Your Ovaries and Gender-Affirming Surgery
Keep One, Keep Both, or Let Them Go

By Lasara Firefox Allen, MSW | they/them

For folx with ovarian systems preparing for gender-affirming surgery

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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If you're planning a gender-affirming hysterectomy, you'll also be making a decision about your ovaries. You can keep both, keep one, or have both removed. That choice shapes when and how you move through menopause, sometimes with implications that last for decades.

Most people are not walked through this decision thoroughly. You deserve to be. And you deserve to be walked through it well in advance of making any impactful decisions.

Before we go further, let me set the foundation: Gender-affirming care is life-saving care—full stop. Everyone deserves access to the care that makes them feel most themselves, and most at home in their bodies. That is the baseline.

And, that does not remove the fact that we still need to be educated on the impacts of whatever choices are in front of us, so that we can be fully aware of what consent to care means.

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 our community, folx from many historically and ongoingly marginalized communities have told me they received little to no education about what menopause would look like and how it would affect their bodies and their mental health before a gender-affirming hysterectomy (or even a hysterectomy for cancer prevention). I have had a front-row seat on more than one life-saving surgical intervention that has had a rough adjustment period, and even some less-than-ideal long-term outcomes, due to lack of education.

This article is an effort to start to close that education gap in the case of gender-affirming hysterectomy, and specifically, the possible impacts of different choices regarding your ovaries. This article covers what each option can mean for you, the questions worth asking, and why your family history matters.

I am not a medical professional (though this article has been reviewed and affirmed by some), and this isn't medical advice. It's more of a what to expect and how to engage with the process primer.

We'll start here: There's no single right answer for everybody. The right choice for you is the one that fits your body, your gender, your symptoms, your desired treatment outcomes, and your life.

Why your ovaries matter for menopause

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Your ovaries produce hormones, including estrogen and progesterone, until they wind down during menopause. They produce about a quarter of your body's testosterone directly, plus precursors that convert to testosterone elsewhere in the body; production peaks in our 20s and decreases slowly throughout life, independent of menopause.[1]

If both ovaries are removed, menopause happens right away. This is called surgical menopause, and it causes an abrupt drop in estrogen, progesterone, and testosterone. People tend to report more sexual symptoms and worse hot flashes after surgical menopause compared with non-surgical menopause.[2] Symptoms are also precipitous in the case of surgical menopause—coming on literally overnight, or when you come out of surgery—as opposed to menopause via ovarian aging, which happens over a longer, less abrupt timeline. Rapid onset symptoms are also often experienced as more severe.

Even if you keep your ovaries, surgery can still affect menopause timing. Research on hysterectomy with the ovaries left in place (ovary-sparing hysterectomy) shows menopause tends to arrive earlier. One cohort found nearly twice the risk of early ovarian failure over about four years,[3] and another found menopause came about 3.7 years sooner in women (no stats specifically for trans and gender-expansive [TGE] folx) with standard pre-surgery hormone levels.[4] If you retain a single ovary, menopause via ovarian aging may come even earlier.[4,5] And if you're on testosterone (T), your ovaries still go through their own menopause eventually. Some people notice symptoms like hot flashes or sleep changes even on T.

Research specific to TGE people is still very limited. A 2022 review found there isn't much information yet to guide this decision for people on testosterone.[6] So part of informed consent is knowing what we know, and what we don't.

As you consider your options, it is important to understand the impact ovarian hormones have on health beyond the reproductive system. Before menopause via ovarian aging, estrogen plays an important role in bone, heart, and brain health, while also decreasing overall inflammation. Progesterone impacts mood and sleep regulation. Testosterone supports energy levels, muscle strength, and bones. Each of these hormones can be replaced with pharmaceutical options if desired.[7]

Your options

Removing both ovaries

What it can offer

- Gender affirmation. For many people, letting go of their ovaries is deeply affirming. It ends ovarian hormone cycling and ovarian estrogen production.
- Relief from PMDD and PMS. If you live with severe premenstrual dysphoric disorder that hasn't responded to other treatment, removing both ovaries can end the hormone cycling that drives it.[8,9] Both ovaries need to be removed for this to work.[9]
- Far fewer ovarian health concerns, including a much lower ovarian cancer risk and no future cysts.
- Many ovarian cancers, including the most common type, are thought to begin in the fallopian tubes. If you are concerned about ovarian cancer risk but would like to keep your ovaries for other reasons, talk to your clinician about a bilateral salpingectomy (tube removal) at the time of hysterectomy.[10]

What to plan for

- Menopause begins right after surgery.
- Your clinician will likely recommend taking hormones for long-term protection of your bone and heart health. Most often, your gender-affirming hormone regimen will match these health needs, so steady access to hormones matters a lot.[7,9]

