Trans Care

Gender transition

Surgery: A Guide for FTMs

Sex reassignment surgery (SRS) refers to surgical techniques used to change trans people's bodies. SRS is sometimes called "gender reassignment surgery" (GRS) or "gender confirming surgery."

Not all trans people have SRS. Among those who do, there are various reasons for having SRS. Some people have it to reduce physical dysphoria – strong discomfort with the mismatch between identity and body. Others feel OK about their bodies, but are very uncomfortable with how other people perceive them (social dysphoria), and want to change their physical appearance to be able to live in a way that better matches their identity.

For any kind of health issue, choosing surgery is a big decision, and SRS is no exception. This booklet aims to:

- describe options for FTM[1] SRS
- explain possible risks and complications of FTM SRS
- describe what to expect before and after FTM SRS
- explore issues to consider in making the decision to have SRS

1 We use "FTM" as shorthand for a spectrum that includes not just transsexuals, but anyone who was assigned female at birth and who identifies as male, masculine, or a man some or all of the time. Some non-transsexuals in the FTM spectrum (androgynous people, butches, drag kings, bi-gender and multi-gender people, etc.) may also want some of the surgeries described above, and may not identify or live as men. For this reason we use the term FTM instead of "trans men".

Already sure you want to have surgery? The booklet *Getting Surgery*, available from the Transgender Health Program (see last page), explains the process.

This booklet is written specifically for people in the FTM spectrum who are considering SRS. It may also be a helpful resource for partners, family, and friends who are wondering what is involved in SRS. For health professionals who are involved in caring for someone who is planning to have SRS, there is a detailed set of guidelines available from the Transgender Health Program (see last page).

Surgical Options for FTMs

For FTMs, the goals of SRS are to reduce "female"[2] characteristics and make the body look more "masculine"[2] or androgynous (depending on how you identify). FTM SRS can include some or all of the surgeries listed on the following page.

Each of these surgeries has risks, but they are also proven to help FTMs with physical and/or social dysphoria to live more comfortably. The details of top surgery and lower surgery are discussed on the following pages.

2 The binary terms "male", "female", "masculine", "feminine", "masculinizing", and "feminizing" don't accurately reflect the diversity of trans people's bodies or identities. But in understanding SRS, it is helpful to understand "typical" (non-intersex, non-trans) men's bodies, and "typical" women's bodies. We keep these terms in quotes to emphasize that they are artificial and imperfect concepts.

Options for FTM Sex Reassignment Surgery		
	Medical term	**Explanation**
Top surgery	Reduction mammaplasty	Removing some breast tissue to make the chest smaller
	Chest reconstruction	Removing breast tissue and excess skin, and altering the nipple and dark area around it (areola)
Lower surgery	Hysterectomy	Removing the uterus
	Salpingo-oophorectomy	Removing the fallopian tubes and ovaries
	Colpectomy, or vaginectomy	Removing the vagina
	Colpocleisis	Closing the vagina
	Metaidoioplasty (sometimes spelled "metaidioplasty" or "metoidioplasty")	Making the clitoris appear larger, to form a small penis
	Phalloplasty	Making a penis using tissue from another part of the body
	Urethroplasty	Lengthening the tube that carries urine from the bladder, to exit through the new penis
	Scrotoplasty	Creating a scrotum ("balls")
Other possible surgeries	Liposuction	Removing fat from the hips, thighs, and buttocks
	Implants	Inserting material into the calf, jaw, chin, or chest to make these areas look more muscular

FTM Chest Surgery

Testosterone tends to bulk up muscles and reduce fat, and this can slightly change the shape of your chest, but testosterone doesn't make breast tissue go away. Only surgery can remove breast tissue.

What about binding?

Binding refers to the process of flattening your breast tissue to create a smaller and less noticeable chest. Some FTMs bind all the time; others only do it when they go out in public or in specific circumstances. For some FTMs binding is a viable alternative to chest surgery. For others it's only partially successful and is a short-term, stop-gap measure until surgery. The type of materials used depends on the size of your chest,

your overall build, and what you can afford. Websites explaining how to bind are listed at the end of this booklet.

Binding can have health consequences. Many of the synthetic materials used for binding don't allow your skin to breathe (promoting rashes and fungal infections), and when binding is done too tightly it can cause pain and restrict your breathing. Tight binding is especially dangerous for young FTMs whose bodies are still growing, as it can affect rib and lung development. To reduce the potential risks of binding:

- Loosen your binder if it hurts, cuts your skin, makes it difficult to move, or makes it difficult to take a deep breath.
- Give your skin a chance to breathe. Take breaks from binding.
- Wear a thin undershirt under your binder to help absorb sweat and prevent skin irritation.

Binding over a long period of time makes your skin less elastic, which can affect your surgical options and results. If you are planning to have chest surgery, talk with your surgeon about their recommendations for binding.

For more info on binding, see:

- http://web.mit.edu/hudson/www/binding.html
- http://www.thetransitionalmale.com/Binders

Types of FTM chest surgery

Breast reduction (Reduction mammaplasty)

If you want a smaller chest but not a "male"-looking chest, you might want to consider reduction instead of reconstruction. Getting a reduction affects your options for reconstruction, so it is not recommended that you have a reduction first if you are planning on getting reconstruction later.

The techniques used for reduction in FTMs are the same as reduction for women. The Canadian Society of Plastic Surgeons has a website explaining breast reduction at http://plasticsurgery.ca/breastreduc.htm.

Chest reconstruction

In FTM chest reconstruction, the goal is to create a "male"-looking chest. This can include:

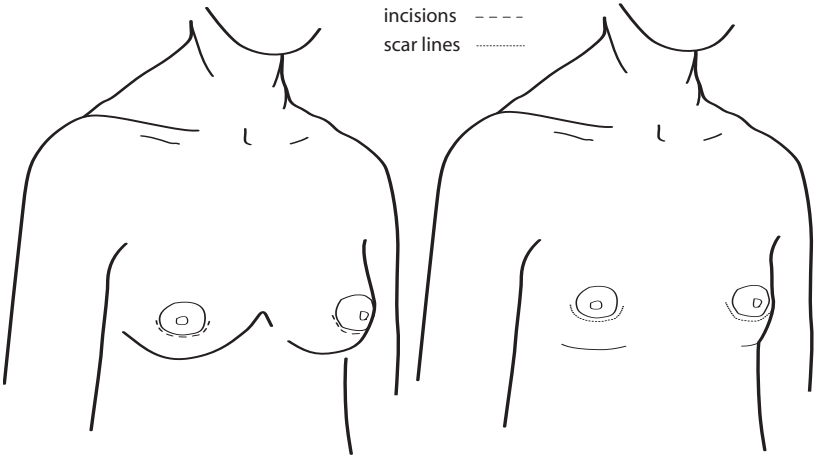
- removing most of the breast tissue
- removing excess skin
- removal of the crease where the breast meets the chest wall (*inframammary fold*)
- resizing and repositioning the nipple and the dark area around it (*areola*)

FTM chest reconstruction also includes preserving as much sensation as possible and trying to minimize scarring.

