Caring for Transgender Patients: What the Primary Care Clinician Needs to Know

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• No disclosures or conflicts of interest
• Discussion of off label medications
Objectives

• Definitions
• Treatment of gender dysphoria & hormone basics
• Basic health screening and primary care
• Pearls to understand as a PCP
• Resources
Definitions

- Lesbian
- Gay
- Bisexual
- Transgender
- vs Cisgender
- Queer
• Sexual orientation is not the same thing as gender identity
• Both increasingly being viewed as a spectrum (vs a binary)

Each of us has a S.O. and a G.I.
• Sexual orientation
  • Physical, romantic, emotional attraction

• Gender identity
  • Deeply held sense of one’s self as male, female or other
2 step method

• How to assess gender identity

• 1. What was your sex assigned at birth?
  • Male, female, decline to answer

• 2. What is your current gender identity?
  • Male, female, transgender man / transman, transgender woman / transwoman, genderqueer, gender non conforming, non-binary, others
• **Gender Identity Terms**

• **Transgender**
  - Umbrella term - discordance between sex assigned at birth and gender identity
  - Best term to use

• **Transsexual**
  - Medical / clinical term applied to those who seek medical interventions for gender affirmation - in general avoid use

• **Cross dresser, drag king/queen**
  - Dresses as opposite gender but doesn’t typically live in that gender or have a transgender identity
  - Don’t use the term transvestite

• **Genderqueer**
  - Term used generally by younger generation for someone who blurs the gender binary or identifies outside the male / female gender binary
• Transgender man or transman
  • Sex assigned at birth was female, but gender identity is male
• Transgender woman or transwoman
  • Sex assigned at birth was male, but gender identity is female
• Non binary, genderqueer, agender

Ask & respect preferred names & pronouns

She / her / hers
He / him / his
They / them / theirs
Zie / zim
Hir
Transgender health disparities

• It is very important to understand that there are large healthcare (& other) disparities in the transgender population

• Closely related to stigma & discrimination

• High rates of violence, harassment and family rejection

• 40-41% reported attempted suicide

• Higher rates of depression, tobacco, substance use
• Poor experiences in healthcare settings results in delaying care
• 19% reported being refused medical care
• 28% - 33% reported harassment in a medical setting
• 50% reported having to teach their provider about their health
• 23% - 28% delayed healthcare due to discrimination
• More likely to be unemployed, underinsured and working in underground economies
• Higher rates of STIs especially HIV
• Less likely to seek primary care, routine health screening based on body parts
  • eg low cervical cancer screening rates in trans men
• Some seek hormones and silicone on the black market
Gender Dysphoria

• Replaced Gender Identity Disorder
• Definition: distress that may be associated with the incongruity between sex assigned at birth and current gender identity
• Being transgender is not a disorder or pathology
• Not all transgender individuals have dysphoria or seek treatment
• If dysphoria causes dysfunction with relationships, work, life - it can & should be treated
• Goal is to reduce distress and dysphoria, improving quality of life

• **Social transition** - coming out
  • changing appearance and gender expression / presentation

• **Medical transition**
  • hormones and/or surgery
• Treatment is individualized & depends on the specifics of one’s dysphoria
  • Cross gender hormones
  • Gender affirmation surgeries
  • Both
  • Neither
  • Therapy for some, not all
• Treatment of gender dysphoria is a medically necessary intervention

• Statements of support from American College of Physicians, American Medical Association, American Psychological Association, American Psychiatric Association, WPATH (World Professional Association on Transgender Health)

• “Being transsexual, transgender or gender nonconforming is a matter of diversity, not pathology.” - WPATH
A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals

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Abstract

Objectives: To review evidence from prospective cohort studies of the relationship between hormone therapy and changes in psychological functioning and quality of life in transgender individuals accessing hormone therapy over time.

Data Sources: MEDLINE, PsycINFO, and PubMed were searched for relevant studies from inception to November 2014. Reference lists of included studies were hand searched.

Results: Three uncontrolled prospective cohort studies, enrolling 247 transgender adults (180 male-to-female [MTF], 67 female-to-male [FTM]) initiating hormone therapy for the treatment of gender identity disorder (prior diagnostic term for gender dysphoria), were identified. The studies measured exposure to hormone therapy and subsequent changes in mental health (e.g., depression, anxiety) and quality of life outcomes at follow-up. Two studies showed a significant improvement in psychological functioning at 3–6 months and 12 months compared with baseline after initiating hormone therapy. The third study showed improvements in quality of life outcomes 12 months after initiating hormone therapy for FTM and MTF participants; however, only MTF participants showed a statistically significant increase in general quality of life after initiating hormone therapy.

