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Notes From The Undergroun d

A FREE PUBLICATION

TRANSGENDER SELF GOVERNANCE

MEDICAL, EMOTIONAL & FINANCIAL

CONTENTS

Due to the number of requests for information regarding TG friendly physicians, hormone therapy and the need for the transgender community to direct their medical care, this edition has been dedicated to providing that background information. NOTE the contents of this publication is for information purposes only. Do not commence any medication strategy without a medical consultation!

See Yourself For the First Time!

By Margo Ross

Like many transgendered people, I have spent every waking hour of my life hiding my feelings, my gender idenity and my desires from the world, I live in. This process has resulted in my impression that I have two distinct and separate sides or personalities. It is the duality that is often referred to when discussing one's desires that do not match with your presenting gender.

The truth is that we are not two persons but one very multi-facited and certainly more aware person. I believe that the concept of division is potentially very negative and harmful. It prevents us from becoming intergrating and utilizing our complete personality. We must settle for parts of our powerful and positive the comprehensive personalities. It entrenches the sense of loss and inadeqatecy that we have for so long endured. In reality it does not matter if you are MtF or FtM, what does count is that you are a whole person you with the right to request, expect and receive the same level of respect and services that is available to others no matter how you present.

If we truly believe this concept, is it not time that we stop self dividing and get on with living?

Think about it for a minute? Now as you go out you expect to be accepted and treated with dignity instead of violence and

rejection. Is that not how you have approached life from your biological gender and now it can be yours as a whole transgender person.

President's Report from her Office in Hull

Some of you know that I went to Provincetown Cape Cod in April and I enjoyed the weekend there. I went as a representative of the Pride Committee to speak about transgender issues in Pride. During the weekend the questions asked of me should have been asked several years ago.

It seems to me that most transgender community don't want to get into dialogue with any association that represents the gay and lesbian communities, yet we are using their foot holds to gain our strength. Organizations like EGALE have taken the bull by the horn and kept on fighting for same sex rights. In our community we will have same sex partners if one of these partners were to have a sex change operation. Will they will have that right to.? They fought for us and this is where our allies are. The court decision was the result of years of lobbing the government from every angle. I know its very hard to cross the lines and say "yes we are different too, we are transgendered" and yes we have been harassed by the greater community just because they don't know where we belong. Our issues are their issues in every sense of the word. We need their guidance and leadership and at the same time we have to get on our soap box and find our way. We have to find new strategies for the next century for our community. We have to form unions, work together, keeping the history we have, and at the same time use that history for the work we have in front of us.

I want to welcome another group starting up in the Ottawa area who's mandate is different that ours. Gender Metaphor started in Kingston several years ago and is now in Ottawa. Good Luck Gender Metaphor.

Gender Mosaic is taking on a new challenge in the general meeting in June. We are changing the bi-laws to reflect the new changes, at the same time keeping Gender Mosaic a safe place to gather. We are trying to respond to all of your ideas handed in, on the questionnaire we gave to you, and if you wish to submit a particular idea let me know at the social or leave a message at 819-770-1945. We are doing our best, trying to keep the socials interesting and informative. If you would like to facilitate one of the social events, let me know.

Summer is here now so I think I will venture out into the sunlight and finish my tan. For those of you that have cottages or on vacation, see you in the fall. The socials will keep on going on the second Saturday of the month.

Ta Ta...Joanne

Hormones for the Transgendered

By Lynn Nicole Lefevre

Many Transgendered people consider taking hormones so that they can develop secondary sex characteristics opposite to those of their biological sex. When underaking such a dramatic step, it is important that they understand the implications of this therapy and what options they have.

The first and foremost item to consider is that hormones are very powerful drugs and the effects need to be monitored very closely by a knowledgeable doctor so as to avoid any serious harm to your body. Many Transgendered people take hormones they have purchased on the street or from foreign pharmacies. This can be extremely dangerous as there is no guarantee of the purity of these hormones, and the people who take them are usually not being monitored by a doctor for adverse side effects. Some

serious side effects include infertility, liver damage or failure and blood clots leading to fatal pulmonary embolism.

The second item to consider is the impact on spouses, family, friends and work, especially if no one knows what you are doing and why. If you are married, it is very important that your spouse is aware of your plans and is in full agreement with them. It won't be long before they figure out something is happening and when it does, the reaction will more than likely be very negative if they haven't been told in advance.