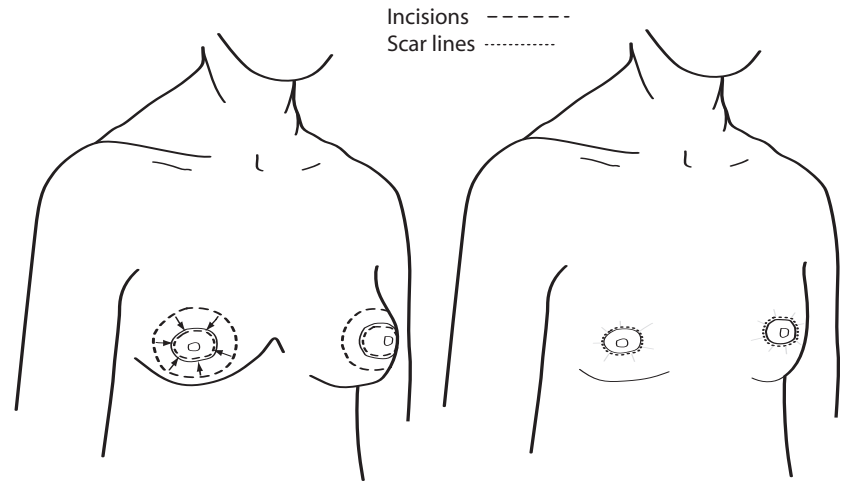
There are three possible techniques that can be used, depending on the size of your chest, the elasticity of your skin, and your preferences:

	Keyhole	Drawstring/ Pursestring	Mastectomy with free nipple grafts (double incision)
Used for	Small breasts (A or small B cup), with good skin elasticity.	Moderate size breasts (B or C cup), with good skin elasticity.	Large or saggy breasts, or inelastic skin.
Incision/ scar	Along bottom border of areola.	Circle around the edge of the areola.	Horizontal or U-shaped cuts across each breast, usually just below the nipple. The aim is to place the incisions just under the line of the pectoral muscles so it is not highly visible.
How it's done	Breast tissue is removed via a small incision under or across the areola.	Breast tissue is removed via an incision around the edge of the areola. A ring of skin is then removed in a wider circle around the areolar incision, and the skin is pulled toward the centre of the opening and stitched to the edge of the areola. This creates an effect similar to pulling a drawstring bag closed.	The skin is peeled back and the breast tissue and excess fatty tissue are removed. The excess chest skin is then trimmed and the incisions closed.
Nipples	Not resized or repositioned.	Areola may be trimmed to reduce its size. It may be possible to slightly reposition the nipple. Some surgeons leave the nipples partially attached via a stalk (pedicle) of tissue and move the entire stalk to try to preserve sensation.	Removed, trimmed to smaller size, and grafted onto the chest to approximate positioning of "male" nipple.

As part of considering which technique to have, it's important to consider your goals in terms of the balance between nipple appearance and sensation. The more the size and position of the nipple is changed, the less sensation you'll have. If nipple sensation is not important to you



Keyhole

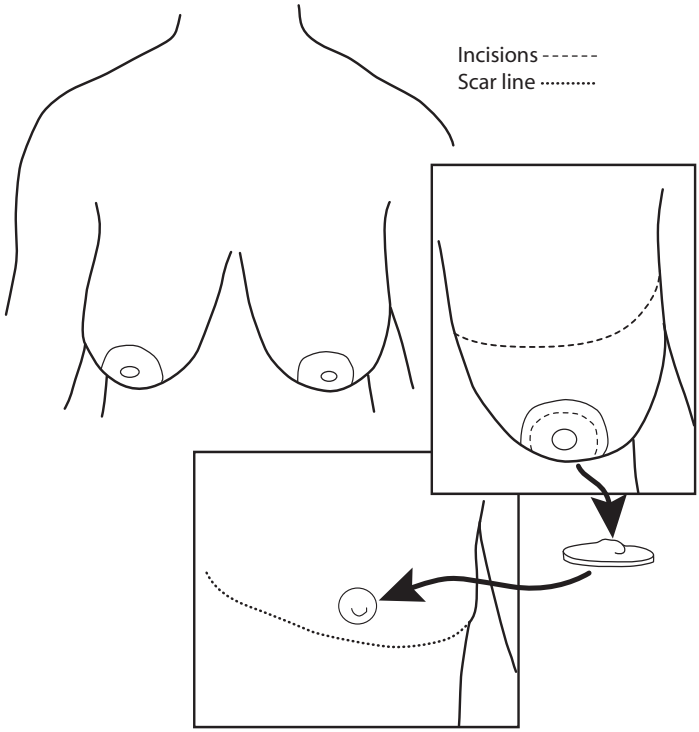


Pursestring

but nipple appearance is, a nipple graft may be your best bet. If nipple sensation is very important to you, talk with the surgeon about techniques to reposition the nipple without removing it.

What will my chest look like afterwards?

Looking at pictures of FTMs who have had chest surgery can help you get a sense of what to expect. The Transster website (http://www.transster.com) includes pictures of FTM surgery results by various



Mastectomy with free nipple graft

surgeons. You can also ask surgeons to see before/after photos of their patients.

If you look at a number of photos you'll see that the results vary greatly. Some FTMs have chests that look exactly like non-trans men's chests, but for most FTMs, getting to that point takes at least one (and sometimes more than one) revision surgery. The final results depend on what your chest was like to start with (chest size, quality of skin, etc.).

It is important to remember that, like non-trans men, not all FTMs have identical chests. Many surgeons' websites have photos of FTMs who are young and relatively thin. But most non-trans men do not have buff, rippling torsos with perky nipples, and it's unrealistic to expect this for yourself if this doesn't match your body. In looking at surgical pictures, look at FTMs who are close to your build and age to get a sense of what a realistic result might be for your body.

Because FTMs have had less exposure to testosterone than non-trans men, FTMs tend to have less developed muscles. A balanced exercise program that includes weight training to build the pectoral muscles (front chest wall) before and after chest surgery can help give a more "masculine" contour.

Timing of FTM chest surgery

Chest surgery can be done at any stage – as a first (or only) step, or after you've already gone through other body changes (e.g., testosterone). In BC FTM chest surgery is usually done as a single surgery, but in SRS programs where there is a team of surgeons working together, it can be done at the same time as hysterectomy/oophorectomy (see pages 13–20) to reduce the number of times you have to go through general anesthetic. The new SRS program that is under development in Vancouver is aiming to bring plastic surgeons and gynecologists together so FTMs can choose to have both surgeries done together. For more information on this program, see the *Getting Surgery* booklet, available from the Transgender Health Program (last page).

What to expect before and after FTM chest surgery

At the hospital

You will most likely be admitted to hospital the same day as your surgery. You may be asked to come to the hospital the day before surgery to go over information about the surgery and to have a last-minute physical checkup. You will be told not to eat or drink after midnight the night before you have surgery.

After your surgery, you will be monitored by hospital staff as you come out of the anesthetic. Chest surgery is a relatively simple procedure and you will probably be sent home the same day as surgery, with medication to help control pain and antibiotics to help reduce the risk of infection as your wounds are healing. FTMs who are having mastectomy may be kept in hospital overnight.

You will need to have someone drive you from hospital or take a taxi, as it's not safe to drive after chest surgery.

After chest surgery

Gauze dressings will be placed over the incisions, with a tensor bandage wrapped around your chest for protection and support. After reduction, a special surgical bra is worn until the swelling and bruising have gone down. After reconstruction, a compression vest is often recommended for one month to prevent fluid buildup and to help the skin tighten. Depending on the amount of tissue removed, you may have drainage tubes in the incisions or drains in the side of your chest to help drain excess fluid.

