Providing Affirming Health Care for LGBTQ+ Patients

Navigating LGBTQ+ Health for Health Care Providers

January and February 2020

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I have no disclosures

…except privilege

Objectives

1. Recognize the value of collecting **SOGI (sexual orientation and gender identity)** data in the medical office setting
2. Describe **affirming** practices in the **sexual and medical health history** assessment for LGBTQ youth
3. Discuss gender affirming **medical treatment options** for transgender youth

Why Talk About Gender?

- Professional responsibility
  - AMA, AAMC, AAFP, AAP, SAHM, APA
    - Recommend training on LGBT health
  - Exclusion of coverage for gender care services illegal in some states
- Gender care is
  - Patient-centered primary care
  - Gender is developmental, universal
  - Anticipatory guidance
  - Prevention
  - Future planning
  - Models and promotes diversity

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Why is Training for LGBTQ-Friendly Care Important?

- **LGBTQ** community are **marginalized** and have **increased health/psychosocial risks**
- Providers rarely receive LGBTQ-specific training
- Providing LGBTQ-friendly care is a **skill**
- National, statewide, and city initiatives to improve access to health care for LGBTQ people

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health and Mai-Anh Tran Ngoc, DO

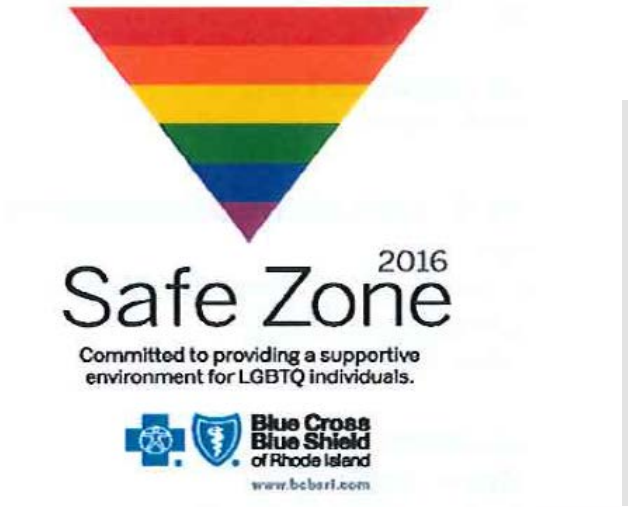
Office Environment and Sexual Orientation/Gender Identity (SOGI) Data

Alex

17 year old **transmale** (assigned female at birth, identifies and presents as male; pronouns “he/him”) walks into a clinic waiting room. He is called by his birth name, asked to leave a urine sample in the “Ladies’” room, and senses confusion and discomfort from staff when asking about his last menstrual period. There are superficial lacerations on his arms, and he is asked, “Oh honey, why’d you do that?”

Where do we start?

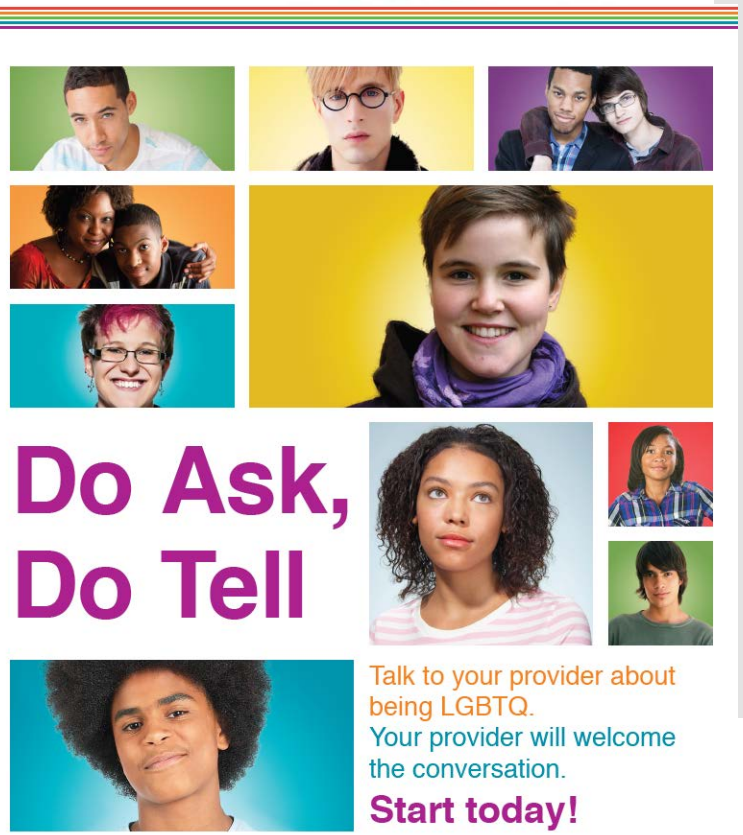
Welcoming Office



Our physicians and staff support the American Medical Association nondiscrimination policy, in that:

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



Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

When greeting others

Avoid:

ladies **gentlemen** **ma'am** **sir** **girls** **guys** etc.

Consider using instead:

"Thanks, **friends**. Have a great night."

"Good morning, **folks**!"

"Hi, **everyone**!"

"And for **you**?"

"Can I get you **all** something?"

Why?

Shifting to gender-inclusive language respects and acknowledges the gender identities of all people and removes assumption.

Be mindful of language

Based on Toni Latour's "Hello there" cards.

Learn more at qmunity.ca

SOGI is Important

- In 2011, the Institute of Medicine called for a research investment in sexual and minorities population health
- The Department of Health and Human Services mandated the inclusion of SOGI data as part of the Meaningful Use of Electronic Health Record Programs
- These data are crucial to:
  - Identify the demography and disparities of this population
  - Ensure surveillance, delivery and evaluation of high-quality, patient-centered care
- Barriers:
  - Patient fear of discrimination, stigmatization and negative effect of quality of care
  - Provider comfort in obtaining this information

Schabath, M. B., et al. (2017). "Ask and Tell: The Importance of the Collection of Sexual Orientation and Gender Identity Data to Improve the Quality of Cancer Care for Sexual and Gender Minorities." Journal of Oncology Practice **13(8): 542-546.**

SO/GI collection

Important personal health history as well

Data that does not allow gender/sex minorities to remain "invisible"

Do you think of yourself as:

- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know

What is your current gender identity?
(Check all that apply)

- ☐ Male
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional Gender Category/(or Other), please specify
- ☐ Decline to Answer, please explain why

What sex were you assigned at birth on your original birth certificate?
(Check one)

- ☐ Male
- ☐ Female
- ☐ Decline to Answer, please explain why

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health
https://prh.org/

Epic | Pt Station | Change Context | Customize eRecord | Web Links | Home | Schedule | Patient Lists | In Basket | Chart | Remind Me | Pregnancy Wheel

Ruben, Billie

Summary | Manage Ord... | Discharge | Chart Review | Notes | Charge Capture | Rounding | Admission | Patient Station | Demogr... | Sexual ...

Billie Ruben
Female ⓘ, 18 y.o., 4/1/2001
Bed: CH8S-1501
eMRN: **E900009158**
Code: **FULL (no ACP docs)**

Search

Allergies: **Penicillins**

COVERING PROVIDER
None

ADMITTED: 5/7/2019 (98 D)
Pleural effusion

Leonard, Michael S, MD
Attending

Ht	Last Wt
177.8 cm (5' 10")	70 kg (154 lb 5.2 oz) > 90 days

BMI
—

NO NEW RESULTS, LAST 36H

NO ACTIVE MEDS

RHIO: **Unknown**

Sexual Orientation and Gender Identity SmartForm

Preferred Name

First Name Only | Complete Name (Last, First) | Billie

Legal Information

Legal first name: William

Legal last name: Ruben

Legal sex: Female | Male | Unknown | X | Other

Sexuality

Patient's sexual orientation: Asexual | Bisexual | Choose not to disclose | Don't know | Gay | Homosexual | Lesbian | Pansexual | Something else | Straight (not lesbian or gay)

Gender Identity

Is your gender identity different than your sex assigned at birth? Yes | No

Autofill with default responses for: Cisgender female | Cisgender male

Patient's sex assigned at birth: Female | Male | Unknown | Not recorded on birth certificate | Choose not to disclose | Uncertain

Patient's gender identity: Female | Male | Transgender Female / Male-to-Female | Transgender Male / Female-to-Male | Something else | Choose not to disclose | genderqueer/gender-non-conforming

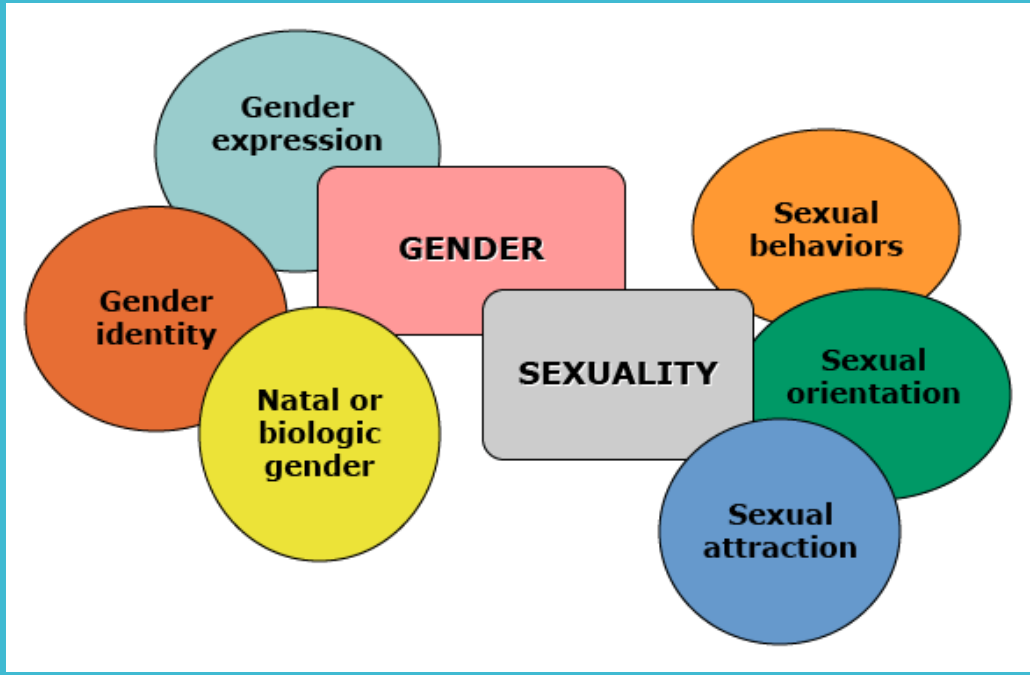
Patient's pronouns: she/her/hers | he/him/his | they/them/theirs | ey/em/eirs | ze/hir/hirs | the patient

Patient's future affirmation plans, if any: Insert SmartText

Slide Adapted from Mai-Anh Tran Ngoc, DO

Terminology, Language

Not sure what that means? Ask!



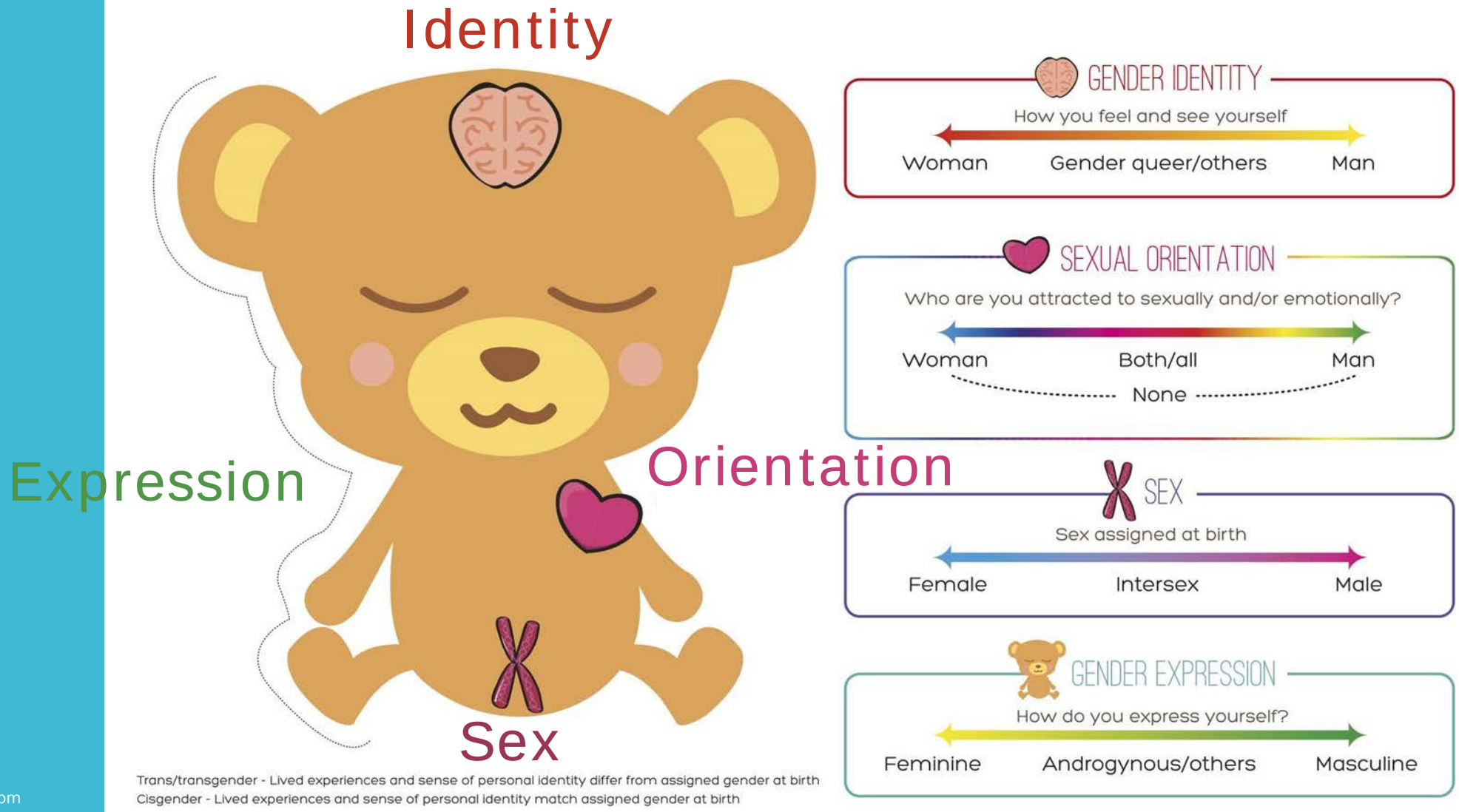
Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Gender Identity Terminology

- **Cisgender:** gender identity aligns with cultural notions of gender and the sex they were assigned at birth
- **Transgender:** a person whose identity differs from their assigned sex at birth
- **Gender diverse/gender variant/non-binary/gender queer/gender-fluid:** people who do not identify or express their gender within the gender binary

Slide Adapted from Mai-Anh Tran Ngoc, DO

THE GENDER BEAR



"The Gender Bear." *Justiceforsisters*, justiceforsisters.wordpress.com/category/infographic/.

