NATIONAL LGBT HEALTH EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE

Creating Programs for Transgender People in Health Centers

Massachusetts League Of Community Health Centers

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Our Roots

Fenway Health

- Independent 501(c)(3) FQHC
- Founded 1971
- Mission: To enhance the wellbeing of the LGBT community as well as people in our neighborhoods and beyond through access to the highest quality health care, education, research and advocacy
- Integrated primary care model, including HIV services and transgender health

The Fenway Institute

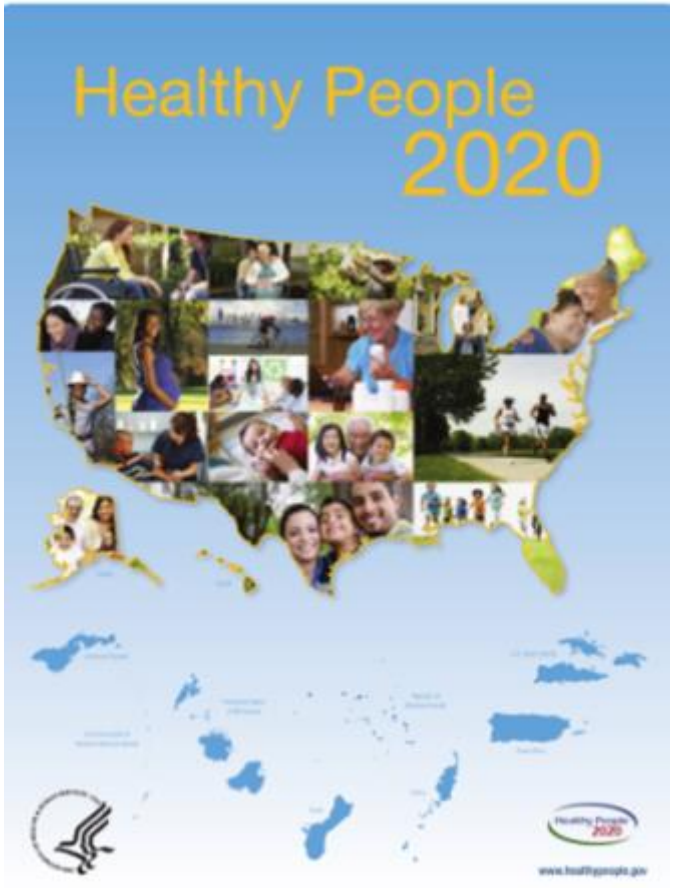
- Research, Education, Policy

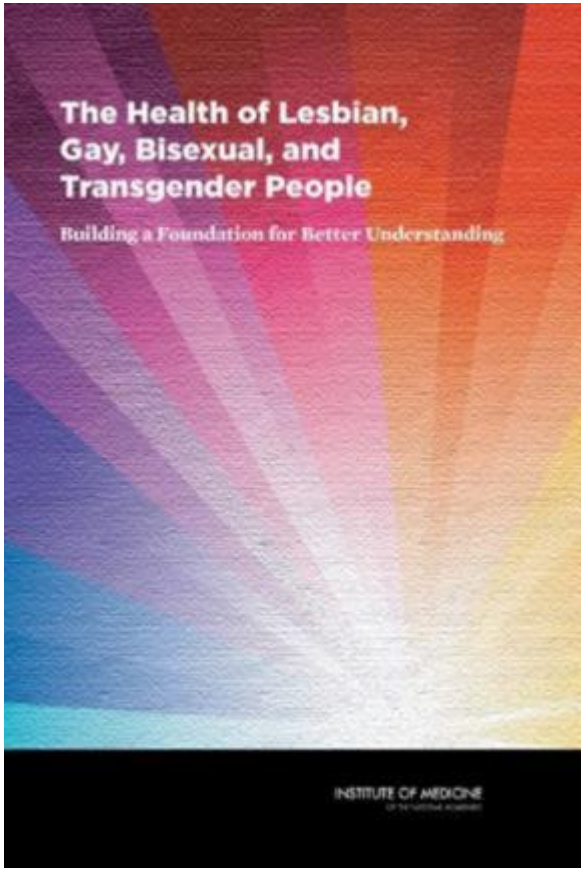
LGBT Education and Training

The National LGBT Health Education Center offers educational programs, resources, and consultation to health care organizations with the goal of providing affirmative, high quality, cost-effective health care for lesbian, gay, bisexual, and transgender (LGBT) people.

