Transmasculine FAQ

Social Transition

I live in the greater Boston area and want to connect with more Transmasculine people.

Come to Compass! http://compassftm.org/ Compass is a support, information, and social group for people assigned female at birth who feel that is not an accurate or complete description of their gender. (Yes, that means both binary and non-binary folks.) We meet on the first Thursday of every month, in Boston, from 7-9 pm. It's a great, laid-back, really supportive group. No one cares if all you want to do is sit in a corner and not say a word, or if you want to ask a million questions. It's all good. Contact via the Compass website for location info.

How do I explain this to children?

The younger they are, the easier of a time they will have. *Adults* make things complicated and are the ones who get confused, not kids. Especially young kids. All kids care about is that you are not going to go away, stop loving them, or turn into a stranger. Reassure them about all of those things, and that you'll still want to talk to them and play with them and do all the same things that you do with them now. It's possible that they may wonder if they also will turn into another gender when they grow up. If they express that at all, you (or their parents) can let them know that they can do that if they want to, but if they don't want to, they don't ever have to.

For a young child, all you need to say is something like "Sometimes people with boy bodies feel like girls inside, and sometimes people with girl bodies feel like boys inside. I have a girl body but I feel like a boy inside, so I want people to call me [new name] and a boy now. When people think I'm a girl, it makes me feel really sad, but when people understand that I'm really a boy, it makes me so happy." (Or, if you're non-binary: "You know that some people are girls and some people are boys, right? Did you know that some people aren't a boy or a girl? I have a girl body, but on the inside, I'm not a boy or a girl. When people think I'm a girl, it makes me feel really sad, but when people understand that I'm not a girl or a boy, it makes me so happy.") Kids tend to roll with that extremely well. If you tell the kid after you've started taking hormones and changes are already becoming obvious, you can say you're taking medicine to make your body more like a boy's, but otherwise you don't need to mention it unless they ask.

Young children are unlikely to have many questions; older children, however, may want more information. They may ask how you know that your gender is different, or if anything about it has been scary or painful, or they may want to know more about medical transition. Answer them honestly, but don't give more detail than they ask for. You can also answer in generics rather than talk specifically about yourself, if that's more appropriate for your relationship or just more comfortable for you. "I'm taking medicine to make my body more like a boy's. When people take

it, they go through boy puberty, so they get all the things that happen to teenage boys. Their voices get lower, they grow facial hair, and some other things, too. But it takes a long time and happens really, really slowly.” Children who are very curious about these changes can be directed to age-appropriate books about growing and changing bodies.

Preteens and teenagers likely already know the word transgender, and may know more about all this than you do, especially if they have trans friends or classmates. Start by asking them what they already know, and go from there. Don’t go into a ton of detail about your own experience, and definitely don’t give details about your body unless 1) they specifically ask; and 2) you have the kind of relationship where such conversations are appropriate. Rather than refer to “medicine”, you can discuss puberty with them, find out what they already know about hormones and their effects, and say that because your body doesn’t make the testosterone you want, your doctor prescribes it, but it’s the same stuff and it works the same exact way.

http://t-vox.org/resources/trans-book-list has an entire section of children's books, as well as a section of books for teens. Don’t just read them when questions come up; the books should become part of the regular rotation and pulled off the shelf as frequently as any other book. The same goes for the amazing books from http://flamingorampant.com/ .

How do I find a therapist? / I tried therapy before and it didn’t help, so now I don’t want to go to therapy.

It can take multiple tries before you find a therapist who’s a good fit for you. It’s well worth the effort, both to find the right therapist for you and to do the actual work of therapy.

See https://www.psychologytoday.com/us/therapists/transgender to find trans-competent therapists in your area. (They also have listings for 14 countries besides the US.) Ask them about sliding-scale fees if you're concerned about the cost. They may be a whole lot more affordable than you think.

For help specifically finding more affordable therapists, see https://openpathcollective.org/ .

Understand, too, that there is no such thing as a "gender therapist" or a "gender specialist", in that there is no degree or certification in gender-related therapy. There are just regular therapists who actually educate themselves about trans issues and choose to work supportively with us.

