

BUILDING NOVA:
AN MTF GUIDE



NSFW IMAGES & CONTENT
BELOW

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Introduction:

Hihi :) I hope you are having a good day and I'm glad you're here. I had the idea to write this in November of 2025, about a year after my egg cracked. I don't want to spend time on "am I trans or not?" This guide assumes you already know who you are.

A little bit about me, I am autistic, a writer (not a great one), a recovering alcoholic, a trauma and abuse survivor. I have faced financial issues, death, hate, loss of self and time; I have made *so many* mistakes.

I was 40 when the realization hit and I really did not see it coming. It was one of the worst nights of my life and I just wanted to kill myself if I'm being honest...I'm really glad I didn't though.

I tried denial, pretending I didn't realize it, avoidance and finally I settled on curiosity. I like to know why things are the way they are and how they work.

I had to figure out how I worked. How did I get this way?

Now that I understand, it's actually pretty straight forward, I just didn't see it all clearly until I gave it the time it deserved.

I started digging through my life and writing down everything I could remember that felt relevant. Sometimes, I'd remember something new branching off a fuzzy memory I'd written down. I did this for about a month, obsessively and I categorized / organized my life.

For me, my path was undiagnosed autism + childhood trauma and abuse (start masking kid!) → toxic masculine household (don't be a girlyman!) → first addiction ([MMORPG](#)) and complete immersion in that world, not living in my body → alcohol → more alcohol → did I mention alcohol? + toxic masculine work environment → do the next thing you're supposed to do...I found true love and I got married, worked a job I hated, stayed drunk as much as I could and then I blinked - those years flew, about 18 years drunk, I got sober when I was 37.5 and realized I was transgender shortly after.

When I finished my self-analysis and understood who I was - I had all the evidence I needed to not only understand that I am transgender, ***I have always been transgender*** and how I misunderstood so many things in my life, I shifted from curiosity to compromise.

My compromise at the time was to tell my wife, my besties, and to never start HRT. I'll never forget how nervous I was telling my wife, I was about 50/50 that she'd stay with me. We were in a rough patch, and this is not an easy thing to deal with, I acknowledge that.

The thing my wife said to me is the thing I wish for every person going through this experience hears. She said, "I don't care. I love *you* more than your body."

Who says that? I'm still floored by that response. I told my besties and that was it, I was good, I felt better.

I remember taking a walk that night. I started thinking to myself about what to do next. I was 40, AMAB, overweight, a hairy man body, bald head, I felt overwhelmed. I didn't know where to start, I had nobody to talk to. The one thing I was sure of was that I wouldn't start HRT because I was afraid of being hated and it was "too late" for me.

I decided to find a workout routine to feminize my figure, remove my body hair, use hair regrowth formula on my scalp and maybe, if I was brave enough, I'd remove my facial hair one day. I wanted to feminize myself as safely / privately as I could.

Seven months later I injected estradiol valerate for the first time and took my spironolactone. I had a bilateral [orchietomy](#) and scrotum removed on March 3, 2026 and I am scheduled for a trachea shave, nose tip feminization, neck lift and lip lift December 16, 2026.

I am Nova, and this is my MtF guide. I am not a doctor, I am not formally educated on any of these topics, but I thought it might be nice to share what I've learned as well as studies, theories and lived experiences. I would never knowingly spread misinformation / disinformation so if you find something in here that is incorrect feel free to reach out to me - or if you just need to say hi to someone and be seen. This document will be a live document that I will update as I transition: buildingnova@proton.me

Peace and love to all of you, and to the people that hate us, we've always been here and we're not going anywhere, so please move on, get educated or just ***fuck off.***

Evidence For My Doubt Spirals

One of the things I've dealt with since this all started is internalized transphobia, self-loathing, self-rejection, denial, questioning if I am making this all up or if this is real. I hate it, these feelings suck and can be destabilizing to me.

Really think about this - my entire life (40+ years) I was told by everyone - "You're a boy / man." In my youth, I was given boy clothes, boy toys, placed in boy centric interests, told to be a man and yet this is not aligned with who I am. Nobody ever asked me if I felt differently.

I was programmed to be a boy. I never had a choice. *I am unlearning as much as I am learning.*

I find facts, data, and peer reviewed studies to be comforting. If I can normalize something through data and proof that it isn't just me, then I can confront these spirals and try to stop them from getting worse when they happen (it's getting less frequent as of writing this, December 15, 2025) but they do still occur.

I'd like to talk about some very important studies regarding sex differentiation, sexual orientation and transgender identity - this is all evidence based and proof that we are real, we do exist, and you or I are not doing anything wrong. We were programmed wrong.

These facts help me accept myself. I hope they help you too.

Bed Nucleus of the Stria Terminalis (BNST) Sexual Dimorphism:

What did the study investigate & find?

The central subdivision of the bed nucleus of the stria terminalis (BSTc), a small brain region involved in anxiety, stress and sexual behavior has been investigated for [sexual dimorphism](#) and its relationship to gender identity (not sexual orientation).

The hypothesis developed by researchers at the Netherlands Institute for Brain Research proposes that BSTc shows sex differences in volume and neuron number and that transgender individuals may show BSTc characteristics matching their gender identity rather than their AGAB (assigned gender at birth).

Studies used post-mortem brain tissue to measure BSTc volume and neuron counts. The research focused specifically on transgender women (male-to-female) and transgender men (female-to-male) compared to cisgender controls.

These studies ([1.](#)) ([2.](#)) found some very interesting things - from what I have been able to find only one FtM brain has been studied and the findings were that he had BSTc volume and neuron counts that matched a cisgender man, aligning his gender identity with what he said he felt like (a man) and not what his sex assigned at birth was.

The same has been found for transgender women, their BSTc volume and neuron counts matched those of cisgender women. What makes this study even more fascinating is that some of the brains that were studied were on transgender women that had taken HRT in their lifetime AND transgender women that had never done HRT and just claimed their entire lives they were in the wrong body. **Their results were the same, they had BSTc volume and neuron counts that aligned with the gender they claimed to be, not their gender assigned at birth.**

Neuron Count and Sex-Dimorphic Brain Regions:

What did the study investigate & find?

Neuroimaging and histological studies have investigated whether sex differences exist in brain structure (volume, neuron density, cortical thickness, white matter connectivity) and whether these relate to sexual orientation or gender identity.

In LeVay's [INAH3 study](#) - they determined the INAH3 in heterosexual men is more than **twice as large** as homosexual men and heterosexual women. Homosexual men and heterosexual women have similar sized INAH3.

The ENIGMA Consortium mega-analysis (Mueller et al., 2021) - the largest study to date with N=803 non-hormonally treated individuals - found transgender persons differed significantly from cisgender persons in subcortical brain volumes and cortical surface area but showed no significant differences in cortical thickness. The key conclusion, "Rather than being merely shifted towards either end of the male-female spectrum, transgender persons seem to present with their own unique brain phenotype." (1.) (2.)

Effects of Hormone Replacement Therapy vs Prenatal Development:

What did the study investigate & find?

This domain investigates the organizational-activational hypothesis - the distinction between permanent effects of prenatal hormones during critical developmental windows (organizational) versus reversible effects of adult hormones on already-established neural circuits (activational). These studies examine what adult cross-sex hormone therapy (HRT) can and cannot change in brain structure and whether sex-atypical brain features in transgender individuals are present before HRT (suggesting prenatal origins) or appear only after treatment.

The findings are clear, organizational effects are prenatal in humans. Phoenix et al. 1959 established the organizational-activational framework in guinea pigs, subsequent research ([McCarthy et al., 2017](#)) established that "the critical period for sexual differentiation is entirely prenatal in humans," occurring during the second trimester testosterone surge. This critical period cannot be reopened in adulthood.

What HRT can change (documented in longitudinal studies):

Effect	Transgender Men (testosterone)	Transgender Women (estrogen + anti-androgens)
Cortical thickness	Increases in some regions	Decreases in multiple regions
Subcortical gray matter	Increased	Decreased hippocampus
Total brain volume	Slight increase	2-3% decrease
White matter	Some masculinization	Variable changes

What HRT cannot change: Total brain size/intracranial volume (determined prenatally), core organizational neural circuit architecture, sexually dimorphic nuclei like BSTc and INAH3, and sex chromosome effects independent of hormones. [Spizzirri et al. 2018](#) noted: "Total brain volume differences are congruent with sex assigned at birth in both transgender groups... brain volume differences are not necessarily related to signs of brain feminization."

Pre-HRT transgender brain findings: The ENIGMA consortium ([Mueller et al., 2021](#)) studied 386 non-hormonally treated transgender individuals and found they show "unique neurobiological phenotypes"—neither shifted entirely toward natal sex nor gender identity. [Guillamon et al. \(2016\)](#) noted that untreated transgender women show "complex mixtures of masculine, feminine, and demasculinized regions." The presence of sex-atypical features **before HRT** suggests prenatal rather than postnatal origins.

Natural experiments support organizational effects:

- [CAH women](#) (46,XX with prenatal androgen excess): ~5% develop gender dysphoria versus 0.003-0.03% in the general female population, though 94.8% retain female identity
- [CAIS women](#) (46,XY with non-functional androgen receptors): Almost universally develop female gender identity despite XY chromosomes and male-typical testosterone, demonstrating androgen action (not genetics alone) is required for male-typical development
- [5-alpha reductase deficiency](#) (46,XY raised female who masculinizes at puberty): 56-63% adopt male gender identity after pubertal virilization, suggesting prenatal testosterone imprinting predisposes toward male identity even when raised female.

Comparative Evidence from Cisgender Men Treated with Feminizing Hormones:

What did the study investigate & find?

This is a really interesting study as well - it looked at cisgender males that were given HRT for prostate cancer treatment.

Physical feminization occurs: Cisgender men on feminizing hormones experience breast development, fat redistribution, loss of libido, testicular atrophy, hot flashes, and body hair changes.

Psychological effects documented:

- Depression risk increases significantly (meta-analysis RR=1.51, p=0.0002)
- Cognitive impairment, particularly visuospatial abilities
- Emotional lability and increased tearfulness
- Masculine identity distress (challenge to existing identity)
- Quality of life impacts from sexual dysfunction

Critical finding—no gender identity changes: Despite extensive literature on ADT psychological effects, **no systematic documentation** exists of cisgender men developing gender dysphoria, and **no case reports** describe prostate cancer patients identifying as female after treatment. Cisgender men experience feminization as an *unwanted side effect* causing distress, not as an identity-congruent change.

[Wassersug & Gray \(2011\)](#) directly compared 12 prostate cancer patients and 12 transgender women on androgen deprivation:

Effect	Prostate Cancer Patients	Transgender Women
Feminization	Distressing/unwanted	Welcomed
Reduced libido	Negative	Accepted
Emotional changes	Shame/confusion	Comfort
Life outlook	Loss/threat	Beginning anew

2D:4D Finger Ratio:

DISCLAIMER: I'd like to state here – as I've had people ask me "What does it mean if my hands don't match this study? Does that mean I'm not transgender?"

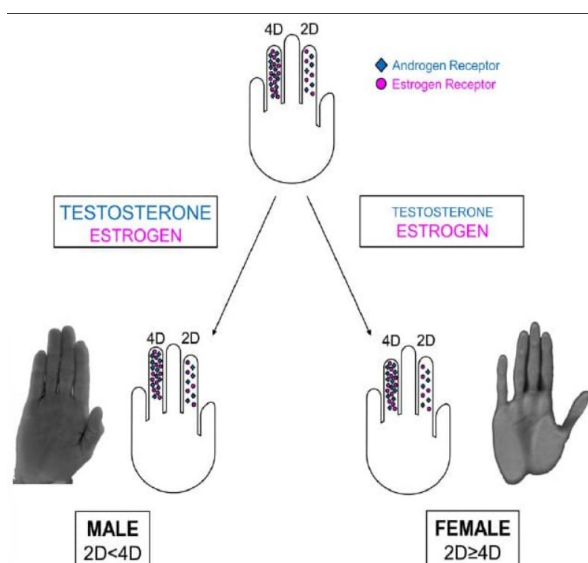
NO!! That is not what this is saying. This study is just a reflection of in utero exposure to testosterone and there is a tendency in transgender women to have feminized digits – not all transgender women have this, and it isn't a requirement to be one.

What did this study investigate & find?

The [2D:4D digit ratio is a study](#) comparing the length of the index finger (pointer finger) to your ring finger. This has been investigated as a biomarker for prenatal androgen exposure (testosterone exposure in utero).

The study proposed that lower ratios (longer ring finger relative to index finger) indicate higher prenatal testosterone exposure. [Research](#) has examined whether 2D:4D differs by sexual orientation (comparing homosexual & heterosexual individuals) and by gender identity (comparing transgender individuals to cisgender controls).

The evidence that women with congenital adrenal hyperplasia (CAH), who experienced elevated prenatal androgens, show lower (more male typical) 2D:4D, while males with complete androgen insensitivity syndrome (CAIS) show higher (more female-typical) ratios. [Experiential manipulation](#) in rhesus monkeys has confirmed that early gestational testosterone exposure affects 2D:4D.

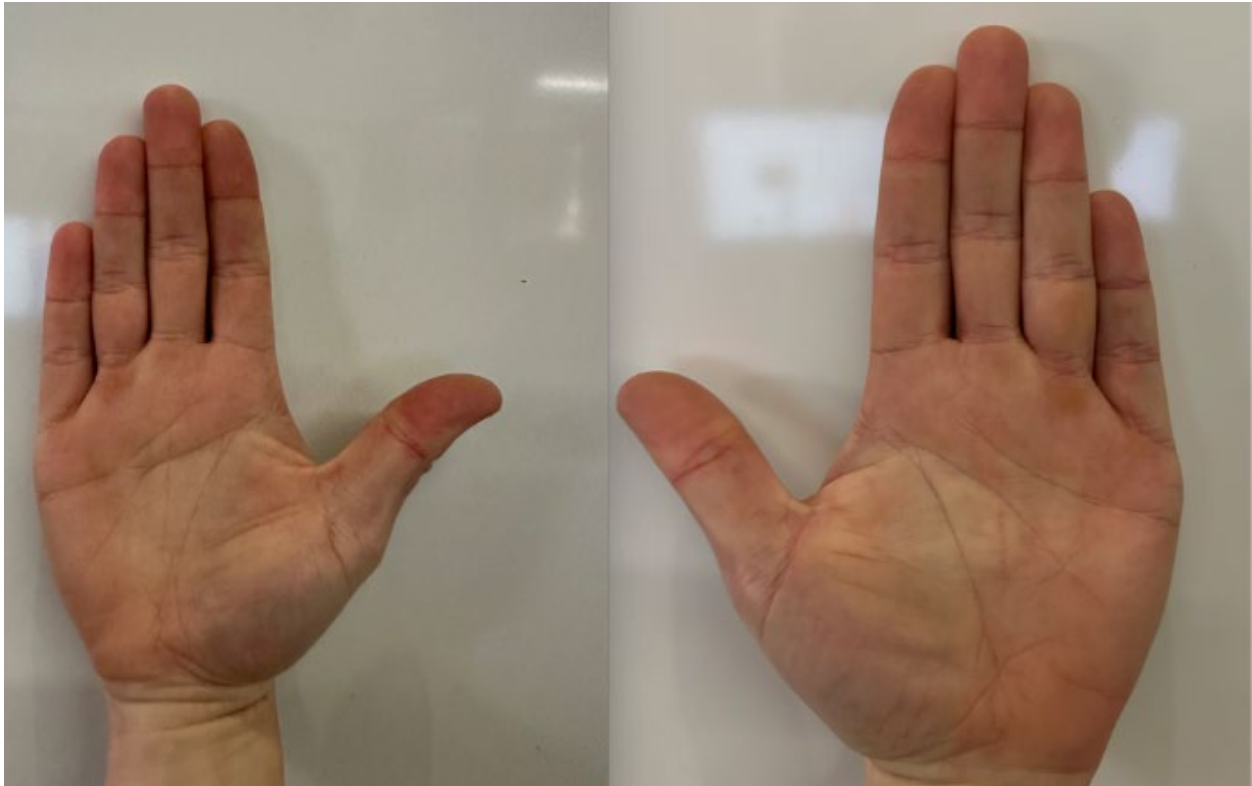


Gender identity findings from three meta-analyses show small effects primarily for transgender women:

Meta-Analysis	Transgender Women vs. Male Controls	Transgender Men vs. Female Controls
Voracek et al. (2018)	$g \approx 0.15$ (small effect)	No significant difference
Siegmann et al. (2020)	$g = 0.15\text{--}0.19$ (feminized)	No significant difference
Sadr et al. (2020)	$d \approx 0.24$ (feminized)	No significant difference

These effect sizes indicate that transgender women show slightly higher (more feminized) 2D:4D than cisgender men, but effect sizes are small. Transgender men show no consistent differences from cisgender women.

My hands:



HISTORICAL EVIDENCE - We have always been here:

HRT and gender affirming care hasn't been around forever, but, gender-variant individuals have. These are humans that like you and I were born in the wrong body and knew it. We have been documented across virtually every human society for which substantial historical or ethnographic records exist.

Western concepts such as "transgender," "[third gender](#)," and "gender identity" emerged from 19th-20th century European sexology and cannot be projected onto other cultures without careful qualification. Indigenous categories frequently combine elements that Western frameworks separate (gender identity, gender expression, sexual orientation, religious/ritual function).

I'm going to go through different regions of the world and just touch on our existence there. I am sure there are plenty I will miss.

South Asia:

[Hijra](#) (India, Pakistan, Bangladesh, Nepal) - self-identification typically as "neither man nor woman" or explicitly as "third gender." The term encompasses diverse individuals including those who undergo emasculation (nirvan), those with intersex conditions, and those who identify with feminine gender without surgery.

[Tritiya-prakriti](#) (तृतीय प्रकृति): Sanskrit "third nature/gender," appearing in Kama Sutra

Ancient roots traceable to Sanskrit text (c. 3rd century CE and earlier), as well as medieval documentation during Mughal period (1526-1857). Colonial suppression (1857-1947) and modern legal recognition (2014-present).

Indigenous Americas:

[Nádleehí](#) (also nadleeh): "One who is transformed" or "one who changes continuously".

[The Diné](#) traditionally recognized a gender spectrum:

- Asdzáán (woman)
- Hastiin (man)
- Náhleeh/Nádleehí (feminine man)
- Dilbaa (masculine woman)

[Two-Spirit \(Pan-Indian Modern Term\)](#)

Historical tribal-specific terms documented in over 130 tribes include:

- [Winkte \(Lakota\)](#)
- [Lhamana \(Zuni\)](#)
- [Boté \(Crow\)](#)
- [He'eman \(Cheyenne\)](#)
- [Alyha and Hwame \(Mohave\)](#)

Muxe (Zapotec, Oaxaca, Mexico):

[Categories: *Muxe gunaa* \(effeminate muxes\); *Muxe nguiiu* \(masculine muxes\)](#)

Middle East:

[Mukhannathun \(Early Islamic Period\) - Pre-Islamic Arabia through Umayyad era \(7th-8th centuries CE\)](#)

Africa:

[Yan Daudu \(plural; Dan Daudu singular\): "Sons of Daudu"](#)

Europe:

[Gallus](#) (pl. galli or gallae—notably feminine form used): Priests of goddess Cybele who underwent voluntary castration, wore feminine clothing, jewelry, makeup, adopted feminine behaviors

I'll be honest, I found tons of other examples but I think there's enough here and I don't want to beat a dead horse, the purpose of this section is not to prove to people that reject our existence that we are real, it is to help myself and people like me if you ever are spiraling and need an anchor. *We have always been here, and we will always be here.*

What HRT Will & Will Not Change Physically

Personally - I have heard a lot of different anecdotal changes reported by transgender people I know - I want to try to keep this document as factual as possible. I am not dismissing anyone's experience, just sharing the available data as of writing this.

Quick Reference:

Body System	Changes?	Onset	Maximum Effect	Reversible?
Breast Tissue	Yes	3-6 months	2-3 years	No
Skin Texture	Yes	3-6 months	Ongoing	Yes
Body Fat Distribution	Yes	3-6 months	2-3 years	Yes
Muscle Mass	Yes (decreases)	3-6 months	1-2 years	Yes
Body Hair	Partial	6-12 months	>3 years	Yes
Scalp Hair	Stabilizes	1-3 months	1-2 years	Yes
Facial Hair	Limited only	6-12 months	>3 years	Yes
Genitals	Yes	3-6 months	2-3 years	Variable
Voice	No	—	—	—
Skeletal Structure	No	—	—	—
Facial Bones	No	—	—	—
Height/Hands/Feet	No	—	—	—

Skin Changes:

Skin becomes softer, thinner and less oily due to reduced [sebum](#) production. Pores appear smaller, acne typically decreases and body odor shifts. Increased tendency to bruise and dryness may occur.

Timeline: Onset at 3-6 months with effects continuing throughout treatment.

Reversibility: Fully reversible if HRT is discontinued ([1](#)).

Individual Variation: Depends on baseline skin type and degree of testosterone suppression achieved.

Body Fat Redistribution:

Fat is redistributed from android pattern (abdominal/waist) to gynoid pattern (hips, buttocks, thighs, breasts). Studies document substantial shifts: fat mass increases approximately 28-30% in the first 12 months, with regional increases of 18% in trunk and 27% in legs and gynoid regions. Long-term studies show body composition approaches cisgender patterns ~32% fat mass.

Timeline: Onset at 3-6 months with maximum effect 2-3 years and continued redistribution beyond ([2](#)).

Reversibility: Yes - largely reversible; fat distribution shifts back toward male pattern if HRT stops, though some effects may persist.

Individual Variation: Highly dependent on diet, exercise and starting body composition.

Muscle Mass & Strength:

Lean body mass decreases progressively. Studies document thigh muscle volume decreasing 5% at 12 months, 12% at 3 years, and up to 17% lower lean mass after 8 years compared to cisgender men. Grip strength and limb strength decrease 25-33%. Importantly, while absolute muscle mass remains higher than cisgender women, **relative lean mass percentage becomes comparable.**

Timeline: Onset at 3-6 months; initial plateau at 1-2 years with continued decline to 3+ years.

Reversibility: Fully reversible - muscle mass and strength recover if HRT is stopped and testosterone resumes.

Individual Variation: Exercise regimen significantly impacts outcomes, starting muscle mass varies considerably.

Hair Changes - Body & Scalp:

Body Hair: Becomes thinner, finer, lighter, and grows more slowly (3). Growth does NOT disappear completely — reduction only. Complete removal requires removal via electrolysis, laser or IPL.

Timeline: Onset 6-12 months (slower than other changes); maximum effect >3 years.

Reversibility: Reversible — growth returns to previous pattern if HRT stops.

Individual Variation: Darker/coarser hair less responsive; ethnic background influences response.

Scalp Hair: Male pattern baldness typically stops or slows significantly (4). Some regrowth possible but highly variable - hairline rarely returns to pre-balding state without intervention. Existing follicles that have been inactive for years may not recover.

Timeline: Onset 1-3 months (stopping further loss); regrowth variable over 1-2 years.

Reversibility: Reversible — hair loss would resume if HRT stopped.

Facial Hair - A Persistent Challenge:

Limited only — may thin slightly and grow slower, but **rarely goes away entirely** (5). A 2023 systematic review confirms GAHT "may reduce" but cannot eliminate facial hair growth. This is because testosterone, during puberty, permanently converts vellus (fine) hair follicles to terminal (coarse) follicles. This conversion cannot be reversed hormonally (6).

Timeline: Onset 6-12 months; maximum effect >3 years (modest improvement only).

Reversibility: Effects are reversible; growth increases if HRT stops.

Effective Treatments: Electrolysis (permanent, FDA-approved, 100+ hours for full beard) or laser hair removal (significant reduction, works best on light skin/dark hair).

Genital Changes:

Testicular atrophy: Testicles shrink to approximately half original size due to suppression of gonadotropins (LH/FSH). Histological changes include decreased tubular diameter, arrest of spermatogenesis, and Leydig cell alterations.

Timeline: Onset 3-6 months; maximum effect 2-3 years.

Reversibility: Variable — some recovery possible if HRT stopped early; prolonged use may cause permanent changes.

Erectile function: Decreased frequency of spontaneous erections; erectile function often diminishes (7). Without regular erections, penile atrophy can occur due to tissue disuse. Ability to achieve orgasm typically preserved but sensation may change.

Timeline: Onset 1-3 months; maximum effect 3-6 months.

Reversibility: Variable — function may return, but prolonged disuse can cause irreversible tissue atrophy.

Fertility: Sperm production decreases or arrests. The risk of permanent infertility increases with duration of treatment. **Fertility preservation should be discussed before starting HRT. ***ALSO DO NOT ASSUME YOU ARE INFERTILE*****

Voice - No Hormonal Effect:

No changes 😞 — estrogen does NOT raise voice pitch in adults (7). This is unanimous across all major guidelines. During male puberty, testosterone permanently lengthens vocal cords (1.6 cm vs 1.0 cm in females), thickens them, and enlarges the larynx (8). These structural changes are irreversible.

Why: Vocal cords are permanently lengthened and thickened. Estrogen cannot shorten or thin established vocal tissue, reverse laryngeal growth, or shrink the vocal tract.

Effective alternatives: Voice feminization therapy with a speech-language pathologist (raises habitual pitch, modifies resonance and intonation; typically, 8+ weeks) or voice feminization surgery.

Skeletal Structure - Fixed After Puberty:

Bone geometry (hips, shoulders, ribcage): No change in adults (9). Multiple peer-reviewed studies confirm bone geometry "remains unchanged during GAH treatment in adult transgender people." A study of 535 transgender women across 25 years of HRT found no differences in [periosteal](#) width or [cortical](#) thickness.

Why: Skeletal dimensions are determined during puberty when testosterone causes broader bone development. After [epiphyseal](#) (growth plate) fusion at ages 18-20, bone geometry is permanently fixed (10). Only adolescents treated with puberty blockers before mid-puberty show bone geometry resembling their experienced gender (11).

What CAN change: Fat redistribution to hips creates a more feminine silhouette. Muscle mass reduction in shoulders changes body contour. Bone mineral density (protective effect) improves.

Surgical alternatives: Hip augmentation (fat transfer or implants), clavicle shortening for shoulder width reduction.

Facial Structure - Bone vs. Soft Tissue:

Facial bones (brow ridge, jaw, chin): No change. Facial bones undergo significant testosterone-driven growth during puberty and cannot be remodeled by estrogen (12).

Facial soft tissue: Yes, changes occur. A 2019 3D scanning study found cheek tissue increased 0.50-1.08mm and jaw tissue decreased 0.18-0.60mm within 3-12 months (13). Fat redistribution creates softer, fuller cheeks. UCSF guidelines note it can take "two or more years for these changes to fully develop."

Recommendation: UCSF advises waiting at least 1 year on HRT before deciding on facial feminization surgery, as soft tissue changes continue developing.

Surgical alternative: Facial feminization surgery (FFS) — brow bone reduction, jaw contouring, genioplasty, rhinoplasty (14).

Height, Hands, and Feet:

Height: No change in adults (15). Anecdotal reports of 1-3 inches lost likely reflect postural changes from muscle mass reduction (affecting spinal curvature) rather than actual bone shortening (16). In adolescents treated before growth plate fusion, high-dose estrogen can reduce predicted adult height by ~4.3 cm (17).

Hands and Feet: No change. Bone structure is fixed after puberty (18). Minor soft tissue changes (muscle/tendon reduction) may cause subtle differences, but no peer-reviewed studies document significant size reduction.

*****Personal Anecdote***** - I'm not claiming this scientifically, I am stating my entire life my brother has been shorter than me, he is taller than me now and I measure 1.25" shorter than I used to. My shoe size is also smaller. This was noticed ~11 months HRT .

Adam's Apple (Thyroid Cartilage):

Changes: No. During male puberty, testosterone causes permanent cartilage growth that cannot be reversed hormonally (19). The angle of thyroid cartilage connection is set (~90° in males vs ~120° in females).

Surgical alternative: Tracheal shave ([chondrolaryngoplasty](#)) — outpatient procedure shaving down prominent cartilage (20). This does not affect voice pitch.

Connective Tissue Effects:

Not included in standard clinical guidelines, but research on estrogen's effects suggests:

- Increased collagen content in skin, tendons, and ligaments.
- Decreased stiffness of tendons and ligaments.
- Increased joint laxity.
- Improved skin elasticity.

These findings come primarily from cisgender postmenopausal HRT studies and have not been specifically validated in transgender populations ([21](#)).

Hormones:

This could get really long and there's a lot of hormones that one could pay to track so I'm going to stick with the standard US clinical guidelines which recommend tracking testosterone, estradiol, progesterone (if supplementing) and then prolactin if you're exhibiting symptoms of high prolactin.

TESTOSTERONE:

- *What does it do?* It is an androgen involved in many body functions and impacts the following: libido, mood, energy levels, bone density, muscle protein synthesis and mass, fat distribution, red blood cell production, cognition, skin, body hair, scalp hair, it's the primary male hormone and makes boys.
- *Where is it produced in cis men?* Testicles produce ~95% of testosterone in cis men and adrenal glands produce a small amount.
- *Where is it produced in cis women?* Ovaries are the primary source, and like cis men the adrenal glands also produce some as well.
- *What do we want to do with testosterone?* We want to lower it, it's like limbo, how low can you go?
- *How do we impact it?* The primary route is medications, specifically anti-androgens, they block the action of testosterone. There are other options that are more costly like GnRH agonists - these functionally shut down signals from the brain that tell the testes to make testosterone more used as a puberty blocker. This guide assumes the reader is an adult AMAB. There's also Cyproterone acetate that both blocks and suppresses testosterone however it comes with risks and added monitoring. Taking high enough doses of estrogen (estradiol monotherapy) will actually lower testosterone levels even without the medications listed above. Finally, the surgical option, orchiectomy is the removal of the testes, I'll go into all of this in more detail below.

