and functional results. The skills of Thai surgeons in this field is second to none and Thailand is considered to be the most advanced country for all what concerns transgender medicine and surgery; between 1985 and 1990 only 5% of transgender patients who underwent SRS in Thailand were medical tourists coming from abroad (https://www.medtravel.asia/what-is-medical-travel-top-9-reasons-to-cross-borders-for-medical-care), but in 2010-2012 that percentage had already risen to 90% as proof of skills and knowledge of Thai surgeons.

Ideal goals in male to female sex reassignment surgery (MtF SRS)

Many authors believe the following to be the ideal goals of MtF gender reassignment surgery:

- The creation of a perineal and genital region as feminine, natural and aesthetically accurate as possible, which includes the mons pubis, vagina, labia majora and minora, clitoris and clitoral hood.
- The creation of a neovagina at least 3 cm in diameter and 10 cm deep, hairless, capable of self-lubricating and elastic to allow for penetrative sexual intercourse.
- The provision of erogenous sensitivity in the neoclitoris, as well as tactile sensation.

From a surgical point of view there are also the goals of using a technique which is effective, easily reproducible, and with consistent results among patients, having low risks and low complication rates.

This branch of medicine, relatively new and not much studied, has made huge progress over the last decades. As of today, it is possible to obtain a vagina and a perineum and genital area aesthetically impeccable, functional and permitting penetrative sex, which allows to reach orgasms and sexual satisfaction. It is not yet possible though to provide for reproductive function, there is no reconstruction or transplant of the reproductive organs, neither menstruation nor menstrual cycle can be obtained.

Pre-op criteria for gender reassignment surgery

The following are the prerequisites to have access to the primary vaginoplasty and set in the Standards of Care 7th edition by the World Professional Association for Transgender Care (WPATH):

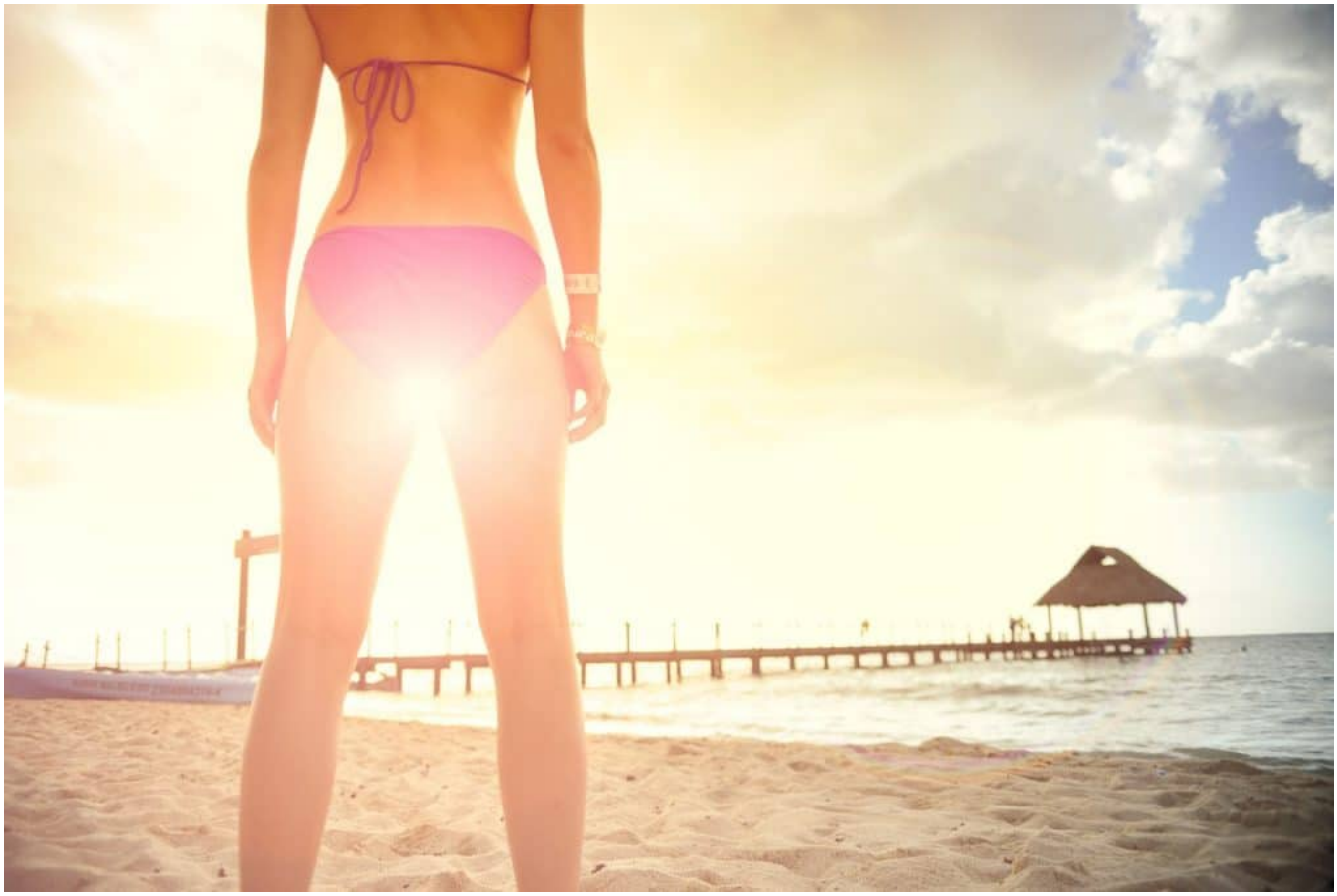
- Persistent and well documented diagnosis of gender dysphoria (https://www.medtravel.asia/what-is-gender-dysphoria-signs-and-symptoms-diagnosis-and-treatment)
- In full possession of one's faculties. Able to make a fully informed decision and to give consent for treatment.
- Age of majority in a given country.
- The absence of absolute medical contraindications (medical conditions which would make it too risky to perform the surgery).
- At least 12 continuous months of feminizing hormone replacement therapy
- At least 12 continuous months of living in a gender role that is congruent with their gender identity.

