Intersex Genital Mutilations

Medically Not Necessary, Irreversible Cosmetic Genital Surgeries On Children With Atypical Sex Anatomy

Documentation: History & Current Practice

Zwischengeschlecht.org

„Human Rights For Hermaphrodites Too!“

http://stop.genitalmutilation.org

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Intersex Genital Mutilations
I. Current Practices
(Most frequent only, in order of frequency)

Introduction

Despite assertions by doctors in the media, medically not necessary, irreversible cosmetic surgeries on children with atypical sex anatomies are still rampant. On the other hand, doctors and hospitals are usually hesitant to disclose actual numbers, or blatantly lie by shamelessly manipulating their numbers resp. minimising them, only counting a small fraction of actual cosmetic treatments.

Example 1: When Dr. Laurence Baskin (Department of Urology, University of California, San Francisco UCSF) testified before the San Francisco Human Rights Commission (SFHRC) in 2005, he claimed:

"normally UCSF performs one 'intersex' surgery annually".

However, research of the Commission at UCSF revealed:

"GRAND TOTAL: ***From 2000 through 2003, doctors at UCSF performed 315 genital surgeries on children with ages from 1 day to 17 years:***

- *241 procedures were performed on children under 2 years of age*
- *164 patients were under 1 year of age."*

Source: Human Rights Commission Of The City & County Of San Francisco: *A Human Rights Investigation Into The Medical "Normalization" Of Intersex People*, 2005, p. 50-53

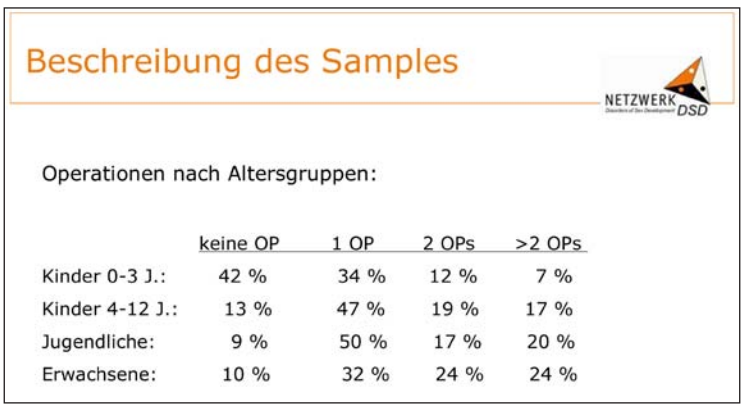
Example 2: In 2012, at the 23rd Annual Meeting of the European Society for Paediatric Urology (ESPU), a presentation *"Changes In Urologist DSD Treatment"* of a survey among members of the Society of Pediatric Urology (USA) boasted: ***"Pediatric urologists increasingly recommended postponing surgery so that adolescents could choose whether to undergo surgery"***.

However, the actual numbers revealed that in 2011, even in *"mild-moderate"* cases of "enlarged clitoris" **only 10.5% of urologists would *"now recommend letting the adolescent patient decide"***. On the other hand, with PAIS ***"79% now recommended surgery between 6 and 12 months"*** (as compared to between 0-6 months in 2003).

Source: Kogan, Sandberg et.al.: "Changes in Urologist DSD Treatment Recommendations From 2003 to 2011", in: *23rd Annual Meeting of ESPU: Abstract Book*, Zurich 2012, p. 314

Example 3: The German "Lübeck Intersex Study" with 439 participants is the most comprehensive evaluation study worldwide, and was only commissioned after a decade of political pressure by survivors. Typically, the official publications are scarce when it comes to actual numbers of surgeries. The most comprehensive statistics were given during a presentation at the Bundestag in Berlin (see slide below): **Of infants 0-3 years, 58% had at least one surgery – children age 4-12, youths and adults, about 90% had at least one surgery**!

Source: Martina Jürgensen: "Klinische Evaluationsstudie im Netzwerk DSD/Intersexualität: Zentrale Ergebnisse", Presentation 27.05.2009, slide 6



Beschreibung des Samples

NETZWERK DSD

Operationen nach Altersgruppen:

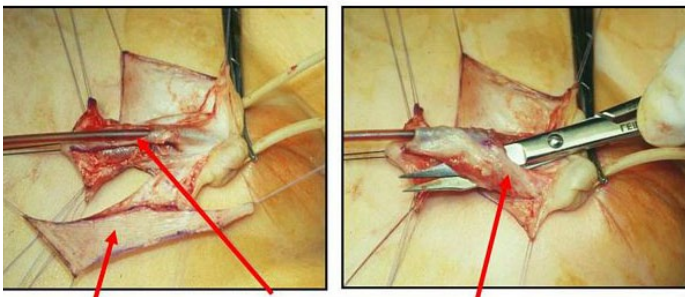
	keine OP	1 OP	2 OPs	>2 OPs
Kinder 0-3 J.:	42 %	34 %	12 %	7 %
Kinder 4-12 J.:	13 %	47 %	19 %	17 %
Jugendliche:	9 %	50 %	17 %	20 %
Erwachsene:	10 %	32 %	24 %	24 %

1. "Hypospadias Repair" a.k.a. "Masculinising Surgeries"

„Hypospadias", i.e. when the urinary meatus is not on the tip of the penis, but somewhere between the tip and the scrotum, is arguably the most prevalent diagnosis for cosmetic genital surgeries. Procedures include dissection of the penis to „relocate" the urinary meatus. Very high complication rates, as well as repeated *„redo procedures"—„5.8 operations (mean) along their lifes … and still most of them are not satisfied with results!"*.

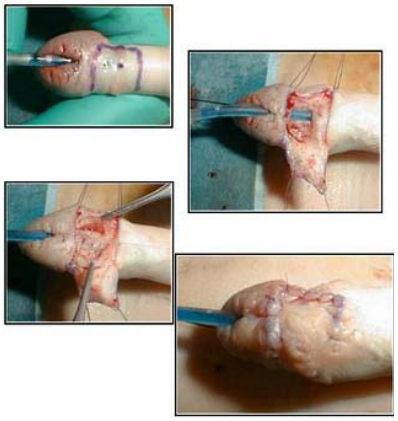
Nonetheless, clinicians recommend these surgeries without medical need explicitly *„for psychological and aesthetic reasons."* Most hospitals advise early surgeries, usually *„between 12 and 24 months of age"*. While survivors criticise a.o. decrease or total loss of sexual sensation and painful scars, doctors still fail to provide any evidence of benefit for the recipients of the surgeries.