ESTRADIOL (ESTROGEN):

- *What does it do?* Estradiol is the most potent estrogen in humans and it impacts nearly every major organ system. It regulates fat distribution, bone density, skin thickness / softness / hydration, it supports scalp hair growth patterns, regulates metabolism, supports vascular and heart health, influences mood, emotional processing, cognitive patterns, menstruation cycles in ciswomen, breast development, shapes pelvis and vaginal / uterine development; it's the primary female hormone and makes girls.
- *Where is it produced in cismen?* Testicles produce a small amount of estradiol, some peripheral conversion from fat tissue and skin convert testosterone into estradiol via aromatase and then the adrenal glands produce very small amounts.
- *Where is it produced in ciswomen?* Ovaries are the main producer, adipose tissue converts androgens into estrogen, placenta produces large amounts during pregnancy and then the adrenal glands produce a small amount.
- *What do we want to do with estradiol?* We want to get to ciswomen levels but **keeping in mind that higher doesn't mean "more feminization"** it does mean higher clot risks, possible mood swings and other medical concerns, I know lots of us DIY, I still would implore you to go to a lab and get your levels checked until you know proper dosage. The goal is to get between 100-200 pg / mL - some transgender women prefer slightly higher levels, me personally I hang out around 245 pg / mL - 275 pg / mL.
- *How do we impact it?* There are multiple delivery methods - oral, sublingual, transdermal and injections. Also, lowering testosterone with anti-androgens (yes they do lower T as well as block, albeit slightly) reduces competition and promotes stabler levels.

PROGESTERONE:

- *What does it do?* Progesterone is a major sex hormone in humans, and it plays key roles in reproductive biology and has systemic effects on the brain, metabolism and tissues. In all humans it modulates mood, anxiety and sleep, it affects neural signaling and GABA activity, supports bone health, influences fat storage, insulin sensitivity and thermoregulation. In transgender women there is a lack of good data on this but studies have shown it can promote fuller, rounder breasts, help mood, and sleep.
- *Where is it produced in cis men?* Adrenal glands (very small amount) and testicles also a very small amount.
- *Where is it produced in cis women?* Ovaries, placenta (during pregnancy) and adrenal glands, levels fluctuate cyclically, low during the follicular phase (early menstrual cycle) and higher after ovulation.
- *What do we want to do with progesterone?* This is still a debate, some doctors will say don't use it, others say try it. My personal lived experience, as of writing this I have been on progesterone (micronized Prometrium) for just over 40 days, I have noticed softer skin, slower body hair growth and my breasts are definitely growing faster / fuller, but I can't know for sure if this is just time on estradiol or progesterone assisting.
- *How do we impact it?* Oral or rectal administration of micronized progesterone. There are two forms of progesterone, one is less effective with higher risks; stick to micronized.

PROLACTIN:

- *What does it do?* Its primary role is in milk production and has other impacts on mood, metabolism, immune and reproductive systems. It is present in all humans.
- *Where is it produced in cis men?* The pituitary gland.
- *Where is it produced in cis women?* The pituitary gland.
- *What do we want to do with prolactin?* Slight elevation is normal from estrogen however very high levels are not desired as it doesn't improve feminization and can lead to headaches, vision changes, hormone imbalances and lactation. If you're experiencing these symptoms and you haven't tested your prolactin levels you should check them, extremely high levels can be an indicator of a brain tumor.
- *How do we impact it?* Estrogen, elevated stress, antidepressants / antipsychotics / GI meds can impact it. Mostly, just be aware of the possible symptoms and things to watch out for.

DIHYDROTESTOSTERONE (DHT):

- *What does it do?* DHT is a more potent form of testosterone driving facial and body hair growth, causes scalp hair loss (male-pattern baldness), increases acne and skin oil, contributes to prostate growth, helps develop genitalia and has a strong impact on libido.
- *Where is it produced in cismen?* DHT is produced by converting testosterone using the enzyme 5 α -reductase in multiple areas (skin, hair follicles, prostate, and testes although most conversion is in tissues, not the testes).
- *Where is it produced in ciswomen?* Ciswomen DO produce DHT but very low levels, mostly in the skin / hair follicles, liver, adrenal glands and ovaries. Again, very low levels compared to cismen.
- *What do we want to do with DHT?* Reduce, remove, get rid of it, stop conversion of T \rightarrow DHT.
- *How do we impact it?* Reduce testosterone AND halt DHT conversion (finasteride / dutasteride).

Medications:

TESTOSTERONE SUPPRESSANTS & ANTIANDROGENS:

TL;DR - Suppressants reduce total testosterone production. Antiandrogens reduce testosterone's effects - either by blocking androgen receptors or by reducing testosterone → DHT conversion.

What to expect: When you reduce / suppress / block testosterone production and receptors you will see some major changes in your body, albeit slowly. Within the first 1-3 months expect to see less spontaneous erections, reduced libido and less oily skin. You'll experience nipple changes, sensitivity and possibly breast buds depending on how you respond. Body and facial hair growth will slow (though existing hair takes much longer to thin out). Between 3-6 months, you'll start losing muscle mass, fat begins to redistribute away from your abdomen to your hips, thighs and butt though this process takes 2-5 years to complete. Your skin gets softer, breast development begins (driven primarily by estrogen, but enabled by low testosterone).

EMOTIONS: This has to be talked about, you're going to feel different. Lower testosterone often means less aggression and anger and more frequent crying. Many transgender women (myself included) describe feeling more emotional, not in a negative way, you just feel your feelings more and in my opinion I feel as though I have better access to the spectrum of emotions I am capable of feeling.

Onto the medications...

Medicine & Brand Names (GnRH Agonists): [Leuprolide](#) (Lupron) / [Goserelin](#) (Zoladex) / [Triptorelin](#) (Trelstar)

How they work: These medications initially stimulate the pituitary gland which actually causes a SPIKE in testosterone production, this spike is temporary and usually lasts 1-2 weeks. Then the gland actually shuts down from overstimulation - a process called downregulation. The result is dramatic suppression of hormones that signal the testes to produce testosterone. Notable mention: there are some medications that bypass the spiking phase and go directly to suppression such as [degarelix](#).

Efficacy: These drugs are incredibly effective, studies show 89% reduction in testosterone from baseline - typically from around 432 ng/dL down to 47 ng/dL within 3-6 months. This compares to only 55% reduction with non-GnRH antiandrogens. Testosterone stays suppressed below 50 ng/dL long term.

Delivery Methods: Injections - subcutaneously (fat tissue) or intramuscular (muscular tissue) at monthly intervals or every three months. There is also a yearly implant under the skin (histrelin/Supprelin LA).

Common Side Effects: Hot Flashes, injection site reactions, headaches, mood changes, fatigue, weight gain and decreased libido.

Serious Risks: Long-term use causes bone density loss, similar cardiovascular risks as any testosterone-suppressing therapy and possible glucose intolerance progression.

Costs: \$\$\$\$\$ - These medications are ridiculously expensive ranging from \$800 - \$1500 / month and the implants can cost \$30k - \$40k per year.

Sources: [1.](#) [2.](#)

Medicine & Brand Names: [Spironolactone](#) (Aldactone)

How it works: Spironolactone operates through multiple mechanisms. It blocks androgen receptors, preventing T and DHT from binding to cells and exerting their masculinizing effects. It also weakly suppresses testosterone synthesis.

Efficacy: Spironolactone is a moderate antiandrogen. A prospective [study](#) found only about 66% of transgender women achieved female-range testosterone levels (below 50 ng/dL) when taking 100-200mg of spironolactone. Another randomized controlled [trial](#) found that after 12 weeks only 19% of spironolactone users achieved full testosterone suppression compared to 90% of users taking cyproterone acetate. **No difference in breast development between spironolactone & cyproterone acetate users**

Delivery Methods: Oral - most prescribers start at 25 - 50mg daily and increase every 2-4 weeks based on labs and tolerability. Standard maintenance is 100mg - 200mg daily typically split into 2 doses (morning / night). Some go up to 300mg - 400mg but higher risks of side effects.

Common Side Effects: Increased urination (it's a diuretic), thirst, occasional dizziness or lightheadedness and initial orthostatic hypotension (feeling faint when standing quickly). These typically improve over time.

Monitoring: You should get a baseline complete metabolic panel, potassium, creatinine, testosterone and estradiol before starting if you're able to. During treatment Potassium and renal function at 3 months, 6 months and then every 6-12 months after that once levels are stable.

Serious Risks: Hyperkalemia can cause muscle weakness, paralysis and potentially fatal cardiac arrhythmias - this is very rare, but this is why we monitor our potassium levels.

Critical Drug Interactions: ACE Inhibitors - (lisinopril, enalapril) or ARBs (losartan, valsartan): Additive hyperkalemia risk - potentially fatal. Do not take potassium supplements. NSAIDs reduce spironolactone's efficacy (effectiveness) and increase kidney damage risks, use tylenol (acetaminophen) instead unless directed otherwise by your doctor. Worth mentioning Lithium has the possibility for increased lithium toxicity.

Costs: \$ - \$10 / month, if you have insurance (I am in the USA and will always be speaking from my experience as an American) - mine covers it 100% and it's \$0 / month for me.

Medicine & Brand Name: [Bicalutamide](#) (Casodex)

How it works: Unlike spironolactone, bicalutamide is a pure androgen receptor antagonist - it binds very tightly to androgen receptors, completely blocking testosterone and DHT from activating them. **IT DOES NOT REDUCE TESTOSTERONE LEVELS.** Your bloodwork will show normal or even elevated testosterone levels, but that T can't do anything because all its receptors are occupied. Some evidence suggests the blocked T gets converted to estrogen, potentially enhancing feminization.

Efficacy: There is limited information on transgender women efficacy, the available data is very promising. A [study at Riley Hospital](#) found that 84.6% of transgender women had breast development within 6 months on 50mg daily bicalutamide alone. A [larger study](#) at Indiana University found 90.4% reported breast development at first follow-up.

Delivery Methods: The standard dose is 50mg once daily, some protocols use 25mg daily or even twice weekly dosing - the drug has a 6-7 day [half-life](#).

Common Side Effects: Hot flashes (reduced when combined with estrogen), breast tenderness (expected), Gi symptoms in about 15%, decreased libido and photosensitivity. Source: [1.](#)

Serious Risks: [Hepatotoxicity](#) (liver damage) is rare but potentially fatal and has been reported, typically within the first 3-4 months. Strict liver monitoring is **required** for this medication. **Note - studies mentioned above found no hepatotoxicity over the course of years. Interstitial lung disease, rare and higher risk at higher doses, bone density concerns with long-term use and cardiovascular risks reported (note this is at higher doses used to treat prostate cancer 150mg vs 50mg).

Critical Drug Interactions: Bicalutamide inhibits CYP3A4 so it can increase many levels of medications ([2.](#)). Statins, benzodiazepines and calcium channel blockers.

Warfarin interaction is significant with increased bleeding risks. ([3.](#))

Costs: \$\$ - Generic costs \$15-25 / month brand names like Casodex are over \$3k / month, but no reason to use the brand name over generic.

Medicine & Brand Name: [Cyproterone acetate \(CPA\)](#) - Androcur or Diane / Diane-35

How it works: For my USA people, this is not available here because the FDA hasn't approved it (hepatotoxicity risks) - however it is the most common antiandrogen outside of our country. CPA is both a potent antiandrogen and a progestogen. It blocks androgen receptors AND reduces testosterone production through negative feedback on the pituitary, the dual mechanism makes it highly effective.

Efficacy: The landmark [ENIGI study](#) (n=882) found that CPA suppressed testosterone dramatically regardless of dose when combined with estrogen. Here's what's remarkable: 10mg CPA was equally effective as 100mg for testosterone suppression.

Delivery Method: Oral, 10-12.5mg daily is now considered the appropriate dose.

Common Side Effects: Decreased HDL cholesterol, elevated prolactin, potential for depression (especially with preexisting depression), weight gain.

Serious Risks: Hepatotoxicity is possible at doses for testosterone suppression however these are rare, liver monitoring is a must. [Meningioma](#) (brain tumor) is a serious potential risk. A French [study](#) found at 60mg+ had a 21.7-fold increased risk, at 36-60mg 11.3-fold increase and below 12mg not significantly elevated. Interestingly enough, meningiomas may regress after stopping CPA on their own.

Costs: \$ - Mostly affordable - \$10 - \$50 per month where available for the medication, monitoring however can be costly if brain scans are not covered.

Medicine & Brand Name: [Finasteride](#) (Propecia) & [Dutasteride](#) (Avodart)

How it works: DHT Inhibitors - both of these are 5-alpha reductase inhibitors however finasteride ONLY blocks type 2 and dutasteride blocks type 1 & 2.

If you can get on dutasteride, it is the better choice assuming you tolerate it. 90-98% blocking of DHT in serum (vs 70% for finasteride) and 51% in scalp tissue (vs 41% in finasteride).

Efficacy: Finasteride is more commonly used, high efficacy in assisting with recovering from male-pattern baldness, very slight impact to body hair growth. Dutasteride, as mentioned above, has higher efficacy for scalp hair repair as well as additional DHT blocking capabilities, both are still excellent choices.

Delivery Method: Finasteride - oral 1mg per day, higher doses have higher risks and efficacy is not significantly changed. Dutasteride - oral capsule taken 1x per day.

Common Side Effects: Finasteride - decreased libido, erectile dysfunction, decreased ejaculate volume and breast tenderness and enlargement. Note all of these are rare. Dutasteride common side effects are very similar to finasteride, they are rare and include decreased libido, erectile dysfunction, decreased ejaculate volume, breast tenderness & enlargement as well as sperm count reduction (25-28% decrease documented).

Serious Risks: Persistent sexual dysfunction - some patients experience persistent sexual issues including numbness that lasts after finasteride is discontinued. The data on this is skewed as the current reports come with selection bias. This is for BOTH medications.

Mental Health Risk: Finasteride & Dutasteride are 5a-rductase inhibitors and while they are great for helping hair – they 100% impact your brain. Multiple studies have shown significant increases in depression as well as suicidal ideations. Sources: [\(1\)](#) [\(2\)](#) [\(3\)](#) [\(4\)](#)

Furthermore – if you are supplementing with progesterone, orally or rectally administered, when your liver processes progesterone it converts some of it to [allopregnanolone](#), a potent neurosteroid with antidepressant and [anxiolytic](#) properties.

Unfortunately, there are no peer reviewed studies confirming this (none I could find) – but the way 5a reductase inhibitors work, they block these wonderful effects of allopregnanolone.

I personally experience both of these, I have always struggled with suicidal ideations as well as depression, as far back as I can remember. They have been worse but not consistently, it comes in waves for me, I have good days and bad.

After my orchiectomy I will stop spironolactone 100% immediately – I am very much considering dropping finasteride as well, but I plan to wean off of it to avoid any shedding.

I know if I trust science, it is just math and numbers, if my testosterone is below 10 ng/dL because I will no longer have testicles, then finasteride isn't really doing much if anything, it is redundant at that point, and yet I am terrified of stopping and losing my hair again.

I spoke to a hair restoration surgeon about my scalp, he insisted stopping finasteride post orchiectomy is 100% safe. I am hopeful to enjoy the positive mental effects of progesterone, I imagine by my 12 months update I will be off finasteride completely.

Costs: \$ - Finasteride \$8-12 / month, no reason to take brand name, generics available. Dutasteride slightly more - \$12-17 / month.

Medicine & Brand Name: Progesterone comes in 2 forms, [micronized progesterone](#) (Prometrium) and then [synthetic progestins](#) (Medroxyprogesterone acetate, MPA / Provera).

How it works: This is really not an easy one to cover, there's a lack of studies, data and inconclusive information out there, however I do take micronized progesterone. I'll start by saying I'm not going to recommend synthetic progestins, they are higher risk and lower efficacy and there is no point in digging into them. If you're going to take progesterone you should only be consuming micronized.

The core controversy:

Proponents argue: Cisgender women have both estradiol and progesterone. If the goal of HRT is to replicate female hormone levels, shouldn't transgender women also have progesterone? Further, progesterone is essential for complete breast development in cisgender females—the transition from Tanner stage 3 (conical, early development) to Tanner stages 4-5 (mature, rounded breasts). Without progesterone, some trans women report their breast development "stalls" at an immature stage. (1.)

***[2024 landmark study I just found](#) on progesterone has very promising results for breast development - the study did determine that genetics remains the strongest predictor of final size, higher body weight correlates with better development and caloric restriction undermines feminization by preventing gynoid fat deposition.

"Among our 90 participants we repeatedly used 3D-scanning techniques to measure breast volume and saw up to an increase of 37%. Crucially, we also saw that the study participants were more satisfied with the size, shape and the growth of their breasts," adds Raya Geels, PhD candidate at Amsterdam UMC and the study's first author.

Guidelines are cautious: WPATH SOC8's systematic review, conducted by Johns Hopkins researchers, was **"unable to uncover any quality evidence supporting a benefit of progestogen therapy for transgender women."** (2.) They also identified potential harms: increased VTE risk with some progestogens, decreased HDL cholesterol with long-term use. **These risks are not associated with micronized progesterone as of today.**

Dr. Joshua Safer, a co-author of SOC8, explained: "We didn't feel we had enough scientific evidence to make a specific recommendation either against or in favor of the use of progestogens... We didn't want to ignore this important area, given the fact progestogen use is widely promoted on the internet."

The Endocrine Society (2017) acknowledges that "current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect." (3.)

This is the frustrating truth: we genuinely don't know if progesterone helps.

Efficacy: This is my lived experience - I started micronized progesterone taken rectally on November 4, 2025, I started HRT May 14, 2025. Today is December 12, 2025, in my time on progesterone I have experienced faster / fuller breast tissue growth, softer skin, slower body and facial hair regrowth and my wife will not stop telling me how much more scalp hair I have "all of the sudden." I waited until I was through tanner stage 2 breast development and into tanner stage 3 to reduce tubular breast shape risk (again, these are theories, not necessarily proven, my lived experience). I will go into this more in the breast section. (4)(5)(6)

Delivery Method: Oral or Rectal are the 2 methods, again I am only talking in regard to micronized progesterone (Prometrium). If taken orally - there is extensive first-pass metabolism; produces high neurosteroid metabolites causing **significant** drowsiness at bedtime. Levels are shown to be less stable when taken orally and spikes and troughs are more frequent. Rectally - bypasses first-pass metabolism - causing less sedation, more stable levels, less liver risk and *from what I have read* higher efficacy for feminization. I cannot highlight enough this is my opinion from lived experience, speaking to other transgender women and finally acknowledging how it is processed in the body rectally vs orally.

Common Side Effects: Drowsiness / sedation (more common in oral), dizziness, breast tenderness, bloating, mood changes (**IMPORTANT - see serious risks**), headaches, not evidence based but in community discussions as well as my own experience - improved libido.

Serious Risks: Depression / suicidal ideations can get worse from micronized progesterone, if you start taking it be mindful of this, I journaled daily and recorded my mood / energy levels etc. [VTEs](#) - there doesn't appear to be evidence of increased VTE risk in micronized progesterone however in synthetic progestins this risk is very real and they should be avoided. As of today it is unknown if breast cancer risk is impacted by progesterone in transgender women.

Costs: \$\$ - Generic Prometrium \$5 - \$33 for 30 - 90 capsules. I believe at Costco where I got mine I paid \$30 for 90.

Estrogen / Estradiol (E2):

Medicine & Brand Name: Estradiol / Estradiol Valerate / Estradiol Cypionate - There are a lot of brands, delivery methods so I'm not going to list them all here.

How it works: All estradiol formulations achieve feminization when dosed appropriately - however - this does not mean they are all equal in efficacy, bioavailabilities, risks and stabilities. Estradiol is what causes feminization, the thing we're here for, when testosterone is suppressed / blocked and estrogen is at feminizing levels (100 - 200 pg/mL) you can expect breast development, fat redistribution, skin softening, decreased muscle mass, decreased facial & body hair, changes to scalp hair, decreased libido & erections, emotional changes.

Choosing a delivery method:

Factor	Oral	Sublingual	Patches	Injectable
Cost	Lowest (\$10-20/mo)	Lowest (\$10-20/mo)	Moderate (\$30-40/mo)	Low-High (\$10-250/mo)
VTE Risk	Highest	Unknown (likely intermediate)	Lowest	Intermediate
Level Stability	Moderate	Poor (peaks/troughs)	High	High
Convenience	Daily pills	Multiple daily doses	Weekly patch change	Weekly injection
Market Availability	Excellent	Excellent	Good	Variable (shortages historically)
Best for T suppression	Usually needs antiandrogen	Usually needs antiandrogen	Usually needs antiandrogen	Can work as monotherapy

***I've been questioned on pricing for injections - please **note there are more than one type of injectable hormone therapy, and some are more expensive than others** (estradiol cypionate) then there's insurance vs no insurance, it is a wide spectrum.

The above chart is the cleanest way I could try to put this comparison together; there's tons of data and resources out there on this, here's where I'm getting my information from:

Target Hormone Levels:

<https://academic.oup.com/jes/article/9/5/bvaf004/7965163?login=false>

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11957913/>

Oral Estradiol information:

<https://transfemscience.org/articles/oral-vs-transdermal-e2/>

<https://pubmed.ncbi.nlm.nih.gov/26544651/>

<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/04/postmenopausal-estrogen-therapy-route-of-administration-and-risk-of-venous-thromboembolism>

<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/04/postmenopausal-estrogen-therapy-route-of-administration-and-risk-of-venous-thromboembolism>

Sublingual Estradiol Information:

<https://www.sciencedirect.com/science/article/abs/pii/S1530891X21013744>

<https://pubmed.ncbi.nlm.nih.gov/33439749/>

Transdermal Patches:

<https://www.ahajournals.org/doi/10.1161/circulationaha.106.642280>

[http://endocrinepractice.org/article/S1530-891X\(22\)00898-9/fulltext](http://endocrinepractice.org/article/S1530-891X(22)00898-9/fulltext)

<https://pmc.ncbi.nlm.nih.gov/articles/PMC9399360/>

Injectable Estradiol:

<https://pubmed.ncbi.nlm.nih.gov/39735380/>

<https://pubmed.ncbi.nlm.nih.gov/38782202/>

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11957913/>

<https://www.sciencedirect.com/science/article/pii/S1530891X24005305>

<https://www.ncbi.nlm.nih.gov/books/NBK593552/>

<https://transcare.ucsf.edu/guidelines/feminizing-hormone-therapy>

<https://pmc.ncbi.nlm.nih.gov/articles/PMC5908424/>

<https://transcare.ucsf.edu/guidelines/feminizing-hormone-therapy>

Personal Summary on Medications:

I was 40 years old when I took my first dose of HRT, I was experiencing severe male-pattern baldness, dysphoria in so many ways and I had no expectations that I would ever pass, and I had little hope that my body would actually change. I started HRT to *feel better*. It wasn't about physical changes for me at that time.

These are the medications & doses I started out on:

- 6mg / week subcutaneous injection estradiol valerate
- 50mg / day oral spironolactone
- 1mg / day oral finasteride
- 5% topical minoxidil 2x per day

When I hit ~6 months of HRT and my breasts were into tanner stage 2 I started:

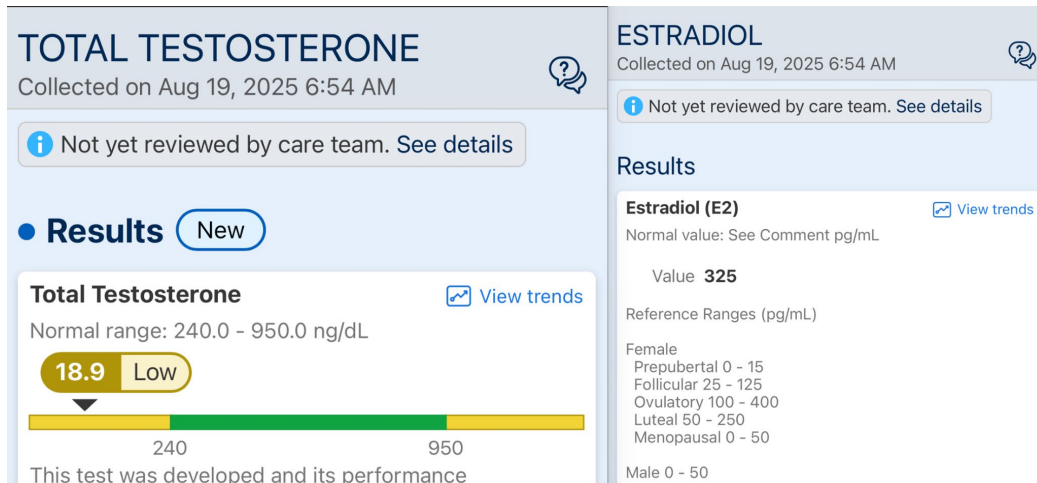
- 100mg micronized progesterone (Prometrium) rectally administered - for me I do this as the last part of my bedtime routine after brushing my teeth / flossing etc. I use a tiny drop of water based lubricant and then go straight to sleep. ([X-Lube](#)) - **I am sure I will mention this again but, I cannot recommend this product enough.**

I went straight for subcutaneous injections of estradiol valerate for a number of reasons that worked for me, my health and my own opinions from my own reading.

- Affordability - the dose I am on, 1 vial lasts 8 months and needles are cheap.
- Convenience - I love doing one injection a week, it takes me 5 minutes every Wednesday morning and then I don't think about it again.
- Stability - my lab work confirms the data I've read; my levels are consistently in feminizing ranges. I remember when I first started injections around day 4 I would start to crave another shot, it was the strangest feeling. I didn't want more just "to want more" - I wanted more because I felt like I didn't have enough. As my journey continued, my testes shrunk, my testosterone production tapered, the estradiol didn't have to compete as much to be my primary hormone and these cravings went away.
- Efficacy - I've read countless stories of transgender women trying sublingual / oral / transdermal and not happy with their results, then they switch to injections and voila - their feminization takes off.

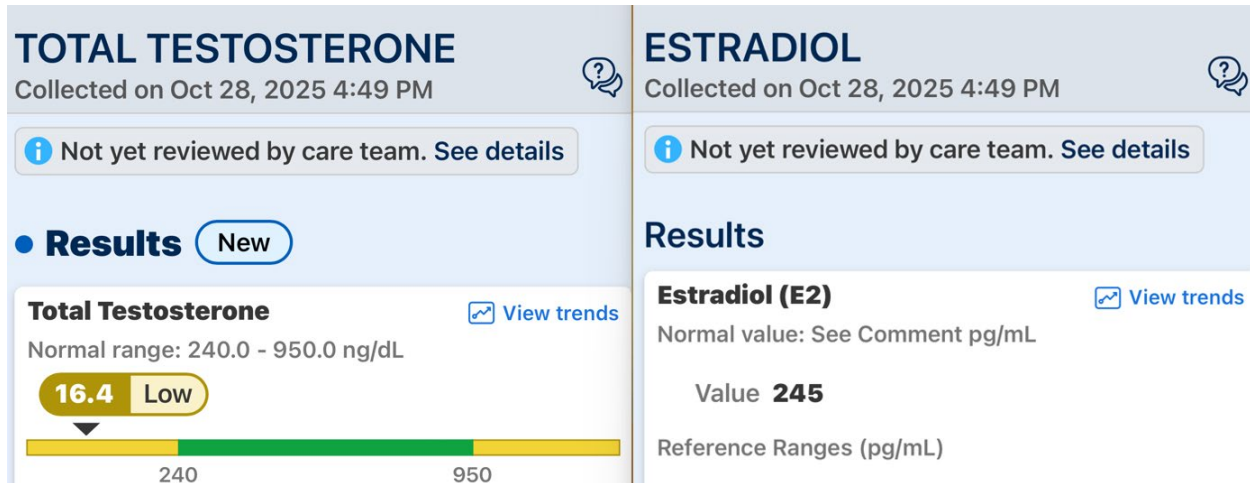
My Actual Labs:

3 Months:



My testosterone levels were optimal however my estradiol levels were a bit high, my doctor and I agreed to reduce my dosage from 6mg / week subcutaneous injection → 5mg / week.

6 Months:



My doctor felt okay with my levels here, as did I, physical results & changes were happening so dosage for now is locked in. I will update labs with progesterone numbers once I get them at the end of January.

Breast Development:

This section will be detailed and lengthy, I'm putting a sub-index for this section as I know to me it is incredibly important and an area that most of us want to understand and are hyper insecure about (at least I am).

1. [Introduction](#)
2. [What to Expect: The Reality of Transgender Women's Breast Development](#)
3. [The Biology: Tanner Stages & Developmental Process](#)
4. [Managing the Experience](#)
5. [Supporting Optimal Development & Progesterone](#)

Introduction

Before we dig into all the information, I am tracking my own breast development, the slideshow of me below is in chronological order: first photo was November 2024 and preHRT → starting HRT May 14, 2025 → current version of this document (live).

*****NSFW Disclaimer these are topless images of me to show what the stages look like on a 40-year-old transgender woman*****

I did include boymode images in these photos. I use [Target brand All-In-Motion](#) sports bras to flatten my chest for days that I go to work.

There are images of me boymoding, one is very early like 1 week into HRT, I started wearing sports bras because my nipple sensitivity was insane. The second set of images was 2 days ago, December 15, 2025, to show I still boymode fine even with fairly developed breasts. As of now, February 6, 2026, boymoding window is closing with fitted tops at least.

I will continue to add images to the slide show as my breasts develop.

[Nova's Breast Development](#)

I want to touch on [gynecomastia](#). I developed gynecomastia when I was 12, it stuck with me my entire life and I was always self-conscious about it. I considered removing it multiple times in my life, I am grateful that I did not do that.

There are no comparative studies examining whether transgender women with pre-existing gynecomastia end up with larger final breast volumes compared to those who start HRT without any existing tissue. I can tell you that [UCLA Health research notes](#) that gynecomastia shows only “ductal and stromal hyperplasia,” while HRT-induced tissue in transgender women develops “breast ducts, lobules, and acini, similar to that of biological women.”

