

## **Gender Reassignment Surgery - Mr. T. Terry**

This is my account of Gender Reassignment Surgery (GRS) carried out by Mr Timothy R. Terry, Consultant Urologist, at the Leicester University Hospitals. Mr Terry performs GRS under NHS “out of area treatment arrangements” at the Leicester General Hospital. Private surgery is performed at the Leicester Nuffield Hospital. My account is of private surgery at Leicester Nuffield Hospital, however, NHS surgery, is substantially similar, as Mr. Terry uses the same anaesthetist, Dr Ogilvy and the same back up surgeon, Mr. D.P.S. Sandhu, both of the Leicester University Hospitals.

### **Surgical Referral**

I had originally decided to follow the crowd and have GRS with Mr. M. Royle. To this end I had obtained surgical Referrals from Dr. R. Reid and Dr. D. Dalrymple, in October 1999, after I had completed 8 months of my Real Life Test. I saw Mr. Royle for a consultation in November 1999 and booked a date for surgery. However, in January 2000 my plans changed. My Local Health Authority refused to fund my surgery privately; on the basis that the guidelines for making out of area treatment arrangements state that they cannot contract for private services where an NHS provider exists. I was therefore offered the alternative of NHS surgery through Charing Cross Hospital or with Mr. Terry at Leicester General Hospital. At the same time my appointment for surgery with Mr. Royle was unilaterally altered to a much later date, which gave me the opportunity to re-examine my initial decision.

I therefore decided to see Mr. Terry with a view to having NHS surgery with him. I saw Dr. Reid again on 12th February 2000; he agreed to provide a new surgical referral to Mr. Terry and attached with it a copy of the earlier referral from Dr. Dalrymple. Although I could have waited for an NHS consultation with Mr. Terry, I decided to circumvent the inevitable delay and opted for a private consultation at BUPA Leicester. This was arranged for two weeks later, about half the time I had waited for my appointment with Mr. Royle. In the meantime, I consulted Dr J. Schofield, a Consultant Dermatologist at BUPA Bushey, to confirm that my eczema would not cause any complications during surgery. Her report was sent to Mr. Terry.

### **Consultation**

Mr Terry’s requirements for gender reassignment surgery are a minimum of a valid one year Real Life Test and two surgical referrals from qualified psychiatrists. I understood this to include, Dr. Reid, Dr. Dalrymple, Professor Green, and Dr. Khoosal. In addition, for NHS surgery, a referral from your G.P. or Local Health Authority is required to confirm funding arrangements.

Although the format of my consultation with Mr. Terry was very similar to that with Mr. Royle: preliminary questions; physical examination; discussion; here the similarity ends. The consultation with Mr Terry was much more relaxed, much less formal, but equally more open, factual and frank. When I left the consultation with Mr. Royle, I remember thinking, thank goodness that is over and I haven't said the wrong thing. When I left Mr. Terry, I felt that I understood a lot better what would happen during surgery, the risks involved and a feeling that I had made the right choice.

As an illustration of the difference in their styles, during the physical examination Mr. Royle looked at the material available and said that he could make no promises as to the depth he would be able to achieve. Mr Terry looked at the same material and said that there was plenty of material to achieve a reasonable depth. Neither actually specified a depth, it was purely how they conveyed their opinion.

After asking some preliminary questions and giving me a physical examination, which entailed checking the strength of my lower abdomen muscles and examining the penile and scrotal material available, we went on to discuss the operation itself. Mr. Terry performs a single stage operation, which involves a penectomy, bi-lateral orchidectomy, followed by the creation of a corpus cavernosum, which is lined with penile and scrotal material (the neo vagina) and a urethra. Labia minora and majora are formed using scrotal skin and an innervate clitoris is formed from the glands from the penis, using a technique from Amsterdam.

The overall vagina differs in appearance from the vagina created by Mr Royle, in that Mr. Terry uses what he describes as a V technique rather than a W technique. I didn't really appreciate exactly what this meant until I saw the results - see below. We then discussed some of the risks: The outer labia produced are rarely symmetrical due to swelling and other constraints during surgery. They can be tied up later, but 85% of his patients are happy with the initial results, 10% were probably never going to be happy and the remaining 5% do actually need some tidy up work. In reality it is not a huge issue, as the labia of genetic females often ends up asymmetrical after childbirth, if indeed it was symmetrical to begin with. There is about a 10% risk that the clitoris will not survive, although this cannot be corrected, patients who underwent GRS, prior to the inclusion of clitoroplasty, generally report good sensation from the vagina. During the creation of the corpus cavernosum, between the prostate gland and the rectum, it is possible that the rectum may be perforated and require repair. This had not happened to Mr. Terry, but had occurred at Charing Cross and with Mr. Royle. I asked, given that prostate gland is not removed, whether it was still possible to contract prostate cancer. Mr. Terry informed me that although the risks are very small, as the gland atrophies, there had been one reported case in Amsterdam. Once the neo-vagina is created in the corpus cavernosum, a pack is inserted to prevent a prolapse. This is removed on the fifth day after surgery. There is a risk that when it is removed, the lining sticks to the pack and prolapses. In this event a new pack is inserted and left in for a further five days, during which time you remain on a liquid diet. Finally we discussed potential blood loss during the operation. Mr. Terry informed me that now, less than 10% of his patients require a transfusion. I then enquired whether it was necessary to have some of the scrotal hair removed by

electrolysis prior to surgery. Mr Terry said that in his experience it was not. In the event the point was moot, as I was already too close to surgery to have it done.