Slide Adapted from Mai-Anh Tran Ngoc, DO

Respecting Individuals

Transman

Transwoman

Nonbinary

Appropriate	Inappropriate
Transgender people	Transgend[illegible]dered
Trans woman/man/person	“Real” [illegible]n/man
Intersex person	“An[illegible]”
Crossdresser, Drag queen/king	Tra[illegible]stite
Assigned male/female at birth	Bi[illegible]e/fe[illegible]
They	“H[illegible]e” or “[illegible]
“When he identified/presented as a woman” “Before he transitioned”	“W[illegible]he was a[illegible]r “[illegible]in a dre[illegible] “I can’t e[illegible]you are [illegible]”
Gender Affirming Surgery	“The [illegible]”

slide adapted from Kyan Lynch, MD, MA, University of Rochester Center for Community Practice, January, 2018

Back to our case…

17 year old **transmale** (assigned female at birth, identifies and presents as male; affirmed name Alex, pronouns "he/him") walks into a clinic waiting room. He is called by his birth name, asked to leave a urine sample in the "Ladies'" room, and senses confusion and discomfort from staff when asking about his last menstrual period. There are superficial lacerations on his arms, and he is asked, "Oh honey, why'd you do that?"

How could this have gone differently?

Introduction Activity

- Pair up
- Introduce yourself
- Ask the other person to introduce themselves
- How did that feel?

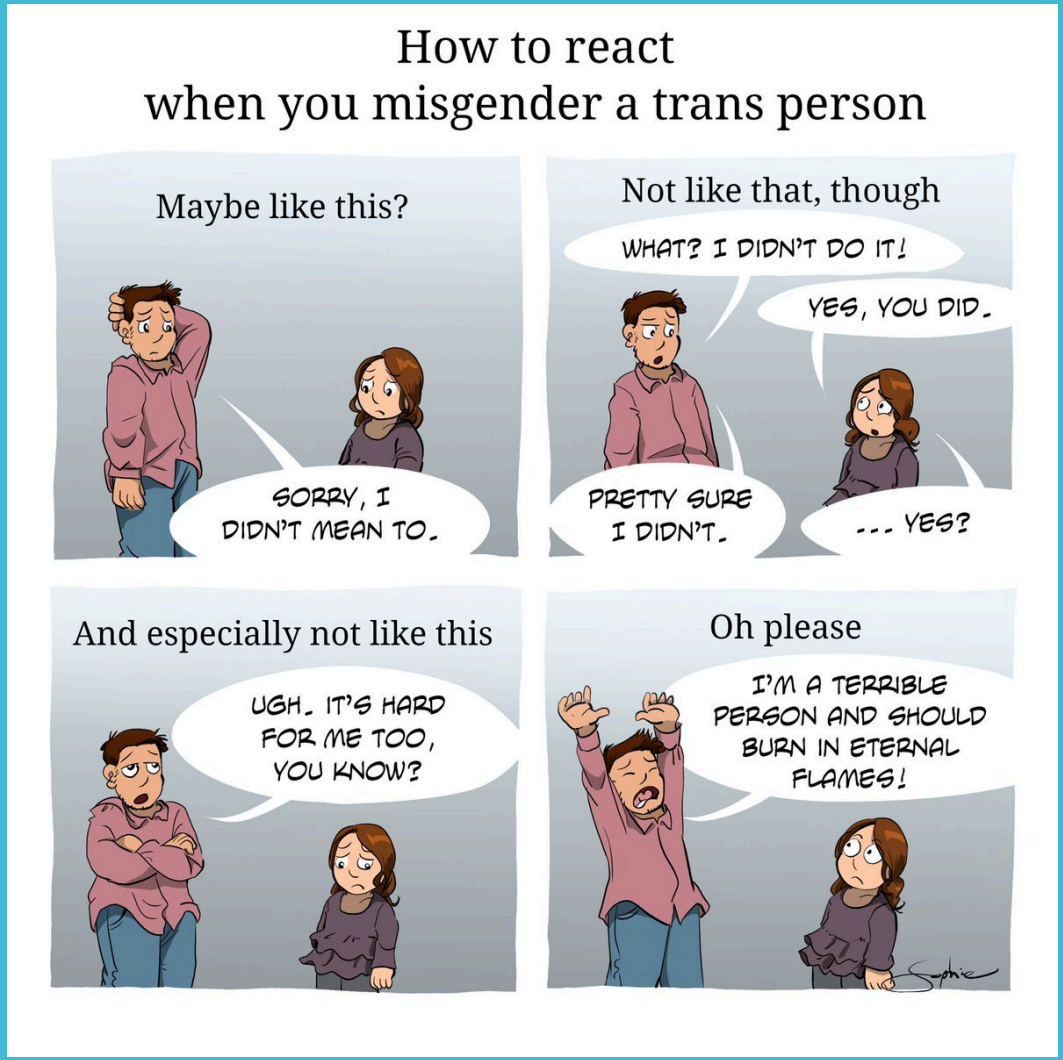
Taylor Mason from Billions on ShowTime

Slide Adapted from Mai-Anh Tran Ngoc, DO

Misgendering

- It happens, here's what you do:
  - Apologize
  - Repeat yourself with the correct pronoun
  - Move on

- Later, take some time to **reflect** so you can do better next time; "what happened?"
  - Anatomy/appearance
  - Difficult to adjust if you knew them before transition?
  - Environment/system
  - Peer pressure, confusion
  - Countertransference
  - Honest mistake



slide adapted from Kyan Lynch, MD, MA, University of Rochester Center for Community Practice, January, 2018

Gender Development

Gender Development

- **~Age 2:** awareness of the physical differences between boys and girls.
- **~Age 3:** label themselves as either a boy or a girl.
- **~Age 4:** have a sense of their gender identity.
- All children tend to develop a clearer view of themselves and their gender **over time** and becomes **insistent, persistent, consistent**

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/Promoting-Healthy-Sexual-Development.aspx

Gender Play

- All pre-pubertal children play with gender expression & roles
  - Passing interest or trying out gender-typical behaviors
  - Interests related to other/opposite sex
  - Few days, weeks, months, years

Slide adapted from *Caring for Transgender Adolescent Patients,* Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Gender Non-Conforming Children may present with:

- Cross gender expression, role playing
- Wanting other gender body/parts
  - OR not wanting either
- Not liking one's gender & body (gender dysphoria)
- Refusing to ascribe to typical masculine or feminine assignments
  - Agender
  - Non-Binary

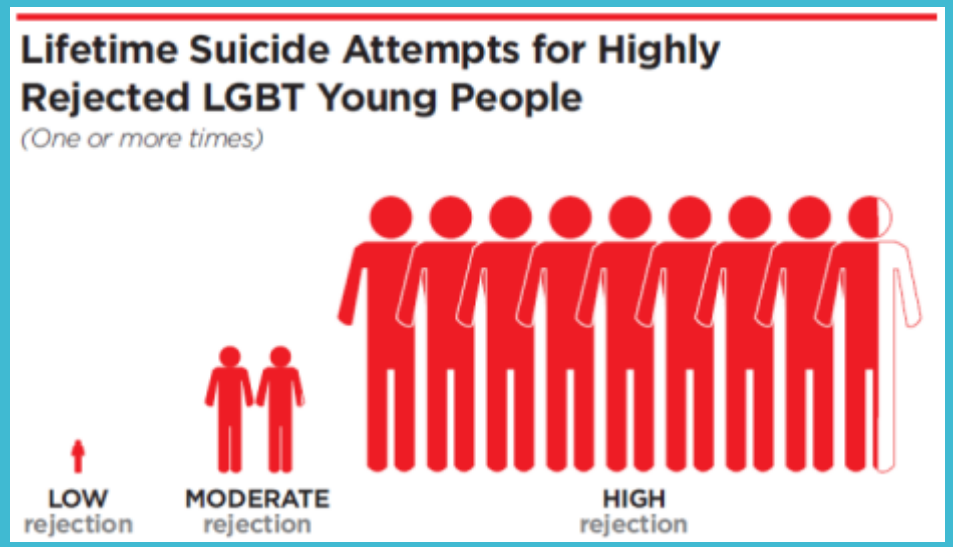
Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Sexual Development

- **Birth – 4 yo**: curiosity about own and other people's bodies
- **4-6 yo:** more aware of differences between people's bodies, copying adult behavior, learning social rules around sexual behavior
- **7-12 yo:** more aware of social rules more modest and want privacy, increased curiosity about adult sexual behaviors, start displaying romantic and sexual interest in peers

- Sexual minority youth are coming out at younger ages
  - 13- to 17-year-olds in 2012

Slide Adapted from Mai-Anh Tran Ngoc, DO



N=245 LGBT Retrospective assess family accepting behaviors in response to gender & sexual minority status

Family Acceptance Project

Predicts Improved:

- Self-esteem
- Social support
- General Health Status

Protects against:

- Depression
- Substance use
- Suicidality

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/; Mai-Anh Tran Ngoc, DO; Ryan CJ; 2009, 2010

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment

Annelou L.C. de Vries, Jenifer K. McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers and Peggy T. Cohen-Kettenis

Pediatrics; originally published online September 8, 2014;
DOI: 10.1542/peds.2013-2958

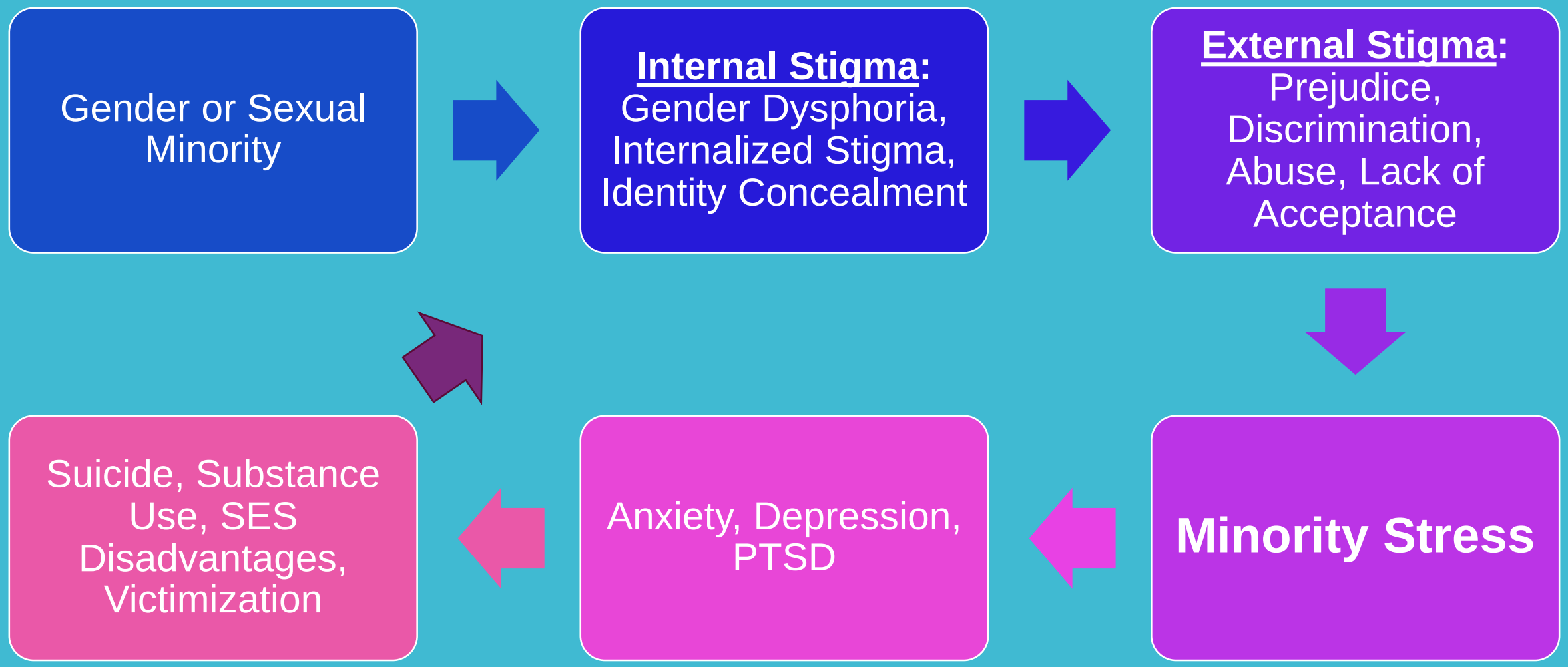
Mental Health of Transgender Children Who Are Supported in Their Identities

Kristina R. Olson, PhD, Lily Durwood, BA, Madeleine DeMeules, BA, Katie A. McLaughlin, PhD

Olson KR, Durwood L, DeMeules M, et al. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics.* 2016;137(3):e20153223

Risks/Disparities

Minority Stress Theory for LGBTQ People



Adapted from O'Hanlan, et al (1997). A review of the medical consequences of homophobia with suggestions for resolution. *JGLMA*;1:25-39.)