The last thing I would mention about gynecomastia is if you had gynecomastia in your lifetime and then had that tissue surgically removed, you should plan on surgical implants if you want breasts. By removing that tissue, it will prevent breasts from developing unfortunately and I am very sorry if this is your situation.

What to Expect: The Reality of Transgender Women's Breast Development

The purpose of this section is to set your expectations based on evidence and my lived experience. This isn't to say ALL people have the same experience as me, this isn't to say it is impossible for a transgender woman to develop breasts smaller or larger than what I present below, I'm using known studies, averages and lived experiences. *Everybody is a little different.*

Breast development in transgender women follows the same biological pathways as cisgender puberty but typically results in smaller final size—**most achieve Tanner stage 2-3 and A-cup range after 2-3 years.**

The most significant growth occurs in the first 3-6 months, driven by estrogen receptor activation and adequate testosterone suppression. (Sources on breast growth timeframe: [\(1\)](#) [\(2\)](#) [\(3\)](#) [\(4\)](#) [\(5\)](#) [\(6\)](#))

My lived experiences have been breast growth exploded after month 6 with rectal progesterone administration. I think the reality is, science can give us averages and likely outcomes but not everyone will fall into that exact time frame. I don't want to say my lived experience outweighs peer reviewed studies so I will share both here and let you the reader use the information as you wish.

Some sources on final breast size:

[\(1.\)](#) Median breast volume was 115 mL (IQR, 68; 203), ie, bra cup size < A. Breast volume was 47 mL (95% CI, -9; 104) larger in the late PS group compared to early PS but this difference was only 4 mL (95% CI, -67; 75) after correction for fat percentage. Breast volume in the adult group was comparable to the early and late PS groups (adult vs early PS 27 mL [95% CI, -28; 83] and adult vs late PS -20 mL [95% CI, -80; 40]). In total, 68% of subjects were satisfied with breast size (57% of early PS, 76% of late PS, and 70% of the adult group).

[\(2.\)](#) Breast volume increased by 72 cc (95% confidence interval [CI], 48-97) to 100 cc (standard deviation 48). This resulted in a cup-size <A-cup in 71% of the participants. Although the change in breast-chest difference plateaued after approximately 9 months, sustained increase in breast volume was observed during the 3-year observation period. Sternal notch to nipple distance increased by 1.3 cm (95% CI, 0.9-1.7) and internipple distance increased by 1.0 cm (95% CI, 0.4-1.5). At least 58% of trans women were satisfied with the gained breast size.

Transgender women that start HRT as a fully grown adult have larger chests and torsos (structurally) than cisgender women typically. This creates a larger surface area for tissue to spread out over - this makes measurements a bit tricky. For example, my measurements as of writing this are:

Underbust: 34.25"

Overbust: 39.75"

Based on these measurements I have a 34" band and I would be a 34DD in the US if you take the under → overbust differences. My breasts have not reached their final shape and I have years of development to go, but there is no way I could fill out a DD bra today. Honestly I hope they don't ever end up that big, but that's me, I'd love a perky full b cup. A girl can hope.

My point for sharing this is that for a lot of transgender women overbust / underbust ratios are not a reliable indicator of cup size due to our larger chest sizes (and staging of breast development obviously).

*****IMPORTANT***** Breasts will swell and shrink (3) (4) (5) (6), this is totally normal for developing breasts and fully sized breasts and is something cisgender women experience as well. This can be due to hormonal fluctuations, initial growth phase, body weight and fat distribution, genetics and anatomy etc. If you're on HRT you will most likely experience this.

The Biology: Tanner Stages & Developmental Process

This is all about hormones - our bodies are shaped by them, including boobs. Estrogen initiates breast development by binding to estrogen receptor-alpha (ER α) in breast epithelial tissue, triggering downstream signaling that stimulates ductal proliferation. This receptor activation produces [amphiregulin](#), a paracrine mediator that activates epithelial growth factor receptors in surrounding stroma, promoting ductal elongation through terminal end bud proliferation.

The result is genuine mammary glandular tissue—containing lobules identical to those in cisgender women—not the gynecomastia tissue sometimes seen with other hormonal conditions.

Multiple hormones coordinate this development beyond estrogen alone. Growth hormone and insulin-like growth factor-1 (IGF-1) enable ductal morphogenesis. IGF-1 synergizes with estrogen and permits its action on breast tissue.

Prolactin contributes to [lobuloalveolar](#) development, and its levels often rise during feminizing HRT due to estrogen's effect on pituitary secretion. Progesterone induces ductal branching, alveolar bud formation, and contributes to mature breast architecture. (1)

The physical timeline follows a predictable pattern. Breast buds typically appear within 3 - 6 months of initiating HRT (2). These feel like small, firm, disc-like areas directly beneath the nipple-areola complex. Maximum development occurs during the first year, with growth continuing gradually for 2-3 years before plateauing.

Tanner Stages:

The [tanner staging system](#) classifies breast development based on shape and structure rather than size, using nipple, areola and tissue characteristics to track progression through 5 distinct [stages](#).

Stage 1: represents the pre-pubertal state—no glandular tissue palpable, flat chest with small nipples. For transgender women, this is the state before initiating HRT.

Stage 2 (breast budding): marks the first visible development: small, firm nodules—typically nickel-sized—form directly beneath the areola. The areola may appear slightly puffy or raised. This stage typically begins **3-6 months after starting HRT** and lasts 6-12 months. Tenderness is often most intense during this phase. One

breast frequently develops before the other; this asymmetry is normal (for me the left breast is consistently larger than the right, left side is more commonly larger).

Stage 3: brings breast tissue extending beyond the areola boundaries. The mound becomes rounder and more pronounced, visible when clothed. The areola enlarges but remains on the same plane as the surrounding breast tissue. Most transgender women reach this stage **6-18 months into HRT**, and this is where development commonly stabilizes.

Stage 4: features a distinctive "double scoop" appearance—the areola and nipple form a secondary mound projecting above the main breast contour. Upper and lower breast poles become more defined. Reaching this stage typically requires **12-24+ months** of HRT; *many transgender women never progress beyond Stage 3*.

Stage 5: represents mature development. The areola flattens back into a single, smooth breast contour with darker pigmentation and well-developed nipple papillae. **Most trans women do not achieve this stage with HRT alone**; estimates suggest fewer than 20% reach Stage 5 compared to approximately 95% of cisgender women.

Managing the Experience

Breast buds are composed of actual mammary progenitor tissue - not fat - and represent the **irreversible foundation** of breast development. They feel like firm, disc-shaped nodules approximately 1-2 centimeters in diameter, located directly beneath the nipple-areola complex. This tissue feels distinctly different from the surrounding chest wall.

The budding phase brings all sorts of sensations - tingling, soreness, sensitivity to touching / bumping (doors hurt), itching at times, the pain fluctuates with hormone levels and stages of development.

The active budding phase typically lasts 3-6 months, with transition to Tanner stage 3 occurring around 6-12 months. Tenderness generally persists throughout periods of active growth but typically diminishes as tissue matures. Some individuals experience asymmetric development initially, one breast budding before the other, which evens out over time, this is totally [normal](#).

Things that you should be concerned about and should speak to your doctor about if you experience them are persistent pain, hard fixed lumps that don't move with [palpation](#), skin dimpling or puckering, bloody nipple discharge or a complete absence of budding after 6 months of adequate hormone levels. Hard immovable masses or lumps not centered under the areola should be evaluated immediately by a doctor.

Binding:

Transgender women bind their chests for numbers valid reasons that deserve non-judgmental acknowledgement. Personally - I have never used a binder but I do wear very tight sports bras when I'm at work because of my own insecurities and concerns of being clocked and harassed at work and outside of work. I am nowhere close to passing or not looking like a dude with boobs right now, I hope that changes, I'm terrified it won't, but I have faith in HRT and time.

Some transgender women may bind for sports / athletics, or when we navigate hostile environments. The bottom line is, binding / tight sports bras are a very real fact of a lot of transgender women's experience, and I wanted to highlight how to do it safely.

First the risk - there is not a ton of research on this, we do know that even with binding breast tissue will form regardless but it does impact skin elasticity and from anecdotal evidence (online stories I have read) - it can impact shape.

Never bind with: ACE Bandages, duct tape or plastic wrap, these can do damage to your body such as broken ribs, fluid accumulation in lungs, restricted breathing; you should always be able to take a deep breath without pain or difficulty.

Do bind with: Sports bras that fit properly, commercial chest binders such as [gc2b](#), [Underworks](#) and [Spectrum Outfitters](#).

Frequency: Binding should never be done for 8+ hours, you need to take it off after 8 hours. At least 1 day / week should be spent out of the binder.

Growing breast tissue is not comfortable in my experience and at times can be somewhat painful. Personally, I'm a bit of a masochist now since I get happy when my breasts hurt because I know there's new growth forming. I try to avoid taking medications because that's just who I am.

Only you know your current medical situation, acetaminophen (Tylenol) is the safest first line pain reliever for those on HRT ([1](#)). It has no known interactions with estradiol, spironolactone, bicalutamide, progesterone, or finasteride.

NSAIDS (ibuprofen, naproxen, aspirin) require caution, particularly for spironolactone users. The combination increases hyperkalemia risk (dangerously elevated potassium).

Warm compresses help with general soreness, cold therapy is best immediately after acute impacts applied sporadically for 48 hours to reduce inflammation. Well-fitted supportive bras minimize discomfort from breast movement for a lot of transgender women.

Personally - I don't wear a bra as often as I can, I work from home a few days a week + the weekend gives me 4 days a week that I am 100% braless, I just prefer it.

Bra Sizing:

I have general anxiety disorders, and I don't come close to passing and I hate shopping for clothing / bras right now. I struggle with this, I have no confidence in this

realm so my lived experience isn't great. I have read up on this for shopping online and this is what I have found.

First you need accurate measurements, get a [tape measure](#) if you don't have one already, you can get it at a hobby store or online.

Underbust (Band Size): wrap a soft measuring tape around the ribcage directly under where breast tissue meets the body, keeping the tape snug but comfortable—you should fit a finger underneath. Note this measurement in inches and round to the nearest even number to get your band size.

Bust Measurement: either lay flat or lean forward at 45 degrees, wrapping the tape around the fullest part of the bust without compressing tissue. The tape should rest naturally across the breast's fullest point (2).

Calculate your size: the band size is your underbust measurement rounded to the nearest even number. Cup size is determined by the difference between bust and band measurements—1 inch equals an A cup, 2 inches equals B, 3 inches equals C, and so on.

A critical concept many miss: **cup size is relative to band size, not absolute.** A 32D has smaller cups than a 38D—the letter indicates the difference between band and bust, not an absolute volume. This means **sister sizing** works: going up a band size while going down a cup size (or vice versa) maintains the same cup volume. For example, 32D = 34C = 36B holds the same cup volume on different band frames (3).

I touched earlier on transgender women having different sized ribcages due to our bone structures from testosterone. This makes bras challenging, and sizing. My advice is to find a brand you like, get a few sizes that are in the right ballpark based on measurements & calculations and then find your size by that brand / style.

Supporting Optimal Development & Progesterone

Believe it or not, the primary restrictor of breast development is not due to low estrogen levels and is more likely due to higher testosterone levels (1).

The most significant growth occurs in the first 6-12 months, with continued but slowing development for the 2-3 years. The best predictor of breast size / shape is genetics - if you have sisters or know your biological mother, this is where to look.

A theory on oral estradiol creating estrone through the liver first-pass metabolism - there are concerns in the community that this will impede breast development. A 2022 study found that "change in fat percentage and breast development in transgender women were not associated with estrone concentrations nor with administration route." WPATH Standards of Care Version 8 explicitly recommends against monitoring this ratio due to lack of supporting evidence (1).

Nutrition:

Okay I'm going to be a little vulnerable here and talk about my personal eating disorder. I struggle with this - I actually struggled with this as a teenager as well, long before I understood that I am transgender. I always wanted to be tiny, lean, not masculine, not muscular. I cannot tell you how many times in my life my mom has given me shit about being too thin (excluding when I was obese and drunk all the time).

Eating disorders are more prevalent in our community, an estimated 8.1% of transgender women have an eating disorder.

Personally, I do restriction / binge cycles. I know it isn't the healthiest and I accept that about me, I have been eating this way for over a decade.

I always eat at least 1200 calories a day, even if I do not want to. I never restrict myself for days unless I'm ill, I almost always skip breakfast and lunch unless there are work events or if we have a family event. I prefer to consume my calories between 4pm → 10pm...except lately.

I wake up every night between 1am - 3am starving, regardless of how much I eat during the day. I've noticed this change since starting progesterone. I have had days where I put down 3k calories and I'll still wake up in the middle of the night. For me, it's peanut butter, I love it. Most nights I get up and make a peanut butter sandwich in the dark, I eat it, have some water and then go back to sleep.

Having shared that - let me actually talk about nutrition and caloric requirements.

[Adipose tissue](#) is an active hormone-producing organ that produces estrogen via the [aromatase](#) enzyme - in postmenopausal women, fat tissue contributes up to 100% of circulating estrogen. Research from the Journal of Clinical Endocrinology & Metabolism found that "breast development seems to be better in transgender women who have a higher body mass index," and weight gain in early HRT phases appears beneficial for both fat distribution and breast development (2).

Caloric restriction directly undermines feminization because new gynoid fat cannot deposit during deficit. The body cannot simultaneously lose weight and deposit fat in feminine patterns (hips, breasts, thighs). While glandular breast tissue may still develop during moderate restriction, overall breast size will be limited without the fatty tissue component that comprises most breast volume. Very low body fat (below approximately 22%) is associated with reduced estradiol levels, further impairing hormonal effectiveness. (3)

On [diet](#) - you need to hit your macros, you need calories based on your activity level, you need fat, protein, carbohydrates - you've got to eat if you want to grow breasts and if you want to give your body enough energy to redistribute fat.

Reducing meat can lower testosterone, I personally don't eat much, I don't ever eat pork or red meat, I only eat chicken and turkey, and it isn't daily. I use whey or pea protein powder depending on what is on sale. I do take psyllium husk daily for fiber, I try to eat eggs, veggies, and I avoid processed foods for many reasons, but I do consume them just not regularly.

Peanut butter is my favorite food; I eat 400 calories a day, I would estimate.

I can tell you with absolute certainty that alcohol and tobacco are not your friend if your goal is to **optimize** HRT feminization.

Progesterone:

I already covered this pretty extensively in the medications section so I'm not going to spend a ton of time on it here.

A randomized controlled trial from Amsterdam UMC presented at the 2024 EPATH congress in Hamburg provides the strongest evidence to date on progesterone's effects. The study enrolled 90 transgender women who had undergone surgical testosterone suppression, randomly assigning them to receive either 200mg or 400mg oral micronized progesterone nightly in combination with baseline or increased estradiol doses over a period of 12 months(1) (2) (3).

The results were significant: **participants receiving progesterone experienced up to 30% increase in breast volume** measured via 3D scanning technology (4). They also reported greater satisfaction with breast size, shape, and growth compared to controls.

The widely circulated theory that **starting progesterone before Tanner stage 3 causes tubular breast development remains scientifically unsubstantiated**. This claim extrapolates from animal studies from the 1940s-1970s and clinical guidelines for cisgender girls with Turner syndrome—no randomized trial has tested this hypothesis in transgender women. The supporting evidence is indirect at best: animal studies showed high-dose progesterone inhibited ductal growth in rabbits, and guidelines for inducing puberty in girls with ovarian failure recommend delaying progesterone for 2 years after starting estrogen. Multiple reviews explicitly note that while this is "biologically plausible," **"a randomized study has not been done,"** and **"limited data link early progesterone exposure to suboptimal breast development."** (5)

The current consensus: many clinicians recommend waiting until Tanner stage 3 (typically 6-12 months of estrogen) out of precaution, but this represents cautious clinical practice rather than established evidence. WPATH Standards of Care Version 8 found insufficient evidence to make recommendations either for or against progesterone supplementation. Those considering progesterone should discuss timing with their prescribing provider, understanding that the tubular breast concern is **theoretical community wisdom rather than proven medical fact**.

I personally waited until after 6 months of HRT, my doctor did not offer it prior to then anyway. I am quite content with my breast growth thus far, this morning (December 17, 2025) was injection #32. I still have 20 more injections to hit my 1-year mark and I

plan to eat as cleanly and in a caloric surplus or as close to that as I can handle mentally.

I have never taken my progesterone orally, the reason behind this is rectal administration bypasses the liver's first metabolism, in doing this there are stabler blood levels of progesterone and less risks, note this is only with micronized progesterone, I will not do any research on synthetic as they are unsafe and have lower efficacy.

Hair Regrowth:

Scalp Hair:

This topic is suuuuuper personal for me. I started going bald in my early 30s, mostly just thinning hair and it accelerated when I hit my mid-30s. By the time I was 38, I couldn't stand to look at photos of myself or myself in the mirror because of my hairline. I never questioned why it made me feel sick; I just avoided looking at myself. Looking back, the dysphoria makes sense.

My hair regrowth photographic timeline is at the end of this section.

Before I started HRT, I used topical HIMS spray (0.1% finasteride + 6% minoxidil) – I did this for one year (May 2024 → May 2025).

When I decided to start HRT, I researched hair regrowth optimization, and I started this routine in May 2025:

- Oral Finasteride 1mg 1x per day (**Had I known about dutasteride, I would've done that**)
- Topical Minoxidil 5% (Costco / Kirkland Brand) 2x per day - it is cheap and works great. I got a year's supply for \$60. *****NOTE***** Liquid has a higher absorption rate than foam but can be more irritating to scalps.
- HRT ([meds listed above](#)) and then adding progesterone rectally once I passed the 6 months' timeline on HRT, some evidence progesterone helps hair growth but limited data.

In addition to these medications, I added:

- [1.5mm microneedle roller](#) – every week depending on scalp health and sensitivity; be sure to disinfect your microneedle with 75%+ alcohol before and after each use. *****REPLACE YOUR MICRONEEDLE EVERY 15 USES*****
- [Instructional video](#). - TIP - I use 100% pure aloe on my scalp the day after microneedling to help reduce inflammation - **DO NOT MINOXIDIL FOR 24 HOURS AFTER MICRONEEDLING.**
 - **Studies show microneedling + minoxidil has a 4x+ increase on hair regrowth. (1.) (2.)**

- *****IF YOU ALREADY HAVE LONG HAIR***** - Get a microneedle stamp like this [one](#) - I have no experience with these but my understanding is to part your hair and stamp it. Here is a youtube [video](#).
- Another product to add is Ketoconazole Shampoo ([Nizoral](#) 1% over the counter) – this helps with scalp inflammation and is a blocker of DHT ([1](#))

*****NOTE***** - Your **scalp should never bleed** from microneedling, if it does – you're pressing too hard. Doing more microneedling from what I've read is not a good idea, you don't want to damage the tissue. 1.5mm depth is recommended for reaching the follicle root.

Hair regrowth is incredibly slow, most days it feels like **it is an act of faith** in my experience, trusting that it will work. It does work, but my god it is slow. **Expect years for full recovery if you were as bad off as I was at the start (Norwood 4+).**

My experience with the “stages” so to speak are:

Little to no hair in an area → vellus patches (peach fuzz / fine white hairs, almost invisible) → thicker & longer vellus hair → lightly colored terminal hair → thicker terminal hair.

There's plenty of data and stories from transgender women, hair regrowth and improvement is an **ongoing process for years**, it is also worth noting strand thickness & texture will change over time (years).

I keep my hair buzzed to 9mm because it allows better penetration during microneedling and easier / more even application of minoxidil.

The science of hair recovery:

I have shared my hair recovery on Reddit and with other transgender women on Discord. I have strangers messaging me now asking questions about my approach and why I did what I did. I am updating the hair regrowth section to include the studies I based my approach on to explain why I do what I do. Here we go.

Finasteride & Dutasteride:

I already explained these in the [medications section](#). I would like to provide the studies that cite their efficacy as well as which product I would use for optimal hair regrowth.

For finasteride – there is no evidence to support [more than 1mg](#) is needed for hair regrowth, if you have prostate issues, 5mg is recommended. [Long-term treatments](#) have shown a majority of cisgender men achieve improvements at 2 years and some continue to see improvements through 5 years. Even at [10 years](#) – some showed improvements past year 5.

For dutasteride – a [meta-analysis](#) of dutasteride 0.5mg vs finasteride 1mg/day at 24 weeks showed dutasteride to be superior. Another [meta-analysis](#) – this one compared monotherapy dutasteride vs combined therapy of finasteride and minoxidil. It still outperformed the combined therapy. A long-term [Korean study](#) again found dutasteride to outperform finasteride.

Clear Winner: 0.5mg Oral Dutasteride

Personally – by the time I'd learned about dutasteride I had been on finasteride for a year, and I was slated for an orchiectomy and just decided to stick with finasteride because I didn't want to be burdensome to my doctor. It was ~6 months – I probably should have spoken up but I didn't, my hair is still coming in and it will continue to (especially now that I have no balls 😊).

Post bilateral orchiectomy without spironolactone but still taking finasteride 1mg orally 1x a day – I had my DHT levels tested. My levels are 10 ng / dL – cisgender women levels are under 23 ng / dL. I have decided to stay on my finasteride for a few more years, my hair follicles are still coming in, anything I can do to reduce DHT in my system is a win right now. I want to give my hair every opportunity for a full recovery that I can.

Microneedling (Including Depths!):

Brief introduction – there are different styles of microneedles – there are dermarollers which is just a barrel with needles all over it that you roll on your skin, there are stamps which are exactly what they sound like a stamp with needles on it and then there are dermapens which have replaceable 1x use heads.

Dermapens *consistently* produce more accurate depth than a stamp or a dermaroller. Dermarollers and dermastamps have fairly similar consistencies and mostly it is about **disposing of them** after 12-15 uses. You should **not** use a dermaroller or dermastamp for more than 12-15 uses.

The reason for disposal is the microneedles get dull / blunt over time and actually will not penetrate to the target depth and can cause more damage to your skin than they are designed to.

You can get depths as shallow as .25mm all the way up to 2.5mm – here's what I was able to find.

For starters – *there was NO SIGNIFICANT DIFFERENTIAL in pooled analysis of rolling (dermaroller) vs electrodynamic pens.*

The landmark study [Dhurat \(2013\)](#) – combined topical minoxidil with 1.5mm dermarolling found, "Hair counts – The mean change in hair count at week 12 was significantly greater for the Microneedling group compared to the Minoxidil group (91.4 vs 22.2 respectively)." **This is 4x+ increase in results.**

[Faghihi et al. 2021](#) compared 0.6mm vs 1.2mm biweekly with 5% minoxidil and found that 0.6mm was more effective than 1.2mm on both hair count and thickness.

The [2025 Ahmed meta-analysis](#) formally compared <1mm vs >1mm depth and found no statistically significant difference in hair-count outcomes.

Cadence – the 2025 Ahmed meta-analysis reviewed the frequency of microneedling and determined that there is a cumulative benefit – weekly or biweekly sessions for 12-24 weeks is the evidence-supported regimen. Between sessions the scalp requires time to complete the proliferative wound-healing phase without chronic inflammation (1).

Clear Winner: From the available data, the winner is to microneedle at whatever depth you feel most comfortable with and follow a proper frequency (weekly / bi-weekly) and then stay consistent with it.

Topical Minoxidil vs. Oral Minoxidil:

The section above covered topical minoxidil in conjunction with microneedling. I'd like to explain oral minoxidil's primary risks and benefits.

Main benefits: oral, if you have cats topical minoxidil is extremely toxic to them and fatal, also you don't have to walk around with serum on your scalp all day long.

Main risks: with oral minoxidil you can experience [hypertrichosis](#) aka – werewolf syndrome meaning you have an abnormal amount of body hair growth including face. There are also very uncommon risks (3-5%) to a condition called [pericardial effusion](#) – an abnormal accumulation of fluid in the pericardial cavity of the heart. Can cause chest pressure & pain, shortness of breath, malaise (feeling unwell), it can get serious quickly so if you experience these symptoms stop immediately and get to your doctor.

Efficacy Comparison: [Panchaprateep & Lueangarun 2020](#) did a study of oral minoxidil 5mg/day for 24 weeks and it produced +35.1 hairs/cm². [Pena et al. JAMA Dermatol 2024](#) did a head-to-head 5mg oral vs 5% topical twice-daily for male androgenetic alopecia ([AGA](#)) found equivalent efficacy (note this did not include microneedling).

I found one article directly for transgender women ([JAAD](#)) – the findings were similar with what I stated above – the oral route vs topical routes are equal except orally has higher risks of hypertrichosis and the heart conditions – when microneedling is brought into the stack, topical is a clear winner.

Clear Winner: Topical Minoxidil when combined with microneedling ****unless you have cats!****

****Notable Mention**** Studies show oral minoxidil caps at 2.5mg – there is no reason to take more than that for hair regrowth. For those with cats that want to take oral minoxidil and avoid the risk of hypertrichosis – I recommend 1.25 – 2.5mg and see how it goes.

It is worth mentioning that anecdotal evidence and one or two studies have shown that microneedling alone will cause hair regrowth – if you're on oral minoxidil and are okay taking the 10-15 minutes a week to microneedle, I highly recommend it.

Red Light Therapy (Low-Level Laser / Light Therapy, LLLT)

[LLLT \(also termed photobiomodulation, PBM\)](#) uses diode lasers or LEDs at wavelengths of 500–1,100 nm (the "optical window") at low fluences (1–10 J/cm²) and low power (1–500 mW). The proposed mechanism is stimulation of bulge epidermal stem cells.

Most FDA-cleared home-use devices use wavelengths of 620-680nm, with the median at 650nm.

Efficacy:

Pivotal HairMax LaserComb RCT ([Leavitt et al. 2009](#), n=110 men): 9 LDs, 655±5 nm, 15 minutes 3×/week for 26 weeks produced a mean +19.8 hairs/cm² vs -7.6 hairs/cm².

[Shin et al. 2026](#) 12-month prospective multicenter trial: Helmet device (146 laser diodes 646–675 nm + 104 LEDs 645–665 nm; 3 mW each; 20 min × 3/week): ~+14 hairs/cm² (~15%) at 24 weeks, with continued increase through 12 months.

Based on the studies I found, optimal protocol:

- Wavelength is 620-680nm
- 20-minute sessions 3x a week on non-consecutive days (low frequency is superior to daily).
- Minimum 16-26 weeks with continued benefits out to 12 months.
- Helmet / Caps are more convenient than combs.
- Side effects are mild – scalp dryness (5.1%), [pruritus](#) (itchy scalp ~2.5%).

Clear Winner: Studies show these do work; just make sure you're getting a reputable brand and following the optimal protocol.

Ketoconazole Shampoo (1% & 2%):

Ketoconazole, beyond its antifungal action, has anti-androgen activity: it inhibits 5 α -reductase locally and disrupts DHT binding to androgen receptors in scalp tissue, also reducing scalp inflammation and sebum (1) (2).

Efficacy:

[Pierard-Franchimont et al. 1998](#) found 2% ketoconazole improved hair density and proportion of anagen follicles in men with AGA, comparable to minoxidil in some parameters.

[Inaba 2006](#) small open-label trial showed visible regrowth with daily 2% ketoconazole lotion in Japanese men.

[Saadawi et al. 2019](#) demonstrated trichogenic effect of topical ketoconazole vs 2% minoxidil in female pattern hair loss, with delayed but real improvement by month 6.

[2% is more effective than 1%](#): 1% is OTC, 2% requires prescription in most countries. The evidence base for clinical efficacy is specifically for 2%.

[Optimal protocol](#): If you can get a prescription for 2% great, otherwise I use 1% OTC – lather it into your scalp and hair 2-3 times per week, let it soak for 3-10 minutes and then rinse it out.

Clear Winner: 2% wins, 1% is still better than not using any. I've found it to be very affordable – a bottle lasts forever I barely need to use more than a nickel sized amount per wash. Studies show it helps grow hair; I'll use it.

OPTIMAL FULL STACK:

For those of you that want to go at this from every possible angle – this is the stack that science recommends and I just gave you all of the studies. If you have further questions, I'd refer you to the guide honestly, I am not a hair guru – I just followed the science.

- Oral Dutasteride 0.5mg
- Microneedling 1x a week or Bi-Weekly depending on your scalp response
- 5% topical minoxidil 2x a day (DO NOT APPLY THE DAY YOU MICRONEEDLE)
- 2% Ketoconazole Shampoo (Or 1% if you can't get or don't want to bother with a prescription) – 2-3x a week let it soak in your scalp for 3-10min
- Red Light Therapy Helmet 620-680nm 20min per session 3x a week non-consecutive days for 12 months

Last mention – platelet-rich plasma ([PRP](#)) – I did not include this in the write up – it is not very affordable in my opinion and not an option for most of us. Studies are skewed on this and lots of conflicts of interests on the studies I could find. I would not recommend this. If you're doing a hair transplant with PRP – that is different.

Combination therapy data:- Note that the [2025 network meta-analysis](#) found microneedling + minoxidil had the highest [SUCRA](#) (87.2%) in women, and finasteride + minoxidil + microneedling was superior to any two-drug combo.

[Nova's Hair Regrowth Images \(PreHRT → Current\)](#)

Fat Redistribution & Weight Cycling

When I first read about weight cycling it made perfect sense to me logically. The idea behind it (assuming MtF here) is that once your hormones have been in stable ranges for months that if you lose weight, you will lose it from masculine regions (stomach / visceral fat) and gain it in feminine regions (hips, butt, thighs, breasts and subcutaneous fat).

I read multiple people talking about cycling 5-10lbs up and down repeatedly to see these changes amplify and speed up the overall feminization process.

Unfortunately - science says this isn't true. I am a person of science, I acknowledge findings change and that there can be conflicts of interest – however in this particular area we do have a decent amount of data, and I'd like to run through that.

