

Transgender Medicine



Why do I do this?



“The world started to snap into focus. I can talk about my feelings, and the dominant feeling isn’t rage.”

- Claire, April 18, 2018

Objectives

- Understand basic medical/surgical treatments for gender affirmation
- Discuss health inequities related to gender dysphoria
- Discussion of basic policy opportunities

Limited Physician Education

- AAMC 2014 recommended guidelines of competencies
- UCD example – 2 mandatory lectures in 1st 2 years
- No residency or even endocrinology fellowship requirements!

The New Standard of Care

AAMC Guidelines Nov 2014

- 30 new competencies for medical student training on LGBT care

“People who are LGBT, gender nonconforming, or born with DSD often experience challenges when seeking care in doctors’ offices...can range from being made to feel unwelcome to outright discrimination and mistreatment, lead to poor physical and emotional health.”

Barriers to Health Care

- Fear of discrimination by health care providers and mental health care providers has led many to avoid treatment

4x



THE NATIONAL
AVERAGE OF
HIV INFECTION

50%

OF TRANS PATIENTS
EDUCATE THEIR
DOCTORS



1 in 4



DELAYED SEEKING
CARE DUE TO
DISCRIMINATION

19%

WERE REFUSED CARE



The Benefits of Treatment

- ✓ Less depression and anxiety
- ✓ Less global psychopathology
- ✓ Improved quality of life and self-esteem
- ✓ Significantly reduced stress, social distress, gender dysphoria

Gorin-Lazard A. J Nerv Ment Dis, Nov 2013.

Colizzi M. J Sex Med, Dec 2013.

Costa, R. Neuropsych Dis Treat. Aug 2016

Professional Organization Support



"RESOLVED, That our American Medical Association **support public and private health insurance coverage** for treatment of gender identity disorder as recommended by the patient's physician." 2008



"Significant and long-standing medical and psychiatric literature exists that demonstrates **clear benefits** of medical and surgical interventions to assist gender variant individuals seeking transition..."



"Primary care is an ideal setting for transgender health care, given that primary care physicians are knowledgeable of and often experienced with the administration of **estrogens** (for menopausal care and contraception), **testosterone** (for androgen deficient states such as with human immunodeficiency virus), and **testosterone-blocking medications** (for hirsutism and prostatic disease), and are aware of **important mental and social health issues.**"

American Academy of Pediatrics

Position statement
July 2013



- “ Transgender adolescents need to be **supported and affirmed**; they need education and **referral for the process of transition** and about avoiding the pitfalls of using treatments that were not prescribed by a licensed physician.”
- “ Pediatricians should support parents in working through adjustment issues related to having a child who is LGBTQ while continuing to demonstrate love and support for their children”

The Basics of Medical and Surgical Tx

Disclaimer: this is not FDA approved use of these meds



<https://healthy.kaiserpermanente.org/static/drugency/images/A3352990.JPG>

What Do All Providers Need to Know?

The ACA prohibits discrimination based on gender

Front line staff matters

- Preferred name
- Preferred pronouns
- Don't make assumptions about anatomy
- Don't assume the hormones are related to the problem
- Avoid invasive and unnecessary questions
- How does this show up in EMR?

Insurance Considerations

It's covered!!

By California insurance plans....
For now... and to varying
degrees...

Informed Consent Model

Supporters...



"Criteria for Hormone Therapy...

1. Persistent, well-documented gender dysphoria
2. Capacity to make a fully informed decision and to consent for treatment
3. Age of majority in a given country
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled."

Masculinizing: Testosterone

Most common preparations

1) Injection:

200 mg/mL IM q 2 weeks
or SC weekly



2) Testosterone Creams



Feminizing: Estrogen

- **Estradiol tabs:** Most commonly used
- **Patches:** Used for women >40 yo and for women at high risk for CV event (smoking, etc)
- **Injectable** – more common, shortages occur
- Creams
- ~~Progesterone:~~ controversial, no evidence base

Feminizing: Anti-Androgen

- Spironolactone: 100-200 mg daily
- Finasteride – less potent, less used



General Principles

- Changes take months to years for full effect
- Reversible vs. permanent effects
- Dose is titrated to effect, within context of monitoring labs and hormone levels
- When considering risks/side effects, consider if it was a cis person with endogenous hormones

