*Thank-you for contacting Dr. Daniel Medalie through the internet. Everything in this document is important. Please take the time to **read it carefully** before you contact him or his patient care coordinator, Valerie. If you have questions please call her at 216-393-9924.*

****Smoking is the number one reason that patients have peri-operative complications (loss or death of tissue). If you smoke, you must quit completely (no nicotine patch etc.) for three months prior to the procedure.****

SCHEDULING SURGERY IF YOU LIVE OUT OF TOWN

I frequently perform operations on FtM patients who live out of town and are unable to easily to see me in consultation prior to the procedure. I have several requirements for these patients:

1) I must have a therapist letter. This letter must adhere to WPATH standards and state that you meet the criteria for gender identity disorder and are a good candidate for this irreversible and life-changing surgery. This must be sent to us (e-mail, fax or mail) before we schedule the surgery. Every year criteria change and some patients claim that a letter is no longer required. For my patients a letter is always required. (I do not require patients to be taking testosterone)

2) I must see pictures prior to scheduling surgery (front view of chest and each side view with arms at your sides). Please do not hold the camera yourself as that distorts the chest.

3) Patients need to go to my website under the transgender top surgery section and download a history form (there is an easily visible link to the form), fill it out, and send it to my patient care coordinator, Valerie.

4) There is a **$65 consultation fee** that will be charged to you once you have all of your material gathered. This fee covers the time spent by my secretary and myself to evaluate your information. To pay, please call Valerie at 216-393-9924. This fee gets applied toward your surgery fee if you proceed with scheduling.

Typically I will perform a phone consultation with a patient 2-4 weeks prior to surgery. The patient will then come in to town 1 day prior to the procedure. I will then perform the operation and see them back in my clinic in 5-7 days to remove drains and change the dressing. This means that the patient will spend around 1 week in the Cleveland area. Patients who live far away, but can drive to Cleveland (2-6 hrs.), can go home the next day and drive back to see me for their first post-operative appointment (they must stay in town for at least 24 hours post surgery). I will then follow the progress of the patient via e-mailed pictures on a weekly basis. Occasionally I have had patients who have gone home and had their primary care doctor remove the drains and perform the first dressing change. I do not prefer this but do allow it if the patient can assure me of good care. My patient care coordinator, Valerie, has information about hotels in the area as well as financing. For all logistical details she is the best person to contact. Her e-mail is Valerie@ClevelandPlasticSurgery.com

FEES

Typical operation times average 1.5-2.5 hours (both for the peri-areolar and double incision with grafting procedures). The average patient spends around $7000-8000 for a procedure (this includes all fees- anesthesia, facility, surgeon).The variability stems from the fact that I sometimes perform more or less extensive procedures (very heavy patients with large breasts require more time for surgery). Revisions (removal of "dog ears" etc.) are a separate procedure and can usually be performed with local anesthesia in my clinic procedure room 6-9 months after the primary surgery. There is

a cost associated with revisions, but usually it is fairly low (on the order of $500-1000). The prices quoted) are cosmetic surgery package prices. They are not the prices billed to insurance and should not be used to calculate deductibles or co-pays!

We do accept some financing through the company CareCredit (http://www.carecredit.com/). Please go to the company website and search for Dr. Medalie to begin your application.

INSURANCE COVERAGE (please read carefully!)

Many patients ask whether we accept insurance coverage for these procedures. We no longer accept insurance for any portion of the procedure. We have a standard letter with standard codes that we will give to you if you want to try and seek reimbursement. The codes for the surgery will be simple mastectomy and nipple reconstruction (CPT 19303, 19350) and the diagnosis codes will be gender identity disorder (ICD-10: f64.1). Do not ask us to contact your insurance company. We will not do it. Starting late next fall, I may be performing part time surgery in New York City at Mt. Sinai Medical Center. Patients from the NY tri-state area who have insurance may be covered. Please be patient as these plans are not yet finalized. I recommend re-contacting us in September.

THERAPIST LETTER

Dr. Medalie adheres to the same guidelines and principles of the World Professional Association for Transgender Health (http://www.wpath.org/). Prior to any surgical procedure, the prospective patients must fulfill the criteria established by the Association and have letters of referral from a therapist (psychiatrist, psychologist or psychiatric social worker) who has had a relationship with the patient. Your therapist should have a copy of these standards.

CONTACT

I would be more than happy to discuss any of these procedures in more depth either by e-mail or in my clinic. If a patient lives far away, then pictures e-mailed or sent to me can help me determine what the best operative course might be. Please contact Valerie first to get things started.

