

The Care and Feeding of the Neovagina

by Dallas Denny

Find the word vagina in your Webster's Dictionary. Point to it. Now lower your finger about a half inch. What do you see? Vaginitis. Now look up the word penis. What is the next word? Penisitis? No, (perhaps appropriately), penitence.

Why do you suppose that the word vaginitis (inflammation of the vagina) is in the dictionary, and a corresponding word for inflammation of the penis is not? Ask any adult who was born with a vagina, and she will tell you: female genital equipment requires a great deal of maintenance.

Problems with Vaginas

Males have the advantage of having a urethra at the end of a long tube, far from the anal opening, and of having genitalia which are exposed to the air and easy to keep clean. In females, the proximity of the urethra and vaginal canal to the anus make contamination by fecal matter more likely, and the vagina, which is in essence a dark, warm, wet (and some would say wonderful) cavity, is difficult to keep clean and odor-free.

Vaginas are particularly susceptible to bacterial and yeast infections, which can be persistent and difficult to control. Such infections cause unpleasant odors and itching, and can make sexual intercourse uncomfortable. Additionally, vaginal disturbances can spread into the uterus, fallopian tubes, and ovaries (with resulting risk of sterility), or to the bladder and kidneys. Because they have a shorter urethra than do males, females are more subject to bladder infections—and kidney infections often arise from bladder infections.

The vagina is lined with mucous tissue, with the result that females are at high risk for acquiring sexually transmitted diseases (STDs) during sexual intercourse. Lesions caused by diseases like Chlamydia, herpes, syphilis, and gonorrhea may be less readily apparent in the recesses of female genitalia than on the external equipment of males, and symptoms of infection may be mistakenly attributed to bacterial or yeast infection. Females seem to be at relatively high risk for acquiring the HIV virus during sexual intercourse.

Vaginas can be a nuisance in another way. From the early teen years until menopause, the female genital tract cleanses itself once a month, sloughing off a layer of skin which is discharged with a bloody fluid. Discharge can be copious. This menstrual process lasts several days. It is triggered by hormonal changes, which also cause emotional stress. Tampons and pads are necessary

"Especially pleasant and pretty I feel is the build of the female genitals in contrast to the male's, particularly their position as inner organs; with women it is discreet, in opposition to the protruding of the male organ."

— "Case 17," p. 116, in
Magnus Hirschfeld's
Transvestites: The Erotic
Drive to Cross Dress,
Michael A. Lombardi-Nash,
translator

in order to control the menstrual flow, and must be changed often, to prevent odors and staining of clothing. As was discovered a decade or so ago, blocking the vagina with a tampon can result in the accumulation of bacterial toxins which can result in illness, or even death. This is known as toxic shock syndrome.

Problems with Neovaginas

A minority of male-to-female transsexual people eventually have sex reassignment surgery (SRS), in which the testicles and penis are removed and an artificial vaginal cavity is built. In most cases, the skin from the scrotum and penis is utilized; this is called penile inversion, and may be supplemented with a variety of other techniques. Some surgeons incorporate a section of bowel into the neovagina, and some use skin flaps or skin grafts.

No surgical procedure is risk-free. There are dangers from anesthesia, from the surgeon (who is only human, and can make mistakes), and from blood (if transfusion is required). Problems can arise afterward: infection, internal bleeding, rejection of transplanted tissue, persistent pain, formation of excess scar tissue— you name it. Negative outcomes are possible under the best conditions, and with the best treatment (something the American legal system does not seem to realize).

SRS risks can be minimized by careful selection of surgeon and hospital. Skills of reassignment surgeons vary widely. A surgeon who has years of experience, who has done scores or hundreds of sex reassignments, who has a good working relationship with an anesthesiologist, and who uses the latest techniques and equipment is much more likely to create a functional, sensate, aesthetically pleasing neovagina, and to have much lower complication rates than is someone who has done only one or two surgeries. Unfortunately, many transsexual people, especially those who have found rejection in their quests for gender consonance, do not comparison shop, but accept the first source for surgery.

A surgeon with limited skill or experience can really wreak genital havoc. It is not uncommon for the result of surgery to be a "pocket" which bears little resemblance to a vagina; for labia to be nonex-

istent, or unaesthetic; for there to be little or no potential for erotic sensation; for neovaginal depth to be insufficient for intercourse; for the urinary opening to point in the wrong direction. I will repeat: selection of a competent surgeon is critical.