Conclusions: Hormone therapy interventions to improve the mental health and quality of life in transgender people with gender dysphoria have not been evaluated in controlled trials. Low quality evidence suggests that hormone therapy may lead to improvements in psychological functioning. Prospective controlled trials are needed to investigate the effects of hormone therapy on the mental health of transgender people.

Key words: clinical care; gender dysphoria; gender transition; mental health; transgender
• Protocols & guidelines
• WPATH Standards of Care
• Endocrine Society guidelines
• Vancouver Guidelines
• Center of Excellence for Transgender Health (UCSF)

• Informed consent model vs traditional mental health model
• Fully reversible interventions
  • GnRH analogues for puberty suppression

• Partially reversible interventions
  • Cross gender hormones (testosterone and estrogen, androgen blockers)

• Irreversible interventions
  • Surgical procedures
    • Gender affirmation surgery, gender confirmation surgery, or sex reassignment surgery, not a “sex change”
  • Don’t refer to individuals as “pre-op” or “post-op”
Criteria for cross gender hormone therapy

- 1. Persistent, well-documented gender dysphoria
- 2. Capacity to make a fully informed decision & 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
Feminizing treatments

• Estrogen: intramuscular estradiol cypionate or valerate, oral or topical estradiol
  • avoid ethinyl estradiol (VTE risk)
  • Contraindicated if estrogen sensitive tumor present
• Androgen blockers (usually spironolactone or finasteride)
• Progesterone is optional
• Voice therapy - feminizing hormones do not change voice
• Effects of hormones
  • Desired: body fat redistribution, softer skin, breast growth, decreased testicular volume, +/- mood changes
  • Less desired: changes in libido/erections, decreased muscle mass, metabolic effects
• Assessing physical changes in conjunction with lab / biochemical monitoring guides dosing
Feminizing procedures

- Laser hair removal, electrolysis
- Facial feminization procedures
  - Tracheal shave (Adam’s apple reduction)
  - Vocal cord procedures
- “Top surgery”
- Breast augmentation / augmentation mammoplasty
- “Bottom surgery”
  - Orchietomy, penectomy, vaginoplasty
  - Prostatectomy is not part of gender affirmation surgery
Masculinizing treatments

- Testosterone: topical, intramuscular (cypionate, enanthate, undecanoate), implanted seeds (Testopel)
  - Oral is available but not recommended
  - + / - Depo-provera, IUD, others for menstrual issues & contraception
- Effects of hormones
  - Desired: Fat redistribution, increased muscle mass, amenorrhea, clitoral enlargement, deepening of voice, facial / body hair growth, vaginal atrophy
  - Less desired: acne, scalp hair loss, polycythemia, +/- mood changes
- Assessing physical changes in conjunction with lab / biochemical monitoring guides dosing
Masculinizing procedures

- “Top surgery”
- Mastectomy / chest reconstruction
- “Bottom surgery”
- Hysterectomy, vaginectomy, metoidioplasty, phalloplasty, scrotoplasty
Primary care

• UCSF Center of Excellence for Transgender Health

• Primary care protocols - http://www.transhealth.ucsf.edu

• Address the issue the patient is presenting for

• Only include discussions of gender identity if relevant (will affect medical decision making?)
• “Anatomic inventory”
• Screening and general care requires knowledge of current anatomy
• Obtain this in a culturally sensitive manner, ask what terms patient prefers
History

• History of feminizing or masculinizing interventions, including unsupervised hormone use, silicone injection

• Past medical history:
  • Previous history / risk factors for: VTE, hormone sensitive cancer, metabolic disorders including dyslipidemia / diabetes / osteoporosis, cardiovascular risk factors

• Gyn & obstetric history in trans men
  • Higher incidence PCOS
  • Last pap smear
CV disease

- Testosterone carries risk of exacerbating risk factors (BP, insulin resistance, dyslipidemia)
- Estrogen carries VTE risk, which can be mitigated by transdermal formulations and/or lower doses
- Ongoing attention to risk factors (BP, lipids, tobacco, glucose metabolism)
- Shared decision making
VTE risk

- Risk factors
  - especially tobacco use
- Risk mitigated with transdermal estrogen (vs oral)
  - weak evidence that SL administration of oral tablets may also mitigate risk
- Avoid ethinyl estradiol
- Shared decision making
• Family history: VTE, CV history, hypertension, diabetes, hormone sensitive cancer

• Social history: family and support networks, economic security, housing, tobacco / substance use

• Many trans individuals live in poverty due to societal & institutional discrimination