For the first three days after surgery, a home care nurse will visit you once a day to check your dressings and monitor and empty your drains. Three days after surgery, the gauze pads over your incisions will be taken off and you will be able to take a shower. There will be adhesive tapes ("steri-strips") along the incision line; leave these on, and be careful not to soak them in the shower (it's OK if they get splashed with a bit of water, but don't run water directly over them). After showering, gently pat the steri-strips dry. They will fall off on their own in 7–10 days. You can use fresh gauze pads as needed to protect the incisions. If you have drains, they will be removed by the surgeon or another doctor 3–7 days after surgery (your surgeon will give you instructions). Antibiotics continue until the drains are removed.

It is normal for the incisions to be red, but the redness shouldn't go beyond the incision for more than 1–2 cm (if this happens, see a doctor right away, as it can be a sign of infection). It is also normal to see or feel the knot in the stitches at the end of the incision. The stitch knot is not a problem; it will either dissolve on its own or come to the surface of your skin, in which case a doctor or nurse can clip it free.

If you had nipple grafts, your nipples will be covered with a special cushion and gauze. These will be taken off by the surgeon 5 days after surgery to check healing.

A medium level of bruising and swelling is normal. Your chest will probably feel sore and swollen for at least a month after surgery; if you have a large amount of swelling, see a doctor. Feelings of sharp shooting pain, burning pain, or general discomfort are common as part of the healing process and will eventually go away. Usually serious discomfort passes 1–2 days after the surgery. Your chest skin and nipples may be

partially or totally numb at first; sensation usually partially returns within a year of surgery, but may not fully return.

You can go back to your usual routine when you feel well enough to do so (i.e., normal movements don't cause pain). This is typically 1–2 weeks but can take longer in some cases. You should avoid any activity that is vigorous enough to raise your heart rate for 3–4 weeks, and should not do anything that involves lifting, pulling, or pushing for at least 6 weeks to help the scars heal.

Risks and possible complications of FTM chest surgery

All surgeries (not just SRS) involve possible risk of infection, bleeding, pain, and scarring. Antibiotics are usually given at the hospital to reduce the risk of infection, and the home care nurse who will check your dressings in the first couple days after surgery will also be looking for infection. It is normal for your chest to be sore after the surgery, and for the incision line to be red. If the redness goes more than 1–2 cm beyond the end of the incision, the skin is very tender or warm, and you don't feel well, see a doctor to check whether you have an infection.

All surgery that involves general anesthetic is a serious medical procedure. With any surgery there is a risk of blood clots (which can be fatal) or a negative reaction to the anesthetic. Surgeons, anesthetists, and surgical nurses are experienced in preventing problems and responding to any emergencies that happen during surgery. After you're discharged from the hospital, to prevent blood clots move around as much as feels comfortable, and drink plenty of water. Get emergency medical help (call 911) if you have sudden shortness of breath, chest pain, dizziness, or tender, warm, and swollen legs – these can be signs of a blood clot and you may need emergency help.

Your GP or nurse can handle minor infection or rupture of a small number of stitches after you've been discharged from the hospital. You will be referred back to your surgeon if you rupture so many stitches that the wound keeps opening more and more, or if fluid/blood builds up in your chest. If your notice an increasing amount of blood in your drains, contact the surgeon immediately.

Possible complications specific to FTM chest surgery include:

- problems with the contouring/skin: puckering, chest sunken or puffy in places, lopsided (one side looks different than the other), "dog ears" (excess skin at the end of the incisions), sagging skin that fails to tighten up after surgery
- lopsided repositioning or resizing of the nipple (one side looks higher/larger than the other)
- change in sensation to nipples/breast skin: less sensation or more intense sensation
- nipple grafts may die and need to be removed
- thick, red, rope-like scars

You will likely have to have further surgery if:

- you have contour problems or your nipples are lopsided: the surgeon will wait 8–12 weeks after surgery to see what your chest looks like after the post-surgical swelling fades
- your nipple grafts die: another graft, nipple reconstruction, or tattooing can be done at a later time
- you have severe scarring

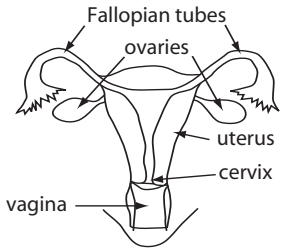
Can I still get breast cancer after chest surgery?

Studies of non-trans women who had breast reduction found reduced risk of breast cancer. Removing your breast tissue decreases the number of cells that can become cancerous. But even a complete mastectomy can't remove all breast tissue cells (there will still be microscopic amounts). This means you will still have a risk of breast cancer. Cases of breast cancer in FTMs after chest surgery have been reported.

Breast cancer is believed to be heavily influenced by exposure to the hormones estrogen and progestin. There is no clear evidence that FTMs who take testosterone are at increased or decreased breast cancer risk.

For more information, see *Trans people and cancer* (available from the Transgender Health Program).

Hysterectomy and Oophorectomy



Hysterectomy refers to the removal of the uterus, including its lining (*endometrium*). Total hysterectomy involves removal of the uterus and the cervix (the cone-shaped neck of the uterus that sticks out into the vagina).

Oophorectomy refers to the removal of the ovaries. The fallopian tubes, which carry eggs released by the ovaries into the uterus, are usually removed at the same time as the ovaries (*salpingo-oophorectomy*).

Both surgeries can be done by a gynecologist or reproductive endocrinologist.

Why get hysterectomy/oophorectomy?

There are various reasons FTMs have for wanting to have their uterus and/or ovaries removed. Like any other type of SRS, there is no right or wrong answer in terms of whether to have a hysterectomy or oophorectomy: it is a personal decision. You might want to consider it if you:

1. Feel dysphoric about having "female" organs or having periods.

Even though the uterus and ovaries are not visible, for some FTMs it is uncomfortable to know they are there. For FTMs in this situation, having the ovaries and uterus removed can help reduce the dysphoria.

Testosterone stops menstrual periods, but some FTMs don't want to take testosterone, experience bad side effects from it, or can't take it for health reasons. Removal of the uterus guarantees no more periods. *Endometrial ablation* – removal of the lining of the uterus by surgically burning it away or vaporizing it – is a possible alternative to getting your uterus removed if your main reason for hysterectomy is wanting to stop periods.

2. Are having gynecological problems.

Your doctor may suggest hysterectomy if you have fibroids, endometriosis, abnormal uterine bleeding, very painful menstrual periods, or another gynecological problem relating to the uterus, and may suggest oophorectomy if you have ovarian cysts or other problems with your ovaries. Usually

surgery is considered a last resort for gynecological problems, but for FTMs surgery may be considered as treatment early on if you were planning to have a hysterectomy or oophorectomy in the future anyway.

3. Are at risk for cancer of the uterus, ovaries, or cervix.

Risk of cancer depends on variables that are different for each person, including genetics and exposure to environmental agents known to cause cancer (*carcinogens*). As discussed in *Trans People and Cancer* (available from the Transgender Health Program), FTMs may be at increased risk of cancer of the uterus, ovaries, and cervix whether or not they take testosterone.

There is also some evidence that testosterone may increase the risks of uterine and ovarian cancer. For these reasons, some doctors recommend that FTMs who are taking testosterone over a long period of time should get their ovaries, uterus, and cervix removed. Other health professionals feel the evidence is not conclusive at this point and that these surgeries are only necessary if there are other risk factors for reproductive tract cancer.

