To,

The Chief Executive

NHS England.

**Dear Madam,**

I previously wrote to the Prime Minister of the United Kingdom to express my concerns about certain surgical procedures being performed under the guise of "gender-affirming care" by the NHS and private surgeons in the UK. These procedures include vaginoplasty, phalloplasty, vulvoplasty, and bilateral mastectomies with no surgical indication. My primary concern is that these surgeries fail to provide patients with anatomically and functionally authentic vaginas, penises, or vulvas, nor do they alter a person's sex.

The Prime Minister’s office forwarded my letter to the Department of Health and Social Care (DHSC), which, while not disputing my claims, directed me to raise these issues with NHS England.

Following this guidance, I am addressing this letter to you, focusing specifically on **Phalloplasty**. Attached, you will find a detailed table highlighting why I believe this procedure is inherently **deceptive** and should be **banned** in the UK.

**Phalloplasty**

In my professional opinion, these vulnerable young adolescents and adults are being misled, consenting to the surgery under the false belief that they will be provided with a functional penis. The very name of the procedure, "phalloplasty," seems designed to perpetuate this illusion.

***The introductory statement of the phalloplasty information leaflet that is given by the NHS to young individuals reads:***

**Masculinising genital surgery aims to reduce gender dysphoria by aligning your anatomy with your gender identity and identity expression goals.**

***The leaflet goes on to state the following:***

Intended results and benefits of Phalloplasty

• To reduce gender dysphoria by **aligning** your anatomy with your gender identity

• Ability to achieve **sexual sensation**, however this will depend on the technique used. There is no guarantee of sensation. UK surgeons report 10% of patients have no sensation after two years with radial artery phalloplasty.

• Ability to achieve an **erection**  
• To allow **penetrative sex** (depending on the type of procedure)  
• To allow **standing urination** (depending on the type of procedure)

*In this analysis, I will critically assess the claims made by the NHS and illustrate how they may be misleading.*

1.The misleading assertion of anatomical alignment

The following table compares the anatomical differences between a typical male penis and the skin flap transferred over the pubis, hereafter referred to as "Skin and fat Flap Transfer."