My patient care coordinator: Valerie@ClevelandPlasticSurgery.com

My nurse: Mary@ClevelandPlasticSurgery.com

My e-mail: DrMedalie@ClevelandPlasticSurgery.com

My number: 216-393-9924

My fax: 216-393-9925

RESULTS

Many of my patients have posted their results on the web site, www.transbucket.com. Please note that some of these do not show the before shots or are taken at variable times after the surgery. The best results are not observed for at least 1 year post-op. I do encourage all prospective patients to visit this site since many surgeons are listed and you can compare the results for yourself.

Please note that I now have several instructional videos on Youtube that describes FtM top surgery. These are the links:

http://www.youtube.com/watch?v=DHwKOto7J3k
http://www.youtube.com/watch?v=qEKPz5zuDjc
http://www.youtube.com/watch?v=h1UealCPtnU

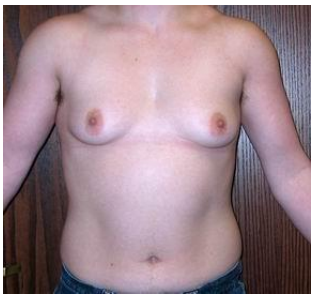
Chest Reduction Surgery

The procedure is based on the following:

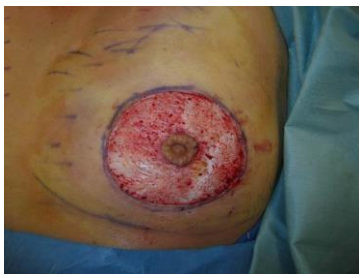
- Size and shape of breast
- Elasticity of skin
- Patient's needs and preferences

In general, patients who have smaller breasts can have the entire surgery performed in a keyhole pattern or in an incision around the areola-("peri-areolar or "purse-string" mastopexy). If the patient is willing to return for an additional procedure if necessary (revision of irregular scars-which are common), this is a very reasonable approach. In those patients with a large amount of breast tissue with excessive skin of poor quality and droop, it is always recommend to remove the excess skin and breast tissue in the crease of the pectoralis muscles (elliptical or double skin excision mastectomy) and put the nipples back on as grafts. This surgery has the advantage of immediate and predictable results. I can contour the skin flaps and place the nipples where I want to. It has the disadvantage of permanently altering the sensation and erectile capacity of the nipples, and it leaves larger scars on the chest. Over time they fade and flatten out. Any of these operations can permanently affect sensation to the chest wall and nipple area. The peri-areolar procedure in borderline patients ("B" cup) can result in nipple loss because of the tenuous blood supply.

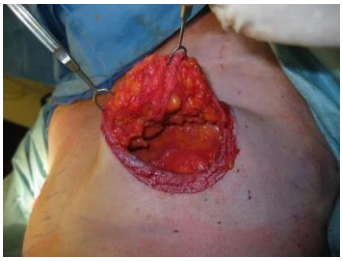
Below is a patient who underwent peri-areolar surgery. The surgery starts with a cookie cutter around the nipple/areolar complex to make it smaller. The surrounding skin is then de-epithelialized, and then a subcutaneous mastectomy is performed. Once the breast tissue is gone, a drain is placed and the incision for the mastectomy is closed. The surrounding skin is then closed down to the smaller areolar with a purse- string suture (like a bag of marbles). This results in scalloping and bunching of the skin, but tightens the surrounding chest skin and elevates the nipples some. Because of the motion of the arms and the underlying pectoralis muscle after surgery, these scars invariably widen and develop an irregular appearance (as in the final post-op picture). I find that my peri-areolar patients ask for more revisions than my double incision patients. I can prevent this by extending the incision to create a true "keyhole" this results in a scar like a lollipop (i.e. a circle around the nipple and a decending vertical line). The advantage of this is more precise control of nipple/areolar position and size, and less irregularity of the scar. The disadvantage is the longer scar (which defeats the purpose somewhat of the peri approach)



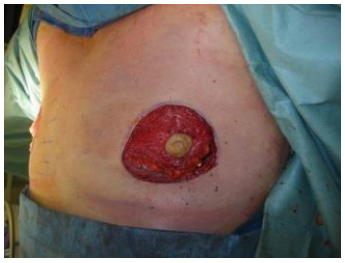
Pre-op peri-areolar



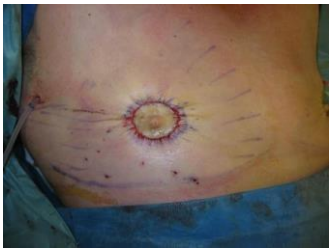
Areola resized and surrounding skin removed