It would behoove the transsexual person to learn not only about the skill and experience and reputation of the surgeon, but about the technique the surgeon will use, for advantages and risks vary with the procedures used. When a bowel segment is used, for example, there are sometimes strictures (partial or total closures) at the place where the penile and bowel tissue meet. When skin grafts are used, there is promise of greater vaginal depth, but also risk of rejection. Even after healing is complete, there may be repercussions. For example, bowel segments are composed of mucous tissue, placing the individual at higher risk for STDs, and at jeopardy for developing gastrointestinal diseases of the neovagina— Crohn's Disease, for instance, or gastroenteritis. These risks are counterbalanced by an equal number of advantages, including greater vaginal depth than is possible with simple penile inversion surgery, and without the unsightly scars caused by skin grafts. Another advantage of this "Cadillac of vaginas" is that it is self-lubricating, freeing its owner from the necessity of using K-Y jelly or other lubricants.

Even the best SRS surgeon will have occasional complications— but they will almost all be what I would call routine complications; that is, their nature will be foreseeable, as will their method of treatment. Routine complications include urethral stricture and vaginal stenosis (closing of the neovagina), and are easily remedied (by dilation, in both instances). Urethral stricture is due to formation of scar tissue at the neo-urethral opening, and can be taken care of on an outpatient basis by a urologist. Vaginal stenosis is caused by the natural tendency of the vaginal dissection to heal, and is the reason why frequent dilation (stretching with a mechanical device) is necessary for some months after surgery. Such dilation is done at home by the individual. Some surgeons favor a mechanical device, much like a vibrator; others provide a stent which is worn in place for several months following surgery.

Some complications are very serious. An example is rectovaginal fistula, in which the vaginal pocket intrudes into the rectum. R-V fistula occurs because there is but a limited space for the vaginal cavity. It is of necessity close to the rectum. Overenthusiastic dilation can cause a fistula, but they are more frequent when SRS is done by inexperienced surgeons, who may tend to dissect too close to the rectum. R-V fistulas often require temporary colostomies (redirection of the bowel to a suitable location on the side, and wearing of a bag to catch feces).

Other serious complications can include infection, incontinence, prolapse of the neovagina (with the neovagina actually becoming everted), and necrosis of the vaginal lining, with the resulting need for a skin transplant. Necrosis can occur because of inadequate blood supply, rejection of transplanted skin, infection, or allergic reaction to vaginal stents.

If sex reassignment surgery is done outside the immediate area of residence (one can always return to the surgeon for aftercare), it can be difficult to find treatment for complications— whether they arise shortly after surgery, or years later. Selection of someone who will give quality postoperative care is as important as selection of a good surgeon, and should occur before surgery, for many gynecologists and urologists are unfamiliar with transsexual patients, and may refuse to treat them. There may be little time or patience for a search when complications arise during the recuperative period. Even in medical emergencies, it is not uncommon for transsexual person to be turned away by private physicians, and even by hospital emergency rooms.

Most practitioners show a great deal of caution in dealing with the unknown, and may order tests and procedures which are unnecessary. This safeguards the patient, and minimizes the risk of a successful lawsuit for malpractice. Most physicians correctly feel 'tis better to err in the direction of caution— but many transsexual people, who have spent their life savings for SRS, are financially depleted and unable to afford expensive after-care tests and procedures which essentially serve educative and self-protective

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functions for the physician who is unfamiliar with gender reassignment surgery and curious to find out about it. Choosing an experienced urologist or gynecologist will reduce such unnecessary medical expenses.

Care and Feeding

Those who are lucky, and who have chosen wisely, will end up with neovaginas which are virtually indistinguishable from natural vaginas. And guess what? They will have most of the disadvantages of natural vaginas: susceptibility to infection, sanitation problems, increased vulnerability to STDs— everything but menstruation (and pregnancy, which is only a disadvantage under certain conditions).

In addition to these problems, the neovagina will have difficulties of its own, including the aforementioned tendency to close up. The new plumbing may not pass aesthetic muster. Inadequate lubrication during intercourse is common. Despite frequent dilation, vaginal depth may be insufficient to accommodate large penises. The urinary stream may be directed forward, rather than downward. If lined with scrotal skin, it may have a tendency to become clogged with hair. And sometimes, even with the best surgery, orgasm is not possible.

