Integrating Transgender Care in a Primary Care Setting

- Ada D. Stewart, RPh., MD, FAAFP, AAHIVS, HMDC
- She, Her, Hers

- 62nd Annual NMAFP Family Medicine Seminar
- August 3, 2019

DISCLOSURES:

- NOTHING TO DISCLOSE.

Objectives:

- Describe/Discuss primary care needs/role regarding persons of trans experience.
- Describe and recognize bias and the unique needs of persons of trans experience.
- Describe challenges to care - discrimination, bias.
- Describe/discuss hormone affirming medication and potential interactions/complications.
- Discuss Protocols and Guidelines:
  - WPATH Standards of Care
  - Endocrine Society Guidelines
  - Center of Excellence for Transgender Health (UCSF)
- Discuss informed consent model.


TIME
THE
TRANSGENDER
TIPPING
POINT
America's next
civil rights frontier


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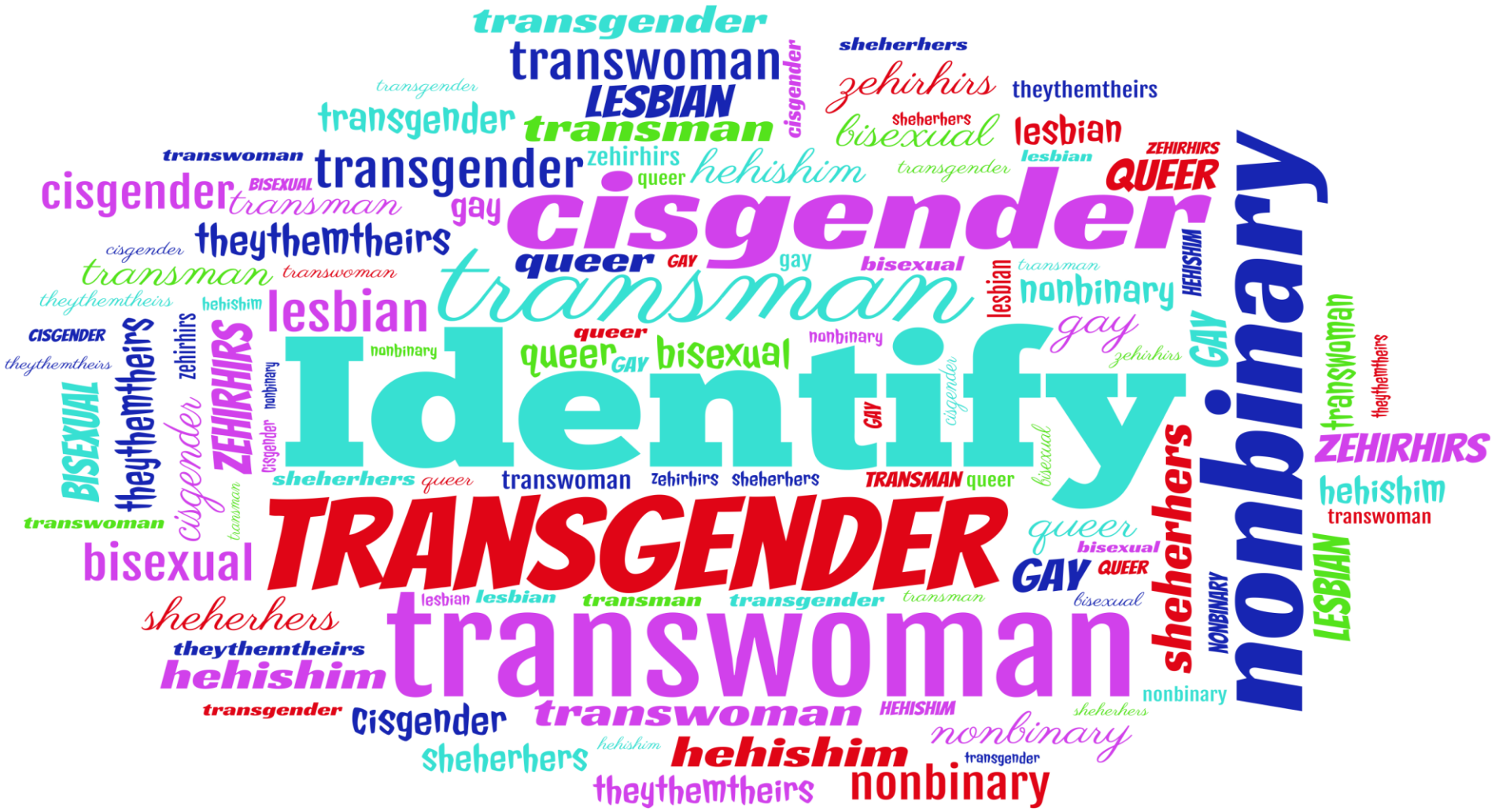
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Introduction:

- 0.6% (approximately 1.4 **million**) of the U.S. population adults in the United States identify as transgender or gender non-conforming (TGNC).
- There is a growing awareness of transgender identity and so there is now an increased demand for health care providers who are medically and culturally competent to provide care for transgender patients.
- Most physicians are not prepared to care for transgender patients.
- Many transgender patients do not seek medical care due to stigma perceived and actually received – yet have **high rates** of HIV, mental illness, alcohol/substance use and physical abuse.
- A Lambda Legal study published in 2010 found that almost 90% of persons of trans experience felt there weren't enough health-care professionals adequately trained to care for people like them.
- Another study reported that access to a provider knowledgeable about transgender health issues was the most commonly reported barrier to care.

https://www.lambdalelegal.org/new/ny

https://ncbi,nlm.nih.gov/pmc/articles/PMC4902845 "Barriers to Health Care for Transgender Individuals"

williamsinstitute.law.ucla.edu

Transhealth.ucsf.edu

Injustice at Every Turn: A Report of the National Transgender Discrimination Survey (2011)

- Health outcomes with appalling effects of social and economic marginalization
  - Much higher rates of HIV infection, smoking, drug and alcohol use and suicide attempts than the general population.
- Refusal of care:
  - 19% of sample reported being refused medical care
  - higher numbers among people of color
- Uninformed doctors:
  - 50% of them had to teach their medical providers about transgender care.
- High HIV rates:
  - Over 4 times the national average of HIV infection.
  - Rates higher among transgender people of color.
- Postponed care:
  - When they were sick or injured, many postponed medical care
    - due to discrimination (28%)
    - inability to afford (48%)

National Transgender Discrimination Survey Report on Health and Health Care. 2011 (6,400 respondents)

Health Care Disparities

- *"Access to health care is a fundamental right that is regularly denied to transgender and gender non conforming people".*

National Transgender Discrimination Survey Report on Health and Health Care. 2011 (6,400 respondents)