4. Find it traumatic to get Pap smears and pelvic exams.

The Pap smear is the main screening tool for cervical cancer. It involves gently spreading the vagina open (with a *speculum*) and taking a sample of cells from the cervix to look for changes that can indicate early stages of cervical cancer. *Pelvic exam*, which involves the health professional putting 1–2 fingers inside your vagina, is done to help feel the size, shape, and position of your ovaries, uterus, and fallopian tubes, and to check for pain or growths. It is the main screening tool for ovarian and uterine health.

For FTMs who feel dysphoric about their genitals or have been sexually assaulted or abused, having anyone look at or put something inside their vagina can feel traumatic or humiliating. Some FTMs refuse to get Pap smears or pelvic exams. This increases the risk of ovarian, uterine, and cervical disease (including cancer) not being caught until it has advanced beyond the point where it can be treated. Removing your ovaries, uterus, and cervix is one way to prevent cancer.

If you have had cervical cancer or high-grade abnormal Pap smears (*cervical dysplasia*) in the past, even after your cervix is removed you will

still need to get samples of the cells of the top of your vagina (*vaginal cuff*) to check for cancer. It is recommended that you get vaginal cuff smears done every year until you have three normal tests in a row, then they can be done every 2 years.

5. Want to lower your testosterone dose.

The ovaries are the main source of estrogen. Having them removed lowers your estrogen and therefore the amount of testosterone you need to overcome the effects of estrogen. The health risks of long-term use of relatively high doses of testosterone are not known, and some doctors and trans people believe that lower doses are lower risk. If your combined estrogen and testosterone are too low you are at risk for loss of bone density (see booklet on osteoporosis), so if you have your ovaries removed you will have to take some type of medication to protect your bones (if you have bad side effects from testosterone, there are other options).

6. Want to be able to change legal sex on your birth certificate.

For FTMs born in BC, the Ministry of Health's Department of Vital Statistics requires that FTMs have had a hysterectomy (plus chest reconstruction or a small chest) to change their birth certificate from F to M. Changing the birth certificate makes it easier to change legal sex on other documents and records.

Other identification can be changed without having had surgery. Transgender community groups have encouraged Vital Statistics to follow the same protocol as the Insurance Corporation of BC, which allows change of legal sex on a driver's license or birth certificate with a letter from your GP stating that you are living full-time as a man and are undergoing medical transition.

Surgical techniques for hysterectomy/oophorectomy

Hysterectomy

In the past the only option for hysterectomy was a large cut across the abdominal muscles. This was a major surgery that involved prolonged recovery time. It is usually done differently now to spare the abdominal muscles. Several small cuts are made in the bellybutton/abdomen and a tiny telescopic camera (*laparoscope*) and other surgical instruments are passed into the pelvis. The camera is used by the surgeon to see the uterus

and other pelvic organs, and the surgical instruments are used to snip the tissues holding the uterus and cervix in place. The uterus (and possibly cervix) is removed through a cut in the vagina (v*aginal hysterectomy*) or alongside the abdominal muscles (*abdominal hysterectomy*), and the top of the vagina is sewn shut.

It is up to you and your surgeon to decide together whether to do abdominal or vaginal hysterectomy. Abdominal hysterectomy involves a larger incision than with vaginal hysterectomy, so can take longer to heal. However, a vaginal hysterectomy can be difficult to do if you have never had penetrative vaginal sex or have a small vagina (especially if your vagina has atrophied from taking testosterone over a long period of time), or if your uterus has become attached to other organs due to adhesions from endometriosis or another gynecological condition.

Oophorectomy

This is usually done at the same time as hysterectomy and usually involves removal of ovaries and fallopian tubes on both sides (bilateral salpingo-oophorectomy). It is usually done through laparoscopic abdominal incisions as described above for hysterectomy.

When can I have hysterectomy/oophorectomy?

If you are having hysterectomy/oophorectomy to treat pre-existing medical problems (pain, bleeding, etc.) you will go through the same process as women who are having the same surgery for similar conditions. The wait for surgery depends on how much of an emergency the condition is; if it's considered serious you will have surgery sooner than if it is considered a minor health problem. Mental health assessment is generally not required to have hysterectomy/oophorectomy for a physical health problem unless the surgeon has concerns about your ability to provide informed consent or doesn't think you are psychologically prepared for surgery. There is no special process you have to go through to get BC Medical Services Plan (MSP) in this case – the surgeon will bill MSP directly after the surgery.

If you are wanting hysterectomy/oophorectomy to reduce dysphoria, to change your legal sex, or for other reasons that are considered part of gender transition, your surgeon will likely treat the surgery differently. Most surgeons follow the Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care* (http://www.hbigda.org/soc.

htm), which state that hysterectomy/oophorectomy should only be done after one year "real life experience" and evaluation by two trans-experienced mental health professionals. If you are applying for coverage under the BC Medical Services Plan you must follow their rules, which are stricter than HBIGDA's: you must have lived as a man for two years and must be evaluated by two MSP-approved mental health professionals. For further details on MSP and HBIGDA criteria, and details of the SRS assessment process, see the booklet *Getting Surgery* (available from the Transgender Health Program).

In BC, FTM hysterectomy/oophorectomy is usually done as a single surgery. Because there is a risk every time you go under general anesthetic, in SRS programs where there is a team of surgeons working together, hysterectomy/oophorectomy is often done at the same time as chest reconstruction or genital surgery. The new BC program that is under development (see *Getting Surgery*) is aiming to bring plastic surgeons and gynecologists together so FTMs can choose to have hysterectomy/oophorectomy at the same time as another surgery.

What to expect before and after hysterectomy/ oophorectomy

At the hospital

You will be admitted the same day as your surgery. You may be asked to come to the hospital the day before surgery to go over information about the surgery and to have a last-minute physical checkup. You may be prescribed antibiotics to help reduce the risk of infection, or laxatives to clean out your bowels. You will be told not to eat or drink after midnight the night before you have surgery.

You will be monitored by hospital staff as you come out of the anesthetic and will stay in hospital for 2–5 days to recover (depending on the type of surgery you've had and your progress in healing). You will likely have a tube in your bladder (*catheter*) to collect urine for the first 48 hours after surgery, as it's often difficult to urinate at first. There may also be tubes from your abdomen to help drain fluids from the operation site.

As with any surgery, you will not be able to drive afterwards so you will need someone to help you get home. You will likely be given antibiotics in the hospital to help reduce the risk of infection as your wounds are healing, and also will be given pain medication. You may be given medication that

you put inside your anus (*anal suppositories*) to help with pain, constipation, bloating, and gas.

After surgery

The aftercare instructions are different for different types of surgery and depend on the specific technique used. Talk with your surgeon before surgery to make sure you understand what to expect and what you need to do after you've been discharged from the hospital, and to talk about pain management options.

Your surgeon will give you information about wound healing and the dressings over your wounds, and a home care nurse will visit you once a day after you are discharged from hospital until the wounds have healed enough for you to take care of them yourself. If you have had surgery done by laparoscopy, the wounds will be very small; if you have had abdominal hysterectomy you will have a larger incision. Do not have a bath or otherwise soak the incisions until they have completely healed.

During the first two weeks, you will need to rest and avoid lifting or other movements that cause pain. After this, you can try slowly working in more daily tasks that do not involve too much physical activity. People describe having a feeling of abdominal pressure; pain when trying to urinate, pass gas, or defecate, or sometimes vaginal bleeding. Once this has stopped, you can go back to most of your normal activities, being careful to not overdo it and to rest when you need to. Complete recovery usually takes 4–6 weeks for vaginal hysterectomy and 6–8 weeks for abdominal hysterectomy. Whichever type you've had, don't have vaginal sex until 6 weeks after surgery, and avoid heavy physical exercise for at least 3 months after surgery. The surgeon will want to see you approximately 6 weeks after surgery to check your healing.

