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October 9, 1984

Louis G. Sullivan
[redacted] Page Street
San Francisco Ca 94117

Dear Mr. Sullivan:

I have enclosed a letter concerning the cost of surgery and what we have to offer in surgical reconstruction. I have also enclosed another article about the surgical procedures.

It has become evident with time that a urinary tract hook-up should not be done as they have not been all that successful. The female urethra makes such a angulation as compared to the male urethra that it is very difficult to avoid break down, strictures, or fistula formation.

If the surgical procedure outlined here appeals to you and you wish to learn further about it, I would like to have you come to Oklahoma City for a conference before we decide on any surgical procedures for you.

Sincerely yours,

David William Foerster, M.D.

a/h

OUT PATIENT SEX REASSIGNMENT SURGERY

David W. Foerster, M.D.

Although it seems improbable that sex reassignment surgery can be done on an "out-patient-surgery" basis there are certain procedures that readily lend themselves to this, thereby reducing overall cost while increasing patient convenience. On the other hand, certain procedures must, of necessity, be done on an "in-patient-hospital" basis due to the complexity of post operative care required. Unfortunately, the one stage male-to-female genitalia conversion falls into the in-patient category. On the positive side, however, nearly all ancillary procedures in the male-to-female conversion are amenable to out-patient surgery, e.g. augmentation mammoplasty, laryngeal cartilage reduction (Adam's apple shave), rhinoplasty, face lift, eyelid-plasty, cheek implants, etc.

The female-to-male conversion may be categorized into 4 steps or stages, two of which can be done in an out-patient surgical setting.

The usual first step is conversion of the female-to-male breasts. One must not think of this as simply "mastectomy", for female nipple areolar complex conversion into male appearing nipple and a male chest configuration is highly desirable as part of the mastectomy procedure. Either wedge resection of large breasts with free nipple grafting or subcutaneous mastectomy with second stage nipple conversion can be done quite successfully in an out-patient surgical facility. Recuperation can take place in an adjacent hotel facility or and intermediate type nursing care center. A friend or relative should accompany the patient if a hotel facility is utilized. (For those arriving without someone to stay with them during the hotel/motel recuperation period a home care facility, operated by a woman who left nurse's training just six months short of graduation to get married, is available at $75.00 per day. Room and board are included in the daily rate.)

The second stage consists of removal of the internal female organs (uterus, tubes, ovaries, and as much of the vagina as possible). This stage can follow the usual third stage (conversion of the external female genitalia to male genitalia) just as well as precede it. The second stage does require hospitalization and, in the hands of a skilled gynecological surgeon, can usually be done vaginally so as to preserve the integrity of the lower abdomen for the tube pedicle construction of the neo-penis. If an abdominal incision must be made it should run vertically in the mid-line toward the umbilicus (belly button). The transverse incision paralleling the top of the pubic hair should be avoided. No gynecologists, associated with the gender reassignment surgeons, is available in Oklahoma City to perform the female organ removal surgery as it is interpreted by the local hospitals as being part of the gender reassignment surgery and unless the patient enters the hospital as a female with female pelvic diagnosis it is simply impossible to do is this area; therefore the reassignment surgery patient should already have had this step completed prior to arrival at Oklahoma City. It it reiterated that the surgery must either be done vaginally or with the mid-line incision so as to preserve the integrity of lower abdominal tissue.

The third step is the conversion of the female-to-male external genitalia and should not be referred to as simply "phalloplasty" as a male appearing scrotum-testicle structure is needed as well as a neo-penis or phallus. Three surgical procedures, two major and one minor, are required. The latter being done under local anesthesia.