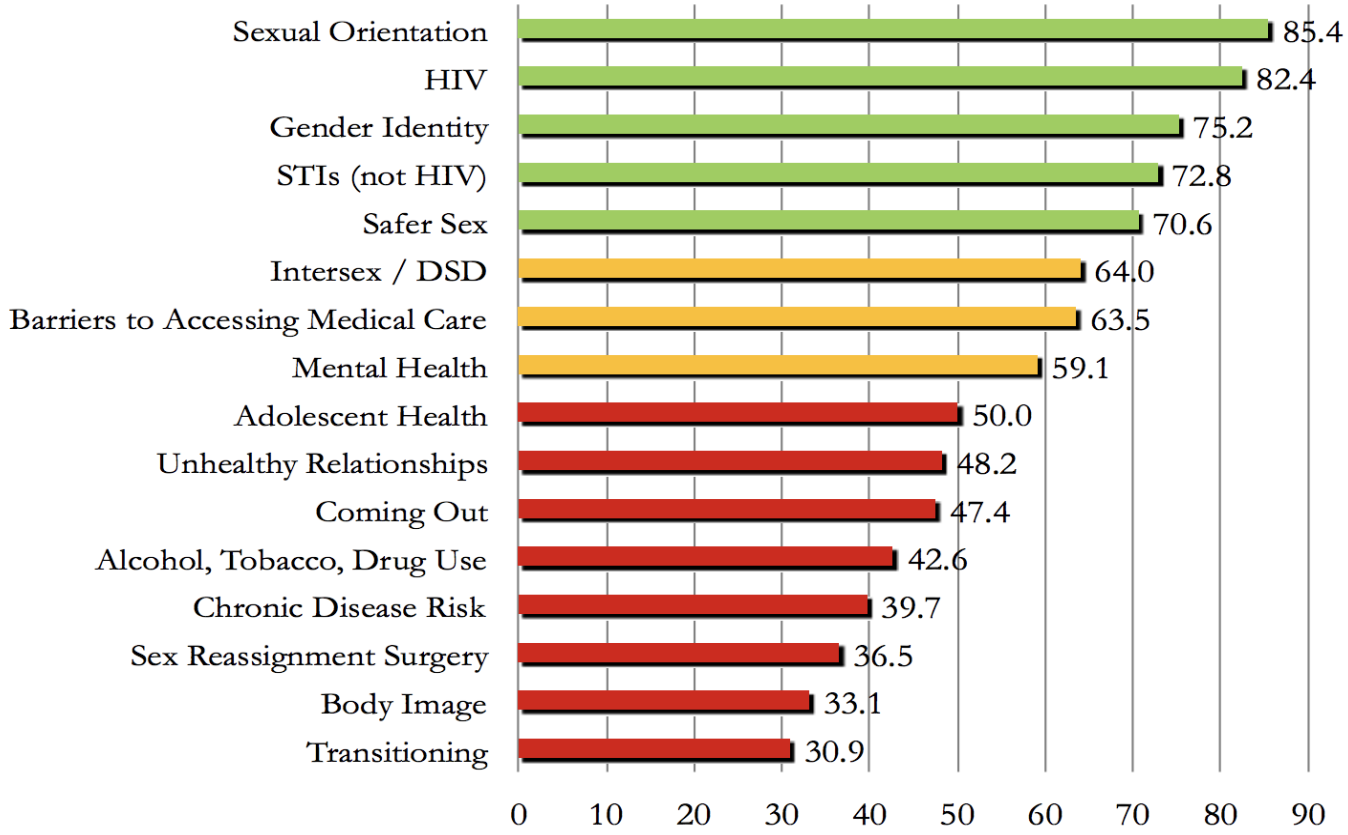
Summary -Our Healthcare System

- 19% doctors refuse care
- 28% avoid care when sick
- 28% report harassment
- 2% report violence in the medical setting
- > 50% had to teach provider
- Transgender persons experience suboptimal health outcomes
- Lack access to health care

Grant et al. 2011.Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

Gaps in Curricula

Percentage of Medical Schools Teaching LGBT-Related Topics in the Required Curriculum