Pediatric Considerations

- Family and support systems
- Counseling
- Social transition
- Blockers vs. cross sex hormones
- Fertility preservation



“Top” Surgery

Masculinizing: mastectomy

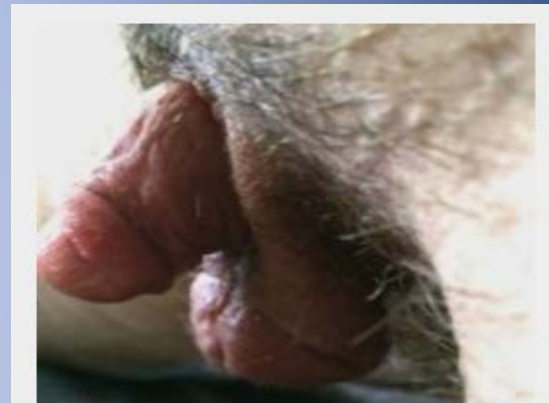
Feminizing: breast augmentation



“Bottom” Surgery (aka GCS, SRS)

Masculinizing

- Metoidioplasty +/- urethral lengthening
- Phalloplasty
- Penile implant
- Scrotoplasty
- Testicular implant
- Oophorectomy
- Hysterectomy
- Vaginectomy



— Patient A: 4 week post op profile view.
Note anteriorly positioned pouch-like scrotum.



Patient F1

1-Stage ALT Phalloplasty 6 month post-op,
with glansplasty and without testicular implants.

Feminizing Bottom Surgery

- Orchiectomy
- Penectomy
- Vaginoplasty

Patient I: 7 months postop



Other plastic surgeries...

- Facial feminization (a variety...)
- Liposuction
- Fat grafting
- Soft tissue fillers
- Voice surgery



— Preop lateral view



— Postop lateral view

Non-Medical Treatments

- Binding, tucking, packing
- Hair removal
- Vocal health (speech therapy)
- ~~Silicone fillers~~
- Legal name/gender changes

Reproductive Health and Fertility

- National Transgender Law Center
- National Center for Lesbian Rights:
<http://www.nclrights.org/>
- SprOUT: <http://www.sproutfamily.org/>
- California Sperm Bank:
<https://www.thespermbankofca.org/>
- Fertility preservation in youth using blockers is on the horizon

Health Inequity Considerations (1/2)

- STIs, increased HIV prevalence
 - >50% in AA transwomen, 34 x greater for all transwomen
 - 35% all transpeople vs. 2% of cis population
- Increased rates of drug and alcohol abuse
- Prostitution
- 25 % experience homelessness
- Psych co-morbidities
- Reduced access to medical care

1. Herbst. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS and Behavior. 2008

2. Grant. Injustice at every turn: a report of the National Transgender Discrimination Survey. 2011

Health Inequity Considerations (2/2)

- 3x more likely than cis to delay getting prescribed medicine
- 4x more likely to experience serious psychological distress
- ¼ have delayed getting timely medical care
- More likely to be disabled (60% vs 27%)

Pediatric Considerations

- LGBTQ youth **without support** are at high risk
 - 8x more attempted suicide than non LGBTQ peers
 - 3x more substance use
 - Increased prevalence in juvenile justice system
 - Increased homelessness
 - More self harm
 - High risk sexual behavior
 - Missing school
- Increased presence in foster care
- LGBTQ youth **WITH support report much better mental health (70% vs 15% without support)**

Policy Opportunities

- Bathrooms
- Schools
- Prisons
- Access to medical care and provider education
- Insurance coverage
- Gender related paperwork
- Athletics
- HIV care
- And?



Runner's World
1 hr · 🌐

"There's not just one way to be a transgender athlete, and I think that's why it becomes so complicated for people to both understand policies and for policymakers to write policies." —Chris Mosier, a transgender triathlete, duathlete, and activist

A photograph of a woman, Chris Mosier, running on a trail. She is wearing a blue jacket and a backpack. The background shows trees with autumn foliage.

Boston Marathon Clarifies Policies on Transgender Runners

Athletes must compete under the same gender identity with which they qualified.

RUNNERSWORLD.COM

QUESTIONS? Call me!



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