Risks and possible complications of hysterectomy/ oophorectomy

Every surgery involves possible risk of infection, bleeding, pain, and scarring. Antibiotics are usually given at the hospital to reduce the risk of infection, and hospital staff and the home care nurse assigned to you after you are discharged will be checking for signs of infection. It is normal for there to be swelling and bruising, but if the skin is very tender or warm and you don't feel well, see a doctor to check whether you have an infection.

Also see a doctor if your incisions are red more than 1–2 cm beyond the end of the incision line.

All surgery that involves general anesthetic is a serious medical procedure. With general anesthetic there is a risk of a negative reaction to the anesthesia or, if you are lying flat for a long period of time, a risk of blood clots (which can be fatal). Surgeons, anesthetists, and surgical nurses are experienced in preventing problems and responding to any emergencies that happen during surgery. After you're discharged from the hospital, to prevent blood clots move around as much as feels comfortable, and drink plenty of water. Get emergency medical help (call 911) if you have sudden shortness of breath, chest pain, dizziness, or tender, warm, and swollen legs – these can be signs of a blood clot and you may need emergency help.

Possible complications specific to hysterectomy include:

- accidental damage to the bladder, rectum, or other internal organs
- bladder or urinary tract infection
- sinking of the top of the vagina (*vaginal vault prolapse*) due to decreased support from other organs: this needs surgical repair
- changes in sexual sensation or decreased intensity of orgasm

Possible complications specific to oophorectomy include:

- accidental damage to the bladder, rectum, or other internal organs
- bladder or urinary tract infection
- menopausal symptoms and loss of bone density related to decreased estrogen (if you're not taking testosterone)
- pain and menstrual bleeding if some ovarian tissue is left behind (see below)

Call your doctor or go directly to hospital if you have:

- severe pain
- nausea or vomiting
- heavy vaginal bleeding (more than a typical menstrual period would be)
- fever of 38°C/101°F or higher
- pain when you urinate, or problems controlling your bladder (*incontinence*)
- a swollen abdomen or inability to pass gas

Whether or not you have vaginal sex, you may find that the removal of your uterus and cervix affects the sensations you experience during orgasm. The uterus changes shape during sexual arousal and contracts

Want more information about hysterectomy/oophorectomy?

Society of Obstetricians and Gynecologists of Canada

http://www.sogc.org/health/health-hysterectomy_e.asp

This web page explains types of hysterectomy, risks, and potential complications. The page is designed for women, so is not sensitive to FTM needs, but the basic information is there.

with orgasm, so its removal can change what you feel when you have an orgasm. If you enjoy vaginal penetration as part of sex, you may find that having your cervix removed makes it harder to have an orgasm or that orgasm is less intense. The loss of the cervix can also impact vaginal lubrication, so you may need more lube after a hysterectomy.

Polycystic ovaries, endometriosis, infections, and other gynecological problems can cause scar tissue (*adhesions*) that attaches your ovaries to your uterus or other organs. It can be hard to separate and pull the ovaries off the other organs. Bits of ovarian tissue may be left behind and grow, causing pain. This situation is called *ovarian remnant syndrome*. In rare cases enough tissue is left to produce eggs, or normal amounts of estrogen – which can bring about a menstrual period if you still have a uterus and are taking low doses of testosterone. Further surgery is needed to remove the leftover pieces of ovarian tissue.

FTM Genital Surgery

As discussed on page 3, FTM genital surgery can involve:

1. removal of the vagina (*vaginectomy* or *colpectomy*) or closure of the vagina (*colpocleisis*)
2. creation of a scrotum and testicular implants (*scrotoplasty*)
3. creation of a penis (2 types of surgery – *metaidoioplasty* or *phalloplasty* – with various techniques that can be done for each type)
   - both techniques can involve lengthening of the urethra – which carries urine from the bladder to outside the body – to allow you to urinate through your penis (*urethroplasty*)
   - phalloplasty can include placement of a device to make it stiff for

sex, and also tattooing of the head to make its color look more like a non-trans man's penis

Each type of surgery is discussed in detail on the next few pages.

Different surgeons do different parts of the surgery:

- vaginal closure, urethral lengthening, metaidoioplasty: urologist (urinary tract specialist)
- removal of the vagina (if done with removal of ovaries/uterus): gynecologist or reproductive endocrinologist
- phalloplasty: plastic surgeon
- scrotoplasty: urologist or plastic surgeon

Timing of FTM genital surgery

There are various ways the surgeries can be grouped together, depending on the protocols used by the surgical team, your health, and your overall goals of genital surgery. Possible combinations include:

- vaginal closure/removal, urethral lengthening, scrotal construction, and metaidoioplasty/phalloplasty done at the same time, along with removal of the ovaries and uterus if they have not already been removed
- vaginal closure/removal, urethral lengthening, and phalloplasty done at the same time, with scrotum construction and placement of a penile stiffening device done later (one year after phalloplasty)
- vaginal/closure removal at the same time as removal of the ovaries and uterus, if there are no plans for urethral lengthening in the future

If you have recently had your ovaries/uterus removed, you must wait at least 4–6 months before having genital surgery, to give your body time to fully recover from the first surgery.

FTM genital surgery techniques

Creation of a penis

There are two options for creating a penis: metaidoioplasty (sometimes spelled "metaidioplasty" or "metoidioplasty," or abbreviated as "met") and phalloplasty. Phalloplasty can be done on top of a metaidoioplasty – in other words, you can have a metaidoioplasty first, then have phalloplasty later.

	Metaidoioplasty	Phalloplasty
How is it done?	Testosterone makes your clitoris grow (usually 1–3 cm). Metaidoioplasty involves cutting the ligament that holds your clitoris in place under the pubic bone, as well as some of the surrounding tissue. Your clitoris is then freed up so more of it is showing (this technique is sometimes called "clitoral free-up" or "clitoral release"). The surgical technique can include modifications to enhance the result: • fat can be removed from your pubic mound and the skin pulled upward to bring the new penis farther forward • flaps from the inner labia can be wrapped around the shaft to make it bigger	There are various techniques, but the most common involves removing a flap of skin/blood vessels/nerves from the forearm (or another area), rolling this to make a "tube within a tube", and then using microsurgery to attach the new penis to your groin (over the top of your clitoris). The end is surgically sculpted to look like the head of a penis. Tattooing of the head can be done 6 months later to help create a visible line between the head and the shaft. A skin graft is taken (usually from your thigh) to cover the graft area on your arm.
Vagina removed?	Optional – done if you get urethral lengthening.	Yes.
Result size	A very small penis.	An adult-male-size penis.
Sexual function	Sexual sensation is generally good, as the clitoris is not impacted much. The new penis will get erect on its own when you're sexually aroused, but won't be large enough to penetrate a partner with.	Pulling on the penis will stimulate the clitoris that is buried at its base. If the microsurgical nerve hookup is successful, you will also have sensation in the skin of the penis. At least 1 year after phalloplasty, a stiffening device can be inserted to create an erection firm enough for penetrative sex.
Urinate standing up?	Yes, if you have urethroplasty done (optional).	Yes. As part of phalloplasty, urethroplasty is done.
Visible scarring	Minimal.	Large scar on the forearm (where the tissue was removed). Scars on the graft sites.

