

M-F 101



This document is one that we found on the internet.

<http://openmindedhealth.com/transgender-101-trans-people/#ftm>. We played with it a bit and took out some of the info that was pertinent to other places in the US and not here in Maine. Whenever possible, additional links were added.

Areas that we edited to make it more local are in italics. We hope this is helpful

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General Questions

Help! I think I'm trans. How do I know for certain?

You very well might be trans. At this time there is no test that will give you a definite "Yes" or "No." You might find it helpful, though, to seek out a psychotherapist well versed in gender issues. Talking to trans people, or attending a trans support group, might also be helpful. Ultimately, though, only you can say whether you are trans or not. No one else can figure it out for you. Definitely do take your time – there is no age limit to transition.

Some people also use thought experiments to help them figure out if they're trans or not.

http://www.reddit.com/r/asktransgender/comments/1fy0zg/what_are_some_questions_i_can_ask_myself_to_help/

Some do flirt with the idea of being trans, and ultimately decide that they are not. It does not necessarily have a negative impact on their lives.

How do I stop having gender dysphoria? Is there a therapy that can cure me?

If you are truly transgender, no. There is no psychotherapy or drug that will make you stop having gender dysphoria. For years mental health professionals tried to "cure" transgender people by making them cisgender (*live as the gender/sex they were born as*)... and it worked about as well as reparative therapy for gay people. That is, it didn't work. Transition is the only thing that I know of that helps.

Is it a brain condition? I heard someone say being transgender is an intersex condition. Is that true?

So, there are some interesting brain data. I covered it previously. It does appear that trans brains may be different from cis brains. I would not take those data as absolute proof until we have more data though. Currently, as far as I know, transgender is not included as an intersex condition by any intersex organization. Transgender is not considered a Disorder of Sex Development.

Can I be trans if I don't identify as a man or a woman? What about being genderqueer?

Yes, and yes. There is increasing awareness that not everybody fits into the man/woman dichotomy. For a good blog on being trans but not gender binary, check out [Neutrois Nonsense](#).

Okay, I'm definitely trans. Now what?



Now you have a decision to make. Do you choose to do something about it or not? You can continue to live your life the way you have been. You do not have to transition. You can postpone any changes. I've heard of some folks waiting until they turn 18. I've heard of other folks waiting for their kids to turn 18, or waiting for their partner to die first, or... any number of other things. You can wait. Or you can do something right now.

Whatever you decide, I do recommend getting support to help with any associated stress. That support can be a group, a therapist, a good friend, whatever.

I want to come out and transition now. Where do I start?!

My very first recommendation? Get your support team together first. Your road may get a bit bumpy. You may lose your job, house, friends or family. Get ready for it. Start saving your pennies. Support can be from a trans-specific group, a more general LGBT group, a therapist, friends, family, people on the 'net.... whatever works for you in your situation.

Strictly speaking, I would classify transition into three categories: Medical, social and legal. Medical being hormones and/or surgery, social being pronouns and presentation, and legal being name and the M/F on all your paperwork. Sometimes these areas intersect (e.g., surgeons may require gender-congruent presentation (*live as the gender you identify with*) for 12 months before surgery), but other times they don't.

It's up to you to decide what and where you want to transition. Now you need to do research. Do you want to do hormones? Surgery? A legal name change? Does your state prohibit workplace discrimination? Does your state require surgery before you can change your name? Now's the time to find out!

If you are a minor, things get complicated even with parental support. That's another question though.

How do I find support?

We have some information on Trans support groups from Maine Transnet which we will be happy to share.

Wait... so am I gay? Straight?

I want to be very clear, first: You can use whatever term you want. Seriously. I won't stop you. Straight, gay, bi, pan, asexual, demisexual, whatever you want to use is cool.

Divorce the concept of sexual orientation from gender identity, and things may make better sense. Did you like masculinity before transition? Chances are you will after too. But the label may change because your perceived sex changes. For example, if you're a trans man who likes only feminine partners, before transition you would've been seen as lesbian. Now you're seen as straight. But who you like? Did that really change? For most trans folks, likely not.

I really like the words androphile (man-loving) and gynephile (woman-loving) instead of straight/gay when I've taught trans issues to cis people before. It helps to simplify the concepts – a trans person who was an androphile before transition is still an androphile after transition. Easy! None of this gay/straight stuff.

So... if you need a label? Look to gender instead of sex.

I only thought about this as a teenager or young adult, so I can't really be trans, right?

It's possible you may be, and it's possible you may not be. Honestly, same as with the "am I trans" question, only you can decide. But you're here now, right? That means there's something up. It may be trans issues, it may not be... but in any case, I recommend seeking professional help so you have a safe place to figure out your feelings. Remember, you have time.



Is it transgender or transsexual?

The difference between **transgender** and **transsexual** differs depending on who you're talking to. Some consider transsexual offensive, others prefer it. Transsexual is an older term and much more common in the medical community. I've also heard that it's used more in countries other than the US.

