Menopause-Informed Consent for Gender-Affirming Hysterectomy and Oophorectomy: An Article for Health Care Providers Offering Gender-Affirming Care

By Lasara Firefox Allen, MSW | they/them

Genderqueer Futures LLC

Lasara Firefox Allen, MSW (they/them) is a certified menopause doula and coach, an IAOTH-accredited menopause educator, the author of *Genderqueer Menopause* (North Atlantic Books, 2026), a #1 Amazon bestseller in Gender Studies and #3 in Menopause that landed on the Independent Press Top 40 Nonfiction List, and the founder of the IAOTH-Accredited Gender-Affirming Menopause Care (GAMC) certification course, which trains clinicians, care teams, and menopause support workers to deliver menopause care that centers trans, nonbinary, and gender-expansive folx.

Reviewed by: *Kristin Gianelis, DNP, APRN, WHNP-BC, ANP-BC, MSCP, CNE, FNPWH; Vanessa Weiland, MSN, AGPCNP-BC, MSCP; and Dr. Claire Phipps, GP and Menopause Specialist.*

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For trans, nonbinary, and gender-expansive (TGE) people with ovarian systems, gender-affirming hysterectomy is a common procedure; in a national database study, 30-day complication rates were similar to those of matched controls.[1] The decision that gets less attention is what happens to the ovaries. Whether a person keeps both, keeps one, or has both removed shapes the timing and character of their menopause, with implications that may last for decades. That decision deserves the same care as every other part of surgical planning.

I wrote this article because of what I've been hearing and seeing. In my experience as an expert in the field of gender-affirming menopause care, and as a witness in the same capacity within the TGE community, people from many marginalized communities have told me they received little to no education about what menopause would look like, or how it would affect their bodies and mental health, before a gender-affirming hysterectomy or a hysterectomy for cancer prevention. I have seen life-saving surgeries followed by rough adjustment periods and less-than-ideal long-term outcomes that more education might have prevented.

This article makes the case for three standard practices:

- Take a family history of menopause.
- Always educate, or refer out for education, on how surgical choices affect menopause.
- When medically responsible, always offer the full range of options (bilateral oophorectomy, unilateral oophorectomy, or ovary-sparing surgery) with honest benefits and risks for each.

The recommendations here offered begin with a frame of three pillars for gender-affirming menopause care as put forth in the IAOTH-accredited Gender-Affirming Menopause Care certification course (GAMC).[2] These three pillars are gender-affirming care, trauma-informed care,

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and person-centered care. It is the opinion and experience of the author that practicing these modalities is more likely to keep TGE people enrolled in care.[3, 4]

All GAMC should be:

- Dysphoria-aware.[5]
- Person-led in language, using the terms each patient chooses for their body, anatomy, and symptoms.[5,6]
- Consent-based, with exams, anatomy discussions, and treatment options introduced only with clear, ongoing consent.[6]
- GAHT-informed, accounting for current or past gender-affirming hormone therapy and surgeries when assessing symptoms and treatment.[5]
- Inclusive of all menopause pathways, including ovarian aging, surgical, medication-induced, and treatment-related menopause.[5]
- Intersectional, recognizing how race, disability, age, class, and other identities shape access to care and care experiences.[4, 5]
- Collaborative, coordinating with gender-affirming providers and respecting the client as the expert on their own body and goals.[5, 6]
- Documented affirmingly, so names, pronouns, and body terms carry consistently through the record.[5, 6]

Further, there are four ethical pillars for gender-affirming care that everyone in the gender-affirming care space should be mindful of:[7]

- Autonomy: self-determination, respect for individual goals.
- Beneficence: potential benefits of intervention (e.g., hormones reduce gender dysphoria, depression, anxiety).
- Non-maleficence: risks, adverse effects, uncertainty.
- Justice: equal and equitable access to appropriate care. (Access is part of clinical care, not separate from it.)

Working from these foundational praxes ensures best practices in gender-affirming menopause care.

Want training to put this into practice? The Gender-Affirming Menopause Care (GAMC) certification course begins November 17. Learn more and enroll on the GAMC certification page, or find a certified provider in the directory.