Biological Mechanisms:

Estrogen acts on adipose tissue through three receptors: ER α , ER β , and GPR30. Subcutaneous fat - the fat directly under the skin in the hips, thighs, buttocks, and breasts - carries more estrogen receptors than visceral (belly) fat. That receptor distribution is the foundational reason estrogen shifts fat *outward and downward* rather than inward toward the abdomen.

The key mechanistic findings from cellular and animal research:

- Estrogen upregulates α 2A-adrenergic receptors specifically in subcutaneous adipose tissue. These receptors are anti-lipolytic – they tell the fat cell to *hold onto* its stored lipids. Visceral fat doesn't get this upregulation. Net effect: subcutaneous fat becomes harder to burn off and easier to accumulate; visceral fat stays metabolically active.
- Estrogen promotes hyperplastic (cell-number) growth in subcutaneous depots rather than hypertrophic (cell-size) growth. Hyperplastic expansion is associated with more vascularization, less inflammation, and better metabolic health.
- Estrogen suppresses visceral fat accumulation through multiple pathways including increased mTOR signaling, suppression of adipogenesis in visceral depots, and direct anti-inflammatory effects. The protective effect against visceral adiposity is one of the most robust findings in the literature on estrogen and fat.

Sources: [\(1.\)](#) [\(2.\)](#) [\(3.\)](#)

Fat redistribution vs. new fat deposition – the critical distinction:

Existing fat cells don't migrate. They cannot pick up and move from your stomach to your hips. What actually happens on HRT:

1. [Adipocyte](#) number is largely set during childhood and adolescence and remains remarkably stable in adulthood ([Spalding et al., Nature 2008](#)).
2. About 10% of fat cells turn over per year, regardless of age or BMI (Spalding et al.). New adipocytes are continuously being born from preadipocyte progenitors; old ones are continuously being cleared.
3. Estrogen changes *where* new adipocytes preferentially develop, and *which existing cells* preferentially store or release lipids. Over months and years, the cumulative effect of this shifted hormonal signaling is a slow change in the body's *fat distribution*.
4. Estrogen does not "tell" abdominal fat to relocate. If you have belly fat at the start of HRT and your weight stays the same, that fat is largely still there years later. The body shape change comes from new subcutaneous fat being preferentially deposited in feminine areas *plus* slow visceral fat reduction *plus* normal adipocyte turnover.

The term "fat redistribution" is shorthand for a real but slower process: the pattern of fat *changes*, but it changes through deposition, turnover, and metabolic preference – not through migration.

What happens to existing male-pattern fat:

The fat cells you accumulated in the abdomen pre-HRT mostly stay put unless you:

- Lose weight (lipolysis empties them, but cell count remains)
- Wait years for natural adipocyte turnover (~10%/year)
- Have liposuction (the only way to actually remove adipocytes)

This is why many trans women see good fat development on their hips and thighs but retain a stubborn abdominal "shelf" they had pre-HRT — the new feminine fat is layering on top of unchanged pre-existing fat.

VAT/SAT ratio: the cleanest single metric:

The visceral-to-subcutaneous adipose tissue (VAT/SAT) ratio is the best single measure of how "masculine" or "feminine" your fat distribution looks. Higher ratio = more belly/visceral fat = more male pattern. Lower ratio = more peripheral/subcutaneous fat = more female pattern.

Key data in trans women on modern estradiol-based HRT:

- [Klaver et al., 2022, Journal of Clinical Endocrinology & Metabolism](#) (n=179 trans women, 1 year): VAT/TBF ratio decreased by **17%** (95% CI -19, -15). Total body fat increased **21%**. Visceral fat itself changed only -1%. Lean body mass dropped 3%.
- [Vienna MRI study, 2024](#) (n=15 trans women, 6 months, 17β-estradiol): VAT/SAT ratio dropped from 0.930 to 0.758 (p=0.011) in just 6 months.
- [Lundberg et al., 2025, Journal of Internal Medicine](#) (n=16 trans women, 5–6 years MRI longitudinal): increased total adiposity, *decreased* visceral fat volume, muscle fat infiltration shifted toward female-typical pattern within 1 year and continued over 5 years.

Translation: the shape change comes mostly from *adding* subcutaneous fat, with modest decreases in visceral fat. The ratio shifts dramatically in a feminizing direction even when total visceral fat doesn't change much, because the denominator (subcutaneous fat) grows substantially.

Timeline and Stages – What the canonical sources predict:

The [Endocrine Society's 2017 Clinical Practice Guideline](#) on hormone treatment of gender-dysphoric persons (Hembree et al., *JCEM*) provides the consensus framework most clinicians use:

- **Onset of fat redistribution:** 3-6 months
- **Maximum effect:** 2-5 years

UCSF's Transgender Care guidelines and Rainbow Health Ontario both adopt the same framework with minor modifications.

What the longitudinal data actually shows:

Time on HRT	What's measurable	What's visible
0–3 months	Subtle changes in waist circumference; minor BMI shift; emotional/skin changes are typically more noticeable than fat changes	Usually nothing externally visible in terms of body shape
3–6 months	Measurable increase in subcutaneous fat in legs/glutes/hips; VAT/SAT ratio starts shifting; some lean mass loss	Subtle softening; sometimes face fills out; hip change usually not yet obvious
6–12 months	Substantial: ~9–10% increase in subcutaneous fat (Body composition follow-up, <i>PMC12744559</i>); 15–25% increase in regional fat in legs/gynoid area (Chinese cohort, 2024); ~21% increase in total body fat (Klaver 2022); ~17% decrease in VAT/TBF ratio	Hip/thigh fullness becomes more apparent; waist-to-hip ratio starts to shift
1–2 years	Body fat continues to accumulate; pattern increasingly feminine; muscle mass decline continues	Most of the dramatic visible change happens here
2–5 years	Lundberg 2025: changes continue; muscle decreases ~7% by 5 years; fat distribution continues toward female-typical	Stabilization for most; refinement continues
5+ years	Most evidence suggests changes plateau but don't reverse as long as HRT continues; muscle fat infiltration fully shifted by year 1, continues subtly after	Pattern is now fully established

Individual variation factors (evidence-based):

Genetics is the single biggest variable, by far. Trans women whose female relatives carry weight in hips/thighs/buttocks tend to mirror that pattern. Trans women whose female relatives are more apple-shaped tend to mirror *that*. HRT works with your genetic blueprint, not against it.

Age at starting HRT:

- Adolescents who start at Tanner stage 2-3 with puberty blockers followed by estrogen develop nearly cisgender-typical fat patterns ([Klaver et al. 2018, J Sex Med](#)).
- Adults starting in their 20s-30s typically see strong fat redistribution but always layered on top of pre-existing male puberty bone structure.
- Adults starting after 40+ years still see fat redistribution but generally slower and somewhat less dramatic; baseline lean mass is lower, baseline visceral fat tends to be higher, and the contrast effect is smaller. There is no evidence of a hard cutoff age.

Baseline body composition:

- Higher pre-HRT body fat = more "raw material" for visible redistribution but also more pre-existing fat in unwanted areas
- Very low pre-HRT body fat = slower visible feminization because there's less fat to redistribute; the body has to *build* new fat depots from caloric surplus
- Athletic/muscular trans women see the most dramatic *relative* changes because they're starting from a more masculine baseline

Hormone levels and regimen:

- Achieving target estradiol levels (most guidelines: 100–200 pg/mL trough, though some target higher) and suppressed testosterone (<50 ng/dL) is more important than the specific delivery route.
- Sub-therapeutic dosing produces sub-therapeutic feminization. This is one of the most common reversible causes of "slow" results.
- Modern 17 β -estradiol regimens produce *better* VAT outcomes than older ethinyl estradiol regimens, which actually *increased* visceral fat (see the [JCEM 2025 cohort comparison](#)).

Antiandrogens: Adequate testosterone suppression is required for feminization. Whether spironolactone, cyproterone, bicalutamide, GnRH analog, or orchiectomy gets you there matters less than the achieved testosterone level.

The Weight Cycling Controversy – What the community says:

I searched trans-focused websites, forums (Susan's Place, r/asktransgender, MyFitnessPal trans threads), and trans-targeted commercial content turns up a remarkably consistent claim:

"Lose 5 pounds, gain it back, repeat. The new fat will go to feminine areas. This accelerates fat redistribution."

This claim appears in articles on TransVitae, Ketch Beauty, Transbeauty, Susan's Place, and numerous YouTube videos. It is presented as common knowledge, often with confident timelines ("cycle every 3-6 months") and specific weight targets ("5 pounds each direction").

Even the more responsible community sources usually present it as "limited research, but anecdotally effective."

What the research actually shows:

Direct research on intentional weight cycling in trans women: essentially zero. No peer-reviewed studies, no clinical trials, no cohort data isolates the variable of "intentional weight cycling for fat redistribution" in trans women on HRT. The community claim is entirely anecdotal.

Weight cycling research in cisgender populations is mixed and contradictory:

- A 2024 systematic review in [Current Obesity Reports \(Petridou & Siopi, "The Physiological Effects of Weight-Cycling: A Review of Current Evidence"\)](#) found that of 23 studies, 13/18 found no association with body weight/BMI, 15/20 found no increase in fat mass, and 0/18 found a decrease in lean body mass. Conclusion: "the overwhelming majority of evidence suggests that weight-cycling is not associated with any adverse effects in body weight, body composition, and metabolic rate."
- A 2024 systematic review ([Zou et al., "The Impact of Weight Cycling on Health and Obesity," PMC11205792](#)) reached the opposite conclusion: multiple weight cycling increased central fat deposition, decreased lean mass during loss periods, increased adipose inflammation, and disrupted insulin/glucose homeostasis.
- A 2020 cross-sectional study in 125 women ([Madhour-Beirut Arab University](#)) found multiple weight cyclers had on average 4.2 kg more total fat and 2.4 kg

more *trunk* fat than non-cyclers — i.e., weight cycling in females was specifically associated with *more* central/abdominal fat, the opposite of what the trans community claim predicts.

- The 1996 study by [Wadden et al.](#) in obese women found no adverse effect of weight cycling on REE, body composition, or fat distribution.

Translating this to trans women - we have 3 problems:

1. The mechanism is implausible. Fat cells don't move. Weight loss empties existing cells; weight regain refills them and/or creates new ones. Where new cells form is driven primarily by hormonal milieu (estrogen-rich on HRT) - but this *already happens* on a stable diet. Cycling weight just means you're losing and regaining fat in essentially the pattern your hormones dictate either way. You're not "tricking" your body into anything.
2. The cisgender data is mixed at best and points toward potential harm in females. The one study that specifically looked at fat distribution in women (Madhour 2020) found weight cycling associated with *more* central/trunk fat, which is the opposite of what trans women want.
3. The behavioral risk is real. Repeated intentional weight loss-and-regain cycles are a documented pathway into disordered eating – particularly in populations already at high risk, like trans women.

What science can say with confidence:

- There is no peer-reviewed evidence that intentional weight cycling accelerates fat redistribution in trans women.
- The proposed mechanism contradicts what we know about adipocyte biology.
- The cisgender data is mixed; the data specific to female fat distribution suggests weight cycling may *worsen* central adiposity.
- The strategy carries real psychological risk in a population already vulnerable to eating disorders.

Optimal Strategies (What Actually Helps)

Stable weight at adequate body fat:

The evidence converges on a boring but clear answer: stay at a stable weight, in a body fat range that gives your body raw material to deposit in feminine areas and let time do its work.

Specifically:

- For most trans women, allowing modest weight gain in the first 1-2 years of HRT produces the most visible feminization. The Klaver data shows ~21% increase in total body fat; if you actively diet against this, you're working against your own redistribution.
- Body fat percentages in the 22-32% range (typical "healthy female") are where the gynoid fat pattern shows most clearly. Below ~18% body fat, there isn't enough subcutaneous fat to produce visible feminine curves regardless of distribution pattern.
- Cisgender women average around 25-30% body fat at healthy weights. Being significantly under that range as a trans woman generally undercuts feminization.

Being underweight during early HRT:

Some trans women aggressively diet during HRT to lose pre-existing weight before "filling in feminine." There is no evidence this helps and considerable evidence it hurts:

- Caloric restriction depletes existing fat depots without preferentially adding to feminine areas (because there's no surplus to deposit). You end up smaller in feminine areas, not larger.
- Severe caloric restriction can lower estrogen sensitivity and may slow feminization through general physiological stress.
- Underweight status reduces breast development potential (breast tissue requires available adipose).

Exercise – what works and what to avoid:

Cardio:

Generally, weight-neutral to weight-losing depending on caloric balance. Excessive cardio without adequate caloric intake works against feminization by depleting fat stores. Moderate cardio for cardiovascular health is fine and beneficial.

Resistance training:

- Lower body resistance (squats, hip thrusts, glute bridges, RDLs, lunges) builds gluteal and quadriceps muscle that can enhance the visual hip-to-waist ratio. This is well-supported in cisgender women's training literature and applies the same way.
- Upper body resistance training in trans women on HRT does *not* produce the bulky shoulders many fear; testosterone suppression dramatically reduces hypertrophy potential. Strength training in the upper body for bone density and functional strength is recommended.
- The community fear of "looking too muscular" is largely unfounded for trans women on properly dosed HRT.

The specific evidence on exercise + feminization: Limited direct studies in trans women, but the broader sports medicine literature on cisgender women's training translates reasonably well, since post-HRT trans women have similar hormonal milieu.

Nutrition:

- Adequate protein (typically 1.2–1.6 g/kg body weight) is important for retaining lean mass during HRT, since estrogen plus testosterone suppression naturally causes lean mass decline.
- Caloric needs typically decrease after 6-12 months on HRT as basal metabolic rate decreases with lean mass loss. Many trans women find their pre-HRT caloric maintenance becomes a slight surplus, contributing to early fat gain.
- No specific nutritional intervention has been shown to accelerate fat redistribution. "Phytoestrogens" (soy, etc.) do not produce meaningful effects on top of exogenous estradiol.

Eating Disorders and Disordered Eating

This is a serious and under-discussed area. The data:

- Meta-analysis ([Qian et al.](#)) estimated eating disorder prevalence at **17.7%** in transgender populations vs. 1.01% in the general population.
- A landmark 2024 study ([Loria, Tabernacki et al., Communications Medicine](#)) using a large electronic health records cohort found that **transfeminine individuals on hormone therapy were 67% more likely** to be diagnosed with an eating disorder than transfeminine individuals not on hormone therapy (HR 1.67, 95% CI 1.41–1.98).
- In college students, ED prevalence among trans students has been estimated at 15.85% (Diemer et al.) vs. 1.85% in cisgender women.
- In treatment-seeking ED populations, trans and gender-diverse individuals make up 2.2–7.1% of patients depending on the study.

The research identifies several mechanisms:

1. "Striving for thinness as a way to suppress birth-assigned characteristics" – pursuing a smaller frame, narrower shoulders, less muscle through restriction ([Heiden-Rootes et al. scoping review; Nutrients 2024 review](#)).
2. Pursuit of feminization through weight manipulation – restrictive eating intended to "shrink masculine features" or produce features perceived as feminine.
3. Surgery preparation – restrictive eating before procedures to meet BMI requirements or "look better" pre-op.
4. Minority stress and trauma exposure – well-established correlates of disordered eating broadly, present at elevated rates in trans populations.
5. Body dissatisfaction – both pre-transition gender dysphoria and post-transition gap-between-current-and-desired body drive the same psychological vulnerability.

Warning signs:

- Tracking weight more than weekly
- Restricting food groups not for medical reasons but for body shape goals
- Daily measurement of body parts (waist, hips, thighs)
- Excessive photo documentation that increases distress rather than decreases it
- Eating behavior contingent on body image that day
- Compensatory behaviors (excessive exercise after eating, skipping meals after "bad days")

- Weight as a primary metric of transition success
- Distress when unable to weigh in
- Intentional weight cycling as a strategy (this overlaps with disordered eating diagnostic criteria)
- Hiding eating behaviors from partners/family
- Increasing time spent on body checking

Resources:

National Alliance for Eating Disorders helpline: 1-866-662-1235. Trans-affirming ED treatment programs exist and are growing; FEDUP (Fighting Eating Disorders in Underrepresented Populations) and the Trans Folx Fighting EDs (T-FFED) organization are community-specific resources.

Body Hair Removal:

Body hair for me was also a major issue, I have hated it for 20+ years now. I was a very hairy person most of my life and I hated touching it, seeing it, I hated everything about it. When I was 18ish I moved out of my parents' house and was living with some friends and felt a bit safer there and I started shaving my body.

I'd even avoid putting lotion on my skin because touching it made me feel gross. I tried electric razors, disposable razors, nair, epilators, from 18 - mid 20s my body hair exploded. This was my baseline:



This was after my first time shaving in 20+ years (pre-HRT):



So, let's talk about shaving. For the longest time I used disposable razors from Dollar General, mostly BIC or whatever off brand cheap one I could find. It did okay.

Today I use a [Merkur Safety Razor 34C](#) - the factory blade it comes with did a horrible job in my opinion - I upgraded to [Astra Superior Platinum Double Edge Blades](#) - I cannot stress how much better this is. Don't do what I did - get the Merkur 34C and the Astra blades, you'll be so much happier and it is **significantly cheaper in the long run**. Also, there is a learning curve with safety razors so just take your time.

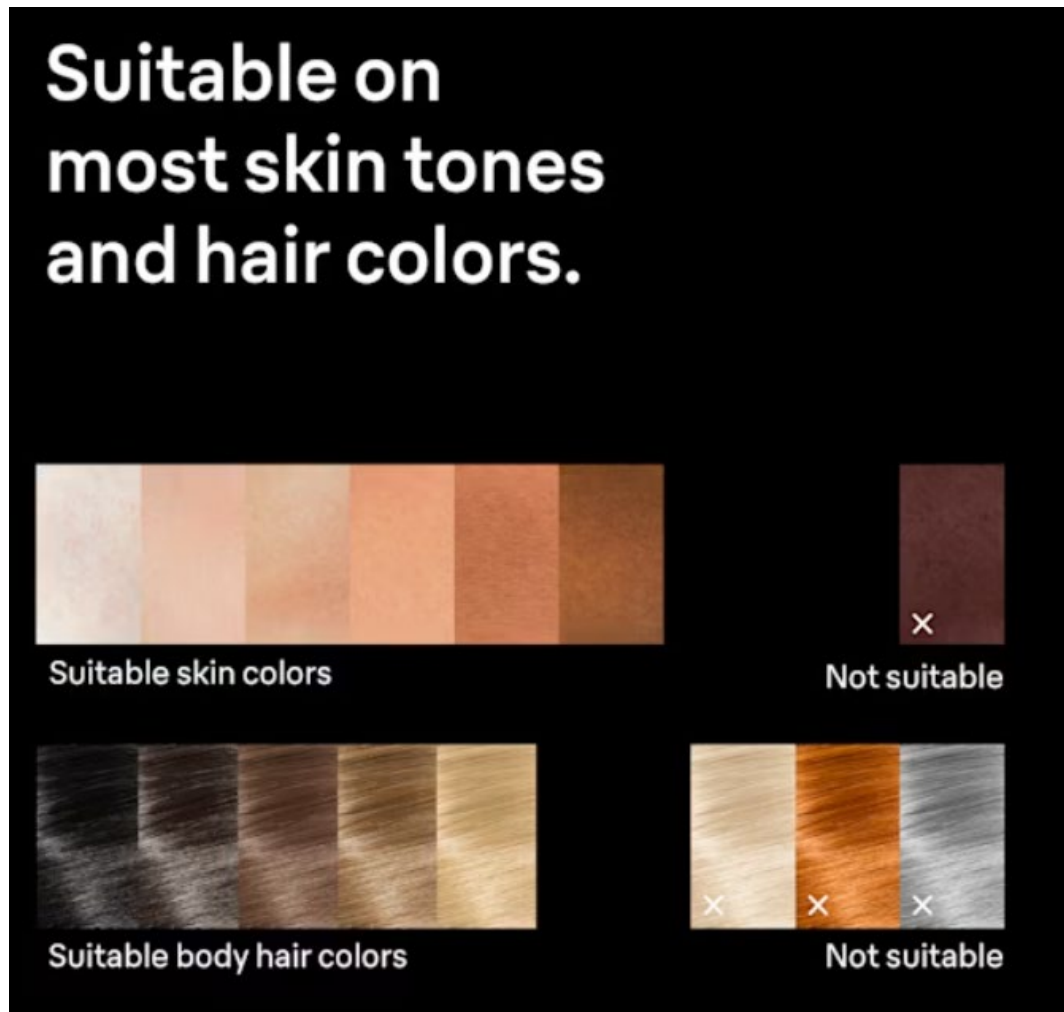
This was my process:

- First time, electric clipper no guard, shaved as close to my skin as I could
- Hot bath, I got the water as hot as I could stand, I love hot water though. I soaked for a while, 5-10 min to soften the hair.
- Apply cheap conditioner instead of shaving cream to the area you're shaving.
- Shaved head to toe - I know people say shave with the grain or don't shave against the grain, I do both, I shave with the grain and then I'll rub my hand against the grain and if it feels ok I skip that spot, otherwise I'll go against it.
- Once shaved completely, I immediately drain the tub and turn the shower on, I exfoliate (GENTLY) to remove any dead skin / hair or clogged pores, and use a sensitive skin body soap, I use [Dove](#).
- Lotion lotion lotion! I'm a bargain shopper - I go to Costco. They have 2 packs of [CeraVe](#) for \$30, but even at Target, it's \$18.
- For me, after I use lotion I like to stay nude. I don't like the feeling of clothing on my skin after shaving, that's just me. I usually do it just before bedtime.

I started this shaving routine in October 2024. I hadn't started HRT yet and the hair grew back overnight. I was a prickly cactus again and I hated that. I was shaving my entire body 2x a week. That was a huge time commitment and waste of razors and I needed something else but I wasn't ready to start HRT.

IPL (Intense Pulsed Light):

This infographic is directly from [Braun Pro IPL 5](#):



I chose this device after spending countless hours on Reddit reading in so many subs about hair removal for both men and women and then also reading on other sites about efficacy etc.

I am Irish / German / Scottish mostly and I have red, brown, white, blonde hairs all over my body. Some of my hairs are in the "not suitable" range and while they aren't going away from IPL, HRT is helping (mostly chest hairs that are white).

*****REALLY IMPORTANT DO NOT HAVE ANYTHING ON YOUR SKIN BEFORE DOING IPL, NO LOTION, CREAMS, NOTHING OR IT WILL NEGATIVELY IMPACT YOUR RESULTS*** I do mine within 12 hours of shaving, if I have time I'll do it immediately after.**

I purchased mine in person at Best Buy for \$299. Had I paid double that I would still be telling every person I know that hates body hair to buy one if their skin & hair colors fall close to the spectrum on the infographic.

I have probably sold dozens of these for Braun and I'm happy to do that. I am not someone that could afford laser hair removal for my entire body.

I did go to Milan Laser Hair Removal Institute and got quoted \$15k to do my entire body, I just don't have that kind of \$\$\$. If \$\$ is not an issue for you → go straight to laser hair removal it is faster, higher efficacy and better results overall **HOWEVER - IPL IS PERMANENT TOO, it is permanent REDUCTION not REMOVAL.**

If you are consistent, if you do it weekly, if you don't stop or skip weeks and combine it with HRT, it will work if your hair / skin falls in the spectrum.

When combined with HRT - so long as your hormones stay in feminizing ranges + DHT suppression is happening, you're going to get good results.

Sources:

<https://pubmed.ncbi.nlm.nih.gov/30681170/>

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I started doing IPL the last week of October 2024, in April 2024 I had my first manic episode of my life, and I didn't do it for 4 weeks and then got back on the horse, I have not missed a week since then.

Worth mentioning IPL does also helps even out skin tones and promotes collagen! I love how my skin looks now

I went from shaving 2x a week and always being stubbly → I shave 1x every 7 days and IPL 1x a week. I have entire sections of my body that used to be covered in thick course hairs, my shins, tops of my thighs, calves, forearms, upper arms, back, most of my stomach are bald mostly now, I plan to keep IPLing until every terminal hair is gone from my body.

This was December 2025 ~60 weeks of IPL – Immediately after shaving:



April 2026 – These photos are a full week of no shaving: ~75+ weekly at home IPL Treatments:







For people of color that are not able to use at home IPL devices - there are options but unfortunately, they are costly. The main thing I've found is a specific type of laser hair removal therapy using Nd:YAG (Neodymium-doped Yttrium Aluminum Garnet) to produce powerful infrared light. Please research the company you work with and make sure they have worked on skin colors close to yours to avoid burns or damage.

The only other option I can find is electrolysis, both of these are costly, and I am sorry 😞 I wish it was more affordable.

Facial Hair:

The industry standard is you need laser + electrolysis unless you're young enough to start transitioning before your hair turns white / gray. If you're able to just do laser and avoid electrolysis it will be much cheaper and faster...unfortunately I am not so lucky.

I can say in my lived experience, it was about 30 days after starting progesterone (so around 7 months total HRT time) my facial hair began to grow significantly slower, I also started laser hair removal in July 2025, and I go every 4-6 weeks (5 treatments done as of writing this). I found a local salon that charges \$225 / session. From what everyone has told me, plan on 10 - 12 treatments 😞 so it isn't cheap but it is worth it in my opinion.

****Bonus tip - Milan Laser Institute does the first laser session for free if you go listen to their sales pitch (was about 1 hour). I got my first face + neck for free there****

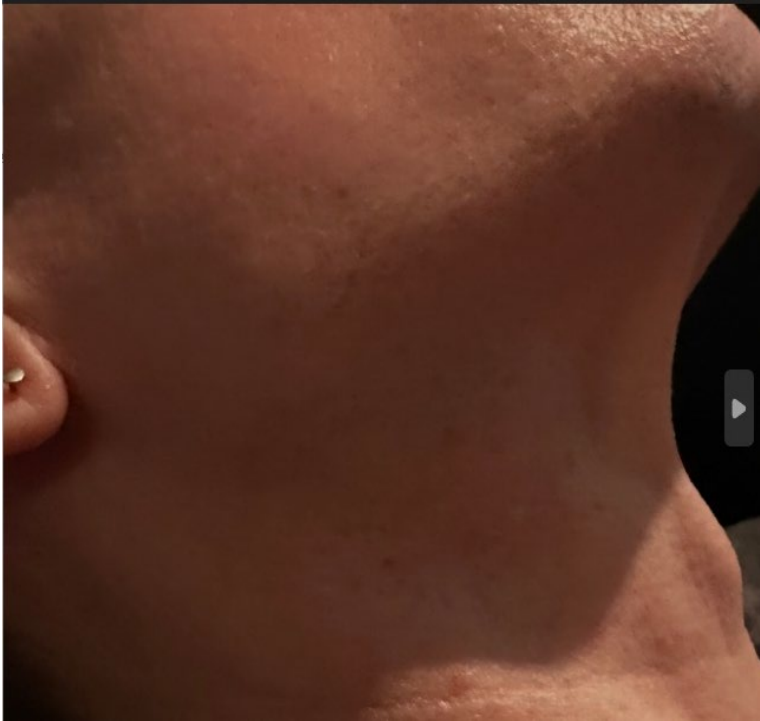
Update April 2026:

I've been doing laser for 9 months, and I have my 10th appointment tomorrow actually. I have had great results, but I still have a lot to clear. I spoke to my laser hair removal tech and asked her what machine settings were at – she confirmed they were not on the 1064nm Nd:YAG and that we can try that setting. I have dark red / auburn facial hair and I'm hoping to get more cleared.

I have also started weekly electrolysis, it's slow – it's also very challenging because you have to grow your facial hair out for 3-4 days before each treatment. I hate having my beard grown out. I am lucky that I work from home on Tuesdays so I can start letting it grow on Sunday, one day in office (Monday) and by Tuesday night there's enough length for the technician to work on it. She told me to plan on minimum 1 year and if I want perfect / full clearance – 2 full years including touch up appointments.

I'm just going to do what I can do for now, accept this is worth it in the long run and deal with the sucky weeks for now. I guess in some ways I'm still 100% boymode so I'd rather do the beard thing now than say 2-3 years from now when (hopefully) I have a harder time boymoding.

Here's my beard then vs now:



Eyebrows:

Okay so I am far from an expert here. I was terrified to do anything about these things; I had two caterpillars living above my eyes my whole life.

PreHRT:



December 11, 2025:



There are a ton of methods to manage your eyebrows:

- [Plucking](#) (Tweezing) - slow and best for small cleanups, removes the hair from the root, precise, cheap and slow regrowth. It's also time consuming and can hurt and then there's the risk of over-plucking if you DIY.

- [Waxing](#) - removes multiple hairs at once using hot or cold wax, best for strong reshaping / thick brows. It's fast, lasts for weeks but it is painful and can irritate the skin. It's less precise than plucking.
- [Threading](#) - uses twisted threads to pull the hairs from the root - best for clean lines, sensitive skins, it is very precise, no chemicals and less irritation. It does require a professional.
 - ***This is what I did*** - I went to a local place, told them to clean up my eyebrows and that I'm trying to look more feminine. It took the technician less than 5 minutes, it cost \$15 and I tipped her \$5.
- [Shaving](#) - cuts hairs at the surface using a razor, best for quick cleanup - it is painless and quick, short lived and good if you're going to try and shape them yourself since it regrows quickly.

There's more topics to cover on this but honestly, it's not my wheelhouse - there's tinting, henna brows, brow lamination, brow markers and pens, microblading (if your eyebrows are super thin, it's like a tattoo), laser hair removal for permanent shape.

In my opinion, for me, going to a pro, having them shape it, and then I tweeze at home to keep the shape was a good \$20 investment plus the cost of tweezers and a compact.

Physique:

I want to preface this by saying these were goals I wanted for me. I have no interest in body shaming anyone. You are no less of a transgender woman than I am if you don't work out, if you are on HRT to feel better mentally and don't care about physical changes, I support you 100%.