Some object to the term transsexual because of the way trans people have been treated by medicine. Others feel it hypersexualizes trans folk or conflates sexual orientation with gender identity. Others object to the term transgender because of its use as an "umbrella" term, lumping transsexuality in with genderqueer, crossdressing and drag.

All this argument is generally why I say trans. Some people say "trans*" instead, to make the dual meaning clear... but I'm lazy. So I say/write "trans", with the implication that I could be using either.

My working distinction between transsexual and transgender? Transsexual is specifically an individual who is cross-sex identified, typically fits within the gender binary, and wants to go through full transition including surgery. Transgender includes non-binary identified people and people who do not want to do a full transition.

Should I transition or not?

Whew. That is truly up to you, in the end.

There is always some risk involved with transitioning. For some people with a great support system of friends, family, and co-workers, the gains may definitely outweigh the costs. For others, transitioning involves a loss of family, friends, and/or a job. For those who do transition, quality of life generally improves. But there is always that risk.

I highly recommend reading [Injustice At Every Turn](#) - it's the best research I've yet seen on discrimination facing trans folk today. *Their report, in summary states "Transgender and gender non-conforming people face injustice at every turn: in childhood homes, in school systems that promise to shelter and educate, in harsh and exclusionary workplaces, at the grocery store, the hotel front desk, in doctors' offices and emergency rooms, before judges and at the hands of landlords, police officers, health care workers and other service providers."*

How and when do I come out?

As safely as possible, and with as many safety nets in place as possible. I would not come out in a situation where another person has power over me. Yet at the same time, I think the earlier the better. Remember that while you've been thinking about it for possibly years, it may be a brand new shocking concept to your loved ones. So for example, you could come out on a first date when you're at a restaurant, in public, with money in your pocket for a taxi home and a loved one knowing where you are and expecting a call. In contrast, coming out while making out with a date in a dark alley if you're relying on the date for a ride home could be very, very dangerous. Think it through, make it as safe as possible.

Beyond that, as for the exact wordings? Be honest. Provide written and video resources if they're not trans aware. Be clear that you're the same person you always were, that nothing has really changed about you. Ask for the pronouns/name you want to be referred to with. Give them time if they need it. And so on...

I would not come out in writing if possible. It's not flexible enough or personal enough. But this is something I would absolutely brainstorm with a therapist or support group, since every situation is different.

Am I too old to transition?

No.

General Medical Questions

Where do I find a health care provider?

First, know that you don't necessarily need to see an endocrinologist. An internal medicine or family practice provider can deliver high-quality care too!

Maine Family Planning is proud to offer safe, confidential trans services by clinicians and staff who are committed to giving the best trans care possible. We are also excited to be associated with an endocrinologist who is very willing to help us out if we have questions about safe trans care.

Maine Transnet also has some info on safe Trans providers.

I was treated badly by a provider or their staff. What do I do?

If you can, please let them know. It may have been unintentional (e.g., an accidental misgendering – yes that does sometimes happen), or there may be corrective actions they want to take as a result of a complaint (e.g., additional staff training). If you can, meet in person with the provider responsible. Stay calm, use lots of “I” statements. Writing a letter is another option. If things go south, find another provider. But you may be pleasantly surprised!

We have some cards designed by Maine Transnet that you may want to give to your other health care provider staff when you check in that may prevent some of the embarrassing/annoying issues with names etc.

Hi, my name is _____ I prefer _____ pronouns You have me listed in your records under the name _____



Wait... don't I need a letter from a therapist or something?

At Maine Family Planning, we use the informed consent model of providing hormonal therapy for transgender people.

- *We do not require that everyone must have a letter from a therapist to start hormone therapy.*
- *We will make an assessment of each person's ability to understand the risks and benefits of starting hormones. Transitioning is such a huge decision involving social, economic, and medical risks that we want to make sure that each patient is sure and secure in their decision to transition.*
- *Our providers do a pretty in-depth intake process and in some cases we request that a patient meet with a therapist and bring a letter to us before starting hormonal therapy.*
- *In other cases, we may require that the patient have an ongoing relationship with a therapist during transition.*
- *While it may not be required, having an ongoing relationship with a therapist can be very beneficial as transitioning is such a huge time of change it can be stressful not only for the patient transitioning but also for the people close to them. If you don't already have a therapist, we have a fairly extensive list of therapists who enjoy working with trans folks.*

Anything I should definitely tell or not tell my provider?

Tell your provider about all your health history. Better yet, have your records sent beforehand! Few conditions actually mean that you can't have hormone therapy, but may need to be controlled. Some conditions (e.g., previous thromboembolism, estrogen-sensitive cancers) may require a different approach to hormones. Tell your provider about any “risky” behaviors (e.g., sex work) – they need to know these so that they can screen appropriately. If you have a trauma history and cannot tolerate some physical examinations or need extra help with them, let them know

that too.

