

# F-M 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/](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 [Neurois 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 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 better sense. Did you like masculinity before transition? Chances are you will after. But the label may change because your perceived sex changes. For example, if a trans man who likes only feminine partners, before transition you would've been as lesbian. Now you're seen as straight. But who you like? Did that really change? 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.



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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 _____
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### 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 men/people assigned female at birth**

Testosterone is the primary hormone therapy medication for trans men. No anti-estrogen medication is required. Be aware that testosterone is a [controlled medication](#), so be sure to carry paperwork when you travel with it!



**Which Testosterone?** Testosterone can be given either as an injection or transdermally. Oral testosterone should never be used because of the risk of liver damage! Also note that with injections, one might be allergic to the oil the testosterone is suspended in – compounding pharmacies can provide alternative oils.

Testosterone should never be given above what your health care provider recommends because the body converts some of its testosterone to estrogen. This can be counterproductive for transition and raises health risks.

- Intramuscular injection (e.g., Depo-Testosterone): The primary form of testosterone given for trans men, especially early in hormone therapy. As with all injections, it requires injection training. Injections can be given weekly or biweekly.
- Subcutaneous injection: This is a new way of giving testosterone. It's given under the skin, rather than deep into muscle (intramuscular). Studies are currently underway to determine efficacy. However, it may be an option offered by your health care provider.
- Transdermal gels, creams, sprays, and under-arm applications (e.g., AndroGel, Axiron): More expensive



than injections, but no needles involved. Common wisdom says transition is slower with transdermal applications but I haven't seen data to support it yet. Gels and creams can be messy and must be kept away from other people especially pregnant people (it can cause harm to the fetus). Gels and creams can also be used on the clitoris, in addition to testosterone injections, to help increase growth.

## **What health conditions affect whether I can take testosterone or not?**

High red blood cell concentrations ([polycythemia](#)) is a really big one. Testosterone can worsen or cause polycythemia by stimulating bone marrow to produce more red blood cells. Typical treatment for polycythemia involves removing "excess" blood (some polycythemic people donate blood regularly, for example). A history of estrogen-sensitive cancers may require an alteration in care. High cholesterol, high blood pressure, and diabetes will likely need to be assessed and controlled before testosterone. Other conditions may also need to be controlled.

## **What other drugs are used?**

- [Depo-Provera](#) can be used to stop menstruation when testosterone can't be given. It appears not to increase gender dysphoria because it doesn't feminize.
- [Aromatase inhibitors](#) may be used for some people. These drugs prevent testosterone from converting to estrogen.
- [Finasteride](#) and related anti-androgens can be used in trans men to prevent hair loss.

Special formulation testosterone and dihydrotestosterone creams can be used on the clitoris to increase growth if desired.

## **What are the major physical and emotional effects of HRT?**

Physical: Cessation of menstruation, deepening of voice, facial and body hair growth, masculinization of face, increase in muscle mass, enlargement of the clitoris, increase in acne and possible male-pattern baldness. Please note that testosterone is not birth control and it is possible to become pregnant on testosterone. Testosterone can also cause vaginal atrophy – that is, drying out of the vagina and loss of elasticity.

Emotionally many men report that they have increased energy and confidence. Some trans men report that they have a harder time accessing their emotions. Some men recommend working to keep that emotional connection. Some have expressed concern that testosterone may increase rage ("Roid rage") or worsen mental health. Anecdotally this does not appear to be the case for trans men. 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.

There is no way to pick and choose effects. Your body will do with HRT whatever it is going to do. Wiki has a [great, detailed, cited list](#). [http://en.wikipedia.org/wiki/Hormone\\_replacement\\_therapy\\_\(female-to-male\)](http://en.wikipedia.org/wiki/Hormone_replacement_therapy_(female-to-male))

## **What kind of blood testing will I need?**

Your provider will likely want to do regular blood tests every couple of months in the beginning to make sure you're staying healthy. Likely tests include a CMP (complete metabolic panel) to check the health of your liver, CBC (complete blood count) to check for polycythemia, lipids (cholesterol/triglycerides), and estrogen/testosterone levels. Other tests may be ordered depending on your health history. Thyroid tests are also common.

## **What won't HRT do?**

It can't remove breast tissue, though some trans men anecdotally report slight shrinkage. Removal can only be done surgically. It can't change bones or height significantly (once you're past natal puberty).

## **Will I be really fuzzy? Really smooth?**

Frankly, nobody knows. Your best bet for a prediction is to look at your closest male relatives. You will likely have similar levels of hair and hair loss.

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

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES <sup>A</sup>

Effect	Expected Onset <sup>B</sup>	Expected Maximum Effect <sup>B</sup>
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months <sup>C</sup>	variable
Increased muscle mass/strength	6-12 months	2-5 years <sup>D</sup>
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

<sup>A</sup> Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.

<sup>B</sup> Estimates represent published and unpublished clinical observations.

<sup>C</sup> Highly dependent on age and inheritance; may be minimal.

<sup>D</sup> Significantly dependent on amount of exercise.

