Treating Transgender Adults in the Primary Care Setting

By Margot Presley, FNP-S
Select material from presentations
by Amy Penkin, MSW & Allison Fox, MSN, FNP
Road Map

• Importance, Language/Terms, Types of Transition
• Personal and Professional Preparation for providing Trans* care
• Informed Consent for Hormones, Managing Patient Expectations
• Hormone Prescribing Guidelines, Monitoring, & Health Maintenance
• Surgery Discussion, Preparation, & Referral
• A Word on Adolescent Care
• Resources
CLINICAL IMPORTANCE: Why now?
Why Should We Provide This Care?

Injustice at Every Turn, 2011: Widespread Discrimination and Health Disparities for Transgender People in Oregon

Workplace Discrimination
- 83% reported harassment

School-based Discrimination
- 84% of K-12 graders reported harassment

Income Insecurity
- 15% unemployment rate compared to 7% national rate

Housing Discrimination
- 23% became homeless due to gender identity

(Nat’l Center for Transgender Equality, 2011)
Rate of suicide attempts (%)

Trans or Gender Non-Conforming
Lesbian, Gay or Bisexual
Overall Population

Data: The Williams Institute
Health Care Engagement

• 28% of transgender people have postponed necessary medical care when sick or injured

• 33% have delayed or not sought preventative care because of experiences of health care discrimination

• 52% believe they’ll be refused care

• 73% believe they’ll be treated “differently”
What does being treated differently mean?

70% of transgender patients reported at least one of these health experiences, based on transgender status:

- Being blamed for their health condition
- Refusal to touch or excessive precautions
- Harsh language
- Physical roughness

**Numbers were much higher for racial/ethnic minorities and low-income transgender people**

Source: When Health Care Isn’t Caring
The health care environment

Source: Transgender Law Center
Hopeful Change In Oregon:

2012 Insurance Division Bulletin 2012-1 Expanded the Oregon Equality Act of 2008:

- “A health insurer may not deny or limit coverage or deny a claim for a procedure provided for GI/GD* if the same procedure is allowed in the treatment of another non-GI/GD-related condition.”

(Insurance Division, 2012; FamilyCare Health Provider Toolkit, 2015)
OHP Coverage: Gender Dysphoria

2015 Oregon Health Plan expanded coverage for transition related medical care

- Puberty suppression in adolescents (Tanner stage 2)
- Cross sex hormones in adolescents and adults
- Gender confirmation surgery + necessary electrolysis (after 12 months of hormone treatment)
AN ALLY’S GUIDE TO
TERMINOLOGY
Talking About LGBT People & Equality

(Image from MAP & GLAAD, 2012)
Clarification:

**SEX**

- *Sex* refers to biological status, indicators include: sex chromosomes, gonads, internal reproductive organs, external genitalia

  Male

  Female

  **Intersex:** person born with ambiguous genitalia

**GENDER**

- *Gender* refers to attitudes, feelings, and behaviors that a given culture associate with a personal’s biological sex

  **Transgender:** umbrella term for people whose gender identity/expression does not align with the gender assigned at birth

  **Cisgender:** term for person whose gender identity aligns with gender assigned at birth
Language

- **Trans** is an umbrella term for a variety of self-described identities
- **Gender Expression**: feminine, masculine, androgynous
- **Gender Identity**: inner sense of oneself

A person’s self-identification is always the best terminology

- Someone may go by he, she, xe, they, or no pronouns at all
- Ask someone their preferred pronoun if you are unsure, intake forms are a great way to obtain this information

(Image from MAP & GLAAD, 2012; FamilyCare Health Provider Toolkit, 2015)
# Trans* Terminology: Out with the Old, In with the New

## Old (can be offensive)

| Term | New
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transvestite</td>
<td>Cross-dresser, drag queen/king</td>
</tr>
<tr>
<td>Transsexual</td>
<td>Transman, FTM, affirmed man</td>
</tr>
<tr>
<td>Gender Reassignment Surgery</td>
<td>Transwoman, MTF, affirmed woman</td>
</tr>
<tr>
<td>Gender Identity Disorder (DSM-IV)</td>
<td>Gender Confirmation Surgery</td>
</tr>
</tbody>
</table>

## New

| Term | New
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Dysphoria (DSM-V)</td>
<td>Genderqueer, genderfluid, gender non-conforming, gender diverse</td>
</tr>
</tbody>
</table>