It will likely be helpful for your provider if you're clear about preferred name and pronouns. Some providers have intake sheets specifically for trans patients which ask about gender history, and pronouns may be included there. If you have a name/pronoun change, please let them know so they can continue to be accurate and respectful. Let them know if you're not out of the closet so they can be confidential in communications (and tell staff if confidential messages can be left on phone numbers). Also let them know if you need a specific name or gender marker on prescriptions and/or lab work for insurance or legal reasons. If you have preferred names for body parts or are very dysphoric, tell them!

If you're genderqueer, neutrois, or just want to individualize your transition (e.g., transition slowly), tell your provider. There are different paths available to you.

Don't lie to your provider. Don't feel you have to spout the "standard narrative" if it's not you. Don't feel you have to wear makeup or hugely baggy manly pants. Be yourself.

Can I start hormones on the first visit?

Not usually with Maine Family Planning. We spend the first visit getting to know you, talking about options, reviewing your medical history and doing a physical. At the end of the visit, we will order some labwork for you to get done. The lab work usually takes about 7-10 days to get all of it back and at a second visit, we review that labwork with you and get you started on your meds that day.

Hormone Therapy



Hormone therapy is a corner stone for medical transition. For many (but not all) trans people, hormone therapy is all they choose to do.

Terminology notes: In the medical literature, hormone therapy is often referred to as "cross-sex hormone therapy". In the community I've seen it more often called HRT for short (and I've often called it that too). It's important to note that trans hormone therapy may be different from the "hormone replacement therapy" used in cis men and cis women.

Which specific hormones get used depend on one's health, age, and money. Some providers choose to do a slow ramp up on dosage. Others do not. Your mileage *will* vary.

Hormones for adult trans women/people assigned male at birth

The modern classic hormone regime includes an estrogen and an anti-androgen. Why the anti-androgen? Well testosterone is very, very powerful stuff, far more powerful than estrogen. To overcome the effects of testosterone you'd need a very large dose of estrogen. We don't want to do large doses of estrogen because of negative side effects and associated health risks. So both an estrogen and an anti-androgen are used.

Which Estrogen? There are three common choices: orally/sublingually, intramuscular, and transdermal.

Oral/sublingual is the most common and cheapest. These forms are also used for hormone replacement therapy for cis women.

- Orally/Sublingually: The current estrogen of choice is [17β-estradiol](#). It comes as a pill which can be either swallowed or dissolved under the tongue. Common wisdom says under the tongue (sublingual) is safer for the liver, but that's not a certainty. To my knowledge this is the cheapest form. Dosage is usually 1-4mg twice a day.
- Intramuscular (e.g., estradiol valerate): Delivered as an injection that goes deep into muscle tissue (usually the thigh). Requires injection training, and you probably should carry paperwork if you're traveling with injection supplies. Some people say they transition faster on injection, but I haven't seen evidence supporting that. Dosing can be done weekly or biweekly. Women sometimes report that they start to feel moody or irritable towards the end of their injection cycle.

- Transdermal (through the skin): Estrogen patches. Expensive if you don't have insurance! But generally considered lowest risk, and provide the most consistent blood estrogen level. Patches are applied twice a week. Different brands of patch are different sizes and ability to stick to skin.
- Other options may be available. I've seen estrogen sprays and creams advertised, but don't know that they're in use for trans care.

There are forms of estrogen which should not be used for transition. [Premarin](#) was originally used, but is currently not recommended because it's [high risk](#). [Ethinyl estradiol](#), commonly found in birth control pills, is also higher risk than the estrogens listed above.

What health conditions may affect whether I can take estrogen or not?

The big ones are previous history of [deep vein thrombosis](#) (a kind of blood clot) and [estrogen-sensitive cancers](#) (breast cancer) because they can be fatal. Tobacco smoking is a big No-No since it increases your risk for deep vein thrombosis. Other conditions which could be factors include high cholesterol or hypertriglyceridemia (high triglycerides), migraines and diabetes type 2. These other conditions may need to be controlled with medications or lifestyle changes before estrogen can be safely prescribed.

Which anti-androgen?

In the United States the anti-androgen of choice is [spironolactone](#). This drug was used for many many years as a diuretic/antihypertensive for people in heart failure so it's safety is very well established. It also happens to act as an anti-androgen and can feminize some on its own. Doses can be as high as 200-300mg per day, but high doses tend to have more side effects without more benefits.

The big side effect that people note about spironolactone is that it... well... it's a diuretic. So lots of trips to the bathroom, lots of peeing. But as always, your mileage will vary.

What health conditions may affect whether I can take spironolactone or not?

A history of hyperkalemia is the big thing. Hyperkalemia means too much potassium in the blood, and can be life-threatening. Spironolactone likes to "hold on" to potassium, so blood tests are important to screen for hyperkalemia. You may need to avoid high-potassium foods, or you may not. It depends on how your body handles it all. [Here's a list to get you started](#) on potassium-rich foods for you to avoid.

http://www.ucdmc.ucdavis.edu/transplant/posttransplant/post_potass_eng.pdf

Other drugs that are used?

[Finasteride](#) is an anti-androgen used to slow/stop a receding hair line. Specifically, it blocks the conversion of testosterone to its more active form, dihydrotestosterone. Some trans women and trans men use it for receding hair line. Other trans women use it when other anti-androgens can't be used for health reasons.