BEGIN

The first procedure, done under general anesthesia, consists of formation of an inverted tube pedicle running vertically from pubis to approximately 4cm beneath the umbilicus and incorporating the full thickness abdominal skin and soft tissue. By tubing this "raw" side out, a 4" x 8" split thickness skin graft taken from the anterior thigh can be wraoped around the pedicle for covering leaving a single vertical seam. This "suit case handle" appearing pedicle (see Figure 1) will eventually form the shaft

of the neo-penis and the grafted skin will mimic the loose skin of the natural male penis much more closely than other methods using non-grafted pedicles. The labia majora is then converted into a neo-scrotum by splitting each lip along its medial border, connecting the two together in the pubic area thus forming an inverted V. The inner layer is sutured separately from the outer layer across the mid-line so as to form a neo-scrotum. Attachment of the labia across the midline "hides" the clitoris and vaginal introidus from view and when completely healed will be available to accept two silicone testicular prosthesis. This procedure is done in the office surgical suite. Recuperation can easily and safely be done in the hotel/motel environment and hospitalizaton is not required. Members of the surgical team see the patient the day after surgery to check on them and do dressing changes as necessary. The same home care facility mentioned in the paragraph concerning breast conversion is available for patients arriving for this without someone to stay with them during the hotel/motel recuperation period. Six to eight weeks, at your home, should be allowed to pass for healing and maturation of the pedicle and neo-phallus.

The second procedure, done under local anesthesia, is simply a "delay" of the abdominal skin between pedicle and umbilicus that will be used to construct the head of the neo-penis. (see Figure 2). This inverted trapezoid is illustrated in the accompanying figure. The incisions are made, as indicated, undermined slightly and closed with simple skin sutures.

The third procedure is carried out approximately two weeks later at which time the incisions are reopened and complete release of the abdomen is accomplished. The free ends of the pedicle are folded toward each other, the points trimmed bluntly and sutured together to form a conical head with central dimpling simulating the male penile head. The abdominal donor site is undermined slightly and closed primarily. The upper bases of the each labia are surgically opened in a transverse manner and each labia "hollowed out" by blunt dissection to accept adult size silicone testicular prostheses. Once in place the pockets are sutured and the neo-scrotum with testicles is completed as is the neo-penis.

Later, sexual functioning can be achieved by inserting a removable silicone rubber rod (baculum) through the hollow tube in the neo-penis (See Figure 3). In some cases the neo-penis may be firm enough for sexual functioning without the need of a stiffening rod.

The clitoris, near the base of the neo-penis, serves as the climactic organ since the head of the neo-penis is usually without sensation. Hair must be shaved or removed by a depilatory creme from the head of the neo-penis as well as through the shaft. Urination, at this stage, is still through the female urethral opening and requires a siting position. A urinary assist device can be utilized at this point in order to urinate through the penis as the sitting position is not always possible, particularly in a working situation.

A fourth stage, requiring hospitaliztion, can be done to route the urine flow through the neo-penis. Complete vaginectomy with perineal body construction is done with burying of the clitoris as preliminary step. Later a tunnel through the neo-penis is made to just above the urethral meatus. A full thickness skin graft is spiraled around a silicone catheter and placed through the tunnel where it is sutured to the freshened edge of the urethra and the anastamosis is buried. A perineal urethrostomy is needed for two or three weeks to allow sufficient healing of the graft prior to urine flow through the neo-penis. By surgically introducing a second conduit through the neo-penis the FTM does not sacrifice sex for standing urination ability. Also, the second conduit avoids the necessity for permanently implanting stiffening rods. (See Figure 4.) Fistula formation and stricture can occur and become major a problem, hence patients who may not wish to take these risks, settle for 3 stages, rather than 4, and

the use of a urinary assist device (UAD).

In summary then, out-patient surgical facilities can be utilized for ancillary male-to-female procedures; conversion of female-to-male breasts and conversion of the female-to-male genitalia resulting in significant savings to the patient who must often carry the full financial burden without insurance help. Futhermore, this circumvents the general dislike most gender patients have of entering a hospital complex with accompanying loss of individuality and privacy.