• Immunizations
Bridging

• You can provide refills / bridge while finding a transgender specialist

• Or, you can take over if the dose is stable
Sexual History

• Sexual history: sexual orientation, risk behaviors, STI screening history, relationship status, gender of partners, type of intercourse
• Don’t assume everyone is cisgender and heterosexual
• Don’t assume anything about sex practices based on SO and GI
• 3 site screening for gonorrhea / chlamydia
• Consider Truvada for Pre-exposure Prophylaxis (PrEP) in individuals at high risk of HIV
  • CDC guidelines: http://www.cdc.gov/hiv/risk/prep
• Pregnancy prevention in trans men without hysterectomy
Mental health

- Gender dysphoria and general mental health screening
- Likely increased risk mental health co-morbidities
  - 39% reported “serious psychological distress” in the month before a large national transgender survey
  - Don’t assume mental health issues are related to gender identity
- A word about Coming Out
- “Conversion” or “Reparative” therapy
  - Ineffective, harmful and unethical
  - Opposition statements from ACP, AAP, AMA, APA, multiple psychology associations
- Relatively recent removal of homosexuality and gender identity disorder from DSM
- Intimate partner violence
Cancer screening

• Screen based on anatomic inventory per cisgender guidelines
  • If you have it, check it

• UCSF CoE Transgender Health:
  • “As a rule, if an individual has a particular body part or organ and otherwise meets criteria for screening based on risk factors or symptoms, screening should proceed regardless of hormone use.”
Cancer screening - trans men

- Colon cancer: same guidelines as for cisgender individuals
- Breast cancer:
  - Can consider chest wall / axillary exam annually if s/p mastectomy
  - Mammography per cisgender guidelines if no mastectomy, or if only a reduction was done
- Cervical cancer: same guidelines as for cisgender women, unless s/p total hysterectomy
- “If you have it check it”
- Cervical atrophy from testosterone can make pathology evaluation challenging
Cancer screening - trans women

• Colon cancer: same guidelines as for cisgender individuals

• Breast cancer: mammography > 50 q2 years

• Prostate cancer: shared decision making
  • PSA falsely low in androgen deficient milieu - limit to high risk patients

• Pap tests not indicated in neovaginas
LGBTQ Aging

• LGBTQ elders grew up in a very restrictive cultural milieu, generally experienced a lifetime of discrimination - survived by being silent - esp those who came of age prior to Stonewall

• Isolated, lack of social support

• Less likely to have biological family support, more likely to rely on “families of choice”

• Support networks are much more informal - key issues for management of geriatric syndromes

• Decision makers - 1/3 lack formal documents

• Discrimination, abuse in LTC settings widespread

Gen Silent film
“For many [LGBT seniors], they don’t have doctor relationships they can call on because of their fear of being outed.”

“They grew up at a time when it was illegal, it was against the law, it was sinful. They have never really felt comfortable or secure being out in public.”

Barbara Satin
Key Points

• Ask about sexual orientation and gender identity

• Ask about names and pronouns

• Be aware of the life experiences of this community

• Incorporate sociopolitical aspects into transgender care

• Take an culturally competent anatomic inventory and provide screening accordingly
Resources - Local

- Transgender Health clinics
  - Park Nicollet Gender Services Clinic
  - HCMC Gender and Sexual Health Clinic
    - Adult
    - Pediatrics
  - Family Tree Clinic
  - Program in Human Sexuality - University of Minnesota
  - United Family Medicine
  - Smiley’s Clinic
  - Reclaim (therapy)
- Rainbow Health Initiative (advocacy)
- Outfront MN (Advocacy)
- Minnesota Transgender Health Coalition
- Training to Serve:  [www.trainingtoservec.org](http://www.trainingtoservec.org)
Resources

• WPATH: World Professional Association for Transgender Health
• GLMA: Health Professionals Advancing LGBT Equality
• **UCSF Center of Excellence for Transgender Health**
  • Primary care protocols - http://www.transhealth.ucsf.edu
• National Center for Transgender Equality
• **Fenway Health & National LGBT Health Education Center**
  • Webinars, multiple resources
• **Fenway Guide to LGBT Health, 2nd Ed. (ACP)**
• SAGE: Services & Advocacy for GLBT Elders
• Transline (at Lyon / Martin Health Services): Web based medical consultations
• Journals: [www.liebertpub.com](http://www.liebertpub.com)
  • LGBT Health
  • Transgender Health
• MedLine clearinghouse: [https://medlineplus.gov/gaylesbianbisexualandtransgenderhealth.html](https://medlineplus.gov/gaylesbianbisexualandtransgenderhealth.html)
• Consider adding yourself to an LGBT friendly referral site:

• GLMA (national): [www.glma.org](http://www.glma.org)

• Rainbow Health Initiative (local): [www.rainbowhealth.org](http://www.rainbowhealth.org), [mnlgbtqdirectory.org](http://mnlgbtqdirectory.org)
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Photo Credits

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5: (Transgender health)

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