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| --- | --- |
| Normal Male Penis | Skin and Fat Flap mound (phalloplasty result) in a biological female. |
| |  | | --- | | The penis consists of three parallel cylindrical bodies: two dorsally placed corpora cavernosa and a ventrally placed corpus spongiosum. The corpus spongiosum enlarges proximally to form the bulb of the penis and distally as the glans penis.  ***These cylindrical bodies are the building blocks of erectile tissue of penis.*** |  |  | | --- | |  | | |  | | --- | | The skin flap transfer, derived from the forearm or thigh, lacks the anatomical complexity of the penis. It is simply a chunk of skin and subcutaneous tissue, with no bulb or cylindrical structures. No erectile tissues. |  |  | | --- | |  | |
| The skin of penis is delicate, elastic and hairless except at the base. Distally this skin forms a tubular fold called the prepuce.  The penile skin is freely movable over the surface of the penis due to the presence of underlying loose areolar tissue(superficial fascia) | |  | | --- | | The skin flap transfer does not include a prepuce. Instead, it is made from the coarse skin of the forearm, including its natural appendages(hair). This artificial skin flap lacks the mobility of penile skin, as it does not have the underlying loose areolar tissue. |  |  | | --- | |  | |
| The corpus spongiosum encases the urethra and expands distally to form the glans penis, into which the tapered ends of the corpora cavernosa are inserted. The urethra runs through the glans and exits through a vertical slit at its tip. Microscopic examination reveals that both the corpus spongiosum and the glans penis are composed of a fine mesh of erectile tissue encased in a delicate fibrous capsule. Additionally, two arteries run through the entire length of the corpus spongiosum, reaching up to the tip of the glans penis. It is through this structure the urethra passes and the delicate capsule ensures non-collapsability of the urethra when corpus spongiosum fills with blood during erection. | In this man-made skin flap, there is no corpus spongiosum. The skin and fat flap, which is rolled into a sausage-like shape, lacks both the fine mesh of erectile tissue and the delicate fibrous capsule that typically surround the corpus spongiosum. This mound of tissue tends to contract as it heals. As it contracts the artificial passage that is constructed inside as an artificial urethra also tends to contract and narrow down. This leads to stricture formations and poor urinary stream leading to sepsis.Such strictures become long term issues for the patients and the NHS. |
| In the midline, in the urethral surface of glans penis, a free fold of skin passes from tip of glans to the deep aspect of prepuce. This structure is called the frenulum of the prepuce. The frenulum anchors the prepuce to the glans as the intercourse happens. | There is no frenulum nor prepuce in this rolled up skin and fat. |
| The superficial fascia of penis is of loose areolar tissue. | No similar superficial fascia. Hence the skin cannot freely slide in this fat and skin mound. |
| The deep fascia of the penis creates a snug sheath around the corpora cavernosa. This deep fascia prevents spread of infection to deeper planes of the penis and into pelvis. | In contrast, this man-made mound of skin and fat, derived from the forearm or thigh, lacks a comparable deep fascia. The deep fascia remains in the forearm after the procedure.  Hence this mound of tissue is more vulnerable to spread of infection into depth and subsequent sloughing. |
| The suspensory ligament of the penis is a fibroelastic condensation of the deep fascia extending from the abdomen. It fuses with the deep fascia on the dorsum and sides of the penis, serving to anchor the penis in place during sexual activity. | During the metoidioplasty and/or phalloplasty operation to lengthen the virilized clitoris, the equivalent of the suspensory ligament is disrupted. Consequently, the resulting mound of skin and fat lacks this crucial supportive structure. |
| The superficial and deep dorsal veins are situated along the midline dorsally, with the superficial veins lying above and the deep veins below the deep fascia of the penis. The deep dorsal vein of the penis drains directly into the prostatic plexus of veins.  ***This type of surplus venous channels ensures swift return of blood from an erect penis during the resolution phase following intercourse.*** | In this mound of fat and skin, there is no equivalent venous drainage system, such as the prostatic plexus, to handle the venous return. Instead, the venous return must be anastomosed to the femoral vessels via vascular surgery. This connection can fail either immediately or later due to infection, potentially leading to flap necrosis. |
| The deep dorsal vein is flanked by two deep dorsal arteries and nerves, each located on either side. The deep dorsal artery, a direct branch of the internal pudendal artery, and the deep dorsal nerve, a terminal branch of the pudendal nerve, are responsible for transmitting normal touch and proprioceptive sensations.  This ensures plentiful blood supply to the penis. | The structure in question does not contain deep dorsal vessels or deep dorsal nerves. Instead, the surgeon attempts to anastomose the radial vessels with the femoral vessels and to connect the cutaneous touch sensation nerves of the forearm with the ilio-inguinal nerves. The procedure’s leaflet acknowledges a high failure rate of 10%, which is notably concerning. Furthermore, even in successful cases, only touch and pain sensations of the skin are transmitted, not sexual sensations. The blood supply of this skin and fat mound is fully dependent on the integrity and adequacy of the vascular anastomosis. |
| In a normal penis, independent deep arteries supply the three cylindrical erectile structures: the corpora cavernosa and the corpus spongiosum. This robust blood supply significantly reduces the risk of penile necrosis, making it exceptionally rare at any stage of life. | The blood supply to the skin and fat mound transferred from the forearm is entirely dependent on the delicate anastomosis between the radial and femoral arteries. Any technical failure or postoperative thrombosis can quickly lead to occlusion of this blood supply, potentially resulting in flap necrosis. |
| The corpora cavernosa are a pair of cylindrical bodies located on the dorsal aspect of the penis, each comprising a mass of cavernous erectile tissue. They are encased in a dense sheath of white fibrous tissue known as the tunica albuginea. When the erectile tissues fills up rapidly during erection the tough tunica albuginea does not stretch contributing to the hardness and rigidity of a fully erect penis. | The mound of skin and fatty tissue does not contain erectile tissue or a tunica albuginea.  Hence this mound of tissue cannot erect due to lack of the necessary infrastructure. |
| Bulbourethral glands (Cowper’s glands) opens into the bulb of corpus spongiosum just below the urogenital diaphragm.  Cowper’s glands secrete mucus material during intercourse that helps lubricate the penis. | There is no bulbourethral glands (Cowper’s glands). There is no corpus spongiosum with its proximal bulb in the skin and fat mound.  There is no secretion coming from this skin and fat mound that can lubricate the structure. |
| The mucosa of normal penile urethra is pseudostratified columnar epithelium except at the tip of the penis. | A rolled-up "structure" made of skin lacks the mucosal characteristics found in natural tissue. |
| The urethral glands of Littre have their orifices located within the normal male penile urethra. These glands secretes mucus that lubricates the glans penis during sexual intercourse | There are no urethral glands, and therefore, no corresponding orifices. There is no gland to lubricate the vaginal orifice in this man-made structure as it is just a mound of fat and skin. |
| In a normal male penis, the spongy urethra ends in the navicular fossa of the glans penis. Navicular fossa is important for higher flow rate of urine with its wave like shape. | There is no navicular fossa within the external hole in the skin and fat mound. Hence urinary flow will not be like in a young biological male. |
| The vessels and nerves deep to deep fascia plunge into the glans penis. So, there is rich blood supply and nerve supply to the glans penis. Normal male Glans Penis is rich in special receptors to generate sexual sensation. | There is limited blood supply to so called glansplasty. There is poor nerve supply from the neurorrhaphy (anastomosis between ilioinguinal nerve, dorsal clitoral nerve, and the nerves of the forearm flap). There are no special receptors for sexual sensation. Hence this structure (result of glansplasty) of the fat and skin mound, is just a shape (if it is shaped well) and nothing more. |
| There is bulbospongiosus muscle surrounding the bulb of urethra which aid in emptying of urethra at the end of micturition in a biological male. | The "skin and fat flap mound" lacks the bulbospongiosus muscle, so manual assistance/milking is required to help empty urine from this surgically created structure (fat and skin mound). |
| A normal penis is richly supplied with sympathetic and parasympathetic nerve fibers from the pelvic autonomic plexus, which are essential for sexual function. The glans penis contains specialized receptors that are responsible for perceiving sexual sensation. The parasympathetics are responsible for erection and the sympathetics are responsible for emission and ejaculation phase of intercourse. | This mound of skin and flap contains only neurorrhaphied cutaneous nerves, which are responsible for detecting pain, touch, and proprioception but lack the ability to perceive sexual sensation. Additionally, there is no autonomic nerve supply(parasympathetics and sympathetics) to this surgically created structure.  ***Therefore, there is no framework to perceive sexual sensation or achieve a natural erection.*** |