Because of the above Medical and Social considerations, the Harry Benjamin International Gender Dysphoria Association has developed a set of eligibility criteria for treatment of Transgendered people. Many (not all) Doctors follow these Standards of Care so it is important that the Transgendered person understand them (copies of the latest SOC can be found on the web at http://www.symposion.com/ijt/ijtc0405.htm and in Randi Ettner's new book, Gender Loving Care).

The SOC identifies three criteria for the administration of hormones:
1. age 18 years or older;
2. demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
3. either a documented real life experience should be undertaken for at least three months prior to the administration of hormones or a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months) should be undertaken.

It should also be noted that in addition to the SOC, some Gender Programs have their own standards. For example, the Clarke Institute in Toronto prefers that you live full time for at least one year before taking hormones. As a result, you will find Doctors on Ontario will either follow the SOC, the Clarke program, or a more compassionate course of treatment. Only by talking to each Doctor will you find out which program they follow.

HORMONES AND THEIR EFFECTS

For biological males seeking some degree of feminisation, there are a number of hormone treatments available. These usually include taking an estrogen (such as Premarin or Estradiol) and may include anti-androgens (such as Androcur or Spironolactone) and Progesterones.

Estrogens promote the development of secondary sex characteristics such as breast development, body and facial fat redistribution, reduction of body hair, softening of the skin, loss of muscle mass, heightened senses of touch and smell and a general feeling of being more 'emotional'.

Anti-Androgens suppress the effects of Testosterone so that the Estrogens can have a greater effect.

Progesterones are reported to augment the development of the breast milk duct tissue, although the results vary widely from person to person.

Feminizing hormones are most commonly administered orally; however, depot injections or skin patches are sometimes used, especially in patients with liver problems, as they avoid the 'first pass' through the liver after absorption in the digestive tract.

For biological females seeking some degree of masculinisation, the common treatment is to take Testosterone, either through intramuscular injections or through a patch.

Testosterone promotes the development of secondary sex characteristics such as permanent deepening of the voice, body and facial hair growth, muscle development and fat redistribution. It will also enlarge the clitoris, promote acne, eventually stop the menstrual

periods and increase the sex drive.

The effects of hormones vary greatly from patient to patient. Younger patients generally obtain better and more rapid results, although genetic factors are also highly significant. With appropriate dosage, most patients experience noticeable changes within 2--3 months, with irreversible effects after as little as 6 months. Change continues at a decreasing rate for a period of two years or more.

Dosages and hormones used vary from Doctor to Doctor and will also depend on the effects the patient is looking for. The key item to consider is that once the body is saturated with hormones, taking more will not promote faster growth; it will only lead to more complications. No matter what dosage you are on, the effects you achieve will depend on your age and your genetics. Lower dosages may take longer, but in the end, the effects will be the same.

WHAT TO DO NEXT

If you are really serious about taking hormones then you will need to study the available treatments and their effects. A good place to start is on the web at http://www.savina.com/confluence/hormone/. You should also consider reading the appropriate book from Dr. Sheila Kirk - either Feminizing Hormonal Therapy for the Transgendered, Masculinizing Hormonal Therapy for the Transgendered or Physicians Guide to Transgendered Medicine. All three books are available from the International Foundation for Gender Education bookstore (http://www.ifge.org/books/bookstore_catalog.htm) and many support groups will have copies in their libraries.

Next, you will need to find an understanding Doctor. Your local support group should be able to assist you, or you can do what I did and sit down calling Doctors until you find one who is accepting new patients and willing to provide you with hormones. Two good Doctors in the Ottawa area are:

- Dr. Kelly McGinnis, Suite 208, 381 Kent Street, Ottawa, Ontario, (613) 563-3331.
- Dr. Barwin, Gynecologist, 305-770 Broadview Ave, Ottawa, Ontario, (613) 728-5108.

Referral from GP Required.

You may also wish to see a therapist about your Transgendered issues. As with Doctors, your local support group should have a list of helpful therapists. If not, be brave and start calling around to find one that is experienced with Transgender issues and is comfortable with making recommendations for hormones. Two Therapists in the Ottawa area are:

- Dr. Mary Hogan Finlay, Psychologist, (613) 230-5855.
- Dr. Juan E. Tejeda, Psychiatrist, 1929 Russell Road, Suite 212, Ottawa, ON, (613) 731-7322

The bottom line is, if you know what you are asking for, and what the effects and implications are, you should be able to find a caring Doctor and/or Therapist who will help you achieve your goals. This applies to the Transsexual who is seeking to live full time and have surgery, to those who wish to take low dosages of hormones for some mild effects, and to everyone in between.