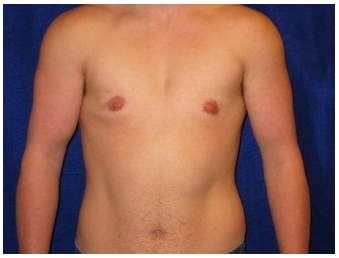
Subcutaneous mastectomy performed



Breast tissue now gone



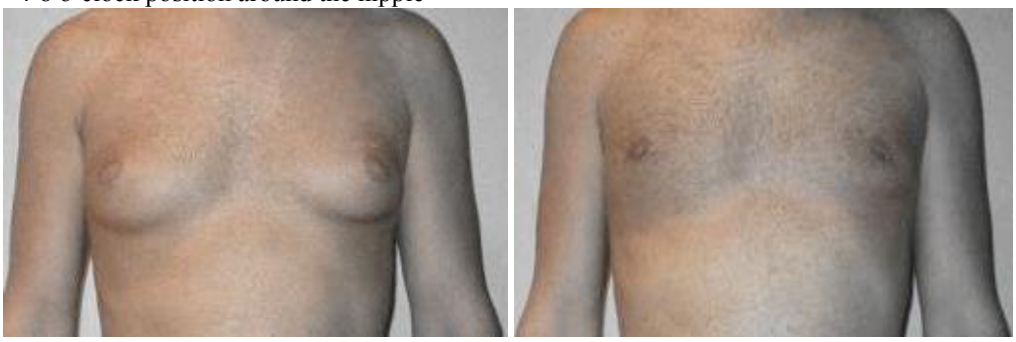
Purse string closure of skin to smaller nipple



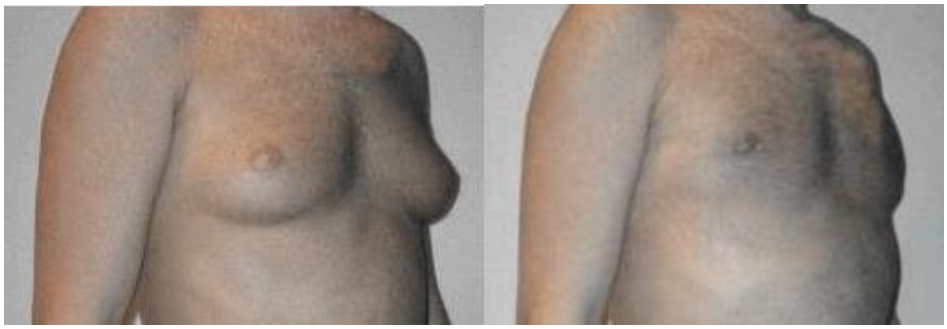
3 months post-op

Some small breasted patients can have an even more limited procedure where only a partial incision is made around the areola. This ensures the blood supply to the nipple but does nothing to take up any loose skin that may result from the subcutaneous mastectomy. I recommend this only for very small breasted patients with

good elastic skin tone. If done on the right patient, the results can be excellent. The example below is liposuction in combination with subcutaneous mastectomy via a partial areolar incision from the 4-8 o'clock position around the nipple