[Progesterone](#) is another drug which is sometimes used. Progesterone is another sex hormone found in high levels in female bodies. Its use in medical transition is currently debated. Some people use it for mood, libido, or breast development. Research supporting these claims is scarce, and progesterone comes with health risks.

What are the major physical/emotional effects of HRT?

Breast growth, fat redistribution, decreased libido, (potential) decreased ability to have an erection, testicular shrinkage, skin softening. Facial hair may grow more slowly. HRT also has psychological effects but these are highly variable. Some report greater moodiness and ability to cry, others feel more calm. Spatial abilities may change. Sexuality may also shift – not just who you're attracted to, but how you're attracted and what you want to do in the bedroom. HRT can cause infertility, so if you want biological children you should bank sperm or conceive them before starting HRT.

There is no way to pick and choose effects. Your body will do with HRT whatever it is going to do.

What kind of blood test monitoring am I looking at here?

Your provider will likely want to do regular blood tests every couple of months in the beginning to make sure you're staying healthy. The big things they'll likely check include potassium levels (via a "complete metabolic panel" or CMP), lipids including cholesterol and triglycerides, and estrogen/testosterone levels (varies by provider). They'll also want to check your prolactin level at least once, since HRT carries a risk of a type of growth called a [prolactinoma](#). Other tests may also be done, depending on your health history. Other common tests include a complete blood count (CBC) which can detect anemia, and thyroid tests.

What about breast cancer?!

There's a lot of fear about breast cancer. There are no large studies of breast cancer in trans women. A few case reports exist, but so far it doesn't appear that trans women are at high risk for breast cancer. Ask your provider what level of screening is appropriate for you, but UCSF recommends the same level of screening as for cis women: yearly clinical breast exams and mammograms starting at age 50 unless you're at high risk.

How big are my breasts going to get?

The "rule of thumb" is that you'll likely be one cup size smaller than your closest women (genetic) relatives. This is by no means accurate, but is a fair place to start. Like all women, it's a roll of the genetic dice.

What won't HRT do?

HRT cannot change your bones. Your height will remain the same. Though the fat on top may redistribute, your hip bones and facial bones will stay the same. It cannot change the deepness of your voice, though you can change the way you use that voice. It cannot reverse a receding hair line or remove facial hair. There are surgeries which can help with some of these. Hair can be removed by electrolysis or laser. Facial feminization surgery is an option for women who can afford it. Voice surgery is also an option.

All this sounds awesome. I just started taking HRT. When can I expect results?

From the WPATH Standards of Care version 7

This is taking way too long. I want changes now!

Take a moment and breathe. I wish I could tell you there was a magic bullet here.... but there really isn't. Consider hormone therapy like a second puberty – it will take years. There is no time deadline for transition, so relax. Take your time.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES ^A

Effect	Expected Onset ^B	Expected Maximum Effect ^B
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/strength	3-6 months	1-2 years ^C
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years ^D
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

^A Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.

^B Estimates represent published and unpublished clinical observations.

^C Significantly dependent on amount of exercise.

^D Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

What if I choose to go off hormones?

You can do that! Some hormone changes are permanent – breast growth is the big one there. So you may need to bind or have breasts surgically removed if you don't want them to show. As long as you still have testicles, many of the other changes (fat redistribution, softening of skin) reverse.

How will my hormones change after surgery?

Once your testes are removed, you will lose your major source of sex hormones. Anti-androgens are no longer needed, though some women choose to stay on spiro lactone at a very low dose. You will likely need to stay on estrogen supplements for the rest of your life. Having no sex hormones is not good for bone health!

What can I do to minimize my risk factors?

Take care of yourself. Don't use tobacco. Drink alcohol in moderation or not at all. Eat a healthy diet – not a lot of red meat, processed food or fast food but lots of fruits, vegetables and whole grains. Maintain a healthy weight – right in the Goldilocks zone, as it were. Avoid crash diets. Exercise!! Find something that works for you and do it. If that means walking on the treadmill while you play your favorite video game (like me when I started), then do it and have fun. If you have any family risk factors, be sure to tell your provider and ask them if they have any recommendations. And take care of your mental health. See a therapist if you need to. And don't forget to practice safe sex.

What side effects should I call my provider about?

In addition to the "usual" stuff, like high fever, chest pains, faintness, or any significant changes, there are certain symptoms you should definitely tell your provider about. Vision changes, sudden headaches and sharp persistent leg pains should be called in. If you develop a rash or swelling after injecting estrogen, you should also tell your provider because that may be a sign you're allergic to the oil the estrogen is suspended in.

For safety, read through the prescribing information packets that come with all your medications and familiarize yourself with the complete list of side effects to call your provider about that's included. If you lose the packet, the information is available from [drugs.com](https://www.drugs.com).

Anything else?

Communicate with your provider! Let them know what effects you're experiencing – the information is useful not just in your care but Make sure you read all your prescribing information and ask your provider or pharmacist if you have questions.