Metaidoioplasty is a simpler and less invasive surgery, but the penis created is too small to have penetrative sex with. Phalloplasty is a more complex and invasive surgery, but the penis created is adult-male-sized

and can be used for penetrative sex. Deciding which one to have depends on many factors, including your overall goals for surgery and the health risks of each.

It is highly recommended that you look at pictures of surgical results from both metaidoioplasty and phalloplasty so you know what you can likely expect from each. There are many techniques that can be used in phalloplasty (pedicle, flaps from areas other than the forearm, etc.) and two metaidoioplasty techniques (basic and Centurion), so make sure the photos you look at match the technique you are thinking about having. There is an online collection of FTM surgery photos at: http://www.transster.com.

There are various options for devices to make your penis erect after phalloplasty. *Hydraulic erectile prosthesis* (e.g., Dynaflex, CXM) involves a pump that moves liquid from a central reservoir (usually in the abdomen) into an inflatable chamber in the penis. Alternatively, a flexible rod can be inserted.

Vaginal removal or closure and urethral lengthening

FTM vaginal surgery can involve removal of the vagina (*colpectomy*) or closure of the vagina (*colpocleisis*). In colpectomy, the entire vagina is removed, usually at the same time as removal of the uterus and cervix. In colpocleisis, the lining of the vagina is removed and the muscles surrounding the vagina are stitched together to close it.

Closure/removal of the vagina and urethral lengthening are a necessary part of phalloplasty, but are optional in metaidoioplasty. They are usually done together because the lining of the vagina is typically used to make the urethral extension. If you're not planning to have urethral lengthening, you can have colpectomy or colpocleisis done separately (usually at the same time as removal of the uterus/ovaries).

Scrotoplasty

Male testicles hang in a pouch of skin called the *scrotum*. The scrotum and testicles provides a significant part of the bulge when men wear underwear or swim trunks. FTMs who identify as men may want a scrotum constructed to help with passing, and/or because having a scrotum is part of their self-image as a man.

Scrotoplasty can be done by a urologist or plastic surgeon at the same time as metaidoioplasty/ phalloplasty or as a later stage. Vaginal removal or closure must be done first. The outer labia are used to create two

pouches, joined in the middle over the former opening of your vagina. After the tissue is stable, silicone implants are placed inside the pouches to simulate testicles. At first the scrotal skin looks oddly tight, but over time the weight of the implants stretch out the scrotal skin to create a more natural appearance.

What to expect before and after FTM genital surgery

Vaginal closure is a relatively simple surgery, but all other FTM genital surgeries are major procedures that require more complex care before and after surgery. As most FTMs have a group of genital surgeries done together, the information below describes what to expect in the typical groupings of genital surgeries.

At the hospital

If you are getting a metaidoioplasty you will be admitted to hospital the same day as surgery. You may be asked to come in a day earlier to get blood work done and go over the instructions for surgery.

Special preparation for phalloplasty

If you are having phalloplasty, there are two special issues that need to be addressed months in advance of your surgery.

1. Removal of hair on graft sites

   Ask your surgeon whether or not you need to have electrolysis to remove hair on any of the donor sites. Electrolysis is usually optional for the skin that will be used to form the shaft of the penis, but mandatory for skin that will be used to lengthen your urethra (as hairs can promote infections and urinary tract stones). Some surgeons require electrolysis to be completed at least 3 months before phalloplasty.

2. Quitting smoking

   Smoking affects wound healing, skin quality, and other aspects of healing after surgery, so surgeons strongly encourage their patients to quit well in advance of surgery. With all types of surgery, the surgeon will ask you whether you smoke as part of the initial consultation (see *Getting Surgery*, available from the Transgender Health Program). With phalloplasty, it is mandatory that you quit several months before surgery. You will not be considered for phalloplasty if you smoke or if your surgeon thinks it is likely you will start smoking soon after surgery, because the likelihood of your new penis dying is much higher if you smoke.

If you are getting a phalloplasty, you will be admitted to hospital the day before your surgery. Blood will be drawn to check your overall health, and you will likely have electrodes placed on your chest (*electrocardiogram*) to measure your heart function; if there are any concerns about your lungs you may have a chest X-ray. You will also have a "bowel prep" to clean out your intestines. This both helps prevent problems during surgery and also gives you a couple days of rest so you don't have to strain to go to the bathroom after surgery. You will be told not to eat or drink after midnight the night before you have surgery. The area that will be operated on will be shaved.

After your surgery, you will be monitored by hospital staff as you come out of the anesthetic. You will then stay in hospital until you are recovered enough to be sent home. This is usually:

- an overnight stay if you are having metaidoioplasty without urethral lengthening
- 5–10 days if you are having metaidoioplasty with urethral extension
- 10–14 days if you are having phalloplasty

After phalloplasty you will need to stay in bed most of the time that you are in hospital. Your penis will be very closely monitored (every hour for the first 2 days) by the nursing and surgical staff. You will likely be hooked up to a PCA (*patient-controlled analgesia*) machine that lets you take pain medication when you need it (up to a limit of what is safe). You will also be given antibiotics and medication to prevent blood clots for the first five days. The skin-grafted forearm will be wrapped under special bandages for 5 days.

If you are having urethral extension done (required as part of phalloplasty, optional with metaidoioplasty), a tube (*suprapubic catheter*) will be placed to bring urine from your bladder out through your lower abdomen. This gives your new urethra time to heal. This catheter is usually removed during the first week. A catheter may also be placed from your bladder out through your new urethra (*Foley catheter*) to help keep your urethra open. The Foley catheter is usually kept in place for 2–3 weeks. You will stay on antibiotics until the Foley catheter is removed.

After surgery

Generally people start to feel more physically comfortable during the second week after surgery, but it can take a long time to fully heal, and there can be pain and soreness for a long time in the surgical sites.

After phalloplasty you will have to follow up with the plastic surgeon and urologist frequently in the first couple weeks after surgery, and periodically after that. You should plan to stay in the same city as the hospital for at least 1–2 weeks after surgery. The surgeon will do a physical exam to check your general health and will also check your new penis for healing, blood flow, and ability to urinate. Your donor forearm will also be checked for healing and hand/wrist sensation and function. All of the surgical incisions will be checked for infection and scarring. The skin graft donor site (thigh) will be covered with a sheet of gauze which becomes absorbed into the scab. It may be gradually trimmed away as it lifts up from its edges over the following 1 to 2 weeks.

You can slowly become more active as you recover and can go back to your usual routine when you feel well enough to do so (i.e., normal movements don't cause pain). This is typically 6–8 weeks but can take longer in some cases. You should avoid any activity that is vigorous enough to raise your heart rate until you have fully recovered. Check with your surgeon if you are not sure.

Risks and possible complications of FTM genital surgery

All surgery involves possible risk of infection, bleeding, pain, and scarring. Antibiotics will likely be given to reduce the risk of infection, and the health professionals who will check your dressings in the week after surgery will also be looking for infection.

All surgery that involves general anesthetic is a major medical procedure. With any surgery there is a risk of blood clots (which can be fatal) or a negative reaction to the anesthetic. Surgeons, anesthetists, and surgical nurses are experienced in preventing problems and responding to any emergencies that happen during surgery. After you're discharged from the hospital, to prevent blood clots move around as much as feels comfortable, and drink plenty of water. Get emergency medical help (call 911) if you have sudden shortness of breath, chest pain, dizziness, or tender, warm, and swollen legs – these can be signs of a blood clot and you may need emergency help.