Mai-Anh Tran Ngoc, DO

2015 U.S. Transgender Survey (n=27,715)

- **39%** experienced serious psychological **distress**
  - Versus only **5%** of the U.S. population

- **40% attempted suicide** in their lifetime**; 92%** of these individuals attempted **before the age of 25**
    - nearly **9x** the rate in the U.S. population (4.6%)

- **7% attempted suicide in the past year**
  - nearly **12x** the rate in the U.S. population (0.6%)

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). Executive Summary of the Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality

Countering Minority Stress

Social stigma

Familial rejection

Social isolation

Fear of physical attacks

Minority Stress

Anxiety

Depression

Victimization

Suicide,
Substance use,
SES disadvantage

Ask questions

Early identification

Connect with resources and support

- **Living safely in authentic gender identity**
- **Improving quality of life**

Improved Health Outcomes

Mental health
Social
Medical
Financial
Educational

School Resources and Protections from NY State

Letter from the Attorney General:
http://www.nysed.gov/common/nysed/files/nysed-oag-joint-guidance-letter-2-28-18.pdf

Transgender and GNC student Guidelines:
https://www.schools.nyc.gov/school-life/policies-for-all/transgender-and-gender-nonconforming-student-guidelines

GLSEN:
https://www.glsen.org/
Specifically
https://www.glsen.org/educate/resources for how to build a safe LGBTQ space in school

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

ERIC T. SCHNEIDERMAN
ATTORNEY GENERAL

NEW YORK STATE EDUCATION DEPARTMENT
THE UNIVERSITY OF THE STATE OF NEW YORK

MARYELLEN ELIA
COMMISSIONER OF EDUCATION
PRESIDENT OF THE UNIVERSITY OF THE STATE OF NEW YORK

February 28, 2018

This letter clarifies the rights of all students in New York to enjoy a safe and nondiscriminatory educational environment without regard to their gender identity; and confirms the ongoing obligation of all school districts in New York State to protect those rights under state and federal law.

On Monday, February 12, 2018, the United States Department of Education ("USDOE") confirmed that it would no longer investigate civil rights complaints from transgender students denied access to bathrooms consistent with their gender identity. In light of this announcement, and the February 2017 decision by USDOE and the federal government to rescind guidance that clarified protections for transgender students under federal statutory law, the New York State Office of the Attorney General ("OAG"), the New York State Education Department ("SED") and the New York State Board of Regents find it imperative once again to remind school districts across New York State that – irrespective of the federal government's recent announcement – they have independent duties to protect transgender students from discrimination and harassment in their schools and at all school functions.

Through our offices' joint efforts, we have committed to ensuring that all students in New York State attend school in safe and supportive environments in which they can learn and thrive. Our offices will continue to use all the existing tools of federal, state, and local law to ensure that transgender students are safe in their schools and have equal access to all programming and facilities consistent with their gender identity. Simultaneously, our offices also seek to provide school districts guidance to assist them with legal compliance.

With those twin aims in mind, our offices first seek to clarify for school districts the scope of USDOE's recent announcement. That announcement was limited to USDOE's own interpretation and enforcement of Title IX, the federal statute prohibiting discrimination on the basis of sex in any education program or activity receiving federal financial assistance.[1]

However, we note that even after USDOE rescinded its Title IX guidance in 2017, school districts in other states have faced legal action under both Title IX and other federal law – *e.g.*, federal constitutional claims – for restricting transgender students' access to bathrooms consistent with their gender identity.[2]

Furthermore, the USDOE's announcement has no bearing upon school districts' independent duties, under New York State law, to protect their transgender students and ensure those students' equal access to all school resources and programming. Specifically, New York State's Dignity for All Students Act ("DASA") expressly prohibits discrimination and harassment, on school property or at a school function, on the basis of a student's gender identity or expression.[3] Based on this, SED issued guidance to all New York State school districts in July 2015, entitled "Guidance to School Districts for Creating a Safe and Supportive School Environment for Transgender and Gender Nonconforming Students."[4] That guidance specifically addresses gender-segregated facilities, like bathrooms, locker rooms, and changing areas. The guidance also addresses other topics that frequently arise in assuring a safe and supportive environment for transgender students, including (i) the use of names and pronouns to address transgender students, (ii) privacy, confidentiality, and student records, and (iii) other gender-based school policies and practices. Our offices strongly encourage school districts to refer to SED's guidance and modify their policies accordingly.

Our offices take seriously any action that compromises the school climate in which our students come to learn every day, and we have provided resources to help school staff, students, and parents report and address incidents of harassment, bullying, and discrimination.[5] The OAG and SED will continue to provide schools and families with guidance and support to ensure that our schools are safe havens for students where they can focus on learning; their civil rights are protected; and they have opportunities to succeed in school and life.

Sincerely,

Eric T. Schneiderman
Attorney General

MaryEllen Elia
Commissioner of Education

[1] *See* 20 U.S.C. § 1681(a).

[2] *See Evancho v. Pine–Richland Sch. Dist.*, 237 F. Supp.3d 267, 284-95 (W.D. Pa. 2017) (issuing preliminary injunction ordering school to allow transgender students access to restrooms that correspond with their gender identities based on federal equal protection claim); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (noting that a "policy that requires an individual to use a bathroom that does not conform with his or her gender identity punishes that individual for his or her gender non-conformance, which in turn violates Title IX," and ruling in favor of student on both Title IX and federal constitutional claims). Both of these legal challenges ultimately resulted in six-figure settlements paid by the school districts. *See* "Transgender Pine-Richland Students Receive Thousands as Part of Lawsuit Settlement," *available at* http://www.post-gazette.com/news/education/2017/08/08/Pine-Richland-School-District-transgender-students-lawsuit-settlement-bathroom-policy/stories/201708080093l; "Unified Settles Transgender Lawsuit," *available at* http://www.kenoshanews.com/news/local/unified-settles-transgender-lawsuit/article_b90c8ac8-9b9e-511e-b01b-f59102c7578a.html.

[3] *See* N.Y. EDUC. LAW § 11(6) (including "gender" as a protected category, which is defined as a "person's actual or perceived sex and includes a person's gender identity or expression").

[4] SED's guidance concerning transgender and gender nonconforming students is available at: http://www.p12.nysed.gov/dignityact/documents/Transg_GNCGuidanceFINAL.pdf.

[5] Additional guidance is available at: http://www.p12.nysed.gov/dignityact/.

Incorporating a Gender Health into Practice

History gathering in a pertinent, age-appropriate, affirming way

What We Know About Trans Health

Nearly one-third (31%) of respondents reported that none of their health care providers knew they were transgender

National Transgender Discrimination Survey, 2015

From A Patient's Perspective

- Disclosing trans status can be **scary** and **potentially dangerous**
  - Being understanding of this and demonstrating appreciation goes a long way
- **Take note of specific language** and reflect back when possible
  - Write it down for next time
- Keep the **patient in the loop**
  - *"You're the doctor. You're supposed to ask weird questions. Just let us know why."*

slide adapted from Kyan Lynch, MD, MA, University of Rochester Center for Community Practice, January, 2018

Setting the Stage (adolescents)

- **Introduce** yourself to **the adolescent FIRST**; then, have them introduce adults in the room
- Ask **adults** if they have any **specific concerns to address**
- Briefly **address confidentiality** (more on this)
- Ask **the adults to step out** of the room

Slide adapted from *Adolescent Medicine: The HEADSSS Assessment* by Katherine Blumoff Greenberg, MD

Communication Tips with Teens

- **Conditional** confidentiality
- Accentuate the positive **(strength-based approach)**
- Ask **open-ended** questions

  "Tell me more about your answer to . . . ."
  "What did you mean by . . . ."

- **Reflect** their answers back to clarify
- Help teens develop their own plan **(motivational interviewing)**
- Break confidentiality only if the patient's or someone else's safety is at risk

Slide adapted from *Adolescent Psychosocial Screening* by Susan "Shellie" Yussman, MD MPH

Adolescent Autonomy and Health Care

- **Confidentiality = privacy, NOT** about keeping secrets
- **Consent:**
  - **Minors** have a right to **consent** for:
    - **sexual/reproductive** health concerns
    - **mental health** concerns
    - **drug or alcohol treatment**
    - **As of 2018, minors now can consent to HIV treatment and preventative services such as PrEP and PEP without a parent/guardian (10 NYCRR Part 23)**
- *Authoritative*, NOT authoritarian approach
- Determine what is essential; negotiate what is optional

Slide adapted from *Adolescent Medicine: The HEADSSS Assessment* by Katherine Blumoff Greenberg, MD

MINORS' RIGHTS TO CONFIDENTIAL REPRODUCTIVE & SEXUAL HEALTH CARE IN NEW YORK

When a young person seeks health care, a parent or guardian is usually involved. However, in some cases communication with parents or guardians about reproductive and sexual health care is difficult, and involving a parent can even be dangerous. In extreme cases, young people have been abused or forced to leave their homes when a parent discovers that a child is sexually active. In fact, fear of the consequences that result from disclosure prevents some young people from seeking necessary treatment or preventive care, leading to serious health consequences. This card outlines the provisions in federal and New York State law that allow minors to consent on their own to confidential health care.

NYCLU
NEW YORK CIVIL LIBERTIES UNION

www.nyclu.org

What is a Strength-Based Approach?

- A set of ideas, assumptions, and techniques based on:
  - **Empowerment**; teens can be active participants in the process
  - **All youth have strengths**, often untapped or unrecognized
  - Strengths foster **motivation** for growth
  - Strengths are internal and environmental

Slide adapted from ACT For Youth,
Jutta Dotterweich 2006.
www.actforyouth.net

Source: Saleebey, Dennis. 1992. The Strengths Perspective in Social Work Practice. Longman: White Plains, NY

Who should be asked about gender identity?

EVERYONE!

- You may be the first person asking!
- You may be the first person this patient feels safe talking about this with
- Particularly children/teens who:
  - Display a stereotypically non-conforming gender expression
  - Children/teens who are experiencing issues with mood, behavior, social interaction with family and/or peers
- Revisit this frequently (eg: yearly well-child +/- acute visits as appropriate)

How to Screen for Gender

- **Ask parents about:**
  - Child's gender expression-changes in play, hairstyles, clothing
  - Concerns about behavior (aggression, isolation), peer interaction/peer group, school avoidance, change in academic achievement

- **Ask patients about (in a developmentally appropriate way):**
  - "Do you feel more like a girl, boy, neither or both?"-**Gender ID**
  - "You were born a _____, do you identify/see yourself as a _____?" –**Sex assigned at birth, gender identity**
  - "Is there a name that feels right to you? What about a pronoun, like 'he/him' or 'she/her' or 'they/them' or something else?"-**Gender ID**
  - "If you could wear any clothes, make-up or hair style that you'd like, what would that look like for you?"-**Gender Expression**
  - "Is there someone that you have a 'crush' on? Can you tell me about them?"-**Sexual orientation**

DSM-5 Diagnostic Criteria for Gender Dysphoria

Persistent

Insistent

Consistent

More Pertinent History (in gender health context)

- **PMH and FHx:**
  - Migraines with aura
  - Hypercoagulable state (VTE, CVA, MI <50 yo, recurrent miscarriages)
  - Breast cancer (more so young adults, adults)
  - Renal issues

- **Thinking about present/future potential C/I or further workup needed prior to starting:**
  - COC for menstrual suppression
  - Estradiol for cross-gender hormone therapy
  - Testosterone for cross-gender hormone therapy
  - Spironolactone for androgen blockade

Preventative Care

"Organ Inventory "

- Pap smear
- Chest exam/imaging
- Contraceptive needs
- Prostate health
- STI screening

LGBT

Would you like to identify your sexual orientation? Yes No

Sexual orientation: lesbian gay homosexual heterosexual bisexual other

Is your gender identity different than your sex assigned at birth? Yes No

What was your sex assigned at birth? male female unknown

Registration System Sex: Female

What is your gender identity? male transmale/transman/FTM genderqueer/gender-non-conforming other

Preferred Pronoun: he, him, his she, her, hers they, them, theirs ey, em. eirs ze, hir, hirs the patient

Have you had any transitional surgeries? Yes No

Current Organ Inventory: Penis Testes Prostate Breasts Vagina Cervix Uterus Ovaries

Restore Close Previous Next

Language

"I know that you are a <insert gender identity>, regardless of which body parts you were born with. But as long as you still have those body parts, it is important for us to talk about them to make sure that you stay healthy. Are there terms that I should use to make this discussion more comfortable?"

