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Issue 43 FTM NEWSLETTER December 1998

The Chest Issue!

Soul and Body

by Sean Gardner

How do you describe what being transgendered feels like? One of the best images I ever came up with is this: Through much of my life I felt like just a head. I loved my brain. I relished thinking and reading and writing. I felt at home there. But it was as if my body didn't even exist. If I thought of it at all, I hated it, so I mostly tried not to think of it.

I avoided most forms of exercise because they made me too aware of my body, the effort to move it around, the sweat, the pounding of my heart, the pain in my muscles. I anesthetized myself with food, depending on that dull, heavy feeling to keep me unaware of my physical self. Even using my voice, speaking or singing, was painful because the sound that came out was never the rich, low sound I expected.

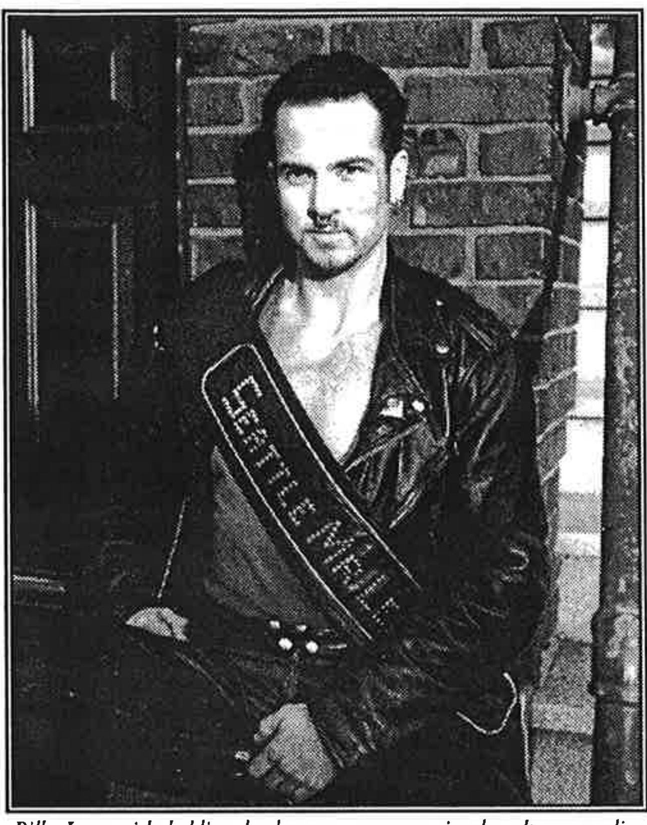
So the most startling part of this whole metamorphosis has been feeling like a whole person. Suddenly I have this living, breathing body that is more and more a part of me. My FTM friends and I remain fixated on the physical. We are worse than a whole herd of self-obsessed, bragging, pubescent boys. Our second puberty is a miracle to us, all the changes we thought would happen to our bodies in our early teens now finally, magically, happening. Every facial hair is cherished and celebrated. We laugh with self-conscious joy every time our voices break or crack or go careening wildly from octave to octave. Muscles appear. Bellies get furry. Skin breaks out. The libido erupts. The whole awkward process is quite adorable.

In the last few weeks I've realized again how important physicality has become for me and what a novelty it still is to finally love my body. I'd been losing weight and lifting weights, getting ready for the final stage of my top surgery which was scheduled for August 19 in Montreal. Deltoids! I had deltoids. And these cool, muscley things in my thighs. And pecs bulging above the remaining bulges of my emptied but still visible breasts. Every week I cut the time it took me to walk to work, my body carrying me effortlessly along the Santa Fe streets. I ran up and down the stairs a dozen times a day, only the slightest jiggling reminding me of my feminine past.

Dr. Menard performed the surgery under local anesthetic. The operation was supposed to last about two hours, but ended up going for three and a half. There were complications. A cyst that had formed after the last surgery had to be removed. A "bleeder" blood vessel opened up that wasn't particularly interested in being cauterized. But I got through it and got home. I hated having to wear the binder again, especially having to wear it day and night after five months of near total freedom. I stretched the brief showering period each morning to stare at my chest in the mirror. It was swollen and massively bruised. The right side looked hideous; the left side looked even worse. It hurt a lot.

The left side did turn out to be worse. It swelled and swelled, the skin stretched glossy and black. After almost two weeks of being macho and toughing it out, I went to see my local physician. Dr. Wright ➢6

More chest surgery articles—see pages 6–7



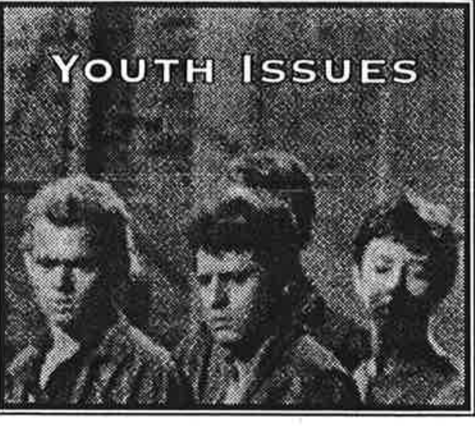
Billy Lane, title-holding leatherman, competes in the ultra-masculine world of International Mr. Leather (page 8). *Photo: James Loewen*

Chocolate Cheesecake Conchita Rodriguez Johnson—a.k.a. FTM Int'l Vice President Yoseñio V. Lewis—was official Festival Diva at the second annual Tranny Fest on Nov. 21. S.F. Mayor Willie Brown proclaimed the day "Transgender/Transgenre Cinema Day" in honor of the festival. More Tranny Fest photos inside...

True Spirit '99! (pg. 17) / FTM Conference in L.A. next fall (pg. 2) / March '99 events (pg. 20)

Transsexual Teens

Two Dutch Studies by Kevin Horwitz



Thanks to Diane Ellaborn, LICSW, for providing these studies to FTM.—Jed

So many books and articles have been written lately on the topic of transsexualism that it begins to feel like an information overload. However, it seems to me that the burgeoning TS literature shelves represent the strength of our movement in the 1990s. At no time in history (that we know of) has so much information been amassed and disseminated on the topic of gender identity. Particularly useful is literature written by transsexuals, because of the unique perspective and insight derived from direct experience. However, some interesting work has come from the medical community as well—even (surprise, surprise) research studies conducted by clinical psychologists!