Any therapist can write a letter. Letters to access hormones and surgery are not governed by any rules or laws; the point of them is that doctors who prescribe hormones or perform transition-related surgeries often require a letter from a therapist. Psychologists, clinical social workers, and any other kind of therapist or counselor can write you a letter to bring to your doctor/surgeon of choice. They can write the letter without ever meeting you if they want; how long you wait is entirely at their discretion.

Are there different rules around transition depending on what state I live in?

No. There are no laws in the US regarding transition. If you have state-funded health insurance, however, there may be specific policies in your state regarding what transition-related care they will or won't cover.

How do you change your name?

Legal name changes are done in the probate court for your county of residence. Again, that's where you live, not where you were born. The form is likely available on your county probate court's website. If it isn't, call them, ask for the Change of Name department, and say you need them to mail you a form.

The name change form has a space for you to list the reason for your name change. You do not have to tell them that you're trans. Most people list "common usage" as the reason, which is completely fine. That just means "everyone calls me that anyway, so I want to make it legal to make my life easier". The court should accept that reason without any issue.

See http://t-vox.org/ and https://www.masstpc.org/identity-documents/ for more information on how to change your name.

How do you change your gender marker?

In the US, your gender marker is changed on each piece of documentation – state ID, Social Security, passport, and birth certificate – separately. Each thing comes with its own set of requirements. You do not need to have had any sort of surgery to change your gender marker with Social Security or on your US passport.

If you live in Massachusetts, you can change the gender marker to M, F, or X on your driver's license or ID. No extra documentation or doctor's notes are required. Just go to the RMV, fill out the form to renew your license/ID, and indicate a change of information and the correct gender marker.

Your birth certificate is changed in the state you were born in, not where you currently live. If you were born in Massachusetts, you can change the gender marker to M or F on your birth certificate. Your doctor has to fill out a specific form, available via https://transequality.org/documents/state/massachusetts , and have it notarized. No surgery is required. The form says that you have "completed medical intervention, appropriate for the patient, for the purpose of permanent sex reassignment". If all you've done is talk to a therapist, that's fine. As long as your doctor is willing to sign that form, no further information or "proof" is necessary.

See http://t-vox.org/ and https://www.masstpc.org/identity-documents/ for more information on how to change your gender marker.

How do I know if I pass?

If you are consistently gendered correctly by strangers, then you pass.

Do I have to have an STP packer in order to use the men's room? Won't they notice if I go in a stall and sit?

No. Men's rooms are not like women's rooms. Women's rooms are social spaces; men's rooms aren't. People only go in there for one reason: they go to the bathroom and leave. No one is paying attention to you. In fact, they are studiously *not* paying attention to you, because they don't want anyone to think they're gay. It's the one time homophobia will work in your favor. (Note that if you are in a gay male cruising space, none of this applies, because men are very much looking at each other in the hopes of finding a hookup.)

Plus: 1) tons of cis men sit to pee; 2) tons of cis men stand to pee, but prefer to use stalls rather than urinals; 3) everybody goes into a stall and sits sometimes, and no one is listening to "catch" you peeing while sitting down.

Medical Transition

Hormones

How do I get hormones?

Any doctor can prescribe you hormones. If you can write a prescription, you can prescribe hormones. The point is that you need to get your hormones from a doctor who knows how to competently monitor your labs, which is most likely to be an endocrinologist (hormone specialist). But loads of people get their hormones from their PCPs (primary care physicians – your regular doctor), and the PCPs do the necessary research and/or consult with an endo until they know what they're doing with their labs. That's part of a doctor's job. If your PCP is willing to prescribe you hormones and isn't sure how best to monitor you, they can consult with an endo. The endo does not have to be local to you.

What's informed consent? How do I know if I live in an informed consent state?

There is no such thing as an "informed consent state". Informed consent exists in every state in the US. It is at the discretion of the specific provider or clinic or hospital as to whether they will prescribe and monitor you on hormones via the informed consent model.

Informed consent, in the context of transition-related care, means that you do not need a therapist's letter to access a particular thing – usually hormones, sometimes surgery. You simply have to sign paperwork that says you understand what the risks and consequences are of taking hormones or having that particular surgery – you are informed, and you consent to this procedure. This does not mean that all you have to do is ask and you'll immediately be given hormones or scheduled for surgery. You may need to meet multiple times with the doctor to make sure that you're entirely on the same page and the doctor is satisfied that you have sufficient understanding to sign an informed consent form. Whether a particular doctor or clinic does informed consent is entirely at their own discretion, as is how they do it. They may have a written policy about it.