Mr. Terry explained that he undertakes his private surgery at Leicester Nuffield Hospital. Nuffield Nursing Homes Trust, is a registered charity and therefore the room rates and other charges are considerably less than at BUPA, where his consultation is held. He carries out his private surgery on a Saturday and only performs one gender reassignment operation that day, so that he is able to devote his time to the care of just one patient the following week. Mr Terry always uses the same anaesthetist for gender reassignment work at both Leicester Nuffield and Leicester General Hospitals. The normal length of stay in hospital is 9 or 10 days, with a follow up out patient's appointment, six weeks later. Surgery is provided under a Nuffield Fixed Price Direct arrangement at a cost of GBP 4,975. I enquired why his rate was so much less than Mr. Royle's charge of GBP 9,000. He said that part of the reason was that room rates at Leicester Nuffield were less than that charged in the south of England. He went on to say that his work was not inferior and that he was not running a "Skoda production line". He charges GBP 4,975 because he thinks that is the amount that it is reasonable for a patient to pay.

We then discussed having surgery on the NHS at Leicester General Hospital. Mr. Terry told me that he was quite happy to add me to his NHS list. At that time it was about nine months long, which is approximately half the length of the Charing Cross list. However, Mr Terry was quite open and did warn me that he has one big disadvantage over Charing Cross: - unlike Charing Cross he does not have any dedicated gender reassignment beds. He has 8 NHS bed spaces to work out of. Although the NHS will give you a date for surgery (which necessitates ceasing hormone administration six weeks prior to surgery due to the risk of deep vein thrombosis, see later) it is possible that when the date arrives, emergency cases have taken all the bed spaces and you have to wait, (whilst off hormones), until a vacancy is available. Operating theatre space is not a problem, but NHS cut backs on bed space is. In the end, this was a major reason why I decided to forego my NHS funding and have surgery privately with Mr. Terry, the other reason being his competitive price. Surgery was booked for Saturday 8th April 2000, six weeks time and just enough time to stop taking the hormones.

### **Day 1 (GRS - 1) Friday**

I travelled to Leicester by train, using the Midland Mainline out of London. The hospital is a 10 minute taxi ride from the station. I arrived at the Leicester Nuffield Hospital just before 10 am and was taken up to my room on the main ward on the first floor. The room had had its own washroom, which included a shower and toilet. The room itself had a television and a nice view from the window, over looking the park.

Shortly after settling into the room a nurse came in and completed all of the admission details. As I have a history of allergies, I was given a red name band to wear on my wrist, to alert staff. I had an ECG test and was weighted. This enabled the nurse to complete my Deep Vein Thrombosis (DVT) risk assessment. I was then measured up for surgical

stockings. The phlebotomist then came to take some blood samples so that my blood type could be cross matched and two pints of blood set aside for me, which is standard for any surgical procedure. At 11 am I was informed that I should not eat anything else and was given my first dose of Picolax (laxative). This started to work about one hour later. At 1 pm I had a second dose of Picolax, this was sufficient to have me trotting to the toilet for the rest of the day.

Most of the day was spent sitting around, but at 6 pm, I had some excitement. The anaesthetist, Dr Ogilvy, arrived dressed in his red bikers gear! Compared to the other doctors about the place he looked young and hunky. He looked through the results of my various tests. We then discussed the possibility of a blood transfusion. He said that a transfusion was necessary in less than one in ten cases for this particular surgical procedure. I then expressed my preference not to have a transfusion unless absolutely necessary.

I had a shower at 9 pm after which I performed the time-honoured ritual of the final stand-up job. I spent the rest of the evening feeling hungry and bored, due to an inability to concentrate on anything.

## **Day 2 (GRS) Saturday**

I woke up at 7 am, the big day had finally arrived. I got up, shaved and washed then got dressed in the surgery gown, which had been provided for me. I had not eaten since breakfast the previous day and had not drunk anything since 10 pm the previous night. I was therefore feeling a little weak and tense. At 8 am the nurse came in to see me and helped me put on my white surgical stockings. At 8.30 Mr. Terry came in to check that I was all right and still wished to proceed. He told me that he had performed six GRS operations in the last four weeks and therefore there was nothing for me to worry about. He also told me that the anaesthetist, Dr Ogilvy, was very experienced and was the head of intensive care at Leicester General Hospital.