Q & A Hormone Therapy For the Transgendered

Edited by Margo Ross

This document is presented for educational interest only, not direct advice. The endocrine feedback system is intricate, delicate, and poorly understood. Even the experts do not entirely agree on how to best meddle with it. Hormone therapy is fraught with risk as well as promise. Be sure you have fully considered the implications before you start. Work with a medical doctor who is qualified to interpret your signs,

symptoms, blood tests, and development in the context of your personal medical history. Do not take hormones that you did not obtain directly from a licensed pharmaceutical distributor; the quality of drugs obtained through other channels is not only suspect, but possibly dangerous--especially those injectable forms.

The adverse effects listed in this document are gleaned primarily from drug information sheets and the Physician's Desk Reference (PDR). They are translated from jargon into English where possible. While this information should not be taken lightly, it should be viewed with slight suspicion, since it is first and foremost advertisement and legal copy from pharmaceutical companies. To attempt to reduce their exposure to lawsuits, they list not only the effects reasonably shown to be caused by the drug during clinical trial(s), but also every other adverse effect that the patients experienced while taking the drug--or any other drug of the same class--whether or not the effect was proven statistically relevant by controlled study for the drug in question. In particular, the reader should not be unduly worried about the mention of increase of body hair and loss of scalp hair from estrogen, nor about increase of body hair and deepening of voice from androgen receptor antagonists and GnRH agonists. Finally, adverse effects are only listed here if they make sense in their application to transsexuals, i.e., adverse effects on uniquely female organs are not listed for drugs intended for male-to-female transsexuals, and vice-versa. One should really read the PDR for the drugs of interest n order to provide context for the adverse effects listed in this document.

Q & A 1. What are hormones, and how do they work?

Hormones are long-range chemical messengers of the body, manufactured and controlled by the endocrine system. Hence the title of endocrinologist for hormone doctors.

The hypothalamus produces gonadotropin-releasing hormone (GnRH). This signals the anterior pituitary gland to synthesize and release luteinizing hormone (LH). To a lesser degree, GnRH also triggers the synthesis and release of follicle stimulating hormone (FSH). Subsequently, LH and FSH signal the gonads (ovaries in females, testes in males) to synthesize and release hormones that cause differentiation of the body tissue into female or male form: estrogen, progesterone, and testosterones. A small quantity of testosterones are also produced by the adrenal gland. Proportionally, females have more estrogen and progesterone than males. Males have more testosterones.

Estradiols are synthetic estrogen analogues. Estrogen and Estradiols excite estrogenic receptors, causing the body to differentiate into female form and function. Natural and synthetic estrogens are hereafter referred to simply as estrogen.

Progestogens (or progestin) are synthetic progesterone analogues. Progesterone and Progestogens excite progesteronic receptors, which in cooperation with estrogenic activity, cause the body to further differentiate into female form and function. Natural and synthetic progesterone are hereafter referred to simply as progesterones.

Various testosterones are collectively known as androgens. They excite androgenic receptors, causing the body to differentiate into male form and function. Natural and synthetic testosterones are hereafter referred to simply as androgens.

Anti-hormones can be useful in transsexual hormone therapy because they block hormone action or production. There are several mechanisms:

* Androgen receptor antagonist: blocks the action of androgens at certain receptor sites.

* Androgen conversion inhibitor: blocks the conversion of one type of androgen to another.

* Estrogen receptor antagonist: blocks the action of estrogen at certain receptor sites.

* GnRH agonist: Briefly overstimulates then effectively suppresses pituitary LH and FSH production.

Aggressive hormone therapy indirectly reduces natural gonadal hormone production by fooling the pituitary into thinking that there are plenty of hormones already in the body; consequently, the pituitary reduces the LH and FSH signals that stimulate the gonads.

Postnatally administered hormones do not cause development of primary sex organs (uterus, ovaries, vagina, testes, or penis) that are opposite those born with. However, postnatal contrasexual hormone therapy does cause development of secondary sex characteristics as described below.

Q & A 2. What effect does female hormone therapy have on a male, and how soon?