The last criterion is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

Pre-op procedures

Before undergoing the vaginoplasty procedure for MtF sex reassignment surgery some exams and medical interventions might be needed, which can vary depending upon the surgeon, the surgical technique and the clinic or hospital at which the procedure will be performed.

- Surgical consultation
- Labs and medical imaging exams
- Autologous blood donation for intraoperative and postoperative use
- Stop hormone replacement therapy with estrogens 1 month prior to surgery to decrease the risk of cardiovascular events
- Prophylactic antibiotic therapy 24h prior to surgery
- Laser or IPL hair removal (https://www.medtravel.asia/permanent-hair-removal-laser-and-intense-pulsed-light-ipl) in the perineal region to avoid growth of hair inside the neovagina. Some surgeons prefer removing the follicular units surgically during the SRS procedure.
- Bowel preparation with liquid diet, enemas and/or laxatives, depending upon the chosen surgical technique and the surgeon.



Surgical techniques for sex reassignment surgery in MtF transgender patients

Over the years, several surgical techniques have been developed to address sex reassignment surgery in transgender women. The most widely used technique and the **"gold standard" for primary vaginoplasty is the penile skin inversion procedure**; for secondary vaginoplasty, the sigmoid colon vaginoplasty procedure is the technique usually employed. The latter is also chosen for patients with specific anatomical characteristics and is anyway the second most performed MtF SRS technique.

1 .Penile skin inversion vaginoplasty

Known as the standard procedure for male to female sex reassignment surgery, the penile skin inversion vaginoplasty is a surgical technique that includes an orchiectomy, a partial penectomy, penile dissection with creation of the vaginal canal, a labiaplasty and a clitoroplasty.

There are some slight modifications to this technique depending on the surgeon who performs the procedure, hence some of the passages described below might be executed differently.

Surgery begins with the insertion of a urinary catheter. An incision is made along the scrotal raphe, the midline of the scrotum, and the orchiectomy is performed. The penis is then dissected: the glans is separated from the shaft and the dorsal neurovascular bundle is dissected from the underlying corpora cavernosa. Corpus spongiosum is then excised performing an incision at the base of the penis; this is done to avoid possible swelling due to erogenous stimulation in a sexual intercourse, which would cause the neovagina to narrow too much. Corpora cavernosa are excised as well, but a small portion is left to constitute the base of the neoclitoris, which will be reconstructed using the dorsal part of the glans previously dissected. An internal pouch is then created in the region between the penis and the rectum, the penile skin is inverted and stitched at the end to create the vaginal lining and is then inserted in the space created. The urethra is then shortened, and a new urinary meatus is created. The neoclitoris is then positioned and the clitoral hood is reconstructed as well as the labia minora. Scrotal skin is then employed to reconstruct the labia majora and a stent is inserted in the neovagina to keep it dilated.