Onlay island flap urethroplasty



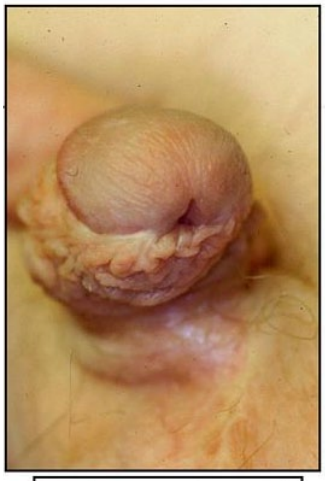
Treatment of isolated fistulæ

- Rectangular skin incision around the fistula orifice, often lateral
- Dissection and excision of the fistula tract
- Urethral suture
- Multilayer cover with well-vascularized tissue (tunica vaginalis, dartos, dorsal subcutaneous flap …)
- Problem: coronal fistula +++: Prefer redo urethroplasty
- Suprapubic diversion ? Elbakry

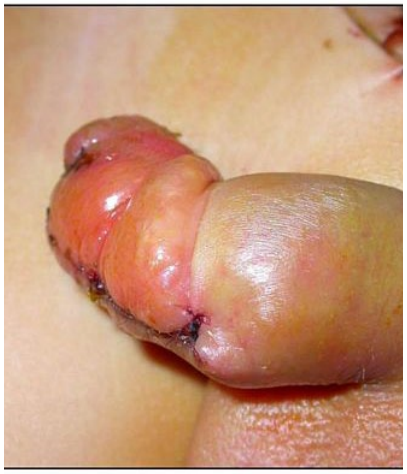


Onlay / Duckett - results

- Elbakry (BJUI 88: 590-595, 2001): 42% complications
  - 5 breakdowns (7%)
  - 17 fistulæ (23%)
  - Urethral strictures (9%)
  - Urethral diverticulæ (4%)
- Asopa / Duckett tube
  - 3.7% (El-Kasaby J Urol 136: 643-644, 1986)
  - 69% (Parsons BJU 25: 186-188, 1984)
  - 15% (Duckett - 1986)



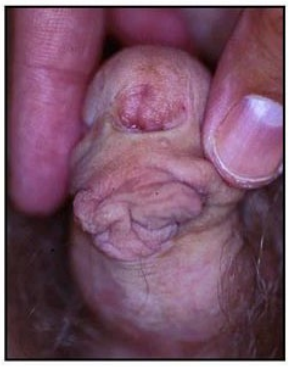
Bad cosmetic result



infection

Hypospadias - Procedures for cripple hypospadias

- No standardized procedures
- Personal experience of the surgeon
- Importance of a uro-endocrine approach of complex cases to increase the healing abilities of the penile tissues



Official Diagnosis „Hypospadias Cripple"
= made a cripple by repeat cosmetic surgeries

Hypospadias - Conclusions

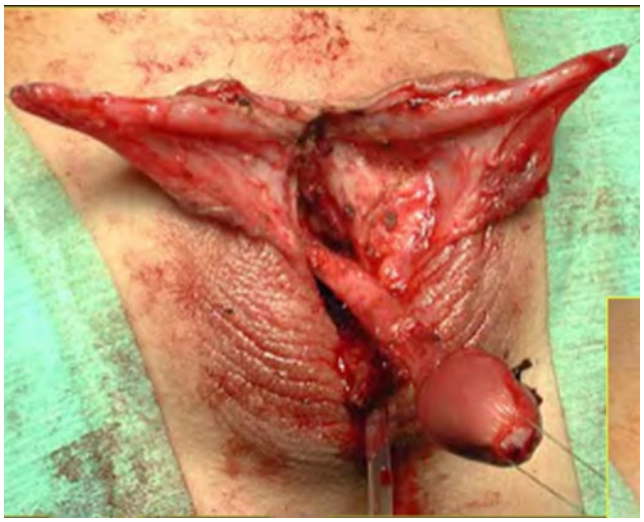
- Hypospadias surgery remains a surgical challenge
- Long-term results are poorly reported
- Essential joint uro-endocrine approach
- Psychological consequences poorly assessed
- Informing parents is crucial: 50% of all hypospadias will require further surgical attention during their life.
- Research: Essential role of the placenta / Penile growth factors / healing factors / blood supply …

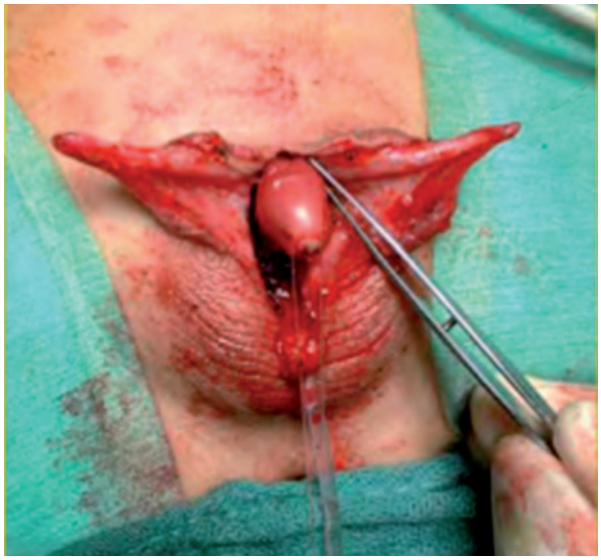
Source: Pierre Mouriquand: „Surgery of Hypospadias in 2006 - Techniques & outcomes"

2. “Clitoral Reduction” resp. “Recession”; “Vaginoplasty”

(Partial) amputation of clitoris, often in combination with surgically opening or widening of the vagina. „Congenital Adrenal Hyperplasia (CAH)“ is probably the second most prevalent diagnosis for cosmetic genital surgeries, and the most common for this type (further diagnoses include „Partial Androgen Insufficiency Syndrome (PAIS)“ and „Leydig Cell Hypoplasia“).

Despite numerous findings of loss of sexual sensation caused by these cosmetic surgeries and lacking evidence, current guidelines nonetheless advise surgeries *„in the first 2 years of life“, most commonly „between 6 and 12 months“,* and only 10.5% of surgeons recommend letting the persons concerned decide themselves later.