The longer after puberty hormone therapy is started, the less effective it is--but not a linear scale, e.g., results are considerably more dramatic in an 18 year old than a 28 year old, but results are not on the average dramatically different between a 38 year old and a 48 year old.

The following effects have been observed in varying degrees--anywhere from little to moderate--with extended treatment. With effective and continuous dosages, most of the changes that a particular body is genetically prone to start within 2 to 4 months, start becoming irreversible within 6 to 12 months, start levelling off somewhat within 2 years, and be mostly done within 5 years. The levelling may take longer if the testes are not removed. High levels of estrogen will cause faster development up to a point, but not better results in the long term than moderate levels of estrogen.

* Fertility decreases. Sperm count drops rapidly. Sometimes it returns to almost normal if hormonal treatment is discontinued within the first couple of months, but permanent sterility can occur in as little as six months. This should not be counted on for birth control, because a minuscule sperm count might remain until the testes are surgically removed. Estrogen, progesterone, and gonadal androgen production inhibitors are the chemicals responsible for lowering fertility. It appears to the author that the other types of anti-androgens do not necessarily effect fertility--but one would be wise to take frequent fertility tests if one chooses to employ only the other types of anti-androgens with the intent of maintaining fertility.

* Male sex drive and enjoyment decreases. Directly stimulated erections become infrequent and difficult to maintain. Spontaneous erections eventually stop. Semen secretion decreases, resulting in less intense or unobtainable ejaculatory orgasms. The testes and prostrate atrophy. The penile skin also shrinks if erections are not regularly encouraged.

* Breast size increases. Typical growth is to one to two cup sizes below closely related females (mother, sisters). The growth is not always symmetrical--neither is it for females. Sometimes the areoles and nipples swell, but generally not significantly, unless the body is less than a decade past puberty.

* Fat is redistributed. The face becomes more typically female in shape. Fat tends to move away from the waist and toward the hips and buttocks.

* Body hair growth (not including head, face, or pubic area) slows, becomes less dense, and may lighten in colour.

Many people also report the following effects, but they are not

verified in any medical literature that the author has read:

* If exercise is not increased, some muscle tone is lost--especially from muscles that were not well-developed before hormone therapy.

* Outer skin layer becomes thinner, lending a finer translucent appearance and increased susceptibility to scratching and bruising. Tactile sensation becomes more intense.

* Oil and sweat glands become less active, resulting in dryer skin, scalp, and hair.

* Scalp hair becomes thicker, and male pattern baldness generally stops advancing. In some cases, a fine fuzz may grow back along the line of where scalp hair was recently lost--but only from the living follicles, not dead ones.

* Metabolism decreases. Given a caloric intake and exercise regimen consistent with pre-hormonal treatment, one tends to gain weight, lose energy, need more sleep, and become cold more easily.

* Fingernails become thinner and more brittle.

* Body odours (skin and urine) change. They become less "tangy" or "metallic" and more "sweet" or "musky".

* Internal emotions are amplified, becoming more apparent, distinguishable, and influential. Some people report reduced anxiety and increased sense of well-being. This could be a placebo effect. Changing the hormone therapy (adjusting dosages up or down in the regimen) sometimes causes a week or two of depression and otherwise unexplainable emotional angst.

* "Female" sex drive and enjoyment increase. This observation is obviously completely subjective since males have no way to directly compare the experience. Non-ejaculatory orgasms become more likely for those with the predisposition to have them, if for no other reason than the fact that ejaculatory orgasms are difficult or impossible to achieve, and the need for sexual release forces a rewiring of perceptions and responses.

Female hormones do not:

* Cause the voice to increase in pitch.

* Dramatically reduce facial hair growth in most people. There are some exceptions with people who have the proper genetic predisposition and/or are less than a decade past puberty.

* Change the shape or size of bone structure. However, they may decrease the bone density slightly.

Q & A 3. What effect does male hormone therapy have on a female, and how soon?

The longer after puberty hormone therapy is started, the less effective it is--but not a linear scale, e.g., results are considerably more dramatic in an 18 year old than a 28 year old, but results are not on the average dramatically different between a 38 year old and a 48 year old.