The urinary catheter and the vaginal stent are left in place for the first 4-7 days; when the stent is removed, the patient will begin the dilation of the neovagina following a schedule as advised by the surgeon, by daily inserting expanders for the first 6 months. During the first days, the patient will stay in bed and will receive heparin injections to prevent venous thromboembolism. Once the vaginal stent will be removed, the patient will be allowed to walk. The neovagina will be cleaned daily with antiseptic solutions such as betadine. 7 or 8 days after surgery the patient is usually discharged from the hospital. After 6 to 8 weeks from surgery and once surgeon's approval is received, it will be possible to have penetrative sexual intercourse.

The prostate is usually not removed during surgery; this is because it constitutes an internal erogenous structure which is similar to the so-called female g-spot. For this reason, the patient will have to check its health status following the international guidelines or the GP's advice.

Permanent laser hair removal (https://www.medtravel.asia/permanent-hair-removal-laser-and-intense-pulsed-light-ipl) is a fundamental step in this surgical technique to prevent hair growth within the neovagina or other reconstructed structures, with the risk of causing infections or constrictions. This is usually performed in the weeks and months prior to the surgery, but in some cases manual removal of the follicular units is performed by the surgeon during the primary vaginoplasty procedure.

Advantages of the penile skin inversion vaginoplasty

The advantage of using this technique is the avoidance of the risks involved with abdominal and intestinal surgery.

Disadvantages of the penile skin inversion vaginoplasty

The disadvantage of this technique is that to obtain an adequately sized neovagina, you need an adequately sized penis; hence, this type of technique might not be possible for patients with smaller penises, which is common especially among patients who started feminizing hormone replacement therapy (https://www.medtravel.asia/feminizing-hormone-replacement-therapy-guide-for-the-mtf-transgender-patient) before the full male sexual development, in adolescence. In the case of previous surgeries, such as circumcision, there might again be not enough tissue to reconstruct the neovagina; sometimes grafts of tissue from regions of the body other than the penile shaft can be used to avoid such issues.

Another disadvantage of this technique is the lack of natural secretions and lubrication, unless some modifications to this technique are performed, hence the use of a lubricant will be necessary to allow sexual intercourse.

Moreover, the neovagina will have the tendency to get narrower and its initial dimensions won't allow for penetrative sexual intercourse, hence the patient will have to follow a dilating schedule as advised by the surgeon.

2. Sigmoid colon vaginoplasty or intestinal vaginoplasty

With this technique, the neovagina is reconstructed starting from a portion of the intestine, usually a section of the sigmoid colon when the large intestine is chosen, but sometimes the small intestine is chosen and in that case a portion of the ileum is resected. The benefit of using the sigmoid colon over the ileum is the larger diameter and the reduced secretions, far more abundant in other parts of the gastrointestinal tract.

A 12-15 cm section of sigmoid colon with its vascular pedicle still intact is removed; an internal pouch in the perineal regions is created by the surgeon and the intestinal section is transposed where the neovagina is intended to be. One of the ends is sutured to the opening of the neovagina, whilst the opposite end is sutured closed; the whole segment is anchored internally to the pelvis to avoid migration or torsion. The intestinal tract is anastomosed and checked for possible leaks.

Since part of the colon is used to create the neovagina, after surgery it is advised to follow international guidelines regarding screening, conduction of regular checks and prevention of colon tumors.

Sigmoid colon vaginoplasty is often the first choice as operative technique in secondary vaginoplasty, when the primary vaginoplasty failed or did not yield the expected results.

Advantages of sigmoid colon vaginoplasty

The advantage of this technique is that the neovagina will surely have sufficient dimensions to be functional, it will have a mucosa as internal lining which is physiologically lubricated and there will be reduced need of following a dilating regimen post-op. The appearance and the consistency of the

tissues is also much more like the ones from a cisgender vagina.

Disadvantages of a sigmoid colon vaginoplasty

The main disadvantage of this technique is the fact that it involves abdominal and intestinal surgery, with an intestinal anastomosis, which carries all risks related to this type of surgery. Another disadvantage of this technique is the fact that the secretions produced by the neovagina might be too abundant or with an unpleasant odor; this is more likely when the ileum is used instead of the sigmoid colon. Moreover, this surgery will leave some visible abdominal scars due to the need of performing abdominal incisions.

3. Scrotal skin graft vaginoplasty – Dr. Suporn's technique

Dr. Suporn Watanyusakul (https://www.medtravel.asia/listing/dr-suporn-watanyusakul-md-chonburi) has developed his own proprietary technique for the vaginoplasty procedure, performed for the first time on a patient in the year 2000.