Consider:

- **Chest exam (instead of breast exam)**
- **External genitalia or "down below" (instead of "penis" or "vulva/vagina")**
- **Monthly bleeding (instead of menses or period)**
- **"People with a cervix/ovaries/uterus/breasts/vagina" instead of women**
- **"People with a penis/testes/prostate" instead of men**

adapted from Kyan Lynch, MD, MA, University of Rochester Center for Community Practice, Jan 2018, Mai-Anh Tran Ngoc, DO

Social History-The **HEADSS** Model for Adolescents

H: Home

E: Education/Employment/Exercise/Eating

A: Activities

D: Drugs

S: Sexual History (can include gender identity screen here)

S: Safety

Asking About Sexual Behaviors

Use **language** that is developmentally **appropriate** and also reflects the terms that make the patient most **comfortable**

- **Younger kids:**
  - *Have you held hands or cuddled?*
  - *Have you kissed or touched each other's private parts?*
  - *Describe to me what a person that you "like" looks like?*
  - *Has anyone touched you in a way that you were not OK with?*
- **Older teens/adults:**
  - *Have you ever had: oral sex, vaginal sex, anal sex* (may need to describe what these mean)?
  - *What does "safe sex" or "using protection" mean to you?*
  - *Have you ever had sex for drugs, money or shelter?*
  - *Has anyone touched you in a way that you did not consent to or agree with?*
  - *Do you have any concerns about sex?*
  - *Looking forward, do you see yourself becoming a parent in the next few years?*

Harm Reduction

- **Access to Sexual and Reproductive Health services:**
  - Condoms
  - STI screening (normalize as part of all visits)
  - Comprehensive contraception counseling and provision (facilitate referral if need be)
    - LARC is a great option for any patient regardless of gender (menstrual suppression, non-estrogen containing, pregnancy prevention)
  - HIV prevention services→ PrEP, PEP
  - Plan for close follow-up to continue the conversation (may need a few visits to build rapport)
- **Psychosocial Support:**
  - Case management, vocational assistance
  - Mental health services, substance abuse resources
  - Housing/food/shelter resources

Why so much talk about sex?

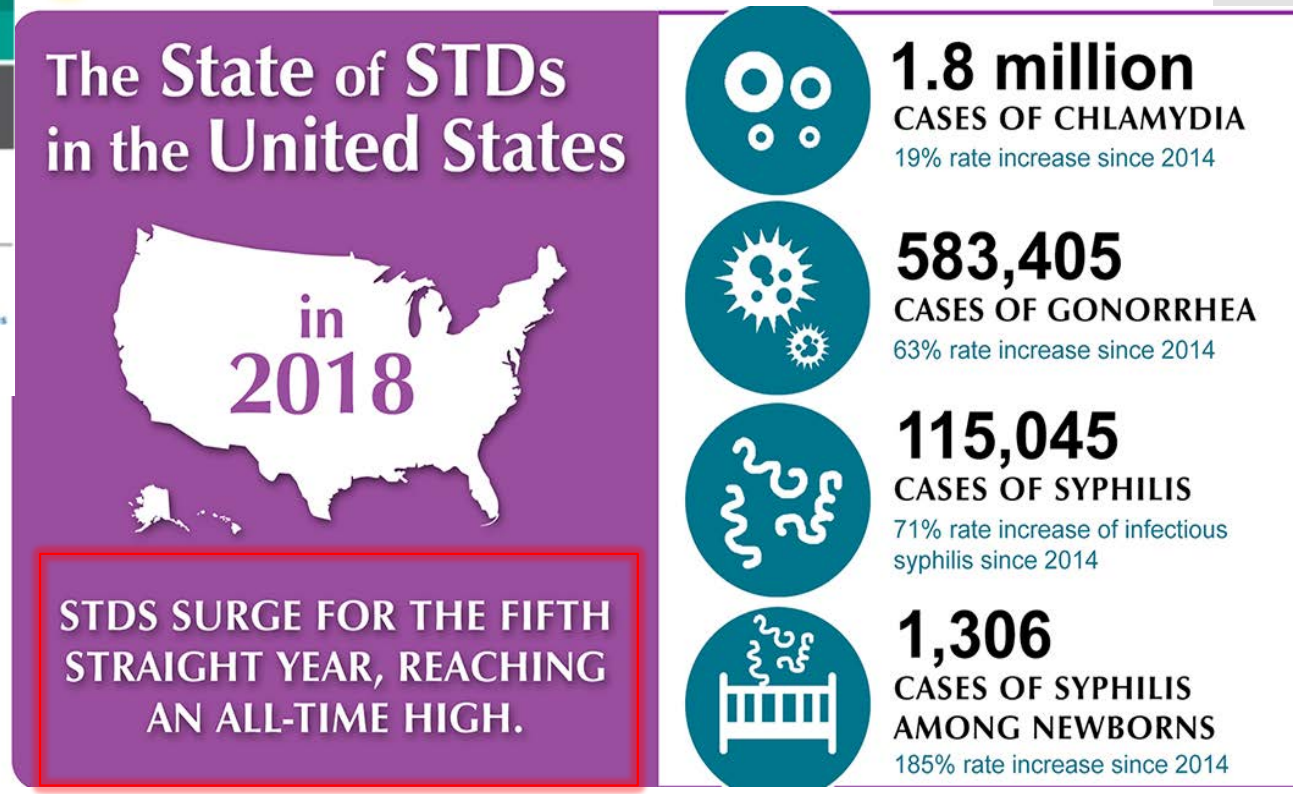
STD DIAGNOSES AMONG KEY U.S. POPULATIONS, 5-YEAR TRENDS

	2013	2014	2015	2016	2017*
Chlamydia	1,401,906	1,441,789	1,526,658	1,598,354	1,708,569
Among young women (aged 15 to 24)	715,983	709,170	724,709	735,027	771,340
Gonorrhea	333,004	350,062	395,216	468,514	555,608
Among women	163,208	162,608	173,514	197,499	232,587
Among men	169,130	186,943	221,070	270,033	322,169
Primary & secondary syphilis	17,375	19,999	23,872	27,814	30,644
*Among MSM***	10,451	12,226	14,229	16,149	17,736
Combined cases	**1,752,285**	**1,811,850**	**1,945,746**	**2,094,682**	**2,294,821**

*Preliminary data
**Men who have sex with men

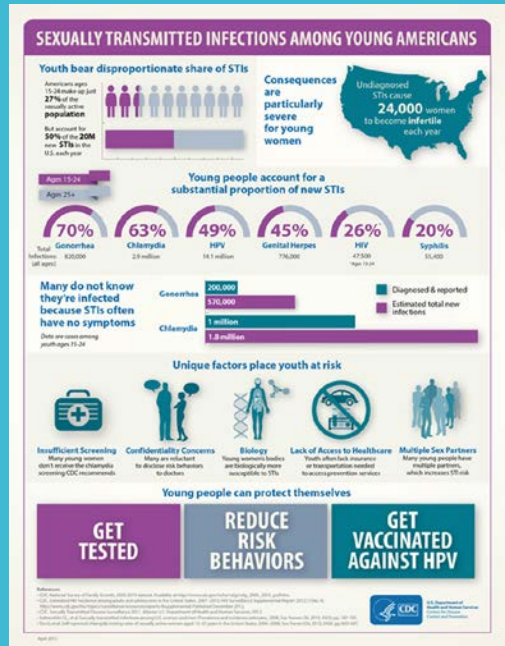
For more information, visit
cdc.gov/nchhstp/newsroom

CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



STDs in Adolescents and Young Adults

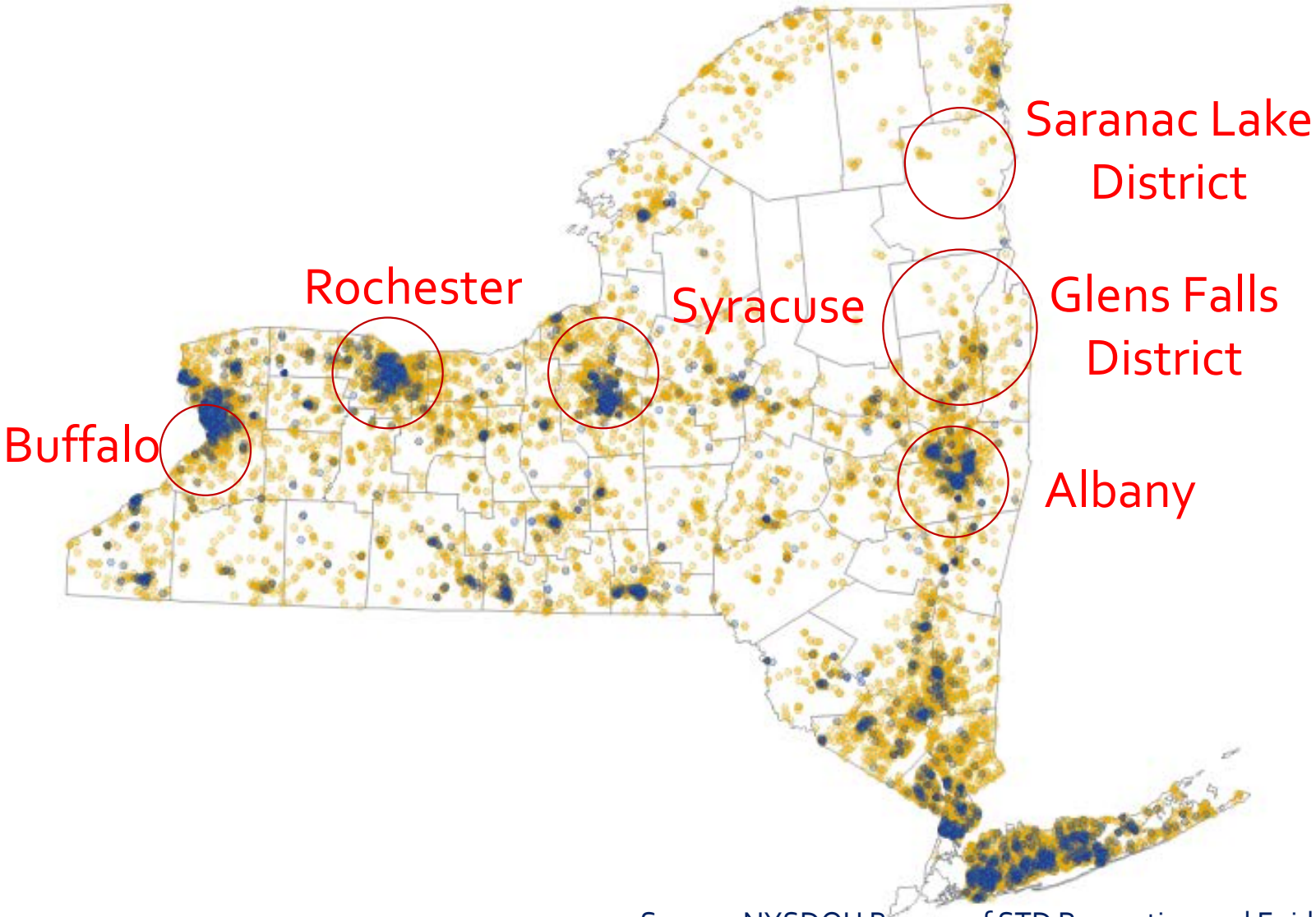
- **1 in 4** sexually active **adolescent females has a STD**
- **1 in 5** of all new **HIV** diagnoses in the US in 2017 were in **13-24 year olds**
- **~50%** of the 20 million **new STDs** reported **each year** are in people **15-24 years old**
- In 2017, there were **>1 million cases of chlamydia in people 15-24 years old** (**62.6%** of all reported chlamydia cases)



CDC. Youth Risk Behavior Surveillance—United States, 2017. MMWR Surveill Summ 2018;67(No. SS-8).
CDC. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016. HIV Surveillance Report 2016, vol. 28; November 2017.
https://www.cdc.gov/healthyyouth/images/hiv_among_youth_infographic.png
https://www.cdc.gov/std/stats17/adolescents.htm

Distribution of Chlamydia and Gonorrhea Among Young Adults 15 to 24 Years in Age, New York State, excluding NYC, 2015

Gonorrhea
Chlamydia



Source: NYSDOH Bureau of STD Prevention and Epidemiology

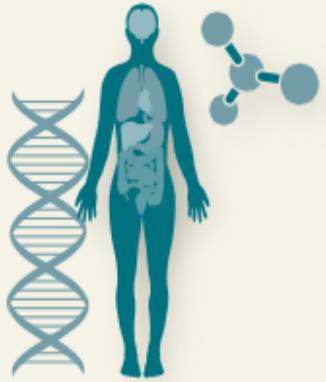
Slide adapted from *Adolescents and STDs: Case Studies* by Tia Babu, MD

STD Risk Factors in Adolescents

Unique factors place youth at risk

Insufficient Screening
Many young women don't receive the chlamydia screening CDC recommends

Confidentiality Concerns
Many are reluctant to disclose risk behaviors to doctors