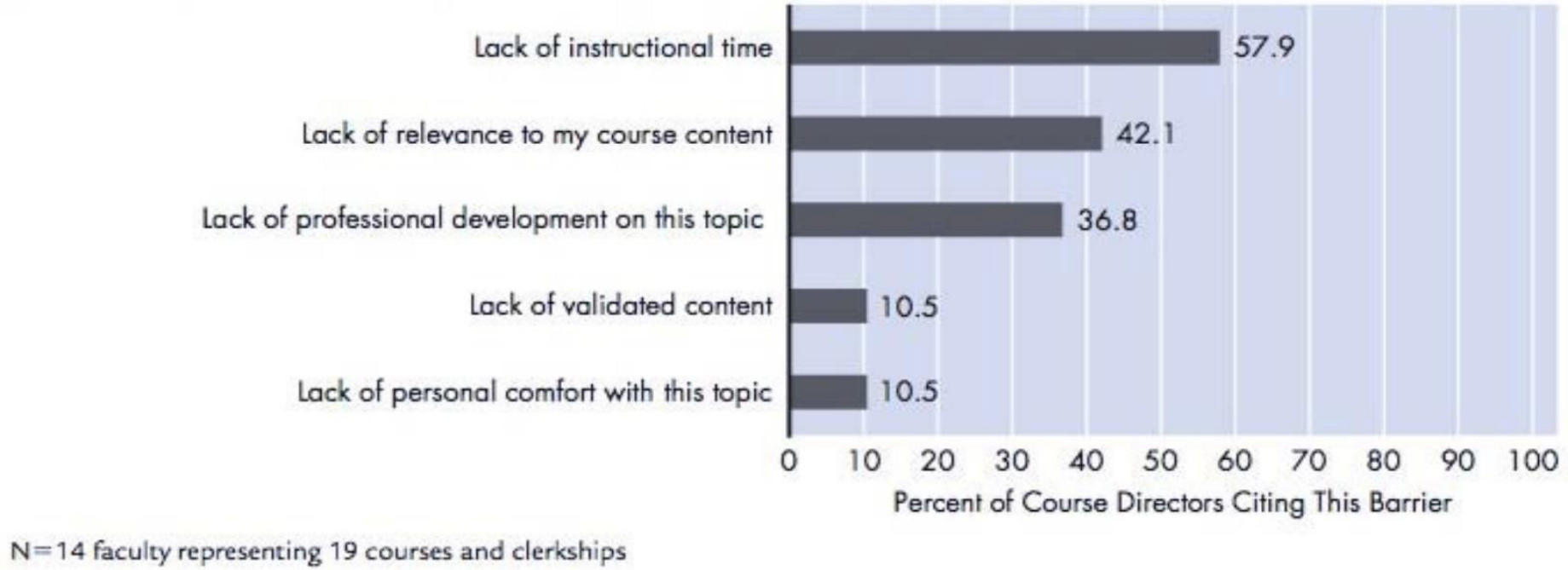


AAMC

Source: Obedin-Maliver, et. al. JAMA 2011

Gaps Among Faculty

Perceived Barriers to Including LGBT Content in a Course



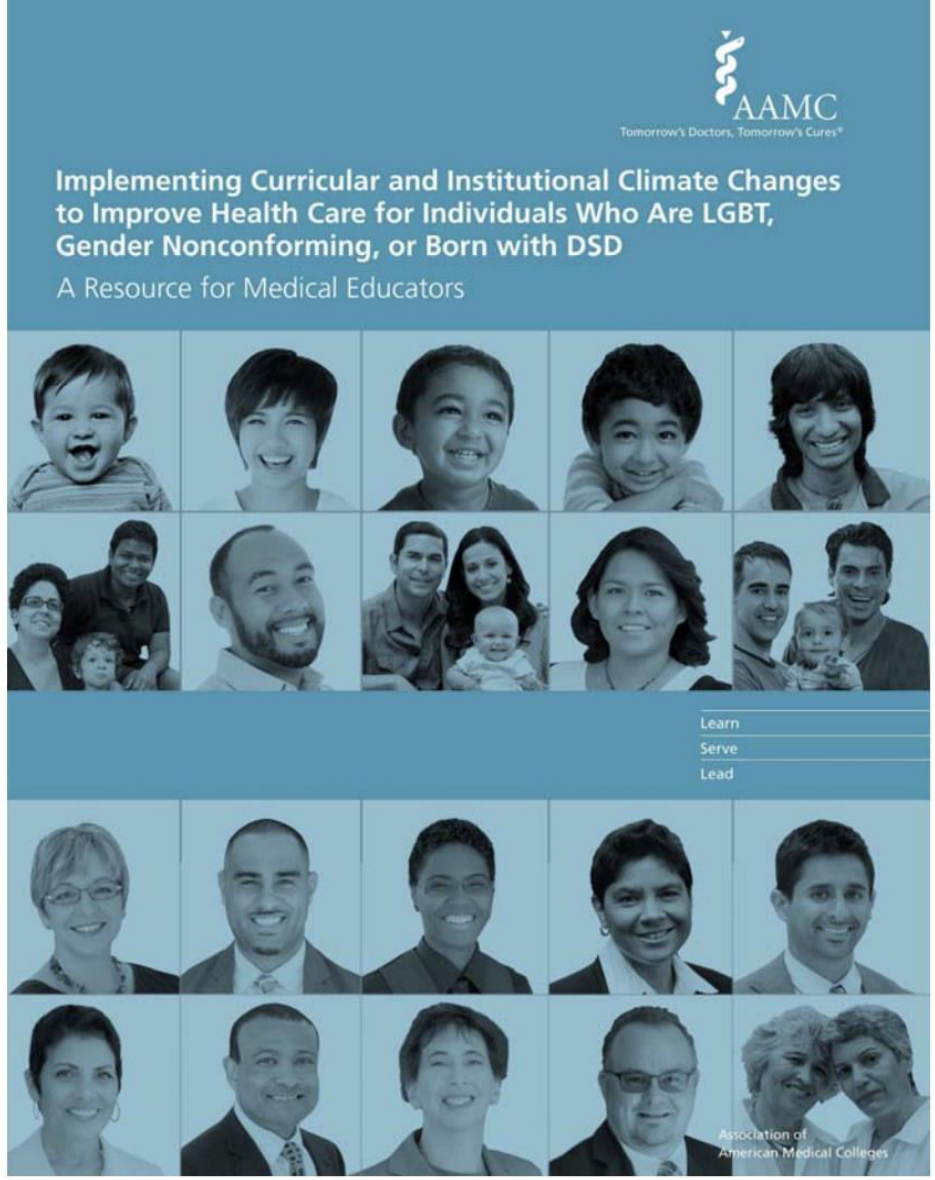
N=14 faculty representing 19 courses and clerkships

Source: Tamas et. al. Academic Psychiatry, 2010

AAMC

Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD:
A Resource for Medical Educators

Available online TODAY!
www.aamc.org/publications



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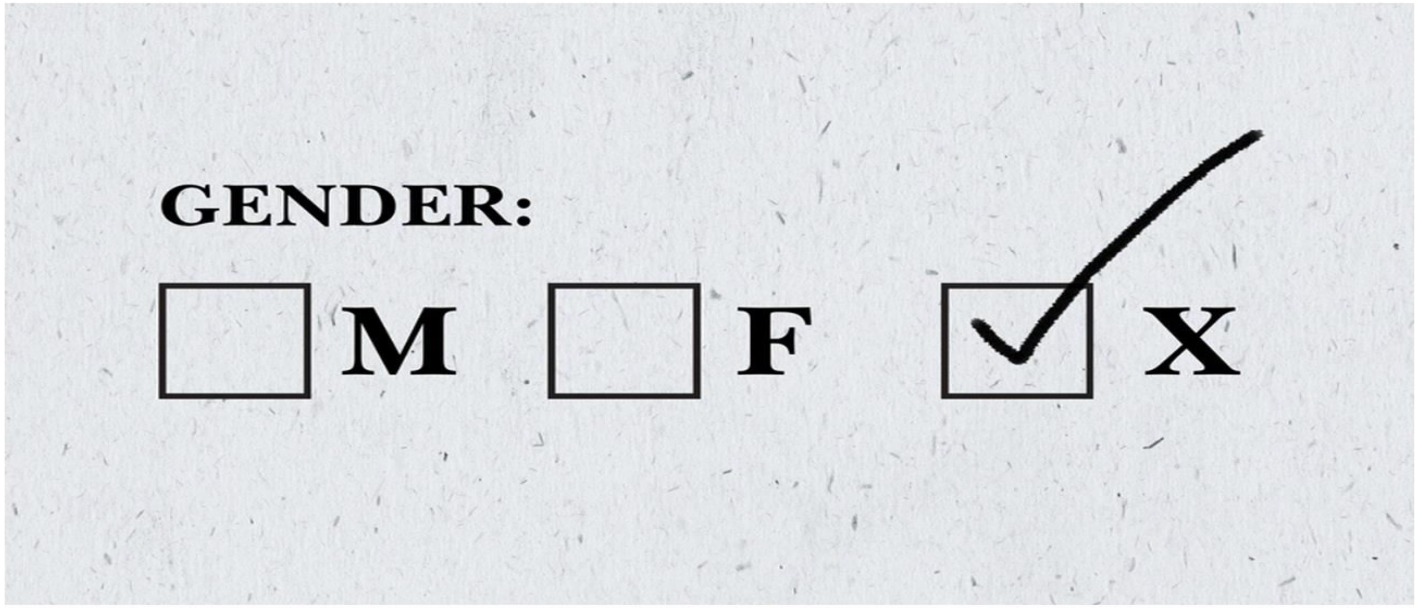
We’re Missing the Boat

Health Care Reform

- Medicaid Expansion /Medicare
- Millions more LGBT, gender non-binary and gender creative people coming into our health care systems
- Obama administration stated that it is wrong to discriminate against Transgender people in healthcare settings and insurance coverage. The Health Care Rights Law did protect transgender people and the rule prompted a titanic shift among insurers.
- New administration – potential reversal of above!!!!!

An Important Win for the Transgender Community

Governor plans to sign law to simplifies the process of changing one's gender on birth certificates

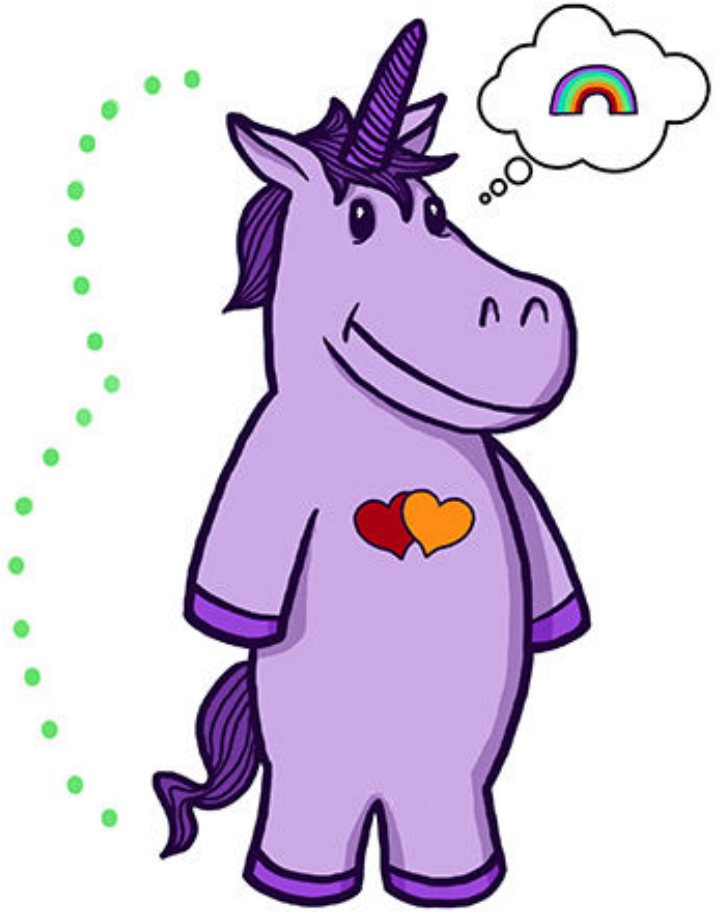


By Leah Cantor | March 14

A bill that makes it easier for transgender and non-binary New Mexicans to match their birth certificate to their gender identity has successfully passed through the House and the Senate and now heads to Gov. Michelle Lujan Grisham for final approval. The bill will also create a new label, "X," on birth certificates to reflect a non-binary identity.