How do I get insurance to cover my hormones/doctor's visits/labs?

In the US, injectable T is very cheap. (If your local pharmacy tells you otherwise, try mail-order compounding pharmacies like https://newerapharmacy.com/ and https://womensinternational.com/ .) It's doctor's visits and lab work that cost, and those should be covered as long as your prescribing doctor knows to code it properly on the paperwork. It's only quite recently that *any* insurance plans in the US didn't specifically exclude all transition-related care. We've all been getting our therapy and hormones covered anyway, for decades. Your provider has to know how to word things on the paperwork. That's it. (Obviously if your plan doesn't cover mental health care at all, though, it's not going to cover therapy no matter what you tell them.)

Every time your provider sends a bill to your insurance, it includes a diagnostic code. You have to be diagnosed with something as justification for the visit/labs/treatment. "Code" doesn't mean they put down something false and then wink at you. It's literally a code that is used to indicate diagnosis.

For therapy, depression or anxiety or anything equally generic works fine.

For hormones and their related costs, "endocrine disorder not otherwise specified" (i.e., hormone imbalance). That's it.

What dose should I be on? / What dose are you on? / What's a standard/high/low dose?

Comparing doses is not productive and can do a lot of harm. Other people's doses are not relevant, because their bodies are not your body. All that matters are what your labs are telling you and how you feel.

What happens if I miss a dose? / Do I have to be really precise about when I inject?

Very little will happen. Changes aren't going to all revert back. You'll just be moody for a few days. Try to keep your shot day consistent, but otherwise it doesn't really matter. You aren't going to run into problems because you did your shot at 2 pm instead of 8 am.

When will shark week stop?

It's common for shark week to stop within 1-3 months, but sometimes can take as much as six months. If it's not gone by the six-month mark, talk to your prescribing doctor about adjusting your dose. You should be having labs done at that point anyway, so you'll have a sense of how you might be able to make changes to your dose. It's also not uncommon to have shark week go away and then come back after years of being on testosterone. Do not let "oh well, I guess it just isn't going away" become your new normal. If it's not feasible to increase your dose any further, you may need to discuss other options with your doctor, such as estrogen blockers, a hysto, or certain types of non-estrogen-based birth control.

When will I have a beard?

T puts you through puberty. It's not similar to puberty; it's not kind of like puberty; it's not that it gives you puberty-like changes. It literally puts you through puberty. Puberty takes a decade, not a year. For most pubescent boys, whether they're trans or cis, it's many years before they can grow a good beard. A high schooler with a proper beard tends to get noticed, because that isn't common at all. (If you are chronologically 45 years old, but you have been on T for less than ten years, you are still a pubescent boy.) Many of the big pubertal changes happen within about 3-5 years, but puberty is nowhere near done at the five-year mark.

Remember that the people you see posting photos online of their impressive beards after just months on T are not the norm. You only see pictures from people who are happy and excited about their changes, which tends to mean they're experiencing very rapid and noticeable changes. You are not seeing pictures from the overwhelming majority of people, who are still counting chin hairs at the two-year mark.

People tend to expect that pretty soon after they go on T, they'll start to look and sound like a man of their own age. That's not how T works. You have to go through puberty – all of it – and that takes time. Think about cis boys going through puberty. A cis boy who's been in puberty for six weeks is literally not even aware he's in puberty, because nothing he'd notice has happened. A cis boy who's been in puberty for five months is still 12 or 13. He doesn't look or sound like an adult man and he isn't supposed to. He will in time, but he doesn't yet. A cis boy who's been in puberty for three *years* is about 15; he doesn't look or sound like a child, but he doesn't look or sound like an adult man yet either. T doesn't care how old you chronologically are; you have to go through all of puberty just like cis guys do. It sucks, but patience is a virtue. You'll get there.

The very best thing you can do on T is forget about it. Go about your life, stay busy, and let puberty run its course. You are going to drive yourself crazy if you sit around angsting about

when this is going to happen and why that hasn't happened yet. As long as your hormone levels are within the healthy range for a male of your age, and you feel fine, you're fine. ("Otherwise fine but really impatient" is still fine.)

What are the first things that change?