At 9 am the porter arrived and I was asked to get into my bed. I was then wheeled out of the room and up in the lift to the second floor where the operating theatre is situated. Mr. Terry and Dr. Ogilvy were waiting for me in the preparation room. Dr. Ogilvy inserted an intravenous line into a vein in my left hand. He then gave me an injection in to my left arm, I started to say a prayer and then I was gone.

The next thing I remember was waking up in the recovery room, my records seem to indicate that this was about 2 pm. I was aware of Mr Terry telling me that the operation was successful and of having terrible cramps in my legs and the nurses trying to straighten them out. I then recall being back in my room and being awake for periods of time. I did not seem to have any pain, but this could have been due to the morphine. On the evening I got a call from my wife and told her that everything was fine.

### **Day 3 (GRS + 1) Sunday**

This was by far my worst day, the point I reached my lowest ebb and the only time I questioned whether I had made the right decision to have the operation. I do not have a clear recollection of what happened that day, events seemed to follow a cycle: a morphine injection was made into my thigh muscle; I was then able to sleep for an hour or so; I then woke up and was relatively comfortable for a further hour or two; then the effects of the morphine wore off and I was in considerable discomfort for the next hour until I reached the time for my next injection. The main source of pain was from my lower spine, the surgical area being virtually pain free. I had experienced pain in my lower spine before the operation, both when wearing a tight boned corset and when lying on my back in bed too long. The T-bandage and bed rest proved to be a lethal combination.

When I woke I seemed to be attached to various pieces of equipment. On my left hand side was a stand to which a saline drip bag was attached. A second bag of saline containing antibiotics was also attached here at regular intervals. On my right hand side was a urinary catheter bag; clipped to a finger on my right hand was a pulse oximeter monitor checking my pulse and oxygen levels in the blood and further up the arm was attached an blood pressure monitor, which inflated and performed a check every hour. Underneath I had a disposable bed pad, into which the vaginal drains discharged. In addition to the morphine shots, I received injections of Heparin (an anti-coagulant) into my stomach muscles. As a further preventative measure against DVT, the nurse gave me instructions on exercises I could perform in bed which involved moving my feet in order to improve circulation.

During the day Mr. Terry came into see me. He told me that the operation had been a success and that he had managed to achieve reasonable vaginal depth. He also explained that there had been a complication during the procedure: after making the incision through the pelvic floor muscle to create the corpus cavernosum, he had found things quite stuck down and narrow, and by accident he had perforated the rectum. He had recognized this straight away and repaired the perforation with three rows of sutures. This was a risk that we were both aware of and discussed at the consultation, however, it was the first time that it had happened in over 70 similar procedures. As a consequence of the complication Mr Terry decided to keep me in hospital an extra two days to ensure that I had no problems with bowel movements.

Dr. Ogilvy came into see me later in the day to check on my recovery. Despite my dazed state, I was pleased to see that he was back in his bikers' gear with a rough unshaven look. Well it cheered me! At night I was offered some sleeping tablets. I decided to take these, but after lying awake from over an hour, I concluded that they were completely ineffective and did not use them again.

### **Day 4 (GRS + 2) Monday**

I did not sleep well and it seemed as if I had been awake the whole night, although in reality I must have dozed off throughout the night. I was alternating between shivering and feeling very hot and sweaty. I had no pain from the surgical area, however the pain from the lower area of my spine was acute. I therefore continued on the morphine injections into my thigh. During the night I had mineral water to drink and after 8 am black tea. My liquid intake continued to be supplemented by a drip into my left hand, to which antibiotics were regularly added.

Mr. Terry came in during the morning and I told him about the pain in my back, in addition I was beginning to experience cramping pains in my stomach from trapped wind. He looked at my T-bandage and with the assistance of the nurse, tried to loosen some of the ties. He then changed his mind and said let's take it right off. He proceeded to cut through all of the bandages, asked me to raise my bottom, and pulled away a huge mass of blood soaked bandages and packing. The relief to my back was instant and from that moment on I did not require any further painkillers. This was my first chance to look at the surgical area. My prayers had been answered; I had woken up a girl. Thank you, Lord. All that remained was the pack, a sort of rectangle shape, slightly raised, and covering all of the vaginal area. Small sutures, through the skin, anchored it right the way round. The pack itself was black with stale blood. Mr. Terry seemed happy that it was securely in place and asked the nurse to give me a pair of surgical knickers to put. The ECR machine, which had been left attached to my right arm and inflated each hour, was removed, although it continued to be used on a less regular basis over the next few days.

Although the removal of the T-bandage gave instant relief to my back, the trapped wind remained a problem and caused me a lot of discomfort throughout the day. The main problem was getting the wind out of my body, as laying flat, with the pack in place, blocked the normal exit. Some skilful movement on to my side eventually relieved the problem, although the manoeuvre had to be repeated regularly throughout the day.

With the removal of the T-bandages, I felt well enough to have my first bed bath, during which the monitor pads on my chest were removed, and to change my nightie. I was also able to have a shave and remove the stubble, which had grown since Saturday morning. Clearly two years of electrolysis had not been enough. I also felt a mixture of emotions, being complete down below, yet still having this maleness about me. The daily bed change was much easier with the T-bandage removed.