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



Gender Identity

- Female / Woman / Girl
- Male / Man / Boy
- Other Gender(s)

Gender Expression

- Feminine
- Masculine
- Other

Sex Assigned at Birth

Female | Male | Other/Intersex

Physically Attracted to

- Women
- Men
- Other Gender(s)

Emotionally Attracted to

- Women
- Men
- Other Gender(s)

To learn more, go to:
www.transstudent.org/gender

Design by Landyn Pan and Anna Moore

Terminology

- **Sexual orientation** – physical, romantic, emotional attraction, not the same as gender identity.
- **Gender-** Broad term used to describe the societal and cultural perceptions of sexuality.
- **Sex** – Biological characteristics based on genitalia (chromosomes).
- **Gender Identity** – Self- view as man, woman, neither, both or in- between.
- **Transgender -** umbrella term that describes people whose gender identity does not correspond with societal expectations based on their sex assigned at birth.
- **Cisgender**- Individuals whose gender identify conforms to societal norms based on their sex assigned at birth.
- **Transgender men**- Persons assigned female at birth who identify as men/male.
- **Transgender women-** Persons assigned male at birth who identify as women/female.
- **Male-to-female (MTF) or female-to-male (FTM)** are used mainly in research and health records (not preferred for direct patient use).

Terminology

- **Gender Dysphoria (GD**)- is the distress that results from having an internal sense of gender identity that does not match one assigned sex at birth.
- **Gender Non-Conforming** (GN) – the extent to which a persons gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (masculinity/femininity). Not all GN identify as transgender people, nor do all transgender people identify as GN.
- **Transitioning** – process of living as the gender with which a transgender person identifies, rather than the gender assigned to them at birth.
- **Medical transitioning** – using hormone therapy, surgeries, or both, to reduce gender dysphoria.

Terminology

- **Genderqueer**- Term typically used by younger generation for someone who does not subscribe to conventional gender distinctions but identifies with neither, both, or a combination of male and female.
- **Gender non conforming** – person whose behavior or appearance does not conform to prevailing cultural and social expectations about what is appropriate to their gender.
- **Non-binary** – (see also genderqueer,agender) – person who does not fit the male and female binary.
- **Pronouns** -Ask and respect Preferred Pronouns: She/her/hers; He/him/his; They/them/theirs……

How To Ask ‘Sensitive’ Questions

- “I will discuss some sensitive topics.”
- “I will be asking you questions about your sexual behavior.”
- “I will ask you what body parts you use for sexual activity.”
- “I do not want to assume anything.”
- “Most of all, I want you to feel comfortable.”
- “If you prefer me to use other words to describe body parts, let me know.”

You want to make all patients feel welcome and included in your office. Your LGBTQ* patients will be looking for:

A. Posted nondiscrimination statement
B. An intake form with more than M/F for gender
C. Being greeted by front desk staff with a preferred name and pronoun
D. Open ended, nonjudgmental listening by all providers
E. All of the above

What does affirming-care look like?

- Creating a Trans-Friendly Environment.
- Establishing a patient-provider relationship.
  - A trusting relationship is paramount.
- Refer to the patient by their preferred name.
  - Irrespective of names on legal documents.
- Use preferred pronouns and salutations.
  - Avoid misgendering by using incorrect pronouns and terms until known.
- Gender-relevant patient education and health promotion.
- Medically affirming care may include hormone therapy and referrals for gender-affirming surgeries and procedures.

Collecting Information on Gender Identity and Sexual Orientation (SOGI)

Gender Identity

- What is your sex or gender? (*Check **ALL** that apply*)
  - ☐ Male
  - ☐ Female
  - ☐ Transgender woman/Transwoman
  - ☐ Transgender man/Transman
  - ☐ Gender Non-Conforming neither exclusively male or female
  - ☐ Additional Sex or Gender: Please specify: _____
  - ☐ Decline to answer
- What sex were you assigned at birth? (*Check **one***)
  - ☐ Male
  - ☐ Female
  - ☐ Decline to answer

Sexual Orientation

- How do you think of yourself?
  - ☐ Straight or heterosexual
  - ☐ Gay
  - ☐ Lesbian
  - ☐ Bisexual
  - ☐ Queer, pansexual and/or questioning
  - ☐ Something else; please specify

    _____
  - ☐ Don't know
  - ☐ Decline to answer

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This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex or gender identity.

AMA
AMERICAN MEDICAL ASSOCIATION

Gender - Affirming Hormone Process

Process of Gender Affirmation

- Many transgender people go through a multifaceted process of recognizing, accepting, and expressing one's gender identity known as gender affirmation aka gender transition which encompasses social, legal and medical aspects.
- Psychotherapy or counseling to discuss gender issues
- Real-life Experience
- Changing gender markers on legal documents
- Gender-affirming hormone therapy +/-
- Gender-affirming procedures/surgeries +/-

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH)-International, multidisciplinary, professional association.

Mission: Promote evidence based care,research,education,policy and respect for transgender health.

Current Press Releases

Current Press Releases

Press Release Archives

ENDO Annual Meeting

Society in the News

Podcast

Experts issue recommendations to provide gender-affirmation treatment for transgender individuals

September 13, 2017

center of excellence for TRANSGENDER health

Increasing access to comprehensive, effective, and affirming healthcare services for trans communities

Overview of masculinizing hormone therapy

Primary author: Madeline B. Deutsch, MD, MPH

Introduction

The goal of masculinizing hormone therapy is the development of male secondary sex characteristics, and suppression/minimization of female secondary sex characteristics. General effects include the development of facial hair, virilizing changes in voice, a redistribution of facial and body subcutaneous fat, increased muscle mass, increased body hair, change in sweat and odor patterns, frontal and temporal hairline recession, and possibly male pattern baldness. Sexual and gonadal effects include an increase in libido, clitoral growth, vaginal dryness, and cessation of menses. An ovulatory state is common, though not absolute and long-term fertility may be affected, though some transgender men are able to discontinue testosterone and achieve successful pregnancy.[1] Masculinizing hormone therapy may bring about changes in emotional and social functioning, though these can vary from person to person and stereotypes should be

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Hormone therapy information for patients

Informational video on testosterone hormone therapy

Testosterone hormone therapy overview

About consent forms for hormone therapy:

Informed consent is a process

Gender-Affirming Hormone Therapy Recommendations:

These recommendations are based on evidence from multiple current clinical, gender studies, and social science research literatures. No uniform consensus guidelines were used. However, Endocrine Society's guidelines may be preferred.