Gender envy is something I have experienced my entire life. My first memory of gender envy was Geena Davis when I saw the movie, "A League of Their Own" in 1992; I was 8 years old. I don't know exactly how old I was when I started confusing gender envy and attraction, but it was sometime in my early teens.

I've craved a certain physique my entire life, it is one of the most constant, prominent feelings I have experienced in my life. As a teenager I remember saying that I was a lesbian trapped in a man's body. It was the only words I had back then for it.

My main focus was to tighten my stomach, add mass / shape to my thighs, hips, butt and then I wanted to keep my upper body as it was. I do not have small arms, but they are also not huge, I do a lot of manual labor and I want to keep my strength.

I'm proud of my transition and my changes, I've worked so hard at it. My worst (for me) was almost 250lbs, this was peak alcoholism for me, I was so miserable for so long. I went from hating myself:



To loving myself:



This is how I got there:

[Ketogenic diet](#) + [intermittent fasting](#)

*****There is a lack of studies regarding ketogenic diets & HRT - I was NOT on HRT when I went from ~250 → 155ish - I started HRT after losing the weight for clarity. From what I have read, I would not advise doing ketogenic while you're starting HRT, it could also impact bioavailability, feminization results by impacting hormones...there's just not enough information to really cover this safely.**

Quick thing I want to point out for people that have never fasted a single meal or think they cannot: Get your body into a ketogenic state BEFORE trying to start fasting for the first time. When you're burning ketones for energy, you're burning fat, if you're already in ketosis then you'll not experience the "crash" that comes from fasting when you are running on carbohydrates.

An easy way to tell if you're in a ketogenic state is to buy [urine strips](#), they are cheap and accurate.

My weight loss was not linear, it was more like: 250 → 210 → 220 → 205 → 210 → 195 → 205 → 190 → 195 → 185 → 190 → 175 → 185 → Egg Cracked → 155 in about 2 months → 145 about 2 months later → 139+ (gained weight since I started progesterone).

My anxiety is very much tied to my stomach, it will twist into knots that are quite painful for me, it has been that way my entire life.

Early realization was one of the worst times of my life. I felt so alone, I felt cornered, I felt like there was no path forward that ever would let me be happy.

My anxiety was through the roof, I stopped eating, I started walking 2-4 miles a day, 7 days a week. This grew organically, my peak was 70+ miles a week, but I was eating more by then. 😊

Winter is here and with lots of snow and ice, I hate being cold and my walking is down but I just got a [walking pad](#) and my miles per day are heading back into the right direction, I miss my walking time.

I remember before I realized everything I'd think to myself, "Why do boys workout? Who would want to look like any of them? If I were a girl...I'd work out all the time because I know how I'd want to look." I was sooooooooooooo stupid; my entire life I have thought this.

I had NO booty - I mean the worst boy flat-butt with double cheeks on the bottom.

Exercise routine 3x per week + walking 5-7 miles a day:

[Donkey Kicks](#) + [Fire Hydrants](#) (combined as one movement - I do the donkey kick and bring my leg back to neutral, I don't put my knee down, go straight into the fire hydrant and that's one rep).

- 15 reps x 2 sets each leg

[Bodyweight Hip Thrusts](#)

- 15 reps x 2 sets

[Glute Bridges](#)

- 15 reps x 2 sets

[Bodyweight Squats](#)

- 15 reps x 2 sets

[Side-lying leg rises](#)

- 20 reps x 2 sets

[Ab Crunches](#)

- 30 reps x 2 sets

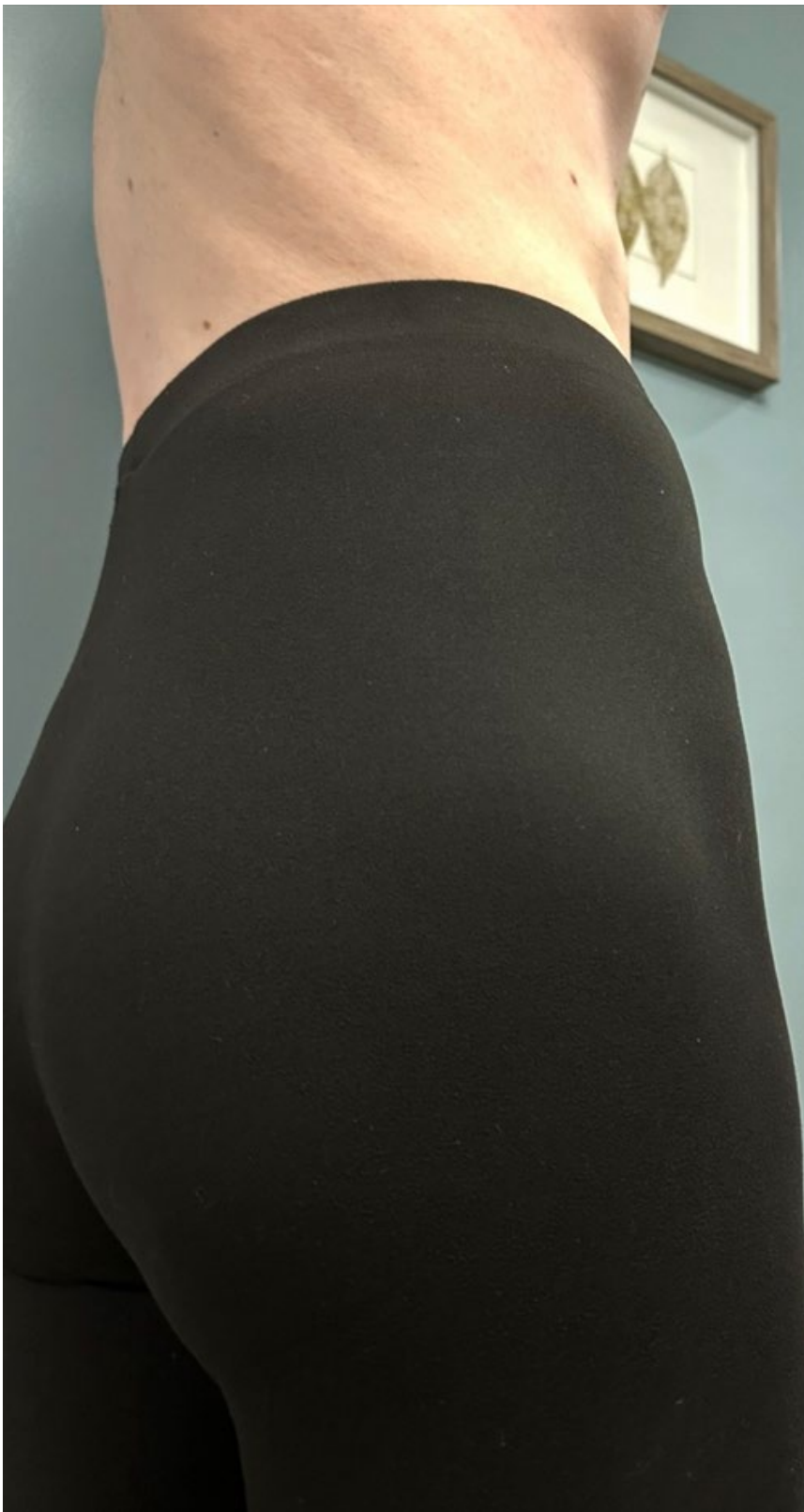
[Leg Raises \(lie flat on back bring legs up for lower core work\)](#)

- 20 reps x 2 sets

[Push-ups](#)

- 15 reps x 2 sets

Walking + this workout routine + HRT took me to this in ~6 months:



Yesterday I did my first updated routine, it is time to add weights / resistance:

Donkey Kicks + Fire Hydrants 2x15 each leg with ankle weights

Push-ups - 2x15

Crunches 2x30

Side lying leg raises 2x20 each leg with ankle weights

Back lying leg raises 2x20 with ankle weights

[Planks](#) 2x45-60s

[Dumbbell Bulgarian Split Squats](#) 2x10 each leg

[Dumbbell Romanian Deadlifts](#) 2x10

[Dumbbell Goblet Squats](#) 2x8

[Band Hip Thrusts](#) 2x8

As far as home equipment goes - I spent ~\$350 including the walking pad.

[Bands](#)

[Ankle Weights](#)

[Adjustable Dumbbell](#)

Body Odor:

This doesn't need a ton of detail, but it should be mentioned. Since we're talking about getting all sweaty and working out may as well touch on it here. I do not smell like a boy anymore, it's the strangest thing and I much prefer it.

Let's Talk About Sex

1. [Introduction](#)
2. [Erectile Function & HRT](#)
3. [Anal Pleasure Physiology & Sensitization](#)
4. [Prostate Pleasure Physiology & HRT Effects](#)
5. [Nipple Pleasure Development During HRT](#)
6. [Attraction & Feeling Attractive](#)
7. [Cleanliness, Lube, Sex Toys & Vibrators](#)
8. [My Path To Enjoying Anal / Prostate Play](#)
9. [Vulnerability During Intimacy](#)

Introduction

This section needs to be labeled clearly, this is not sexual content or anything in that realm, this is sexual education and sexual health. This will include my personal experiences as well as information I was able to find.

I am writing this document because I want to help people like me - people that have trauma, neglect, abuse, internal transphobia, self-doubt, concerns about their perception in the world, fear of trying new things (including sex). But I'll be honest, if you're reading this and you're not transgender, I'd still love to help you here.

In my lived experience I can tell you I'm pretty sure a lot of the world's problems could be solved if men knew how to enjoy their prostate and anal sex. I say that part jokingly but really, there is so much hate centered around anal sex and homophobia and it's nonsense. So many boys are missing out on some of the best feelings I've ever experienced at least.

From a sexual health perspective, the stigma around anal & prostate pleasure is cultural rather than biological.

I have been with my wife since I was 21, this April 2026 is 20 years, I don't have any wild stories or adventures and my sex life for the most part was and is fairly vanilla. There are parts of my life I am not going to share but I will do my best to be as open and honest in this section as I can be.

Erectile Function & HRT

When we start HRT and our testosterone levels drop our bodies change in so many ways, including our genitals. **Erectile capacity typically decreases** while **orgasmic quality often improves**, becoming longer, more diffuse, and "whole-body" rather than genitally focused. New erogenous zones develop, particularly nipples, while existing ones like the prostate remain functional despite tissue changes. The sexual and gonadal effects begin within 1-3 months of starting feminizing HRT, with maximum effects occurring over [3-6 years](#).

It is pretty straightforward, estrogen combined with anti-androgens suppresses testosterone, the primary driver of erectile function. Spontaneous and nocturnal erections typically decrease dramatically or disappear entirely. However, erections from direct sexual stimulation often persist longer than spontaneous ones [\(1\)](#). Some transgender women keep erectile function regardless of testosterone suppression - the mechanisms remain [unknown](#).

Genital tissue changes include **testicular volume reduction to less than half original size**, penile tissue softening and potential atrophy, and significantly reduced or absent ejaculate. [\(2\)](#) [\(3\)](#).

If you keep using your penis function from the week you start HRT and you are able to [maintain erections](#) for at least 10 minutes, 3 times a week, you should avoid significant atrophy.

If you're unable to sustain erections without medicine, that's okay you can still use medications to counteract these effects. You should work with your doctor on what does or doesn't work for your specific medication regimen. Here are the options I am aware of:

PDE5 inhibitors remain first-line treatment. The UCSF Guidelines explicitly state: "Sildenafil (Viagra) and tadalafil (Cialis) can be used for preservation of erectile function at any stage or with any feminizing hormone regimen." [\(4\)](#).

Sildenafil (Viagra) works by inhibiting PDE5, preventing cGMP breakdown, causing smooth muscle relaxation and increased penile blood flow [\(5\)](#). Standard dosing is 25-100mg taken approximately 60 minutes before activity, with effects lasting 4-6 hours. Common side effects include headache (>10%), flushing, nasal congestion, and occasional visual disturbances due to PDE6 cross-reactivity.

Tadalafil (Cialis) uses the same mechanism but offers significant advantages: longer duration (up to **36 hours**), allowing greater spontaneity, and the option for daily dosing at 2.5-5mg (6). This daily low-dose approach may help mitigate penile atrophy by maintaining regular blood flow to genital tissue. Back pain and myalgia occur more frequently than with sildenafil.

Topical testosterone represents an emerging option for genital tissue health without compromising feminization. Dr. Will Powers and other specialized providers prescribe compounded testosterone cream applied directly to genital tissue. The rationale: very low localized doses may promote tissue health without raising systemic testosterone levels. A pilot study by [Schultheiss et al. World Journal of Urology, 2000](#) found 32.6% of hypogonadal cis men improved erectile function with topical penile testosterone application. No standardized protocols exist for trans women - this approach is best pursued with urologists experienced in transfeminine care.

Penile Orgasms & Sensations:

The most comprehensive research comes from Garcia and Zaliznyak at Cedars-Sinai/UCSF, surveying 126 trans women on hormone therapy for at least one year (1). Their findings challenge assumptions that HRT impairs sexual function:

- **Time to orgasm** increases by approximately 7 minutes (onset around 7.3 months HRT)
- **Orgasm duration** increases by an average of **27.5 seconds** (onset around 9.4 months)
- **70-71%** reported experiencing orgasms in new or additional body locations—described as "whole-body" versus genitally focused
- **52-65%** reported shifts from single-peak to **multiple-peak** orgasms
- Post-orgasm refractory period decreased
- Overall satisfaction improved

Qualitative descriptions consistently describe orgasms as "longer, more intense, came in great tingling waves" with less peak intensity but more diffuse, full-body sensation. (2). Ejaculation becomes decoupled from orgasm and may occur without ejaculate (3)(4). Published research in the *Journal of Urology* concludes: "HRT results in more orgasm features that more closely resemble those of cis-women." (5)

The "use it or lose it" principle applies directly to penile tissue. Nocturnal erections in testosterone-dominant physiology exercise penile elastic tissue, keeping it soft and stretchy. HRT typically eliminates nocturnal erections; without regular

erections, tissue can lose elasticity, experience smooth muscle contraction, and atrophy.

*****IF YOU PLAN TO GET BOTTOM SURGERY AND PLAN TO HAVE A VAGINAL CANAL MADE, YOU WILL WANT TO KEEP YOUR PENIS ELASTICITY*****

Anal Pleasure Physiology & Sensitization

I'm going to use a lot of biological terminology here, not to confuse you the reader or me for that matter, a lot of this is dense and hard to read, but I want to show the overwhelming evidence on how our bodies are designed for pleasure.

The anal canal possesses rich specialized [innervation](#), it is approximately 2cm-4cm long, containing [two muscular components](#): the internal anal sphincter (involuntary smooth muscle, autonomically controlled) and the external anal sphincter (voluntary striated muscle, controlled via the [pudendal nerve](#)). This anatomy allows for both reflexive relaxation and conscious control, but it does take practice to learn how to control in my experience.

Specialized sensory receptors present include [Meissner's corpuscles](#) (light touch), [Krause end-bulbs](#) (temperature), [Golgi-Mazzoni bodies](#) (pressure and tension), [Pacinian corpuscles](#) (deep pressure and vibration), [genital corpuscles](#) (friction—specifically relevant to erogenous response), and free nerve endings (pain, temperature, general sensation) (1).

The [pectinate \(dentate\) line](#) marks a crucial sensory boundary: above this line, sensation is transmitted via autonomic parasympathetic pathways (less specific, primarily stretch-sensitive); below the line, rich somatic sensory innervation via the pudendal nerve enables discriminative touch, pain, temperature, and pleasure sensation. Research in [The Journal of Sexual Medicine \(Walton et al., 2022\)](#) found the superficial anterior area is the most commonly reported erogenous zone, likely due to proximity to internal erectile structures and higher density of friction-responsive genital corpuscles.

Multiple neural pathways mediate anal pleasure.

The [pudendal nerve](#) (S2-S4) serves as the primary somatic pathway. Its inferior rectal branch provides sensory innervation to the anal canal and perianal skin; [TeachMeAnatomy](#) its perineal branch supplies the perineum. The pudendal nerve carries afferent signals for touch, pressure, and pleasure from the anal canal to the spinal cord and brain (1) (2).

The [pelvic splanchnic nerves](#) (S2-S4, parasympathetic) provide visceral afferent fibers detecting stretch and fullness, contributing to [vasodilation](#) of erectile tissues during arousal.

The [hypogastric nerves](#) (sympathetic, L1-L2) carry proprioceptive signals and contribute to sphincter tone and orgasmic contractions.

A 2024 comprehensive review in *Nature Reviews Gastroenterology & Hepatology* (Dickstein et al.) explains: "Pleasurable **RAI (receptive anal intercourse)** occurs through stimulation of the perianal or anal nerves and prostate or paraurethral glands, inducing vasodilation, erectile tissue engorgement, anopelvic tissue sensitization, and anal sphincter and pelvic muscular contractions." (3)

Evidence strongly supports experience-dependent neural adaptation - your first time most likely won't be great AND THAT IS TOTALLY NORMAL!

The most compelling evidence for anal sensitization comes from [Gaither et al. \(2023\) in the Journal of Sexual Medicine](#), surveying 975 people with prostates (including transgender women) about receptive anal intercourse sensations:

Lifetime exposures	Reporting pleasure	Reporting severe pain
<10	41%	39%
11-50	~65%	~25%
51-200	~80%	~18%
201-500	~87%	~15%
>500	92%	13%

This study strongly suggests that experience-dependent neural adaptation occurs: pleasure pathways strengthen with repeated positive experiences while pain/discomfort pathways become less dominant, regardless of starting age (4) (5).

[Neuroplasticity](#) provides the biological mechanism: general neuroplasticity principles apply - synaptic plasticity means repeated stimulation strengthens neural connections through [long-term potentiation](#); cortical remapping occurs because sensory maps are use-dependent, frequently stimulated areas expand their cortical representation and associative learning means stimulation paired with arousal/pleasure trains the brain to associate that stimulus with reward (6).

Timeframes from neuroplasticity literature suggest short-term plasticity occurs over minutes to hours, medium-term structural synaptic changes begin over days to weeks, and long-term cortical reorganization with dendritic spine changes occurs over weeks to months (7). Musicians show structural brain changes after 15 months of training, with cortical changes visible in as little as 1 week with consistent practice, stabilizing over months. For sensory adaptation specifically, studies show cortical changes occurring within 1 week of new sensory experiences, with major adaptation typically over 3-6 months (8).

Estrogen enhances sensitivity to tactile stimulation of perineal skin and affects dendritic spine density and synaptic plasticity - I can't prove this impact on transgender women, this is just a theory (9).

TL;DR - to highlight in layman's terms - your anal canal is literally designed to feel sensations that are bad (to prevent harm) and good (to enjoy pleasure). This is how your body works, and mine, but just because you try anal once does not mean you will immediately feel pleasure. You have to LEARN how to enjoy anal sex - it just takes time and practice, same as learning any other new skill.

Prostate Pleasure Physiology & HRT Effects

The [prostate](#) possesses extraordinarily dense innervation and is often referred to as the “p-spot” or male analog to the “g-spot”. The prostate is approximately walnut-sized and positioned inferior to the bladder, wrapping around the proximal urethra, anterior to the rectum and accessible approximately 1.5 inches / 4cm from the anus via the anterior rectal wall. Approximately two-thirds glandular tissue and one-third fibromuscular tissue, it is surrounded by a thin fibrous capsule and the prostatic plexus of nerves (1).

The prostatic capsule is “covered by numerous nerve fibers and [ganglia](#) which form a true periprostatic nerve network.” The periurethral zone is “widely innervated by nerves arising from the periphery.” (2) (3) *This density of innervation underlines its capacity for intense pleasurable sensation.*

The prostate receives complex innervation from three main pathways: pelvic splanchnic nerves (S2-S4, parasympathetic), hypogastric plexus (T11-L2, sympathetic), and pudendal nerve (S2-S4, somatic), creating a rich sensory network with multiple receptor types including alpha-1 adrenergic, muscarinic, and mechanoreceptors.

Prostate-induced orgasms differ markedly from penile orgasms: they involve 12 pelvic muscle contractions versus 4-8, are described as more intense and diffuse, can occur without erection or ejaculation, and allow for shorter refractory periods with potential for multiple orgasms. Orgasm and ejaculation use separate neural pathways—emission (T11-L2) and expulsion (S2-S4)—meaning orgasmic contractions can occur even without ejaculation.

HRT causes substantial prostate changes: volume decreases significantly, PSA levels drop 50-fold (median 0.02 ng/mL versus 1.0 ng/mL in cis men), and **prostate cancer risk decreases 5-fold** (4)(5). Standard PSA screening thresholds are inappropriately high for trans women; UCSF recommends lowering the upper limit from 4.0 to 1.0 ng/mL.

Critically, sensitivity changes remain poorly studied with no controlled research on HRT's effects on prostate sensation. **Anecdotal reports suggest the prostate may remain sensitive or become more sensitive on estrogen**, though size reduction might require medication adjustments for optimal sensation.

*Developing prostate pleasure involves neural plasticity—the brain “rewiring” through peripheral sensitization, dorsal root ganglion upregulation, and cross-organ sensitization between prostate, bladder, and pelvic structures. **This process requires***

relaxation, time, and practice, though specific timeframes lack scientific documentation. More sources: [\(6\)](#) [\(7\)](#) [\(8\)](#) [\(9\)](#)

Nipple Pleasure Development During HRT

The nipple-areola complex receives innervation primarily from the 4th intercostal nerve (lateral cutaneous branch), though nerve supply varies significantly between individuals and even between breasts. Contrary to expectations, nipple sensitivity doesn't rely on typical skin mechanoreceptors but instead depends on rich smooth muscle innervation in the deep dermis and Piezo2 expression in mammary gland tissue—a unique sensory mechanism distinct from ordinary touch.

A fMRI discovery found that nipple stimulation activates the genital sensory cortex in both women and men, not just the expected thoracic region of the somatosensory homunculus. This suggests either a direct pathway (convergence of nipple and genital sensory afferents on the same cortical neurons) or an indirect pathway (nipple stimulation → oxytocin release → uterine contractions → genital cortex activation). The finding in men supports a direct pathway mechanism (1) (2).

[Breast development on HRT](#) follows a predictable timeline: breast buds become palpable in months 0-3 with nipple tenderness; most rapid growth occurs in months 3-6 (+1.3-1.8cm); development slows significantly after 6 months; and growth typically plateaus at 2-3 years. Most trans women develop AAA to A cup size, and importantly, high-dose estrogen doesn't improve outcomes.

Sensitivity evolves through distinct phases: early nipple tenderness/soreness (often within the first weeks), heightened sensitivity during months 1-3 (sometimes uncomfortable), breast bud formation during months 3-6 (hard pea-sized lumps beneath nipple with intensified sensitivity), and gradual transition from discomfort to erogenous sensitivity as tissue matures. Research shows breast tactile sensitivity significantly increases after puberty in women compared to men, with 82% of young women reporting nipple stimulation enhances sexual arousal (3).

Neural pathways strengthen through neuroplasticity—the sensory homunculus reorganizes based on input, and repeated stimulation (physical or imagined) strengthens these pathways. Trans-specific research on this reorganization during HRT remains absent, representing a significant research gap (4).

Okay, that was dense and my head hurts but I'd like to keep writing about this and now get into other areas regarding sexual health as a transgender woman, including my lived experiences and my path to enjoying anal sex.

Attraction & Feeling Attractive

I have always been attracted to females, femininity, and I have always found masculinity and men repulsive (sexually speaking). Today, I identify sexually as [sapphic](#) - I have identified this way since I discovered the term. But lately, something new, there are a few men I've been attracted to, which is very confusing for me but I am learning through the transgender community this is fairly common for a lot of us after starting HRT.

I don't know if this change is a direct result of HRT or just allowing ourselves to exist openly and allowing our minds to explore new / more feelings, but this is something that I am experiencing. I don't know if I'll identify as pansexual one day, I don't really care to be honest. I am happily married and lucky in that regard, I do not feel that I am missing out on any experiences in life at this point and I am grateful for that. **I hope you find the same wholeness whatever path your journey takes you on.**

Regarding feeling attractive - I have spent my entire life, even through today, seeing an unattractive, ugly person in the mirror. It is just what I see when I look at myself. I have never in my life looked at myself and had positive recognition of myself in a photo or the mirror. That is changing, slowly. I'm starting to see parts of myself in a positive way, I love my legs, watching my booty take shape, seeing my breasts grow, my skin glows now in a way it never has, I often will go to grab something and I see my arm and hand and it looks foreign to me in the best way → euphoria follows every time.

This is my favorite image of my body to date:



Cleanliness, Lube, Sex Toys & Vibrators

I will confess I have a ridiculous collection of toys because I was trying to discover what did and what didn't work for me. I'm just going to break them down into subsets by type of toy with brief summaries on what I've found to work.

Cleanliness - I cannot express the importance of this. I recommend taking a fiber supplement daily - I use [psyllium husk](#) - it is cheap, easy to find, it has multiple benefits for your overall health and it makes staying clean easier.

I use an [Aneros enema bulb](#) - the reason I am recommending this product over your basic store bought enema bulb is the airtight design. This thing will only push water inside of you, no air, no bloating - it makes everything more enjoyable. You can read up on using an enema bulb for anal sex but my tl;dr - wash the bulb with soap and water, fill the bulb with sterile water that is room temp, assemble the bulb (I use a drop of lube to get the nozzle into the bulb because of the airtight design), lube the nozzle as well as your anus, insert, I will on the first pass use the entire bulb's contents. Once I have sprayed all the fluid in, I'll take it apart, wash it in the sink, fill it and prepare it for the second pass, wait 3-5 minutes, do my business on the toilet, wipe, go back in, rinse and repeat (literally) until the water coming out is clear. *****Do not over do this, typically it is 2-3 passes for me, if you're needing to do more cycles than that, in my experience you need more fiber.*****

Lube - I use one product, it is the only product I use and I recommend it to anyone. It is incredibly affordable, you mix it yourself so you can change the viscosity (thickness) of the lube and this stuff just works. One bottle of [X-Lube](#) makes 5L of lube - it stays on the toy, it lasts a long time and it doesn't take long to mix.

Personally - I use a 5oz bottle, I use reverse osmosis water from my at home RO system, if you do not have an RO system I would advise getting distilled / bottled water AND / OR at minimum boiling tap water before use.

My process is to pour ~12oz of water into a glass measuring cup, microwave it until it is not hot but warm (20 seconds) I will fill the 5oz bottle halfway, I measure $\frac{1}{4}$ teaspoon of powder and pour it into the 5oz bottle, then I will measure a second $\frac{1}{4}$ teaspoon scoop (rounded) and put that into the bottle, I'll top the bottle up with the warm water, put the cap on the 5oz bottle, shake it vigorously until there are no visible clumps. Lay the bottle down flat (with the cap closed) and let it sit for 5-10min, shake it vigorously again, lay it down again flat, less than 5min and it is ready to go, store at room temp for no more than 2-3 weeks.

Plugs - I have used [stainless steel plugs](#) & [silicone plugs](#). Early on I really was focused on stretching because I had assumed bigger = better for prostate stimulation. **I was wrong, at least for me I was.** Initially I would just put a small plug in and → size up safely, I solely used the plugs as a warm up for sex. This has come to change, specifically with the silicone plugs, I really like the [squarepegtoys.com](#) egg plugs - I had a small, it just was pointless for me, I upsized to a Medium, Large and I also have an XL. I rarely use the XL these days, I will often use the M and the L.

I no longer use these just for stretching, as my prostate has gotten more sensitive I have found I enjoy having a plug in, rocking it back and forth inside of me causes a lot of pleasure and if I'm relaxed enough, just insertion and removal is also very enjoyable.

Dildos - I have tried extremely firm dildos all the way to super soft ones that are squishy. I have tried large diameter and not too long as well as narrow and longer. The [sigmoid colon](#) is located past the [rectum](#) - the rectum is approximately 12cm (4.7 inches) and then you get into the sigmoid. I personally don't go super deep, I know some people enjoy depth play like 12+ inches - I know there are risks involved with this and large amounts of lube are required for depth play, I find 5-7 inches is my happy place. You do you, explore, find what works and enjoy your body.

I already linked [squarepegtoys.com](#) multiple times - but I will say they make some of my favorite products, [Leo](#) or [Leo Harness](#) is my favorite dildo from them.

Double Dildos are fun, I had my first experience with those recently and it might be my new favorite thing to do with a partner. This is the [exact one](#) we got and it's hilarious to me because I have tried so many brands of dildos and this thing is actually one of my favorites. It is narrow, very flexible, I can get deeper penetration and then by bending it inside of me I'm able to just rub my prostate, it's amazing, I lost count last night but I had over 5 orgasms in an hour using this specific toy.

I don't enjoy vibrating toys anally, that's me, I have tried b-vibe's vibrating plug with rotating beads, I have tried Lovense Edge 2 and a few vibrating dildos, it just doesn't work for me, but I know lots of other people swear by it so YMMV.

Vibrators - [Magic Wand](#) - this is a whole different ballgame, we're moving away from anal here and talking about stimulating the penis / glans through vibrations only. I can also have multiple orgasms from this thing as well but it usually is 2-3 and then I'm just done. My experience is using this at the base of the shaft on low, the rumble / vibrations is amazing, I prefer to have leggings on or have a sheet tightly wrapped to

keep everything in place and prevent my penis from moving around. If I stimulate directly underneath the glans (tip) I will finish very quickly usually and have an intense orgasm but it is one and done, much more similar to my sexual experience when I lived life as a man, it's nice and enjoyable but not the same as my other orgasms now. I find the base and then staying below the glans on the underside of the shaft to be the best approach, when combined with anal it makes everything go faster and more intense but also shorter lived.