Risks/complications of metaidoioplasty and phalloplasty

Possible complications specific to metaidoioplasty without urethral lengthening include:

- dissatisfaction with the length of the penis (shorter than expected)
- change in sensation: loss of sensation, persistent tenderness, or hypersensitivity
- temporary or permanent narrowing of the vaginal opening, making penetration difficult
- change in urine spray, resulting in splashing of the labia and vaginal skin

Possible complications specific to urethral lengthening include:

- *urethral fistula*: opening between the urethra and the skin, leading to leakage of urine (very common: occurs in around 45% of phalloplasties)
- partial or total death of the tissue used to create the new urethra
- narrowing or closure of the new urethra
- hair growth in the urethra (from hair-bearing tissue used as urethral lining)

Phalloplasty includes all the possible complications of urethral lengthening as well as possible:

- partial or total death of the tissue used to create the new penis
- numbness or hypersensitivity of the skin of the penis
- decreased sexual sensation, possibly with decreased ability to have orgasm
- compromised sensation and/or function of the hand and wrist of the donor arm (approximately 5% of patients need a long period of physiotherapy to recover fully)
- dissatisfaction with the size or shape of the penis
- excessive scarring in the donor sites (arm/thigh)

Some of these are long-term risks, while others are only likely to happen in the hospital (where they can be taken care of by hospital staff. For example, partial or complete death of the new penis – a rare complication of phalloplasty – is most likely early in recovery while you're still in hospital; by the time you are discharged, the risk is very low. Hospital staff will also take care of any bleeding or swelling that happens right after surgery.

Decreased sensation at all surgical sites is common and usually resolves spontaneously within a few weeks to months. After phalloplasty the penis has no sensation for the first several months, with sensation gradually progressing from base to tip throughout the following year. You may have significantly decreased sensation in your donor forearm; although this usually improves over time as small nerves branch into the skin graft, sensation will never fully return.

Your GP or nurse can handle minor infection or rupture of a small number of stitches after you've been discharged from the hospital. You will be referred back to your surgeon if:

- you have a serious infection
- you rupture so many stitches that the wound keeps opening more and more
- you have any signs of tissue death (mottled skin that progressively becomes darker)
- you have difficulty urinating, painful urination, decreased amount of urine, or need more time and effort to urinate
- urine is leaking from a hole in your skin (fistula)
- your penis is getting swollen from fluid buildup
- you have severe scarring

Urethral fistula is very common (45% of phalloplasties). You should let your surgeon know if this happens. Your surgeon will give you instructions on how to monitor it and keep it clean. Most fistulae heal on their own, but if it doesn't heal within 2-3 weeks, you will likely need to have it surgically repaired by a urologist.

You will also have to have further surgery if:

- the new penis dies (after phalloplasty)
- your urethra gets severely narrowed or blocked
- you have severe scarring

Scrotal implants and erectile prosthetics

With any implant there is a risk of the implant become infected, coming out of the skin, or breaking down (scrotal implants can rupture; hydraulic erectile prosthetics can have mechanical failure in the pump system). The implant must be surgically removed, with the option of later replacement. After having an implant, see your surgeon if:

- your incisions are warm, red, or leaking pus/blood

- you can see the prosthetic coming out from the skin
- one testicle is swollen or changes size/shape (you will need to get a scan done to see if the implant has ruptured)
- your erectile device isn't working (your penis doesn't get hard)

Making the Decision to Have SRS

Part 1: *Am I sure*?

There is no one right way to make the decision to have surgery. As with any big life-changing decision, it is normal to have doubts, fears, and anxieties about SRS. But as part of the decision-making process, it is important that you are sure you want to go ahead with surgery.

We know from our own experiences and from listening to many other people that every person's situation is unique, that there is no one way to make a decision about SRS, and that it is not as simple as a one-time yes or no – it is often a long process that is shaped not only by internal feelings and beliefs but also by ever-changing external circumstances that are not necessarily in your control (health, money, family responsibilities, limited access to services, etc.)

It's been our experience that people tend to make decisions about SRS the same way they make decisions about the rest of life. Some trans people look for a strong internal feeling that SRS is right and don't want to be influenced by what other people think, while others want to get opinions from friends, family members, other trans people, counsellors, or other health professionals as part of making the decision.

Whatever way you think things through, some questions to consider are listed below. There aren't any right answers to these questions, they are just ways to think through various aspects of SRS so you can better understand your feelings, values, and expectations.

- Do you have a clear mental picture of what you want to look like after SRS? How do you think you might feel if the results don't match that mental picture?
- Are you hoping SRS will fix anything, and if so, what?
- What parts of your life might change after SRS? What do you hope might change, and what do you fear might change?
- Do you think your hopes for SRS are realistic? How can you tell if they are or not?

- How much do you know about the options for SRS? What more do you need to know to be able to make a fully informed decision?
- Are the parts of your body that will be changed by SRS part of your sexuality? What will happen if you lose that part of your sexuality?
- Who else in your life will be affected by your decision? How do you think they will feel about you having SRS? How will their reactions impact you?
- What do you think is a "wrong reason" to have SRS? What do you think are the "right reasons?"

What SRS won't do for you

SRS can be a great relief for trans people and allow us to live more comfortably. But there are some things SRS won't do.

1. SRS won't solve all body image problems

The point of SRS is to feel more comfortable with your body by bringing physical characteristics closer to your internal sense of self. This relief can increase self-esteem and make you feel more confident and attractive. However, you will find that there are also attractiveness standards after SRS, and you may not fit them.

Comfort with your body is made more complicated by the social pressures and gender stereotypes about appearance. Some FTMs respond to this by obsessively working out or having endless surgical revisions, chasing an idealized stereotype of attractiveness.

It can be hard to separate out gender dysphoria from body image problems. Professional and peer counselling can be helpful to sort out your expectations about your appearance, and to work towards greater self-acceptance after SRS.

2. SRS won't solve all sexual problems

For some trans people, wanting to feel more comfortable about sex is an important reason for having SRS. SRS can help ease feelings of dysphoria that impact negatively on sexuality. However, not all sexual problems are due to dysphoria. Sexuality is complex and can be impacted by many things, including physical problems, stress, relationship dynamics, body image problems, past sexual abuse or other kinds of trauma, and cultural and personal beliefs about sexuality. SRS will not automatically fix all of these areas of your life. If you are having sexual difficulties, consider peer

or professional counselling to explore the reasons and to find out about sexual health treatment options. The Transgender Health Program (see last page) can assist if you need help finding a trans-positive sexual health professional.

SRS often has a positive impact on sexuality. In numerous studies, the majority of trans people who participated reported increased sexual satisfaction after SRS. But SRS can also have a negative impact. Change in sensation is very common after surgery. You may find that touch is not as intense, or that it is more intense (to the point of being uncomfortable or painful). Some FTMs have difficulty reaching orgasm after surgery, or report that orgasm is less intense. Making the decision about surgery includes considering the possibility that SRS may negatively impact your sexuality, and thinking about how you might cope with that possibility.

Whether or not you decide to have SRS, some trans people find counselling useful in dealing with the impact of internalized transphobia on their sexuality. Living in a transphobic society, many trans people internalize negative messages about being trans. This can include shame about erotic crossdressing or other trans-specific sexual desires and fantasies, or shame about having a body that does not conform to societal norms. Peer or professional support can be helpful in working towards greater self-acceptance of your sexuality (with or without SRS).

