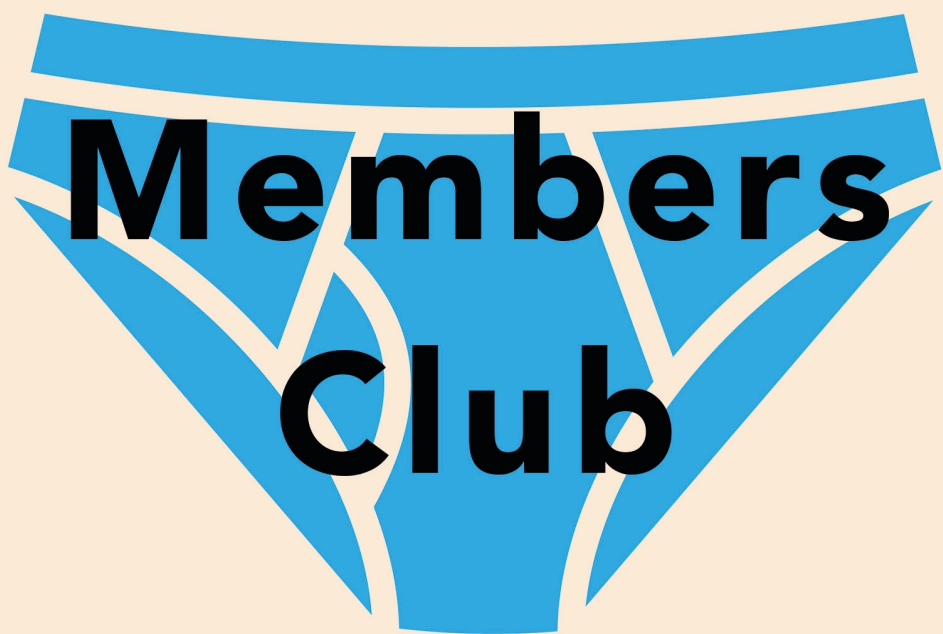


A User's Guide to the Penis



PIET HOEBEKE

GREEN TREE

**A User's Guide
to the Penis**

Members Club

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*I dedicate this book to all my patients who have a penis
that differs from the norm, but who live
a life close to perfection.*

*You prove each and every day that it doesn't matter what
kind of penis you have. The most important thing
is how you live with it.*

I admire you for that.

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Introduction

When I was younger, I actually wanted to be a vet. As a child, I dreamed of helping sick animals, but in the end I chose to train as a doctor. I found animals didn't have much to say.

During my first few years as a medical student, I never could have guessed that I would specialise in the urinary tract and genitalia. A body has so many fascinating organs and structures – the penis didn't immediately stand out as the most interesting part. I knew I wanted to operate on people and that I wanted to be more than your average surgeon. Many surgeons work on behalf of a specialist and don't see the patients again after the surgery. An abdominal surgeon, for example, will often do a lot of treatment for diagnoses already made by the specialist gastroenterologist, and then not be involved with the patient again. That didn't appeal to me. I wanted to diagnose patients and then support them throughout their treatment, from start to finish.

Wanting to do something both surgical and diagnostic left me with relatively few options – you either became a urologist (working on genitalia) or an otorhinolaryngologist (working on mouth, nose and ears). Urology fitted best with my ambitions. It was a wide-reaching field; it not only covered the penis, but also the kidneys and bladder. It even covered cancer.

Armed with much enthusiasm, but no definite career plan, I became a urologist in training at Ghent University Hospital. I followed my interests and by all kinds of chance occurrences, new worlds opened up to me.

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In autumn 1992, the urology department at the hospital was going through a difficult time. I was still in training, but had operated on, or assisted in operations of, barely two hundred patients or so in a year. I felt I had far too little experience to become a specialist urologist, as the Programme Committee required. The then dean and chief physician at the University Hospital knew I was concerned. They advised me to do a year abroad. 'By the time you come back, we'll have sorted things out and you can continue your training position here,' they promised.

I went to the Wilhelmina Children's Hospital in Utrecht in the Netherlands and there I met a remarkable colleague in the

This is how, quite unexpectedly, I performed my first operation on a trans woman.

paediatric urology department, Tom de Jong. He introduced me to the fascinating world of congenital disorders of the urinary tract and sex organs. This is what I specialised in.

A year later, when I returned to Ghent, the dean and chief physician had kept their word – a new department head, Wim Oosterlinck, had taken over the running of the department and things were far better organised. Wim immediately asked me to put paediatric urology on the map in Belgium.

