



# The changing image of gender

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How we think about ‘gender’ has come a long way in the past couple of decades. Central to the shift in attitude is the widespread acceptance of ‘gender dysphoria’, where a person’s true gender is not necessarily in keeping with their biological gender. Medical care has embraced the concept of gender dysphoria in several ways, most obviously in the rapid advances and availability of gender reassignment therapy.

This therapy combines endocrine and surgical interventions to effect a change in body habitus—traditional male phenotype to female and female phenotype to male—to align a person’s appearance with their expressed gender.

The specialist surgical procedures, and the complications that can beset this type of surgery, are varied combining both organ removal, augmentation and/or plastic surgical based techniques. Any subsequent imaging either for complications of the surgical therapy, or to investigate pathology in other organs at a later time (for example, suspected rectal disease) may be complex both to perform and to interpret.

With the increasing likelihood that transgender people will be imaged in the general medical centres and not only in specialist centres, a knowledge of the more common post surgical findings becomes important. Without familiarity of how such interventions may look within the pelvis, there is a risk that radiologists will misinterpret the findings; this is all the more true if information of the previous interventions is not provided.

In the article ‘Imaging of transgender patients: expected findings and complications of gender reassignment therapy’, Arvind Shergill et al describe and illustrate for both male-to-female and female-to-male patients the surgical procedures; they relate these to the expected imaging appearances on CT and MRI and on certain fluoroscopic tests. The piece moves on to describe complications such as bowel injury in male-to-female pelvic surgeries and urethral complications

associated with female-to-male reassignments. The problems and conditions that may be seen in the longer term, such as prostate cancer in male-to-female patients or breast cancer in the same cohort, are described, raising awareness of these potential diagnoses in this setting.

The problem of inadequate clinical information being provided on the imaging request, a situation well known to every radiologist, can lead to interpretation problems in this patient setting on several levels. These include inadvertently causing offence as well as causing alarm to the patient. The article conveys the sensitivity issues adroitly, so that the reader is reminded of the cultural prejudices that may be expressed in the matter of ‘gender’, without the tone coming over as overbearingly politically correct.

The article merits this editorial for several reasons: the text and images are an impressive resource in helping radiologists report on this patient cohort; the increasing recognition of gender dysphoria means that reassignment surgery is becoming more commonplace so that there is a need to image these patients in the acute or remote setting; the impetus in the uptake in this type of intervention means that patients who have undergone this type of surgery will be encountered in general practice; the imaging findings and pitfalls are presented in the wider context of some of the unique sensitivity issues that pertain; and in reading the article, radiologists are more likely in future to consider this possibility when interpreting seemingly confusing axial studies.

The article is commendable, well presented and illustrated, and its clear messages help fill a void in reference material within the growing field of imaging people who have undergone gender reassignment therapy.

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