This technique uses scrotal skin for the reconstruction of the vaginal canal, using groin skin flaps if scrotal skin is not sufficient. Penile skin is used instead to reconstruct the labia minora, the clitoral hood and other aesthetical details of the external genitalia. This technique is generally capable of obtaining a neovagina of greater dimensions when compared to the penile skin inversion technique; it is considered superior from the aesthetics' and erogenous sensation's side due to the usage and preservation of tissues that are each other's embryologic analogues in male and female development. Moreover, while dissecting, Dr. Suporn always retains the Cowper's glands (aka bulbourethral glands), positioning them within the neovagina, hence guaranteeing natural lubrication when sexual arousal occurs.

This technique is performed only in Chonburi, Thailand, at Dr. Suporn's Clinic. (https://www.medtravel.asia/listing/suporn-clinic-chonburi-bangkok)

4. Scrotal skin graft vaginoplasty – Dr. Chettawut's technique

Dr. Chettawut Tulayaphanich (https://www.medtravel.asia/listing/dr-chettawut-tulayaphanich-md-bangkok) developed his own proprietary technique for the vaginoplasty procedure, using a scrotal skin graft similarly to Dr. Suporn.

Dr. Chettawut utilizes penile skin to create the labia majora and minora and to reconstruct the clitoral hood; scrotal skin will constitute the vaginal lining, sometimes by adding groin graft if the skin available is not sufficient, and with this surgical approach the depth obtained is generally greater than with that of the penile skin inversion technique. In his technique, Dr Chettawut retains bulbourethral glands too, to allow for a natural lubrication of the neovagina.

This technique, like Dr. Suporn's, is regarded as superior to the others both in terms of aesthetics and in terms of functionality. The sensitivity is defined as excellent and it is possible to reach an orgasm. Two are the areas that retain erogenous sensitivity: the clitoris, which is reconstructed from the dorsal part of the glans and which is innervated by the pudendal nerve, and the vulvar vestibule which is reconstructed from the ventral part of the glans and is connected to the pudendal nerve branches as well. Moreover, Dr Chettawut preserves the sensory innervation of three more nervous branches: at the level of the clitoral hood, of the inner labia and in the vaginal canal adjacent to the prostate. This is a guarantee of further and greater sensitivity of the reconstructed structures.

This surgical technique is performed in Bangkok, Thailand, at Chettawut Plastic Surgery Center. (https://www.medtravel.asia/listing/chettawut-plastic-surgery-center-bangkok)

5. Non-genital skin flaps vaginoplasty

This technique was used in the past to perform secondary vaginoplasties when the primary vaginoplasty with penile skin inversion did not provide satisfactory results. It utilizes flaps harvested from the medial region of the thigh or from the inguinal region to create the neovagina, sometimes combined with penile flaps by using sutures for the creation of a single flap of greater dimensions.

The advantage of this technique is that non-genital flaps contract less after surgery, so they require less post-op dilatation. The main disadvantage is the possible complication to the flap donor site, scarring where di flap is harvested, unnatural consistency of the reconstructed tissues. Moreover, there are no structures which allow for natural lubrication of the neovagina.

6. Genital graft vaginoplasty

This technique was used in the past utilizing skin grafts harvested from the penis or from the scrotum to reconstruct the neovagina. The advantage of the penile graft over the scrotum one is that it has fewer hair follicles, nevertheless it is a rarely used technique since it is possible to achieve better results by using penile skin as a pedunculated flap. Scrotal grafts instead are used currently when the penile skin obtained from penis dissection is not sufficient to create a neovagina of functional and acceptable dimensions.

7. Non-genital skin graft vaginoplasty

This is one of the first techniques ever used to perform the vaginoplasty in transgender patients. It utilizes non-genital skin grafts to create the neovagina; the grafts usually come from abdomen skin. The advantage is that there is no risk of having insufficient tissue for the reconstruction of a functional neovagina, the limited presence or absence of hair follicles and the low risk of post-op complications. The disadvantage is the tendency of the skin grafts to shrink, the suboptimal sensitivity, the absence of natural secretions and the scarring of the donor area.

Recently, the use of grafts harvested from the buccal mucosa is being investigated. In some cases, grafts or micro-grafts have been harvested and then stitched together to obtain a graft of the desired dimensions. In other cases, a small portion of tissue has been harvested and then cultured in the lab to increase the number of cells and the size of the graft. This technique is not yet widely used but has the advantage of having a high survival rate and the presence of natural secretions, reason for which it might be utilized in the future.