A new wave of serendipity sent me in the direction of transgender patients – people who feel like a man in the body of a woman, or vice versa. Or, from a urologist's perspective, people who don't have a penis but want one, or vice versa.

Professor Guido Matton, a famous name in plastic surgery, was the first to perform the operation to turn a penis into a clitoris in a trans woman in Ghent in 1987. As chance would have it, I was on call, assisting in a prostate resection in a nearby theatre. I was suddenly called to help Professor Matton, who couldn't find the nerve leading to the tip of the penis. I showed the professor what he was looking for and he wouldn't let me leave. This is how, quite unexpectedly, I performed my first

operation on a trans woman. Afterwards, the Professor said to me, 'Right, from now on, you can help me anytime.'

I did transgender surgery from then on, and I've been doing it for 25 years. For the first few years, I operated on trans women, but from 1996 onwards, my patients were mainly trans men – biological women who wanted a male body.

Five years ago, I stopped doing these operations. Something had been bothering me about them for a while. Instead of sleeping, I would lie in bed worrying and didn't know why. During a holiday in Israel with my husband Roberto and our two best friends, overlooking the incredible view of the river valley in Be'er Sheva, we chatted about my sleeplessness and my work. Suddenly, the pieces of the puzzle fitted together.

I treated trans people with heart and soul, but I was weighed down by the number of patients there were and, in particular, the complications which some of them were fighting with. I was a *second victim*, I realised. That is a typical phenomenon for doctors. It starts with trouble sleeping, and if you don't do anything about it, you start to get nightmares, lose your self-confidence and are overcome by severe startle responses. The next stage is burnout.

It was then that I knew I could no longer handle the complications. The patients coming to me were getting younger and younger, and the complications more and more painful. I made a decision: I would stop operating on trans people.

I stuck to that decision for a few years, until I felt I was free from my 'second victim' problem. I have since started treating trans men again, albeit less than before and always together with two colleagues. That takes the pressure off my shoulders.

However, I continued to operate on biological men who, for one reason or another, were born without a penis or who had lost their penis in an accident. For these patients, we make a new penis, and that entails fewer complications than the genital reconstruction required in trans people.

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There is also another kind of procedure that I'm doing less and less, but for a very different reason than my psychological burden. In the course of my career, opinions have changed about some procedures and therefore so has the way in which I go about them. I'm talking about children with both male and female sexual characteristics.

During my year in the Netherlands, I was not only fascinated by paediatric urology, but also by differences in sex development – something we used to call 'intersexuality'. This involves differences in the three levels of sex that someone has. First, there is genetic sex – your DNA says whether you are a male or female. Then, there is gonadal sex – you have testicles or ovaries. Finally, there is external sex – a penis or vulva. The three levels of sex are usually the same in most people, but they can also vary in some people.

For example, someone can have the typical XY chromosomes of a man but look like a woman on the outside, i.e. with a vulva instead of a penis – and with testicles in her abdomen. There are hundreds of variations that deviate from the traditional 'difference' between man and woman. Just thinking about the way in which such deviations occur, and why, was something that always kept me busy.

When I moved back to Ghent from Utrecht, I immediately set up a special group of colleagues to consider the diagnosis and treatment of such conditions. We were the first – and, as yet, still the only – multidisciplinary centre in Belgium fundamentally dealing with children with differences in sex development, and their parents. Simply put, we were dealing with boys who were not developing sufficiently as males or girls who were developing with male characteristics.

Treatment was simple: boys who weren't male enough underwent surgery to strengthen their male characteristics, girls underwent surgery to strengthen their female characteristics.

I use the past tense very consciously here. Our surgical model was heavily based on the dichotomy between male and

female: you were either one or the other and, as a child, it was best to be placed in the right category as soon as possible, if necessary with the help of surgery.

This strict categorisation didn't stand the test of time. There is no longer a wall standing between male and female. We discovered that it is more like a spectrum, a gradual transition. Gender fluidity has become more widespread than the traditional division of male and female, and it is therefore no longer taken for granted that young children should be operated on without them first giving their consent. Just because mummy and daddy want a 'normal' girl or 'normal' boy, it doesn't mean that child should be moulded to their wishes. You never know how such a child will develop, and that is why we now prefer to wait.