One such interesting study out of the Netherlands, "Sex Reassignment of Adolescent Transsexuals: A Follow-up Study," (Peggy T. Cohen-Kettenis, Ph.D., and Stephanie H.M. van Goozen, Ph.D., *American Academy of Child and Adolescent Psychiatry*, 36:2, February 1997) offers new insights into the possibility of transitioning during adolescence. The study is carefully plotted out, assessing fifteen FTMs and seven MTFs who were the first adolescents in treatment at the University of Amsterdam Free Clinic (where 95% of Dutch transsexuals go for treatment). The purpose of the study is to explore the positives and negatives of starting transition before the onset of puberty. Authors Cohen-Kettenis and van Goozen do a good job of carefully differentiating between adolescent and adult gender identity issues. They point to research showing a low percentage of adolescents with gender identity issues who actually pursue SRS as adults. They also mention the difficulty of getting parental consent, the importance of stability, and the stipulation that only transsexuals who score high on gender dysphoria assessments were allowed to progress to the second phase of the treatment plan.

Lynne Chan's Faggot/Cholo *was just one of the gender-bending flicks in twelve hours of films and videos at Tranny Fest on November 21.*

Within these rather stringent guidelines, however, the positives of early hormone treatment appear to be very strong. MTFs were able to pass much more easily by preventing their voices from dropping early on, and by getting only a little facial hair. FTMs benefited from slowed breast development and early masculinization. The emotional relief in moving ahead quickly with hormone treatment and SRS was seen as a big plus for both groups.

Apparently, the groups were first placed on a regime of partial hormonal treatment, which blocked effects of innate hormones without creating irreversible changes. Although the study did not mention dosages or types of hormones used, it implied that suitably low doses of estrogen or testosterone were administered. Then, after cross-living for a period of time, and passing the "real life test," the adolescents were allowed to receive higher doses of hormones. SRS also became a possibility at this time, although most FTMs opted to wait longer for lower surgery.

Unfortunately, not much was mentioned specifically about the extent of pre-pubescent physical change. It seems likely that FTMs got a more dramatic masculinization from taking testosterone before puberty. It would be interesting to find out if starting hormones before the menstrual cycle would increase muscle mass or increase the chances of penile growth. Also, a comparison of MTF and FTM bone/muscle/hair growth after hormones would've added a useful element to the study.

Although the authors referred to FTMs as having an easier time after transition than MTFs, they did not mention specific reasons for this difference. They did say that MTFs were more likely to benefit from early hormonal treatment than FTMs, particularly because of an improved vocal quality. Of the problems affecting FTMs, living without a normal-size penis seemed high on the list, and this cannot be (fully) corrected with early hormone treatment. Starting early is, nevertheless, an advantage to those who are absolutely sure this is what they want. In spite of the surgical snafus, and taking into account other life problems that aren't specifically related to gender, the adolescent transsexual group seemed well-adjusted and comfortable, and all said that they would do it again.

The study shows fairly conclusively the great potential for early treatment, particularly for MTFs. It seems as though those who are in a position to actually get hormones and surgery in their teens are relatively few in number. Parental consent is necessary, and the guidelines are more defined than for adults. But this is a good start, and maybe it will open up the possibility of early transition to an increasingly large number of youth in the future.

A second study, "Psychological Functioning of Adolescent Transsexuals: Personality and Psychopathology" (Lee Cohen, Corine de Ruiter, Heleen Ringelberg and Peggy T. Cohen-Kettenis, *Journal of Clinical Psychology*, 53:2, 1997), seems less engaging, perhaps because it wastes time trying to disprove the obsolete concept that transsexuals are mentally ill. Specifically, this study is devoted to disproving a 1984 compilation of research (Lothstein, L.M., "Psychological testing with transsexuals: A 30-year review," *Journal of Personality Assessment*, 48, 1984), which indicates that psychopathology is an underlying pattern in transsexuals. The focus here is also on adolescent transsexuals receiving treatment at the University of Amsterdam Free Clinic.

The study compares a group of adolescent transsexuals with a group of nontranssexual psychiatric outpatients, and uses a control group of first-year university students as a "normative" sample. The object is to determine whether or not psychopathology is a requirement for transsexualism. The study proves that the transsexual group is not primarily "ill," and uses Rorschach as well as a battery of Dutch personality tests in order to do this. The test results are analyzed, compared, and charted in highly technical jargon. While it is good to know that, according to this study, our collective elevator does go to the top floor, the question is why does one study contradict the others? Isn't it possible to "prove" your own subjective hypothesis when appearing to offer objective data? And why is it necessary to spend so much time proving or disproving the "illness" factor of transsexualism? Time might be better spent on researching improvements that will directly affect transsexual lives. However, perhaps the study will help offset some of the damage done by Lothstein and others, whose research has gone unchallenged for a number of years.

Chest Surgery 101—AN OVERVIEW OF THE ISSUES by Dylan McClintock

Most of us would not ordinarily be candidates for plastic surgery, barring some unfortunate accident that required reconstructive surgery. And our frequently awkward dealings with health care practitioners are compounded by the fact that we're dealing with a body/identity issue that is painful to us and perhaps out of the norm for them. This can make it difficult to get the care we need and deserve.

There are several well-known surgeons we tend to gravitate toward; we lean towards them partly because their experience with people like us lessens the awkward discussion of what we want and why. They also have some visible track record of success. Every one of these surgeons has his/her cheerleaders (usually their patients) and most have at least a few detractors as well (typically those who chose to go elsewhere). Most of the surgeons working in our community have done good work for many of their patients and ultimately, most of us are so relieved to get rid of our breasts that we think the surgeon did a great job even when it's far from perfect.

For many years there were essentially two approaches to chest reduction and reconstruction: the double-incision and the keyhole [see page 7 for more detail]. The keyhole was generally performed only on very small-breasted individuals because this technique removed little or no skin and the nipple-areola complex was not moved. Anyone with larger or more pendulous breasts—anything more than an A-cup with no droop—got the double-incision with nipple/areolas reduced in size and grafted in proper position.

A note here about cup size: Many of us avoid bras and the lingerie department at all costs and don't know what our cup size might be now except too big! Yet, there's often talk of cup size when discussing these surgical options. Two elements play a part in the discussion of size relative to the surgeries: mass and length. The A-cup appropriate for the keyhole would be that "fit-in-a-champagne-glass" size—and I don't mean a flute glass!