Source: Christian Radmayr: *Molekulare Grundlagen und Diagnostik des Intersex*, 2004

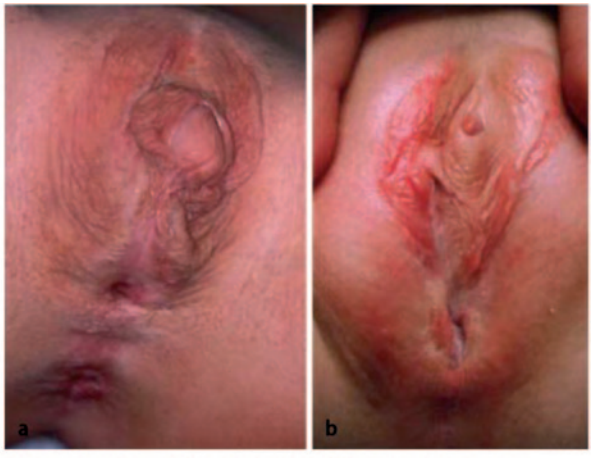
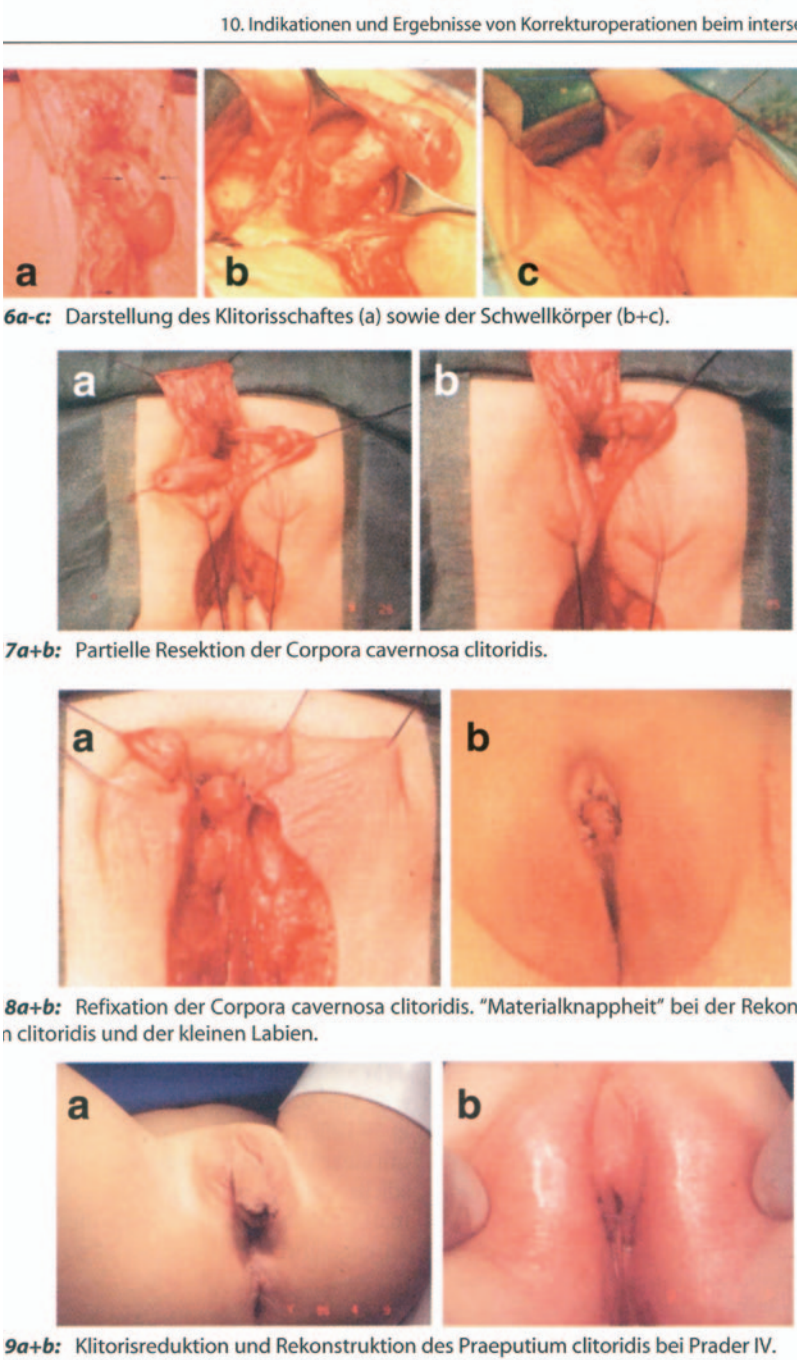


Abb. 2 ▲ a, b Schlechte Korrekturergebnisse nach Feminisierung



6a-c: Darstellung des Klitorisschaftes (a) sowie der Schwellkörper (b+c).

7a+b: Partielle Resektion der Corpora cavernosa clitoridis.

8a+b: Refixation der Corpora cavernosa clitoridis. “Materialknappheit” bei der Rekon
n clitoridis und der kleinen Labien.

9a+b: Klitorisreduktion und Rekonstruktion des Praeputium clitoridis bei Prader IV.

Source: Finke/Höhne: *Intersexualität bei Kindern*, Bremen 2008
Note Caption 8b: ***„‚Material Shortage‘ [of skin] while reconstructing a Praeputium Clitoridis and the inner labia“***

Bottom Left - Source: M. Westenfelder: „Medizinische und juristische Aspekte zur Behandlung intersexueller Differenzierungsstörungen“, *Der Urologe* 5 / 2011 · p. 593–599
Caption 2a,b: ***„Bad Results of Correction after Feminisation“***

3. Castration / "Gonadectomy" / (Secondary) Sterilisation

Removal of healthy testicles, ovaries or ovotestes potentially, and other potentially fertile reproductive organs. „Complete Androgen Insufficiency Syndrome (CAIS)" is arguably the 3rd most common diagnosis for cosmetic genital surgeries, other diagnoses include „Partial Androgen Insufficiency Syndrome (PAIS)", or male-assigned persons with „XX-Congenital Adrenal Hyperplasia (CAH)", who have their healthy ovaries and uteruses removed, or persons with ovotestes.

Castrations usually take place under the pretext of an allegedly blanket high risk of cancer, despite that an actual high risk which would justify immediate removal exists only in specific cases (see table below), and the true reason is „better manageability". Although in many cases persons concerned have no or limited fertility, the gonads by themselves are usually healthy and important hormone-producing organs.

Nonetheless, clinicians still recommend early gonadectomies – despite all the known negative effects of castration, a.o. depression, obesity, metabolic and circulatory troubles, osteoporosis, reduction of cognitive abilities, loss of libido. Plus a resulting lifelong dependency on artificial hormones (and adequate hormones are often not covered by health insurance, but have to be paid for by the survivors out of their own purse).