Increased appetite and increased libido tend to be the very first things that people notice. You may find that you're suddenly craving meat, even if you've been vegetarian for years; this is because your muscles are growing and your body needs more protein. Many people also notice that they suddenly feel a lot calmer and more even-keeled. The way you smell will often start to change early on as well; you may need to change deodorants to find something that works with your new body chemistry.

Which changes are permanent?

The majority of changes on T are permanent. Feel free to talk to adult-transitioning trans women about the changes they experienced during male puberty that did *not* go away once they were on estrogen. If you stop taking T before your male puberty is over, it will not progress any further, but it won't go backwards either. Your voice won't continue to drop, but it won't go back up; genital changes may revert slightly, but will not go back to the way they were pre-T; you won't get any new facial or body hair, but the hair that already came in will continue to grow; if you were starting to develop male pattern baldness, you won't lose any more hair, but the hair that's gone won't come back.

What *does* change back, mainly, is body shape. Muscle growth from T will slowly melt away, and fat redistribution (from your hips/thigh/butt to your stomach) will slowly redistribute back. Your skin and hair will also soften again, because T will have made them coarser, and the way you smell will change back to the way it was pre-T.

If your chest was done growing and you had top surgery, and then you go off of T, your chest will not grow back unless you add more estrogen to your system than was there pre-T. If your chest wasn't done growing and you still have ovaries, it will resume growing where it left off.

What if I only want some changes and not others?

There's only one master switch. You don't get to pick and choose the order that changes start in, or how long they take to finish. You can absolutely take T for a while and then stop once you're satisfied with the changes you have; just remember that a handful of changes will revert back.

I heard T ruins your singing voice?

That is a myth. You may have noticed that lots of adult men can sing. T doesn't ruin your ear; therefore it doesn't ruin your ability to sing. It just changes your range, and yes, you will likely sound awful for a while, as pubescent boys tend to do. The best thing you can do to retain your singing voice is to keep singing through puberty even though you'll be frustrated at how you sound. Sing the notes you can sing; don't try to constantly push back into your old range. The effect of that will be that you retrain your voice as it changes, rather than waiting for it to settle and trying to completely retrain it all at once, which will be more work and more frustrating and may lead to you to think that T "ruined" your singing voice. If you continually retrain it as it changes, by the time it settles, it will probably sound fine.

If you're concerned about retraining your voice properly, work with a vocal coach, ideally one who has experience with teenagers.

Does your sexual orientation change on hormones?

No, but you may notice a change anyway. For a lot of people, sexual orientation isn't about attraction to men vs. women, it's about attraction to sameness vs. difference. So if your attraction is primarily to people whose genders are similar to yours as you're currently experiencing it, you may be more attracted to women pre-transition and more attracted to men later on in transition.

You're also becoming more comfortable in your own skin as you transition, which is enabling your brain to consider possibilities it didn't before. When being with a guy would have meant that you were his girlfriend, your brain may not have gone anywhere near that idea. Now that your brain is learning that being with a guy does not make you "the girl in the relationship", it may become more open to the possibility of attraction to guys. Likewise, your brain may not have gone anywhere near the idea of being with a woman when it meant you'd be perceived as lesbian, but once it learns that being with a woman means you'll be perceived as her boyfriend, it may become more open to that idea.

What are the health risks of long-term T use? I heard it shaves years off your life?

Testosterone puts you at a male level of risk for assorted health issues (most notably heart disease/high blood pressure/high cholesterol), and a male life expectancy. Men, on average, don't live as long as women do. Plenty of men still live to a ripe old age, and if you take care of your health, so can you.

You will be at the same level of risk for various problems as any other guy in your family. Your risk level is down to your genetics. If you develop high cholesterol, high blood pressure, or any other health problem, you'll need to manage it just like any other man in your family does.

Do you have to have a hysto if you're on T long-term?

There is no evidence whatsoever that T increases risk of any sort of cancer or other diseases of the reproductive system. There's also no solid proof that it doesn't; we simply don't have the data. But the reality is that most guys on T, including guys who've been on T for decades and have never had a hysto, do not have cancer, and their reproductive organs are completely fine.

The bottom line is that whatever parts you have, you are responsible for their health. If you have ovaries, that means having pelvic exams. If you have a cervix, that means having pap smears. Both should be done as frequently as you and your doctor decide is appropriate for you. Your risk of cancer fatality goes WAY up as a direct result of not having preventative screenings, because if you're having screenings, they're more likely to catch it early, and the earlier they catch it, the better your prognosis is.