The following effects have been observed in varying degrees--anywhere from little to moderate--with extended treatment. With effective and continuous dosages, most of the changes that a particular body is genetically prone to will start with the very first administration of androgens, start becoming irreversible (only the vocal cord thickening) almost immediately, start levelling off somewhat within 2 years, and be mostly done within 5 years. The levelling may take longer if the ovaries are not removed.

* The vocal cords thicken, deepening the voice--although not necessarily all the way down to an average male frequency.

* Fertility decreases. Menstrual cycle becomes irregular then stops.

* Sex drive increases. Sexual enjoyment may also increase, but the clitoris may become so sensitive as to make direct stimulation painful.

* Clitoris elongates, eventually reaching 3-8 cm.

* Body and facial hair growth speeds up, becomes much thicker, and may darken.

* Male pattern baldness may set in.

* Muscle mass increases with exercise. It may even increase slightly with no exercise.

Many people also report the following effects, but they are not verified in any medical literature:

* Outer skin layer becomes rougher in feeling and appearance.

* Oil and sweat glands become more active. This may result in acne.

* Fat is redistributed. The face becomes more typically male in shape. Fat tends to move away from the hips and toward the waist.

* Metabolism increases. Given a caloric intake and exercise regimen consistent with pre-hormonal treatment, one tends to lose weight, gain energy, need less sleep, become hot more easily, and feel generally more alert. However, appetite usually increases, so one may gain weight because of increased caloric intake and increased muscle mass.

* Body odours (skin and urine) change. They become less "sweet" or "musky" and become more "tangly" or "metallic."

* Emotions change. Aggressive and dominant feelings may increase.

Male hormones do not:

* Significantly decrease the size of the breasts. However, they may soften somewhat.

* Change the shape or size of bone structure. However, they may decrease the bone density slightly.

Q & A 4. How are hormones administered?

Administration of female hormones

The popular treatment combinations are:

* Estrogen alone

* Adding an anti-androgen

An anti-androgen fights the androgens remaining in the body. This may enable one to reduce the estrogen dosage and still obtain acceptable development speed. and very similar results in the long run. However, the author is not aware of any one person who has tried the two regimens (high estrogen dosage vs. moderate estrogen dosage plus anti-androgen) for long enough to be able to objectively compare their performance.

* Adding a progesterone

Progesterone administered with estrogen promotes extra breast growth by increasing the volume of the lactation and ducting tissue. Some studies of birth control pills in females seem to show that progesterone administered with estrogen reduce the risk of cancer from administration of estrogen alone.

* Adding another type of estrogen

This may cause faster results for some people, but not necessarily better results in the long run.

Some endocrinologists mimic a female cycle by decreasing of eliminating estrogen for one week of the month and/or adding or increasing progesterone for the same week. The author is not aware of solid evidence that this is either beneficial or harmful, although a recent study in females seemed to show that cycling progesterone may decrease the beneficial effect of estrogen on cardiovascular

health. The primary effect of cycling is the invocation of extreme mood swings similar to PMS in females.

Administration of male hormones

The popular treatment combinations are:

* Single androgen.

Hormones are delivered by the following methods:

* Oral (estrogen, progesterone, androgens)

This is the popular delivery method for estrogen and progesterone. The main advantage is convenience. The main disadvantage is increased stress on the liver since it has to process the hormones twice instead of just once.

* Injection (estrogen, progesterone, androgens)

This is the popular delivery method for androgens. The main disadvantages are unsteady hormone levels (except for sustained-release preparations in oil or microscopic beads), and pain and infection risk from hypodermic needle usage.

* Dermal patch (estrogen, androgens)

* Single androgen.

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* Injection (estrogen, progesterone, androgens)

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* Dermal patch (estrogen, androgens)

The main disadvantage is skin irritation. Androgen patches are meant to be applied to a post-surgical genital site.

* Cream (estrogen)

The main disadvantage is the low transfer rate into the body, too low to be effective unless it is very frequently rubbed on very large skin surfaces. Application to just the breast area does not limit the distribution to that area; the little estrogen absorbed is distributed throughout the body and in insufficient quantity to make the breasts grow significantly. The only obvious effect is moister and healthier skin.

A hormone therapy regimen that works well for one person may not for another. If development is not well under way in, say, 4 months, some experimentation may be in order; try different hormone types and/or combinations.

Hormone dosage can usually be reduced to a nominal maintenance level after the testes or ovaries are surgically removed.

Q & A 5. How can the intended effects of hormone therapy be maximized and the dangers minimized?