My entire professional career pivots around the three core areas that crossed my path by chance: congenital urological and genital disorders, transsexuality and differences in sex development. I saw penises of all shapes and sizes. Some people only felt complete once they finally had a penis between their legs. Others couldn't get rid of theirs quickly enough. Many patients feel miserable because they think their perfectly normal penis is too small. Others feel like the king of the world when their clitoris becomes a micropenis.

The best part isn't when an operation has been successful, but when someone feels you have really helped them. I therefore still love my work.

What continues to interest me is the relationship between the body and how people experience sexuality. For men, there is no escaping the penis. No, men don't think with their penis, but the penis is an extension of the brain more than any other organ. That's not just because of the many neural pathways between the penis and the brain, but also because of the psychology of sexuality and the libido, which all goes on in the brain.

Some find penises nice to look at, others find them ugly. But what always stands true is that the identification of a man is

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largely related to his penis. Even if they have a perfectly normal specimen, men still worry about it. Is it stiff enough? Does it ejaculate enough sperm? Does it turn women off?

Approximately half the world's population has a penis, and the other half regularly make use of one. Some people have a penis and don't want one, others don't have a penis and do want one. Some men get rid of their penis, others think theirs is too small, too bent, too limp or too thin. In very rare cases, they complain that their penis is too long or too wide. Sometimes

Wherever there are people, there are penises, but even though penises exist all over the world, a lot of ignorance still surrounds them.

a penis has an abnormality and we need to operate, other penises are circumcised without any medical need.

Wherever there are people, there are penises, but even though penises exist all over the world, a lot of ignorance

still surrounds them. There are so many myths out there, which means that useful knowledge often doesn't get through. All these myths burden men with frustrations, and I unfortunately have met too many men – young and old – whose quality of life completely diminished because they had a false image of their penis.

What is the penis and why is it what it is? How should you look after that sausage-shaped organ and can you 'train' your penis?

Nearly every man is born with one, but it doesn't come with a user manual. Let's do something about that with this book.

1

And then came the penis

Why do men have a penis?

All men – correction – *nearly* all men, have a penis. But why?

Our distant ancestors didn't have penises at all. When a man met a woman and they wanted to make babies, she laid eggs and he discharged his milt (semen) over them. That wasn't easy, because they lived in water. Our (very) distant ancestors were fish after all and most types of fish still don't have a penis.

One blue moon, some fish had had enough of all that water and they crawled ashore. From those pioneers came amphibians. Amphibians still need water to breed, which explains why frogs don't have a penis either.

When you can only reproduce with enough water nearby, you're not, unfortunately, free to roam the world. So reptiles invented internal fertilisation – the females mimicked the wet conditions of the frog pond inside their bodies. This meant they could be fertilised wherever they wanted, even without any water in sight. All that was needed was for the male to have an organ that would bring his sperm into contact with the eggs inside the female's body.

And thus the penis took to the stage. We are still walking around with that organ today.

As with all other mammals, fertilisation takes place internally in humans and the penis is the instrument with which the

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sperm cells are delivered to the female partner. Once an egg is fertilised, it grows into a foetus in the womb. Without internal fertilisation, men wouldn't have a penis and we would only be able to reproduce by cuddling up in a bath or pond. At least the penis doesn't stop us from still enjoying a nice warm bubble bath!

Birds, the descendants of dinosaurs, have since lost their penis. Only 3 per cent of bird species still have one. In all other species, the male has to press his cloaca (opening for stool, urine and sperm) against the female's to sow his seed. If humans had gone down that route, too, we wouldn't have gynaecologists and urologists today, only *cloacologists*.

The penis initially came about for reproduction, but the chance events of evolution found a sideline for it: it is also used as the body's drainage channel. Ejaculation and urination take place via the same tract, even though sperm and urine have very different biological functions: the purpose of sperm is to find a fertile place, while urine removes waste substances from the body.

For young boys, their penis is mainly a tool for urinating, an attachment for which there is no other conceivable purpose. Only in puberty do they discover that urinating is only one thing you can use a penis for. It is then that they begin to understand why girls don't have one, even though they still urinate.

With the penis serving as a drainage channel, men make good use of it to urinate standing up. However, when you look at the internal plumbing system, you soon see that urinating while standing isn't the intention at all. I'll come back to this later.

Major transformations

You don't just get a penis because you have male genes. Before birth, foetuses have to work hard to become a male – if they don't, they stay female.