### Terms to Use

- transgender (adj.)
  - "transgender person"
  - "transgender advocate"
  - "transgender inclusion"

### Terms to Avoid

- "transgendered"
- "a transgender" (n.)
- "transgenders" (n.)
- "transvestite"
- "tranny"

(IMAGE FROM MAP & GLAAD, 2012)
Types of Transition

Not everyone transitions in the same way or toward the same end goal
Types of Transition

**Medical Transition**

- Pubertal Suppression
  - E.g. Lupron

- Cross Sex Hormones
  - E.g. testosterone, anti-androgens, estrogen

- Gender Confirmation Surgery
  - E.g. mastectomy, removal of gonads, surgeries on external genitalia

**Physical Transition**

- Clothing, hair, make-up, binding, breast forms, packing, tucking

**Social Transition**

- Name change, coming out to family and friends

(Images from MAP & GLAAD, 2012)
Preparing Yourself and Clinic for Providing Trans* Care
Preparation

For Yourself

- We all have biases—investigate your own
- What assumptions/attitudes do you have about gender roles, sexuality, racial and ethnic identities?
- Understanding our assumptions/attitudes can positively impact our patient relationships and possibly prevent clinical decision-making that lead to disparities in health outcomes

(Hall et al., 2015)

In the Office

- Invite a trans* justice educator to train ALL STAFF or utilize online trainings
- Make sure all staff use preferred names/pronouns for patients
- Review intake forms/EHR to be gender inclusive
- Identify/create gender neutral bathrooms
- Increase visibility with LGBT posters/pamphlets. Post nondiscrimination policy
- Get to know your local, regional, and national resources

(Hall et al., 2015)
Sample Patient Intake Questions:

1. What is your current gender identity? (Check ALL that apply)
   □ Male
   □ Female
   □ Transgender Male/Transman/FTM
   □ Transgender Female/Transwoman/MTF
   □ Genderqueer
   □ Additional category (please specify):__________________
   □ Decline to answer

2. What sex were you assigned at birth? (Check one)
   □ Male
   □ Female
   □ Decline to answer

3. What pronouns do you prefer?__________________________

(UCSF Primary Care Protocol, 2015)
EPIC screens

OHSU Transgender Identity Form

Gender Identity

- Gender Identity: [M, F, FTm, MTF, TG, GQ]
- Sex Assigned at Birth: [Male, Female, Intersex]

Transition Summary

- Organ Inventory: [Phallic, Testes, Prostate, Breasts, Vagina, Cervix, Uterus, Ovaries]

- Treatments and Procedures:
  - Cross-sex hormone therapy, current user
  - Cross-sex hormone therapy, past user
  - Vaginoplasty, penis inversion
  - Vaginoplasty, colon graft
  - Phaloplasty, free flap
  - Metoidioplasty
  - Scrotalplasty
  - Urethroplasty
  - Scalp advancement
  - Forehead reconstruction
  - Reduction rhinoplasty
  - Labiaeal feminization surgery
  - Soft tissue filler injections
  - Bilateral total reduction mammoplasty
  - Voice surgery
  - Other unrelated surgical procedure

Future Plans: [Blank]
Medical Management of Gender Dysphoria
Informed Consent Model for Hormone Treatment

- The World Professional Association for Transgender Health (WPATH) offers internationally accepted Standards of Care (SoC) for treatment of gender dysphoria (free to download)

- SoC utilize an “informed consent model,” which includes a detailed conversation about the risks and benefits of hormone treatment

- SoC by WPATH and UCSF Center of Excellence for Transgender Health offer samples of informed consent forms