- Treatments for the development of secondary sexual characteristics of the desired gender and reduction/suppression of biological hormones.
- Recommendations suggest living 12 months full time in the desired gender role prior to initiating hormone treatment.
- There are individuals who desire hormone therapy prior to starting the real life experience. They should be handled on a case by case basis.
- Clinicians should review with patient all potential effects of hormones as well as address the patient's desired effects and any unrealistic goals.

- Hembree et al. J Clin Endocrinol Metab. 2009 Sep;94(9):3132-54. doi: 10.1210/jc.2009-0345. Epub 2009 Jun 9

Initiation of therapy

- Initial visit = “getting to know you”.
- Health history.
- Establish commitment to next steps:
  - Gender questioning, in congruency, dysphoria
  - Readiness for medications, exploring gender, and/or planning transition
  - Expectations, goals
  - Management plan
- Obtain informed consent.
- Order baseline labs.
- Establish follow-up.

Questions to ask:

How would you like to be addressed? What name and pronoun would you like me to use?

https://www.rainbowhealthontario.ca/TransHealthGuide/gp-initialassess.html

Summary: Goals of Care

- Create a safe welcoming environment
- Provide quality care
- Address preventative care
- Recognize needs regarding transition
  - Informed consent vs old mental health evaluation
  - Social transition - changing appearance and gender expression/presentation
  - Medical transition – hormones and/or surgery
  - Recognize that this is considered “medically necessary”
    - Support from many medical organizations including the American Medical Assoc., American College of Physicians, American Psychiatric Association, the World Professional Association on Transgender Health (WPATH)

Informed Consent Model:

"The **informed consent model** for gender-affirming treatment seeks to acknowledge and better support the patient's right to, and capability for, personal autonomy in choosing care options without the required involvement of a mental health professional. Clinicians' use of the informed consent model would enable them both to attain a richer understanding of transgender and gender-nonconforming patients and to deliver better patient care in general."

- https://journalofethics.ama-assn.org/article/informed-consent-medical-care-transgender-and-gender-nonconforming-patients/2016-11

Sample of Informed Consent Form:

Informed Consent for Feminizing Hormone Therapy

The use of hormone therapy for gender transition/affirmation is based on many years of experience treating trans persons. Research on hormone therapy is providing us with more and more information on the safety and efficacy of hormone therapy, but all of the long-term consequences and effects of hormone therapy may not be fully understood.

This informed consent asks you to consider the expected benefits of hormone therapy and the possible side effects of hormone therapy, so that you can decide, with your medical provider, if hormone therapy is right for you. By signing this form, you are stating that you have discussed the risks and benefits with your medical provider or a member of the medical team and that you understand how these benefits and risks apply to you personally.

Androgen (testosterone) blockers are used to decrease the amount and/or block the effect of testosterone on and reduce the male features of the body.

Estrogen (usually estradiol) is used to feminize the body; estrogens can also decrease the amount and effect of testosterone. Your medical provider will determine the form of estrogen (pills, patches, gels or shots) and the dose that is best for you based on your personal needs and wishes, as well as considering any medical or mental health conditions you might have.

Each individual person responds to hormone therapy differently, and it is difficult to predict how each person will respond. You agree to take the androgen blockers and/or the estrogen only as prescribed and to discuss your treatment with your medical provider before making any changes.

The Expected Effects of Feminizing Hormone Therapy

The feminine changes in the body may take several months to become noticeable and usually take up to 3 to 5 years to be complete.

Changes that will be PERMANENT; they will not go away, even if you decide to stop hormone therapy:

- **Breast growth and development. Breast size varies in all women; breasts can also look smaller if you have a broader chest.**
- **The testicles will get smaller and softer**
- **The testicles will produce less sperm, and you will become infertile (unable to get someone pregnant); how long this takes to happen and become permanent varies greatly from person to person**

https://fenwayhealth.org/documents/medical/transgender-resources/Fenway_Health_Consent_Form_for_Feminizing_Therapy.pdf

Gender Dysphoria

DIAGNOSIS of GENDER DYSPHORIA

(F64 ICD 10)

- New Diagnosis Class in DSM 5
- Causes clinically significant distress or impairment in social, occupational, or other important areas of function.
- Marked difference between expressed/experienced gender and gender others would assign
- Must continue for at least six months
- In children, the desire to be of the other gender must be present and verbalized

Expectations:Goals of Therapy

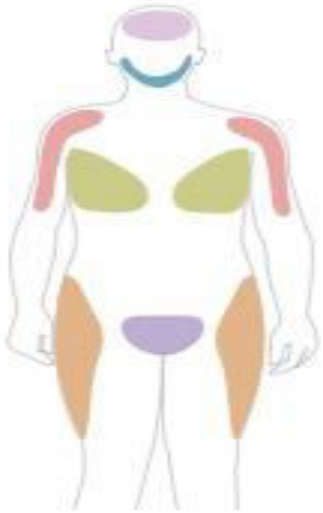
EFFECTS AND EXPECTED TIME COURSE OF A REGIMEN CONSISTING OF AN ANTI-ANDROGEN AND ESTROGEN

IRREVERSIBLE
Chest growth

REVERSIBLE
Skin softening/Decreased oiliness
Thinned/slowed terminal hair growth
Decreased muscle mass/strength

VARIABLE
Decreased spontaneous arousals
Decreased libido
Decreased testicular volume
Decreased sperm production
Erectile Dysfunction

VARIABLE
Fat redistribution



Years: 0 | 1 | 2 | 3 | 4 | 5

PHYSICAL EFFECTS	REVERSIBILITY	ONSET
Softening of skin/decreased oiliness	Reversible	3 - 6 months
Body fat redistribution	Reversible/Variable	3 - 6 months
Decreased muscle mass/strength[b]	Reversible	3 - 6 months
Thinned/slowed growth of body/facial hair[c]	Reversible	6 - 12 months
Male Pattern Baldness[d]	Reversible	1 - 3 months
Breast growth	Irreversible	3 - 6 months
Decreased testicular volume	Variable	3 - 6 months
Decreased libido	Variable	1 - 3 months
Decreased spontaneous erections	Variable	1 - 3 months
Decreased sperm production	Variable	variable
Erectile Dysfunction	Variable	variable

a) Estimates represent published and unpublished clinical observations
b) Significantly dependent on amount of exercise
c) Complete removal of male facial and body hair requires electrolysis, laser treatment, or both
d) No regrowth, loss stops

Expected Onset
Expected Maximum Effect[a]

Common Physical Findings in Patients on Cross-Gender Hormones

Biologic males on estrogen

- Gynecomastia/breast tissue development*
- Enlarged areola and nipple
- Redistribution of body fat to natal female
- Softened body skin
- Testicular atrophy
- Decreased spontaneous erections
- Emotional lability
- Reduced testosterone levels
- Decreased facial/body hair (variable)
- Decreased libido
- Weight gain

Biologic females on testosterone

- Deepened voice*
- Laryngeal prominence*
- Cessation of menses
- Hirsutism
- Clitoral growth, average 4-5cm*
- Increased libido
- Mild breast tissue atrophy*
- Increased testosterone levels
- Possible male pattern baldness*
- Weight gain
- Acne
- Increased facial/body hair*

* *Notes changes that may NOT resolve when hormone therapy is terminated*

Patient: JAMEY

Jamey, is a 26 yo FTM transgender patient presenting to your office with a past medical history of mild intermittent asthma and tobacco use presenting for refill of his Albuterol. During the office visit he wants to discuss with you about officially starting his transition to his identified gender.