In recent years, surgeons have discovered that skin is elastic enough to "shrink to fit" if given encouragement. It may not shrink as much as desired, but it can shrink a lot more than surgeons once thought. This, along with advances in liposuction technology, prompted new thinking about breast reduction and made keyhole-type small-incision methods accessible to patients with larger and more pendulous breasts—though still not widely recommended for those larger than about a C-cup, which means from about the mass of a large orange to a small grapefruit.

For a while, there was talk that this new development would eliminate the old double-incision method—but the reality is that double-incision may still be the way to go for some people. Some of the surgeons are expanding double-incision skills to include the new methodology, which generally is called lipo/excision, or modified keyhole.

We each choose our surgeon and surgical technique based on our own particular sets of criteria and with our own Perfect Male Chest fantasies in our hearts. For some folks, it is just enough to get it done so they can get on with their lives and hope that their chest hair fills in to cover what scarring they might have. For others, the desire to retain nipple sensitivity or to have less scarring is more important, so they are willing to go to extra effort to ensure these results. For some, there is very little choice because of the type of breasts they have.

Some of us are lucky (?!) enough to be very large and can get insurance coverage for a reduction; if the doctors available are willing, the reduction can be complete, although these doctors are rarely "artists." If handled very carefully, this can be a positive first step with revisions to tidy things up later as needed.

For very large individuals who have the desire for less scarring and more sensitivity, one approach might be to have a significant, not total, reduction with the lipo/excision technique; then allow the skin to shrink up, and finally have the procedure again a year or so later when the skin will likely shrink up more. At the point of the second procedure, even if a double incision is necessary, the incisions wouldn't need to be as large and thus the scars would be smaller. Ideally, the first procedure >13

SOUL AND BODY from page 1

drained a lot of blood out of the left side and told me to keep wearing the binder. He had to drain my chest again a few days later. The swelling was a nightmare. All my life the one thing I had most dreamed of was a flat chest. And now, after the pain and expense of two surgeries, instead of finally achieving my life's dream I was left with a chest that seemed less flat than ever before. It felt like yet another betrayal in a lifetime of betrayals. It felt like the universe saying, yet again, "No. You can never be who you really are."

Dr. Wright drained my chest a third time and again I had to endure the pain of the pressure bandage and the day-and-night constriction of the binder. But as of today, I think this story is going to have a happy ending. This is my second day of being free of tape and the binder. My chest is staying flat. No more blood is accumulating in the cavity. The pain has mostly given way to an occasional twinge and fierce itching around the stitches. A little blond crewcut is coming in where I shaved my chest for the surgery. I'm not even thinking of doing push-ups yet—well, not too much—but at least I'm able to move and walk again in relative comfort.

In the past I often ignored the discomforts of my body. My brain and spirit soared on in spite of what was happening below my neck. But now I find that I'm a whole human being, and the recent struggles of my body pulled my spirit way down as well. As I'm healing, I feel that adolescent joy coming back, a joy that fills me from toe to head, soul and body. Who ever thought that being me could feel this good?

Next issue: more on chest surgery, including Belgian techniques!

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LIPO/EXCISION: One Approach to FTM Chest Surgery by Russell Hilkene

MEDICAL ISSUES

Double-mastectomy options for FTMs fall into two basic, broad categories: double-incision and liposuction-excision. I'll refer to liposuction-excision as "lipo/excision" for short—it has also been called "modified keyhole." To incise is to cut into; to excise is to remove by cutting out, or to remove surgically. The difference between the two methods has to do with the kind of incision made, and the amount and method of tissue excision. Within each surgical category are a number of variations. In the U.S., both methods are almost always performed under general anesthesia on an outpatient basis (no overnight hospital stay). *[In Belgium, a three- to four-day hospital stay is standard.—Ed.]*

While this article focuses on lipo/excision methods, I first want to briefly discuss the more traditional double-incision techniques to give a basis of comparison. The double-incision method involves what's called full male chest reconstruction: the surgeon first makes large incisions, usually in a horizontal line across the base of the breasts and across the breasts themselves, removing the mammary gland and the vast majority of the fatty breast tissue. The remaining fatty tissue is then contoured by the surgeon—"feathered out"—to produce the appearance of "pecs" (chest or pectoral musculature) immediately after surgery. The nipple and areola are removed in the process, resized, and grafted back onto the chest.

Lipo/excision, the second approach to surgery, is a broad category that encompasses several options: liposuction alone, excision alone, or lipo and excision in combination. These procedures can be single- or multi-staged. In the case of a multi-staged procedure, the incisions may be made in the first stage and the tissue removal left for the second stage.

A key question is where are incisions made—where does the surgeon actually cut open the skin—and how big are the incisions? Incisions can be made in the armpit (in the case of lipo only), in a crescent shape at the bottom of the areola (the pigmented area surrounding the nipple), or around or across the areola. Incisions made in the areola, if it is pink as is the case with lighter-skinned people, will generally heal almost imperceptibly. In the double-incision method, much larger incisions are made in the crease of the pectoral muscle. The size and shape of the incisions that must be made with either method will be determined largely by the size and shape of the breast (volume of tissue and amount of droop), and the degree of elasticity in the skin.

The other key question is how much breast tissue does the surgeon remove? In the case of lipo/excision, nearly all of this tissue is removed. But even though with this method you emerge from surgery with a flat-as-a-pancake chest, not absolutely all of the breast tissue is removed. Some tissue remains there, meaning that a possible risk of breast cancer remains—albeit a small one. This is true regardless of the surgical method undergone.

The nipple is a great deal more likely to retain sensation with the lipo/excision than with double-incision. Necrosis (death of tissue) of the nipple is also unlikely, and scars tend to be smaller and less visible.

A note about contouring: the post-surgical appearance with lipo- and/or excision is a very flat chest. Re-contouring of the chest can take place with the other major surgical method, double-incision, because the surgeon makes much larger incisions. This opens the chest to a much greater extent, allowing more access to the fatty tissue, and allows for the "sculpting" of the post-surgical appearance. Lipo/excision methods, with their smaller incisions and more exclusive focus on tissue removal, don't allow the same opportunities for positioning and re-shaping tissue. In the case of lipo/excision, what will affect the post-surgical result is the surgeon's degree of artfulness and skill: the fatty tissue must be removed in such a way as to avoid contour deformities (valleys or lumps), and the remaining tissue feathered/sculpted/contouring to produce a smooth surface. Symmetry between the two sides is also important.