- Consent is obtained once at beginning of hormone treatment

- Also a good time to discuss
  - Timeline and expectations for hormone-related changes
  - Supportive scaffolding patient has throughout transition
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Feminizing hormones</th>
<th>Masculinizing hormones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely increased risk</td>
<td>Venous thromboembolic disease(^a)</td>
<td>Polycythemia</td>
</tr>
<tr>
<td></td>
<td>Gallstones</td>
<td>Weight gain</td>
</tr>
<tr>
<td></td>
<td>Elevated liver enzymes</td>
<td>Acne</td>
</tr>
<tr>
<td></td>
<td>Weight gain</td>
<td>Androgenic alopecia (balding)</td>
</tr>
<tr>
<td></td>
<td>Hypertriglyceridemia</td>
<td>Sleep apnea</td>
</tr>
<tr>
<td>Likely increased risk with presence of additional risk factors(^b)</td>
<td>Cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>Possible increased risk</td>
<td>Hypertension</td>
<td>Elevated liver enzymes</td>
</tr>
<tr>
<td></td>
<td>Hyperprolactinemia or prolactinom(^a)</td>
<td>Hyperlipidemia</td>
</tr>
<tr>
<td>Possible increased risk with presence of additional risk factors(^b)</td>
<td>Type 2 diabetes(^a)</td>
<td>Destabilization of certain psychiatric disorders(^c)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type 2 diabetes</td>
</tr>
<tr>
<td>No increased risk or inconclusive</td>
<td>Breast cancer</td>
<td>Loss of bone density</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breast cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cervical cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ovarian cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uterine cancer</td>
</tr>
</tbody>
</table>

(WPATH, 2012)
Fertility Preservation and Contraception

• Important to discuss fertility preservation before initiating hormone treatment depending on a person’s family planning goals

• “Cross-sex hormone use may reduce fertility, and this may be permanent even if hormones are discontinued” (UCSF, 2015)

• Cryopreservation: Northwest Fertility Center, NW Cryobank, etc.

Also...

• Testosterone reduces fertility in transmen but testosterone IS NOT A CONTRACEPTIVE. Transmen on T are at risk for pregnancy. Discuss contraception when appropriate.

Support for Prescribers

You’ve prescribed these medications before

Estrace: menopause
Testosterone: hypogonadism
Spironolactone: CHF, acne, HTN

Prescribing Guidelines and Support Are Freely Available Online

1. UCSF Center of Excellence for Transgender Health Primary Care Protocol
2. International Endocrine Society Clinical Practice Guideline
3. Project Health: Transline (e-mail specific questions to experts)
4. WPATH Standards of Care
Masculinizing Hormone Treatment

- **Baseline Labs:** CBC and lipids. Use cismale reference values for transmen taking testosterone.

- **Hormone Regimen:** Androgen Testosterone (available IM, transdermal patch or gel, or subcutaneous implant)
  - **Initial dose:** Depo-testosterone 50-200 mg IM every 2 weeks (comes 200 mg per 1 mL)
  - Most adults can start at 200 mg q14 days
  - If emotional SE related to peaks and troughs, change to more frequent doses e.g. 100mg q7 days

**Pearls:**
- IM solutions needs to be in a warm room otherwise it will crystalize
- Some patients using subQ vs. IM, not enough data to support safety
- T is suspended in cottonseed oil or sesame oil, discuss allergies
- Polycythemia tx by lowering dose of T, donating blood, or (if MSM) therapeutic phlebotomy

(UCSF Primary Care Protocol, 2015)
## Timeline of Masculinizing Changes

Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline

Table 13. Masculinizing effects in FTM transsexual persons

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>ONSET(^a) (months)</th>
<th>MAXIMUM(^a) (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin oiliness/acne</td>
<td>1 – 6</td>
<td>1 – 2</td>
</tr>
<tr>
<td>Facial/body hair growth</td>
<td>6 – 12</td>
<td>4 – 5</td>
</tr>
<tr>
<td>Scalp hair loss</td>
<td>6 – 12</td>
<td>b</td>
</tr>
<tr>
<td>Increased muscle mass/strength</td>
<td>6 – 12</td>
<td>2 – 5</td>
</tr>
<tr>
<td>Fat redistribution</td>
<td>1 – 6</td>
<td>2 – 5</td>
</tr>
<tr>
<td>Cessation of menses</td>
<td>2 – 6</td>
<td>c</td>
</tr>
<tr>
<td>Clitoral enlargement</td>
<td>3 – 6</td>
<td>1 – 2</td>
</tr>
<tr>
<td>Vaginal atrophy</td>
<td>3 – 6</td>
<td>1 – 2</td>
</tr>
<tr>
<td>Deepening of voice</td>
<td>6 – 12</td>
<td>1 – 2</td>
</tr>
</tbody>
</table>

\(^a\) Estimates represent clinical observations. See Refs 81, 92, 93.
\(^b\) Prevention and treatment as recommended for biological men.
\(^c\) Menorrhagia requires diagnosis and treatment by a gynecologist.