I've been on T for a few years now so that means all the changes are done, right?

Unlikely, unless it's been over ten years. It's very common for people to think everything is done after two or three years because a lot of big changes have happened, and those changes seem to have slowed way down or stopped. Puberty gets more subtle as it goes along, but that doesn't mean it's over. Plateaus happen, too. The fact that your voice hasn't dropped in a while doesn't mean it's done changing, and the fact that you don't have a full beard now doesn't mean you never will. Whether you're 15 or 50, puberty is an exercise in patience.

I've been on T for about a year and shark week stopped in the first month, but suddenly I'm bleeding again! What's going on?

Just because you haven't been bleeding doesn't mean you haven't been ovulating or building up endometrium. It's very common to have some spotting around the one-year, two-year, and even three-year mark on T. Always let your prescribing doctor know if you're experiencing spotting or bleeding, but it doesn't necessarily mean something's wrong.

Surgery

How do I get top surgery?

Top surgery is performed by plastic surgeons. While it is technically a mastectomy, it is not the same thing as mastectomies that are performed on breast cancer patients. Top surgery does not disturb the muscles or lymph nodes, and is not just about removing the breast tissue; it's specifically about creating a male chest. The three things that make the chest look as expected for a male are nipple size, nipple placement, and overall contour (*not* the presence or absence of scars); if those are off, people will be more likely to notice that something looks off.

Spend a lot of time with http://transbucket.com/ (NSFW). Focus on people who have similar body types and pre-op chests to yours. Remember to always judge a surgeon by their *worst* results, not their best, and by their overall consistency. You want to feel confident that you're

going to have good results even if your surgeon is having a *really* bad day. And you have top surgery exactly once, and will be living with the results for literally decades after the novelty wears off, no matter how hard that is to imagine now. Go to the surgeon you have your heart set on, and choose based on the results they're likely to give you, not how convenient they are in the short term.

What are the options for top surgery?

Double Incision (bilateral mastectomy) is when the skin is opened in two incisions along the bottom of the pecs, from the center of chest out toward armpits. Almost all of the breast tissue is removed by scalpel. The nipples and areolae are removed, resized, and repositioned in grafts higher up on the chest. Some surgeons will maintain the original nipples/areolae on their stalks ("dermal pedicle") instead of grafting, to preserve nerve sensation. The **Inverted-T** procedure is the most common for nipple preservation.

Double incision scars are larger and more prominent than the scars for peri or keyhole. A good surgeon will place the incisions along the underside of the pecs, following the natural contour of the chest. (Pec development is not necessary for a competent surgeon to know where your pecs are.) They will fade with time; how long that takes will depend on how your body heals. Look at other scars you have for some indication. Good scar care will go a long way towards helping them fade more quickly.

Most people will have the best results from double incision. The bigger you are, and/or the less skin elasticity you have (i.e., the more your chest sags rather than sticks out), the more likely it is that you will need double incision. If you're a B cup or bigger, plan to have double incision, but if you're a small B with good skin elasticity, you may find surgeons who can give you good results with peri-areolar.

Peri-Areolar (subcutaneous mastectomy) is when the skin is opened along the entire circumference of each areola and separated away from the underlying breast tissue. Most of the breast tissue is removed by scalpel. The nipple nerve and blood supply are maintained on a stalk ("dermal pedicle"). Excess skin is trimmed from around the circumference of each areola in a “doughnut" shape, and minor liposuction is sometimes used to contour the fat at the borders of the surgical area. The areolae are resized without removing them, and the skin is then reattached to the areolae at their borders. The nipples can be reduced in revision if desired. The areolae may be repositioned to a limited extent, depending on your original chest size (i.e., the amount of chest skin available), but often aren't repositioned at all.

Peri can give very good results to people with small chests and good skin elasticity.

Keyhole (subcutaneous mastectomy) is when the skin is opened along only part of each areola border. Most of the breast tissue and surrounding tissue is removed via liposuction through this

small hole. The nipples may or may not be resized, but cannot be repositioned. The areolae and surrounding chest skin are not reduced.

Keyhole can give very good results to people with very little breast tissue (small A cup or smaller) and good skin elasticity.