Why the ovary decision matters

Research on oophorectomy in trans populations is limited. A 2022 systematic review in *Sexual Medicine Reviews* screened 469 studies and found only 39 that addressed ovaries in transmasculine and gender diverse people on testosterone (T).[8] The authors concluded there is little information to guide the choice between removal and retention. They found that bone mineral density decreases after oophorectomy (though fracture data are lacking), that current evidence does not support routinely lowering testosterone dose after oophorectomy, and that no studies had examined neurocognitive outcomes.[8]

Newer data adds to the picture. A 2024 longitudinal study in *Frontiers in Endocrinology* followed 243 transmasculine people on testosterone. Significant declines in bone density Z-scores at five years appeared only in the subgroup who had bilateral oophorectomy, and estradiol levels were higher in those who kept one or both ovaries.[9]

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Because trans-specific data are thin, providers also draw on the broader literature. The Mayo Clinic Cohort Study of Oophorectomy and Aging found that removing both ovaries prior to menopause via ovarian aging was associated with higher long-term risk of parkinsonism, cognitive impairment or dementia, and depressive and anxiety symptoms, though the causes remain unresolved.[10] Removing both ovaries before age 45 was also associated with higher cardiovascular mortality.[11]

Some studies have found higher rates of cardiovascular events in transgender men compared with cisgender women.[12] However, evidence on the long-term cardiovascular effects of oophorectomy in transmasculine and gender-diverse people taking testosterone remains limited. The uncertainty inherent in under-researched outcomes is itself information people deserve to hear.[8]

Practice 1: Take a family history of menopause

Age at menopause via ovarian aging—often called "natural menopause," but this terminology is avoided here to decrease stigma—is substantially heritable. A study of mother and daughter pairs estimated heritability at 44%,[13] and sister studies estimate it higher.[14] Family history is one of the few tools we have for anticipating when someone's ovaries will wind down on their own.

Ask, in inclusive language:

- When did biological relatives with ovaries (parents, siblings, grandparents) go through menopause?
- Did anyone go through menopause early (before 45) or experience premature ovarian insufficiency (before 40)?
- Is there a family history of ovarian, breast, or endometrial cancer, or a known BRCA or Lynch syndrome variant?
- Is there a family history of cardiovascular or heart disease, osteoporosis, metabolic disorders, cognitive impairment, or other diseases or disorders that may be increased by menopause?
- Were there substantial mental health impacts in the menopause transition? If so, what did this look like?
- What was menopause like for them?

Many people won't know. Adoption, estrangement, and families who never talked about menopause are common. "I don't know" is a complete answer and a reason to lean on other factors, including the person's own mental health history and experience of hormonal cycling.

In the cases where family history is known, the family history changes the counseling. Someone whose relatives reached menopause in their early forties may have fewer years of ovarian function to protect by keeping one ovary. Someone with a BRCA variant may be well served by risk-reducing removal.[15] Someone whose relatives experienced strong emotional disruption during the menopause transition benefits from preparation before surgery: mental health support lined up in advance, and practical supports such as mindfulness practice, staying physically active, and limiting use of alcohol and other recreational substances.

Practice 2: Always educate, or refer out for education

Most people arrive at a hysterectomy consult focused on gender affirmation, and rightly so. Few have been told what their surgical choices mean for menopause. Education should cover:

- **What surgical menopause is,** that bilateral oophorectomy causes it immediately, and its impact on endogenous hormone production

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- **That hysterectomy alone can shift menopause earlier. In a prospective** cohort, people who had ovary-sparing hysterectomy had nearly twice the risk of ovarian failure over about four years (HR 1.92) compared with a group with intact uteri.[16]
- **That retained ovaries still go through menopause. A person on** testosterone will still experience ovarian menopause, and symptoms can show up even on T. Even if symptoms are not apparent, menopause may still impact health and well-being.
- **Long-term considerations** for bone, heart, and brain health, and the role of consistent hormone access.[8-11] Also advise regarding ongoing cancer screening by anatomy.
- **Fertility preservation.** WPATH Standards of Care 8 advises that fertility preservation be discussed and offered, and that gender-affirming care not be denied if a person declines it.[17]
- **The "mini-pause,"** for anyone keeping one ovary, which is described under unilateral oophorectomy below.[18]

Before the decision about ovarian removal is finalized, the surgical team should discuss the hormonal consequences as part of informed consent, including how this differs depending on current and planned hormone use, and fertility preservation options. Where the expertise isn't available within the surgical pathway, referral to a menopause-trained provider (ideally working alongside the gender service), without letting this delay wanted surgery. A coach or doula can offer valuable additional support.