Initial Health Assessment:

- Thorough history and exam- Need to assess appropriateness and readiness
  - Personal/FHx of cardiovascular disease, breast cancer, diabetes mellitus, hyperlipidemia, hypertension
  - History of hepatitis, cholelithiasis, venothromboembolic phenomenon
  - History of prescribed or medically unmonitored hormone use
  - Mental health history/screening – untreated or undiagnosed depression, anxiety, PTS or other mental health condition
    - GAD 7, PHQ 9 screening tools, others
  - Substance use/abuse history

Initiation of Hormone Therapy:

- Prescribing provider will establish:
  - Address other medical issues and concerns
  - Discuss Informed consent
  - Discuss reasonable goals, expectations
  - Baseline screening labs - STI's, chemistry,CBC,hormone levels – estradiol testosterone
  - Sexual history
  - Preventative care- vaccines, PAP smears etc.. – discussion????
  - Schedule follow up, set up referrals if necessary
- Provider and patient should establish:
  - Trusting relationship - use of appropriate pronouns
  - Disclosure when patient is ready
  - Sources of social support
  - Impact on school or work

Sexual History:

- What name or pronouns should I use?
- What are gender(s) of your partner(s)?
- Have you ever had anal, genital, or oral sex?
  - Do you give, receive, or both?
  - Other sexual activities?
- How many partners have you had in past six months?
- Do you use condoms…never, some, most, all of the time?
- Any symptoms of STIs?
- Any sex for shelter, food, drugs, other?
- Any forced sex or rape?

Physical Exam for TransMasculine:

- **Chest Exam**
  - This includes patients who have residual tissue post-mastectomy.
  - Mammography when indicated by glands present, age, clinical indication, or family history.

- **Pelvic Exam**
  - If the uterus and cervix are present, pelvic exams and Pap smears should be performed on a routine basis.

Medication therapy:

- **Hormone regimes for transgender men (female to men, FTM) -** No single protocol when administering hormone therapy to transgender patients

1. Parenterally (i.m. or subcutaneous)

- Testosterone enanthate or cypionate 100mg IM weekly or 200mg IM every 2 weeks (may begin 40-80mg weekly and increase by 20-40mg every 2 to 4 weeks) Max 400mg/every 2 wks
- Testosterone undecanoate (long-acting) start 750mg IM initial dose, 750mg IM at 4 weeks, then injected every 10 weeks after

2. Transdermal

- Testosterone 1% gel *2.5gm – 10 g/day (Androgel-2.5gm=25mg testosterone….*
- Testosterone patch *4mg patch daily to upper arm,thigh,abd,back every 24 hours*

3. Oral

- Testosterone undecanoate* *160-240mg/day*

*Not available in the USA.

Medication therapy: Masculizing therapy

- **Hormone regimes for transgender men (female to men, FTM)**
  - Others:
    - Implantable Pellets
    - Depo-Provera 150mg IM every 3 months
      - May be used before starting testosterone to provide cessation of menses for those patients whom menses is particularly troublesome, or use early in the course of testosterone therapy if menses does not cease with therapeutic levels of testosterone.
    - Finasteride 1mg to 5mg daily (also treats male pattern baldness from testosterone treatment)
    - Topical testosterone applied to the clitoris

Masculinization therapy - Testosterone

- Topical
  - Gel
  - Topical patch 2-4mg q24hr
  - Can rub off and masculinize other females

- Injection (IM vs SQ)
  - Testosterone cypionate
    - 50-100 mg IM q weekly
    - 100-200 mg IM q 2 weeks
  - Usually start with lower dose at first (test dose)
  - Gradual increase q 3-6 months
  - SQ injections appear to be effective and well tolerated in the short term (Olson, 2014)

Care of Transmasculine People:

- **Monitoring for transgender men (FTM) on hormone therapy:**
- Monitor for virilizing and adverse effects every 3 months for first year and then every 6 – 12 months.
- Monitor serum testosterone at follow-up visits with a practical target in the male range (300 – 1000 ng/dl). Peak levels for patients taking parenteral testosterone can be measured 24 – 48 h after injection. Trough levels can be measured immediately before injection.
- Monitor hematocrit and lipid profile before starting hormones and at follow-up visits.
- Bone mineral density (BMD) screening before starting hormones for patients at risk for osteoporosis. Otherwise, screening can start at age 60 or earlier if sex hormone levels are consistently low.
- FTM patients with cervixes or breasts should be screened appropriately.

"Practical Guidelines for Transgender Hormone Treatment"- www.bumc.bu.edu

Risk of Masculinizing:

- **Common, mild**
  - Initial mood changes, resolve by 3-4 months
  - Initial weight gain, restabilize after 3-4 months
  - Acne
  - Increase in Hgb, Hct
- **Over time**
  - Male pattern baldness
  - Pelvic pain

Risk of Masculinizing:

- **Not clinically significant**
  - TG ↑ HDL ↓ LDL ↑
  - Insulin resistance
  - Increased homocysteine
  - Polycythemia

Screening considerations:

- **Clinicians should engage in dialogue with transgender men who have undergone bilateral mastectomy about the unknown risks associated with residual breast tissue**, as well as the possible **technical limitations of mammography** (Grading: X C S).
- **Transgender men are at risk for cervical cancer.** Cervical cancer is the third most common cancer globally [1]; more than 99% of which are caused by infection with one of several high risk oncogenic strains of the human papilloma virus (hr-HPV).[2] Pelvic exams to obtain pap smears may be challenging for transgender patients.
- **Cervical cancer screening should never be a requirement for testosterone therapy. Cervical cancer screening for transgender men, including interval of screening and age to begin and end screening follows recommendations for non-transgender women as endorsed by the American Cancer Society, American Society of Colposcopy and Cervical Pathology (ASCCP), American Society of Clinical Pathologists, U.S. Preventive Services Task Force (USPSTF) and the World Health Organization**
- www.transhealth.ucsf.edu Center of Excellence for transhealth

Care of Transmen - Surgical Options:

- **Top**
  - Mastectomy with chest reconstruction
- **Bottom**
  - Hysterectomy
  - Metoidoplasty
  - Phalloplasty
  - Urethroplasty
  - Clitoral free-up
  - Vaginectomy
  - Implants (testicular,erectile,liposuction,lipofillers

Surgical Intervention for Transmen
Bilateral Mastectomy and Creation of Male Chest

- **WPATH Standards of Care**
  - Persistent, well-documented gender dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Age of majority in a given country (if younger, follow the SOC for children and adolescents).
  - If significant medical or mental concerns are present, they must be reasonably well-controlled.
- **Hormone Therapy is not a pre-requisite.**

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Surgical Intervention for Transmen (two referrals) Hysterectomy and Bilateral Salpingo-Oophorectomy, Metoidioplasty or Phalloplasty

- **WPATH Standards of Care:**
  - Persistent, well-documented gender dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Age of majority in a given country (if younger, follow the SOC for children and adolescents).
  - If significant medical or mental concerns are present, they must be reasonably well-controlled.
  - 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
- 12 continuous months of living in a gender role that is congruent with their gender identity.

www.wpath.org

Preventive Care:

- PAP Smear
- HPV Vaccine
- Breast screening if no top surgery
- Binders
- Bone density screening
- Smoking cessation
- Screens:
  - Mental health and substance use
  - Violence
  - STIs