In general:

* Before starting hormone therapy, take a physical exam and the following blood tests:

Minimum: liver, thyroid, kidney and lipid (cholesterol) profiles; serum prolactin and sugar levels; blood clotting time.

Interesting: calcium and phosphorus (skeletal health); serum androgen levels. The androgen test is rather expensive,

and not necessary if one is using clinical results (visible body changes and, for male-to-female transsexuals, cessation of spontaneous erections) for feedback of therapy effectiveness. Particularly in female-to-male transsexuals, androgen therapy creates such dramatic clinical results that there is usually little reason to pay for the test except to satisfy curiosity, or if the clinical results are unsatisfactory.

* Be constantly aware of the body so that adjustments can be made if any new problems develop during therapy.

* Have regular medical checkups (every 2-3 months); pay close attention to vital signs.

* Eat well, and take a good multi-vitamin/mineral supplement to help be sure the body has everything it needs for new development.

* Do not start taking the maximum planned dosage of all hormones at once. Start with a low dose of one, and carefully watch for negative vital signs and symptoms. If there are no problems after one month, increase the dosage to the planned level. Wait another month before adding the next hormone or anti-hormone. Do not change the regimen radically or more often than once per month. Give the body time to adjust.

* Use the lowest hormone dosage that affords the desired changes. Not everyone needs the same dosage, because of differences in body weight and genetically-disposed sensitivity to the hormones. Hormone dosage can usually be reduced to a nominal maintenance level after the testes or ovaries are surgically removed. It is not recommended to take pre-operative dosages of hormones for more than about 3 years.

* Have bone density checked once every few years.

* Try the daily dosage of a hormone before moving to a sustained-release version, e.g., make sure you are not allergic to Provera tablets before you use Depo-Provera (the sustained release intramuscular injection).

Male to Female

* Use the lowest hormone dosage that affords the desired changes. Even without an expensive blood serum androgen level test, one can tell when their androgen level is being pushed to the minimum possible level by noting that spontaneous erections become very infrequent or cease entirely, and that body development is as expected.

* Estrogen delivered orally strain the liver more than other delivery methods. However, it is not highly dangerous unless the liver is already weakened by alcohol, drug use, or infection. It is a good idea to reduce alcohol and other drug intake. Monitor liver stress with a liver profile blood test every 6-12 months.

* Susceptibility to hardening of the arteries decreases somewhat, but susceptibility to blood clots, phlebitis (inflammation of lower extremity and pelvic veins), varicose veins, elevated high blood pressure increases somewhat. Stop smoking, reduce stress, and increase aerobic exercise. Investigate severe leg pain by x-ray or ultrasound to determine if it is caused by a blood clot before massaging it. Leg and foot cramping not caused by a blood clot might be reduced with potassium and vitamin E supplements (but one should not take potassium concurrently with spironolactone). Monitor blood clotting time with a test every 6-12 months. Stop or drastically reduce estrogen dosage at least one month before having major surgery. Take about 80mg/day aspirin to reduce the risk of blood clots; take it with food and liquid to reduce the risk of stomach ulcer--or, better yet, use the enteric safety-coated variety.

* Significant discharge from the nipples (more than would cause about a 2cm diameter stain on the bra) may be a sign of a dangerously elevated prolactin level due to intolerance of the estrogen dosage. Immediately take a test to measure the serum prolactin level; otherwise, take the test every 6-12 months anyway. Note that there may be a dramatic spike in the prolactin level, causing significant lactation for up to a week, if a high estrogen dosage is suddenly stopped; this is similar to the process in a female who has just bore her child.

* Since spironolactone (Aldactone) is a diuretic, anyone taking it should drink plenty of water, especially before and after exercise, and may need to reduce dietary intake of potassium--especially if the kidneys are already stressed. Take a blood electrolyte balance test every 6-12 months.

* Breast cancer risk seem to be low in comparison to females receiving estrogen replacement therapy. Certain studies in females seem to show that the cancer risk is lowered by consistently administering progesterone with the estrogen. Perform regular breast self-exams, anyway; take mammograms every 2 years before age 35, every year thereafter. Prostate cancer risk is significantly reduced in comparison to males not receiving estrogen therapy. Have the prostate examined once a year if possible, anyway.

Female to Male

* There is an increased risk of arterial hardening (particularly in the heart) due to increased serum cholesterol levels. Change the diet to reduce cholesterol.