3. SRS won't make you into someone else

Many people experience positive emotional changes with SRS. But you'll likely find, after the excitement wears off and you've incorporated the changes into your day-to-day life, that if you were shy you're still shy, if you didn't like your laugh you still don't, and you're still afraid of spiders. Whatever things you think of as your strengths and weaknesses will still be there. Hopefully, you will be happier, and that is good for anyone. SRS may help you to be more accepting of yourself. But if you are expecting that all your problems will pass away, and that everything is going to be easy emotionally and socially from here on in, you're probably going to be disappointed.

This extends to mental health concerns as well. Trans people who were depressed because of gender dysphoria may find that SRS greatly alleviates their depression. However, if you have depression caused by biological factors, the stresses of transphobia, or unresolved personal issues, you

may still be depressed after SRS. Likewise, if you are having problems with drugs or alcohol, SRS will not necessarily get rid of those problems.

4. SRS won't provide you with a perfect community

For some trans people, SRS is a ritual affirming that they are who they say they are. Making physical changes is a way to bring who you are to the rest of the world so other people can see it. This process of self-emergence can be very liberating, but it does not guarantee that you will find acceptance or understanding.

Some FTMs hope that after they make physical changes they will be validated as "real" men, or feel more accepted by the trans community. But the idea that trans people aren't "real" unless they've changed their bodies is transphobic, and communities or groups that have this belief are not likely to be fully respectful in terms of trans people's identities and bodies.

During the various stages of transition, it's common to dream about finding an ideal community of trans people. When undergoing SRS there can be a particular drive to find other people who have gone through similar experiences. There are a lot of very cool trans people to talk with about SRS. But having had SRS doesn't automatically make trans people welcoming, approachable, or sensitive to the needs of others, and despite having some experiences in common you will likely find that no trans person will exactly mirror your personal experiences, identity, and beliefs. Being realistic about the likelihood that you will at times feel lonely and alone after you start taking hormones is part of emotionally preparing for SRS.

Part 2: *Am I ready*?

It's not enough to be sure that SRS is right for you: you should also be sure it is the right time in your life to have SRS. This depends both on your readiness for the physical stress and mental adjustment involved in SRS, and also your readiness to deal with the reactions of others.

As discussed in the booklet *Getting Surgery* (available from the Transgender Health Program), for any kind of surgery the patient needs to be both physically and psychologically ready. Physical readiness means you are in reasonable health overall, and you have completed any of your surgeon's physical requirements (e.g., electrolysis before phalloplasty,

quitting smoking). Physical readiness also includes arrangements for the physical care you will need after surgery – having a safe place where you can recover after surgery, understanding what is involved in aftercare, and having friends, family, or health professionals who can help look after you.

Mental readiness doesn't mean you have no mental health problems or life stresses, it means you have:

1. A solid sense of your gender identity

SRS is not for people who are just starting to question, explore, and think through issues around gender identity. If you are thinking about SRS as part of your initial process of exploring gender issues, give yourself some time to get a clear sense of how you identify and how surgery will contribute to this sense self before making a decision.

2. Enough mental stability to make an informed decision about your medical care

Times of chaos and crisis are not the best times to make big decisions. Being in crisis can make it hard to think clearly and make fully informed decisions. If you are finding it hard to make general life decisions because you're overwhelmed by anxiety, depression, drug or alcohol problems, family stresses, work problems, or other issues, you're not in a good place to make a big decision like whether to have surgery and what kind of surgery to have. Get peer or professional support to work on whatever is making it hard to think things through, and then come back to the question of whether to have SRS when your mind is clearer.

3. Enough coping skills and supports to withstand the typical stresses of SRS

Trans people often feel exhilarated and liberated after SRS, but it is also common to have emotional ups and downs after surgery. It can be difficult to adjust to changes to how your body looks and feels, to cope with pain or other physical complications, and to deal with other people's reactions. For some loved ones, SRS is the first time it really sinks in that gender issues are not going to go away and that you really are trans. This can be a hard emotional process for them and can affect the support they can offer. If you don't feel you have the emotional resilience to deal with these possibilities, now is not the right time for SRS.

If you are sure that SRS is right for you but you are not sure that you are ready at this point in your life, you don't have to abandon SRS altogether. You can still work towards SRS by thinking about what might help you get to the point where you are ready – counselling, advocacy, peer support, etc. – and slowly but steadily making life changes to move closer to readiness.

What Happens if I Regret Having Surgery?

Surgery is a powerful experience. Dissatisfaction, disappointment, and doubt are relatively common after any surgery, and (for trans and non-trans people) typically relate to post-operative pain, surgical complications, discrepancy between hoped-for results and actual results, a sense of "now what?", and the reactions of other people. These are all normal parts of adjustment and usually resolve within the first year after surgery. Studies have consistently found that less than 1% of FTMs who go through SRS have deep and long-lasting regrets.

If you are having trouble coping with surgical ups and downs, peer and professional counselling can be helpful. It is important that the counsellor have strong experience with trans issues and understand issues relating to surgery. The Transgender Health Program can help you find mental health professionals with this experience.

Many people who experience persistent regret come to peace with their decision to have had surgery – even if they wouldn't do it again, they feel that at the time it was the right decision. Some people decide that surgery and transition was wrong for them, and want to transition back. This is a big decision and should not be made without professional counselling.

FTM SRS Resources

Note: Websites change frequently, and we cannot guarantee the full accuracy of all of the content of the following sites. We recommend reading all health information with a critical eye, and checking with a medical provider before making any treatment decisions. If you have any concerns about the sites listed here, contact the Transgender Health Program by email at trans.health@vch.ca or by phone at 1-866-999-1514 (toll-free in BC).

Indigo pages

http://wolfandturtle.net/Indigo/index.php/Surgeons_:_Female_to_Male
The Indigo pages list surgeons around the world who do FTM SRS.

Transster

http://www.transster.com
Photos, descriptions of FTM surgery results, and listings of surgeons.

Yahoo Group: FTM surgery information

http://groups.yahoo.com/group/ftmsurgeryinfo
http://community.livejournal.com/ftmsurgeryinfo
Information, photos, research, and discussion relating to surgery options for FTMs. For FTMs only. The Yahoo site has an extensive links page. The LiveJournal community is a companion to the Yahoo group.

Yahoo Group: FTM surgery support

http://health.groups.yahoo.com/group/ftmsurgerysupport
Support and discussion of issues facing FTM people who are considering, undergoing, or have completed any FTM surgery, including chest surgery. Non-FTMs (partners, family members, friends, etc.) are welcome.

Questions? Contact the Transgender Health Program:

Office: #301-1290 Hornby Street, Vancouver, BC V6Z 1W2
Phone/TTY/TDD: 604-734-1514 or 1-866-999-1514 (toll-free in BC)
Email: transhealth@vch.ca
Web: http://www.vch.ca/transhealth

The Transgender Health Program is an anonymous and confidential free service for anyone in BC who has a trans health question or concern. Services for trans people and loved ones include:

- information about trans advocacy, medical care, hormones, speech change, and surgery
- help finding health/social services, and help navigating the trans health system
- non-judgmental peer counselling and support
- information about trans community organizations and peer support groups

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For more copies, email the Transgender Health Program at trans.health@vch.ca or call/TTY 1-866-999-1514 (toll-free in BC) and quote Catalogue No. GA.100. Su771.