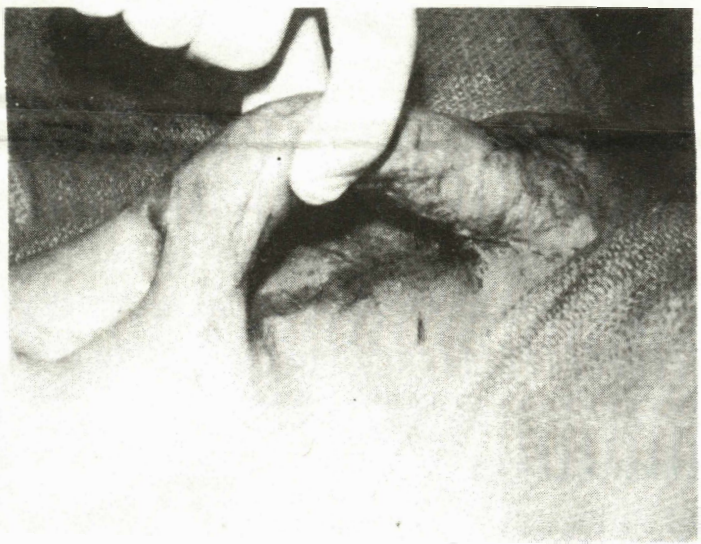

Figure 1
The so called "suitcase handle" pedicle on the lower abdomen ready for surgical delay and eventual release.

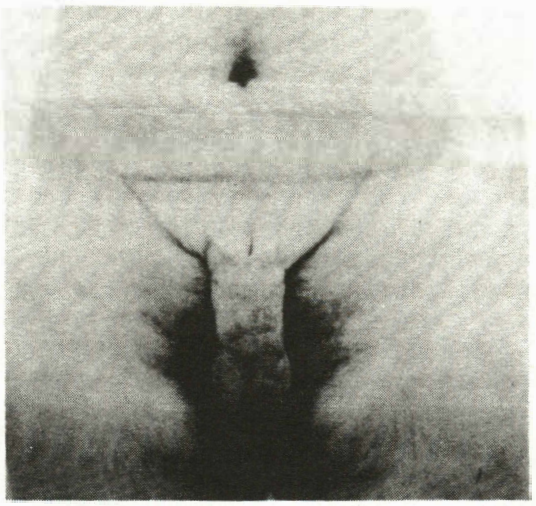

Figure 2
Pedicle has been sugically delayed and ready for release from the abdomen to form head of the neo-penis.

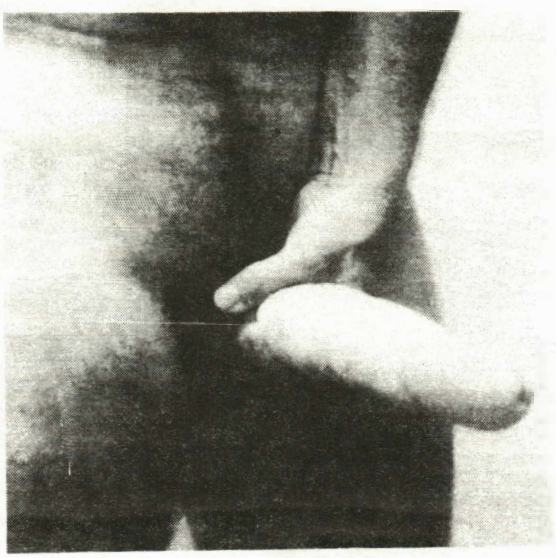

Figure 3
Completely formed neo-penis - silicone stiffening rod has been been inserted down hollow shaft to allow erection.

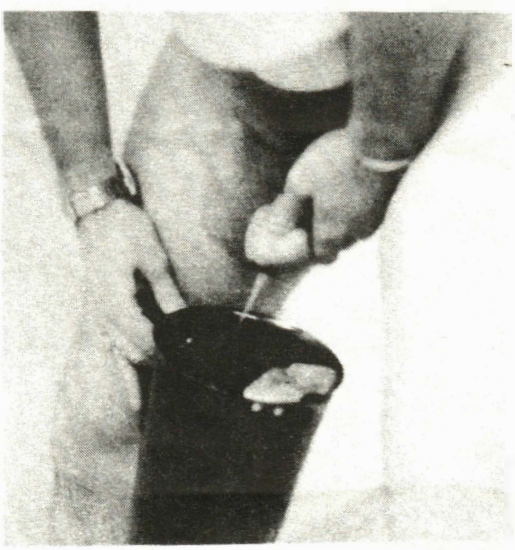

Figure 4
Urinary conduit constructed down center of neo-penis and urinary hook-up is complete.

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International support organization
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