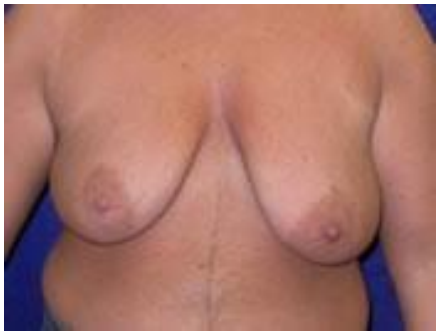


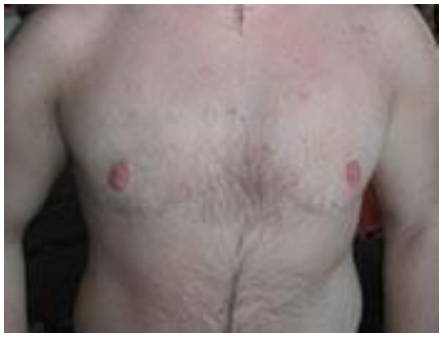
Before After



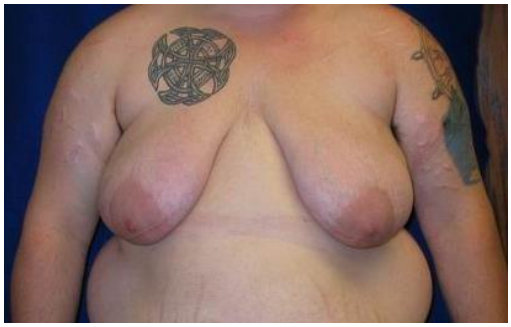
Before After

Chest surgery is routinely done as an outpatient. Depending on the extent of the surgery, silicone drains will be placed that will have to be removed in five to seven days. These drains help keep the tissues approximated and remove excess fluid. Removal is quite simple and can be done by any health care provider. If the elliptical (double incision) mastectomy is performed then the dressing holding the nipples in place needs to be removed at five to seven days. Immediately below is an example of elliptical mastectomy with nipple grafting at six months. Note that the red scars take up to a year to fade. The next picture shows a different patient at the 9th month post-op.

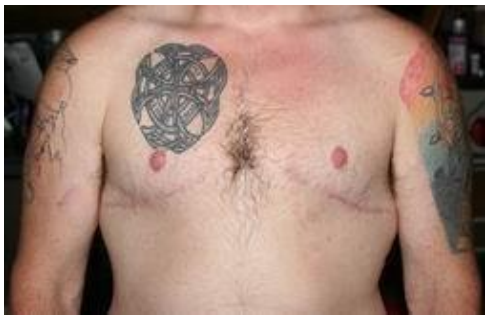




Before After



Before



After

Risks and complications

Obviously, procedures such as this are not without risks or complications and I want to review these with you.

- **Bleeding:** Bleeding is a risk of any operation, but the need for transfusion is extremely unlikely. More likely is the unwanted collection of blood beneath the skin (hematoma). This may require simple monitoring or possibly another procedure to drain the excess blood. It is most common in the first 24 hours after surgery and that is why I require patients to stay in town for at least that amount of time. Blood that is left sitting under the skin can result in unwanted asymmetry or even infection.
- **Infection:** Infections are rare complications and usually treated with a course of oral antibiotics.
- **Nipple complications:** The nature of mastectomy is to remove tissue and by necessity small nerves. While there is some regeneration, sensation changes such as hypersensitivity or partial numbness can occur. When the nipples are used as grafts there will be a loss of sensation and erectile capacity. The blood supply of the nipple might be damaged with the more extensive surgery, and the nipple could die (particularly in smokers). If the nipples are used as grafts, then it is also possible that they might not survive (full loss is very unlikely, but partial loss can happen).
  These complications are rare in my experience. Dark skinned patients who have nipple grafts will invariably have some depigmentation of the nipples. This improves slowly over time but may ultimately require tatooing.
- **Scarring:** The scars of the areola grafts usually heal very well, but the scars of the peri-areolar mastopexy can be bunched and pleated. Over time they will flatten out, but it is quite possible that they will need to be revised at a later date. The scars below the pectoral muscles (present in removal of large breasts) will take longer to fade out and will widen as mentioned above;
  however, a raised or excessively wide scar is possible and might need further treatment. It is possible that there may be residual tissue left, which appears as a contour deformity (especially at the sides where they are called "dog ears"). This would need to be removed at a second stage.
- **Other risks:** Depression of the skin where the breast tissue was removed is a risk and possible complication. The possibility of this complication can be reduced or avoided by leaving some breast tissue on the skin. Since not all the breast tissue is removed, you are still at risk for developing breast cancer, and therefore, you should still be vigilant in routine self-exam and screening for breast cancer.
- ****Smoking is the number one reason that patients have peri-operative complications (loss or death of tissue). If you smoke, you must quit completely (no nicotine patch etc.) for three months prior to the procedure.****

OTHER PROCEDURES

Many patients ask whether other procedures can be performed concurrently with the top surgery. The most common procedure asked about is **liposuction of the flanks, hips and abdomen**. I do this frequently to help contour the whole trunk and would be happy to discuss this with any prospective patient. Please include the whole trunk (front and back) in the photos sent to me so that I can effectively evaluate you. The cost is variable and depends on the extent of extra liposuction performed and the anticipated time that it will take.

CONTACT

I would be more than happy to discuss any of these procedures in more depth either by e-mail or in my clinic. If a patient lives far away, then pictures e-mailed or sent to my secretary can help me determine what the best operative course might be.

Thanks, and I hope to see you soon.

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