2008). There are various procedures of which, currently, the most preferred for women is cricothyroid approximation. This may precede or follow other types of gender-change surgery and should be followed by further voice-therapy review to optimise surgical results (Antoni, 2007). Objective results are variable at present (Wagner *et al*, 2003), although personal satisfaction rates are high (Kanagalingam *et al*, 2005).

Thyroid chondroplasty may also be offered to reduce the prominence of the thyroid cartilage for cosmetic appearance (Sandhu, 2007).

### *MEN*

Pitch-changing surgery for men is not as well developed. There have been attempts to lower the pitch further with surgery (e.g. Isshiki type III thyroplasty), but both subjective and objective results are not favourable at present.

## SUPPORT MECHANISMS AND CONTINUING PROFESSIONAL DEVELOPMENT

Adults with gender dysphoria are likely to form a small part of a voice therapist's case-load unless the therapist is attached to a gender clinic. It is therefore essential that access to specialist colleagues and national support networks is available.

Regular updating of clinical skills is advised through designated courses, study days and individual learning opportunities.

## DISCHARGE

Discharge will be at the discretion of the speech and language therapist following discussion with the patient. Reasons for discharge may include any of the following:

successful completion of the therapy aims and objectives

no further progress deemed possible

patient is unable to commit to therapy/practice required to achieve therapy goals.

# Appendix 8 Storage of gametes*

If a person seeks advice on storage of gametes then they should be put in touch with a fertility centre offering licensed treatment. A list of centres in the UK can be found at the Human Fertilisation and Embryology Authority's website (www.hfea.gov.uk).

Gametes can only be stored if the provider has given appropriate informed consent. The implications of the storage of sperm or eggs will require careful counselling/psychotherapy. The provider will have to undergo testing for blood-borne viruses including HIV, hepatitis B and C. A support infrastructure, including hepatology services, should be available to deal with screening positive individuals.

The normal maximum storage period of gametes is 10 years. However, in the case of the transsexual individuals this can be extended up to a maximum of 55 years. Centres will normally contact all individuals with gametes in storage on an annual basis to ensure that continued storage is desired. It is the responsibility of the gamete provider to ensure that the clinic is aware of the individual's contact details for this purpose. The clinic may be required to destroy stored samples if the provider fails to keep in touch with the clinic.

Gametes can be stored only after appropriate consent has been given. The centre offering storage will be required to register with the Human Fertilisation and Embryology Authority the fact that sperm or eggs from the named provider have been stored in accordance with statutory guidance. Gametes can be stored for use in the treatment of a named individual, in the treatment of others (sperm/egg donation) or for research. If the specimen is to be used for treatment subsequently, then further counselling/psychotherapy and consent issues will have to be addressed before treatment can take place, including reference to the welfare of any child that might result from treatment.

Hormonal therapy has the potential to disturb the endocrine control of gametogenesis. It is advisable for individuals who wish to store gametes to stop therapy before provision of sperm specimens or undergoing treatment to procure eggs.

## Storage of sperm

Providers of sperm will be expected to produce five to ten ejaculated semen samples over a period of several weeks. If sperm quality is satisfactory this

*Written by Dr Mark Hamilton, Royal College of Obstetricians and Gyneacologists.

will allow the samples to be split and stored in separate straws or vials, allowing for 10–15 cycles of opportunity for conception through artificial insemination in the future. If sperm quality is poor then discussion may be required regarding the use of assisted reproduction procedures such as *in vitro* fertilisation in the future. Should the individual be unable to ejaculate, the clinic may be able to offer alternative methods of obtaining sperm through surgical sperm retrieval or electro-ejaculation.

## Storage of eggs

Egg quality, unlike sperm quality, is greatly influenced by the age of the female. Female fertility in the late 30s and beyond tails off dramatically and even *in vitro* fertilisation techniques are associated with poor success rates. In younger individuals the use of assisted reproductive technology techniques can be considered. Providers of eggs would be required to undergo a cycle of controlled ovarian stimulation leading to egg recovery in order to obtain a reasonable number of eggs for storage. The process of stimulation can take as long as 5 weeks to complete and involves injections of gonadotrophins to stimulate the ovary to generate multiple follicular development. Under ultrasound guidance and with sedation, vaginal oocyte retrieval can be performed. On average, between 8 and 12 eggs can be obtained in this way. Egg storage as a technique is not as reliable as sperm storage and pregnancy rates through the transfer of embryos derived from cryopreserved eggs are as low as 2% per egg frozen. If the egg provider has a male partner, consideration can be given to fertilising the eggs with his sperm. The generation of embryos in this way would offer the possibility of transfer of the embryos into a surrogate host. Embryo cryostorage is more reliable than egg storage and pregnancy rates of up to 20% per embryo transfer cycle can be anticipated with frozen embryos. Consent of the sperm provider for storage or use of embryos derived from his sperm is obligatory. Surrogacy raises further complex ethical questions, which require the input and expertise of counsellors trained in the field.

## Storage of ovarian tissue

Freezing of ovarian tissue is experimental at present and it is unlikely that this will be available as a clinical service in the near future.