To wrap up, these two questions, where incisions are made and in what

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A View from the O.R. by Paula-Jo Husack, M.A., M.F.C.C

Paula-Jo Husack is a therapist in the San Francisco Bay Area who has contributed this unique operating-room perspective on a Montreal chest surgery.-Ed.

Dr. Yvon Menard is a plastic and reconstructive surgeon who has been performing female-to-male and male-to-female gender reassignment surgeries since 1971—back when he was a resident and asked to assist senior physician Dr. Claude Dupont with a male-to-female penile inversion procedure. Canada has been lengths ahead of U.S. insurance companies in its health care system's approval of such surgeries. But back then, when Dr. Menard first scrubbed for the procedure at the University of Montreal's Notre Dame Hospital, the gender reassignment surgery (GRS) was called the "first" within Montreal's health care system. Previous FTM and MTF surgeries there were not documented. Physicians were not applauded by colleagues or others for using their skills on behalf of the transgender community. Dr. Menard describes the difficulty in finding a hospital that would accept such a medical procedure within its walls: Catholicism is a huge influence in the society, and Catholic monies owned and maintained the hospitals. Through the humanitarian efforts and advocacy of many, this now well-documented surgery came to be.

From that time on, Dr. Menard has been interested in the art, science, and advocacy of such surgeries. As he sees it, the influence and implications on the individual's quest for internal and external unity and harmony ultimately became his, too. Dr. Menard has taught and lectured worldwide, training surgeons in GRS over the last 15 years—four from the U.S., one from Japan, and three others from Quebec.

Taking a taxi across the beautiful international city of Montreal, I passed through residential neighborhoods where some children were off to school with books in tow. I noticed other children playing in very gender-specific ways. I reflected on my clients' stories over the past eleven years. They had painfully recounted their discomfort and confusion in similar childhood scenes. The commute traffic was dental-floss thin by Bay Area standards. It was 7 a.m.

The taxi driver stopped the meter. We arrived at Chirurgie Esthetique St. Joseph with its non-descript facade, where Dr. Menard works with colleague Dr. Pierre Brassard. No neon sign with arrow blinked "Transgender Surgeries—Bargain Prices." But pricing in Canada for medical service is in fact much different than here in the U.S., and tends to be much lower. One designated price is given for pre-surgery care, the surgery itself, and the post-operative care; the one price covers everything. Because of socialized medicine, medical costs are not inflated as they are here in the United States. In addition the current exchange rate means the U.S. dollar buys much more. Some approximate prices (in U.S. dollars):

MTF Gender Reassignment Surgery
Canada: $11,000 U.S.: $17,000

FTM Phalloplasty
Canada: $60,000 U.S.: $100,000

FTM Metaoidioplasty
Canada: $9,000 U.S.: $20,000

FTM Mastectomy
Canada: $4,000 U.S. : $6,000

Most U.S. plastic surgeons do very little GRS. It's often a very small

➢13

Man Among Men at Mr. Leather by Billy Lane

Editor's note: Men's leather competitions test one's ability to pull off an ultra-masculine look and aesthetic; Billy Lane has done so with wild success. Read on...

In 1997 I attended the International Mr. Leather (IML) contest, the most prestigious title in the leather world. The winner represents alternative leather, S/M (sadomasochistic), and fetish sexualities to the public in the coming year—worldwide. For a gay leatherman like me, IML is also an opportunity to see friends from all over the world, shop at the biggest and best leather market, and cruise several thousand hot guys.

I, however, had another mission: to meet as many members as I could of one particular organization, a very old and venerable club (not affiliated with IML). They were soon going to be deciding whether or not to allow FTMs at their private functions. Over the course of the IML weekend, I was introduced to several key men in this club who were not only friendly to me, but happy to hear that I would be attending a party in the near future—that is, until they discovered that I was an FTM. Some suggested that I attend but not divulge that I was transsexual. Others became visibly upset and excused themselves politely from the conversation. More often than not, a wall was erected—a wall that nobody saw but everybody felt.

As a member of the leather community for nine years, I felt sure that these men would meet, discuss the situation, and come to the rational and logical conclusion that if an FTM identified as a gay man, then he would be welcome—as would be all other gay leathermen. I thought that all they needed was a face to go with a concept: "This is what a gay FTM leatherman looks like." I was wrong.

Like most of us, I had walked a long and difficult path to manhood and I was angry that a small group of men had decided that I wasn't "man enough" for their events. After discussing the situation with a few close friends, FTM and non-FTM alike, I decided that maybe if I did this "education" on a larger scale it would be more effective. The idea that I would run for International Mr. Leather in 1998 was born.

Almost every one of the men who compete at IML has first won a contest in his own city or state, at a leather bar or in affiliation with a leather club. I decided that I would compete for Seattle Mr. Leather. The current titleholder was a good friend, and very encouraging of my efforts. As a long-time member of the organization that sponsors our local contest, I knew that I would be happy to fulfill my many obligations and responsibilities as a titleholder and would be able to work with the board of directors as well. [*Leather titleholders are busy people: community figures who officiate at numerous events, organize fundraisers, and generally work to support the leather world and the broader queer community.—Ed.*]

Billy Lane (center) competes at the International Mr. Leather contest. Photo: James Loewen

Each Seattle Mr. Leather contestant is judged on the following categories: pre-contest interview, speech, leather image, surprise question, jockstrap, and fantasy (a kind of skit involving S/M and/or leather). I prepared quite extensively for this competition. I met with several of the older members of the Seattle leather community, and learned of the community's history prior to my arrival in 1992. I also studied the many issues facing the community. I wrote and memorized my two-minute speech. In addition, I wrote and produced a five-minute fantasy. Oh, and I worked out a lot! If I was going to be prancing around almost naked in front of a bunch of people, I wanted to look as good as I could!

I had a good time competing and enjoyed being in the spotlight more than I had thought I would. When I won, the leathermen (and women) in Seattle embraced me as their male leather leader for the year without regard to my being FTM. They believed, as I do, that it doesn't matter how you became a man. This is also the stated policy of IML. After I won my title as Seattle Mr. Leather 1998, I sent a request for an application to the IML offices, completed it and mailed it back.

After a little discussion about my "legal" status as male, I was accepted as a contestant and began the preparations for that contest. I broadened the scope of my studies to include more international leather history as well as international community political issues. In addition I worked out even more, drafted several possible speeches and instead of preparing a fantasy (not a requirement for IML), I prepared an extensive wardrobe for the various competitive events of the weekend. As the contest approached, I was nervous about how I would be received by the international leather community. I had heard some negative things through the grapevine and was steeling myself for some unpleasantness.