And then came the penis

Have no illusions: in the womb, we are all the same to begin with. At the very beginning, there are no differences between male and female genitalia. Both the clitoris and the penis develop from the same structure, the primordial phallus. Then there are the labioscrotal swellings, which either develop into a scrotum or into labia. Every embryo can potentially develop into a human with male or female sex organs.

The difference lies in the chromosomes. Every human has 46 chromosomes, divided into pairs. In a female, the 23rd pair consists of two X chromosomes. A male only has one X chromosome, the second is replaced by a small stump, known as the Y chromosome – the male chromosome.

Both the clitoris and the penis develop from the same structure, the primordial phallus.

I don't want to alarm anyone, but the Y chromosome is the smallest of the chromosomes and it appears to be disappearing somewhat. Male fertility is therefore also in decline. That doesn't necessarily mean that men are going to die out, but nothing is impossible in the process of natural evolution.

So long as the Y chromosome does its work, we will continue to have men and their penises. It is precisely this small Y chromosome that sets a few major transformations into motion, by which an embryo can develop into a male.

The genetic blueprint for the genitalia can differ considerably from man to man, but your penis is probably around the average length of that of your closest relatives. Some families have longer penises on average, others have a shorter average length.

At least, that average length is in principle reached if the blueprint is followed correctly. That can only happen if the right substances are released in the right order. But things can go wrong.

The formation of the female sex organs is largely an automatic process. It happens naturally and no extra effort is required in girls. The phallus remains small in female foetuses and, for the

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most part, in the same place, between the legs. The labioscrotal swellings continue to consist of two separate halves. They become the labia majora, between which you find the vaginal opening.

Making a penis and scrotum from the same structures requires a lot of energy. The fact that you have a blueprint for a penis in your DNA doesn't automatically mean that you'll be born with a penis. Substances are needed to actively stimulate the building work. If that doesn't happen, the blueprints aren't followed, and the sex structures develop in the female way.

The substances that organise the building site of the male genitalia are the sex hormones. They are produced by the sex glands or gonads. In boys, the gonads develop into testicles under the influence of the Y chromosome; in girls, they become the ovaries. The testicles are therefore the building developer of the penis.

In boys, the phallus grows and becomes more prominent, and it holds the urethra within its structure. The labioscrotal swellings fuse together to become a pouch to hold the testicles in, once they are ready to descend from the abdominal cavity. The sex hormones testosterone and its derivative dihydrotestosterone are the drivers behind these transformations.

In addition to major building works, a male foetus also has a whole demolition process ahead. The anti-Müllerian hormone (AMH) is responsible for this. Under the influence of this 'anti-female hormone', the male foetus does away with the primordial female structures that every embryo has and which would otherwise grow into internal female sex organs, such as the vagina, womb and fallopian tubes.

A female foetus doesn't have the energy to waste on drastic renovation works. The primordial female sex organs continue to grow as usual and, in the absence of male hormones, the male structures dissolve spontaneously.

The entire development process of external and internal genitalia is especially complex and things can go wrong at every

stage. The blueprint in the DNA needs to be right, the sex glands need to develop and produce hormones, parts that don't fit need to be got rid of. If things go wrong, this is when we see variations in sex development. This is the field of 'intersex' or 'differences in sex development' – one of my specialist areas as a urologist.

For example, there could be just one error in the DNA's genetic blueprint. Or, the DNA could be perfectly fine, with the correct blueprint for the penis and scrotum, but there is a problem with the hormones. Then the finishing work won't be right. Hormonal problems

can be internal, i.e. caused by the foetus itself. But hormones from the mother or the environment can also throw a spanner in the works. Without

male hormones, the embryonic phallus automatically develops into a clitoris, and labia majora and minora grow, regardless of the DNA blueprint.

Some abnormalities are mild, others are very pronounced. The primordial gonads usually develop into ovaries or testicles, but sometimes you get a combination of both. Some patients have one ovary, half a vagina and half a womb on one side and one testicle with the vas deferens (tube that carries the sperm away) on the other.

We used to call these people 'true hermaphrodites'. That was a dreadful term, but it has been replaced by an equally dreadful one, namely 'a chromosomal ovotesticular disorder of sex development'.

In extreme cases, a genetic girl can be born with a fully developed penis, or a genetic boy can be born with a completely normal-looking female sex organ.

A condition exists where the body doesn't produce any dihydrotestosterone, the potent hormone that ensures men get a penis with a scrotum below. Without this hormone, you

**In extreme cases,
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be born with a fully
developed penis.**