Anyone with a neovagina needs to have a gynecologist who they see twice yearly. Vaginal inspection should be done annually, for the medical literature includes a number of reports of cancer of neovaginas created with skin grafts (both in genetic females and in post-operative transsexual people). Although the gynecologist may not be able to tell that the vagina has not been present from birth, it is wise to reveal the facts of the surgery; it will help him or her to make good medical decisions.

Dilation is essential to maintain (and increase) vaginal depth. For the first six months to a year, it must be done several times daily. Occasional dilation will be necessary for the rest of the individual's life.

One form of dilation requires manual insertion of a vibrator-like device into the vaginal cavity. Moderate pressure is placed on the form, which is kept in place

for about 20 to 30 minutes. Some individuals simulate the in-our movements of intercourse with their dilators. As previously mentioned, overenthusiastic dilation can lead to rectovaginal fistula. A good rule of thumb, according to an Atlanta gynecologist with a number of transsexual patients, is that dilation should be uncomfortable, but not painful. With the passage of time, progressively longer and thicker dilators are used.

Another form of dilation requires the wearing of an internal stent. Some are solid, and others pneumatic. Stents are sometimes covered with latex, in the form of condoms. Prolonged contact of skin to latex can lead to an allergic reaction; great pain or discomfort caused by an internal stent is not normal. Those who experience it should check with their physician.

Regular dilation can result in considerable increases in vaginal depth and diameter. Conversely, lack of dilation can result in a vagina of fingernail width and depth. Surprisingly, many, and perhaps most post-operative transsexual women do not dilate sufficiently, and lose vaginal depth.

Sexual intercourse is possible as early as six weeks following SRS, and— good news, here, neoladies— serves as a dilation. Sex is, in fact, the best way to dilate. But remember the old adage that if a couple puts a penny in a jar every time they have intercourse during their first year of marriage, and take a penny out every time thereafter, the jar will never be emptied. Our Atlanta gynecologist tells a similar story, about a transsexual woman who married soon after surgery. She lost half of her vaginal depth during the second year of marriage. Sex should be supplemented with dilation.

Although some lubrication occurs naturally (perhaps due to discharge from the prostate gland), artificial lubrication is usually necessary for sexual intercourse, in order to protect the delicate vaginal

tissues. Water-based lubricants like K-Y jelly are preferred, as they will not harm latex. Petroleum-based products like Vaseline are death to latex condoms.

When the neovagina incorporates a segment of bowel, lubrication is not necessary. However, overlubrication may sometimes be a problem, necessitating the constant wearing and changing of pads or sanitary napkins.

Keeping the genital area clean is important. Care must be taken after defecation, to keep from wiping fecal matter into the vagina, which lies dangerously close. One postoperative woman remarked at a support group meeting, "Do you know how difficult it is to learn to wipe in a backward direction after 34 years of wiping forwards?"

Douching flushes warm water, usually containing vinegar, Betadine, or other cleansing substances, through the vagina, killing bacteria and eliminating odors. It is accomplished by use of a rubber bag with a long tube— and now you know about that alien looking apparatus that your mother kept hanging on the wall in the bathroom. Genetic females should avoid douching too frequently, as it tends to dry out the mucous tissues which line the vagina, but neovaginas can be douched four or five times a week without harm.

As neovaginas are susceptible to various STDs, it is important that safe sex techniques be practiced. Use of condoms, dental dams, and antiviral lubricants significantly reduce risk of infection.

Properly cared for, a vagina is unlikely to cause significant problems. Certainly, proper sanitation and frequent inspection will minimize risks. If infection or side effects of surgery are ignored, serious problems can result. Painful or slow urination, itching, lesions, or presence of a discharge are a sign to immediately see a physician. Over-the-counter products are no substitute for good medical care. ☞

Larry M. Nahmias, M.D., P.A. & Associates
Diplomate American Board of Psychiatry & Neurology

Alice Webb, M.S.W., CSW-ACP

18333 Egret Bay Blvd., #560
Houston, TX 77058

By Appointment
(713) 333-2278