### What if I choose to go off hormones?

You can totally do that. Keep in mind that many of testosterone's effects are permanent (voice deepening, hair growth, ). Some of its permanent effects can be reversed by surgery or other procedures (e.g., body hair removal). If you still have your gonads then menstruation will resume, fat will distribute, etc. Going off testosterone when you do not have ovaries can lead to loss of bone density and increased risk of a bone break.

### My health care provider says I have high testosterone levels before I even started T! What gives?

You may have [polycystic ovarian syndrome](#) (PCOS). No one knows why, but trans men are more likely to have PCOS than cis women. In PCOS, cysts form on the ovaries, resulting in a high level of testosterone and sometimes masculinization (e.g., body hair). PCOS is often associated with obesity, metabolic syndrome and diabetes, which carry health risks. PCOS itself is not a danger, though it does affect fertility.

### How will my hormones change after surgery?

Once your ovaries are removed, you will lose your major source of sex hormones. Your testosterone level may need to be changed. Check in with your health care provider. However you will need to stay on testosterone for the rest of your life in order to preserve bone density. Some men also report needing a change in dosage after top surgery.

### 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.
- 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 health care 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 health care provider about. Symptoms of polycythemia include shortness of breath, headaches, dizziness, numbness or itchiness in hands and feet, and fatigue. If you develop a rash or swelling after injecting testosterone, you should also tell your provider because that may be a sign you're allergic to the oil the testosterone 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 health care provider about that's included. If you lose the packet, the information is available from [drugs.com](https://www.drugs.com).

### **Anything else?**

If you do weight lifting, be careful when you start testosterone! Ramp up very slowly in the first few months at least. Testosterone causes an increase in muscle mass, but it takes longer for your tendons to strengthen as well and you may snap a tendon if you try to lift too much too soon.

Communicate with your provider! Let them know what effects you're experiencing – the information is useful not just in your care but for everyone who may see that provider in the future.

## **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?**

For people who are masculinizing (e.g., trans men), options include:

**Top surgery:** removal of most of the breast tissue and formation of a masculine chest. Not the same thing as mastectomy. Various techniques exist, all with the same aim.

**Hysterectomy/oophorectomy:** removal of the uterus, fallopian tubes, ovaries, and cervix. Permanently ends menstruation. Sex hormone supplementation may be necessary to maintain bone health. Can be a first step to genital surgery.

**Facial masculinization surgery.** Not common, but I've seen it around the 'net. Implants can be added to the brow ridge, jaw and/or nose to masculinize the face.

**Metoidioplasty (“meta”):** One of the genital surgeries. Uses only existing genital tissue, “releasing” the clitoris/penis from





surrounding tissue and adjusting its position so it hangs in the right place for a penis. Can, and often does, include creation of a scrotum (scrotoplasty), routing the urethra through the penis (urethroplasty), and testicular implants. A phalloplasty can be done at a later date. With a meta, the penis can become erect on its own.

**Phalloplasty:** The other genital surgery. Uses tissue from elsewhere in the body – tissue from the forearm is common, as is part of the latissimus dorsi muscle. Usually 3-4 surgeries. Can include creation of a scrotum (scrotoplasty), routing the urethra through the penis (urethroplasty), penile implants to allow erection, and testicular implants. Erogenous sensation is preserved by weaving the clitoris into the penis and/or scrotum.

**Scrotoplasty:** Creation of a scrotum. often a component of metoidioplasty or phalloplasty. The scrotum is usually made from the outer labia (labia majora). A vaginectomy is often involved here.

**Vaginectomy:** removal of the vagina.

**Urethroplasty:** Routing the urethra through the penis. This involves using other tissue to extend the urethra. The labia majora (inner labia) are sometimes used.

Other plastic surgeries can be done to improve aesthetic appearance.

Top surgery (chest reconstruction) may be the single most important surgery for trans men.

### **Why would I want top surgery?**

Often simply called “top surgery”, chest reconstruction is a surgery where breast tissue is removed and a more masculine, flat chest is produced. There are functional benefits in addition to helping reduce dysphoria.

- Binder no longer required. Before top surgery, a binder is usually needed to reduce the visibility of feminine breasts. With top surgery, the binder is no longer needed, which has a myriad of effects. Binders can be uncomfortable and reduce one’s ability to breathe fully. Being without a binder may mean you’re better able to exercise and improve your health overall.
- Increased ability to “pass”. With healed top surgery, one could walk around topless like any other guy. There is more mobility in male spaces (especially locker rooms). Top surgery, in other words, helps make you safer in a potentially hostile world.
- Dysphoria. Having a masculine chest may be very important for psychological health.

Other benefits may include a reduction in back pain if you are large-chested.

### **Is top surgery different from a mastectomy or breast reduction?**

Yes! A mastectomy just removes breast tissue. It does not create a masculine chest. A breast reduction removes some breast tissue, but leaves the feminine breast shape intact. Neither of these would produce a masculine chest. While they may be options for some trans people, they’re not usually chosen by trans men today.

### **Is chest reconstruction done on cisgender people?**

Not exactly. Gynecomastia (development of breast tissue in cis men) may be treated similarly, but the techniques may differ. One technique for gynecomastia I’ve seen is liposuction only. Liposuction only would not be enough for many trans men, as it removes fat only but not breast tissue.