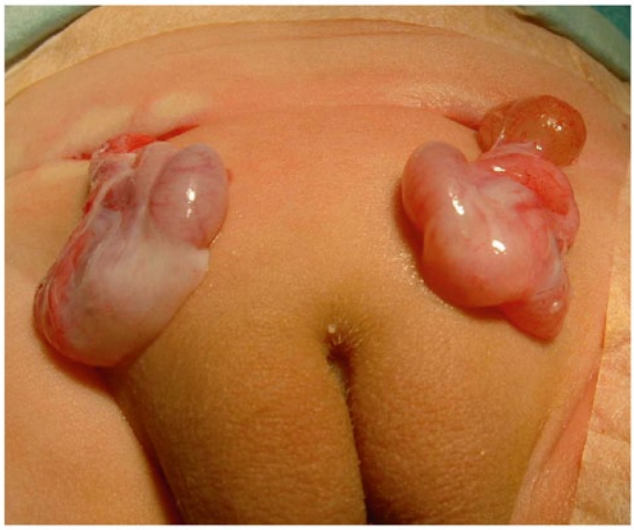


Fig. 91.6 An inguinal approach for gonadectomy in a CAIS patient with two palpable gonads

Source: Maria Marcela Bailez: „Intersex Disorders", in: P. Puri and M. Höllwarth (eds.), *Pediatric Surgery: Diagnosis and Management*, Berlin Heidelberg 2009

Table 1. Prevalence of type II GCT in various forms of DSD

Risk	Type of DSD	Prevalence %
High	GD in general	12*
	46,XY GD	30
	Frasier syndrome	60
	Denys-Drash syndrome	40
	45,X/46,XY GD	15–40
Intermediate	PAIS	15
	17β-hydroxysteroid dehydrogenase deficiency	17
Low	CAIS	0.8
	Ovotesticular DSD	2.6
Unknown	5α-reductase deficiency	?
	Leydig cell hypoplasia	?

GD = Gonadal dysgenesis; PAIS = partial androgen insensitivity syndrome; CAIS = complete androgen insensitivity syndrome.
* Might reach more than 30%, if gonadectomy has not been performed.

Source: J. Pleskacova, R. Hersmus, J. Wolter Oosterhuis, B.A. Setyawati, S.M. Faradz, Martine Cools, Katja P. Wolffenbuttel, J. Lebl, Stenvert L.S. Drop, Leendert H.J. Looijenga: „Tumor risk in disorders of sex development", in: *Sexual Development* 2010 Sep;4(4-5):259-69. Epub 2010 Jun 17.

Intersex Genital Mutilations
II. Historical Examples

1763: Call for early "Cutting" of "perversely enlarged" Clitorises

Upon the examination of a hermaphrodite, the Silesian-German Doctor Gottfried Heinrich Burghart (1705-1776) generally suggested amputation of „too big" clitorises as soon as possible during *"childhood or youth"*, arguing no significant *„blood vessels or nerve branches to be feared"*.

Source: Gottfried Heinrich Burghart: *Gründliche Nachricht an seinen Freund *** von einem neuerlich gesehenen Hermaphroditen*, Breslau/Leipzig 1763, p. 18

19th Century: Clitoris Amputations prevalent in Western Medicine as "Cure" for a) Masturbation, b) Hysteria, and c) "enlarged Clitoris"

Many prominent doctors in Europa and North America propagated and perpetrated clitoris amputations on young girls, a.o. Carl Ferdinand von Graefe (1787-1840), James Marion Sims, "The Father of Gynecology" (1813-1883), Isaac Baker Brown (1811–1873) and Gustav Braun (1829-1911). **While amputations motivated by a) and b) attracted mounting criticism and eventually had been abandoned between 1900 and 1945, amputations of "enlarged clitorises" took a sharp rise after 1950 and became de facto medical standard on newborns in the 1960s**, partly in combination with castrations / gonadectomies (see below).

1900: End of legal Self-Determination for Hermaphrodites in Europe

From the canonical law of the middle ages up until the Allgemeines Preussisches Landrecht (1798-1900), European hermaphrodites were mostly privileged by being specifically allowed to choose their legal sex when becoming adults, possibly overthrowing the earlier decision granted to their parents. After 1900, medical doctors officially became the sole new legal "experts", "determining" the sex of "dubious cases" by performing "exploratory" surgeries to assess the gonads. Only in the very rare cases when they found ovaries and testicles or a mixture of both tissues ("ovotestes"), a specimen was considered a "true hermaphrodite". All others were classified male or female "pseudo hermaphrodites", notwithstanding their physical appearance and self-identification.

le extirpó, y presentaba en su base, bien manifiesto el surco determinado por las gomas constrictoras (dato suministrado por la historia clínica del Hospital Alvear, fotografía n.º 111).

Fotografía n.º 111.

He tenido oportunidad, posteriormente, de examinar la pieza anatómica extirpada.

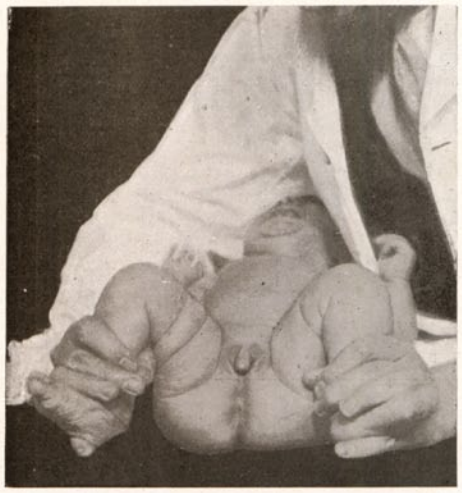
Fotografía n.º 112.

Fotografía n.º 112'.

El aspecto de ese clítoris es de un pene de tamaño semejante al que corresponde a un joven de catorce o quince años. Está constituído por un glande

quizá un poco exagerado, está cubierto por prepucio por su parte dorsal en casi toda su longitud. En su extremo anterior, termina por un glande, con su correspondiente surco balano-prepucial. Este glande es imperforado. Por debajo falta el prepucio y la uretra, existiendo sólo un débil surco en parte mucoso y en parte cutáneo. Detrás de la base de implantación de este miembro y vecino al periné, semioculto por un repliegue cutáneo, se advierte un orificio por donde sale orina, y por donde, introduciendo un estilete, se llega a una cavidad que, por su situación, debe ser la vejiga. Las bolsas escrotales no existen. En los repliegues cutáneos laterales, no se palpan glándulas sexuales, como tampoco en las regiones inguinales. No hay pelos en la piel del pubis.

Fuera de las deformidades de la esfera genital, muchas de las cuales se



Fotografía n.º 11.

ven en la fotografía, el niño presenta, por el resto, una buena constitución. Su estado general era muy bueno y se encontraba en perfectas condiciones de nutrición.

Habiéndose hecho el diagnóstico de hipospadia y teniendo en cuenta la corta edad del paciente así como la ausencia completa de trastornos funcionales, se resolvió esperar a que el niño cumpliera cuatro años de edad, para, entonces, someterlo a una intervención quirúrgica destinada a corregir su hipospadia.

Es cuando el niño cumplió cuatro años de edad, que fué traído nuevamente al Hospital, levantándosele el estado actual que a continuación exponemos. Fué, entonces, también, que se obtuvieron las fotografías números 13 y 14.