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- Folx not taking hormones (either by choice or because of medical contraindications) should have conversations about the need for increased health vigilance (for example osteoporosis and monitoring for CVD - and this is more important in individuals who have a surgically induced menopause at a younger age), as long-term implications on health are not widely researched.[6] This is not a reason to dismiss this option out of hand, but it is something worth being aware of.
- Some studies of people on testosterone show lower bone density after both ovaries are removed, so bone health is worth being aware of.[6,11] Talk with your medical team about appropriate testing.
- If you might want genetic offspring from your own eggs, fertility preservation needs to happen before this surgery.[12]
- Reproductive desire does not invalidate gender identity; transgender men with a uterus have the right to pursue pregnancy.

Keeping one ovary

What it can offer

- Your own hormone production continues, which can be a safeguard against health impacts if hormonal treatment is no longer an option.
- Some fertility options may stay open. But if you are sure you want genetic offspring, discuss with your healthcare team your best options for ensuring that outcome.[6,12]

What to plan for

- Menopause may come earlier, especially if surgery happens before age 40.[5]
- Keeping one ovary won't resolve PMDD or other cycle-related concerns.[9]

Know about the "mini-pause." If you keep one ovary, you may go through what I call the mini-pause: weeks or even months while your remaining ovary heals from surgery, blood flow shifts, and your body finds a new balance.[13] During that time, lots of folx notice a temporary menopause-like stretch, most often night sweats, hot flashes, emotional ups and downs (bursts of rage or moodiness included), and disrupted sleep.

Some also notice genital dryness or discomfort. Catheters and antibiotics during surgery can raise the chance of urinary tract infections and yeast infections while you recover, too, so check in with your provider about any new symptoms.

I wrote about the mini-pause for the *Queer Trans Hysto Zine* in "The Mini-Pause: What Nobody Told You About Hystos with Unilateral Oophorectomy."[13]

The mini-pause hasn't been formally studied yet, but the stories are seen and heard far and wide. These symptoms are not a sign that something went wrong. It's your body finding its new normal, and support is available if symptoms are rough.

At this point, you may know more about the mini-pause than your provider does, so bring this information with you to your consults. Some folx notice a similar temporary shift after keeping both ovaries, too.

Keeping both ovaries

What it can offer

- Insurance against needing to take hormones forever. If you ever stop testosterone, lose access, or hit a coverage gap, your own ovaries keep producing hormones until menopause via ovarian aging, and produce some testosterone lifelong. That protection may matter, as dystopian as it is to admit it, especially in an uncertain policy climate.
- A more "standard" menopause timeline

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- Fertility options may stay more open

What to plan for

- Menopause may still come a little earlier than it otherwise would.[3,4]
- Your ovaries keep doing their hormonal work, which some people find dysphoric, and PMDD symptoms may continue.[9]
- Your ovaries still need the same health attention as anyone else's.

Your mental health matters here, too

Menopause isn't only about hot flashes. Our brains and moods are shaped by ovarian hormones, so the changes of menopause can impact our mental health, whether those changes arrive gradually through ovarian aging or overnight by way of surgery.[14] Here is what's worth knowing before you decide.

You don't need a history of depression to develop it in perimenopause. While research regarding TGE people and menopause-related mental health impacts is nearly non-existent, in studies of women with no prior history of depression, entering the menopause transition raised the risk of a first episode of depression,[15,16] and perimenopause was also linked to a higher incidence of first-onset mania.[17]

Though research is lacking even concerning women and suicidal ideation (SI) and suicidal completion during this transition, what we do know from age-based data is that midlife is the highest risk window for suicide deaths in women: in the US, suicide deaths among women were highest at ages 45 to 64 in every year from 1999 to 2021.[18,19] We do not know whether that data bears out for all people born with ovarian systems.

Correlation of the timing of SI and the menopause transition has barely been studied, which is astonishing given what's at stake. Menopause usually arrives in that same chronological window, so the timing lines up, but we have no studies showing that menopause is the cause. The handful that exist are small and limited.[20]

All this to say, if you ever have thoughts of harming yourself, take it seriously. Tell someone you trust and call or text 988 (in the US), trans lifeline, or another hotline right away.

Perimenopause is linked to a higher incidence of first-time mania,[17] and the transition can bring first-time psychosis or make existing psychosis worse. How often psychosis happens is not well established; most of what we have is clinical reports and hospital data rather than large studies[21-24]. The leading theory is that falling estrogen removes a protective effect.[25] While there is no clear evidence of family history being an indicator, this area is vastly under-researched. And there is ample evidence of bipolar disorder being heritable.[26] This being the case, if a relative experienced paranoia, a break from reality, or a psychiatric hospitalization around the menopause transition, it's worth telling your clinician.