To this day, I am delighted that none of my fears were realized. The people who knew me were incredibly supportive and reminded me that I wasn't given my place on that stage with those 61 other leathermen but that I had earned it. The others who didn't know me (including the other contestants with whom I had been sharing dressing rooms for the past three days) had no idea that I was FTM until I announced it at the beginning of my speech. And that announcement was greeted with a standing ovation. I still get choked up when I remember that moment.

Although I didn't win (I am proud to have placed tenth out of 62 contestants), I have been interviewed for publications and radio shows, and spoken to other groups about my experience. This summer, I was invited to and attended two other leathermen's functions similar to the one that kicked off this chain of events. To this date, I am unaware of any negative repercussions. I have traveled all over the country representing Seattle as Seattle Mr. Leather 1998, and have tried to put a face on gay FTM leathermen.

I have earned my manhood in a way that non-transsexual men cannot fully comprehend. As a leatherman, I have the right to walk where other leathermen walk. I am proud to be a gay leatherman and I am equally proud to be an FTM. I am not ashamed and will not hide aspects of my past or present because they make others uncomfortable. I will not accept the limitations of ignorance.

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The Truth About a Woman's Body

by Susan Williamson and Rachel Nowak

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Thanks to Julian for pointing out this article and its relevance to FTM genital surgery.—Ed.

Penis envy may be a thing of the past. The clitoris, it turns out, is no "little hill" as its derivation from the Greek kleitoris implies. Instead, it extends deep into the body, with a total size at least twice as large as most anatomy texts show, and tens of times larger than the average person realizes, according to new studies by Helen O'Connell, a urology surgeon at the Royal Melbourne Hospital in Melbourne.

The clitoris earned its Lilliputian reputation, in part, because much of its elaborate 3D structure is on the inside, hidden by fat and bone—an anatomical smoke screen that has helped fool lay people and experts alike. "There is a lot of erectile tissue down there that is not drawn in any anatomy textbooks...." says O'Connell. "Just because you can't see the rest does not mean it is not there."

Nor does it mean it is not important. O'Connell's detailed descriptions of female sexual anatomy could help prevent women who have pelvic operations from ending up with impaired sexual function.

"The dissections are wonderful," says Cindy Amundsen, a gynecologist at the University of Houston in Texas. "The erectile tissue is closer to the urethra and encompasses a far larger area of the anterior vaginal wall than most people thought."

O'Connell first realized just how little was known about female sexual anatomy when she was studying for her surgical exams in the late 1980s. Even nowadays, she says, textbooks routinely recycle decades-old, inaccurate illustrations of female sex organs, or omit diagrams altogether....

And none of them—not even the anatomists' bible, Gray's Anatomy—describe in detail the nerves and blood vessels that go to the clitoris. "For a surgeon," says O'Connell, "that's unacceptable."

Details, details

The study of men's sexual anatomy has fared slightly better. Back in the 1970s, modern microdissection techniques were brought to bear on the nerves and blood vessels that supply the penis. The information gleaned helped spawn "nerve sparing" surgery that reduces the risk of impotence following operations for diseases like prostate or bladder cancer. Helped by John Hutson, an expert on pediatric genital reconstruction at the University of Melbourne, O'Connell hoped to do the same for women's sexual anatomy and surgery. But as she started to map

A new anatomical study shows there is more to the clitoris than anyone ever thought

out the nerves, she realized it wasn't just the fine detail that was missing from the textbook picture of the clitoris. "I thought, Damn! I'm not sure the gross anatomy is correct, either," she says.

Since then O'Connell and her assistant Robert Plenter have dissected the bodies of 10 adult women, relying heavily on photography to capture the 3D structure of the clitoris. She has described in detail the dorsal nerves (much bigger than in the anatomy books) that are thought to carry the sensory information on the first step of its journey to the brain, as well as the cavernosal nerves that probably control the smooth muscles of the clitoris, and the size of its blood vessels, enabling it to swell during sex. She has also concluded that the clitoris as described in most textbooks is a mere shadow of its real self.

According to O'Connell's dissections, the external tip of the clitoris, or glans, connects on the inside to a pyramid-shaped mass of erectile tissue, far larger than previously described. The "body" of the clitoris, which connects to the glans, is about as big as the first joint of your thumb. It has two arms up to nine centimeters long [over three and a half inches] that flare backwards into the body, lying just a few millimeters from the ends of the muscles that run up the inside of the thigh. Also extending from the body of the clitoris, and filling the space between its arm, are two bulbs, one on each side of the vaginal cavity.

The bulbs do, in fact, make an appearance in at least some textbooks, but few recognize them as part of the clitoris. Indeed, they are usually referred to as the "bulbs of the vestibule"—the vestibule being the vagina. To make their origins clearer, O'Connell wants to rename them the "bulbs of the clitoris." The penis also has bulbs of erectile tissue at its root that extend into the body cavity, but "the bulbs are more prominent in females," she says.

Gray's Anatomy and other texts also claim that the clitoris, unlike the penis, is entirely separate from the urethra, the tube that connects the bladder to the outside. O'Connell disagrees. According to her dissections, the clitoris surrounds the urethra on three sides, while the fourth is embedded in the front wall of the vagina.

That layout makes perfect sense if you think about....[the fact that] the clitoris helps squeeze the urethra shut during intercourse, perhaps stopping bacteria making their way up to the bladder and causing an infection. The engorged bulbs of the clitoris may also help hold the walls of the vagina rigid, aiding penetration.

Understanding the clitoris's design could also help protect women's ability to have good sex. According to O'Connell's ➢12

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Submission deadlines are the 15th of the month before release.

LIPO/EXCISION from page 7

size and shape, along with the surgeon's skill, will impact a number of other factors: general appearance, scarring, nipple sensation, possibly the recovery process and length, and whether your surgical experience is ultimately single- or multi-staged.

To sum up more specific features of the particular options within the broad category of lipo/excision:

Liposuction Only

- Incisions can be made in the armpit and/or the areola.
- Appropriate only for those starting with very, very little breast tissue
- "Cannulae" are used to grind and cut up the breast tissue (the glandular component being very tough), which is then aspirated (vacuum-suctioned) out.
- Costs less; nipple sensation not affected if incisions are made in armpit only; sensation affected to some extent, which varies, if incisions are made in areola; no visible scarring.