8. Acellular Dermal Matrix vaginoplasty (ADM Vaginoplasty)

This technique has not yet been used for surgery on transgender women, but it has been performed on cisgender patients suffering from cervical cancer or from vaginal agenesis. For this surgery, an acellular dermal matrix is used; ADM is one of the most used biomaterials in reconstructive surgery in recent years, consisting of the dermal matrix harvested from tissues in humans or animals, without the cellular components. In the future this technique might be employed also for the transgender women, but the main disadvantage is the high costs.

9. Zero Depth Vaginoplasty (ZDV) – Vulvoplasty – Cosmetic SRS

This technique utilizes the tissues harvested from the male sexual organs to create an aesthetically pleasing and accurate vulva (the external female genitalia) like the above surgical procedures, retaining erogenous and tactile sensitivity. However, the vaginal canal is not reconstructed hence penetrative sexual intercourse is not possible.

This is the ideal surgery for all those patients not interested in having vaginal sexual intercourse. The advantages are shorter surgery time, less expensive surgery, lower risks and no need for continuous dilatation of the neovagina or daily cleaning of the reconstructed vaginal canal.

Post-op information after vaginoplasty

Dilatation is usually recommended for the first 6 months post-op. After 6 months, if the patient has regular sexual intercourse the use of dilators will not be needed. The dilation regimen requires the use of tutors increasing in diameter from 20mm to 32mm with a length of about 13cm; initially they are used three times a day for about 50 minutes each time. Once the desired dimensions are reached, it will be sufficient to use them 2-3 times a week, or less if the patient has regular sexual intercourse. It is required to apply a generous amount of water-based lubricant before using the dilators, to avoid tissue damage and pain.

Surgical wounds are cleaned daily and have to be kept dry and clean until complete healing. The vaginal canal will require daily hygiene to avoid complications and infections.

Until the transplant of the female reproductive organs will be made possible by medical advances, pregnancy is not possible for transgender women.

When evision surgeries are requested it is usually to improve the aesthetics of the results, but sometime a secondary vaginoplasty is indicated to improve the functionality of the neovagina.

4-6 weeks after surgery it is generally possible to go back to work.

Risks and complications of the vaginoplasty in MtF SRS

Risks and complications of male to female sex reassignment surgery include general risks which are not specific to this surgery but shared with any surgery such as risks related to general anesthesia, intra-operative and post-operative bleeding, infections, scarring, delayed healing, accidental damage to surrounding tissues.

Among the specific risks related to SRS there are urethral strictures, narrowing of the neovagina, meatal stenosis of the new urethra, rectovaginal fistulae, graft necrosis, loss of sensitivity, unsatisfactory dimensions of the neovagina.

Sigmoid colon vaginoplasty also carries the risk of abdominal adhesions and anastomotic leaks.

Male to female (MtF) sex reassignment surgery in Thailand

As of today, about 20 surgeons perform gender reassignment surgery in Thailand, most of them working in the following clinics:

- PAI – Preecha Aesthetic Institute in Bangkok (https://www.medtravel.asia/listing/preecha-aesthetic-institute-pai-bangkok), founded by Prof. Preecha Tiewtranon (https://www.medtravel.asia/listing/dr-preecha-tiewtranon-md-bangkok)
- Suporn Clinic in Chonburi – Pattaya (https://www.medtravel.asia/listing/suporn-clinic-chonburi-bangkok), founded by Dr. Suporn Watanyusakul (https://www.medtravel.asia/listing/dr-suporn-watanyusakul-md-chonburi)
- Chettawut Plastic Surgery Center in Bangkok (https://www.medtravel.asia/listing/chettawut-plastic-surgery-center-bangkok), founded by Dr. Chettawut Tulayaphanich (https://www.medtravel.asia/listing/dr-chettawut-tulayaphanich-md-bangkok)
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- PPSI – Phuket Plastic Surgery Institute in Phuket (https://www.medtravel.asia/listing/phuket-plastic-surgery-institute-ppsi), founded by Dr. Sanguan Kunaporn (https://www.medtravel.asia/listing/dr-sanguan-kunaporn-phuket)

At present, about 2-3 sex reassignment surgery are performed in Thailand every day on foreigner transgender women (MtF medical tourists (https://www.medtravel.asia/why-is-thailand-our-top-destination-for-medical-tourism)).

Thailand is considered the best country in the world to undergo SRS as well as other surgical procedure for the transgender patient; this is because of the great skills and expertise of local surgeons, the innovative techniques and great number of surgeries performed, the excellent quality of the hospitals and clinics, the unique hospitality and the lower costs.

Costs vary depending on the clinic, the surgeon and the operative technique, ranging between US$ 10,000 and US$ 20,000. Length of stay is about one month, 1-week pre-op and 3 weeks post-op.

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