My Path To Enjoying Anal / Prostate Play

Alright so, it's super interesting to me that my sobriety is linked to all of this. When I was 24 years young, I quit drinking for a year. I knew I had a problem and I told myself if I can quit drinking for 365 days then I can control alcohol. I did it, I didn't drink for exactly one year and then I started back up again. During that year of sobriety, I bought an [Aneros](#) because I wanted to explore my body. I remember feeling really self-conscious about using it and I even hid it from my wife initially.

I used it sporadically, incorrectly (because I didn't know how to use it) and mostly expected magic after insertion and instead what I got was a feeling of pressure and fullness with no pleasure associated with it. I felt like I had been scammed. I put it on the shelf somewhere in a closet and forgot about it, eventually started drinking again and threw it out.

Fast forward 13 years, I was 38 and sober again and for some reason that I could not figure out, I wanted to explore anal sex again. I was more open with my wife about it this time but not inclusive with her, I just told her what I was doing.

It started out very similarly as the first time, the first toy I bought was a Lovense Edge 2, I wanted handsfree. I thought using a dildo was "too gay" (**sorry it's who I was and I was ignorant**) but that is my truth. I'd put it in, play with the vibrations and hoped; nothing happened though.

I spent hours doing what I do, reading on Reddit and other sources about my prostate and body and tried to figure out how to make mine work. When I learned it was about time, practice and patience I decided to just incorporate it into part of my life. If I masturbated, I'd use the Lovense Edge 2. If I had sex, I used it sometimes.

I was hypersexual back then, I would masturbate & have sex sometimes 4-6+ times a week; that's gone way down, now. I would say it's 1-2 sessions a week but they last much longer and I have a lot more orgasms per session.

I started to find my climaxes with my penis were more intense when I had the Lovense Edge 2 in, and insertion and removal started to feel better, but still nothing going on with my prostate. I decided to try something that I could insert in and out without it being a dildo because of my own internal phobias back then. I bought an [njoy wand](#).

I would try using this multiple ways, small end first and I worked my way up to the larger side, I would just insert and remove it (thrusting) or I would let it rest against what I THOUGHT was my prostate because honestly it felt numb in there, I couldn't find it.

I can't express how frustrated I was, this search for my prostate took over a year before I started feeling anything there, anal enjoyment improved much faster once I started getting sensations.

Everyone says "don't chase climax" and to just follow the feelings, as frustrating as that advice is and it is vague, it is true. Once I started to have feelings in my prostate they were very enjoyable and when combined with penile climax, I was very happy. I was late into 39 at that time and still not aware that I was transgender. I finally bought a dildo.

The first time I used a dildo, I did enjoy the thrusting more than I thought I would, I just bought a cheap one at the store, nothing too big, I had already explored into other plugs (as mentioned above) and my comfort around my sexuality was improving. I was feeling less shame about enjoying this and more curiosity about exploring it.

I continued to basically use my prostate / anal as a combination with penile climax for a long time, I was happy with how everything worked and I felt like I'd peaked.

Then my egg cracked; then everything changed.

I stopped doing anal / prostate play, I was ashamed again and hated what I had discovered about myself. For a while there, I regretted ever trying anal sex / prostate play because at the time, in my mind, it was the door to realizing I am transgender.

In hindsight today, I can say it was a big part of my discovery but it was just one door in a long hallway filled with other doors that all led to the same room.

When I reached acceptance of who I am, and began to love myself, I immediately got back into anal play. I decided to try something new, something **incredibly frustrating**. I stopped touching my penis during masturbation. The anal / prostate play felt great, but I couldn't finish. Some nights I would explore myself for hours if I had time, other nights it might only be 30-45min.

I was determined to have a prostate orgasm, it was a slow progression but it kept getting better. Eventually I went back to finishing with my penis but I didn't finish every time I masturbated and I always would start with anal / prostate play.

A week before I started HRT, I had my first prostate orgasm with the njoy wand, toe curling, giggling, loss of time, I almost fainted - it was amazing and incredibly affirming.

There are a lot of guides out there on how to use the wand but what has worked for me is either gentle thrusting in and out OR keeping it inside me and slowly, like glacially slow rocking back and forth once it is on the prostate.

Bonus tip on prostate access with a dildo - if you lay on your side, I typically will be on my left side and I'll take my right leg and bring it up slightly and let my right knee rest over my left leg on the bed and tuck my genitals in between my thighs, it's a very affirming view and it seems to make it easier for me to reach my prostate.

I started HRT, I tried again, but I couldn't get it. I was chasing an orgasm and not enjoying the experience. I was in my head, the science was clear - I should be able to replicate this experience and HRT is supposed to make this easier so what the hell was wrong. I got frustrated again.

Luckily, HRT changed a lot of me, it's helped me to be more calm, less demanding, and mostly more present in my body and life. I slowly got to the point that I stopped chasing that climax and just enjoying the experience.

Today, when I have anal sex I would describe it as waves that reverberate with each other and the intensity climbs and falls. I have mini-orgasms that feel amazing.

I would describe it as warmth, tingling, just pleasure radiating from my prostate and outward. I also feel it in my brain / head, it's everywhere really but those are the two most intense places for me.

Once I have a mini-o or a prostate orgasm - I might get numb for a bit, or just not super great feelings but not bad, just sort of a recovery (refractory?) window and then there will be another climb and climax, again intensity can vary but typically it is mini → bigger mini → bigger mini → bigger mini → full climax at some point → refractory → if I keep going more minis and back into larger climaxes.

Sometimes I will ejaculate solely from prostate / anal sex, if that happens I have found that is the end of that session but it doesn't happen often and the further I get into HRT the less ejaculation I experience overall which I prefer.

I do still combine penile climax with anal / prostate but something new is happening and this is like, within the last few weeks. It used to be if I was doing anal and touched my penis all sensation switched, it went away from my prostate and straight to my penis, but now it's not quite like that. My penis can't steal the show anymore and I love that. It does enhance sex, it does get a fuller / bigger climax for me when I combine them and it is usually how I finish a session after having already had many orgasms from prostate / anal.

It keeps getting better - I don't understand how - but it does. Every time I do it I'm like how in the hell is it better, and yet it does. If you go down this path, I hope you learn faster than I did. It took me years, I also will say I am so glad I didn't quit and I had faith in science and my body's ability to rewire.

One last thing to mention is the refractory period for transgender women in my experience definitely gets better and from what I've read the longer I'm on HRT the better that will get for sometime.

Vulnerability During Intimacy

I just wanted to touch on this, it took me a year to feel safe enough to perform sexually as a bottom role with my wife. It had nothing to do with her and everything to do with me, comfort with how my body responds, comfort with the idea of being penetrated by someone else. I am so glad I finally got there, I hate that it took me so long and I am grateful that my partner was understanding, compassionate and most of all loving.

If you find yourself in a similar situation, I don't have a "this is when I knew I was ready" moment - I wasn't 100% sure when it happened honestly, I just reached a point that I felt confident enough to try with no expectations. I was open with my partner about what I was and wasn't comfortable with, consent was clear and that should always be the case. It went very well - that's all I'll say, that and I'm looking forward to exploring more with her.

Medical Discrimination

I really didn't want to do this section mostly because it makes me sad to know it is real. It's just so sad to me that we are hated this much - while I would never equate our existence to other minorities, it does help me empathize with them. Here's the very real data and some stories I've found.

Medical discrimination against transgender women is not anecdotal—it is systematically documented across decades of research involving hundreds of thousands of participants. The largest survey ever conducted, the **2022 U.S. Transgender Survey** with 92,329 respondents, found that **48% of transgender people** who saw a healthcare provider in the past year experienced at least one negative experience because they were transgender.

Healthcare is harder for us to receive, “Transgender people are often denied the care they need—especially gender-affirming care. While 84% of respondents wanted hormone therapy or surgeries, only 60% had ever received them. Even when care is available, access can be geographically limited: trans people were more than twice as likely to travel 50+ miles for transition-related care than for routine healthcare (11% vs. 5%).”

Almost half of respondents (47%) claimed to have at least one negative experience with a healthcare provider during the prior year. These ranged from being misgendered to having to educate their provider on trans healthcare and needs. Of the respondents, 28% claimed they avoided healthcare because of costs and 24% avoided care out of fear of mistreatment.

In **2015 the USTS surveyed 27,715** transgender adults and documented pervasive discrimination: 33% of those who saw a healthcare provider reported at least one negative experience related to being transgender - including verbal harassment, refusal of treatment or being forced to educate their provider about transgender care - 23% did not seek healthcare due to fear of mistreatment; among those seeking care 55% were denied care and 25% were denied coverage.

An analysis published in “Transgender Health” found that transfeminine individuals - transgender women - experienced the highest rates of discrimination at 31%, compared to other gender identity categories.

The trend from 2015 → 2022 shows one thing, it's getting harder for us to seek care, get coverage and afford it - and this breaks my fucking heart.

The Lambda Legal “When Health Care Isn’t Caring” survey (2010) found that 70% of transgender and gender-nonconforming respondents experienced discrimination, including refusal of care, harsh language, or physically abusive treatment - rates 2-3 times higher than LGB respondents. Nearly 90% believed there were not enough properly trained medical personnel to care for them.

The data and studies show another consistent problem - discrimination occurs across all healthcare settings. Another study in Transgender Health examined emergency department experiences found that 62.9% of transgender patients reported staff refusing to use correct pronouns, 45.7% witnessed medical personnel gossiping about or mocking transgender patients and 8.6% were outed by healthcare professionals to others without consent.

A [42 year old transgender woman](#) recorded the audio during her surgery while she was under, she is now suing Memorial Sloan Kettering Cancer Center in New York City after she listened to the recording she said she felt unsafe and humiliated.

Research published in the Annals of Emergency Medicine studying Ontario transgender patients found that over 50% who accessed emergency departments had negative experiences, and 21% avoided ever seeking emergency care due to anticipated discrimination - even in medical emergencies.

A study in Medical Care analyzing the National Transgender Discrimination Survey found that transgender adults who had to teach their providers about transgender identities were **four times more likely** to delay necessary care. Another study found that 82.5% of emergency physicians had received no formal training on transgender patient care.

Provider refusal of care is documented extensively. The Center for American Progress 2017 survey found that 29% of transgender people reported a healthcare provider refused to see them due to their gender identity—not for transition-related care, but for any care at all. 21% experienced harsh or abusive language from providers, and 23% were deliberately misgendered.

The 2008 - 2009 National Transgender Discrimination Survey found 19% were refused medical treatment outright because of their transgender status, with MtF respondents experiencing higher refusal rates (22%) than FtM. **Of the respondents,**

28% were verbally harassed in medical settings, and 2% were physically attacked in a doctor's office.

Racial disparities are stark - 36% of American Indian respondents and 27% of Black respondents were refused care, compared to 15% of white respondents.

Insurance discrimination operates through explicit exclusions, coverage denials, and administrative obstacles. Research published in the *Journal of General Internal Medicine* by Bakko and Kattari (2020) analyzed data from 11,320 transgender adults and found significant disparities by insurance type: those with military insurance (TRICARE) were 1.53 times more likely to be denied transition-related surgery, with **87.2% experiencing surgery denials.**

Medicaid recipients were 1.22 times more likely to be denied hormone therapy and 1.54 times more likely to have no in-network surgery providers. Geographic disparities were also significant, with Midwest and Southern states showing higher denial rates.

A Williams Institute study (2022) found that of 276,000 transgender adults enrolled in Medicaid, only 60% had affirmative access to coverage. 27% lived in states with unclear or silent policies, and 14% lived in states with express bans on gender-affirming coverage.

The MACPAC Issue Brief (2022) documented that over half of Medicaid-covered transgender adults were denied coverage for gender-affirming surgeries. A study in the *Journal of Sexual Medicine* found only 67% of state Medicaid programs include hormone therapy and only 49% include genital surgery - patients required up to 12 phone calls totaling 125 minutes just to confirm whether coverage existed.

Corporate insurance exclusions persist despite improvements. A 2021 study in *Transgender Health* analyzing 435 health insurance contracts from 40 self-insured corporations found that 9% maintained total exclusions for transgender care, with significant variability even among companies with perfect Human Rights Campaign equality scores.

Federal agencies have documented transgender health disparities through multiple data collection efforts. CDC surveillance data (2024) from the National HIV Behavioral Surveillance Among Transgender Women found that 69.9% experienced at least one type of discrimination in the past 12 months, 53.9% were verbally abused, and 10.8% were denied healthcare or given lower quality care specifically because they were transgender.

CDC MMWR data (2023) on transgender youth—the first nationally representative data—found that 3.3% of U.S. high school students identify as transgender. Among these students, 40% were bullied at school, 72% experienced persistent sadness or hopelessness, and 26% attempted suicide in the past year, compared to 5% of cisgender males.

The Williams Institute TransPop Study (2021), funded by NIH and using the first probability-based sampling methodology, found that 33% of transgender people avoided healthcare due to cost (compared to 15% of cisgender people), 62% worried about being judged because of their gender identity when seeking care, and only 20% were "very satisfied" with healthcare received (compared to 45% of cisgender people).

The Institute of Medicine's 2011 report "The Health of Lesbian, Gay, Bisexual, and Transgender People" established the scientific foundation documenting LGBT health disparities, identifying lack of research on transgender-specific health needs and recommending NIH prioritize this research.

Every major medical organization in the United States has formally acknowledged healthcare discrimination against transgender people and its harmful health consequences.

The American Medical Association maintains multiple policies recognizing that discrimination exists and causes harm. AMA policy H-185.950 supports "public and private insurance coverage for gender dysphoria treatment" and the organization has stated that "gender-affirming care is medically-necessary, evidence-based care." AMA documentation notes that access to appropriate care reduces suicide attempt rates from 30% to 8% post-treatment.

The Endocrine Society, in clinical practice guidelines published in the *Journal of Clinical Endocrinology & Metabolism* (2017) and co-sponsored by seven medical societies, established that "there is a durable biological underpinning to gender identity" and that medical intervention is "effective, relatively safe, and established as standard of care."

The American Psychological Association (2024) adopted policy supporting "unobstructed access to healthcare for transgender individuals" and opposing state bans as "contrary to principles of evidence-based healthcare, human rights, and social justice."

WPATH Standards of Care Version 8 (2022), the international clinical guidelines, explicitly states: "TGD people commonly experience transphobia, stigmatization, ignorance, and refusal of care when seeking health care services" and documents that

minority stress from discrimination leads to increased rates of depression and suicidality.

The American Public Health Association declared in *AJPH* (2024) that "the impact of such antitransgender policies extends far beyond legal and political spheres; it is a critical public health crisis that threatens not only access to care but also the physical and mental well-being and survival of the more than 1.6 million transgender people in the United States."

As of December 2025, transgender healthcare access varies dramatically by state. Movement Advancement Project tracking shows that 24 states plus DC prohibit transgender exclusions in health insurance, while 25 states plus 4 territories have no LGBTQ-inclusive insurance protections. **Two states (Arkansas, Mississippi) explicitly permit insurers to refuse gender-affirming care.**

For youth, **27 states plus one territory** ban or restrict best-practice medical care for transgender youth—affecting **38%** of transgender youth ages 13-17. **Six states** make providing such care a felony crime. Meanwhile, 14 states plus DC have enacted "shield" laws protecting access to transgender healthcare.

Religious exemption laws create additional barriers. **45 states allow healthcare providers to refuse services based on religious beliefs** and **7 states** permit providers to decline to serve patients specifically based on beliefs about gender identity - **including for routine care unrelated to transition.**

Sources: [\(1\)](#) [\(2\)](#) [\(3\)](#) [\(4\)](#) [\(5\)](#) [\(6\)](#) [\(7\)](#) [\(8\)](#) [\(9\)](#) [\(10\)](#) [\(11\)](#) [\(12\)](#) [\(13\)](#) [\(14\)](#) [\(15\)](#) [\(16\)](#) [\(17\)](#) [\(18\)](#) [\(19\)](#) [\(20\)](#) [\(21\)](#) [\(22\)](#) [\(23\)](#) [\(24\)](#) [\(25\)](#) [\(26\)](#) [\(27\)](#) [\(28\)](#) [\(29\)](#) [\(30\)](#) [\(31\)](#) [\(32\)](#) [\(33\)](#) [\(34\)](#)

Advocacy

Personal Experiences:

Today, December 30, 2025, I have been openly transgender for less than a year and I have already dealt with some of this. I am lucky in many ways, I live in a blue state, with very strong protections for transgender people and I am super lucky that I was able to find a primary care physician in network that is nonbinary transgender and I am able to be incredibly open with them about this entire experience and they are supportive AND knowledgeable.

I had skin cancer last year, I had to have it surgically removed from my face, my nose is even more messed up. I hate it. I hated my nose before the surgery, now it has an extra spotlight on it and massive scarring and it's always red and veiny and gross looking, it makes my already existing face dysphoria worse.

My surgeon is refusing to recommend reconstructive surgery - it costs him nothing and yet he refuses to help me. I can't say for sure that he is a bigot, some of our conversations he has seemed quite liberal but regarding transgender care he is completely ignorant. I tried discussing FFS and dysphoria with him and he said my nose is healing as expected.

So, what's a girl to do? I could pay out of pocket for a nose job, and that might be the route I go, but not until I exhaust every other option first.

For me - what that looks like is this:

- I scheduled another follow up and I'm going to require him to put in writing the denial of my request for reconstructive surgery and why he is denying it.
- I have reviewed my insurance provider's long form and reconstructive surgery for cancer treatment is 100% covered.
- The job of insurance **is to make you whole. I am not whole.**
- Once I have his written refusal, I will reach out to my insurance provider and request a second opinion from a separate surgeon at a separate facility.
- I haven't looked into state laws, but I will, if my rights are being violated by the surgeon then I will file complaints with the state licensing department against the surgeon - knowing fully this will terminate my care with this facility moving forward - so I'll be sure to get all my records before filing said complaint.
- If a second surgeon agrees reconstructive surgery is not required, I will have exhausted my options for the most part and I will have to pay out of pocket.

Medical Advocacy is state / facility / location globally dependent and everywhere has different policies, laws and it is impossible for me to tell you what to do.

The general advice I can give is - if you live in a place where it is illegal to exist, get out as soon as you can, if you live somewhere that is legal to discriminate against you for existing, get out as soon as you can, if you live somewhere that it is illegal to discriminate against you - ***flex your rights and do not let them push you around.***

How to flex your rights (if you have them):

- Document discrimination with dates, names, exact words used, record office visits with your physician and always get consent if required by your location.
- Use a search engine and look up your laws, medical boards, insurance commissioner offices, licensing departments - I cannot tell you how many times I've even *threatened* to contact a licensing department and made massive progress while advocating for other issues in my life (insurance related).
- Find legal resources - there are lots of nonprofits that will work with you even if only to point you in the right direction. Go to your local city offices (if it is safe to) and ask for resources if you don't want to look online.
- Contact LGBTQ+ legal organizations and local / state resources if you have them, or neighboring states.
- **GIVE YOURSELF GRACE** - this is never an easy fight, it is always uphill, it shouldn't be, but it is. When you make these appointments, be 100% present at what you're doing, be detailed, be prepared, I know it is a lot of work, but that's the world we live in.

Update March 30, 2026:

My surgeon provided a referral letter to the plastic surgeon I am seeing in 3 days! I will continue this in the surgery section – assuming I get my nose fixed. 😊

Medical Advocacy Update:

I have unfortunately experienced discrimination firsthand and I have exhausted all options; I want to explain in great detail for all of my American friends what we are up against currently.

For starters let's talk about American insurance plans that I am educated on – I want to start with the disclaimer that this is not legal advice, I'm not a lawyer and there are options I will not go into as I have no information on them.

There are two primary types of insurance:

Fully insured plans – these plans the INSURANCE COMPANY assumes the risk. Either an employer pays a premium for these plans OR they are purchased through healthcare.gov. Fully insured plans **MUST** comply with state laws. KNOW YOUR RIGHTS – LOOK UP YOUR STATE LAWS.

Self-funded plans – these plans the EMPLOYER assumes the risk – they do not pay a premium, but they pay all claims – the insurance provider they select works as a claims processor and manages the plan for the employer's behalf. Self-funded plans **BYPASS** state laws and are regulated by [ERISA](#) and the [Department of Labor – Employee Benefits Security Administration](#).

Mental Health Parity and Addiction Equity Act ([MHPAEA](#)) 2008 – let me summarize this for both plan types:

MHPAEA generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Specifically, financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.

Importantly, MHPAEA does NOT require group health plans to cover MH/SUD benefits at all — but if they do, the rules apply.

Are Self-Funded and Fully Insured Plans Treated Equally?

Fully Insured Plans are regulated by the state insurance department where the coverage is purchased. The insurance that is purchased, whether by an insured group health plan or in the individual market, is regulated by the State's insurance department.

This means state mental health parity laws can layer on top of — and be *stricter* than — federal MHPAEA requirements.

Self-Funded Plans pay for coverage directly without purchasing from an insurance issuer. Private employment-based group health plans are regulated by the Department of Labor, while non-Federal governmental plans are regulated by HHS.

Self-funded plans are generally governed by ERISA at the federal level, meaning state insurance laws typically do *not* apply to them — they only have to meet the federal MHPAEA floor.

One key distinction from the 2024 rules: the final rules implement the sunset provision for self-funded non-Federal governmental plan elections to opt out of compliance with MHPAEA. So, there was previously an opt-out available for certain self-funded governmental plans that have now been eliminated.

My story:

In January 2026 I received a bill for lab work I had done in October of 2024. My insurance denied coverage and I received a "discount for services." I reviewed the explanation of benefits because in my employer's contract with Cigna, it states lab work is covered 100%.

I called Cigna, the first representative I spoke to was unkind to me, she told me my claim was denied because I am transsexual and this is behavioral health, not medical. I was offended and I told her that it is outdated language, she told me that is what they classify me as internally. She then went on to tell me that the lab work was coded with diagnostic code "F64.0 Gender Dysphoria" — she said that gender dysphoria is a behavioral issue, not a medical one and that is why the lab work is being denied.

I demanded to speak to a supervisor.

The supervisor did not call me that, but he told me the same thing, exactly the same words, "F64.0 Gender Dysphoria is behavioral and not medical."

I opened my employer contract, and I read 120+ pages. It was time for me to learn about medical insurance, laws etc.

I learned that my employer plan was self-funded, meaning state laws did **not** apply to me – that means my plan fell under federal policy. I learned that my contract states MHPAEA compliance. I learned that Cigna's own public policy on transgender healthcare states that lab work, surgeries, HRT etc. are all covered.

I was furious. I had multiple representatives and supervisors tell me that my gender dysphoria was behavioral and therefore not covered – this is discrimination and a violation of my rights.

I did not know how self-funded and fully insured plans were governed, I reached out to the Michigan Department of Insurance and Financial Services (DIFS) as well as the DOL EBSA, I also contacted the Michigan Department of Civil Rights (MDCR).

I got quicker responses from the DIFS & MDCR. They both told me the same thing – "your plan is self-funded and falls under ERISA & DOL EBSA – we cannot do anything to enforce against them."

Learning all of this, and the amount of time I spent on the phone with Cigna spanned weeks by the way, it was probably 20-30 hours of time invested reading, calling and learning.

I filed claims internally with Cigna's ACA Grievance team as well during this time frame. I documented every call, every employee ID# (many refused to give me their Employee # or a reference #). I took screenshots directly from my employer's contract and emailed them to Cigna.

I cannot place enough emphasis on this – when you do these calls, sit in front of your laptop, write down what they say that is discriminatory, demand employee ID#s – START THE CONVERSATION ASKING FOR AN EMPLOYEE ID# if they refuse demand a supervisor, they are lying to you. They must provide reference numbers for calls and ID#s.

I had more labs done in January 2026; they did the same thing for this claim. During this time, I was also preparing for surgery – orchiectomy with scrotoectomy. I reached out to the University of Michigan to make sure my preauthorization was approved.

It was at this time I spoke to a very kind woman in the preauthorization department, and she told me that up until 2026, United Healthcare was by far the worst insurer to work with. She said that Cigna has now taken first place for her. She told me – they keep telling me that "F64.0 Gender Dysphoria is behavioral and not medical; this surgery will not be authorized."

I cried for a day at this point. I was so excited to get my surgery, it wasn't just about helping my dysphoria – for me – this surgery was the permanence for me. It was the inability to force me to detransition; something I worry about in the current political climate.

I called Cigna, I spent 3 hours on the phone the next day, I had my contract open and I read pages from the contract, I cited where it said specific language that genital reconstruction surgery is covered for me. I got a preauthorization number.

I called the UoM and gave it to them – my surgery was scheduled – I was ready to give up on the lab work claims and call it a loss. I decided to reach out to my HR department as a last-ditch effort.

This for me was embarrassing, not because I am ashamed of being transgender – but this is very personal stuff to be talking to a stranger about. I told my HR rep I have already filed claims with Michigan and the federal government, and I am waiting for a response from the DOL EBSA. I requested my HR to speak with our insurance broker at Cigna and ask them why we are denying claims that are clearly covered in our contract.

By this point, I knew our plan was self-funded and asked HR to explain why Cigna even cares – they aren't paying for this. A week or two passed, my claims were paid, but I was told this was a one-time exception and that moving forward they will not be covered.

I'd like to pause my story, and discuss the current administration in the USA and things that they have done to harm us:

- [Trump Pauses MHPAEA Enforcement](#)
- [DOL EBSA loses over 20% of staff](#)
- [Trump signs EO defining gender as binary & halting diversity programs](#)
- [Federal government scrubs transgender, nonbinary & intersex data from databases](#)
- [EEOC Drops gender discrimination cases after Trump EO](#)

I learned all of this before my surgery on March 3, 2026. I told myself that I had a preauthorization number – I took the risk and I went ahead and had the surgery.

I put together over 200 pages of documentation citing [ACA 1557](#) discrimination protections, my plans actual contract, letters from Cigna's ACA Grievance team admitting wrongdoing in writing, Cigna's public corporate policy stating that lab work is part of gender care as well as surgeries, my explanation of benefits, detailed itemized invoices from Cigna, my lab work that was covered in 2024 with a different diagnostic code than F64.0 and I submitted a packet to the DOL EBSA.

Today, March 30, 2026, the DOL EBSA finally responded to me. They told me that Cigna is operating within the confines of the law, I asked how they are allowed to violate the MHPAEA and they were unable to answer that directly and instead gave me a runaround answer about current administration policies.

The bottom line is this ***if you are using medical insurance that is self-funded and falls under ERISA & DOL EBSA – you have no protections for gender dysphoria.*** Even in a blue state like Michigan with gender protection laws like [The Elliott-Larsen Act](#).

This is quite disheartening to hear and accept, and I can tell you that this is our reality. Now for me specifically – I had my surgery, Cigna coded my surgery as "therapeutic services" and it is billed under behavioral.

I can't believe they did this to me. In what world is a bilateral orchiectomy and scrotoectomy behavioral health? It's a medical, surgical procedure and should be treated as such.

My plan has one deductible and as an individual I have a \$6,000 maximum out of pocket per calendar year. I have since hit that and it seems like they are paying for the rest of my surgery as they are contractually obligated to.

For the remainder of calendar year 2026, any work I have done under F64.0 – including labs – will be paid 100% so long as it is in network. I have no copays for services or medications.

What am I going to do with that?

I had a consultation with a genetic specialist – I am requesting [karyotype testing](#) – I have a few signs that suggest I may be intersex. In the event I am, I am hoping to

use this diagnosis for 2027 to have my care switched from F64.0 to a different diagnostic code.

I will be going back to therapy weekly, it's free, may as well take advantage of it. I also no longer have testicles meaning I have a few medical disorders that are undeniably real:

- E89.5 — Postprocedural Testicular Hypofunction
- Z90.710 — Acquired Absence of Both Testes
- E29.1 — Testicular Hypofunction
- E34.9 — Endocrine Disorder, Unspecified

I have a very good relationship with my doctor; I plan to request this change to my diagnostic codes with them during our next visit in May. I want to clarify this is not illegal – all of these are actual medical conditions I now qualify for with no hormone producing organs.

Accurate diagnostic coding also creates a medical record that reflects your actual physiological reality — which matters for your ongoing care regardless of insurance.

The truth is we need to be creative to get our care covered now, I hate it, but it is the truth unfortunately.

I am on the right side of the law as it reads, but when there is no one to enforce the law – I lose. I wanted to share this section to help anyone in a similar situation and bring light to how predatory the current administration is and hopefully save you some reading and searching.

Another thing that came out of this – Cigna has assigned me permanently my own claims representative, she and I have monthly calls, I have her direct email address and phone number – it's not perfect but it is something.

The last thing I want to share about this – I have reached out to Lambda Legal and the ACLU, I have volunteered to be a front person for class action lawsuit against Cigna and offered to share all of my medical records, denials, notes, recordings, employer plan and letters / emails I have regarding this matter.

I have no interest in making money on this – I only want to stop them from harming all of us.

USA State Guide

I originally had a link to a section where I reviewed each state one by one and scored them – unfortunately, things are going to shit so quickly here I don't feel my updates are accurate enough.

If you are visiting the USA from another country trying to determine where to visit, if you are a resident in the USA considering another state or if you are a resident trying to determine the safety of your state and / or if you have legal issues regarding your gender or sexual orientation – I recommend the following links:

- Movement Advancement Project (<https://www.lgbtmap.org/>)
- Lambda Legal (<https://lambdalegal.org/>)
- ACLU State Chapters (<https://www.aclu.org/affiliates>)
- National Center for Transgender Equality (<https://transequality.org/>)
- Transgender Law Center (<https://transgenderlawcenter.org/>)
- Out Leadership (<https://outleadership.com/>)

Coming Out:

I just wanted to share how I did it, how I got to the point that I was ready to do it and what worked and what didn't work.

I'll start with some backstory, I was born and raised in the south. I come from a Catholic / Conservative / MAGA type family. I relocated to the Midwest because my wifey is from here and her family is here, but MAGA is here too, her family also has MAGA people in it.