Surgeries



Ah, surgery. Certainly surgery is what the average cisgender person thinks of when they think of transition. It's certainly important (and expensive), but not the be all and end all of transition.

What kinds of surgery are available for trans people?

That depends on your anatomy. For people who are feminizing (e.g., trans women), options include:

- Vaginoplasty. Literally means "vagina molding". This is the "sex reassignment surgery" commonly referred to by the media. A vagina is created, commonly using penile tissue. It can be done as 1 surgery or 2. Can include the creation of labia (labiaplasty). If testes are still present they are removed.
- Orchiectomy/orchidectomy ("orchie"): removal of the testes only. A much smaller procedure than vaginoplasty. Vaginoplasty can be done after an orchie, but make sure you let your orchie surgeon know that's your plan – the technique can differ. After an orchie, sex hormone supplementation may be necessary to maintain bone health.

- Breast augmentation/implants. For feminine people who aren't happy with the size of their breasts at full growth, this is an option.
- Chondrolaryngoplasty: Shaving of the Adam's apple.
- Voice surgery: Vocal chords can be shaved to raise the voice. Unusual and typically considered risky.
- Facial feminization surgery (FFS): A complex combination of facial modification, depending on need. It can involve shaving bone off the brow ridge, jaw line, and nose.

How can I get surgery? Pre-requisites?

Depends on the surgery, surgeon, and the laws where you live. Many, but not all, surgeons follow [WPATH's recommendations](#), which I paraphrase here:

- For top/chest/breast surgeries, 1 letter from a mental health care provider. Hormone therapy generally not a pre-requisite for top surgery for trans men. For breast augmentation for trans women, 1-3 years on hormones is highly recommended if not required.
- For bottom/genital surgeries, 2 letters from mental health care providers. 1 year of hormone therapy and being out of the closet, living as your gender not as your sex, is required.
- Surgeries performed for a reason other than transgender (e.g., hysterectomy/oophorectomy for cancer) do not require any letters.

Many surgeries (especially bottom surgeries) require you to be the "age of majority" in your country. In the United States, that's age 18. Some surgeons, however, do not follow that recommendation and do perform surgeries on younger people. More letters or visits with the surgeon may be needed for people under the age of majority in their country.

Some countries or clinics require you to work within their system. Others allow you to surgeon-shop, or even require you to do your own foot work. I'd generally start this whole process by asking your primary care provider and/or surgeons about local requirements.

A surgeon may also request letters from your primary care provider verifying your health history, current health status, and readiness. Make sure you consult with your surgeon early so you get all your paperwork in order!

Will my insurance cover it?

Insurance may be willing to cover an orchie, hysterectomy/oophorectomy or top surgery but is unlikely to cover any other surgeries. Genital surgeries are often deemed "cosmetic" or "optional" by insurance companies. Your best bet is to ask beforehand. One discreet way of asking might be to ask to see a list of covered procedures.

Your provider may also be able to advocate for you, arguing that the surgery is medically necessary and thus not cosmetic. Definitely keep your primary care provider in the loop and ask them for help if you run into trouble.

What kind of cost am I looking at?

Depends on the surgery and where you get it...but no matter what it's going to be thousands of dollars. Cost may go up if you have complications, or down if you have a very simple case. For accurate numbers your best bet is to surgeon shop and ask!

Want some really rough estimates? Okay! The more "simple" surgeries like orchiectomies, hysterectomy/oophorectomy, top surgeries, and the simple versions of metoidioplasty, can be anywhere from \$2,000 to \$10,000. Facial feminization, complex metoidioplasty, and vaginoplasties could be \$10,000 to \$20,000 or higher. Phalloplasty is generally the most expensive, and I've seen it quoted anywhere from \$40,000 to \$100,000.



Holy crap how can I afford it? My insurance won't cover surgery!

First: I am so sorry! Besides saving pennies, a private or medical loan may be possible. Some surgeons allow payment plans too. And some people are now fundraising for their surgeries through the internet. Any of those might be an option for you.

How can I get the best results possible?

Be as healthy as you can before surgery. Exercise is important – the more muscle tone you have, the faster you'll be able to recover. Eating well can make sure that you have the nutrients your body needs to recover. Not using tobacco speeds up your healing time – avoid other drugs too, as your provider advises. Having a stable weight can maintain your good results. Control any health conditions you have (e.g., diabetes).

Choosing your surgeon carefully is also very important. Look at their results, ask to speak with people who have had the surgery. Think carefully about your own needs and make sure that your chosen surgery/surgeon can meet them.

Lastly, follow all post-operative instructions. If they say “no ibuprofen for 3 weeks” – do it!

What could lead a surgeon to decline operating on me?

Every surgeon has their own criteria. However, being overweight or obese, using tobacco, and the presence of certain health conditions may lead a surgeon to conclude that surgery is too risky for you. Health conditions may include uncontrolled diabetes, cardiovascular or respiratory problems.

No surgeon should refuse on the grounds that you're not “masculine/feminine enough”. If they do that, I'd seek care elsewhere.