Excision Alone or with Liposuction

- Can be single-stage (for small to small-medium breasts) or multi-stage (for medium to large breasts).
- Incisions are made in the areolar region: across or around, or in a crescent shape in the lower portion Surgeon may or may not use lipo along with the excising (cutting out of) tissue.

In multi-stage procedures, residual breast tissue and excess skin remain following the initial procedure. Think of the skin as a container for the tissue. When a good deal of what's inside the container is removed, extra skin is left behind. One of the amazing things about skin is that it both stretches and shrinks up. The extra (or, in surgical parlance, "redundant") skin will retract/shrink up to a great extent on its own with time; give it six months or possibly even a year. Wearing a compression garment during this period will do a lot to assist in this process and improve the ultimate result. Lifting weights will also help by bulking up the muscle in the area—which takes up some of the slack—and by encouraging blood flow into the area, which is so vital to healing.

At this point you're flat-chested and can wear tight-fitting clothes with a big ol' grin on your face. For those who wish a more aesthetically-friendly clothing-free appearance than initial surgical intervention may have provided, surgical revision can be performed following the waiting period to take up the excess skin, and also to remove any residual breast tissue and/or correct any contour deformities. This second stage will likely involve small, visible scars (depending on where incisions need to be made), and may be able to be performed under local anesthesia. A product called Scargo (containing olive and peanut oils, lanolin, camphor and yellow beeswax) will help minimize these. Silicone gel, or silicone sheets from companies such as Allenderm, can also be used (though the sheets may be cumbersome). For those with darker skin, I've heard good things about a silicone gel product called Kelocote.

Nipple sensation will be affected with the multi-stage route. The amount and type varies and is difficult to predict. Talk with others who've undergone similar procedures, and/or gone to the same surgeon. At least some of what's lost usually returns over time. Again, this varies and is difficult to predict.

It should be emphasized that the number of revisions required—and ultimate success—of the multi-stage route depends upon a variety of factors, primarily the size and shape of the original breast and degree of elasticity of the skin. These factors also include the surgeon's skill, aftercare, and what is desirable or acceptable to you.

Christopher Lee directs Buck Davis and Angel in Alley of the Tranny Boys, *one of the films at this year's Tranny Fest. Photo: P. Wise*

TRUTH ABOUT BODIES from page 9

descriptions, the cavernosal nerves travel alongside the walls of the uterus, vagina, bladder and urethra. And although practically nothing is known about how operations for, say, incontinence or bladder cancer or hysterectomies affect sexual function, the positions of the nerves suggest that it could be at risk. "Lots of operations involve dissections around the urethra. That could affect patients' sexual function," says Amundsen.

Just as doctors routinely ask men who have had prostate surgery about their erections, they should ask female patients who have had comparable operations about any changes in their sexual function, she says.

Now the nerves' pathways are known, it should also be possible to modify at least some operations to reduce the risk of sexual dysfunction. "There have been tons of studies about how to prevent impotence after radical prostectomy," says John DeLancey, an expert on gynecological anatomy at the University of Michigan in Ann Arbor. Anatomically speaking, a radical hysterectomy for cancer of the cervix is similar to a radical prostectomy. "Given this beautifully detailed knowledge of the interrelationship between the female urethra and sexual organs," it should be possible to develop similar nerve-sparing operations for women, he says.

Victorian prudes

So why have anatomists routinely got the clitoris wrong? Part of the problem may be a Victorian prudishness about examining women's sexual organs in detail. Then there's the fact that most of the clitoris is hidden inside, shielded by lots of fat and the arch of the pubic bone. Another obstacle to accuracy is that anatomical studies are usually done on the bodies of women in their 80s and 90s. Just as muscle and bone wither with age, so does the mass of erectile tissue in the clitoris. In men, shrinking erectile tissue is less of a problem, at least for the anatomist. More men die in accidents, so young bodies routinely find their way to the dissection table. And as the erectile tissue of the penis is mainly on the outside in one compact piece, it's easier to spot.

O'Connell had two cadavers of women under forty. The older bodies had much smaller clitorises (although still far larger than in the textbooks), but once O'Connell had identified the erectile tissue in the younger women it was easy to find in the older ones. "We lucked out," she says, "one of our cadavers was 36 years old. She looked like an Amazon."

O'Connell is now studying the cellular structure of the clitoris, urethra and vagina. Amundsen, meanwhile, suggests another topic for research: "We have Viagra. We know anatomically what's going on [in the clitoris]. We need some studies on erectile dysfunction in women."

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CHEST SURGERY 101 from page 6

would be done prior to hormone therapy, as there is a theory that when testosterone thickens the skin, it affects its elasticity and thus its potential to shrink up.

Lipo/excision is not necessarily much less expensive than double-incision, especially not when there are two procedures. With lipo/excision the time in the operating room is longer, as is the time under anesthesia, since the surgeon is working through much smaller openings to remove the tissue.

Some things that should be considered when making a decision like this:

- What size and shape are your breasts to start with? If small enough for a keyhole, the remaining issues are probably moot. If very large, some of the remaining issues will not apply.
- How important is nipple sensation? If the breasts are very large, the connective tissue leading to the nipple/areola is just too long to compress, and isn't always feasible to maintain sensation.
- How important is nipple/areola size and appearance? For some, it is critical that they be reduced, while others like them as they are.
- How important is appearance, i.e., a "sculpted" masculine chest [see page 7] vs. a basic mastectomy? Fewer surgeons are actually sculpting the chest these days, but the only way to accomplish this is the double-incision method.
- How important is the presence or lack of scars?
- How does your skin scar—e.g., do you form keloids (more common for darker-skinned people)?
- Can you wait a year or more for the final result or do you need immediate completion/gratification?
- Are you willing to do what it takes to get the results you want? With the lipo/excision method, it's important to restrain the skin as it shrinks and to assist it to adhere again to the chest wall by wearing a binder for several weeks—generally twice as long as is necessary with double-incision, and especially important if breasts were on the large side.
- Can you travel for surgery or do you need to be close to home?
- What are your financial circumstances?

The bottom line is that we have our fantasies about how our post-surgical chest will look, we make our decisions, and then we deal with the outcome—which in all honesty is almost never what we envision. Our chests are just not going to look like typical male chests right away. They're usually much flatter post-surgery, because we haven't had years of muscle development. We've also had fat removed. And, of course, there will be some evidence of the surgery in the form of scars or asymmetrical positioning or droop or sag.