Dr. Ogilvy came to see me in the afternoon. I told him that I was no longer in pain, however, he left me the option of taking painkillers if I needed them. We discussed the surgery and he said that although I had lost some blood, a transfusion had not been necessary. We also agreed that I preferred to be allowed to be slightly anaemic, rather than have a transfusion.

My diet for the day was mineral water and black tea. I also had two Heparin injections into my stomach.

## **Day 5 (GRS + 3) Tuesday**

Compared to the previous nights, I seemed to have slept quite well, although wind had remained a problem and had disturbed me during the night. Generally I felt much better and more alert, I could pull myself up in bed and do a few things for myself, including drinking without a straw. The only discomfort I felt was on my left heel, where it had become sore, through dragging my leg on the bed to move about. I was still on a drip bag and was also being given an IV antibiotic. During the morning I felt a lot of pain around the site of the IV line as the vein into which the needle was inserted had started to collapse. The house-doctor was called, and he put a new needle into my right hand. The one on my left hand was removed. I also had a bed bath and then got rolled about the bed, whilst the sheets were changed. Mr. Terry came in during the afternoon and removed my surgical knickers. The rectangular black mound of the pack, covering the whole vaginal area was very visible. Above the surgical area, my skin was very yellow, a result of the betadine (iodine) used to clean the area, prior to surgery. There was no sign of any bruising round the surgical area. Mr Terry produced a small blade and cut free the vaginal drains and removed these. There was a slight tingling sensation as they came out, but no pain.

My diet remained unaltered, black tea and mineral water. In addition to the antibiotic, I had two Heparin injections during the day. I did not require any painkillers.

## **Day 6 (GRS + 4) Wednesday**

I had a reasonable nights sleep, better than the previous night, but still disturbed by some wind and I was generally hot and sweaty. During the previous 24 hours I had managed to drink a steady flow of fluids and maintain my urine a straw yellow colour. I had kept checking my Catheter pipe to ensure this was the case. The nurse was therefore satisfied that I no longer needed the drip. The IV needle in my right hand was removed. My antibiotics were changed to an oral tablet. Again I had very little pain, other than the sore spot on my left heel. I was given a bed bath and then rolled about whilst the bed was changed.

Mr. Terry came in and had a quick look at the surgical area, then promised to come in at 10 am the following day to remove the pack. Dr Ogilvy also came in, again looking very hunky in his biker's gear. He had a quick check through my medication list, but as I did not require any painkillers, there was nothing for him to prescribe. My diet during the day was just mineral water, as I could no longer face anymore black tea. Most of the day was spent thinking about how hungry I was and what I was going to eat the next day. The hospital menu had been left in my room and by the end of the day I had decided to order virtually everything on the menu! I was disparate for food.

## **Day 7 (GRS + 5) Thursday**

“Pack out day” and the moment of truth had finally arrived. I had slept reasonably well and without any pain, the only thing that had really disturbed me was the smell coming through the sheets from the pack. The nurse came in at about 8 am, opened the curtains and propped me up in bed. I then had a Heparin injection and was given an anti-biotic tablet.

At 10 am Mr. Terry came in to remove the pack. I held on to the bars at the head of the bed expecting it to hurt, however, apart from some slight discomfort as the stitches, (there seemed to be about 6 or 8), holding the pack in place, were cut through. I did not really feel anything and once the stitches were cut, the pack just seemed to slide out. As soon as the pack was removed Mr. Terry had a quick look at the area and told me that my clitoris had survived. He then got a mirror and I had my first view of his handiwork. The first thing I noticed was that it did not look the same as a Mr. Royle /Charing Cross vagina and I then appreciated what had been meant by a “V technique”. The photographs I have seen of Mr. Royle’s work indicate that he uses a “W technique”, smoothing out the excess skin from the scrotal area and taking a flat suture into the sides of each inner thigh. The V technique, from Amsterdam, deliberately bunches up some of the excess scrotal material and uses it to make the outer labia, which runs up in a narrow V shape, each side of the vaginal - inner labia area, finishing about 1.5 cm above the clitoris. This gives the vagina a very satisfactory, if somewhat elongated, appearance. The clitoris itself is placed at the top of the inner labia, slightly above the urethra. The clitoris does not have a hood, although it is tucked in and protected by the sides of the inner labia and its apex.

Once I had looked at my new vagina, Mr. Terry asked the nurse to bring the dilators. Mr. Terry provides a set of four Amielle dilators. They appear to be different to those provided elsewhere. They consist of a grey plastic handle/shaft, to which hollow, pale cream, dilator heads are clipped, using a bayonet type, screw in fastening. The smaller two dilator heads were described as “useless” and Mr Terry told the nurse to throw them away. This left the larger two, of these, the smaller has a diameter of about 30mm (just smaller than the Intelligence Engineering No.20 stent) and the larger has a diameter of about 38mm (just smaller than the IE No. 24 stent).