For bottom surgeries, what about erogenous (sex) sensation?

Surgeons no longer simply cut out whole clusters of nerves. Bottom surgery is complex, and care is taken to preserve as much sexual tissue as possible. The vast majority of people who have had bottom surgery have as much of a sex life as they want, and are happy with their results. The old sexual tissue is often “woven” into the new structures, so orgasm is possible. Orgasm itself may feel different too, as some trans people have reported.

For vaginoplasties, extra lubrication may be needed but penetration is often possible.

However, all surgeries carry the risk of nerve damage. Care is taken to try to avoid it, but it is possible that some sensation will be damaged. Your surgeon should go over all the risks of the surgery with you beforehand. Consider them carefully.

How can I reduce scarring?

Scars are going to happen, and the degree of scars will depend on your surgeon, your body, and the complications you have. More complications will likely mean more scars. And everyone scars differently – some, like me, scar very easily. Others do not.

The single more important thing you can do is to follow all post-operative instructions! Call your surgeon if you see signs of infection. And ask your surgeon or provider about over-the-counter scar-reduction products before you use them. Some very wide scars can be reduced surgically. But please, consult your primary care provider first.

What new surgical advances can I expect to see in the future?

The thing everyone is waiting for is bioengineered genitals and gonads. Sadly, that is many many years away – I'd guess 10+ years.

In the short-term, there is focus on improving the current techniques.

What about surgery overseas?

It's an option, and it may be cheaper than pursuing surgery in the United States. Thailand is popular for trans women, Serbia for trans men. However, keep in mind that there may be language issues... and if problems come up once you're back in the States, it's not exactly easy to hop on over to see your surgeon. Not all surgeons will even take patients from outside the country (e.g., some Canadian surgeons won't treat non-Canadians).

Choose your surgeon even more carefully when looking outside your country. Listen to the community and former patients. Ask to hear experiences and see results. There are unscrupulous surgeons out there, bad results do happen, and corrective surgery is expensive and doesn't always fix the damage. Remember: it's your body, and it the body you get to live with for the rest of your life. Choose carefully and well.

What if I don't want surgery?

Then don't have it. Don't do anything you don't want to do! It's your life and your body – take control, choose what you want and do not want to do, and go enjoy yourself.

Orchiectomy



Orchiectomy/orchidectomy, also known as an “orchie”, is the surgical removal of the testicles. If both testicles are removed, it's a bilateral orchiectomy.

Why would I want an orchiectomy?

With an orchiectomy, anti-androgens are usually no longer needed. Some may choose to stay on anti-androgens at a lower dose. Estrogen doses may also be lowered after an orchiectomy.

While everyone has their own, deeply personal reasons for choosing one surgery over another, there are some potential common threads, including:

- Health concerns. For someone who cannot be on an anti-androgen, or has a bad reaction to an anti-androgen, or has health conditions that make HRT risky, an orchiectomy may make hormonal transition safer.
- Money. While orchiectomy costs somewhere around \$4,000, it may be more cost effective in the long run to get an orchie. In my area at the time of writing this, without insurance an orchiectomy is about the same cost as 10 years of spironolactone.
- Permanent pregnancy prevention (try saying that 5 times fast!). While hormones do have the potential for permanent infertility, an orchiectomy is a much surer thing.
- Dysphoria. Some may be distressed by having testes but have no desire for a vaginoplasty. An orchiectomy may be the only genital surgery they desire or need. Some may also have no desire for penetrative vaginal sex, and thus no desire for a vagina.
- Aversion to higher-risk surgeries. An orchiectomy is generally safer and less painful than a vaginoplasty, which may be a factor in deciding to have an orchie.

Are orchiectomies done on cisgender people?

Yes. It's a fairly unusual procedure, though. Most commonly an orchie is performed for testicular or prostate cancer.

Would an orchiectomy keep me from getting vaginoplasty?

Very likely not. It used to be thought that the shrinking of the scrotum after orchiectomy would make later vaginoplasty difficult. However surgeons now say that's not a problem.

What you do want to do, though, is talk with your various surgeons and providers. There are different methods of scrotoplasty, with different incision points (places that they cut). I heard one surgeon comment that some methods are better for future vaginoplasty than others. If possible, tell your orchiectomy surgeon whether future vaginoplasty

is a consideration and refer him/her to your potential surgeons for consultation. You may also choose a surgeon who does both orchiectomy and vaginoplasty to do your orchiectomy.

Can you tell me more about the surgery? Does it require full anesthesia? How long would I be in the hospital? What kind of recovery time am I looking at?

All of those factors will vary depending on the surgeon, but here are some generalities to give you an idea. Orchiectomy can be done under full anesthesia, or only under a light sedation. You will likely be able to leave the hospital the same day. Some surgeons ask that you stay in the area for 3 days after. You may be able to return to work in 3-5 days. Pain is reported to be “minimal.”

As with all surgeries, there will be some preparation required. You’ll need to meet with your surgeon for a consultation beforehand. Many medications, including estrogen, aspirin, and other blood thinners will have to be discontinued for a certain period before the surgery.