Niño en buen estado general y en regular estado de nutrición. Coloración normal de la piel y las mucosas. Buena constitución esquelética. Fuera de la anomalía existente en su aparato genital, no presenta ninguna otra deformidad aparente.

Examinado desnudo, llama inmediatamente la atención el insólito des-

Buenos Aires 1925: Medical Display, “Trophy Shots”, and Cosmetic Genital Sugeries on Children

Las deformidades de la sexualidad humana by Carlos Lagos García (1880-1928) is arguably the first modern medical book dedicated exclusively to “genital abnormalities” and their surgical “cure”. It was highly influential both in Europe and the Americas, pioneering forcible medical display, “trophy shots” of amputated healthy genitals and reproductive organs, and advocating cosmetic surgeries on little children, both “feminising” and “masculinising” – expressly without actual medical necessity, but as “correction” for “anomalies”.

Source: Carlos Lagos García: *Las deformidades de la sexualidad humana.* Buenos Aires, 1925, p. 438, 262.

Young to investigate the pelvic generative organs. It was decided to carry out the laparotomy through the inner edge of the right rectus muscle. A testicle was discovered on the left side, with a definite vas; also a Fallopian tube leading to an undeveloped uterus behind the bladder; and a Fallopian tube also on the right side, but no gonad. The conditions found are shown in the

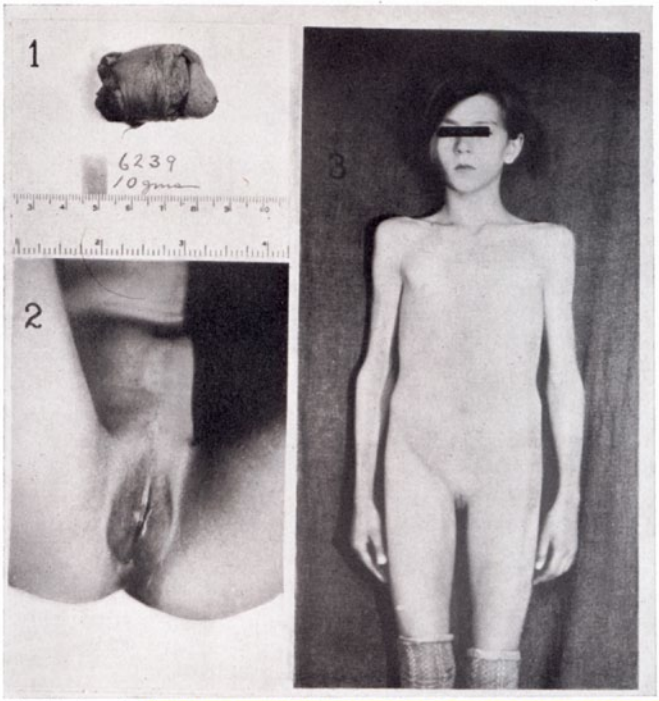


FIG. 63. Case 5. Age 9 years. *1*, Phallus supposed to be hypertrophied clitoris; *2* and *3*, condition after amputation. Note undeveloped labia majora. BUI 14127.

accompanying illustrations (fig. 65) by Mr. Didusch. Low down behind the bladder was a uterus about 1½ cm. wide, perhaps 1 cm. thick, and Fallopian tubes, which extended outward and backward (fig. 65, *2*). On the right side there was a scar (previous removal of the supposed ovary; found microscopically to be a gland). On the left side the tube ran backward, ended in a fimbriated end and partly encircled an ovoid body about 4 cm. long, 2½ cm. wide

and 1½ cm. thick, which was covered by smooth mucous membrane, rather firm, with no evidence of ovulation, which looked like a testicle (fig. 65, *3*). Posterior to this was a mesentery in which the vas deferens could be palpated for a short distance, and then disappeared in the deep tissues at the pelvic brim. This could not be followed downwards toward the urethra nor upwards.

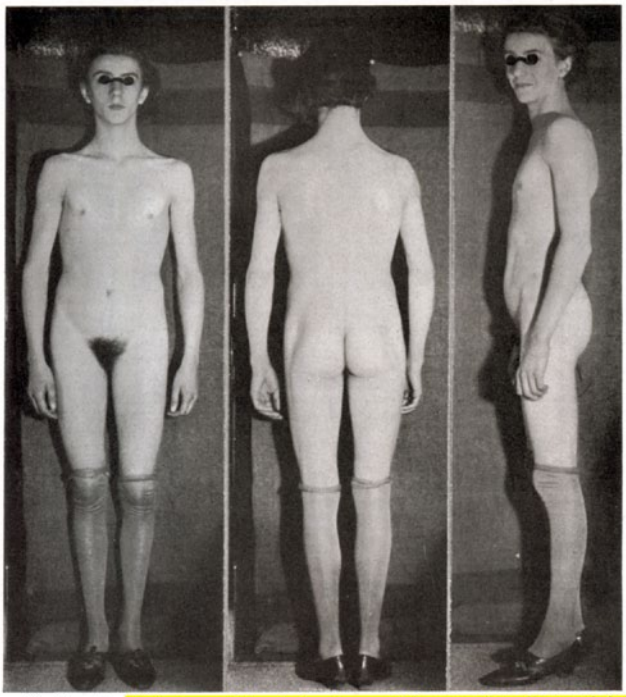


FIG. 64. Case 5. Patient, aged 15, raised as boy until 7 years; then diagnosed female. Phallus amputated; put in girl's clothes. At age of 16, operation for inguinal hernia, supposed ovary found to be testicle. Patient put back in male attire. BUI 14127.

No epididymis could be made out. The tip of the sex gland was excised and showed normal looking testicular tissue (fig. 65, *4*). After a long discussion, it was decided that, as the penis had been excised 6 years before, it would be best to excise the testicle with as much as possible of its mesentery containing the supposed vas deferens, and also a large part of the Fallopian tube. This was accordingly done (fig. 65, *5*). The peritoneal surfaces were then drawn

Baltimore 1937: Haphazard Decisions, more "Trophy Shots", and Step by Step "Genital Corrections" for every possible Occasion

Hugh Hampton Young (1870-1945), "The Father of American Urology", also pioneered Intersex Genital Mutilations at the Johns Hopkins University Hospital in Baltimore – a fact nowadays often "neglected" in official hagiographies, despite that Young's disturbing textbook *"Genital Abnormalities, Hermaphroditism, and Related Adrenal Diseases"* was considered a breakthrough by his colleagues and was received globally. It even saw not only one, but two updated revisions edited by Young's successors Howard W. Jones and William Wallace Scott in 1958 and 1971 under the only slightly modified title *"Hermaphroditism, Genital Abnormalies, and Related Endocrine Disorders"*, and still containing many of Young's original step by step illustrated tutorials e.g. of *"Plastic operations to construct a vagina and amputate hypertrophied clitoris"*, or how to otherwise freely "cut up and re-assemble" so called *"Genital Abnormalities"*. Even the Fig. 64 above right showing the ruthlessly and tragically mutilated young person *"Case 5 / BUI 14127"* appeared again in Jones' and Scott's editions, although erroneously attributed to another *"Case"*. For the 1958 edition, Young's colleague at Johns Hopkins and the "inventor" of systematic cosmetic genital surgeries on children, Lawson Wilkins, contributed a foreword, praising Young's original 1937 edition as a *"classic"*.