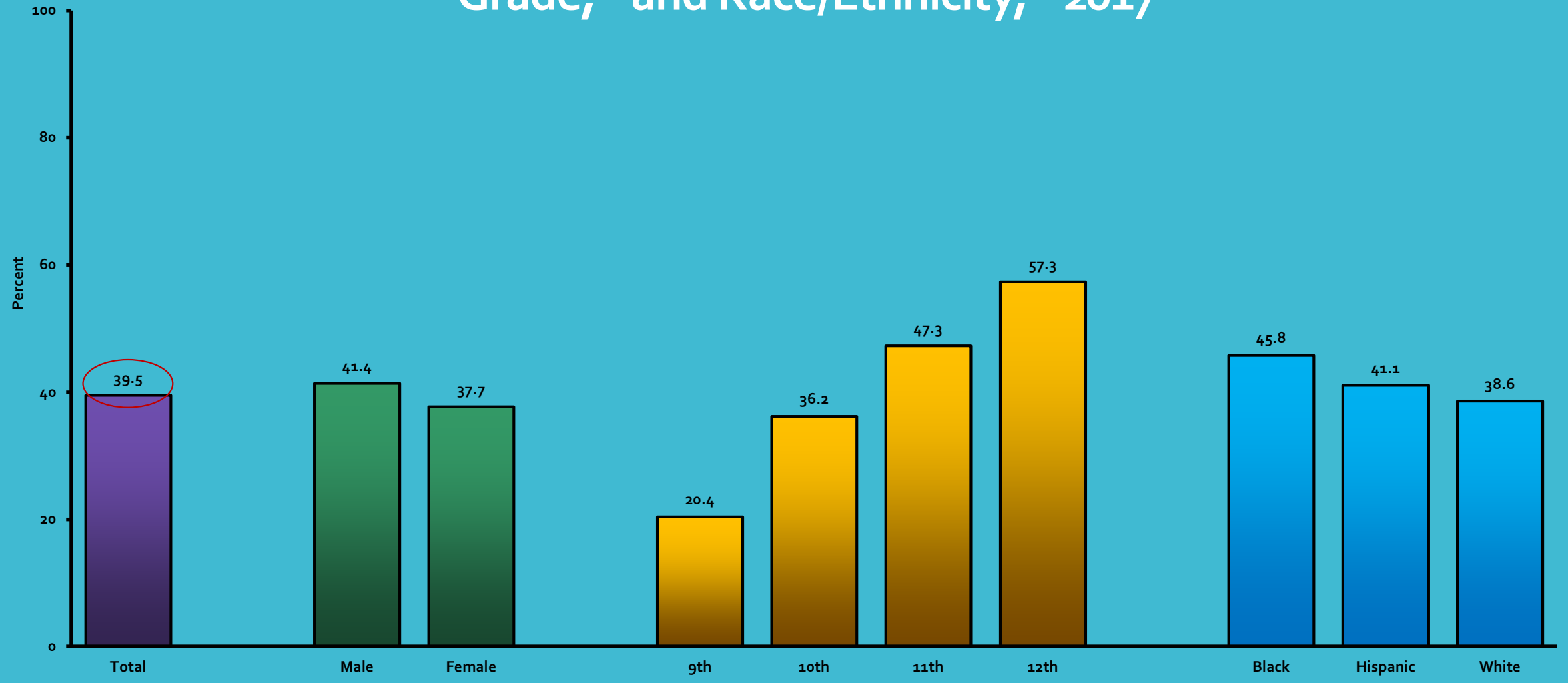
Biology
Young women's bodies are biologically more susceptible to STIs

Lack of Access to Healthcare
Youth often lack insurance or transportation needed to access prevention services

Multiple Sex Partners
Many young people have multiple partners, which increases STI risk

https://www.cdc.gov/std/products/youth-sti-infographic.pdf

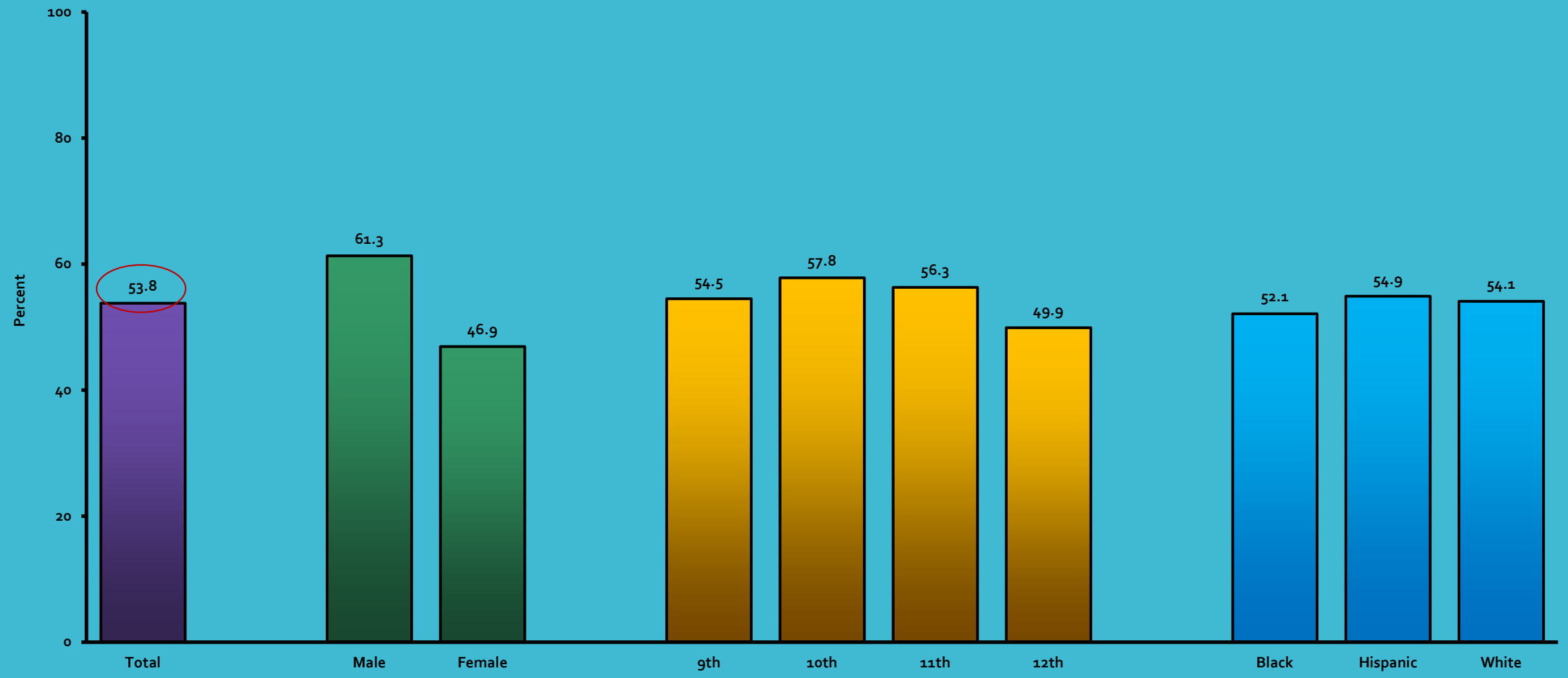
Percentage of High School Students Who Ever Had Sexual Intercourse, by Sex,* Grade,* and Race/Ethnicity,* 2017



*M > F; 10th > 9th, 11th > 9th, 11th > 10th, 12th > 9th, 12th > 10th, 12th > 11th; B > W (Based on t-test analysis, $p < 0.05$.)
All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.
Note: This graph contains weighted results.

National Youth Risk Behavior Survey, 2017

Percentage of High School Students Who Used a Condom During Last Sexual Intercourse,* by Sex,† Grade,† and Race/Ethnicity, 2017



*Among students who were currently sexually active
†M > F; 10th > 12th, 11th > 12th (Based on t-test analysis, $p < 0.05$.)
All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.
Note: This graph contains weighted results.

National Youth Risk Behavior Survey, 2017

NEW YORK STATE OF OPPORTUNITY. | Department of Health

BREAKING NEWS!

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

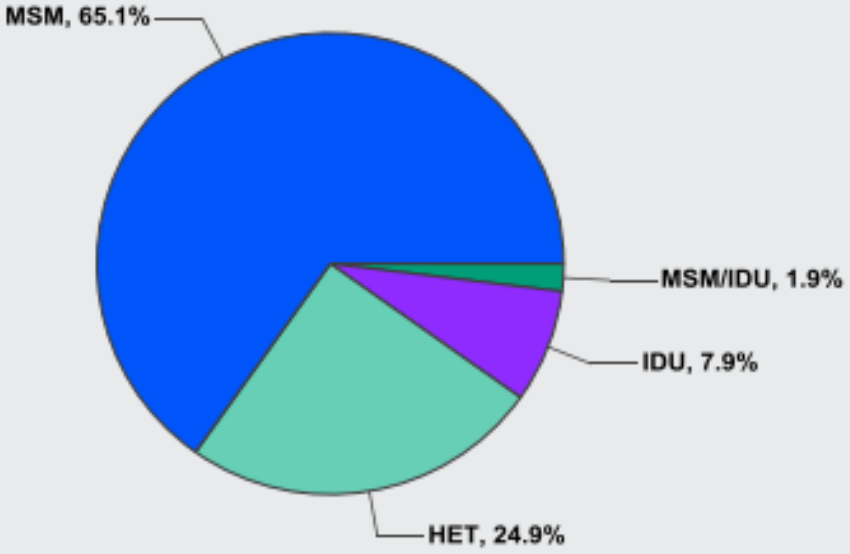
DATE: January 8, 2020

Chapter 298 of the Laws of 2019 amended New York State Public Health Law (PHL) §2312 which currently allows a health care practitioner who diagnoses chlamydia infection in a patient to prescribe and provide antibiotic drugs to the patient's sexual partner(s) without an exam. Effective January 1, 2020, PHL §2312 was expanded to permit expedited treatment for other sexually transmitted infections (STIs) for which the U.S. Centers for Disease Control and Prevention (CDC) recommends the use of expedited therapy. In addition to supporting expedited partner therapy (EPT) for chlamydia, the CDC guidance, available here, supports EPT for "heterosexual partners of gonorrhea patients [who are unlikely to] access timely evaluation and treatment…with cefixime and azithromycin…as not treating partners is significantly more harmful than is the use of EPT for gonorrhea."

HIV and HIV Pre-Exposure Prophylaxis (PrEP)

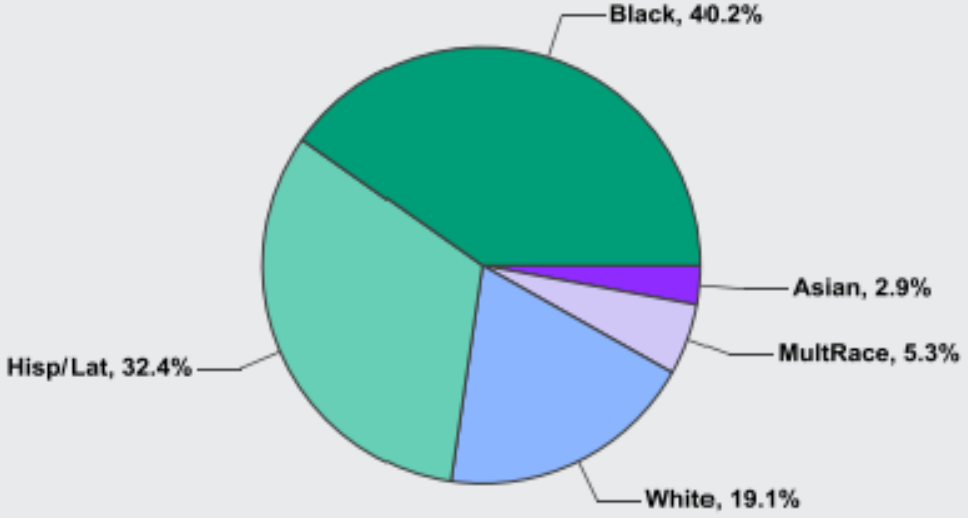
NY State HIV Epidemiology

Estimated adults and adolescents diagnosed with HIV, by transmission category, New York, 2015



**MSM, men who have sex with men; IDU, injection drug users; MSM/IDU, men who have sex with men who also inject drugs; HET, Heterosexuals*
***Other: <0.160%*

Estimated adults and adolescents diagnosed with HIV, by race/ethnicity, New York, 2015



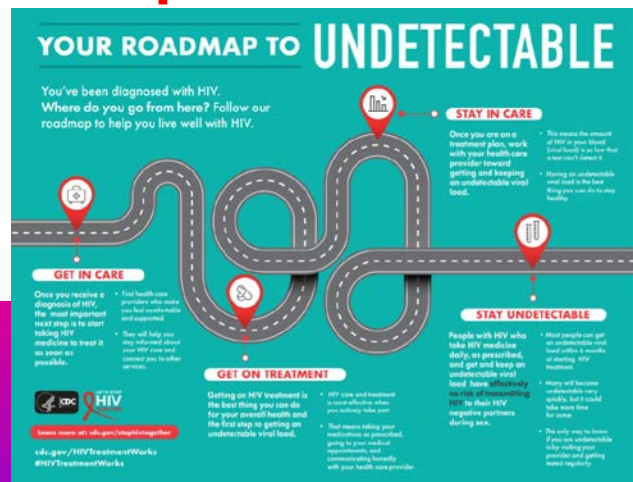
**AI/AN, American Indian/Alaska Native; Black, Black/African American; Hisp/Lat, Hispanic/Latino; MultRace, Multiple races; NHOPI, Native Hawaiian/Other Pacific Islander; Unk, Unknown*
***AI/AN, NHOPI: <0.13%*

https://www.cdc.gov/nchhstp/stateprofiles/pdf/New_York_profile.pdf

Ending the AIDS Epidemic in NY State

The 3-point plan by Gov. Cuomo in 2014 to decrease HIV prevalence in NYS by 2020:

- **Identifies** persons with HIV who remain undiagnosed and **link** them to health care.
- Links and **retains** persons diagnosed with HIV in health care to **maximize virus suppression** so they remain healthy and **prevent further transmission**.
- **Facilitates** access to Pre-Exposure Prophylaxis **(PrEP) for high-risk persons** to **keep them HIV negative**.



https://www.cdc.gov/hiv/risk/art/index.html
https://www.health.ny.gov/diseases/aids/ending_the_epidemic/

What Is PrEP?