- Training and Technical Assistance
  - HRSA Cooperative Agreement
- Grand Rounds for Faculty, Staff, and Trainees
- Webinar Series with free CME's/CEU's
- Consultation on Creating Strategic Change
- Resources and Publications

Why Programs for LGBT People



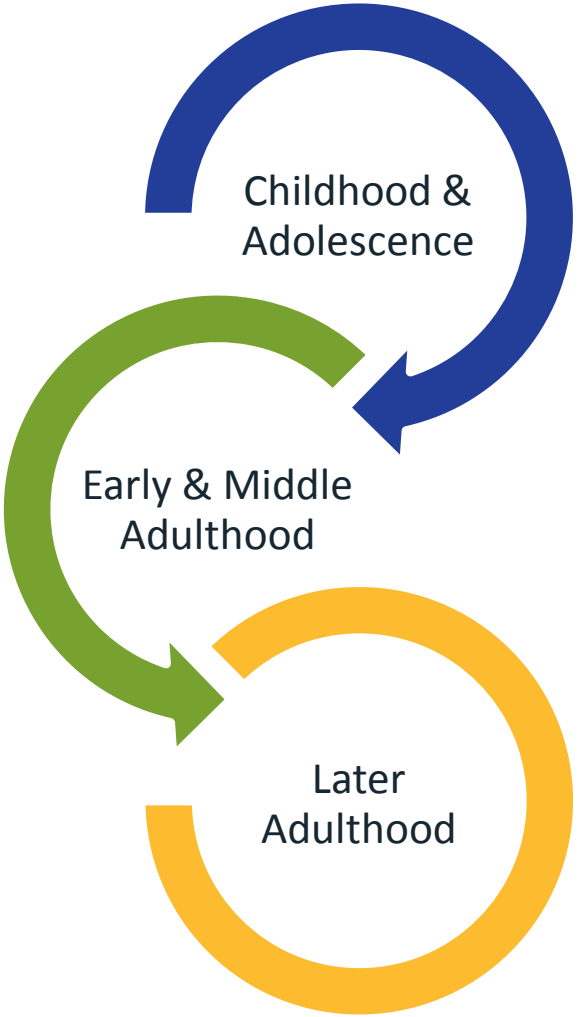


The Impact of Stigma and Discrimination

Effects of Stigma on Health

- LGB people who experienced a prejudice-related stressful life event (e.g., assault, being fired from a job) were three times more likely than those who did not to suffer a serious physical health problem over a one-year period (Frost, Lehavot, & Meyer, 2011)
- Exposure to discrimination was related to number of sick days and number of physician visits in gay/bisexual men (Huebner & Davis, 2007)
- Internalized homophobia, experiencing discrimination, and expectations of rejection, were associated with HIV risk behavior (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008)

Health Issues Throughout the Life Course



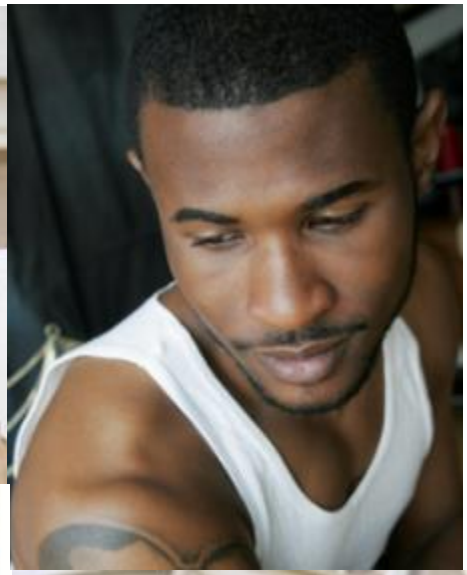
LGBT Disparities: Healthy People 2020

- LGBT youth
  - 2 to 3 times more likely to attempt suicide.
  - More likely to be homeless (20-40% are LGBT)
  - Risk of HIV, STD's
- MSM are at higher risk of HIV/STDs, especially among communities of color
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use
- Lesbians are less likely to get preventive services for cancer