Sources: Hugh Hampton Young: *Genital Abnormalities, Hermaphroditism, and Related Adrenal Diseases.* Baltimore, 1937, p. 88-89.

Se manifesteront-elles dans le sens féminin : on peut alors se demander si des érections survenant dans la verge enlisée ne seront pas cause de gêne, peut-être même de douleur. Il sera toujours temps, à ce moment, d'amputer en totalité le membre à forme virile, si la femme avertie ne tient pas à conserver la sensibilité balanique.

Mais au moins, chez la fillette impubère que nous considérons, l'avenir n'est pas irrémédiablement orienté.

Ceci dit, nous apporterons nos observations personnelles concernant des fillettes à grande verge.

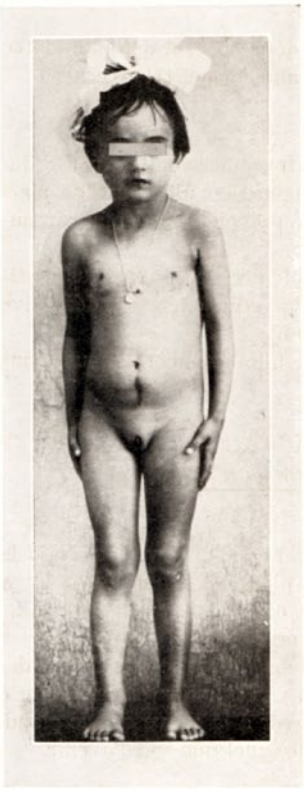


Fig. 56. — Cecilia M... (observation XII). (Alberto Lagos Garcia.)

Observation personnelle XII. — Bilan féminin après laparotomie. Amputation du clitoris. — Le Dr Alberto Lagos Garcia, frère du regretté chirurgien que nous avons si souvent cité, nous a envoyé en espagnol l'observation que nous résumons ici.

Cécilia M... est une fillette de trois ans (fig. 56). Clitoris de 2 centimètres (fig. 57), avec un orifice unique ouvert au-dessous de lui. Aucune glande n'est perceptible dans les bourrelets génitaux.

Laparotomie exploratrice : utérus atrophique, deux ovaires et deux trompes.

On enlève l'ovaire gauche pour examen histologique ; le laboratoire a répondu : ovaire.

Six mois après, incision qui sépare les deux bourrelets coalescents. Grâce à elle, on découvre deux conduits distincts, un antérieur, l'urètre, et un postérieur, qui est un vagin de 5 centimètres de profondeur et qui admet une sonde. Les bords de l'incision sont soigneusement ourlés.

Résection partielle du clitoris hypertrophique (fig. 58). Suites très simples. Il faudra procéder à des dilatations de son vagin.

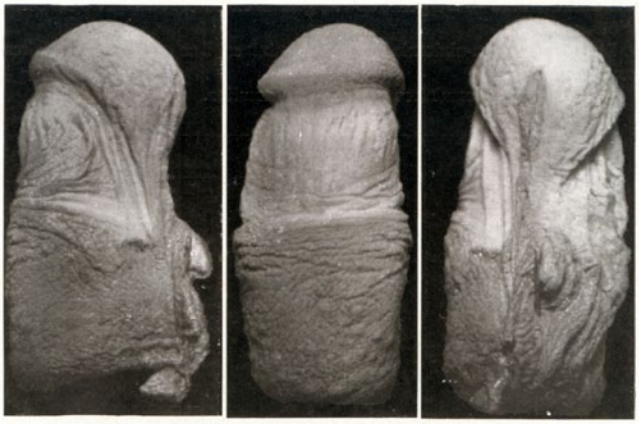


Fig. 93. — Le clitoris de Marguerite, après amputation (observation XX).