All of this should be trauma-informed and dysphoria-aware: ask what language the person uses for their body and record it, offer neutral alternatives to "menopause" if helpful, and make room for whatever they feel about these organs, whether that's relief, ambivalence, grief, or all three.

Helpful resources to share include the author's most recent book, *Genderqueer Menopause* (North Atlantic Books, 2026),[3] an accessible, affirming primer on symptoms, treatment options, and self-advocacy, and the directory of certified gender-affirming menopause care providers at the Genderqueer Futures provider directory. A companion article for patients, "Your Ovaries and Gender-Affirming Surgery: Keep One, Keep Both, or Let Them Go," walks through the same decision in plain language for community members.

Mental health in the menopause transition

Include mental health in menopause education and follow-up, both for people planning for bilateral oophorectomy and for those keeping one or both of their ovaries. People born with ovarian systems can experience changes in mood and cognition across the menopause transition, whether it arrives gradually through ovarian aging or abruptly through surgery.

Onset of mental health impacts without a history. While this area is not yet studied in TGE populations, cohorts of women with no prior depression found increased risk of first-onset depressive symptoms and disorders in the transition.[19,20] A UK Biobank analysis found first-onset psychiatric disorders rose in perimenopause (incidence rate ratio 1.52), driven by major depressive disorder (1.30) and mania (2.12).[21]

Suicidality. Again, while not yet studied in TGE populations, and vastly under-researched in women, age-based national data show midlife is an elevated-risk window: US suicide rates for women were highest at ages 45 to 64 in every year from 1999 to 2021.[22,23] While vital statistics record sex at death and say nothing specific about trans and gender-expansive people, my recommendation is that this timing be taken into consideration when educating anyone born with an ovarian system about menopause impacts.

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The menopause transition generally falls in the same window, so the timing lines up, but the possibility that menopause drives this risk needs further research across populations of concern. A 2025 systematic review of 19 studies found that 16 reported an association with increased suicidality, particularly in perimenopause, but the authors note limits in study design and heterogeneity.[24] In a naturalistic study of 928 women with bipolar, depressive, or anxiety disorders, onset of illness in perimenopause was associated with higher suicidal risk than premenopausal or postmenopausal onset.[25]

Screening for suicidal ideation belongs in menopause care.

Psychosis and mania. Again, this area has not been researched in TGE populations. However, in women, menopause can bring first-time psychosis or mania, or worsen existing psychosis. Incidence is not well established; the evidence is mainly clinical series and hospital data rather than large studies. A UK early intervention service reports the transition as a vulnerable period for first and repeated psychotic episodes,[26] small case series in women with schizophrenia spectrum disorders describe perimenopausal exacerbation,[27] and hospital data show a higher share of admissions among women after menopausal age, with age used as a proxy for menopausal status.[28]

A 2026 review summarizes symptom exacerbation and relapse risk during the menopause transition and reduced antipsychotic response after menopause.[29] The UK Biobank cohort found first-onset mania more common in perimenopause (incidence rate ratio 2.12) but no observed rise in first-onset schizophrenia spectrum disorders.[21] For new-onset mania in perimenopause, consider a neurologic and autoimmune workup (brain MRI and autoimmune panel); one case report of late-onset mania was ultimately attributed to primary progressive multiple sclerosis.[30]

The working hypothesis is that estrogen decline removes a protective effect, and trials of adjunctive estrogen modulators are preliminary.[31] It is my recommendation that the family history of menopause should include psychotic episodes, mania, and psychiatric hospitalizations, and a positive history warrants closer follow-up.