### **I’ve heard there are different techniques. What are they?**

The most common techniques are the keyhole method and the double incision method.

**Keyhole:** Keyhole, or peri-areolar, can only be done on small breasts. The breast tissue would be somewhere around an A cup, where there is little to no “extra” tissue. In this technique, a small cut is made on the edge of the areola and the

breast tissue is removed through that. Thus, a “keyhole”. The nipple is not moved.

**Double Incision:** The double-incision method is much more common. The nipples and areolae are temporarily removed, and a cut is made under the breast tissue. The breast tissue is removed through that lower cut. The nipples and areolae are grafted on once the chest is shaped.

A few surgeons perform an **anchor technique**. This is similar to the double incision, but the nipples are left connected. This results in better sensation and possibly better placement, with an inverted T scar pattern.

Generally speaking, the keyhole method helps to save nipple sensitivity and reduce scarring, but can only be done on a limited number of people and may not produce the most aesthetic result. In the keyhole, the nipple is not moved so it may be lower/higher than is typically seen on a masculine chest. The double incision method, on the other hand, can be done on many more people and allows customization of the nipple position.

For many, double incision or anchor are the only choice. However, it’s good to know your options. In addition, each surgeon has their own tweaks to each basic procedure – so do go ahead and ask them detailed questions! They should be able to answer after all...

### **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?**

Full anesthesia is definitely involved in top surgery. Most can return home the same day. You will probably go home (or to wherever you’re staying for initial recovery) with surgical drains. These are tubes that go into your tissue to help drain away excess liquid into a little container that gets emptied. Initial recovery time may be about a week.

It will take longer for the cuts to fully heal. They may be red for a few months after. You may also have areas that are numb after surgery. Sensation may or may not return over the next few years (nerves grow slowly!). You may need to continue to wear a binder for the first week to month to assist healing. While healing, your movement may be restricted. You will also need to refrain from lifting objects above a certain weight for a period of time. Your surgeon will advise you on the specifics, and you should follow their recommendations!

### **What are the possible risks of top surgery?**

The usual risks with surgery apply here: adverse drug reactions, bleeding, infection and the like. Permanent loss/reduction in sensation may occur, as with many surgeries.

Your aesthetic result may also not please you – the nipples may not be placed quite right, or there may be puckering or sagging in odd places. Wait until you’re fully healed before speaking with your surgeon about a revision.

With the double-incision method there is the risk that the nipple grafts will not hold. The tissue may die. That tissue can never be recovered, but other tissue can be used to make nipples and the skin surrounding them can be colored (medical tattooing) to look like areolae.

### **What about scars?**

You will have scars from top surgery. Period. The keyhole method results in a much smaller scar, but it will still be there. A double-incision surgery results in scars under the chest/pecs and scars at the end of the areolae.

How much you scar will be unique to you. You can guess based on past scarring, but there is always the risk that these scars will be particularly noticeable. They may be raised or discolored. Be prepared for the possibility. Scar revision surgeries may be possible.

My recommended scar strategy? Spend some of your recovery/prep time making a really awesome story. Maybe involving a bear or a daring rescue!

## How will top surgery affect my long-term health?

Because top surgery does not remove gonads, it has relatively few long-term health effects compared to other trans-related surgeries. As with all surgery, it can be immensely helpful for combating gender dysphoria and may improve your mental health.

## Would I be able to breast feed a child after top surgery?

Possibly. Definitely speak with your surgeon about it, but I know of at least [one case](#) where a trans man was able to breast feed after having a child.

## More information?

I am not a surgeon, nor an expert on surgeries! Check out some of these other resources and surgeon websites for more information:

[Hudson's FTM Guide](http://www.ftmguide.org/chest.html) <http://www.ftmguide.org/chest.html>

For images, I highly recommend joining [transbucket](http://www.transbucket.com/). <http://www.transbucket.com/>

[Dr. Garramone's website](http://drgarramone.com/surgery-types/) <http://drgarramone.com/surgery-types/>

[Dr. Crane's website](http://brownsteincrane.com/ftm-top-surgery/) (please note that Dr. Crane's practice was formerly Dr. Brownstein's practice)  
<http://brownsteincrane.com/ftm-top-surgery/>

[Dr. Steinwald's website](http://www.chicagoftmtopsurgery.com/about-ftm-chest-recontouring-chicago/) <http://www.chicagoftmtopsurgery.com/about-ftm-chest-recontouring-chicago/>

[TopSurgery.net](http://www.topsurgery.net/) <http://www.topsurgery.net/>

## 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!

## **Why would 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.

## **I've heard that bottom surgery for trans men doesn't give good results. Is that true?**

NO! And I need to apologize for my own part in spreading this myth. Bottom surgery, both metoidioplasty and phalloplasty, can give very very good results. For wonderful first-hand accounts of results, check out [Hung Jury](#). Testimonies of Genital Surgery by Transsexual Men <http://www.transgresspress.org/shop/individuals/>

## **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 metoidioplasties, erection is possible as is penetration (though some creativity in angles may be required). For phalloplasty, a penile implant allows for erection.

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.