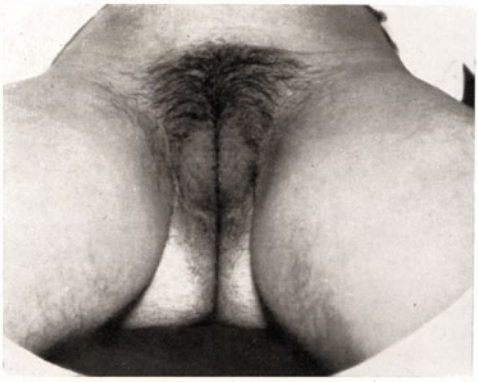


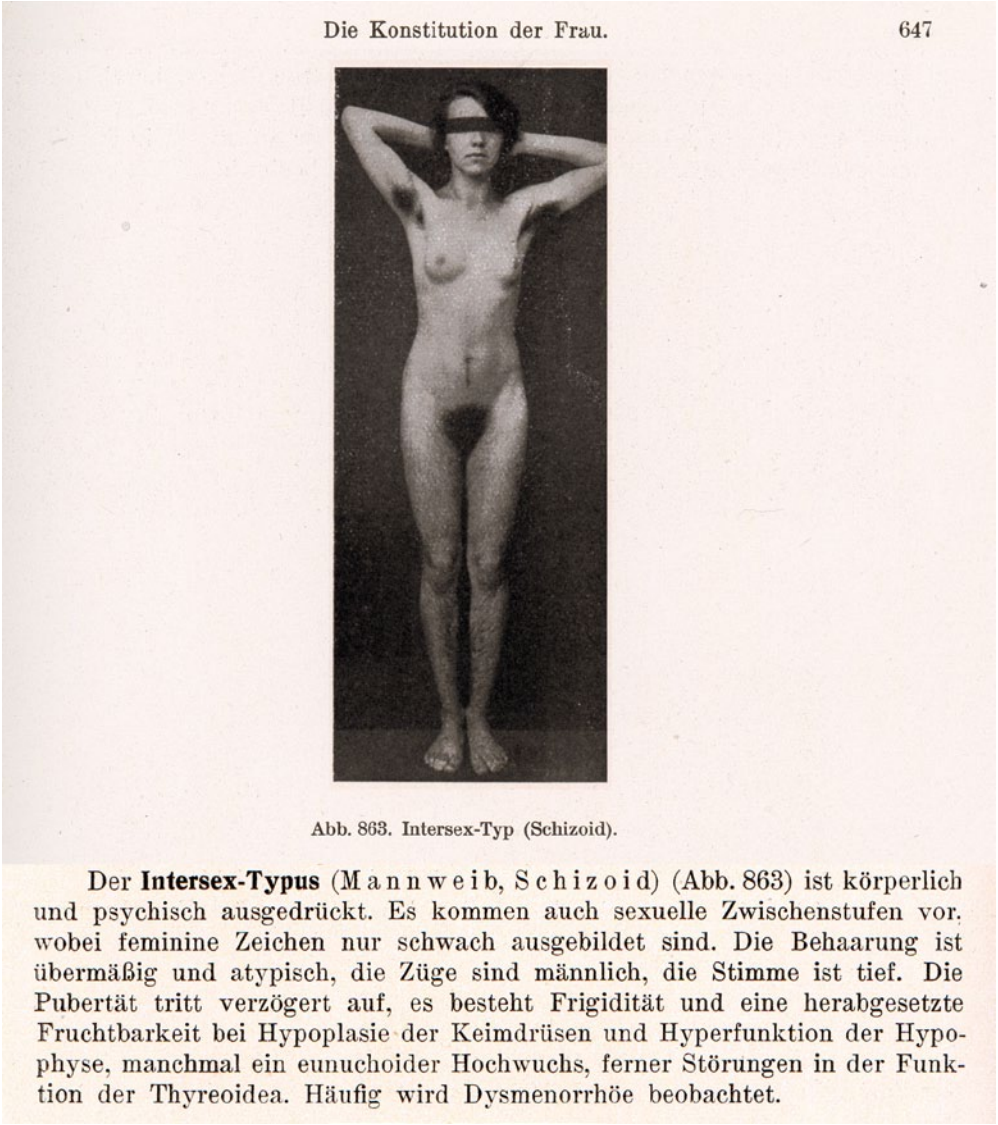
Fig. 94. — Aspect de la région génitale de Marguerite un mois après la dernière opération (observation XX).

Observation personnelle XXI. — Organes a forme masculine. Fonctions féminines. Ablation de la verge et des glandes. — Hortense F... est née le 26 décembre 1907, à Bathincourt (Belgique); elle a donc trente ans. Déclarée fille à sa naissance.

Paris 1939: "Embarrassing Erections", yet more "Trophy Shots", and even younger Children submitted to Cosmetic Genital Surgeries

Louis Ombrédanne (1871-1956) set the standard for "Hypospadias Repairs" a.k.a. "masculinising corrections" for more than 50 years, as well as for medical musings about allegedly *"embarrassing and maybe even painful erections"* of *"enlarged clitorises"* (note how he's talking to himself, NOT to his patients). Ombrédanne's book titled *"Hermaphrodites and Surgery"* drew heavily on Carlos Lagos García, and was received internationally from Zurich to Baltimore and beyond.

Sources: Louis Ombrédanne: *Les Hermaphrodites et la Chirurgie.* Paris, 1939, p. 248, 284.



Die Konstitution der Frau. 647

Abb. 863. Intersex-Typ (Schizoid).

Der **Intersex-Typus** (Mannweib, Schizoid) (Abb. 863) ist körperlich und psychisch ausgedrückt. Es kommen auch sexuelle Zwischenstufen vor, wobei feminine Zeichen nur schwach ausgebildet sind. Die Behaarung ist übermäßig und atypisch, die Züge sind männlich, die Stimme ist tief. Die Pubertät tritt verzögert auf, es besteht Frigidität und eine herabgesetzte Fruchtbarkeit bei Hypoplasie der Keimdrüsen und Hyperfunktion der Hypophyse, manchmal ein eunuchoider Hochwuchs, ferner Störungen in der Funktion der Thyreoidea. Häufig wird Dysmenorrhöe beobachtet.

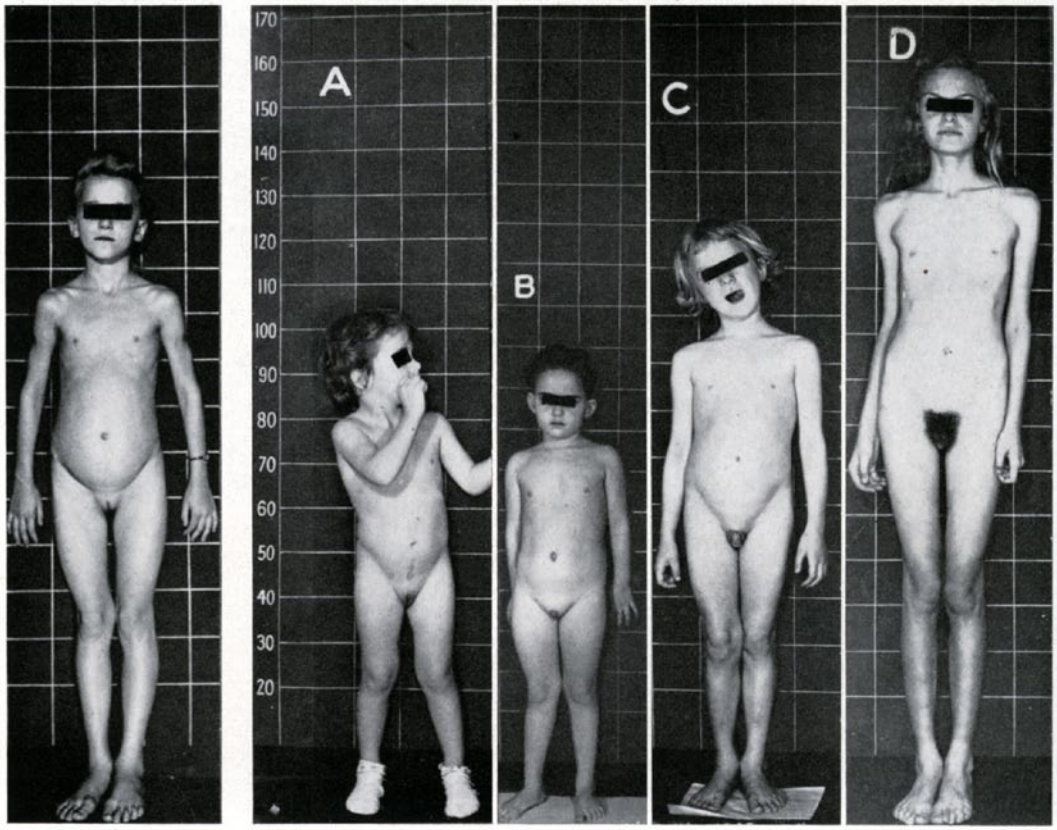
Wilhelm Weibel: *Lehrbuch der Frauenheilkunde*, Berlin/Wien 1944
(note fresh "exploratory" scar on abdomen)