(Hembree et al., 2009)
## Monitoring & Health Maintenance

### TABLE 16. Monitoring of FTM transsexual persons on cross-hormone therapy

1. Evaluate patient every 2–3 months in the first year and then 1–2 times per year to monitor for appropriate signs of virilization and for development of adverse reactions.

2. Measure serum testosterone every 2–3 months until levels are in the normal physiologic male range:*
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured mid-way between injections. If the level is >700 ng/dl or <350 ng/dl, adjust dose accordingly.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection.
   c. For transdermal testosterone, the testosterone level can be measured at any time after 1 week.
   d. For oral testosterone undecanoate, the testosterone level should be measured 3–5 hours after ingestion.
   e. Note: During the first 3–9 months of testosterone treatment, total testosterone levels may be high although free testosterone levels are normal due to high sex hormone binding globulin levels in some biological women.

3. Measure estradiol levels during the first 6 months of testosterone treatment or until there has been no uterine bleeding for 6 months. Estradiol levels should be <50 pg/ml.

4. Measure CBC and liver function tests at baseline and every 3 months for the first year and then 1–2 times a year. Monitor weight, blood pressure, lipids, fasting blood sugar (if family history of diabetes) and hemoglobin A1c (if diabetic) at regular visits.

5. Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.

6. If cervical tissue is present, an annual pap smear is recommended by the American College of Obstetricians and Gynecologists.

7. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

* Adapted from Refs. 83, 85

(Hembree et al., 2009)
Feminizing Hormone Treatment

- **Baseline Labs:** Fasting lipid panel (if on oral estrogen). CMP if patient is on spironolactone (Cr & K+). Prolactin? Use female reference values for transwomen taking estrogen.

- **Hormone Regimen:** Spironolactone (anti-androgen) + Estrogen
  
  **Anti-Androgen—Spironolactone most common (obtain renal hx)**
  
  - Start with 50 mg bid, move to 100 mg bid
  - Some people need up to 200 mg bid
  - Check potassium after starting or changing dose
  - Ensure healthy kidney function, review hx of renal dx or surgery

  **Estrogen (PO, patch, IM)**
  
  - 3-5x normal cisgender replacement doses (feminization and testosterone suppression)
  - PO Estradiol dose ranges from 1-6 mg/day (most common dose is 4 mg)
  - Start with 1mg BID and increase to 2mg BID
  - IM- Delestrogen 10-40 mg q14d (usual 20 mg) (not covered by OHP)
  - Transdermal- Estradiol patch 0.1-0.3 mg/day (1-3 patches at a time) (Not covered by OHP)
  - Safest for transwomen with risk factors
  - Evamist

- **Pearl:** Discuss how the patient is taking the PO estrogen. Some patients take it sublingually, and this can be the cause of high peaks and low troughs.

  (Project Health Lab and Monitoring Summary, 2012; UCSF Primary Care Protocol, 2015)
Timeline of Feminizing Changes

Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline

TABLE 14. Feminizing effects in MTF transsexual persons

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>ONSET (^{a})</th>
<th>MAXIMUM (^{b})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redistribution of body fat</td>
<td>3 – 6 months</td>
<td>2 – 3 years</td>
</tr>
<tr>
<td>Decrease in muscle mass and strength</td>
<td>3 – 6 months</td>
<td>1 – 2 years</td>
</tr>
<tr>
<td>Softening of skin/decreased oiliness</td>
<td>3 – 6 months</td>
<td>Unknown</td>
</tr>
<tr>
<td>Decreased libido</td>
<td>1 – 3 months</td>
<td>3 – 6 months</td>
</tr>
<tr>
<td>Decreased spontaneous erections</td>
<td>1 – 3 months</td>
<td>3 – 6 months</td>
</tr>
<tr>
<td>Male sexual dysfunction</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Breast growth</td>
<td>3 – 6 months</td>
<td>2 – 3 years</td>
</tr>
<tr>
<td>Decreased testicular volume</td>
<td>3 – 6 months</td>
<td>2 – 3 years</td>
</tr>
<tr>
<td>Decreased sperm production</td>
<td>Unknown</td>
<td>&gt; 3 years</td>
</tr>
<tr>
<td>Decreased terminal hair growth</td>
<td>6 – 12 months</td>
<td>&gt; 3 years (^{b})</td>
</tr>
<tr>
<td>Scalp hair</td>
<td>No regrowth</td>
<td>c</td>
</tr>
<tr>
<td>Voice changes</td>
<td>None</td>
<td>d</td>
</tr>
</tbody>
</table>

\(^{a}\) Estimates represent clinical observations. See Refs 81, 92, 93.
\(^{b}\) Complete removal of male sexual hair requires electrolysis or laser treatment or both.
\(^{c}\) Familial scalp hair loss may occur if estrogens are stopped.
\(^{d}\) Treatment by speech pathologists for voice training is most effective.