So, once we've healed, we start thinking about fixing what doesn't look right. Most of us go back to our surgeons for scar revision. Surgery, especially plastic surgery, is not an exact science and it's rarely perfect the first time. And in truth, most of us can't afford the time and money and energy that near-perfection would require.

Be that as it may, we can still take an active role in determining what we get: by carefully considering our individual needs and desires, by talking to doctors and their patients and by taking care to do everything possible to promote healing and minimize scarring once the surgery is done.

VIEW FROM THE OR from page 7

part of their overall practice. Thus, their skill levels can be much, much lower. Fifty per cent of Dr. Menard's practice is in transgender surgery: the majority are MTF, but a substantial number are FTM.

Patients arrive in Montreal prior to their surgery date. They share comfortable apartments nearby, provided by the center as part of the package of services. (Meals, lodging and transportation are included in the one overall fee for the surgery.) Here, patients tell each other their stories, reflect down the long road to this landmark commitment, and share their excitement. It's also where patients "come home" to recuperate after the post-operative critical care.

Clinique de Chirurgie Esthetique St. Joseph is technologically state-of-the-art. Patients are treated with deserved, and often-overdue, dignity and respect.

In my view, Dr. Menard's abilities add a unique artistry and skill to his work. I watched him from several observation points in the O.R. I, too, was in scrubs from 7:35 am until mid-afternoon on two successive days. This opportunity to observe also gave me a chance to ask questions; and there were many. I had so much to compare with surgeries I'd previously observed elsewhere.

There are transgender surgeries performed each week. The week I observed, all day Monday through Wednesday was scheduled. Ninety per cent of patients are from the U.S., eight per cent from Canada, and two per cent from Europe, Asia, and Australia. As with any serious artist, this amount of time and dedication is evidenced by repeatedly good results. While similar procedures are done, there are no two body shapes exactly alike. Each individual's needs are truly individual. For example, the surgery can be a one- or two-step procedure. It depends on the size of the chest and the amount of skin. Menard uses a small, semicircular incision along the bottom of the areola whenever possible. This technique avoids the long horizontal side-to-side scars other methods leave. If he performs a second stage to the procedure, he'll return to the same incision site to ensure less scarring.

Some patients haven't had favorable outcomes the first time, with other surgeons. They travel here seeking "redos" for their prior, often disfiguring outcomes. Some may feel immense fear and distrust one feels after having previously chosen a surgeon who could not deliver. I, too, felt some sadness, though mostly anger and disdain, as the surgically inept outcomes were uncovered.

The "boom box" has a place of honor on a top cabinet shelf in the operating room. Favorite musical selections provided accompaniment. Glen (not his real name) came for a subcutaneous mastectomy. Both breasts were removed. In the process, one mastectomy yielded a white, pearly cyst, which was sent to pathology for analysis. An additional short, simple procedure was done under local anesthesia to remove the excess skin. Incisions were made around the nipples to hide scarring. This was Glen's first procedure. He had seen friends' results from other surgeons which had been aesthetically displeasing and, in some cases, alarming. He recalled large horizontal scars on each side of their nipples. Some chests still had the excess skin. Yet, his friends' surgeons had considered the procedures complete. Glenn told me he respected all scars as badges of honor in this war of self-unification.

"It's a longer surgical process to do this," described Menard. "But the results are much nicer because his breast size was small." Glen's would be a two-step process; part done today and part a few days later. This strategy is not universally used by all surgeons; for one thing, it takes more time. For many surgeons, more time equals less profit.

After my second day of observation, I remove my scrubs and bid adieu. I'm feeling sentimental and joyous: for the patients, whose very intimate passage I was privileged to observe. For my clients over the past eleven years, who have entrusted me to team up on their roads to unity; and for the clients whom I have yet to work with, who will board the future flights to Montreal. I decided to walk a while. My heart was soaring. I had observed the highest-quality final steps of clinical care. It was almost as though the experience had been mine. Now, I was feeling that kind of exhilaration that artists describe when they reach the final pinnacle of their long-labored and carefully-tended masterpieces.

Clinique de Chirurgie Esthetique St. Joseph; the destination joining scalpel and soul. Hmmm...I wonder if St. Joseph was previously St. Josephine.

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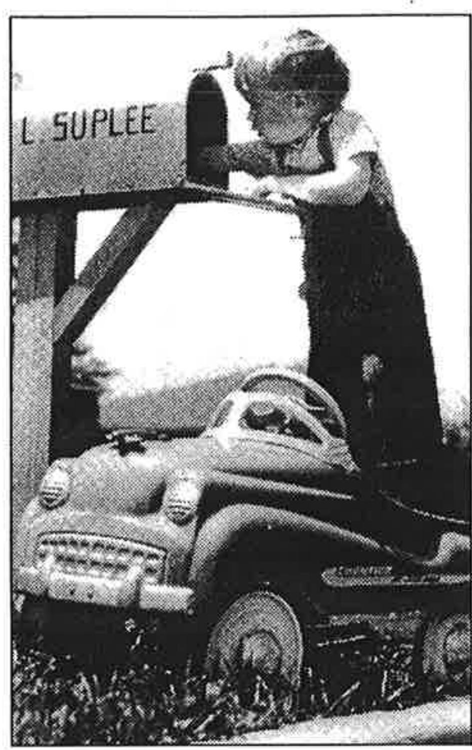

DEAR FTM:

Greetings. I come to you with a challenge and an opportunity. I am a post-op F to M. I went through transition in Seattle, Washington. I had been working for the City of Seattle (Department of Parks and Recreation) for seven years when I started my transition. No one in my unit was upset or even shocked when they found out I was transitioning. No one except my boss. He "came unglued." I do not believe it hurt his ego, but I do believe other managers and park department employees were inclined to ask him about "it" and "it" made him uncomfortable. So he began systematically harassing me. He got me placed on "Administrative Leave" for "showing my mastectomy scars to employees". He continued his pursuit of my termination month after month.

Needless to say I was laid off December 31, 1996. Seattle is supposed to be one of several cities to have adopted a non-discrimination policy against transgendered people. I moved to Fresno. I have worked here for a year. Prior to my transition I held a Bachelor's Degree in Education. I will not be able to teach again and I know that. I have filed a lawsuit against the City of Seattle. It is going to be a hard battle. I need all the support I can get. Winning this lawsuit would benefit the entire transgendered community across the U.S.. Anyone with information on cases, people that can give advice, or even the printing of this letter in the F to M Newsletter would be appreciated. I have no idea(s) how to set up a legal fund. If anyone knows please let me know. I am moving back to Seattle to fight.