## Changing or withdrawing consent

Any consent relating to the use and storage of gametes or embryos can be changed or withdrawn at any time by the person who gave the original consent as long as the gametes or embryos concerned have not already been used in treatment or research. The right to change or withdraw consent is an important part of effective consent in ensuring that clinics adhere to the wishes of the provider. Any consent for storage that is given to a clinic should include a statement of what should happen to the gametes or embryos in the event that an individual becomes mentally incapacitated or dies.

# Appendix 9 Genital surgery for trans women or certificated women*

There is no level 1 or 2 evidence (Oxford levels) supporting the use of feminising vaginoplasty in women but this is to be expected since a randomised controlled study for this scenario would be impossible to carry out. A useful review of the evidence of the benefits and adverse outcomes of feminising vaginoplasty in female transsexuals is reported by Peter Day. In his report '593 possibly relevant articles in abstract form were identified of which 70 articles were retrieved in full text. Ten studies were selected for appraisal after the application of the inclusion and exclusion criteria. The study designs of the included studies comprised one systematic review, one prospective controlled study, one retrospective cohort study and seven quasi-experimental studies' (Day, 2002: p. 6). He concluded that 'gender reassignment surgery may benefit some carefully assessed and selected transsexual people who have satisfied recognised diagnostic and eligibility criteria, and have received recognised standards of care for surgery. More research is required to improve the evidence base identifying the subgroups of transsexual people most likely to benefit from sex reassignment surgery' (p. 7).

Positive outcomes in the non-controlled studies were reported in areas of cosmetic appearance, sexual functioning, self-esteem, body image, socioeconomic adjustment, family life, relationships, psychological status and satisfaction. However, these 'benefits' were not validated. Significant morbidity can include urethral stenosis or swelling from retained corpus spongiosum, vaginal stenosis or loss of vaginal depth due to necrosis of the penile skin flap, vaginal prolapse, lack of clitoral sensitivity or painful clitoral sensation, necrosis of labial flaps, patient concerns regarding cosmetic outcomes, thromoembolic events including deep venous thrombosis and pulmonary embolism which may be fatal, haemorrhage, and rectal injury requiring faecal diversion (Goddard *et al*, 2007). Rarely, a patient may request reversal of the genitoplasty.

Current retrospective short- and intermediate-term follow-up studies suggest about 80% of patients undergoing feminising vaginoplasty are pleased with the function and cosmetic outcome of their operation (Krege *et al*, 2001; Goddard *et al*, 2007; Tugnet *et al*, 2007). The remainder are pleased that they underwent surgery but report that their pre-operative expectations have not been met with post-operative reality. The majority of these patients may benefit from secondary surgery. It is clear therefore

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that the vast majority of patients, at least in the short and intermediate term, derive important benefits from feminising vaginoplasty at a low risk of serious complications (Krege *et al* 2001; Lawrence, 2003). Other researchers have reported excellent outcomes from feminising vaginoplasty when stringent selection criteria are used and a good surgical result obtained (Green & Fleming, 1990; Eldh *et al*, 1997). However, the long-term surgical, psychological, social and sexual benefits/hazards remain unquantified. As such, it is important to undertake high-quality, multicentre, prospective, long-term studies to determine the risks/benefits of feminising vaginoplasty. Such studies should be restricted to specialist centres with a proven track record in gender reassignment surgery and standardised protocols for patient selection.

# Appendix 10 Genital surgery for trans men or certificated men*

The current options available in the UK are listed below. Patients must be warned that all of the surgeries involve multiple stages, and complications may occur. Consent forms and information sheets, explaining all expected outcomes, including potential complications and risks, must be provided several weeks in advance of surgery.

## Metatoidoplasty

This involves releasing the clitoris and bringing the urethra to its tip, thus forming a micropenis. The scrotum is fashioned and testicular prostheses inserted at a second stage. Patients will be able to stand to void but only 50% will be able to use a male urinal as the microphallus is too small. Otherwise it is a simple one- or two-stage operation, but penetration for sex is usually not possible due to phallus size.

## Total phalloplasty

### *Pubic phalloplasty*

A good-size phallus is fashioned from lower abdominal wall skin that has had laser hair removal prior to the initial operation. Alternatively, patients can use depilatory creams or shave the phallus. The urethra is formed from labial hairless skin in two stages but often the opening is 1–2 in from the tip of the phallus. All scars are low down on the abdomen and below the underpant line.

### *Forearm flap phalloplasty*

The phallus is fashioned from the depilated skin of the forearm with a urethra incorporated within. The vessels and nerves of the forearm skin are divided and joined to vessels and nerves in the genital area. The phallus is sensate, is cosmetically realistic, and the patient can void from the tip of the phallus. The main disadvantage is the unsightly resulting scar on the arm that has been skin-grafted. Once the total phalloplasty has been completed and urethral continuity established, patients are offered testicular and penile prostheses and the formation of a glans. Often hysterectomy and oophorectomy can be performed at the same time as one of the stages, either by open or laparoscopic techniques.

*Written by Mr David Ralph, Royal College of Surgeons.

# Appendix 11 Supplementary reading

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