My plan when I finally started HRT was to try it out and see if my mental health improved. It did. HRT didn't cure me of my ailments, I'm still in therapy, I'm still discovering things about my mental health but I am much better today than I ever was preHRT in my opinion, my wife would agree.

I remember around day 8 my nipples started to change, puffier and more sensitive. I didn't expect to feel the breast change so quickly, I had read it happened but once I was feeling it, I was so afraid.

I flipped out, I thought what if my boobs get too big to hide and out me. I would spiral at night about it, I just wanted to try HRT and see how I felt - I knew how I wanted to look. I just didn't want other people to see me. I wasn't ready for that. I'm still not always - and that is **okay**.

About 3 weeks into HRT I told myself I should stop, that I'll never be a woman or enough, I'll never be transgender enough, I'll never pass, I'll always look like an ugly old man-freak and I'm only going to bring spotlights and harm to my family.

I stopped spironolactone for 2 days, then I was due for an injection and I didn't want to go back, I didn't want to stop; so I didn't.

I came out to my wife before I started HRT, I told her at that time that I didn't know what my future looked like - which was 100% true in that moment - I wasn't sure if I wanted to transition, I wasn't sure if I wanted to try different clothing, I just knew I was transgender and that huge chunks of my existence felt like a lie to me. I told my best friends that same day and then I didn't say anything to anyone.

There's a woman at work I've been friends with for 7 years or so. I went with her to lunch a few months into my realization and I told her, I knew she was accepting of

transgender people and she was the first person that I would describe as not “family” that I told. Our relationship has only grown and I do see her as family now.

I had a few distant relatives that I knew were allies (a niece, my aunt, my best friend’s parents) I probably had told 8 - 10 people before I just shouted it.

In July 2025, I had been on HRT for just over 2 months, I was 100% sure I never wanted to run on T again and I felt a crushing weight to come out.

This is the order I did everything in:

- I read the employee handbook to check for protections - gender was listed, so I felt secure at work.
- I talked to my therapist about it, she agreed if I felt ready and we both thought it would alleviate my anxiety to do it.
- On the same day - I told my boss, HR, some executives I know at work, some gossipy people I know at work and then I took a week off to let people talk about it without me around.
- That same afternoon I sat down with my siblings and told both of them together. After I talked to them I called my Mom and told her.
- The only people left to tell that were concerning me was my wife’s family, and I let her do that one for me (good choice imo).

What worked? I really am glad with how I did it at work. Taking the time off to let people talk and let the word spread just made it easier for me. I returned the following Monday and let HR know my new name and requested IT change it in the system. I printed a new name tag for my desk that is light pink and light blue and I still smile every day when I see it.

What didn’t work? I flubbed telling my siblings, I got startled, nervous, they are older than me, my sister said awful things to me that I was not prepared for. I could’ve done better with that. I would say if I could redo that part, I would’ve role played with my therapist about dealing with difficult / not accepting people.

Since coming out, my sister and her husband don’t talk to me, my Mom and her husband don’t either, my Dad and stepmom died when I was in my early 20s so my only immediate family left is my brother and while that sounds awful, I am much happier. I don’t have to “people please” anymore, that is so relieving. I get to just be me and I’m getting a lot more comfortable telling people to fuck off.

My kid is young, I didn't come up with any cool nickname or have him switch to Maddy or whatever, he just calls me, "Nova" or "My Nova" which melts my heart when he says it.

I found an amazing discord group and I have found a community there. I hope to grow in my local community as well. My family just relocated closer to the city center and I know of a few other transgender women that have kids at the new school our child attends. *I cannot stress how nice it is to see other LGBTQ+ people at my child's school. It was 100% worth moving.*

I've been lucky to watch other eggs hatch, other people come out and learn more from their experiences and from shared experiences with the trans community I am grateful to be a part of.

Something we all have come to learn is to not make promises early on. Promises to friends, family, coworkers, etc. The fact of the matter is – in my experience with this – a lot of us don't know what we don't know. A year ago if someone had told me that I would identify as pansexual today, and be attracted to cismen, I would've told them they are fucking insane. And yet, that is my truth today.

My advice here – tell people that this is all new territory for you, that you're figuring yourself out and the only way to know what that actually looks like is time and experience.

Presentation:

TBD:

This section for me isn't something I really do yet, one day hopefully, but today, I boymode 100% of the time unless I'm home and feel like wearing something cute around the house.

I still have serious dysphoria with my face / head / scalp hair and 99% of the pics I have of myself I'm the headless horsewoman or something. I imagine I will feel more confident in the coming months / years.

I'll update here on hair, nails, makeup, clothes as those things change, if they do, if they don't that's fine, I still am transgender and I love me <3 I am no less transgender because I wear boy clothes and I'm not competing with anyone. I'm just finding myself, my authenticity.

I am going to get a tattoo soon; I will meet my artist in January. I'm hoping the area I want to get the tattoo on is hair free by then, let's gooooo IPL.

I do like to paint my nails, I don't have many tips, I'm not great at it.

I am meeting with a voice coach starting in March. I don't know if I'll do anything with it, but I want to try and see what it's like and how my voice can sound.

I found this additional resource on Reddit – I will include it in the additional resource section below as well but wanted it here incase readers did not check:

<https://sonjamblack.substack.com/p/the-secret-power-of-presentation>

Name Change:

I legally started the process to change my name - this is the process I am following. **Again I'm not a lawyer, not a doctor, just someone that reads and is passionate about sharing information.**

1. Filed proper documentation with state probate court, waited for the judge to approve, got an official court order.
2. Filed with the Social Security office - scheduled in person meeting, bringing court order, driver's license, birth certificate, passport - probably more than I need but I like to overkill.
3. Once SS is filed and I have the docs showing that the name change is filed → Secretary of State / DMV or whatever it's called where you get your license. Update driver's license photo / name / gender (not all states let you do gender).
*****DO NOT FORGET TO UPDATE VOTER REGISTRATION AND VOTE BLUE*****
4. File for updated birth certificate in the state I was born in.
5. Once I have my new driver's license, SS card and court order → file docs with employer + bank + credit cards + 401k / retirement funds + lawyer + medical facilities + credit bureaus (Transunion / Equifax / Experian).
6. Don't forget utilities, cell phone, passport (if you're okay with gender marker).

9 Month Update:

It is done :) I am legal. My work, taxes, bank, credit cards, medical, insurance, everything is legally Nova. I am so happy. It was worth it and it was a pain in the ass.

Common Surgeries:

Orchiectomy - Surgical removal of the testicles, reducing testosterone production and eliminating the need for antiandrogens.

Vaginoplasty - Construction of a vagina and vulva using penile and scrotal tissue, creating a functional vaginal canal with depth. Note dilation is a lifetime commitment.

Zero-Depth Vaginoplasty - Creates external vulva anatomy without a vaginal canal, offering shorter surgery/recovery, no penetrative sex.

Penis-Preserving Vaginoplasty - Creates a vaginal canal while retaining the penis, though options for this are limited and relatively new.

Breast Augmentation - Implant placement to enhance breast size beyond what hormone therapy achieves.

Facial Feminization Surgery (FFS) - Collection of procedures reshaping facial features (forehead, jaw, nose, chin, cheeks) for a more feminine appearance.

Tracheal Shave - Reduction of the thyroid cartilage (Adam's apple) for a smoother neck contour.

Voice Feminization Surgery - Procedures to raise vocal pitch by tightening or shortening vocal cords (less common than voice training).

Body Contouring - Liposuction and fat grafting to create more feminine body proportions (hips, buttocks).

Hair Restoration - Hair transplants or scalp advancement to address male pattern baldness and lower the hairline.

I'll expand this section eventually. I will also do a lived experience section regarding my orchiectomy as that comes to pass and it will be interesting to see how my feminization changes post op.

Additional Resources:

Reddit User: u/Transcontinental-Bicycle sent me the following doc to share, this has tons of useful info for [mental health](#).

A dear friend of mine named Rana made a guide on sex – I highly recommend reading through it if you are sexually active:

<https://fuckingguide.thecakeofinsanity.com/>

A resource on presentation: <https://sonjamblack.substack.com/p/the-secret-power-of-presentation>

9 Month Update:

Alright, so I'll try to keep this organized and relevant for you the reader, but this is all personal about me, my changes, my experiences and everyone is different. This section will not be science based, just lived experiences so feel free to skip it if you're just here for science.

I'd like to start with my mental health, I have a lot of baggage, my life was far from easy, and I experienced a lot of bad shit firsthand. I have CPTSD, major depressive disorder, anxiety disorders etc.

This experience, transitioning, has made me more present in my life, which is an amazing gift, but I feel things more frequently, I'm not numb to them anymore. My joyful moments are significantly better than they had been prior to transitioning, and my lows seem to hit harder as well.

The things that seem to be most triggering to me are societal acceptance, fear of my government, self-love / self-acceptance, and body image issues primarily.

On societal acceptance & fear of my government – there isn't a whole lot that I can do to control this unfortunately. I have been very lucky genetically speaking, my over-bust today is now measuring at 41" and my under-bust is measuring at 34.25" and it is getting harder to hide my breasts.

This causes me anxiety because I'm not ready to be seen publicly as Nova, because I know I will be hated by strangers, not all of them but a lot of them. I know that "man with boobs" look will draw attention from Law Enforcement / ICE agents, although they aren't going after us (yet), I am fearful of that happening sooner than later.

I can't make my boobs stop growing and I don't want to, I shouldn't have to deal with this, but I do, it is the world we live in. I don't have any advice here, some days I'll walk around in my fitted tops, and I see my breasts jiggling while I walk and it makes me happy, other days I ask myself if I should layer more and get tops that are more "box" shaped to hide them. I think this is just a "you do you" sort of thing.

This problem is approaching rapidly though for me; I imagine my next bud cycle it'll be time to change shirts or start presenting differently. For me it's all about hair, I don't have enough to grow it out yet, so I am stuck in this in-between stage, and it is brutal.

On the topic of self-love and acceptance, I'm making a lot of progress here. I actually wrote something to myself that I'll share:

Looking at that photo of me, my arms, my chest, what if I'm just allowed to be me? I don't have to be he or him, they or them, she or her, I am just Nova.

A transgender human that likes soft skin, no body hair, more scalp hair, soft features and still quite strong. I don't have to be anything I don't want to be. I don't owe anyone an explanation or definition of beauty. What if I define myself as beautiful?

That about sums up how I am feeling these days – when I wrote that to myself it actually planted the seed for the next section I just added (What makes a man? What makes a woman?).

The reality is this is all bullshit, the external factors shouldn't exist and I'm getting better at realizing and seeing them for what they are – systems of comfort for people that exist in this world in a way that I do not.

I am not asking them to change their own comforts, I am *asking them to allow space for me to exist in them as well.*

The last thing that is on my mind is my body issues, I have always seen myself as fat, even when I was thin. I still see myself as fat, I have never been thin enough, I have never had a flat enough stomach, I have never had the exact texture to my skin and shape of my body that I've so desperately desired.

I am 41 years old now and the reality is that ship has sailed, I will never be what I wanted to be – but I am still much happier with who I see in the mirror today than I was a year ago.

What I'm coming to learn in this experience ***is to stop focusing on my current physical appearance and instead focus on the trajectory I've been on since starting HRT.***

If I focus on the trajectory, when I compare images of my scalp hair, my chest, my body overall, my face, I look soooooooo different and it has only been 9 months.

This is a long, multi-year process – I won't consider myself "transitioned" until year 3-5 I would imagine. I have to remind myself *constantly* that **if my chest is feminizing, my face is too**, but not everything changes at the same rate which is disorienting and frustrating, but it is the reality.

I am grateful for the changes I have had so far, and I cannot wait to see who I am in 9 more months.

My mental health issues are far from resolved, but I am starting to experience windows with no suicidal ideations, which is new for me. I usually have them daily.

I am starting to think in my inner monologues of myself as her / she / Nova and not my deadname. These are small victories that I'll take and celebrate.

My body hair is almost dead, I have reached a point that I have less body hair than my wife (on my legs) – my back is bald, my stomach is 99% there, chest is close, but I do have some patches of white hair that are slowly thinning.

Unfortunately, IPL won't work on those, I might have to get some electrolysis on my chest but it's mild. I love how my skin feels, I am so happy when I touch my arm, leg, anywhere now really.

The last tidbit – sexual orientation – I am pansexual, I'm into just about anyone that isn't an alpha male type. That entire vibe is a giant turn off for me. I know I'm just casually dropping this here, but it is a big deal to me, it's just another layer of myself that I never knew or understood. My entire life I identified as a straight male.

I don't want a different life than I have today, but I wish my history was different and filled with the experiences I will most likely not go through. The loss is real, I am so grateful to have a supportive spouse, that is still very much into me and has been amazing about my transition. But the losses I'm experiencing and realizing are valid, real and painful.

I suppose that covers most of the things that have changed since I released version one of this, things to look forward to (for me and if you're interested in my story) – I'm getting my orchiectomy on March 3, 2026. I will do a full write up on that experience scientific & personal and it'll be in my 12-month update. I'm getting 2 tattoos on March 23 >,< I am also very excited about this.

The last thing is I will be going back to my second ayahuasca retreat in May. My first one was in July 2024, and my egg cracked 78 days after the retreat.

I am going this time with the intention to let go of my old self, hopefully completely. I'm changing my birthday to the day I started HRT, so May 14, 2026, Nova turns 1!

I'm hoping I will be ready to grow my hair out and really start the next phase of this journey.

9 Month Labs:

Results

Total Testosterone

 [View trends](#)

Normal range: 240.0 - 950.0 ng/dL

20.3 Low



Estradiol (E2)

Normal value: See Comment pg/mL

Value **178**

My estrogen is a little lower than I want it, my T is a little higher than I'd like but overall, these are still very good ranges. The [study I referenced](#) in the breast development section on progesterone and the 30-37% more volume requires higher estrogen levels than this and 200mg oral progesterone.

I take 100mg progesterone rectally which has similar bioavailability as 200mg orally, so I did a slight bump to my E this week and took an extra 2mg in the middle of the week and my normal dose as normally scheduled, this should bump me closer to 250 pg/mL at troughs. That's just a rough estimate from my responsiveness over the last 9 months.

I imagine every few months I'll need a mild bump to achieve the breast growth I'm going for.

My orchiectomy is just around the corner as of writing this (25 days) and that will definitely finish off my testosterone levels, I imagine they will be less than 10 ng/dL or maybe even undetectable, I'm hoping for undetectable, bye bye T.

MAH BOOTY:



Still a work in progress, but I am happy with the progress. I'm hoping by 18 months to actually have the butt I've always wanted, I'm still doing the same routine in the "Physique" section (the 2nd [routine](#) with weights) and I've slowly been increasing the weight I lift with.

Attractiveness:

I bought myself something cute just to try and it turns out I really liked the way I looked in it. My face, neck, and hair are still a huge problem for me, but I'm working on them. I have a consultation for plastic surgery in April, hoping I can afford it or make it work somehow.

Here's my cute pics that I still am struggling with accepting are actually me, I still have a way to go, but not bad for 41 and 9 months of HRT:





Anyone interested in my breast changes, I did update that in the "Nova's Breast Development" file – here is that link to save you some searching:

[Nova's Breast Development](#)

Hair Recovery Update:

[Nova's Hair Regrowth Images \(PreHRT → Current\)](#)

What makes a man? What makes a woman?

For the start of this exercise, let's call me a man. I was born with male genitalia; I was raised as a boy. I'd like to talk about my experiences as a boy throughout different periods of my life.

I have no recollections before 4 or so, I can remember brief flashes of preschool, I can remember playing tag with my friends, there was a window unit air conditioner and during the hot summers my friends and I would stand under it and take turns letting the condensation water running out of the drain hose drip on us. Sometimes I would point the tip of my hair into a horn shape and try to poke people with it.

I remember eating sand and getting yelled at for it. I remember picking my nose and flicking it. I remember playing kids' games and wearing boys swimming trunks and doing thousands of cannonballs into the pool.

I remember wearing my mom's heels and walking around with her purse on my shoulder, pretending to be her, a woman.

As a preteen I had a very vivid imagination, I would make up invisible creatures that lived in the walls, I called them flatmen. I would play outside with my friend from next door and we'd imagine silly games, I remember making a grappling hook out of coat hangers & yarn, trying and failing to climb trees with it.

Sometimes I would mix random flowers together and pretend I was making potions. I don't remember what they were supposed to do, but they were important.

When I was a teen, I tried many looks, grungy, preppy, different hair styles, I'd say shirts with print on them became my "authentic" look at the time.

I had one shirt I got made at the local mall that said, "Future Husband of Britney Spears" and I loved that one. Speaking of Britney, I had posters of her all over my room, but I also had football teams, I had glow in the dark stars on the walls or ceiling depending on the year, I had a large sound system that would shake the house if I cranked it up, I've always loved to feel my music and hear it.

I had two best friends that were amazing to me since I was 12, I spent most of my time with them. I did poorly in school unless I needed to pass, then I'd try and do just enough to get by.

I started shaving my body and legs at 18, but I never asked why or tried to understand what that meant.

I wore a woman's dress and makeup once when I was 19, I loved how I looked and also felt shame for liking it.

During my time as a boy, I listened to rap, punk, progressive metal, pop, female artists, male artists, anything that felt like good music was all I needed, I didn't get fixated on the category of music, just if I liked the sound.

I stopped shaving when I started drinking alcohol heavily, I didn't realize what I was doing at the time, but I understand now I was just numbing out of my experiences.

In my early 20s I mostly wore black shirts and jeans / shorts – this became my permanent look for almost the entirety of my adult life. Sometimes I'd wear a suit for a job interview, wedding, cruise or big social event but I always hated it. I felt like I was performing being an adult or something, and mostly those clothes *felt* uncomfortable to me.

As a boy, I played video games, watched TV, I walked a lot, I did drugs, I drank alcohol, I had sexual desires, I desired to look like girls, I felt loneliness and solitude, I wanted to be desired, I wanted to have a girlfriend, I wanted to feel loved.

When I was 21 to 35; I fell in love, I had sex, I got married, I started a family. I became a spouse and a parent.

I learned so many skills throughout my life as a man, work related, writing, construction, carpentry, electrical diagnosis, I have renovated multiple homes myself, floors, windows, doors, siding, painting, electrical, decks, stairs, fixtures, custom built ins, framing, drywall, tiling...etc.

Today, I no longer identify as a man, and for the purpose of this portion of the exercise, let's call me a girl. A good girl if you like :)

I have been a girl for a lot less time than I was a boy – and these are some things I've done in that time.

I've worn my boy's clothes and girl's clothes, makeup and no makeup. I have renovated an entire home as a girl; I moved my family. I am parenting my son; I am still my wife's spouse.

I still get lost in my imagination and daydream just like I always have. I still don't play sports or have much interest in them. I would totally put posters of Britney on the walls if my wife was on board for that.

I have the same two best friends, and I still talk to them both daily, I love them and I always will.

I still have sex, I still wish I looked like a woman (even though I'm starting to), I listen to the same genres of music and my openness to listening to all music hasn't changed, if it is good, it's good.

I can still build things, I'm actually a little calmer when I'm building than I used to be. I still shave my body, I'm still me, but I'm no longer trying to be something I never wanted to be.

As far as I can tell, from my lived experiences as a boy and a girl, I'm just Nova, I do the same things, I want the same things, I feel the same ways I always have. HRT has given me better access to the full spectrum of my emotions and experiences, but it hasn't made me a different person.

Everything I ever did as a boy; I've also done as a girl.

I'm not special in this explanation; I am simply using my own life to prove this point. If my lived experiences show anything, it is that societal norms do not define a man or a woman.

Anything he can do she can do and anything she can do he can do. I am living proof of that statement.

So, I suppose that means the difference between a man and a woman must be scientific in nature. *Right...?*

If I were to ask a random person what makes a man biologically speaking, I would expect responses of bone structure, muscle mass, testicles, a penis, facial and body hair, possibly male pattern baldness, maybe they'd mention chromosomes.

If I were to ask that same person what makes a woman biologically speaking, I would expect responses of softer skin, less body hair, breasts, a vagina and uterus, menstruation, the ability to carry a child to term, different chromosomes etc.

I'd like to dig into these now.

Chromosomes:

Approximately 1 in 400 people are born with sex chromosome variations other than typical XX or XY (1). The vast majority of these humans live [phenotypically](#) typical lives without ever being diagnosed – meaning their outward appearance is cis male or cis female even though they have these mutations.

The 2024 Million Veteran Program study analyzed 595,612 men and found that 73.8% of XXY males and 98.6% of XYY males had no documented clinical diagnosis; these individuals successfully served in the US Military. (2).

Prevalence data for major chromosomal variations:

- 47,XXY (Klinefelter syndrome): 1 in 500-650 males (3) only 25% - 37% are ever diagnosed.
- 47,XYY: 1 in 1,000 males; 90% never diagnosed
- 47,XXX(Triple X): 1 in 1000 females; fewer than 10% diagnosed (4)
- 45,X (Turner Syndrome): 1 in 2,500 females

Even more interestingly – chromosomes can completely contradict phenotype. In [De la Chapelle syndrome](#) (1 in 20,000 – 25,000) individuals have XX chromosomes but develop as phenotypically male (5) (6).

In Swyer syndrome (1 in 30,000 – 80,000) – XY individuals develop female external genitalia with a functional uterus, capable of carrying pregnancies via donor eggs (7) (8) (9).

These conditions demonstrate definitively that chromosomes do not determine sex phenotype.

A personal tidbit about me and my outward appearance, as I have said, I am assigned male at birth, and yet at age 12 I grew breast tissue (gynecomastia), I had breast buds behind my nipples since I was 12 and an A cup my entire life.

Hormones:

The [GH-2000 Elite Athlete Study](#) (2014) measured testosterone in 693 athletes and found "complete overlap between men and women" in testosterone concentrations. Specifically, 16.5% of males demonstrated testosterone levels below the lower limit of the male reference range (8.4 nmol/L), while 13.7% of females demonstrated testosterone levels above the upper limit of the female reference range (2.7 nmol/L).

- PCOS affects 6-13% of reproductive-age women and causes elevated testosterone with some approaching low end male values. (10)
- Nonclassical congenital adrenal hyperplasia occurs in 1 in 100-200 people, causing androgen excess. (11)
- Up to 70% of PCOS cases remain undiagnosed.

Among cisgender men, 2.1% aged 40-79 have symptomatic hypogonadism (European Male Aging Study), rising to 5.1% by ages 70-79. More than 60% of men over age 65 have free testosterone levels below the normal values of men aged 30-35 years. The Massachusetts Male Aging Study found 6-12% of men had symptomatic androgen deficiency. (12)

Skeletal Determination:

Forensic anthropologists explicitly recognize that skeletal sex assessment operates on probability, not certainty (13).

The FBI's DNA-validated casework study (Thomas et al., 2016) found a 5.3% misidentification rate even among experienced examiners with complete skeletons (14).

When applied to South Asian populations using standard Western methods, 36.7% of individuals were misidentified (15).

The overlap is significant in my opinion:

- 35% of pelves exhibit "sexually intermediate morphology" (16).
- Sciatic notch alone achieves only 70-93% accuracy (17).
- Skull features alone: 70-80% accuracy (18).
- Single skeletal elements: accuracy drops significantly

"The morphological overlap in sexual dimorphism is accounted for by the ordinal nature of many sex estimation methods, e.g., scores 1 to 5... thus accommodating the continuum of sexual dimorphism." (19)

Height distributions show substantial overlap: a person of 169.25 cm is statistically equally likely to be male or female (20).

Body Fat Distribution:

Android (abdominal/"apple-shaped") and gynoid (hip/thigh/"pear-shaped") fat distribution patterns exist on a continuous spectrum heavily influenced by hormonal environment. Postmenopausal women show a 42.1% increase in android body fat distribution compared to premenopausal women, with 49% greater intra-abdominal fat accumulation—approaching male-typical patterns ([21](#)).

The WHO MONICA study of 32,000+ participants found that only 30% of variance in waist-to-hip ratio in women and 49% in men is explained by height, BMI, age, and population—indicating substantial individual variation within each sex ([22](#)) ([23](#)).

Women with PCOS develop android adipose tissue distribution, while men with declining testosterone shift toward gynoid patterns. Hormone therapy studies in transgender individuals demonstrate complete reversibility of fat distribution patterns, proving these are not fixed by chromosomal sex.

Reproductive Capacity:

The assumption that cisgender women can bear children and cisgender men can produce sperm fails for substantial minorities of both populations. The WHO (2023) reports that 1 in 6 people (17.5%) worldwide experience infertility during their lifetime.

Among cisgender women:

- [MRKH syndrome](#) (1 in 4,000-5,000 female births): Born without a uterus or upper vagina, despite 46,XX chromosomes, normal ovaries, and female secondary sex characteristics.
- [Turner syndrome](#) (1 in 2,500 females): 95% develop ovarian failure.
- [Primary ovarian insufficiency](#): Affects 1-3.7% of women before age 40.
- [Hysterectomy](#): 17-21% of American women; approximately 33% by age 60.

Among cisgender men:

- [Azoospermia](#) (no sperm): Affects ~1% of all males and 10-20% of infertile men.
- [Klinefelter syndrome](#) (1 in 500-1,000 males): Causes sterility; 50-75% never diagnosed.
- [Congenital absence of vas deferens](#): Found in 2% of infertile men

Menstruation:

Never menstruating ([amenorrhea](#)) affects approximately 1% of females. Secondary amenorrhea (cessation of menses for 3+ months) affects 3-5% of reproductive-age women at any given time, with 5-7% experiencing it annually. The causes are diverse:

- Turner syndrome accounts for 29.7% of primary amenorrhea cases Medscape ([24](#)).
- MRKH syndrome causes 15-16% primary amenorrhea.
- Functional hypothalamic amenorrhea affects 1.62 million U.S. women and causes 20-35% of secondary amenorrhea.
- Female Athlete Triad affects 5-25% of female athletes depending on sport

Early menopause (before age 45) affects 12.2% of women worldwide. Combined with congenital conditions, over 15% of cisgender women will experience significant periods without menstruation unrelated to pregnancy.

Body Hair:

5-10% of women across all ethnic backgrounds meet clinical criteria for hirsutism (excess terminal hair in male-typical patterns), according to [Stat Pearls](#) and the [American Academy of Family Physicians](#).

Depending on the definition, approximately 40% of women have some degree of facial hair. The Ferriman-Gallwey scoring system explicitly uses different diagnostic thresholds across ethnicities (≥ 8 for British women, ≥ 2 for Asian women), acknowledging that "normal" varies substantially.

[Idiopathic hirsutism](#) – excess body hair with completely normal hormone levels – represents 10-15% of all hirsutism cases. These women have regular menses, normal ovarian morphology, and normal androgen levels, demonstrating that masculine hair patterns occur even without hormonal explanation.

On the male side, Androgen Insensitivity Syndrome (1 in 20,000-64,000 XY births) causes individuals to have female-typical sparse body hair despite XY chromosomes ([25](#)).

Male hypogonadism, affecting 2-30% of men depending on age and population, reduces body hair growth. The presence or absence of body hair cannot reliably distinguish biological sex ([26](#)).

Intersex:

The range of prevalence estimates reflects definitional differences rather than scientific uncertainty. [Anne Fausto-Sterling's](#) 1.7% figure (Blackless et al., 2000, American Journal of Human Biology) includes any deviation from absolute sexual dimorphism; [Leonard Sax's](#) 0.018% (2002, Journal of Sex Research) restricts to genital ambiguity or chromosomal/phenotypic discordance

Well-documented conditions and their prevalence:

- Hypospadias (urethral opening variations): 1 in 250-300 males (0.3-0.4%) ([27](#))
- Cryptorchidism (undescended testes at 1 year): 1-1.5% ([28](#)).
- Classic CAH: 1 in 10,000-15,000 ([29](#)).
- Complete Androgen Insensitivity: 1 in 20,000-64,000 XY births ([30](#)).
- Ovo-testicular DSD: ~1 in 83,000 births ([31](#)).

So where does this leave us?

If presentation, activities, abilities, interests, careers, family structures, relationships, hormones, don't define a man or a woman and science has done nothing but show us this is all a spectrum, maybe it's time to throw out the entire idea of men and women.

That last sentence might upset some people; I want to clarify what I mean here.

The point that I am trying to make is let's say masculinity and femininity exist on a spectrum, they are opposites if that's how we want to define them. But cisgender men, transgender men, cisgender women and transgender women can land all over the place on that spectrum. I don't want it to be divisive.

How about we just start accepting we are all humans. I am a transgender human, I was born with the wrong sex organs and that's it.



Surgery Takes Balls.

There's a ton of options out there for bottom surgery and there are pros, cons, and risks for transfemmes. If I could wave a magic wand and have a vagina, that would be my obvious choice. Unfortunately, that's not how this works so we have to make difficult choices.

Once I learned about [dilation requirements](#) and complications with [vaginoplasty](#) I knew that wasn't for me; I determined that I wanted a [zero depth vulvoplasty](#). I attended the virtual consultation with the University of Michigan, it was quite graphic, and the zero depth had quite a few potential risks and complications that I wasn't willing to take – mainly – potential loss of function.

This risk is low, but it isn't zero, and I don't think I'd do well without function - I enjoy orgasms too much.

The other issue with this was recovery time. I am in my 40s, career, a 5-year-old, I can't park it for months.

I decided that I hated my old man balls sac more than the likelihood that I will change my mind in the future and signed up for a bilateral [orchietomy](#) and scrotoectomy (removal of the [scrotum](#)).

In making this choice, if in the future I decide to do a vaginoplasty / zero depth vulvoplasty, I will need to have skin grafts taken elsewhere and it also won't be as good as an overall result.

It's just less tissue to work with. I know this, I chose this, and so far, I am very happy with my decision.

Before surgery, I decided to go get a pedicure. I had just painted my fingernails and wanted my feet to look nice in the O.R., bright pink sparkly toes.