- Once-a-day pill that stops HIV from establishing an infection in the body

  -combination of nucleoside and nucleotide reverse transcriptase inhibitors→ interferes with HIV viral RNA dependent DNA polymerase→ inhibition of viral replication

- Data suggests therapeutic concentration at ~20 days for blood and cervicovaginal tissue; ~7 days in rectal tissue; requiring an average of 4 pills per week

- Safe in pregnancy

https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf

As of October 3, 2019…

PrEP STUDY

DISCOVER is a new clinical study for men who have sex with men and trans women who have sex with men. This study is to evaluate if a once-daily investigational medicine can help reduce the risk of getting HIV infection from sex ("PrEP", or Pre-exposure Prophylaxis).

TO BE ELIGIBLE:

- You must be at least 18 years of age
- You must be HIV negative

If you are accepted into the DISCOVER Study, you will receive study-related exams, lab tests, and study medicine at no cost.

For more information, please contact:
Linden Lalley-Charezcko at 215-525-8695
Or go to www.clinicaltrials.gov and search NCT number 02842086

GILEAD DISCOVER

FDA NEWS RELEASE

FDA approves second drug to prevent HIV infection as part of ongoing efforts to end the HIV epidemic

Share | Tweet | Linkedin | Email | Print

For Immediate Release: October 03, 2019

U.S. Food and Drug Administration today approved ***Descovy® (emtricitabine 200 mg and tenofovir alafenamide 25 mg)*** *in at-risk* ***adults and adolescents*** *weighing at least 35kg for HIV-1 pre-exposure prophylaxis* ***(PrEP)*** *to reduce the risk of HIV-1 infection from sex,* ***excluding those who have receptive vaginal sex.***

Patient selection for PrEP

- **PrEP is an option for anyone who is HIV negative**
- **Highest risk groups include people who:**

  -have multiple or anonymous sex partners

  -do not use condoms or use condoms irregularly

  -people who have anal receptive sex; including gay men and trans females

  -drug use; esp. IV or mood-altering

  -survival sex

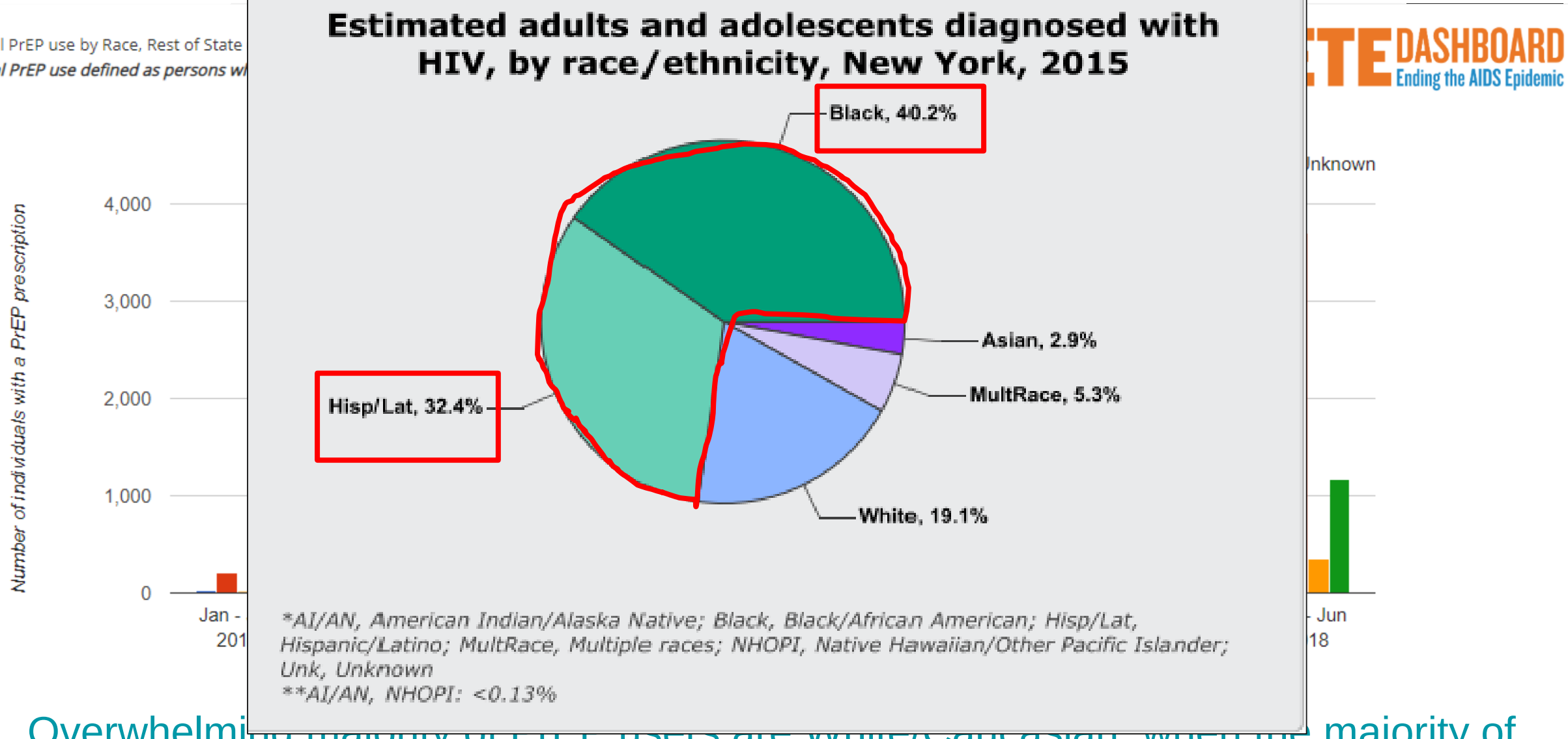
  -serodiscordant partners

PrEP is a prevention method in which **people who do not have HIV** infection **take a pill daily to reduce their risk** of becoming infected.

People who use PrEP must **commit to taking the drug every day** and seeing their health care provider **every 3 months for follow-up.**

Slide adapted from Fernando Mueller, Ashley Zuppelli and Mai-Anh Tran Ngoc

PrEP use by race/ethnicity in NYS (excluding NYC)



Overwhelming majority of PrEP users are White/Caucasian, when the majority of those diagnosed with HIV are Black and Hispanic

http://etedashboardny.org/data/prevention/prep-nys/

Warnings and Precautions for PrEP

- **Boxed Warning:** Risk of drug resistance in undiagnosed early HIV-1 infection and post-treatment acute exacerbation of Hepatitis B
- **Contraindication:** Positive or unknown HIV status (emtricitabine/tenofovir alone is NOT a complete regimen for treating HIV-1)
- **Adverse Reactions:**

  -**Minor:** Headaches, GI upset, abnormal dreams, weight loss→ usually self-resolve in a few weeks to 1 month

  -Severe: renal impairment (avoid in CrCl<60), possible BMD changes, lactic acidosis, severe hepatomegaly w/steatosis, drug interactions

PrEP Follow-up

- **Baseline:** 4th gen HIV test, CMP, UA, Hep panel, site-specific STI screen, Upreg
- **1 month after initiation:** confirm HIV negative status (evaluate for acute HIV), assess tolerance, adherence
- **Q3-6 months:** CrCl, 4th gen HIV test (q3), site-specific STI screen, Upreg, assess tolerance, adherence
- **At 12 months** recheck UA, HCV, assess tolerance, adherence and indication to continue PrEP

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Recommendations

Published Final Recommendations

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Final Recommendation Statement

Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis

Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Recommendation Summary

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.

Adolescent Confidentiality & Consent

- **Confidentiality: privacy, NOT** about keeping secrets
- **Consent:**

Minors have a right to **consent** to care for **sexual/reproductive** health concerns, **mental health** concerns, **drug or alcohol treatment**

As of 2018, minors now can consent to HIV treatment and preventative services such as PrEP and PEP without a parent/guardian (10 NYCRR Part 23)

Authoritative, NOT authoritarian approach

Determine what is essential; negotiate what is optional

Slide adapted from *Adolescent Medicine: The HEADSSS Assessment* by Katherine Blumoff Greenberg, MD

MINORS' RIGHTS TO CONFIDENTIAL REPRODUCTIVE & SEXUAL HEALTH CARE IN NEW YORK

When a young person seeks health care, a parent or guardian is usually involved. However, in some cases communication with parents or guardians about reproductive and sexual health care is difficult, and involving a parent can even be dangerous. In extreme cases, young people have been abused or forced to leave their homes when a parent discovers that a child is sexually active. In fact, fear of the consequences that result from disclosure prevents some young people from seeking necessary treatment or preventive care, leading to serious health consequences. This card outlines the provisions in federal and New York State law that allow minors to consent on their own to confidential health care.

NYCLU
NEW YORK CIVIL LIBERTIES UNION

www.nyclu.org

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HOME > PREP TO PREVENT HIV AND PROMOTE SEXUAL HEALTH >

PrEP to Prevent HIV and Promote Sexual Health

https://www.hivguidelines.org/prep-for-prevention/prep/#tab_0

Transitioning

Transition

Process <u>and</u> time when person goes from living as one gender to living as another gender

Slide Adapted from Mai-Anh Tran Ngoc, DO

Transitioning

Social
(reversible)

- Name, pronouns
- Clothes, gender roles, voice
- Non-medical body modification methods
- Menstrual suppression

Medical
(partially reversible)

- GnRH analogues *(most effects are reversible)*
- masculinizing and feminizing hormone therapy

Surgical
(irreversible)

- Mastectomy/chest augmentation
- Vaginoplasty, phalloplasty

Slide adapted from: Olson J. Hormonal Therapy for Transgender Youth. Society for Adolescent Health and Medicine presentation, April 7, 2010. Toronto, ON.

Benefits of Early Treatment

- Children with gender diversity or questions:
  - Identify ideally BEFORE puberty
  - Gives providers time to engage with family and patient, build rapport and trust
  - Offer relief to patient worried about upcoming puberty
- Consider “blocking” puberty
  - Effects are fully reversible
  - “Pushes the pause button”
  - Psychotherapy facilitated when distress eased
  - Prevent unwanted, permanent secondary sex characteristics
  - Reduces needs for future medical interventions

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Lily

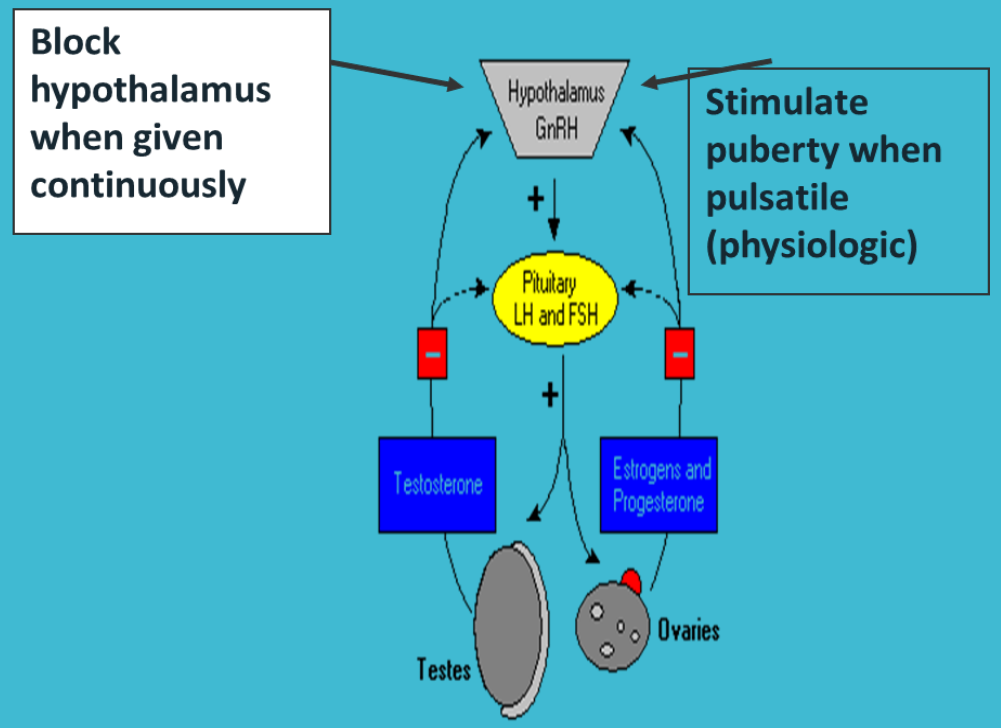
Lily is a 13 year old assigned male who identifies as female. She has felt like a girl for as long as she can remember. She still goes by her birth name and pronouns and presents as a male in public. She has already noticed some changes to her body and finds them "terrifying." Her anxiety and depression have worsened since pubertal changes have begun, and she has been isolating herself. Her family supports her gender identity and are getting very worried about the significant changes in her mood.