Mr Terry lubricated the 30 mm stent and pushed it carefully into my vagina, warning me as he did so, not to push down on the rectum, due to the sutures in that area. I was surprised by how easily the dilator slipped in. Shortly afterwards he withdrew it and showed me the depth achieved about 4 inches, which given the material available was good. He then proceeded to lubricate the 38mm stent and pushed that in. This was a little more painful as it involved more stretching. Mr. Terry told the nurse that I should dilate twice more that day and that I should have a betadine vaginal douche after the evening dilation. He also said that I could start eating again from lunchtime, but that he wanted me to start on a low-fibre diet because of the sutures in the rectum. I was then left to clean myself up and admire my new asset.

The nurse returned at 11 am to help me out of bed and start me walking again. I managed to sit up and get my legs out of bed, but felt too light-headed and faint when standing up

and had to sit down again. I tried again half an hour later and this time managed a few steps, catheter bag in hand. My legs were very stiff and my right leg felt quite numb.

Lunch is served at midday and I had tomato soup, followed by an egg custard. After eating it, I was surprised by how full I felt and it was a good job I hadn't ordered the entire menu! I also had my first cup of milky tea. After lunch the nurse came in to help with the afternoon dilation. I got myself ready and tried with the Amielle 30 mm stent. It went in a little way, but I could not get it passed the Pubococcygeus Muscle. The nurse came to my assistance and I held the dilator in place for 15 minutes.

In the afternoon, I continued to get up and move about. It was also the first time that I was able to watch the nurse changing my bed, rather than being rolled about the bed. The evening meal is at 6 pm, I had poached plaice with mash potato followed by a crème brulee. At 7 pm I prepared for my evening dilation. I had brought with me a set of five stents manufactured by Intelligence Engineering, LLC. As I had experienced difficulties using the Amielle 30 mm stent during the day, I decided to start off with the IE No. 16 (25mm) stent as a pathfinder probe. This slipped in quite easily and a short while afterwards I was able to ease in the Amielle 30 mm stent and hold it in place for 15 minutes. Once I had completed the dilation, I called the nurse and my betadine vaginal douche was prepared. Apparently the easiest way to demonstrate this was on the bed, so a disposable bedpan was placed under my bottom and the nurse proceeded with the douche. Not the most comfortable of positions and certainly not one I could repeat by myself. Getting up was difficult as betadine was dripping everywhere.

After the douche, my surgical stockings were removed and I was sent for my first shower, yes! a shower! There are no salt baths at Leicester Nuffield. The only real problem I had with the shower was deciding whether to take the Catheter bag in the shower with me or leave it outside with the curtain raised for the tube. In the end I took it inside to avoid flooding the washroom. The only other difficulty concerned the use of the seat inside the shower. After gingerly trying to sit down on it, I gave up the idea, folded it away and stood up. By the time I came out, I felt a little faint, so I had to rest on my bed, before finishing to dry myself and get ready for bed. In addition to finding a clean cotton nightie, I was able to wear proper knickers again, with a Boots maternity sanitary towel inside. Initially I tried to use some Boots disposable briefs, but these were absolutely useless, so I went for a comfortable cotton pair. I finally felt clean. During the evening I had a final dose of anti-biotic tablets and a Heparin injection. I fell asleep just before midnight.

## **Day 8 (GRS + 6) Friday**

I had a reasonable nights sleep and was able to move about a little, although I still had the Catheter in. I woke up a couple of times during the night feeling cold and sweaty. I had a drink on both occasions to try and maintain my urine a straw yellow colour. I woke at 7 am, carefully got up and went with my Catheter bag to the washroom. I was able to wash, shave and remove some of the body hair, which had grown over the past week. I

was also able to put make up on for the first time and make myself look presentable. Shortly afterwards I had my first bowel movement.

My first breakfast arrived at 8 am. Toast, poached egg, tomato, hash brown and mushrooms, life was getting back to normal! Mr Terry came in to see me after breakfast and asked how the dilation was going on. I explained that I had needed to use the IE No. 16 (25mm) stent, before being able to use the Amielle 30 mm stent. He said that it probably wasn't necessary and proceeded to demonstrate, after lubricating everything up, that both the Amielle 30mm stent and the Amielle 38mm stent would slide into a reasonable depth. We then discussed the bruising and swelling of tissue within the vaginal area. Mr. Terry told me that over the next 3 months this would reduce and the tissue would be sucked into the vagina leaving just the inner and outer labia showing.

Lunch was at midday; soup followed by scrambled egg and smoked salmon. I also had to take some more lactulose (laxative). At 1 pm the nurse came in and removed the catheter. There was a small tingling sensation as the tube was withdrawn, but no pain. A couple of hours later I had my first pee. This was into a cardboard container, inserted into the toilet, in order to measure the volume. I was pleasantly surprised; I had a nice straight stream, heading down at the correct angle into the toilet, without any discomfort. The only shock came at the end when the last bit dribbled down to my bum, but my wife assures me this is quite normal! Subsequently, I have had no problems peeing, although during the early days, starting to pee was a matter of waiting for the to correct pressure build up.