I highly recommend doing this...if not for the O.R., for recovery. I am extremely dysphoric and anything that makes me feel a little less gross is a win.

I arrived at the surgical center on time, I checked in under my new name, everything said Nova and I was so glad to have my name legally changed before this procedure. I got taken back and changed into my medical gown.

The staff and nurses were the kindest. I was my normal charming self - so how could they not be?

I asked the nurses to make sure and take my socks off in the O.R. so they could enjoy my cute feet. I was nervous and did my best to keep it light.

I am a huge baby when it comes to IVs, I've gotten over needles, but IVs are not my favorite. They tried in one hand, I got pretty lightheaded, so they stopped and waited a minute, tried the left hand and we were good to go from there.

About 15 minutes later after going through some consent questions, I was pumped with anti-anxiety meds, and I immediately began discussing how happy I was to have my balls removed.

I can't recall my exact words, just some good laughs with the nurses before I went to sleepy land.

I woke up a sobbing mess, so happy it was done. It felt surreal. I texted and called my friends and fam and told them I'm okay and I love them etc. I thoroughly enjoyed the fentanyl.

My wife came back into the recovery area; she sat with me while I sobered up. We had Panera for dinner, a long drive home, I thought for sure I'd vomit a few times, but I managed not to. Thank you cannabis gummies!

I went to bed immediately and slept through the night. The first morning I would say my pain was a 6/10, the oxy and fentanyl felt like they'd worn off by then.

My dressings were pretty soaked, but the blood was dried, I barely had any fresh blood that morning. Getting up felt different, I definitely felt the incision. I'm learning to move a bit slower and I'm conscious about my legs before I actually do the movement.

I try to move them together to avoid spreading them apart and putting tension on the incision.

I have mostly been in bed, I can walk around slowly, I take short walks inside the house just to the kitchen or bathroom, but I'm trying to let myself just close up and heal.

As of writing this I am 53 hours into recovery, pain is tolerable with just acetaminophen and ibuprofen although with my insomnia, I'll keep taking the oxy until they are gone, just one at night. I have 2 left, I had originally planned on avoiding pain meds because of who I am but, here we are, I am weaaaaaaaak. I won't get more, promise.

Let's talk about the **feels**.

Sometimes I get this stupid smile on my face when I remind myself of the permanence, I can never go back to being a boy - and I mean this for me - I'm not saying someone who hasn't undergone surgery can't feel this way, but a huge part of this surgery for me was this feeling. It is very real for me.

I am calmer, this could be all the weed, but I don't think so. I just feel right in my body and it is nice to know there is no T fighting me anymore.

My skin is stupid soft, it has been for a while, but it feels softer, I dunno, can't be from this, it's most likely my perception but I'll take the victory.

Visually I am already happy by day 2 with how things look and it's still black and blue, I didn't realize how much I hated my testicles and scrotum.

I have not wanted to or thought about topping anyone for over a year, the idea of it really bothered me and now...I don't know. Umm, I kind of like the way it looks?? Dare I say it's kind of cute?!

This is such a strange experience. Anyway, who knows, maybe cialis / viagra is in my near future to try topping again. For now, just recover.

Update: 88 Hours Post Operation:

It has not been super eventful and I'm totally okay with that. I woke up this morning, and my bruises are changing to green & yellow colors; that is a good sign. 😊

My body is breaking down / reabsorbing the hemoglobin and healing nicely, in the coming days swelling should reduce.

I have a small swollen mass on my left hip, I sort of lean more to my left side in bed, so I think this is just fluid swelling as it gets reabsorbed.

I called the nurses about my bruise and swelling, they assured me all is normal.

Pain is different, lying down it is not bad at all. Standing up I have some internal discomfort in my lower abdomen. I don't walk like a penguin exactly but maybe close to that, just very short steps.

I have yet to take a step or get out of bed and really feel an "OH FUCK" sort of moment. I am overly cautious with post op stuff and would rather be a little mentally

miserable than overdo it physically, but I cannot fucking wait to get a walk in. A real walk. Just a mile would be nice.

I am having an experience of [paresthesia](#) - it feels as if your arm or leg falls asleep and it's the tingling / pins and needles / not quite numb but sort of numb sensation.

I've got that going on around my [mons pubis](#) (mound) mostly on my right side but some on the left. I'm told this is normal as well, nerves just waking up post operation.

This is a common side effect and intensity can come and go and should improve over weeks to months. Some sources [\(1.\)](#) [\(2.\)](#) [\(3.\)](#)

I'm actually struggling quite a bit today mentally. I have a minor head cold, recovering from surgery and an added complication - my dog is dying.

I spent the day crying in bed and watched Moulin Rouge! It's been a tougher recovery than I expected.

I feel uglier than normal, balder than normal, I fucking hate my lack of hair. I know it's partially the lighting in this space and then just being stuck in bed, but it is how I feel, dysphoric.

I took my second shower today, water cascading down my body feels different down there, the way my thighs touch where I used to have a scrotum is different and wonderful and affirming.

I think that's all I have for now, going to get stoned and watch a movie and probably cry some more.

Update 113 Hours:

A cute interaction between my kid and I this morning.

I opened the bathroom door after my shower and announced, "Game off! Nova is coming through."

I did my "penguin" shuffle through the living space and headed toward the stairs. "Why game off? Because you're fragile?" he asked.

I ascended the stairs slowly with both feet on each step to avoid spreading my legs apart too far.

"Yes, I am fragile but don't worry about me. I'll be fine, I'm strong." I continued my slow climb.

"Why do you say that every day?" He kicked the foam soccer ball against the wall.

"Because I don't want you to worry about me." I spoke from the top of the stairs.

"But I like to worry about you." he shouted.

"SHIT!" I exclaimed. I realized I had left my mouse on my desk downstairs.

"THAT'S A BAD WORD NOVA!" He corrected me.

My life is good and bad; it's simple moments like these that help me feel better.

I suppose that brings us to now, I'm on my second cup of coffee, it's Sunday around 9:30AM and the stupid clocks just changed.

I slept a solid 11 hours; I've been taking my progesterone orally just because...you can look at the photos and see my bruised ass but I'm not reaching back there anytime soon.

Orally is definitely helping me sleep better but once I'm recovered, I'll return to rectal for the boobs. I must get more boobs.

My mind feels a little less depressed, I've really been having a hard time with all of this at once.

I have a ton of work emails so my plan for today is to knock out as much as I can so tomorrow is a gentle integration back into my work and not a bombardment of requests.

Still processing some sadness and loss - it has been a challenging year. I am feeling much better now that I can move a bit easier.

Pain is there, some itching which is not fun but is not that bad, swelling is down, bruising is less, I'm heading in the right direction, it's all about time, patience and rest. I know this, and yet I am ready to be normal.

I just want to take a walk honestly.

The paresthesia I was experiencing seems to be gone; the left side of my mons pubis is significantly more swollen and tender than the right side.

The bruising on the left side is also more.

Gentle pressure around that area causes discomfort but otherwise it's fine. The incision is tight and sitting up can be uncomfortable still.

I am so glad I'm not returning to the office tomorrow. Five days down, I hope I am ready to return to the office in eight more.

I haven't taken a poop since the morning of surgery and honestly, I am quite okay with that.

Normally I'm pretty regular but I had a mental discussion with the bowels and said, "Hey guys let's pause this train for a week so as to avoid sitting on the toilet with a new seam from my taint to halfway up my shaft."

I suppose the last thing is visuals - even bloated from not pooping, swollen and bruised from surgery; I am still much happier with how everything looks down there.

I am so excited to get into my new boyshorts I just ordered and some yoga pants once I'm ready to wear real clothes. I'm living in loose pajama bottoms and no undies at the moment.

Update 138 Hours:

I have returned to work – remotely – and my user account has been temporarily locked out of all systems.

I have a mountain of tasks, and I am unable to do any of them.

I'm quite bored and sitting here sober is much worse than sitting here absolutely stoned out of my mind.

My wife and I scheduled to put our dog down tomorrow. I think I will be up for that trip physically, emotionally I will be wrecked.

Pain is less for the most part, the tightness feeling along the incision specifically in the very center of it is quite uncomfortable while standing, there is no way I would want to be sitting at a desk chair or standing for long periods of time based on my current levels of discomfort.

Mentally, I feel a bit better, the permanence is settling in, I have only cried about the dog today instead of everything else so that's nice.

Nova vs. The Throne

You can prepare for something, if you're someone like me you prepare in great detail. You imagine the system from one point and then work outwards, you look at dependencies and interacting components, you try to map each step and prevent any surprises.

If there are no surprises then things are less likely to go wrong, if you can predict possible outcomes you can attempt to steer the end result by influencing variables and said dependencies.

To me a system can be a project, an actual system of interconnected components or a situation.

It was six days and a few hours ago that I'd made that last deposit. I paid my dues.

I knew that the following days would be challenging, painful, and dazed by medications.

I hadn't spent a ton of time thinking about this particular step in my journey, I mean, I acknowledged it might have some setbacks, it might be strenuous but surely it won't be that bad...that was until I saw the full length of my incision.

What if I just split in two?

The days passed, as they went on and I spent less time on oxy and more time on weed my paranoia grew. "What if I'm not ready to face it? What if it hurts too much?"

It was this day, day 6, that I felt the need, the pressure was too great to ignore and I had to try.

My first attempt was a painful failure; I was too afraid to do much other than just test the throne and see if magic would happen.

Unfortunately, there was no magic – only pain, increased panic and fear.

I shuddered at the thought of trying again but it's day six, much longer and we get into some concerning territory.

I drank more coffee, lay down in bed, told myself not to worry, it'll be fine. I can do this; I can do hard things.

I felt pressure building, I had to know if I could do it, I had to try again.

Round two was another painful failure, but it was not a wasted journey. I discovered a better way to sit and my confidence grew.

I got up and walked around my main floor, anxiously pacing, I checked the cabinets for medications and then it hit me with absolute certainty, this is happening.

I have finally pooped.

Update 163 Hours:

My wife just took our dog to the vet to put her to sleep, and I was in too much pain to attend, so that sucks.

Our house is a bit quieter, she was a black lab and her hair is everywhere. I joked with my wife and said even though she's not with us her hair will never be gone. I find it everywhere.

This has been a very hard week; but time doesn't stop for any of us. I am physically less inflamed, bruising is less, inner pain is a bit milder but it's still not great.

Today is the first day that I feel like, "Returning to work next Monday should be okay."

I took another poo so that's nice, took a shower immediately after that seems to be how I'll approach this for now.

I'm still washing with antibacterial soap, not the wound itself but all the skin around it and the rest of me, I am just trying to heal with no complications.

I'll be honest, the sheer boredom of sitting in a room 24/7 for a week is not the best time, especially for me, I need to walk, move, and this just sucks.

I have no cute anecdotes today, I guess there is one thing that I haven't mentioned, mostly because I'm afraid that it isn't real yet.

I am having a hard time, I am depressed in a lot of ways, crying, sad, lonely, etc. and yet – I am not experiencing suicidal ideations which for me is very abnormal.

I usually have these thoughts daily, "Nova hung herself today" or something along those lines, the visuals are only when it's really bad. Anyway, a small victory maybe?

Update 212 Hours:

Depression is slapping hard atm - between my dog dying, being in bed for 9 days, issues at work, my kid having issues at school, today being the 15-year anniversary of my dad dying, the state of the world – fuck me – I am just having a hard time.

Unfortunately, the whole no ideation thing went out the window, I've been sitting here with some pretty ugly thoughts today.

Physically things are improving, honestly if I wanted to push myself today, I am pretty sure I could walk okay and move around fine but the swelling around my mons pubis is still quite large and I'm just not feeling 100%.

My goal is to push myself to stay in bed, that's actually the harder thing at this point. I hope that in 48-72 hours I'll be able to move around freely without pain.

I did notice in my steps today, I am able to take longer strides and going up the staircase, I was able to just take one foot per step instead of baby steps up the stairs.

Probably won't do as many updates, not much to note, sort of just everything is slowly progressing in the right direction and hopefully I get some outdoor time in soon.

Update 288 Hours:

Okay I just reread this and wow it got dark for a minute there; sorry. I'm feeling much better, I can stand for 20 - 30 min and I seem okay. I haven't pushed more than that.

The swelling on my mons pubis is really odd, it's incredibly firm - almost rubbery - and it gets a bit smaller each day. No fever, no warmth, the nursing team told me everything I'm experiencing sounds typical.

Moving in general is getting much easier, bruising and swelling are improving. I am a little less bored now that I can get up and check things out or even just walk around without it hurting too much.

It wasn't so much in the prior days that the pain was too much - it was more that the pain was significant enough that I figured I was impairing my healing by walking.

An unexpected pain that is quite obvious in hindsight – I'm still getting spontaneous erections on and off with the stitches in my penis; it can be quite uncomfortable to say the least.

My boss told me I can take an extra WFH day if I want next week, so I said sure why not.

I was already scheduled remote Tuesday / Wednesday so now I will be WFH tomorrow (Monday) as well. That gets me 16 days of rest – I am thankful for her consideration.

I think if I had to go in tomorrow, I'd be uncomfortable but okay.

Update Day 19:

It's Saturday and I survived the work week. I managed to go to the office both Thursday and Friday and for the most part it went well.

When I first came out as trans, a coworker approached me and said she supports me and hopes that it goes well – she told me she was there to help if she could.

I trust easily and I am a very open person (can you tell?) – maybe to a fault at times.

She asked me about surgery and if I was doing alright. I told her I was fine and just sore / swelling still and needed to take it easy and move a bit slower.

She pressed, "What was the procedure if you don't mind me asking? You don't have to tell me if you don't want to."

"I no longer produce testosterone is the easiest way I can explain it." I smiled.

Her jaw dropped; she did not want more details which was fine with me.

Physically the bruising is still there around the left side of my mons pubis and extends outward to my left hip. The swelling at my mons pubis is significant but it is reducing, honestly the largest visible reduction appeared to be yesterday to this morning.

I am no longer just horny; I am ready to start rubbing up against anything with a pulse.

This is the longest I've gone without an orgasm since I started having them and it is quite awful to my wellbeing. I think this is worse than the physical pain at this point.

I am beyond happy with the results and I still have months of aesthetic improvements.

Mentally, now that I can walk some, get out of the house, take a poop without pain; I think I am doing much better.

I'm still depressed a bit; I have had ideations so that isn't gone - I figured that was too good to be true.

I will say they aren't daily at least, which is still a relief. I think by now I can say with absolute certainty I avoided an infection; the worst is over. I just want to have sex and try on my new boyshorts.

Update Day 21:

I woke myself up a few nights ago and I was itching the incision. I scratched it open (mildly) and noticed some fluid came out of it the following few days, the fluid had no odor or color to it at any point and has since ceased leaking and itching.

There are no signs of infection, I am through the worst of it I think and now it is just about resting and hydrating and waiting.

I cannot wait to workout, to walk and to have an orgasm. I have been keeping my body shaved from the waist up for my sanity but shaving my lower half and getting back to IPL will also be great.

Update Day 28:

Four weeks, woohoo! 😊 Swelling is so much better and I am really surprised it is still there; I also have mild bruising still.

I finally put on my new undies and these boyshorts are so soft, I have never worn women's underwear regularly before and I have to say men's underwear is not nearly soft enough.

I do still print my "package" in the front some, but once the swelling is down all the way I think it will be minimally noticeable.

Recovery is slow – I was stupid and tried to play soccer with my son yesterday and ended up opening the incision a tiny bit in the back by my anus, I had a little discharge and some bleeding, so I'll be mindful to take it easy.

I have had two orgasms with my wand now, both were incredibly wet with prostate fluid, both felt better than they did pre-op and I am very sensitive in the best way.

I also am sustaining full erections which I was not doing pre-op, so this is all very strange to me. My erections are not causing me dysphoria like they did before surgery, I want to try topping again now...it's all so strange.

I am very relieved to know everything still functions on the front side; I'm not worried about my prostate / anal working – I am mostly just ready to enjoy that part of my life again.

Update Day 34:

Swelling is down - a lot. I am now going out in yoga pants on the regular and I couldn't be happier. My package doesn't print. I am walking a lot of miles again, 5 is a low day, 8 is high.

I still have discharge and minor spotting, but the raphe incision is completely closed and smooth except at the very back.

I am elated.

I put on some weight during recovery. Luckily a lot of that went to my chest and thighs.

Ideations are pretty much gone...I can't explain this. I used to have them daily, it's just different.

I can use my wand. Climaxes are great, some are dry, some are very wet. My refractory period is down from penile orgasms.

I can achieve full erections 6+ weeks post operation and my dysphoria around topping is gone.

I've had a few friends ask me if I can get a full erection without my testes and if I need to use Viagra / Cialis / T-Gel; I do not require any assistance.

I'm really ready to be 100% healed - I can do everything I normally could excluding anal sex and lifting weights. I'll be cleared for both in about two weeks.

I can shave again, I am hairless, I am happy, 10/10 would recommend Dr. Hadj-Moussa at the University of Michigan surgical center and the team was excellent.

Here's Nova in leggings – minimal to no bulge - very happy girl 😊:



******NSFW GRAPHIC CONTENT WARNING******

[Nova's Surgical Recovery \(Orchiectomy & Scrotectomy\)](#)

******NSFW GRAPHIC CONTENT WARNING******

Basic Skin Care

I am far from an expert on this topic. My entire life I avoided sunblock, lotions or anything that involved me touching my skin. When I did wear sunscreen, it was the aerosol type so I could just spray it on and not feel my body hair.

This section covers my specific skin condition, but the routine should work for most people. Generally - gentle exfoliation and good moisturizer is the key.

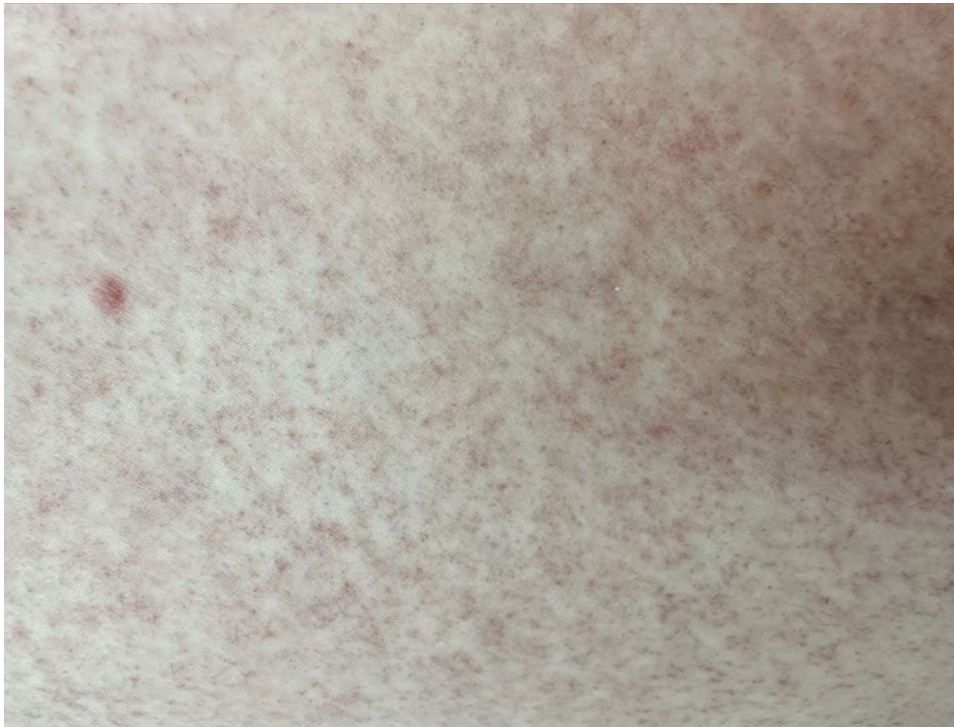
I have a skin condition called [keratosis pilaris](#) (KP). It doesn't impact my whole body, it's just my thighs and shins that get it badly, I really don't notice it anywhere else. This is a common skin disorder, specifically with pale skinned people like me. The root cause of the issue is excess keratin production in hair follicles that clog the pores.

These clogged pores cause itchy bumps and red skin. Dry weather (like winter here in Michigan) can make this worse. I was stuck in bed for weeks after my surgery, I didn't use lotion, I didn't exfoliate, my KP got bad.

To top it off - once I was finally able to exfoliate - I used an old loofah that I believe had bad bacteria in it. I was super frustrated with my skin; I read up on a product that was a chemical exfoliant that was supposed to help treat KP ([Amlactin](#)). I used the old loofah, I applied the Amlactin and this was my result (ow) 😞.



Close Up:



I spiraled pretty hard about this. I was afraid my skin would be ruined forever. I did more reading on skin care, specifically for skin like mine, and scheduled an appointment with my dermatologist. Unfortunately - they were unable to get me in for an appointment for over a week. I ended up not needing to go, these products and routine cleared me up.

I stopped using the Amlactin immediately, I threw out my gross old loofah and I bought a gentler silicone exfoliation scrubber ([Sud Scrub](#)).

These are the products I use:

- [Dove Sensitive Skin Liquid Soap](#)
- [CeraVe Moisturizing Cream](#)
- [Oil of Olay Complete Facial Moisturizer with SPF 40](#)

The cadence of when I exfoliate doesn't seem to be something I can schedule, some days my legs are clear, some days they'll be a little bumpier, so I'll exfoliate. I don't scrub crazy hard; I apply the soap and then just use the sud scrub. I'd say I exfoliate 3 to 5 times a week.

No matter if I exfoliate or not - I always use CeraVe immediately after I get out of the shower, usually the bathroom is still steamy, and it helps to lock the moisture into my skin. I did speak to my dermatologist – she recommended cortisone after I shave as well as my current routine.

I always use the Oil of Olay in the mornings before I head to work on my face and neck - sunblock is the best thing you can do to protect your skin.

I use broad spectrum SPF 50 on my exposed body parts only on days where I'm outside. I get whatever brand is on sale online.

The Sud Scrub + CeraVe has really cleared me up. I highly recommend all the products I listed, and I get nothing to recommend them. This is my skin all cleared up now:



INK!

Yesterday was a big day; I got the first two tattoos of my life!

One on my left inner forearm and one on my right inner forearm. The left one is the autism infinity loop in rainbow color. The right one is a supernova.

It was annoying, scratchy, sometimes painful but overall, it hurt less than I expected. I am fairly confident at this point in my life I have a higher pain tolerance than most people.

I'm basing this on the following reasons – I've had an appendectomy and I did not take pain meds, I stopped taking pain meds after my orchiectomy / scrotoectomy fairly quickly, within a week or so, I did not take pain meds after my wisdom teeth came out.

Some other reasons – I have had friends complain about laser hair removal on their face, it does not bother me, my tattoo artist told me for someone getting their first two tattoos and spending 3 to 4 hours in the chair I did quite well and I was easy to work on (I didn't need breaks really except to pee and I avoided wincing etc.) So, take my review of the discomfort with that in mind.

My worst pain was when she did the outline on my right arm, I would say at worst it was a 6-7 for me out of 10 and I just had to breathe through it, I did box breathing and also was tapping my feet together or I would tap my left thumb and random fingers together and count, anything to focus somewhere else on the body, it worked well.

I am very happy with the results and have another appointment on August 17, 2026. I'm getting a vision I had during my ayahuasca retreat on my upper arm.

My artist placed a second skin over both tattoos and instructed me to keep it on for 7 days if I can. It is already peeling around the edges; I plan to cut it and / or use medical tape to keep it down. There's clear fluid under the second skin but not a ton, I forgot the tattoos were there last night. I have zero discomfort from them at this point, and it has been about 20 hours since they were done.

The tattoos are bringing me quite a bit of euphoria, they are feminine in my opinion, I love the colors and the outward expression of who I am. Each one represents a part of me.

I was talking with a close friend recently and he asked me what my favorite animal was and I had to think about it. When I was a kid, I'd always say dogs but honestly, they aren't my favorite. I love dogs but when I think about it, I am most aligned with the octopus.

They can change shape, color and texture. They are excellent problem solvers, incredibly intelligent beings that can form deep bonds under the right circumstances or enjoy solitude; sort of like me.

I plan to get a large octopus on the side of my torso in 2027. The last planned addition to my tattoos will be a blue moon in the center of my chest but I plan to wait for my breasts to finish developing their natural shape.

A Short Story:

I sat down in the kitchen to get the glue residue off my arms from the second skin on my tattoos - coconut oil worked well.

"Can I touch it?" My son stood next to me with the chewy in his mouth as he gnawed.

"Sure, just be gentle, they are still healing." I smiled and put my arm out.

"Does it hurt?" He gently touched my left arm.

"Not really, I just hate the sticky glue feeling. It's a sensory thing; I'm autistic you know."

"I'M AUTISTIC TOO!" He exclaimed.

"Maybe, we don't know for sure yet, but we do know you have ADHD." I returned to removing the glue.

"Why did you get an 8 on your arm?" He asked as a glob of drool dripped from his mouth and onto the counter.

"It does look like an 8 but if you look at it the other way it's an infinity loop. It's actually the symbol for autism." I finished wiping my left arm clean and kept a thin layer of coconut oil on it.

“What’s the other one?” He started bouncing up and down with excitement. “Is it an exploding sun?”

“Kind of, when a massive star explodes, they are called supernovas, like me.” I smirked and kissed his head.

“If I touched a supernova, would I have to stay in bed with you and recover?”

“Absolutely, we’d have to snuggle until you felt better.” I began to work on my right arm.

He crouched and stuck his head in the empty space between my arm and my torso and hugged me.

“You look more like a mom.”

“I am your mom.” I teared up.

He sees me, and that might be enough.



1 Year Update 😊

It is surreal to be here for me. A year ago, I wasn't even sure I'd stay on HRT.

I hadn't come out yet, I had hardly any hair on my scalp, I was terrified of my breasts growing – mainly for being outed, my body hair was significantly thicker than I have now, I had not even started removing my facial hair, my eyebrows were still bushy caterpillars on my face, my face was fully masculine mode, I had very few friends and I did not know any transgender people.

My self-confidence was in the toilet.

Ten laser hair removal sessions on my face and neck along with two electrolysis sessions; my face is so ridiculously soft now.

Eyebrows threaded at a salon, and I've maintained their shape by plucking a few times a week.

At home IPL sessions on my entire body – I am 80+ treatments now. After a week of not shaving, you can barely see body hair except a few sparsely populated locations on my chest, which are fading.

I added microneedling to my hair recovery and I was told by a hair transplant surgeon my recovery is remarkable.

I have [broken brains](#) on the internet with photos of my recovery. I'm not even done yet; I still have at least twelve more months of filling in and hair strand thickening.

My perky tits are small, but they are mine – I love them.

I'm no longer afraid of growing breasts *because I came out socially and I exist in the world only as Nova now.*

I legally changed my name and I'm so much happier being called a name that fits who I am as a person and not the name that was assigned to me at birth.

HRT has changed my face shape significantly already. I know between now and a year from now these effects will compound and my face will only become more feminine. *I can't wait.*

I had my testicles and scrotum removed and my mental health has improved immensely from this. Having those spare parts removed from my body has made sex more enjoyable as well.

My suicidal ideations are the least they've been in my life, I am still struggling with accepting the reality that this change is real and permanent.

I am part of a transgender community on Discord, and I have tons of people that love me *for who I actually am and not a version of me that I pretended to be.*

I have friends that feel like family. I have made some transgender friends in real life as well.

I recently attended an [ayahuasca retreat](#) – I documented my mental health and healing in real time, I highly recommend reading it if you struggle with your own mental health as my hope is for people to learn from my journey.

I went as Nova; nails painted, feminine clothing, I was just myself. I made cis friends at that retreat, and I had multiple people tell me they were drawn to me because of my self-confidence.

Nobody has ever said that to me before in my life.

I got my first tattoos and I love them.

I am becoming the woman I have always been. I see her more and more in the mirror. I still have bad and good days.

I cry, I laugh, and I long for more changes. I am learning to stay in the present and not in my imagined scenarios – being present is one of the best gifts transitioning has given to me.

I am living my life, I am alive in my existence, and I cannot wait to see what the next year brings. *I am no longer passively waiting for death to come.*

Labs:

Estradiol (E2)

 [View trends](#)

Normal value: See Comment pg/mL

Value **251**

Testosterone, Total MS

 [View trends](#)

Normal value: 2 - 45 ng/dL

Value **23**

Dihydrotestosterone

 [View trends](#)

Normal value: < OR = 20 ng/dL

Value **10**

Medications:

- Estradiol Valerate 4mg Subcutaneous Injection 1x a week
- Oral Finasteride 1mg 1x a day
- 200mg Micronized Progesterone (rectally administered) 1x a day
- 5% Topical Minoxidil 2x per day

Post orchiectomy I no longer need spironolactone and I'm quite happy with my testosterone and dihydrotestosterone levels. I've toyed with the idea of dropping finasteride – for now I have decided to stay on it. I plan to stay on it for ~2-3 years and allow my hair to get fully established before attempting to come off of it.

Breast Update (NSFW):

[Nova's Breast Development](#)

Hair Recovery Update:

[Nova's Hair Regrowth Images \(PreHRT → Current\)](#)

Support Me

This document will always be free - really it just costs me my time and energy which I am happy to dedicate to our community. I have spent hundreds of hours reading, researching and writing this.

Any donation is greatly appreciated and not expected. I truly hope this work helps our community around the world, especially in places where resources are restricted and education is lacking.

As I said at the start of this guide - if you ever have any direct questions, comments or suggestions - please email me directly and I'll do my best to respond as I am able to. I check the email account a few times a month: buildingnova@proton.me

Ko-Fi Tip Link: <https://ko-fi.com/novarain21995>

If you're struggling, I know how hard this is, I see you and you matter. Don't give up. Be kind to yourself and surround yourself with people that accept you, stop trying to make other people get it - they either will in their own time or they aren't worth yours.

With Love & Radical Acceptance,

~ Nova