Reasonable expectations: FTM

Physical Effect	Timeline		Reversibility
	Onset	Max. Effect	
Skin oiliness/acne	1-6 months	1-2 years	Reversible
Body fat redistribution	3-6 months	1-5 years	Reversible/Variable
Increased muscle mass/strength*	6-12 months	2-5 years	Reversible
Cessation of menses	2-6 months	-	Reversible
Vaginal atrophy	3-6 months	1-2 years	Reversible
Facial/body hair growth	3-6 months	3-5 years	Irreversible
Scalp hair loss	Variable		Irreversible
Deepened voice	3-12 months	1-2 years	Irreversible
Clitoral enlargement	3-6 months	1-2 years	Irreversible
Infertility	Variable		Irreversible

*Significantly depends on amount of physical activity

http://transcaremoncton.craigchisholm.me/index.php/mtf/

Jamey

- H & P
  - Physical: voice, hair growth, body distribution, (clitoral growth)
  - Mental/emotional: anger/aggression, shot anxiety, adjustment
  - Other resources needed, plans, questions?
- Labs
  - Testosterone levels
- Lipids, LFTs, hemoglobin
- Preventive Care
  - HPV vaccine, smoking cessation, sexual history, prep/discuss Pap
- Shot anxiety

A colleague's patient is here for an acute visit for UTI symptoms. "Tyeisha," age 19, has a goatee, very short cropped hair and male clothing. When discussing social history, the best question is:

A. Do you have sex with men, women or both?
B. Are you a transsexual?
C. What surgeries have you had?
D. What name and pronouns do you prefer?

Patient: Stacey

- Stacey is a 55 yo African American MTF transgender currently receiving hormone replacement therapy (HRT). She has a history of depression currently on an SSRI (fluoxetine) and is presenting for routine follow up.

Baseline labs for Feminization

No single protocol when administering hormone therapy to transgender patients

- Labs common prior to starting estradiol hormone therapy :
  - CBC,ALT/AST,glucose,lipids,testosterone,hepatitis,HIV
- Labs for spironolactone use:
  - BUN/Cr, Na, K
- Labs for patients already using hormones:
  - Estradiol ?

Feminization therapy

- **Estrogen:**
- **1. Oral estrogen**
  - Oral conjugated estrogens *2.5-7.5mg/day (beginning 0.625mg)*
  - Oral estradiol *2-6mg/day (starting 1-2mg qd)*
- **2. Parenteral estrogen:**
  - Estradiol valerate *5-20mg IM/2 weeks* or cypionate *2-10mg IM/week*
- **3. Transdermal estrogen:**
  - Estradiol patch *0.1-0.4mg/2X week*
- **Progesterone:**
  - No great evidence
  - Side effects: mood, weight gain; possible CV in older age
  - Medroxyprogesterone 5-10mg oral or topical micronized 100-200mg

Transfeminizing care

- **Hormone regimes for transgender women (male to wome MTF) :**
- **1. Anti-androgen:**
  - Spironolactone 50 mg – 200 mg daily (initial 25mg/day)
    - Direct suppression of testosterone
    - Hyperkalemia
  - Finasteride 1mg-5mg/day or Dutasteride 0.5mg/day
    - 5 alpha-reductase inhibitor
    - Blocks peripheral conversion of testosterone to dihydrotestosterone
    - Can cause depressive symptoms
- GnRH agonists *3.75 mg subcutaneous monthly*

Monitoring of Transfeminizing Care

- **Monitoring for transgender women (MTF) on hormone therapy:**
  - Monitor for feminizing and adverse effects every 3 months for first year and then every 6- 12 months.
  - Monitor serum testosterone and estradiol at follow-up visits.**For transgender care, The Endocrine Society recommends monitoring of the total testosterone level, with a target range of <55ng/dl .**
  - Monitor prolactin and triglycerides before starting hormones and at follow-up visits. (***Endocrine Society recommends only checking prolactin if symptoms - such as galactorrhea, visual changes, new onset HA)***
  - Monitor potassium levels if the patient is taking spironolactone.
  - BMD screening before starting hormones for patients at risk for osteoporosis. Otherwise, start screening at age 60 or earlier if sex hormone levels are consistently low.
- MTF patients should be screened for breast and prostate cancer appropriately.

Physical Exam for TransFeminine

- **Breast Exam**
  - Required for any breast tissue development secondary to augmentation or cross-sex hormones
- **Testicular Exam**
- **Digital Rectal Exam**
  - Standard recommendation or clinical indication

*Clinician should document any portion of exam that is omitted or deferred by patient request.

Reasonable expectations: MTF

Physical Effect	Timeline		Reversibility
	Onset	Max. Effect	
Softening of skin/decreased oiliness	3-6 months	-	Reversible
Decreased muscle mass/strength	3-6 months	1-2 years	Reversible
Thinned/slowed growth of body/facial hair	6-12 months	3-5 years	Reversible
Male pattern baldness	1-3 months	1-2 years	Reversible
Body Fat Redistribution	3-6 months	3-5 years	Reversible/variable
Decreased testicular volume	3-6 months	2-3 years	Variable
Decreased libido	1-3 months	1-2 years	Variable
Decreased spontaneous erections	1-3 months	3-6 months	Variable
Decreased sperm production	Variable		Variable
Erectile dysfunction	Variable		Variable
Breast growth	3-6 months	2-3 years	Irreversible

http://transcaremoncton.craigchisholm.me/index.php/mtf/

Adverse Effects

Estrogens

- Venous thrombosis/pulmonary emboli (ethinyl estradiol)
- Hypertriglyceridemia
- Elevated blood pressure
- Gallbladder disease
- Macroprolactinoma

Spironolactone

- Hyperkalemia
- Hypotension

Hembree, JCEM 2009, 94(9):3132–3154

Issues – self prescribed hormones!!!!

- Excessive amounts:
  - Increased risks and medication side effects:
    - Estradiol VTE risks
    - Testosterone conversion to estrogens
  - Does not increase feminization nor override heredity
- Quality:
  - Purity not guaranteed
  - Medication and dose not guaranteed
- Safety:
  - Self-injection poses HIV & hepatitis risks

Ask about silicone injection use….

Potential Devastating Effects:

- Embolism
- Infection (bacterial, HIV)
- Autoimmune phenomena
- Local tissue fibrosis, destruction
- Silicone migration and cosmesis

Surgical intervention for Transfemale Breast Augmentation (implants/lipofilling)

- WPATH Standard of Care:
  - Persistent, well-documented gender dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Age of majority in a given country (if younger, follow the SOC for children and adolescents)
  - If significant medical or mental concerns are present, they must be reasonably well-controlled
- Hormone Therapy for 12 months.

www.wpath.org

Care of Transfeminine People

Preventive Care:

- Mammograms ?
- HPV & possibly hepatitis vaccines
- Tucking (with gaffes)
- Prostate awareness
- Smoking cessation
- Screens:
  - Mental health and substance use
  - Violence
  - STIs