The above descriptive table clearly demonstrates that the surgically created mound of skin and fat lacks any anatomical alignment to the penis that is provided by nature to biological males.

The claim of “achieving an **erection**” with this surgically created structure is misleading: -

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| --- | --- |
| The primary source of sensory nerve signals for initiating a male sexual act is the glans penis. The glans penis is equipped with a highly sensitive sensory end-organ system that transmits signals to the central nervous system, and this specific type of sensation is referred to as “**sexual sensation”**. | ***This surgically created glans-like bulge lacks receptors for sexual sensation.*** Although the skin flap in this man-made structure will have receptors for touch, pain, pressure, and proprioception, these receptors cannot provide sexual sensation as found in the true glans penis of a normal adult biological male. |
| Erection is caused by parasympathetic impulses from the sacral portion of spinal cord and through the pelvic nerves to the penis. | There is no parasympathetic nerve supply from the pelvic nerves to this surgically created structure. Consequently, achieving an erection like that of a biological male is not possible. |
| These parasympathetic nerve fibres to the penis in contrast to most other parasympathetics have an ability to release nitric oxide and/or vasoactive intestinal peptide in addition to the usual acetylcholine. | There is no similar physiology in this man-made structure. |
| The released nitric oxide following sexual stimulation activates the enzyme guanylyl cyclase. | There is no similar physiology in this man-made structure. |
| Guanylyl cyclase causes increased formation of cyclic guanosine monophosphate(cGMP) | There is no similar physiology in this man-made structure. |
| The cGMP especially relaxes the arteries of the penis and the trabecular network of smooth muscle fibres in the erectile tissue of corpora cavernosa and corpus spongiosum in the shaft of the penis. | In this surgical procedure involving the transfer of fat and skin flaps from the forearm, there are no specialized parasympathetic nerves, no nitric oxide mediators, no guanylate cyclase enzymes, no cGMP production, and no smooth muscle fibers that are normally found in the erectile tissues of the corpora cavernosa and corpora spongiosa of a biological male. Hence erection is impossible. |
| As the vascular smooth muscles relax blood flow into the penis increases, causing further release of nitric oxide from the vascular endothelium and leads to further vasodilatation. | No such physiology exists in the man-made skin and fat flap. |
| The erectile bodies especially the corpora cavernosa are surrounded by strong fibrous coverings (Tunica Albuginea). Therefore, high pressure within the sinusoids due to arterial relaxation causes ballooning of the erectile tissue to such an extent the penis becomes hard and elongated, a phenomenon called ERECTION. | This man-made structure has no erectile tissue containing corpora cavernosa, no specialised pelvic parasympathetics, no nitric oxide release, no guanylyl cyclase enzyme, no cGMP generation, no smooth muscle and arterial relaxation, no tunica albuginea and hence NO phenomenon called ERECTION. |
| Parasympathetic innervation contributes to lubrication during intercourse by stimulating the urethral gland and bulbourethral glands to secrete mucus. Without satisfactory lubrication male sexual act is seldom successful. | No pelvic parasympathetic innervation to this skin and fatty mound. The skin roll that is made to take urine to the exterior has no urethral glands or bulbourethral glands to secrete mucus during intercourse. |
| Emission and ejaculation are the culmination of male sexual act. They are the function of sympathetic nerves that leave the spinal cord at T12 to L2 and pass to the penis through the pelvic autonomic plexus. | This surgically constructed flap of skin and fat lacks sympathetic innervation from the pelvic autonomic plexus. Without prostatic secretions, seminal vesicles, functional testes, or a bulbospongiosus muscle, the emission and ejaculation phases cannot occur. |