Anecdotally—in my experience as an expert on gender-affirming menopause and as witnessed in the community—many of us recognize new elements of neurodivergence for the first time in midlife. (This may also happen with earlier onsets of menopause, but there’s no research on that as of yet.) Research shows that people with ADHD report more severe perimenopausal symptoms,[27] and some research suggests autistic people do, too.[28]

Eating disorders (EDs) can emerge or return during perimenopause,[29] and may be more likely after the ovaries are removed.[30] EDs are also more common among trans and gender-expansive folx, though much of that research is on younger people.[31,32] Tell your care team about any changes in how you eat or how you feel about food or your body.

Mindfulness practices can help with the mental health side of menopause, including mood, anxiety, sleep, and how much hot flashes bother us.[33,34] They haven't been shown to make hot flashes less

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intense, so think of mindfulness as support, not a hot flash treatment.

Taking all of this into consideration, if you are able, lining up mental health support before surgery would be a beneficial addition to your care team.

Know your family story

The age your biological relatives went through menopause is one of the best clues to when you might. Menopause timing runs strongly in families. One study of mothers and daughters put the heritability of menopause timing at about 44%,[35] and studies of sisters estimate it even higher.[36]

If you can, find out:

- When relatives with ovaries (a parent, siblings, grandparents) went through menopause.
- Whether anyone went through it early (before 45), or experienced premature ovarian insufficiency (before 40).
- Whether there's a family history of ovarian, breast, or endometrial cancer, or a known BRCA or Lynch syndrome variant. If so, ask your practitioner about genetic screening. There are several low-cost programs available, and insurance will often cover this testing.
- Whether there's a family history of heart disease, osteoporosis, metabolic disorders, cognitive impairment, or other conditions menopause can make more likely.
- Whether your family members experienced substantial emotional disruption during peri-/post menopause.
- What menopause was like for them.

Your family history of menopause can shape your choices. If your relatives went through menopause early, keeping one ovary may buy you less time than you'd hope. If there's a strong family history of ovarian or breast cancer, removing both ovaries may make sense, and a genetic counselor can help you weigh whether removing only your fallopian tubes is an option for you.

If there was strong emotional disruption, some preparation is your best bet. Mindfulness practice, staying active, and limiting recreational toxins can all help you weather the impacts more easily.

If you don't know your family history, that's okay. Not knowing is a complete answer. Many people don't, whether because of adoption, estrangement, or families that never talked about menopause. Your care team can work with what you do know.

Your personal history, such as premenstrual symptoms, postpartum symptoms, or irregular periods, also gives your clinician valuable information about what to expect in menopause.

Get educated about menopause and its implications

Menopause isn't referred to as “the change” for no reason. The menopause transition deeply impacts the body, mind, and spirit. Knowing what to expect is going to allow you more bodily sovereignty, empowerment, and better decisional power as you weather the transition.

A great place to start is my book, Genderqueer Menopause (North Atlantic Books, 2026).[37] This is an accessible and affirming primer that covers a lot of ground. You will be walked through symptoms, treatment options, and lifestyle changes in an empowering and affirming manner. It will give a great starting point for self-advocacy with your medical team.

If you want even more support, find a coach or doula to work with who can help you to define your desired outcomes. www.GenderqueerMenopause.com has a directory of certified gender-affirming providers.

Questions to bring to your surgeon

- Which options for my ovaries are available to me with this surgery?

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- How would each option affect the timing of when I may go through menopause?
- How does my family history change your recommendation?
- If I keep my ovaries, what should I watch for later?
- If I remove them, who will prescribe my hormones long term?
- If I need to go off hormones for some reason, what are the possible health implications?
- Can I talk with someone about fertility preservation before surgery?
- Can you refer me to someone who can help me understand menopause before I decide?
- If I keep one or both ovaries, could I go through a mini-pause after surgery, and who do I contact for symptom support?

If your surgical team can't answer these, you're allowed to ask for a referral or seek out a menopause-literate provider, coach, or doula to help you prepare before you set a date.

Making the choice that's yours

Removing both ovaries is a valid, affirming choice. So is keeping one or both. What matters is that you choose with full information, on your own terms, and with support for what comes after.

For a fuller guide to gender-expansive menopause, Genderqueer Menopause (North Atlantic Books, 2026) walks through the hormone shifts ahead, and Genderqueer Futures offers coaching for people navigating surgical decisions and the menopause that may follow.

Huge gratitude to my reviewers. Each suggestion offered improved the article vastly.

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Please note that some references cited here are not gender-affirming. If you want to go down the rabbit hole, be forewarned.

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