Community Engagement

	21-64 YEARS	>65 YEARS
LABS/INVESTIGATIONS:	☐ **Mammography** (estrogen > 5 yrs and avg risk: age 50-64 q2 yrs) ☐ Hemoccult mutiphase (age 50-64 q2yrs) OR sigmoidoscopy OR Colonoscopy ☐ **GC/CT/Syphilis/HIV/HBV screen (high risk)** ☐ **Yearly trans bloodwork** Fasting glucose and lipid profile Cr, lytes if on spironolactone CBC, ALT+/-AST Estradiol, Prolactin, LH ☐ **Bone Mineral Density** if at risk	☐ **Mammography** (estrogen > 5 yrs and avg risk: age 65-71 q2 yrs) ☐ Hemoccult mutiphase 2 yrs (age 65-74 q2yrs) OR sigmoidoscopy OR Colonoscopy ☐ **GC/CT/Syphilis/HIV/HBV screen (high risk)** ☐ **Yearly trans bloodwork** Fasting glucose and lipid profile Cr, lytes if on spironolactone CBC, ALT+/-AST Estradiol, Prolactin, LH ☐ **Bone Mineral Density** ☐ Audioscope (or inquire/whispered voice test)
IMMUNIZATIONS:	☐ Tetanus vaccine q10yrs ☐ Meningococcal vaccine (high risk) ☐ Influenza vaccine q1yr ☐ Herpes zoster vaccine (age >60) ☐ Pneumococcal vaccine (high risk) ☐ Acellular pertussis vaccine ☐ Human papillomavirus vaccine (3 doses) (age 9-26, **consider up to age 45**) ☐ MMR vaccine (ensure 2 doses rec'd if born >1970) ☐ Measles immunity ☐ Varicella vaccine (2 doses) ☐ Varicella immunity ☐ **Hepatitis A/Hepatitis B** ☐ **Hep A immunity** ☐ **Hep B immunity**	☐ Tetanus vaccine q10yrs ☐ Influenza vaccine q1yr ☐ Pneumococcal vaccine ☐ Acellular pertussis vaccine ☐ Herpes zoster vaccine ☐ Varicella vaccine (2 doses) ☐ Varicella immunity

HIV Among Transgender People

Transgender populations in the United States have an increased prevalence of HIV infection and risk behaviors associated with susceptibility to contracting the disease.

Gender-Affirming Hormone Therapy is *Not* Contraindicated in HIV Infection

No Known Interactions Between Hormonal Therapy and First-line ART

Care of HIV-Positive Individuals

- Allow patient to participate in care planning
- Select ARV regimens that meet mutual goals
- Incorporate supportive care modalities to aid disease coping and ARV adherence
- Offer gender-affirming hormone therapy as part of HIV care
- Re-assess for changes or barriers to achieving viral suppression at each clinical visit

Case for PrEP: Ryan

- 21 year old male
- No significant PMHx
- Identifies as bisexual with multiple partners that are male, female, and MTF
- “verse” partner with men and transwomen
- Uses condoms inconsistently
- Smokes marijuana regularly
- Remote use of IVDU
- Physical: unremarkable
- Labs: HIV-must be neg,Hep B, Hep C,STI,CrCl- must be >60ml/min

Ryan:

- Would you prescribe PrEP in this patient
  - 1. Yes
  - 2. No

PrEP – HIV Prevention

Summary of Guidance for PrEP Use

	Men Who Have Sex With Men	Heterosexual Women and Men	Injection Drug Users
Detecting substantial risk of acquiring HIV infection:	• Sexual partner with HIV • Recent bacterial STD • High number of sex partners • History of inconsistent or no condom use • Commercial sex work	• Sexual partner with HIV • Recent bacterial STD • High number of sex partners • History of inconsistent or no condom use • Commercial sex work • Lives in high-prevalence area or network	• HIV-positive injecting partner • Sharing injection equipment • Recent drug treatment (but currently injecting)
Clinically eligible:	• Documented negative HIV test before prescribing PrEP • No signs/symptoms of acute HIV infection • Normal renal function, no contraindicated medications • Documented hepatitis B virus infection and vaccination status		
Prescription	Daily, continuing, oral doeses of TDF/FTC (Truvada), ≤90 day supply		
Other services:	• Follow-up visits at least every 3 months to provide: • HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, STD symptom assessment • At 3 months and every 6 months after, assess renal function • Every 6 months test for bacterial STDs		
	• Do oral/rectal STD testing	• Assess pregnancy intent • Pregnancy test every 3 months	• Access to clean needles/ syringes and drug treatment services

Source: US Public Health Service. Preexposure prophylaxis for the prevention of HIV infection in the United States —2014: a clinical practice guideline.

A transgender man, age 47, presents to establish care. He had a top surgery but never a hysterectomy. He has been on testosterone therapy for 10 years. Which of the following is the most appropriate testing?

A. Pap test with HPV
B. Mammogram
C. Pap/HPV and mammogram
D. Neither Pap nor mammogram

His wife, a transgender woman, age 52 is also a new patient. She has had full top surgery with breast implants and full bottom gender affirmation surgery. She has been on estrogen therapy for 12 years. Which of the following is the most appropriate testing?

A. Pap test with HPV
B. Mammogram
C. Pap/HPV and mammogram
D. Prostate exam

Summary:

- **Transgender people may be of any age, race, ethnicity, or socioeconomic status and represent a wide variety of healthcare needs- and has most likely experienced discrimination.**
- Trust takes time.
- Physical examination should be relevant to the anatomy that is present, regardless of gender presentation, and without assumptions as to anatomy or identity
- The pelvic exam may be a traumatic and anxiety inducing procedure for transgender men and other trans-masculine persons. Transgender men are less likely to be up to date on cervical cancer screenings.
- Thorough and sensitive history and education.
- Creating a safe physical and emotional environments is paramount.
  - Use tools to train staff, obtain preferred name.
- Patients are forgiving to those who are sincere.
  - OK to get pronouns wrong the first time, but make an effort to address the patient by the preferred name and pronoun.
- **Need providers to have the open-ness, willingness to learn.**

References:

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  - http://www.transhealth.ucsf.edu
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  - http://www.transhealth.vch.ca
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  - Transgender Top 10 Health List
  - http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=692
- American Psychological Association handout
  - "Answers to Your Questions About Transgender Individuals and Gender Identity"
  - http://www.apa.org/topics/transgender.html
- Understanding and Assessing the Sexual health of Transgender patients
  - http://www.lgbthealtheducation.org/wp-content/uploads/Understanding-and-Assessing-the-Sexual-Health-of-Transgender-Patients.pdf

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  - Endocrine Society Guidelines for Endocrine Treatment of Transsexual Persons
  - Tom Waddell Health Center Protocols for Hormonal Reassignment of Gender
  - TransLine Medical Consultation Service Transgender Lab and Medication Protocol
  - UCSF Center of Excellence for Transgender Health Primary Care Protocol
    Vancouver Coastal Health Guidelines for Endocrine Therapy for Transgender Adults
  - World Professional Association for Transgender Health (WPATH) Standards of Care

Selected References

- Selected slides - "Practical Skills in LGBTQ Care"- Dr. Keisa Fallin-Bennett, Dr. Christine George
- Selected slides - "Transgender Primary Care" – Dr. Benjamin Simmons III
- Selected slides – " Integrating Gender-Affirming Care and HIV Prevention and Care for Transgender and Gender Non – Conforming People: Concepts and Practice" – AAHIVM Dr. Asa Radix MD,MPH,FACP & Dr. Ada D. Stewart, MD,AAHIVS,FAAFP,HMDC
- **Practical Guidelines for Transgender Hormone Treatment**<u>**Adapted from:**</u> **Gardner, Ivy** and **Safer, Joshua D.** 2013 Progress on the road to better medical care for transgender patients. Current Opinion in Endocrinology, Diabetes and Obesity 20(6): 553-558.

ICD - 10 Diagnosis Codes

Diagnosis	Code
Endocrine Disorder NOS (hormone disturbance)	E34.9
Hypogonadism	E28.39 (female) E29.1 (male)
Gender Dysphoria	F64

OPPORTUNITIES FOR LEARNING:

- Advancing Excellence in Transgender Health:

  A Core Course for the Whole Care Team

  Friday - Sunday

  November 1-3, 2019

  Boston Park Plaza Hotel

  Boston, Massachusetts

QUESTIONS?

RESPECT AND EQUALITY