Do you pass the pencil test? Stand up straight and place a pencil under one breast, parallel to the floor, as high up under the breast as it will go. Let go. Does the pencil stay put or fall to the floor? If it stays put (pass), you'll very likely need double incision. If it falls (fail), there may be a chance that peri-areolar or keyhole would give you good results.

Do I have to have a hysto? What happens if I don't?

You don't have to have a hysto unless a medical need presents itself, but whatever parts you have, you are responsible for their health. If you have ovaries, that means having pelvic exams. If you have a cervix, that means having pap smears. Both should be done as frequently as you and your doctor decide is appropriate for you. Your risk of cancer fatality goes WAY up as a direct result of not having preventative screenings, because if you're having screenings, they're more likely to catch it early, and the earlier they catch it, the better your prognosis is.

Remember that if you haven't had a hysto, it is possible for you to become pregnant, even if you've been on T for many years. The fact that you aren't bleeding doesn't necessarily mean that you aren't ovulating or building up endometrium. If you haven't had a hysto and you're having sex with someone who produces sperm (this includes trans women who have been on estrogen long-term, unless your partner has had recent fertility tests that definitively place her sperm count at zero), use protection every time.

How do I get insurance to cover surgery?

You need to look at your specific health insurance plan, not just the company. Find out if your plan explicitly excludes transition-related care, explicitly covers it, explicitly covers some care but not everything, or doesn't mention it at all.

If your plan explicitly excludes transition-related care, you are very unlikely to get coverage for bottom surgery. You are also unlikely to get coverage for top surgery unless your surgeon is willing to bill it as a reduction, or unless your chest is big enough that it's been causing you back problems for a long time. The longer your paper trail of complaints to the doctor that you're having back issues, chiropractor visits, etc., the more of a chance you might have for accessing coverage.

If your insurance plan explicitly covers the surgery you're seeking, you need to look at the plan's specific criteria for coverage. They may require a particular diagnosis, particular paperwork submitted in advance of billing, etc.

If your insurance plan doesn't mention transition-related care at all, you can have your surgeon submit a claim, but be prepared for the insurance company to reject it or to only cover part of it. (It's common for plans to cover hospital/anesthesia/pathology fees for basically everything, but not the surgeon's fees for procedures they consider cosmetic.) You may have luck appealing a rejection, particularly if you provide them with as many official-looking letters from as many official people as possible asserting that this procedure is medically necessary for you.

What's recovery like? / How long until you're recovered from surgery?

Typically for top surgery and hysto, surgeons tell you to wait six weeks before returning to all normal activity, but your recovery will depend on your body. Always discuss things with your surgeon and do what they tell you. Recovery for bottom surgery, especially phalloplasty, is significantly longer. If you have questions or concerns as you're healing, don't hesitate to contact your surgeon and ask about it; that's part of their job. Don't just google it or ask on social media.

"Recovered from surgery" is also a very vague question. Long before you're able to return to all normal activity, you will be able to lift a glass of water, go to the bathroom or take a shower without assistance, drive a car, walk around the block, etc. You will be able to return to a quiet desk job quite a bit sooner than you would be able to return to a heavy laboring job.

Immediately after your top surgery, you will likely be able to lift a glass of water or a sandwich; sit in a chair and stand up again; use a computer, game controller, or TV remote; and go to the bathroom without help. You may need a little help with getting in and out of bed, because you use your arms and chest muscles for more than you think you do. You should not fight with the childproof cap on your pain meds; have someone open them for you. Your main issue will be that you're very tired. You won't be able to shower right away anyway, but you will likely be able to wipe yourself with baby wipes and wash your hair in the sink with little or no assistance. If you find yourself struggling with any of these things, ask for help. The first few days are the hardest. Listen to your body and don't push it, even if you're bored and restless.

Many people find hysto recovery significantly easier than top surgery recovery. Immediately after your hysto, you will likely be able to lift a glass of water or a sandwich; move your arms freely; walk around your house; and use a computer, game controller, or TV remote. You may need some help sitting and getting up again, which includes chairs and toilets, as well as getting in and out of bed. Again, you will be tired, and once the fatigue starts to lift, you will be very bored. Remember that you literally just had organs removed from your body, and even if you feel completely fine and aren't in pain, that doesn't mean you're done healing. Don't push it.