Neurodivergence. In my experience, and anecdotally within the TGE community, more people recognize ADHD or autism for the first time in midlife. While research specific to TGE populations, especially during the menopause transition, is lacking, women with ADHD had more severe perimenopausal symptoms in a population cohort (54.2% vs 30.1% with severe symptoms),[32] and a systematic review reports greater symptom severity for autistic people, with limited quantitative data and no intervention studies.[33]

Eating disorders. Perimenopause may be a window of vulnerability for developing or redeveloping an eating disorder (ED), though this is a hypothesis from a narrative review.[34] In one survey, eating disorder symptoms were more prevalent after oophorectomy (29%) than after hysterectomy alone (11%); the difference from menopause via ovarian aging did not persist after adjustment.[35] Prevalence of ED is higher in trans and gender-expansive populations, with 20-50% reporting disordered eating and 2-12% a clinical diagnosis,[36] and transgender college students had 4.6 times the odds of a past-year diagnosis compared with cisgender heterosexual women.[37]

I found no studies of eating disorders in trans or gender-expansive people during menopause, but the research regarding TGE people and EDs and women in menopause and EDs point toward concern. My recommendation is that patients be screened for EDs and body image concerns before surgery, and that care providers pair gender-affirming care with specialist eating disorder treatment when needed.

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Mindfulness. Evidence is preliminary but supportive for mental health outcomes: a 2026 meta-analysis of 10 studies found a large effect on menopause-related psychosocial quality of life and smaller effects on anxiety and depression.[38] A randomized trial found mindfulness-based stress reduction reduced how much hot flashes bothered participants, not their intensity.[39] The 2023 NAMS position statement does not recommend mindfulness-based intervention for vasomotor symptoms (Level II evidence), while recommending cognitive-behavioral therapy and clinical hypnosis (Level I).[40]

Practice 3: When medically responsible, always offer the full range of options

Bilateral oophorectomy (both ovaries removed)

Benefits

- **Gender-affirming.** For many people, removing the ovaries relieves dysphoria and ends ovarian estrogen production and hormonal cycling.
- **Can resolve PMDD/PMS.** For people with severe, treatment-refractory premenstrual dysphoric disorder or premenstrual syndrome, hysterectomy with bilateral oophorectomy has been used as a definitive treatment, with small uncontrolled studies of severe premenstrual syndrome reporting resolution of cyclical symptoms and improved quality of life.[41,42] Both ovaries must be removed; unilateral oophorectomy or hysterectomy alone does not treat PMDD.[43]
- **Greatly reduces ovarian cancer risk,** which matters most for people with high genetic risk.[15]
- **No future ovarian surgery** for cysts or torsion.

Considerations

- Immediate surgical menopause.
- Bilateral oophorectomy is associated with lower bone density on testosterone,[8,9] and, before age 45, with higher cardiovascular mortality that estrogen treatment may reduce,[11] so any interruption in hormone access (cost, insurance, policy) carries more weight. Discuss baseline and follow-up bone density assessment as appropriate.
- Long-term outcomes for people on testosterone are not well researched.[8] This is not a reason to discourage the option, but it belongs in the consent conversation.
- Ends the possibility of genetic parenthood from one's own eggs unless preserved beforehand.[17]

Unilateral oophorectomy (one ovary kept)

Benefits

- Keeps some endogenous hormone production and acts as a buffer if hormone access is disrupted
- May keep some fertility options open. For people who are sure they want genetic offspring, discuss the most reliable path to that outcome, since evidence on fertility after hysterectomy with ovarian retention is limited.[8,17]

Considerations

- Associated with earlier menopause via ovarian aging, especially when done before 40. A Canadian cohort of more than 23,000 people found higher odds of early menopause and

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nearly four times the odds of premature ovarian insufficiency.[44] Other studies find a smaller effect, around one to two years.[45,46] When combined with hysterectomy, retaining one ovary rather than two was associated with menopause arriving about 4.4 years earlier, though this estimate comes from a small group (28 women with unilateral oophorectomy) and is imprecise.[47]
- Does not resolve PMDD/PMS.[43]
- The remaining ovary still carries typical ovarian risks.