I dilated at 2 pm, again using the IE No. 16 (25mm) stent to open the vagina up followed by the Amielle 30mm stent for 15 minutes. I dilated for a third time at 8 pm. After this I had to attempt my first unassisted vaginal douche. In the absence of a bath to lie in, I initially tried the toilet, but the bowl was not deep enough, so I had to settle for standing up in the shower, using a small mirror to guide the tapered head into my vagina. The process was a little messy, with betadine running down my leg and splashing everywhere, but it worked and the mess soon washed away. Moving around the shower was easier, as I no longer had the catheter, but I still had some mobility problems due to numbness in my right leg. After this I rested in bed and went to sleep about midnight.

During the day I had two injections of Heparin into the stomach muscles. This was the only medication I was required to take, apart from the lactulose.

### **Day 9 (GRS +7) Saturday**

Saturday, Day 9, is the normal discharge date, if there have been no complications. In my case I was due to be detained an extra two days to ensure that there were no problems associated with the sutures in my rectum. I had slept well, although I had woken once at about 2 am to have a pee. I got up about 7.15 am, washed and made my self ready for breakfast. After breakfast I dilated using the IE No. 16 stent to open the vagina up, followed by the Amielle 30mm stent for 15 minutes. Shortly afterwards Mr Terry came

in to check up on me. He looked at the vaginal area and asked how I had got on without the Catheter. I had been fine, and we then discussed dilation and care after I had been discharged. He then told me that as I was now mobile, it should be all right to remove my surgical stockings. After he left, I removed the stockings and started walking about to try and ease some of the numbness I felt in my right leg. About 30 minutes later I noticed that my right ankle and lower leg had suddenly swollen up. Why this should have happened then is a matter of some speculation, it was not the first time I had removed my stockings as I had showered both Thursday and Friday nights. When the swelling did not reduce, I called the nurse and he recommended that I put the stockings back on again. The nurse then called Mr. Terry at home to inform him of the problem. I continued walking up and down the ward corridor to see if exercise would assist in helping the swelling to go down, but there was no change.

During the day I had two injections of Heparin into the stomach muscles. This was the only medication I was required to take. I dilated after lunch and again an hour after the 6 pm evening meal. I then had a vaginal douche in the shower area, followed by a shower. Although I had removed my stockings before showering, there was no alteration to the level of swelling. I went to sleep just after midnight.

### **Day 10 (GRS + 8) Sunday**

I had a good nights sleep, although I again woke to have a pee. I woke again at about 7.30 am, got up and washed ready for breakfast. Unfortunately there had been no improvement in my right leg. The calf and ankle were still very swollen, despite the pressure of the surgical stockings overnight. After breakfast I dilated as normal, using the IE No. 16 stent and Amielle 30mm stent. Just before midday, Mr. Terry came to check up on my condition. He took various measurements around my right calf and ankle, and then told me that he thought I had a DVT. He then left to telephone a Radiologist to get a scan of my leg veins. Within 10 minutes, the hospitals Consultant Haematologist, Dr J.K. Wood, came in to see me. I was his second patient of the day with D.V.T. He checked my leg and confirmed Mr Terry's diagnosis.

The phlebotomist was then called in and a blood sample taken to measure my INR (International Ratio) count, which shows the level of anti-coagulants in the blood. This came out at 1.0 (Normal). Shortly before 2 pm, the Radiologist arrived and I was taken down to the X-ray room, where the Ultrasound equipment is kept. I removed my surgical stocking and then watched the screen as my veins were checked. He took a number of colour images showing the effected area. The Radiologists' report stated:-

*Ultrasound Right Leg Veins: Femoral and Popliteal veins clear. There is acute thrombus through much of the perineal veins in the calf extending as high as the tibio-perineal trunk. The posterior tibial veins are normal. Conclusion: Calf Deep Vein Thrombosis.*

Based on this report and the INR count Dr Wood stopped my Heparin injections and replaced it with a different anticoagulant. Again, this was injected into the stomach muscles, this time 11,375 units of Tinzaparin (a type of Heparin which has a long half life in the bloodstream). I was also prescribed 10 mg of Warfarin Sodium (commonly known as “rat poison”). I was then informed that I would need to stay in hospital until Friday, whilst the anti-coagulants in my blood were stabilized. Given that all of this happened on a Sunday and that staff had to be called in from home, I was very impressed by how quickly the situation was dealt with and corrective action taken. I should also stress, as noted in Day 1, a full risk assessment of DVT was undertaken before surgery and normal preventative measures taken, unfortunately in my case, it seems that I have a genetic predisposition towards thrombophilia.

I continued to exercise by walking up and down the ward corridors. I also continued dilating in the afternoon and in the evening using the IE No.16 stent and Amielle 30mm stent. After the evening dilation I had a vaginal douche in the shower and then had a shower.