What are the possible risks of an orchiectomy?

Orchiectomies are relatively low-risk for surgery. The major risks are infection, excessive bleeding, and bad reactions to medications given in the hospital. Your surgeon should go over all possible risks of surgery with you before you give your consent to surgery.

How will an orchiectomy affect my long-term health?

Orchiectomy removes the majority of your body’s sex hormones. Sex hormones help to maintain bone density, among other things. Without testes, your sex hormone levels will be below that of a post-menopausal cis woman. To help prevent osteoporosis you may need to be on hormone replacement for the rest of your life. Different providers have different philosophies about life-long HRT, though, so your mileage will vary.

Removal of the testes greatly reduces any chance of testicular cancer. The drop in testosterone may also help prevent prostate cancer. In any case, with that drop in testosterone your prostate will shrink. There may be sexual side effects, similar to the effects of anti-androgens. Sex drive may go down, and your sexuality may feel different. Erections may be more difficult. Also remember that removing the testicles makes you permanently sterile. Unless you have sperm stored or have children already, you will be unable to have genetic children.

Vaginoplasty

Often known as “the surgery” by the media, genital surgery for trans women has come a long way since 1930.

What exactly is vaginoplasty? Labiaplasty? Why different terms?

Vaginoplasty specifically refers to the creation or modification of a vagina. Labiaplasty is the creation or modification of the labia. I used both terms in the title because they can be different surgeries. It’s also important to note that the terms are sometimes used for surgeries for cis women – often to reduce the size of the inner labia to “smooth out” the appearance. For simplicity’s sake, for the rest of this FAQ I’ll use the term “vaginoplasty” to refer to the whole of genital surgery for trans women.

What kinds of vaginoplasty are available?

There are two basic kinds: penile inversion and colon graft. Penile inversion involves taking skin from the penis and using it to create the vagina. The skin of the scrotum is used to create outer labia. The nerves and part of the head of the penis are preserved and used to form a clitoris. Some variations on these basic principles include:

- Using tissue from the urethra to create the lining on the inside of the labia. This may help to produce a pinkish color to the area and additional lubrication.
- Performing a second surgery to refine the labia. This may improve the appearance of the labia.

- Scrotal tissue may be used to line the vagina. Naturally, this tissue would need to have all hair removed by electrolysis or laser therapy beforehand.

Using tissue from the inside of the cheek to line some portion of the vagina. This may provide additional lubrication.

Colon graft is not as common, but still practiced today. This uses tissue from the colon to line the vagina. Many of the other techniques involved are the same. Colon tissue provides its own lubrication, but may also present issues of odor or unusual color.

Why would I want vaginoplasty?

Everyone is different, but these are factors I have heard...

- Reduction of dysphoria, whether you desire simply not to have a penis or desire to have a vagina.
- No more need to “tuck”, which can be uncomfortable and encourage yeast infections. No more bulge to hide!
- Safety. No more fear of being accidentally “outed” by a straying hand or eye and assaulted because of it.
- Better access to women-only spaces, such as changing rooms and bathrooms. Also, no staring in clothing-optional spaces such as hot springs!
- Being better able to sit down to pee

Having vaginal penetration during sex

Vaginoplasty is major surgery. It absolutely requires full anesthesia (besides, would you really want to be conscious?!). Surgery length depends on the type of surgery and your surgeon. Expect to be in the hospital for several days, and staying in the area for at least a week.

Full recovery will take months. You may be able to return to a desk job in two weeks, and able to return to more strenuous activity in eight. This depends on your surgeon of course. As I said, this is major surgery.

Your surgeon and their staff will instruct and assist you in specific aftercare: Drains, antibiotic ointments, cotton packing/padding, hygiene, and so on. Dilation I’m covering in a separation question.

Naturally you’ll need to abstain from sex for a period of time. Your surgeon will give you thorough instructions. If s/he omits an activity you’re interested in, please ask before trying!

Tell me about dilation!

The “neo”-vagina needs to heal. The body’s natural response to “wounds” is to close them up. Your body responds to your new vagina as if it’s a wound and tries to close it up. A dilator is a plastic rod that is inserted into the vagina to hold it open and stretch out the tissue, keeping it open. [Some dilators even come in pretty colors!](#) You can think of it like a new piercing – a new piercing will close up without something in it to keep it open. Unlike a piercing, a dilator is not used constantly.

Dilation needs to be done multiple times a day at first. Your surgeon will instruct you in their use and make sure you’re using them correctly. Over time you will be able to go down to once a day or even less often.

If by any chance you lose depth, dilation may be a possible way to regain it. It’s been used to increase depth in cis women who are born with short vaginas. But it takes time, and please do consult your provider.

Penetrative sex can help keep the vagina open, but not as well as a dilator. Don’t replace dilation with penetrative sex unless your provider(s) tell you it’s okay!

What are the possible risks?