Prepare people for the mini-pause. After hysterectomy with unilateral oophorectomy, many people go through what I call the mini-pause: a period of weeks or even months while the remaining ovary recovers from surgery, reestablishes blood flow, and settles into a new homeostasis.[18] During that time, people may report night sweats, hot flashes, emotional volatility (sometimes bursts of rage), and sleep disruption. Some also notice genital dryness or discomfort.

Post-surgical factors like catheterization and antibiotics can raise the risk of urinary tract and genital yeast infections during recovery as well, so any new genital or urinary symptoms should be evaluated.

The mini-pause has not yet been formally studied. The evidence so far is anecdotal and abundant, which is exactly why it belongs in pre-surgical counseling. People who know it may happen can recognize it as a phase of recovery rather than a sign that something went wrong, and they know to ask for symptom support.

Many patients may have heard of the mini-pause before their providers have, so take their reports seriously. Some may also notice similar temporary shifts after ovary-sparing hysterectomy, possibly because of disruption to ovarian blood supply (a hypothesis, not established), so it is worth mentioning there too.

Ovary-sparing surgery (both ovaries kept)

Benefits

- **Insurance against lifelong dependence on exogenous hormones.** If someone later stops testosterone, loses access, or faces a coverage gap, their own ovaries continue producing hormones until the onset of menopause via ovarian aging. Beyond menopause, retained ovaries continue to produce endogenous testosterone as well. In an uncertain policy climate for gender-affirming care, this protection carries real weight.
- Preserves a more standard menopause timeline.
- Keeps fertility options more open, though evidence on fertility success after hysterectomy with ovarian retention is limited.[8]

Considerations

- Menopause may still arrive somewhat earlier after ovary-sparing hysterectomy.[16,47]
- Ovarian hormone activity continues, which some people experience as dysphoric, and PMDD may persist.[43]
- Ovarian cancer risk continues at typical levels, with no effective screening for average-risk people;[48] retained ovaries need the same ongoing health attention as anyone else's. However, removal of both fallopian tubes at the time of surgery may mitigate ovarian cancer risk and can be discussed with the surgical team.[49, 50]
- Possibility of future surgery for ovarian issues.

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A counseling checklist

Before a surgical date is set, the person should be able to answer yes to each of these, or know who can help them get there:

- I know which options for my ovaries are available with this surgery.
- I understand how each option could affect when I may go through menopause.
- My family history of menopause, including mental health considerations, has been discussed and factored into the recommendation.
- I know what to watch for later if I keep one or both ovaries, including signs of ovarian cancer, torsion, ovarian cysts, and other ovarian complications.
- I know what to watch for if I keep no ovaries.
- I know who will manage my hormones long term if my ovaries are removed.
- I have been offered a conversation about fertility preservation.
- I have been offered education or a referral to help me understand menopause before I decide.
- I know about the possibility of a mini-pause and other possible impacts of surgical options, and who to contact for symptom support.

Consent that centers the person

None of these options is the right one by default. Bilateral removal is a valid, affirming choice. So is keeping one or both ovaries. The right decision depends on the person's gender goals, mental health, family history, genetic risk, relationship to hormone access, and plans for their life.

Present the options without steering. Document the conversation. Revisit it if the surgical timeline shifts. When people understand what they're choosing, they can make the decision that fits their body and their future, and they enter menopause prepared instead of surprised.

Want to build menopause-informed consent into your practice?

Gender-affirming, trauma-informed, and person-centered surgical counseling is part of the Gender-Affirming Menopause Care (GAMC) certification course. The Fall 2026 cohort is IAOTH-accredited, meets live on Zoom on Tuesdays at 4PM PT from November 17 to January 26, and includes workbooks and recordings of every session. Seats are limited to fifteen. Enrollment starts at $1,500, and payment plans and Giving-Back Grants for Trans and QTBIMPOC practitioners are available. Enroll on the GAMC certification page. Not ready yet? Join the Genderqueer Futures newsletter for news on the next cohort. For trainings, talks, and consulting for your clinic or team, write info@genderqueermenopause.com.

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Please note that some references cited here are not gender-affirming in their language or framing.

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