### **Day 11 (GRS + 9) Monday**

Another good nights sleep and up at 7.30 am. Mr Terry arrived early to check on me, as he was going away for the rest of the week, having delayed his departure from Saturday. We discussed post-operative maintenance once I returned home and also restarting hormones. Ordinarily I could have restarted hormones 14 days after surgery, however, the DVT gave rise to some concerns. I therefore agreed that I would speak to my G.P. when I returned home and would get a hormone level blood test to establish a new base-line. I would then speak to Professor Green (or alternatively Dr Reid) about a post-operative hormone regime. Mr. Terry then told me that he had arranged for his colleague, Mr. Sandhu to check on me each day.

Shortly after Mr. Terry left, I attempted my morning dilation. I was quite shocked to find that the level of bleeding from the vagina and the amount of blood on my stents had increased considerably. This appears to have been a consequence of having the Tinzaparin injections, (the Warfarin tablets take longer to have an effect). I informed the nurse, who then contacted Mr Sandhu. The house-doctor was also called and after he had checked the bleeding it was agreed that I should cease dilation, until Mr. Sandhu could come in and check the extent of the problem.

Further blood tests were performed during the morning; my INR count had increased to 1.5 (target range 2.0 - 3.0). It was also established that I was very anaemic, with my haemoglobin count at 8.8 against a normal lower limit value of 15.0. It should be noted that I had agreed with Dr. Ogilvy, as a deliberate policy decision, that I preferred to be slightly anaemic rather than have a blood transfusion. Dr. Wood appeared to disagree with this and sent a message to Mr Sandhu, asking whether he wanted me to have a blood transfusion. I still didn't want a transfusion, so I asked the nurse to prescribe Ferrous Sulphate (Iron) tablets. By the time Dr. Wood raised the issue of a blood transfusion

again, my iron count had increased and the issue was dropped. The Warfarin prescription was 10 mg for the day.

I continued to exercise by walking up and down the ward corridors. Mr Terry telephoned me at 8 pm and I explained my concerns about the level of vaginal bleeding. He said that the position would stabilize again and that I should continue dilating as normal, 3 times per day, although I shouldn't attempt to use the Amielle 38mm stent. Mr Terry also told me that he would be returning to Leicester on the Saturday and that if I wished to remain in hospital until his return, I could. I then commenced my evening dilation, as I was finishing, Mr Sandhu arrived, he checked the amount of bleeding and the residue on the stents. He said that he was not worried and that I should continue as before. I then had my vaginal douche and a shower before bed.

### **Day 12 (GRS + 10) Tuesday**

I overslept and was woken up at 8 am when my breakfast was brought in. After breakfast I dilated as normal, this time the level of bleeding had decreased, although it had not returned to the pre-anti-coagulant levels. I had a further INR test in the morning, this time it had increased to 1.8, just short of the target range. Dr Wood seemed pleased with this when he saw me after lunch. He cancelled the Tinzaparin prescription and reduced the level of Warfarin to 1 mg. He also explained to the nurse who was with him, that I had responded very quickly to treatment, the Tinzaparin had left very little bruising on my stomach and my INR counted had risen, whereas his other DVT patient, who was older and carrying a lot more weight, had major bruising to the stomach and had not responded quickly to the Warfarin. My dosage of 3 iron tablets was maintained.

I dilated and exercised as normal during the day. Mr Terry called during the evening and I also got a visit from Mr. Sandhu.

### **Day 13 (GRS + 11) Wednesday**

I got up at 7.30 am and followed my normal routine. I was now getting very bored with hospital life, as it seemed the only reason for being there was to have my daily INR check. This came out at 2.1, within the target range. Dr Wood seemed happy with this and prescribed 3 mg of Warfarin for the day. He also asked me to contact my G.P. to check on local arrangements for anti-coagulant treatment. Having checked with my surgery, I established that the practice nurse runs a daily clinic, with the blood test being performed in the surgery. I therefore made an appointment to see the nurse the following Tuesday, (Monday was a bank holiday) and an appointment to see my G.P. on the Wednesday. I also had an appointment with Professor Green at Charing Cross, to discuss hormones, on the Thursday.

In the afternoon I decided to relieve my boredom, so I got dressed and went for a walk in the park opposite the hospital. I also successfully attempted the hospital stairs. In the

evening I went for another walk outside, I also got a telephone call from Mr Terry. He seemed pleased with my progress and as there were no further surgical issues for him to deal with, gave me his home number and asked me to call him in a week's time to confirm everything was still all right. I also had a visit from Mr Sandhu.

Dilation continued as normal and I felt confident enough to start using the IE No. 20 (32mm) stent.