(Hembree et al., 2009)
**TABLE 15. Monitoring of MTF transsexual persons on cross-hormone therapy**

1. Evaluate patient every 2–3 months in the first year and then 1–2 times per year to monitor for appropriate signs of feminization and for development of adverse reactions.

2. Measure serum testosterone and estradiol every 3 months.
   a. Serum testosterone levels should be <55 ng/dl.
   b. Serum estradiol should not exceed the peak physiologic range for young healthy females, with ideal levels, 200 pg/ml.
   c. Doses of estrogen should be adjusted according to the serum levels of estradiol.

3. For individuals on spironolactone, serum electrolytes particularly potassium should be monitored every 2–3 months initially in the first year.

4. Routine cancer screening recommended in non-transsexual individuals (breasts, colon, prostate).

5. Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.

(Hembree et al., 2009)
OHP Requirements for Surgery Referral

- Cross-sex hormone therapy for **12 months prior**
- Top surgery: **one letter** from a medical provider
- Bottom surgery: **two letters**, one of which needs to be from a doctorally prepared MH provider
- **Letter templates** available online (Transline) and in the OHP provider tool kit
- **Start referral process early**—wait lists can be months long
- Discuss who is providing **post-op care** (you and/or surgeon)

OHSU Currently Offers:

- Chest surgery (FTM and MTF)
- Facial feminization surgery
- Oophorectomy/hysterectomy
- Orchietectomy
- Metoidioplasty
- Vaginoplasty
- Phalloplasty (summer/fall 2016)

(OHP Provider Toolkit, 2015; OHSU Trans Health Program, 2015)
Working with Adolescents

- Consult with pediatric endocrinology for patients who wish to suppress puberty or start cross-sex hormone therapy before 18 years of age
- Puberty suppression starts no earlier than Tanner Stage 2
- Lupron/Lueprolide 7.5mg IM monthly most common regimen
- Collaboration with MH provider encouraged

Portland-based Pediatric Trans* Specialists:
- OHSU—Kara Connelly, MD & Lindsey Nicol, MD
- Legacy Trans Clinic—Karin Selva, MD & Valerie Tobin, PMHNP

(OHSU Trans Health Program, 2015; UCSF Protocol: Youth Considerations, 2015)
What can you do?

• Become aware and knowledgeable
• Educate others
• Advocate for change
• Hold others accountable
• Be aware of your biases, beliefs, behaviors
• Be genuine
• Be an ALLY!
Trans* Healthcare Resources
Prescribing Guidelines & Support:

UCSF Center of Excellence for Transgender Health Primary Care Protocol
http://transhealth.ucsf.edu/trans?page=protocol-00-00


OHP Provider Tool Kit http://www.healthshareoregon.org/for-providers/provider-resources/Provider%20tool%20kit%20v4.pdf

Project Health: Transline http://project-health.org/transline/

WPATH Standards of Care http://www.wpath.org/site_home.cfm

Trans* Education and Advocacy

National LGBT Health Education Center (a lot of free webinars on working with trans* patients)
http://www.lgbthealtheducation.org/training/on-demand-webinars/

TransActive Gender Center (Youth Organization) http://www.transactiveonline.org/index.php

Gay & Lesbian Alliance Against Defamation (GLAAD) An Ally’s Guide to Terminology

National Center for Transgender Equality (has IDs Document Center and more) http://www.transequality.org
Conferences

LGBTQ Meaningful Care Conference—Portland, OR
- Bi-annual spring conference http://oregonlgbtqhealth.org/mcc

Trans Rounds Portland—Portland, OR
- Quarterly Grand Rounds and Case in Portland, OR
- For more information join the facebook group: “Trans Rounds Portland”

National Transgender Health Summit—Oakland, CA
Bi-Annual spring (April) conference
http://transhealth.ucsf.edu/summit

National Transgender HIV Testing Day 4/18 (UCSF)

Philadelphia Trans Health Conference—Philadelphia, PA
15th Annual Conference June 9-11, 2016
https://www.mazzonicenter.org/trans-health
References


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