What can we offer this patient and family?

Pubertal Suppression

- **Delays irreversible secondary sex characteristics**
  - "Pushes pause," allowing pt and family more time to explore gender and consider later starting cross-gender hormones
  - Allow time for parent and social support to develop

- **Gonadotropin-Releasing Hormone (GnRH) agonists:**
  - Leuprolide (shots, q1 month or q3 months)
  - Histrelin, Supprelin (implant changed q1 year)

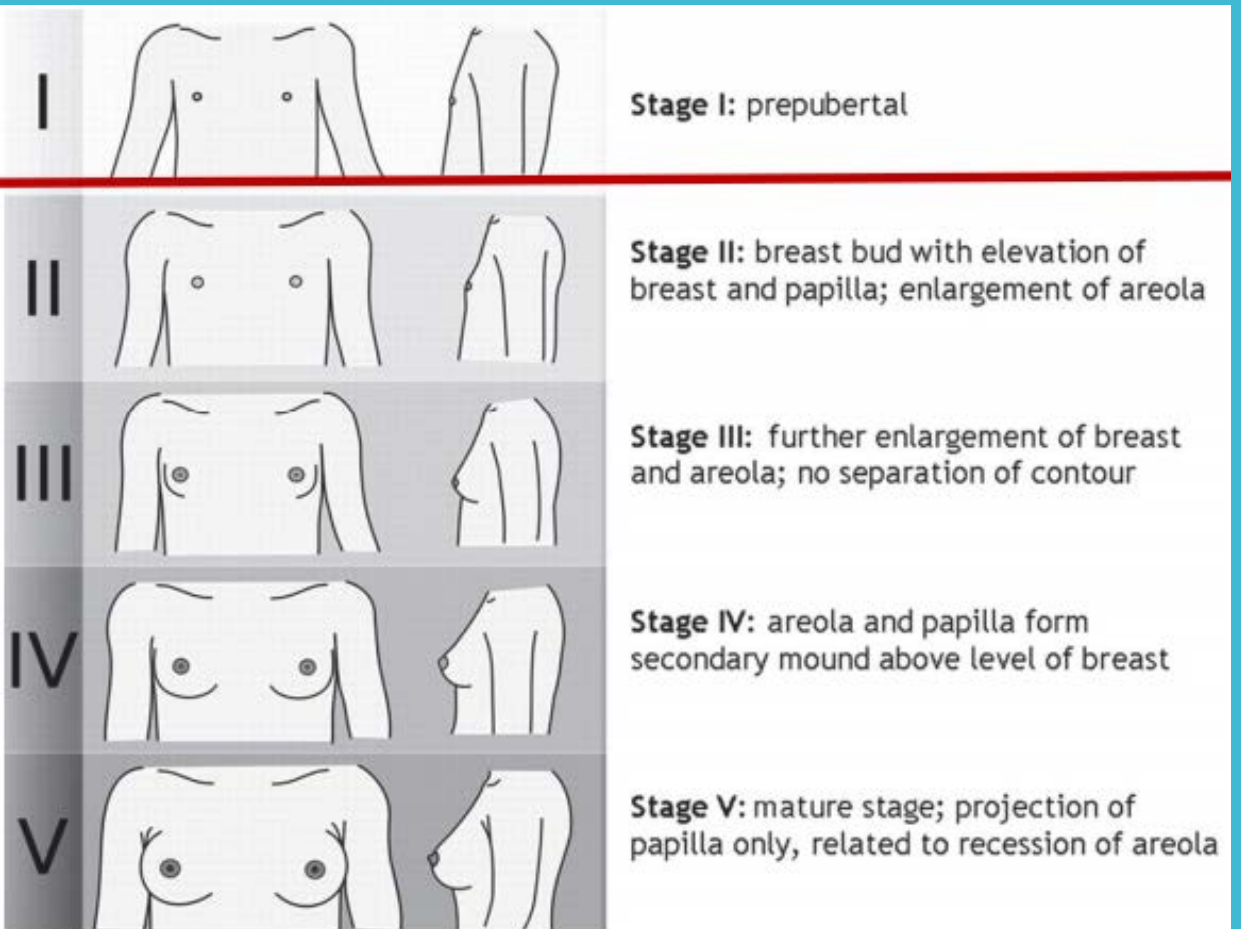


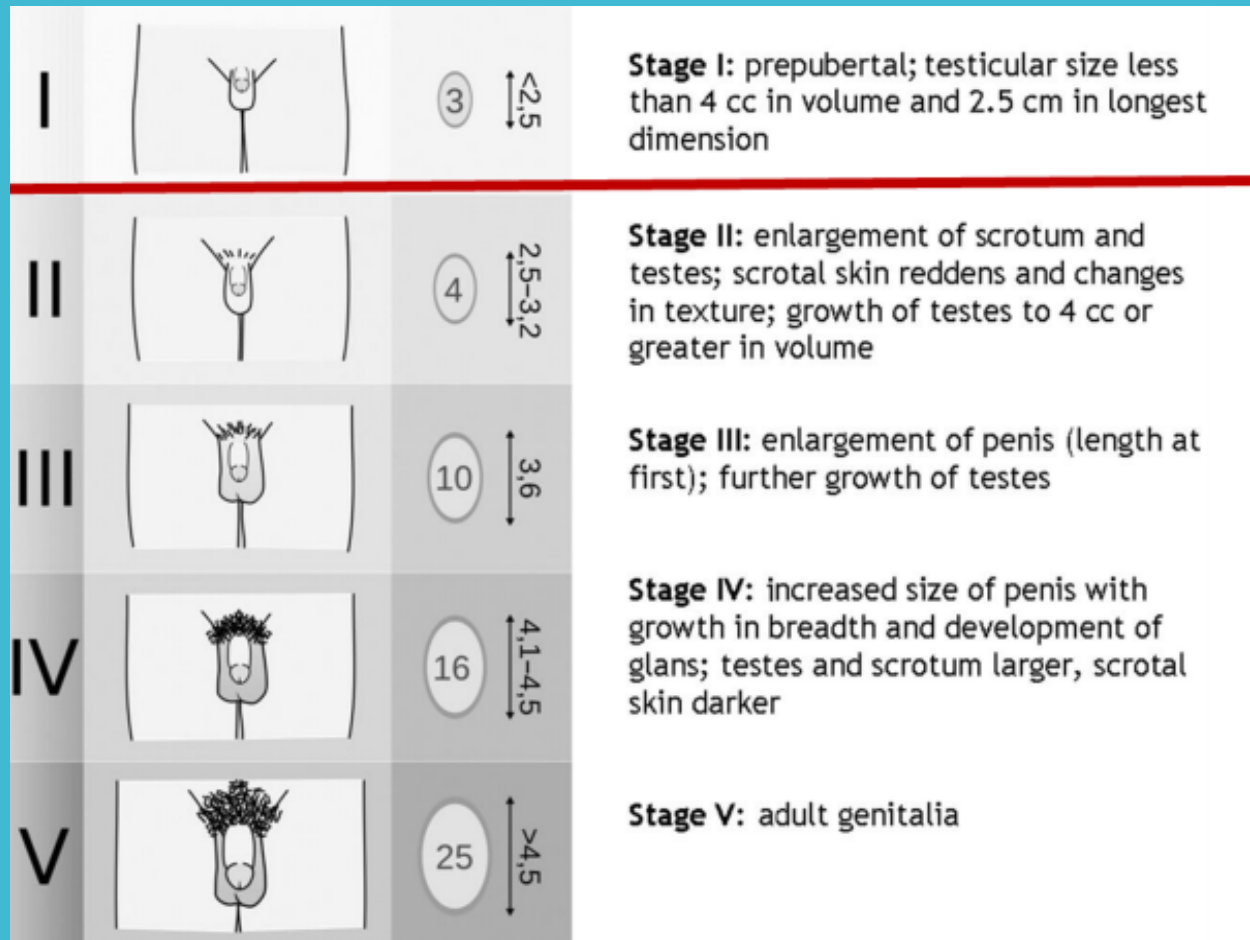
Continuous GnRH secretion →Initial ↑ LH, FSH followed by desensitized pituitary → LH, FSH secretion suppressed

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Tanner Staging

- For Puberty Blockade:
  - Tanner 2-3
  - Exam > labs





GnRH Analogues

Generally, benefits FAR outweigh the medical/psychosocial risks

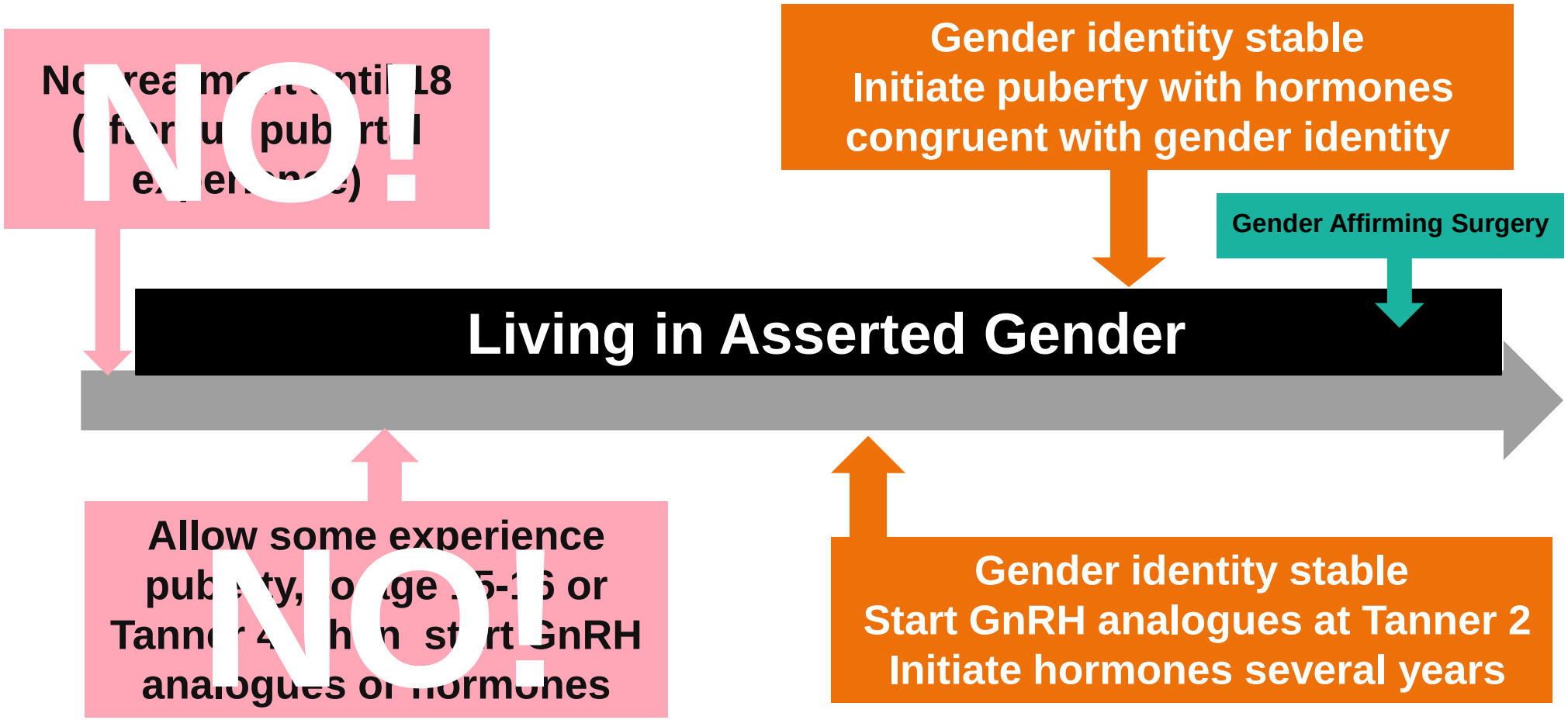
- Counseling and consent:
  - Few side effects (injection pain, blood draws & follow up)
  - Height consideration (poor data on “catch-up growth”)
  - Withdrawal bleed
  - Hot flashes, mood changes…. “menopausal symptoms”
  - Expect to see some “effects” in 2-4 week range
    - Effect = no changes, halting new gender characteristics, no menses, erectile dysfunction
  - Expensive (though mostly covered with a PA)
  - Fertility (lost if transitions directly to cross-gender hormones later)
  - Bone mineral density reduced (likely reversible once hormones initiated)
  - Lack of 2’ sex characteristics compared to peers

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Puberty Blockade Protocol

- **Anthropometric measurements**: height, weight, blood pressure, Tanner stage
  - Calculate **height velocity** at baseline (use sex assigned at birth)
    - Pre-pubertal = 4-6cm/year
    - Pubertal = 6-10cm/year (around Tanner stage 3)
    - Puberty suppressed = 4-6cm/year
- **Tanner Stage**: do physical exam at baseline and prior to initiating cross gender hormones
- **Labs**: early AM
  - **Ultrasensitive LH (us-LH)**:
    - **us-LH > 0.2** indicates central puberty
    - If **< 0.2**, then patient is not pubertal and therefore will need more time until eligible for initiation of puberty blockers
  - **Estradiol by TMS**: only if patient is female assigned at birth
  - **LCMS Testosterone**: only if patient is male assigned at birth
  - **25-OH vitamin D:** Recommend vitamin D supplement of 600-1000 IU daily for all patients on blockers.
    - If 25 OH D <20, recommend vitamin D supplementation of 2000-4000 IU daily. Target would be >30 ng/mL
    - Calcium supplements should only be started in patients not taking recommended dietary allowance (3+ servings of a dairy daily)
- **Imaging**:
  - **DXA**:
    - Radiologists should be using sex assigned at birth for interpretation until initiation of cross gender hormones
    - total body less head (TBLH), LS, hip" (good for follow up as adults)
    - A Z-score of < -2 at any site is low and should be discussed with Peds Endo (and DXA should be repeated in 1 year in this case)
    - Risk factors supporting annual DXA scans include: a minimally traumatic long bone fracture, inconsistency with adherence to sex steroid regimen, coexistent eating disorder or other chronic disease associated with skeletal fragility (IBD, CF, type 1 diabetes, daily oral steroid use, etc)

Range of Treatment Approaches



Slide adapted from presentation from ARSHEP

Planning for Initiation of Hormones

- Prescribing provider will establish:
  - Informed consent
  - Reasonable goals, expectations
  - Baseline screening labs
  - Set up referrals and/or follow up
- Provider (medical and/or mental health) and patient should establish :
  - Disclosure when patient is ready
  - Sources of social support
  - Impact on school or work

★ Letters from mental health professionals may help inform providers and allow for coordinated care. Practices vary in terms of requiring a letter of support of starting hormones.