### **Day 14 (GRS + 12) Thursday**

Another boring day, although there was one amusing incident. During morning dilation the phlebotomist came in to take a blood sample. Previously the technicians had all been female and had been completely undisturbed by the fact that I was dilating on my bed. However, this time it was a male, whom I had not seen before, and who seemed quite inexperienced. He appeared visibly shaken by what he saw, he knocked some of my clean dilators on the floor, pushed my table and its contents out of place and then left in such a hurry that he left his elasticated tourniquet still hanging loose round my arm. It later transpired that he had also forgotten to take the sample of blood required for the INR count and the house-doctor had to come in and take a further sample. I never saw the poor guy again!!

My INR count had dropped to 1.8, a consequence of only having 1 mg of Warfarin two days earlier, my dose was therefore increased to 4 mg a day.

In the afternoon I decided to go for a walk to the far side of the park. This proved to be a complete ego trip for me, as instead of finding rows of houses in a suburb of Leicester, I found a small village, where everything, shops, schools, park and church had my name on it - Humberstone! Even down to the pub, which was called "The Humberstone".

In the evening I had my final visit from Mr. Sandhu. Dilation continued as normal, using 2 of the IE stents and the smaller Amielle stent.

### **Day 15 (GRS + 13) Friday**

Overslept again and was woken by the arrival of breakfast at 8 am. After breakfast I dilated as usual, whilst I was doing this, the house-doctor came in to take a blood sample. After dilation I got dressed and started packing ready for my discharge. Dr Wood came in during the morning and told me that my INR counted had fallen slightly to 1.7, therefore he was leaving me on a dose of 4 mg of Warfarin, until my INR was checked again by my G.P.'s practice nurse. My discharge sheet was prepared and I was given a supply of 1 mg Warfarin tablets and 200 mg Ferrous Sulphate tablets.

I made arrangements to see Mr. Terry in 6 weeks time for a follow up appointment and was discharged about 2 pm. Before leaving I waited until I had been for a pee, although

urination was never a problem, I was still not able to pee on demand, I had to wait until I needed to go. I was collected by my wife and had very little difficulty getting into her car. I also found the one and a half hour journey home fairly comfortable. After two weeks away, I was glad to be home again.

I should say, as I have not mentioned it anywhere before, that the standard of nursing care was excellent throughout my stay. All of the nursing and support staff were very friendly and none of them seemed to have a problem with a transsexual patient. The catering and hospital menu were also excellent.

### **Day 16 (GRS + 14) Saturday**

This was my first full day back home and I decided to make some minor changes to my dilation routine. Various friends had recommended doing some Kegel exercises, to tighten up the Pubococcygeus muscle, whilst dilating. I was somewhat reluctant to try this with the Amielle stents, because they are hollow and I had visions of them cracking inside me. I therefore stopped using the Amielle stents and instead used three of the IE stents, which are solid. The ones I chose were No 18. (29mm) to open up the vagina and then the two graduated stents No. 20 (32mm) and No. 22 (35mm). I continued dilating three times a day.

Whilst preparing for my evening dilation, I found parts of a suture on my sanitary towel. On closer inspection of my vagina, it transpired that the sutures on both sides, just below the vaginal entrance and running down to the anus, had started to dissolve. As a consequence the scrotal skin in the central section had pulled away slightly from the inner thigh tissue leaving a small opening in the incision. During the next couple of days further sutures dissolved in this area. According to “Zen and the Art of Post-Operative Maintenance”, this is a common problem, particularly in the area between the vagina and the anus. It appears that the flap of scrotal tissue, which is taken from the centre section of the scrotum and tucked down into the vaginal entrance, is not good at bonding to the inner thigh tissues. Although the opening up of the incisions is rarely a long-term problem, it is uncomfortable, particularly when dilating or walking. Given this, it does beg the question as to why permanent sutures are not used in this area, as they could easily be removed at the six-week follow up appointment.

### **Day 21 (GRS + 19)**

Mr. Terry telephoned me at home to check that everything was all right, as it was one week since my discharge. I explained about the sutures dissolving and he said that it should not be a problem and that provided I kept the area clean, it would heal over.

### **Day 23 (GRS + 21)**

It is now three weeks since the operation. Bleeding from the surgical area and from the vagina has now ceased and my IE stents are coming out of the vagina clean. There is still some yellow discharge into my sanitary towel, which appears to be a mixture of betadine, surgical lube, and plasma and dead skin cells.

## **Conclusion**

I found Mr Terry and his team to be highly competent. I was pleased with the overall results of surgery and with my post-operative care arrangements. I would have no hesitation in recommending him to other transsexual patients. Compared to other UK / EU surgeons, his charge is very competitive and he is a very credible alternative to either Mr Royle or Dr Seghers and has substantially more experience than Ms Evans.

## **Disclaimer**

Whilst every effort has been taken to ensure that the facts included in this paper are accurate, any errors or omissions are my own and not those of the medical professionals involved. The views and opinions in the paper are solely my own. This paper does not constitute a recommendation or advice to either take or refrain from a particular course of action; it is purely my personal account of the way it was in April of the millennium year.

Kim E. Humberstone  
6<sup>th</sup> May 2000