From the above table it is obvious that the “skin and fat mound” which these surgeons create after destroying an anatomically and physiologically perfect normal female genitalia can never achieve a natural phenomenon of ERECTION. **Hence in my opinion, giving false hopes of erection to a vulnerable population is very misleading and deceiving.**

Misleading claim of achieving penetrative sex by the NHS leaflet: -

The claim that phalloplasty enables penetrative sex is **misleading**. True penetrative sex requires a functional erection in the penis, followed by the natural phases of emission and ejaculation. Without these physiological processes, authentic penetrative intercourse cannot be achieved.

For emission and ejaculation to occur, a functioning prostate, seminal vesicles, and vas deferens, along with their autonomic sympathetic innervation, are essential. Additionally, specialized receptors in the glans are crucial for sexual sensation. The 'skin and fat flap mound,' often referred to as the neophallus, lacks these specialized receptors for sexual sensation, as well as the necessary structures like the prostate, seminal vesicles, and vas deferens. The **absence of sympathetic innervation** further impedes emission and ejaculation. Therefore, claims of achieving functional penetrative sex is fundamentally **misleading and in my opinion a deception.**

The Phalloplasty leaflet given out from NHS mentions as follows under the heading “intended results and benefits of phalloplasty:

• Ability to achieve **sexual sensation**, however this will depend on the technique used. There is no guarantee of sensation. UK surgeons report 10% of patients have no sensation after two years with radial artery phalloplasty.

Performing such a radical operation without a guaranteed outcome of sexual sensation is unacceptable.

Under the heading Radial artery urethroplasty the leaflet says the following:

• A potential side effect of the surgery is that because there is a nerve supply to the neourethra, in 50% of cases, there may be some sensation to the tip of the phallus after this surgery.

This can mislead the unsuspecting adolescent in to thinking that there is a viable nerve supply when it means that 50% may not have sensation at all. These cutaneous nerves are not connected to any specialised receptors that give sexual sensation.

The patient will not have sexual sensation due to the following reasons.

1. There are no sensory end organ receptor systems in the skin and fat flap mound similar to the receptors in a true glans penis. Hence no sexual sensation is perceivable.
2. The glans clitoris is relocated in front of pubis and buried under the “skin and fat flap mound”. Hence there will be no access for foreplay in a sexual activity.
3. The vestibular tissue is dissected and utilized to form the neourethral membranous lining. As a result, the specialized receptors for sexual sensation within the vestibules are likely disrupted, along with their autonomic nerve supply.

Hence, I conclude that assurance of achieving sexual sensation in the neophallus (skin and fat flap mound) is misleading the young person.

Final Thoughts:

The operation irreversibly destroys the individual's natural female anatomy, leaving no possibility of restoration in case of regret, which is not uncommon among patients undergoing these procedures.

NHS England must fulfil its responsibility to stop these surgeries being performed on healthy female adolescents and young adults who do not have any underlying physical illness.

Yours Sincerely,

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