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Fertility

- Sperm preservation
  - 1 month
  - Masturbate, freeze
- Oocyte preservation
  - 1-3 months
  - Consult, labs, TVUS
  - Daily US x 2 weeks cycle
  - 1-3 cycles

Ever changing technologies

- Post GnRA, no change in fertility or birth defects (Lazar 2014)
- Live births after cryopreservation prepubertal ovary (Demeestre 2015)
- Uterine transplant, successful live birth (Brannstrom 2015)
- Trans men experiencing pregnancy (Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. Obstet Gynecol. 2014;124(6):1120–7.)

Of note, we counsel patients going directly from GnRH agonists to cross-gender hormones that they will NOT be able to have biological children, which is something to consider while puberty is being suppressed

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Guidelines

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

Center of Excellence for Transgender Health

Department of Family & Community Medicine

University of California, San Francisco

2nd Edition – Published June 17, 2016

Editor - Madeline B. Deutsch, MD, MPH

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

J Clin Endocrinol Metab, November 2017, 102(11):1–35

CLINICAL PRACTICE GUIDELINE

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen,[10]

Transmales

Testosterone

Initial Lab Testing for Masculinizing Hormone Therapy

- Baseline labs prior to starting testosterone hormone therapy:
  - BMP, LFTs
  - CBC
  - Cholesterol panel
  - LC-MS Testosterone (liquid chromatography–tandem mass spectrometry) most accurate for comparing measures over time
  - Estradiol

Testosterone Formulations and Dosing

★ dose adjustments typically q3 months

Androgen	Initial – low dose[b]	Initial - typical	Maximum - typical[c]	Comment
Testosterone Cypionate[a]	20 mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	For q 2 wk dosing, double each dose
Testosterone Enthanate[a]	20mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	"
Testosterone topical gel 1%	12.5-25 mg Q AM	50mg Q AM	100mg Q AM	May come in pump or packet form
Testosterone topical gel 1.62%[d]	20.25mg Q AM	40.5 – 60.75mg Q AM	103.25mg Q AM	"
Testosterone patch	1-2mg Q PM	4mg Q PM	8mg Q PM	Patches come in 2mg and 4mg size. For lower doses, may cut patch
Testosterone cream[e]	10mg	50mg	100mg	
Testosterone axillary gel 2%	30mg Q AM	60mg Q AM	90-120mg Q AM	Comes in pump only, one pump = 30mg
Testosterone Undecanoate[f]	N/A	750mg IM, repeat in 4 weeks, then q 10 weeks ongoing	N/A	Requires participation in manufacturer monitored program[f]

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Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

Lab Follow-Up for Masculinizing Hormone Therapy

- Frequency (per Endocrine Society):
  - Q3 months x 1 year (and achieve maintenance dose of Testosterone)
  - Q6-12 months onward
  - Test according to need/while making dose adjustments
- Testosterone 300-1000 ng/dL
  - Goal “average male levels”
  - Reassure patient
  - Allows titration to goals, side effects
  - If IM admin, obtain “mid-cycle level” whenever possible
- Estradiol (yearly or if concerns arise)
- CBC (specifically H/H, IM route higher chance of erythrocytosis)
- +/- LFTs
- Lipid Panel
- Also monitor BP and weight

Risks of Masculinizing Hormones

Common, mild:

- Initial mood changes, usually resolves by 3-4 months
- Initial weight gain, usually restabilizes after 3-4 months
- Acne
- Increase in Hgb, Hct

Over time:

- Male pattern baldness
- Pelvic pain

Present, but not usually clinically significant:

- TG ↑ HDL ↓ LDL ↑
- Insulin resistance
- Increased homocysteine
- Polycythemia

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Source: Oriel K., Journal of the Gay and Lesbian Medical Association 2000;4:185–194.

Management of Side Effects of Masculinizing Hormones

- Finasteride to treat pattern baldness
- Estrogen vaginal cream for atrophy
  - Lubricant
  - Premarin vs estradiol, cost & coverage issue
- Retinoids, benzoyl peroxide, doxycycline for acne
- Creating amenorrhea
  - Usually occurs over time & appropriate dosing of testosterone

If menses continue OR if needs additional contraception

- LNG IUD, Etonorgestrel implant
- DMPA (usually for 6 months while reaching therapeutic T levels)
- POP (usually for 6 months while reaching therapeutic T levels)

★ Rule out STIs as a common cause of break-through bleeding

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Predicting Effects of Masculinizing Hormones

Action	Onset	Max
Male pattern facial/body hair	6–12 mo	4–5 yrs
Acne	1–6 mo	1–2 yrs
Voice deepening	1–3 mo	1–2 yrs
Clitoromegaly	3–6 mo	1–2 yrs
Vaginal atrophy	2–6 mo	1–2 yrs
Amenorrhea	2–6 mo	
Emotional changes/ ↑ libido		
Increased muscle mass	6–12 mo	2–5 yrs
Fat distribution	1–6 mo	2–5 yrs

★ **Testosterone does NOT decrease breast size**

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Health Maintenance for Transmales

- Emotional well-being
- STI testing
- Family planning
  - Contraception, fertility
  - Testosterone ≠ birth control
- Breast cancer screening
  - +/-self breast exam
  - Mammography according to cis-F guidelines (discuss w/surgeon if s/p top surgery)
- Pap cancer screening per cis-F guidelines
  - Note FTM on testosterone
  - Atrophy can look like dysplasia
- ? Dexa scans
  - Testosterone > 5 yrs
  - Age > 50

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Gender Confirmation Surgeries for Transmales

- Male chest construction
  - Different technique than mastectomy or implants
- Hysteroopherectomy w salpingectomy
- Phalloplasty/metoidioplasty
  - No function without pump
  - Rarely covered by health insurance
  - Performed by specialized surgeons

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Transfemales

Estradiol

Anti-Androgen

Initial Lab Testing for Feminizing Hormone Therapy

- Baseline labs prior to starting estradiol and anti-androgen therapy:
  - BMP (particularly K+ and Cr), LFTs
  - CBC
  - Cholesterol panel
  - LC-MS Testosterone (liquid chromatography–tandem mass spectrometry) most accurate for comparing measures over time
  - Estradiol
  - Prolactin (yearly x 3 years vs only if sx of Prolactinoma)

Estrogen Formulations and Dosing

★ dose adjustments typically q3 months

Little data to support use BUT benefits of a trial likely outweigh potential risks (breast growth, libido/ED, sleep)

Hormone	Initial–low[b]	Initial	Maximum[c]	Comments
Estrogen				
Estradiol oral/sublingual	1mg/day	2-4mg/day	8mg/day	if > 2mg recommend divided bid dosing
Estradiol transdermal	50mcg	100mcg	100-400 mcg	Max single patch dose available is 100mcg. Frequency of change is brand/product dependent. More than 2 patches at a time may be cumbersome for patients
Estradiol valerate IM[a]	<20mg IM q 2 wk	20mg IM q 2 wk	40mg IM q 2wk	May divide dose into weekly injections for cyclical symptoms
Estradiol cypionate IM	<2mg q 2wk	2mg IM q 2 wk	5mg IM q 2 wk	May divide dose into weekly injections for cyclical symptoms
Progestagen				
Medroxyprogesterone acetate (Provera)	2.5mg qhs		5-10mg qhs	
Micronized progesterone			100-200mg qhs	

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Anti-Androgen Formulations and Dosing

Hormone	Initial–low[b]	Initial	Maximum[c]	Comments
Spironolactone	25mg qd	50mg bid	200mg bid	
Finasteride	1mg qd		5mg qd	
Dutasteride			0.5mg qd	

- **GnRH analogues** can also be used post-pubertally, as E2 alone is not typically sufficient to suppress endogenous testosterone fully
  - There is no consensus of when to discontinue GnRH analogues (or anti-androgen agents) after starting cross-gender hormones
  - Q1 month or Q3 month frequency
  - Discuss with patient a trial period off, with plan to restart if T level rises and/or clinical signs of androgenism vs continue until gonadectomy

- **Cosmetics:** Hydroquinone, Vaniqua®, laser, electrolysis

Lab Follow up for Feminizing Hormone Therapy

Alternatively LCMS Testosterone

Test	Comments	Baseline	3 months*	6 months*	12 months*	Yearly	PRN
BUN/Cr/K+	Only if spiro used	X	X	X	X	X	X
Lipids	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					X
A1c or glucose	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					
Estradiol			X	X			X
Total Testosterone			X	X	X		X
Sex Hormone Binding Globulin (SHBG)			X	X	X		X
Albumin**			X	X	X		X
Prolactin	Only if symptoms of prolactinoma						X

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Lab Follow-Up for Feminizing Hormone Therapy

- Frequency (per Endocrine Society):
  - Q3 months x 1 year (and achieve maintenance dose of Testosterone)
  - Q6-12 months onward
  - Test according to need/while making dose adjustments
- Testosterone < 55 ng/dL (per Endo Society)
- Estradiol 100-200 ng/dl (per Endo Society)
- BP, Na, K (Cr)
  - If on spironolactone
- +/- LFTs
- Prolactin only if symptoms vs yearly x 3 years

Risks of Feminizing Hormones

- VTE
- Increased Weight
- Decreased Libido
- Erectile dysfunction
- Liver dysfunction
- TG ↑ (pancreatitis)
- HDL ↑ LDL ↓

- Increased BP
- Glucose intolerance
- Gall bladder disease
- Pituitary adenoma
- Breast cancer (3 cases)
- Anti-androgens
- ↑ K and Cr (with spironolactone)

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Predicting Effects of Feminizing Hormones

Action	Onset	Max
Breast growth	3-6 months	2-3 yrs
Body fat, muscle changes Softening skin Softer, less male pattern terminal hair Emotional changes	3–6 months 3-6 months 6-12 months 1-3 months	2-3 yrs > 3 years
Change in libido, erectile dysfunction Decrease testicular volume Decrease sperm production	1-3 months 25% see change in 1 yr ?	3-6 months 50% see change by 2–3 yrs ?

Estrogen does NOT affect voice or prevent body/facial hair growth

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Health Care Maintenance for MTFs

- Emotional well-being
- STI testing, prevention
- Breast cancer screening:
  - +/-Self breast exam
  - +/-Mammography 10+ years estradiol and/or age 40-50
  - According to cis guidelines at present
- Additional screenings, limited evidence:
  - ?Prostate screening for older patients
  - ?Pap if neo cervix created

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

Gender Confirmation Surgeries for Transfemales

- Vaginoplasty
- Labioplasty
- Tracheal shave
- Liposuction
- Breast implants
- Jaw shaping
- Orchiectomy

Slide adapted from *Caring for Transgender Adolescent Patients*, Adolescent Reproductive and Sexual Health Education Program (ARSHEP), Physicians for Reproductive Health https://prh.org/

What Can YOU Do?

- Transgender people are **a lot more like** cisgender people than unlike them
- Focus on the **patient's specific needs**, rather than on their gender identity
- Recognize that you are in a **position of power**
- Offer **sex and gender** blanks on the intake form
- **Involve** transgender people in your practice
- **Don't** rely solely on your patients to educate you
- **Network** with transgender-affirming clinicians and organizations in your field

Slide Adapted from Mai-Anh Tran Ngoc, DO

Questions?

AS PARENTS, YOUTH-SERVING PROFESSIONALS AND ALLIES, WE ALL HAVE A RESPONSIBILITY TO CREATE SAFE AND AFFIRMING SPACES SO **EVERY LGBTQ YOUTH** CAN BE **OUT**, **PROUD** AND ABLE TO **THRIVE**

https://www.hrc.org/resources/2018-lgbtq-youth-report