Dean Rigney (Internet ONOINRNG.COM)

> PLEASE NOTE: The FTM Newsletter is now quoted in books and magazines outside the FTM community. Your words here may be quoted elsewhere. If you don't want your name to appear in another publication, ask to use a false name (or no name) if you want us to publish your letter.

HEY GUYS,

Don't know if the rest of you saw this bit of good news but just in case you didn't...

The basic story is that a well-known SRS surgeon in Italy is ready to perform a penis transplant and has 2 ftms ready to be recipients. He has done other types of ftm bottom surgery, as well as reconstructive surgery on non-transmen, and believes that this will actually be fairly simple.

It is not yet known whether there will be any erectile possibility, by the way.

Read more about it at the dejanews.com website. Do a search for "penis transplant" to see a number of posts on a variety of newsgroups—actually quite amusing to see who has noticed this news! The Reuters release is reprinted in its entirety in a post on soc.culture.iranian, in addition to the transgender groups.

This URL should take you to the Iranian news post: http://x10.dejanews.com/getdoc.xp?

Dylan McClintock

HEY!

Can't we support FTM porno? I thought the review of *Alley of the Tranny Boys* was closed minded to the differences in our community. It reminded me of the Dyke—S/M fights that I hoped had gone out with the eighties!

Porno is a personal taste thing!

It makes me mad to see this historic first FTM porno movie, made by our own local boys, put down in this FTM newsletter.

Will there be anymore FTM/by FTM porno movies made if we keep cutting each other down?

Sincerely,

Cole Rowan

Hey there, Cole. I certainly hope there will be more FTM porn! And, in fact, this newsletter has unfailingly promoted Alley of the Tranny Boys *from day one—on the cover, in ads and in articles. I saw Kris's review not as a cut-down but as a clear statement that these were merely his personal reactions to the films, colored by his own tastes and his expectations after reading the festival catalog. Both his review and this newsletter encourage readers to get their hands on all these movies if they can, and judge for themselves.—Jed*

DEAR FTM:

I am trying to locate Les Nichols, and would really like to hear from him. Please contact Kevin Horwitz or Julian Leonard at the following address: PO Box 3087, Santa Rosa CA 95402, phone 707-579-8022, or email Kevwitz@aol.com.

Thanks a lot,

Kevin

HI,

I've just accepted the title/role "Gay/Bi FTMs & SOs Liaison" with American Boyz. I will be compiling resources specifically for/about both those groups. If any of you have articles, books or websites you found especially helpful, enjoyable, and relevant, please let me know about them! Firsthand accounts, writings, graphics, and webpages are very much welcome.

Anyone who wants to write to me as a gay or bi FTM, and/or SO thereof, please do. Eventually, I'd like to do formal "needs assessment" surveys of both groups.

Arthur

<AFreeheart@aol.com>

DEAR JED:

Enclosed is a photocopy of a yellowed clipping that recently surfaced in my files. I don't know if any FTM historian is aware of this person in the article. I think his story deserves to be better known. Sixty-two years is a long time to pass without the benefits of hormones or surgery.

The author, John Burch, no longer lives in the area, but if anyone is seriously interested in finding what sources he used, I believe I would be able to track him down.

Peace!

Evan Lawrence

Thanks, Evan! Any interested readers can contact us and we'll forward inquiries to you. Below I've excerpted Burch's article ("Charlie Smythe was a nice fellow—sort of," from the October 29, 1989 Post-Star out of Glen Falls, New York). The author treats Smythe's story with a fair amount of respect, despite reducing "her" actions simply to economic need—Jed.

"Charlie Smythe, who was born in Canada in 1846 and moved to Saratoga in 1866, may have pulled the ultimate deception...Charlie seemed like any other of the hard working men this era produced. He was called an exceedingly good looking young man. He made a lot of friends. He drank with the best of them and even chewed tobacco. He spent many a night playing poker with the boys...For over 60 years, Charlie worked hard and made friends in the Saratoga area.

...When doctors examined Charlie they made a remarkable discovery: Charlie was a woman...

I have called Charlie's masquerade a deception. I was careful not to call it a practical joke. There were some critical >19

social reasons for her deception. I said that she had a problem finding a job that paid a livable wage...Charlie found that the skills she possessed, as a woman, were not worth much. These same skills when possessed by a man produced a comfortable wage. A haircut and change of clothing [were] all she needed to dramatically increase her earning potential. It was a choice she had to make."

DEAR READER,

GBT (Brazilian Transsexuals' Association) was founded on January, 1995 during the Eighth Brazilian Gay & Lesbian Meeting. Ever since, GBT has aimed and worked to help hundreds of Brazilian Transsexuals in need of relief or guidance. Moreover, GBT has developed a very active information service in order to rise public awareness of the transsexual issue. It is also an important part of our job, to reinforce the self-esteem of all transsexuals who seek our help.

In 1997, one great battle has been won by GBT. As a result of our political pressure, Brazilian National Medicine Board (Conselho Federal de Medicina) has decreed to its regional branches the FAVORABLE status must be now given to Sexual Reassignment Surgeries. So far, that has been GBT's greatest achievement.

However, there is still another very important battle to be won: Make Brazilian Congress legalize the SRS procedure. We hope to conquer that before this year's end. Despite of the very powerful reactionary forces that we have struggled against, we will not give up our ideal of justice.

And though we are plenty of confidence and actually inspired for the fight, we unfortunately have still got some strategical limitations that have kept us from doing a much better job. Thus, we are now counting on our transsexual sisters or sympathizers of the TS cause for helping us help our needy Brazilian TS sisters. In order to provide them faster efficient assistance, we are in need of a small personal computer. That little device will undoubtedly make a big difference for a lot of people. TS people who will be in closer touch with GBT, now stronger and growing.

So, if you feel like helping some people who really need your help, people who will have their pain relieved by your smallest contribution, just send it to: GBT—Grupo Brasileiro de Transexuais, Caixa Postal 1097, Cuiaba-MT, 78.005-970, Brazil.

Any kind of help will be appreciated, especially financial help. Books, magazines about Transgenderism also very welcome.

Thank you very much. Yours most sincerely,
Astrid Bodstein

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