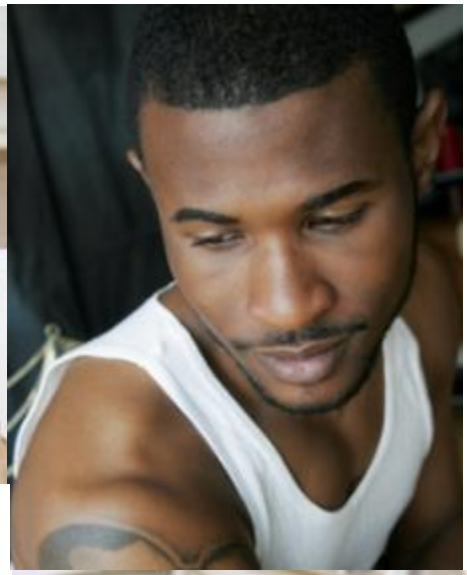
LGBT Disparities: Healthy People 2020

- Transgender individuals experience a high prevalence of HIV/STI's, victimization, mental health issues, and suicide
  - They are also less likely to have health insurance than heterosexual or LGB individuals
- Elderly LGBT individuals face additional barriers to health because of isolation, fewer family supports, and a lack of social and support services

LGBT Concepts


L,G,B,T Concepts

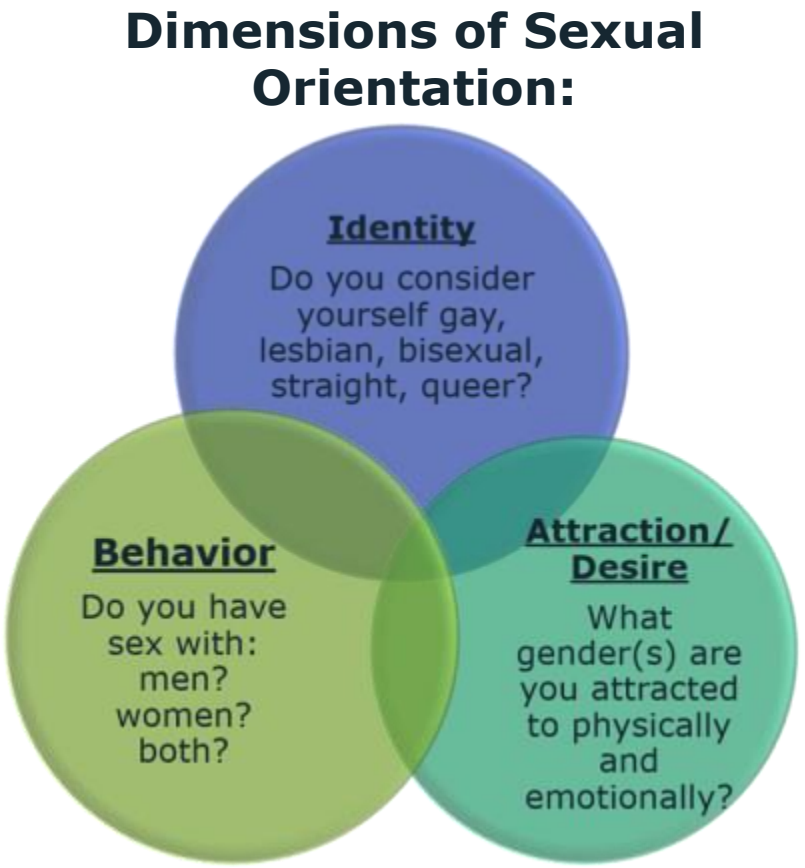




Sexual Orientation and Gender Identity are Not the Same

- All people have a sexual orientation and gender identity
  - How people identify can change
  - Terminology varies
- Gender Identity ≠ Sexual Orientation