* Androgens can stimulate various kinds of liver tumours and cysts, especially if the liver is already weakened by alcohol, drug use, or infection. Reduce alcohol and other drug intake. Monitor liver stress with a liver profile blood test every 6 months.

* If the menstrual cycle has not ceased within about 5 months of a steady androgen regimen, take a blood test to check the serum androgen level.

* Some recent studies seem to show that tobacco or marijuana smoking reduces the efficiency of androgen uptake.

* Even if most of the breast tissue is removed by a mastectomy, there is enough tissue left to place female-to-male transsexuals at approximately the same risk for breast cancer as genetic males. Perform regular breast self-exams; have any unusual lumps checked immediately.

Q & A 6. How can one obtain hormones?

In the most reputable therapists and medical doctors who regularly work with transsexuals are aware of and follow the guidelines found in the Harry Benjamin Standards of Care, a plan that specifies that one must undergo a minimum of 3 months of psychotherapy to obtain a letter of recommendation to an endocrinologist. One can choose to work with doctors who do not follow the Benjamin Standards, but, in any case, it is a very good idea to meditate and cogitate on the implications for at least 3 months before starting hormone therapy. Some transsexuals find the Benjamin Standards too constrictive--even insulting; others find it worth the trouble to go through the hoop in order to be referred to an endocrinologist who is particularly knowledgeable in the treatment of transsexuals. Choose carefully.

Male-to-female transsexuals: if a sympathetic endocrinologist is not available, try local gynecologists; they are sometimes more understanding, and are used to prescribing estrogen and progesterone.

One should only take hormones that were obtained directly from a licensed pharmaceutical distributor; the quality of drugs obtained through other channels

have realized the following:

have the most incredible ntuitive gift.

have the ability to see people nd situations from both erspectives.

am a whole, healthy person

The rest of the world now has to understand who I am and realize hat there are many, many, more people like me in this world. In fact, there are probably a far arger number of transgender people in the world than most people though possible. It is time these people that are hiding in dark places because they think there is something wrong with them, emerge into the light and reflect the gift they have within them.

Confessions of a Transgender Garage Sale Shopper

By I'm So Embarrassed

OK so I plan my life around garage sales and I buy more than I need or is that really possible for a transgendered person to ever have more than they need?

But I have discovered several key TG purchasing secretes which I can only now share with you.

First never decide if a skirt, top , dress, pants or blazer will fit you based upon the manufactures size tag. They lie! Look at the size of the person selling the clothes, are they your size, bigger or smaller. Then decide. PS in the case of multi-family sales it is important to find the original clothing owner or you will be selling it at your end of season misfit sale.

Second barter on everything even if it is the best price you have ever seen and you have to have it. Failure to follow this rule ruins it for the rest of us cheapies.

Third you do not have to make an excuses such as saying it is really for your dear friend who is at home with a broken leg but when she gets better she will really love this see through top and matching spandex tights (as if you ever needed to). Remember they want to get rid of this stuff.

Fourth and final hint that I will share with you, otherwise you may get all the good stuff before me. That is start early but buy late. If you really have to have it and the price is reasonable go for it however at 3 pm they have a choice to sell it for less or bring it back into the house which was not their goal.

The Starfish Story

by Ellen Bell

As the old woman walked the beach at dawn, she noticed a young woman ahead of her picking up starfish and flinging them into the sea. Finally catching up with the young woman, she asks why she was doing this. The answer was that the stranded starfish would die if left until the morning sun. "but the beach goes on for miles and there are millions of starfish," counter the other. "How can your efforts make any difference?" the young woman looked at the starfish in her hand and then threw it to safety in the waves. "It makes a difference to this one," she said.

Upcoming Events

- GM Monthly Meeting July 1999 - Fashion Flare and Style

- General Meeting BBQ August 1999

- GM Support and discussion Group fourth Thursday of each month

- TS Support and discussion Group contact Petra

Local Gm Hint

Randy's Shaving hint try the new triple blade shaver

Next Edition September 1999

Triple Echo

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This is an important edition to read and ponder. One of the greatest problems of the Canadian transgender community is the lack of a historical awareness and the opportunity to understand not just where you personally are going but also what others have prepared for your next steps.

I strongly recommend that you obtain a subscription to this paper and support the growth of our Canadian history and knowledge base.

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