1916–1950s: "Intersexuality = Bastardisation" caused by "Racial Mixing"; Racist Diagnosis "Intersexual Constitution"

Geneticist Richard Goldschmidt (1878–1958), before becoming director at the "Kaiser-Wilhelm-Institut für Biologie" in Berlin, coined the terms "Intersex" and "Intersexuality" when internationally publicising his experiments of crossbreeding *"different geographic races"* during a stay in the USA (first in English, later in German), claiming to be able to produce "hermaphroditic" a.k.a. "intersex" specimens of any grade and shape at will, and thereafter extrapolating his findings to humans. Of jewish descent, Goldschmidt was forced to leave the "Kaiser-Wilhelm-Institute" in 1936 and emigrated to the United States. Despite Goldschmidt's downplaying the "racial" background of his findings since the early 1930's and later renouncing the underlying genetic theories altogether, the term "Intersex" and its racial implications prevailed. The derived diagnosis "Intersexual Constitution" (coined by Austrian Gynecologist Paul Mathes in 1924), associated with "biological inferiority", mental illnesses, "hypertrophied clitorises", and the strict verdict "not fit for marriage" was particularly popular among prominent eugenicists and nazi doctors, a.o. Fritz Lenz, Lothar Gottlieb Tirala, Robert Stigler, Wilhelm Weibel and Walther Stoeckel, and kept being used in publications long after World War II.

Sources: Richard Goldschmidt: "Die biologischen Grundlagen der konträren Sexualität und des Hermaphroditismus beim Menschen", in: *Archiv für Rassen- und Gesellschaftsbiologie* 12, 1916.
Helga Satzinger: *Rasse, Gene und Geschlecht. Zur Konstituierung zentraler biologischer Begriffe bei Richard Goldschmidt und Fritz Lenz, 1916–1936*. Research Program "History of the Kaiser Wilhelm Society in the National Socialist Era", Ergebnisse 15, 2004.
Wilhelm Weibel: *Lehrbuch der Frauenheilkunde*, 7th ed., Berlin/Wien 1944 p. 647 (photo), 648 (text).

CONGENITAL ADRENAL HYPERPLASIA—FEMALE PSEUDOHERMAPHRODITISM



Normal age 9 yrs.	Age 2 yrs. 11 mos. Ht. age 4–3 Bone age 6–0 17–KS: 2 yrs. 9–12 mg/d. 3 yrs. 15–25 mg/d. Pubic hair appeared at 20 mos.	Age 4 yrs., 2 mos. Ht. age 5–0 Bone age 7–6 17–KS: 16–22 mg/d. No sexual hair.	Age 4 yrs., 5 mos. Ht. age 7–0 Bone age 11–0 17–KS: 17–22 mg/d. Pubic hair at 2¾ yrs.	Age 9 yrs. Ht. age 14–6 Bone age 15–0 17–KS: 14–22 mg/d.
	Small urogenital sinus. Siblings: 1. ♀ pseudohermaphrodite. 2. Female—normal. 3. ♂—macrogenitosomia 4. ♂—macrogenitosomia Clitoris amputated. Raised as girl. (H.L.H. A59183)	Urogenital sinus non-communicating. Raised as boy. Plastic operations on hypospadic penis and scrotum. (H.L.H. A52394)	Small urogenital sinus. Raised as girl. Clitoris excised. (H.L.H. A47344)	Pubic hair at 4½ yrs. Axillary hair at 8 yrs. Large urogenital sinus. Raised as girl. Clitoris excised. (H.L.H. A26544)

Patients all had enlarged phallus, urogenital sinus and absent vagina at birth. Patient B had been mistaken for a boy and raised as such.

NOTE the excessive somatic growth, advanced skeletal development, high 17-ketosteroid output and early appearance of sexual hair. Patients were well developed muscularly, but did not seem especially "masculine."

Baltimore 1950: From Experimentation to Extermination

Lawson Wilkins (1894-1963), "The Father of Pediatric Endocrinology", was also the "inventor" of systematic cosmetic genital surgeries on children. As his monograph illustrates, in 1950 at Johns Hopkins in Baltimore, any child diagnosed "not normal" was submitted to drastic "Genital Corrections", either "feminising" or "masculinising". Often John Money gets erroneously credited as having started the systematic mutilations, however, it was Lawson Wilkins; Money "only" delivered a "scientific" rationale five years after the fact.

Sources: Lawson Wilkins: *The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence.* Springfield, 1950. Alison Redick: *American History XY: The Medical Treatment of Intersex, 1916-1955*, Dissertation 2004

STOP Intersex Genital Mutilations!

Plastic Operations on the Genitalia

The surgical correction (see p. 474 *et seq.*) of the masculinized genitalia of girls with the congenital adrenogenital syndrome is desirable for several reasons: (1) in order to make the vagina a functional organ; (2) in order to prevent troublesome erections of the clitoris; (3) in order to prevent psychological conflicts, which are particularly liable to occur in girls with male characteristics.

Whenever possible surgery should be carried out before the children reach four years of age. In mild cases removal of the clitoris is all that is necessary. The clitoris should be *totally* removed and not just amputated, otherwise troublesome erections of the remaining stump may occur. As Hampson (1956) was able to show in a large series of women subjected to operation, removal of the clitoris does not interfere with the ability to achieve orgasm. If masculinization of the genitalia is more extreme further surgery may be required to open and enlarge the urogenital sinus.

Source: Jürgen R. Bierich: "The Adrenogenital Syndrome" In: Claus Overzier (Ed.): *Intersexuality*. New York, 1962, pp 345–386

1956–1993: "The Clitoris is not essential for normal Coitus." "No Evidence of Loss of Orgasm after Clitoris Amputation."

The number of "Intersex-Experts" and involved clinicians claiming that amputating "enlarged" clitorises was a rational and beneficent thing to do is legion – e.g. Joan Hampson (1956), John Money (1956, 1971), Jürgen Bierich (1963, 1971), Robert E. Gross (1966). Even in 1993, surgeon Milton Edgerton claimed, unchallenged by his peers: *"Not one has complained of loss of sensation, even when the entire clitoris was removed."*

Since then: "Surgery is better now ..."

In 1993, Cheryl Chase founded the first Intersex Lobby Group ISNA by declaring: *"Unfortunately the surgery is immensely destructive of sexual sensation and of the sense of bodily integrity."* Since then, the mutilators just changed their mantra to *"Surgery is better now"* – again without evidence, but despite survivors deploring decrease or total loss of sexual sensation, painful scars and frequent complications also with the "modern improved techniques", and studies again and again corroborating their grievances.

Zwischengeschlecht.org
„Human Rights For Hermaphrodites Too!"
http://stop.genitalmutilation.org