Above all, listen to your surgeon about how long you should wait before returning to various activities – it's better to wait too long and be frustrated than to do too much too soon and damage your health. Be sure to ask your surgeon specific questions: "When can I drive?"

“When can I return to my desk job?” “My job involves being on my feet all day; when can I return to work?” “When can I lift/wrangle my 30-pound child?” “My dog pulls me sometimes when I walk her; how long should I have someone do that for me?” Etc.

How do I get bottom surgery?
Bottom Surgery is a journey and is not as straightforward as top surgery and hysto are, with longer wait times and more intense procedures and recovery times. This is not to disillusion anyone who wants to pursue bottom surgery, but to emphasize that bottom surgery is a process that can potentially take years. Bottom surgery is as much a mental and emotional process as it is physical. Getting bottom surgery starts with researching the different available procedures listed below. Ranking an individual’s priorities for bottom surgery is helpful when deciding what type of surgery to pursue.

Rank on a scale from low to high (1 to 5) or describe expectations post surgery of the following:

- Ability to stand to pee
- Having erotic secation
- Ability to penetrate
- Visual appearance of genitals (expectations of girth and length, glans at the tip of penis if applicable)
- Visual appearance of bulge

Bottom surgery is also a logistical undertaking because of the recovery time is anywhere from 6 weeks to 3 months or longer depending on complications and due to the availability of surgeons. There are surgeons and surgical teams in AZ, CA, IL, MA, MI, NY, PA, and TX, to name a few. It’s not uncommon to have to travel and initially recover away from one’s home depending on expectations and surgeons.

What are the options for bottom surgery?

Phalloplasty utilizes a graft taken from another part of the body. There are several different locations to harvest a graft from. Look at websites like http://phallo.net/ for a more in-depth review of these sites.

Phalloplasty is an intense process to go through. It can involve many stages over several years. There can be many complications; most come from urethral lengthening. Each person should make a list of pros and cons for themselves to figure out if it is right for them.

Metaoidioplasty does not use a skin graft; it uses what you already have. The clitoris already grows into a micropenis with testosterone, so the ligaments holding it in place under the pubic bone are cut. That enables the penis to hang more freely and stick out more when erect, but no nerves are disturbed and the penis retains full sensation.

Urethral lengthening (UL) can be done as a part of either phallo or meta, if it's important to you. This allows you to pee standing up, but is also the cause of most complications when it comes to bottom surgery recovery. **Scrotoplasty** (creation of the testicular sack) and **vaginectomy** (closing of the front hole) can also be done with either of the above procedures. They are not mandatory; you can have surgery with or without them. Some surgeons won't perform UL unless a vaginectomy is also performed – this is due to potential complications. Implants happen six months to a year after the other surgeries happen. **Glansplasty** can be done as part of phalloplasty and creates a penis that looks circumcised. (As of this writing in 2020, it is not possible to have a retractable foreskin as part of phalloplasty.)

It is also possible to have a **simple clitoral release**, where the micropenis is freed to hang in the same way that meta does, but the urethra is not extended and a scrotum is not created.

For both meta and phallo, the testicular implants are silicone and do not produce semen or sperm. As of this writing (2020), there is no available medical procedure that will enable you to produce semen or sperm if you were not born with testicles.

I heard bottom surgery results are bad and that's why most Trans guys don't get bottom surgery.

That is a myth. It's up to you to talk to surgeons and to people who've had bottom surgery within the last few years, learn as much as you can about your various options, and decide whether they will meet your needs. The current options don't yield results that meet absolutely everyone's desires, but that is not the same thing as "results are bad". Lots of people have bottom surgery and are extremely happy with the results. An increasing number of people are having bottom surgery these days, both because surgical techniques have improved a lot in the last ten or so years and because insurance plans are finally starting to cover it, making it accessible to tons of people who couldn't afford it before.

http://groups.yahoo.com/group/ftmsurgeryinfo and http://groups.yahoo.com/group/ftmphalloplastyinfo are both very good groups to connect online with people who have either had bottom surgery or are actively considering and researching it. On Facebook, there are a couple of excellent groups for learning more about bottom surgery: https://www.facebook.com/groups/764636093625483/ (FTM Bottom Surgery Discussion) and https://www.facebook.com/groups/422469398173499/ (Metoidioplasty Discussion).

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