As with any major surgery, vaginoplasty carries risks that could affect your long-term health. In addition to the risks of anesthesia, vaginoplasty carries the following health risks:

- Urinary problems, including urinary stricture (narrowing of the opening of the urethra)
- Fistula, or a hole between the vagina and rectum. This requires follow-up procedures and may require the complete closure of the vagina to allow for healing.
- Blood clots. The risk of blood clots is reduced by stopping hormones before surgery, but the risk is still there. A blood clot can, rarely, be fatal.
- Infection and death of tissue
- Blood loss leading to a transfusion – if you are religious this may be an issue for you
- Among the more “minor” problems are...
- Loss of sensation or a change in sensation. This is a major surgery in which nerves are cut, simply because that’s the nature of surgery. Nerves can and do regrow, but they don’t always regrow “right”. You may lose sensation, though surgeons do their best to prevent it.
- Scarring. Scars are usually minor in the end and/or hidden by hair, but scars do occasionally retain color or stay raised.

Be prepared to face these risks. They are generally rare, but they do happen.

How deep will my vagina be? How sensitive with the clitoris be? Will I be able to orgasm? Will I be able to have penetrative sex?

Vaginas made via vaginoplasty are generally about as deep as a cis vagina: anywhere from 5-6 inches. Some surgeons offer a revision surgery which can be used to deepen a vagina if you’re not happy. Modern vaginoplasty techniques are designed to keep sensitivity, so your clitoris will likely be sensitive if all goes well.

Orgasm and penetrative sex are usually achievable. Post-op women generally report that their sexual experiences feel different, but I can’t comment on “how”. Keep in mind that not all cis women can orgasm, so it makes sense that not all trans women can orgasm. Enjoy your experiences, whether they involve orgasm or penetration or not!

Will the fact that I’m circumcised/uncircumcised matter?

Generally speaking, no. Don’t stress about it.

Can I have vaginoplasty if I never went through natal puberty?

Yes! And surgeons are reporting satisfactory depth for people using the penile inversion technique. A skin graft from elsewhere in the body might be necessary for depth, but surgeons are reporting success without it.

How is a trans vagina different from a cis vagina? What about lubrication?

Again, it does depend on the surgeon and the technique. For women who had a penile inversion, in general the vagina is less stretchy and more liable to tearing for a trans woman than a cis woman. But I’ve heard reports of OB/GYNs unable to tell the difference. So relax! 😊

I highly recommend you check out resources like the [Wall of Vagina](#) if you’re concerned about final appearance looking “normal”. Cis women vary enormously. Chances are, you’ll fit right in.

Believe it or not, the vagina of a post-op women does lubricate. The fluid itself is thought to be a result of glands like the prostate which remain. Not all women find that it’s sufficient by itself for vigorous penetrative sex, though. Don’t be afraid to use lube – and do remember to have fun! If your lubrication is still too little for comfort, speak with your provider. An estrogen cream may be helpful.

Will vaginoplasty affect my long-term health? Pap tests?

Aside from the risks of surgery, the biggest effect to long-term health is the removal of the testes. For those risks, check out the FAQ on orchiectomy.

Trans women after vaginoplasty do NOT need a pap smear. A pap smear is a specific test that looks at the cell shapes and types of cervical cells. A vaginoplasty will not give you a cervix, so you are at no risk for cervical cancer and do not need to be screened. However, a “neo” vagina can get torn or for some other reason need to be medically examined. This is part of why it’s important to have a primary care provider you’re comfortable with!

Since you would now have a vagina, there is some TLC that vaginas tend to need. Vaginas are dynamic systems. Your smell, taste and sense of touch will change depending on a myriad of variables. You are still susceptible to sexually transmitted infections. Get to know your vagina so that you can alert a provider if something changes.

Be aware that the vagina is made of skin. Like other vaginas, it can develop cancers. Another good reason to get to know your body!

Your vagina will grow its own set of flora (yes – all vaginas have their own micro-organisms living in them!). While after surgery your surgeon will tell you to douche, after that period douching is typically considered bad. It destroys the delicate balance of flora in the vagina and can lead to yeast infections.

Will the prostate be removed?

No. Depending on what your provider says, you may still need prostate screenings. Some women report that it’s easier to feel the prostate through the vagina than through the rectum. So if you enjoy prostate stimulation, try it that way!

Peeing...?

You will need to learn to pee all over again. Such fun. The shower is a great place to practice, but expect to have some... interesting urinary experiences. Also note that your urethra will be shorter after vaginoplasty, so you may be more prone to urinary tract infections. So hydrate well, and seek medical care if you develop burning during urination that doesn’t go away.

Are there any health conditions that mean I can’t get it?

I do not know of any absolute contraindications. Even if you do not have a penis, tissue from other areas can be used to create a vagina.

However, some surgeons may have their own requirements like being a certain BMI. There are conditions, like diabetes, heart disease, or infection that need to be controlled before surgery can be attempted.

Anything else I should know?

Your mileage will vary, depending on your body, how you take care of yourself pre and post-op, and your surgeon. Remember to do your own research – this is just a starting point! Your surgeon should have results photos s/he can share with you. Talk with other women about their experiences as you make your decision.