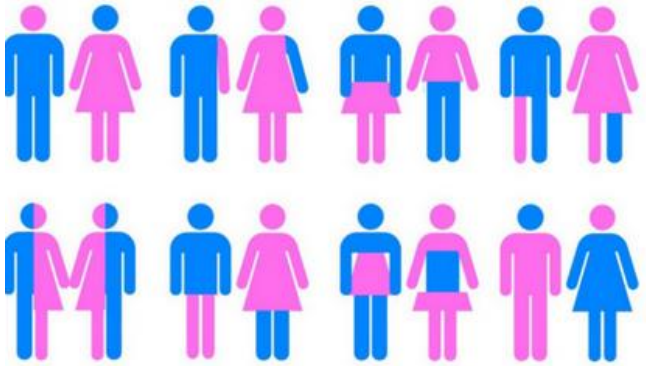
Sexual Orientation

- Sexual orientation: how a person identifies their physical and emotional attraction to others
- Desire
- Behavior:
  - Men who have sex with men-MSM (MSMW)
  - Women who have sex with women-WSW (WSWM)
- Identity:
  - Straight, gay, lesbian, bisexual, queer--other



Gender Identity and Gender Expression

- Gender identity
  - A person's internal sense of their gender (do I consider myself male, female, both, neither?)
  - All people have a gender identity
- Gender expression
  - How one presents themselves through their behavior, mannerisms, speech patterns, dress, and hairstyles
  - May be on a spectrum



The T in LGBT: Transgender

- Transgender
  - Gender identity not congruent with the assigned sex at birth
  - Alternate terminology
    - Transgender woman, trans woman, male to female (MTF)
    - Transgender man, trans man, female to male (FTM)
    - Genderqueer-one who rejects the gender binary

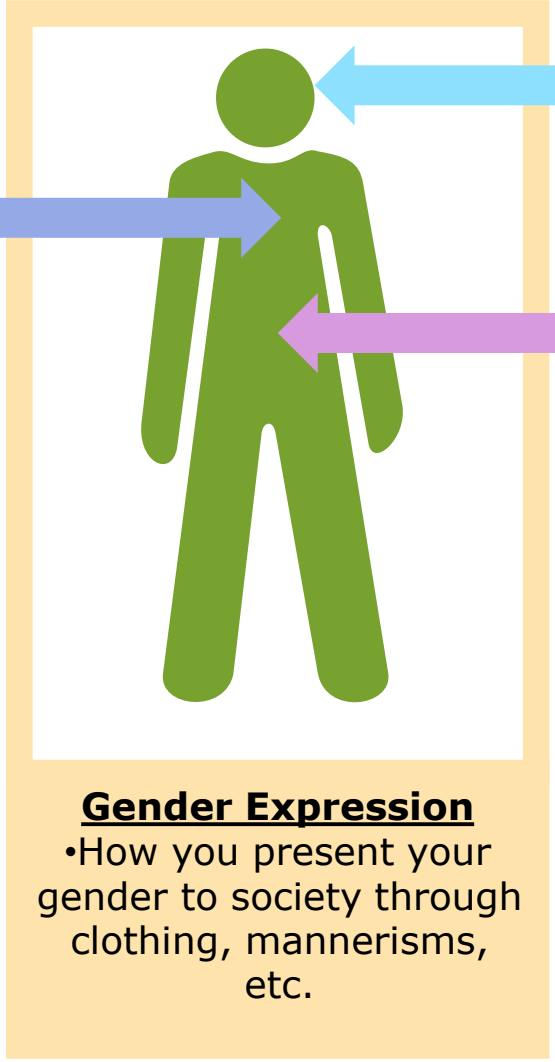
Transgender Demographics

- Massachusetts Behavioral Risk Factor Surveillance Survey (2007, 2009)
  - 0.5% of population between ages 18-64
- California LGBT Tobacco Survey
  - 0.1% of adult population
- Estimate in U.S. from the Williams Institute
  - 0.3% of adults
  - Approximately 700,000 people

**MN Study: 45% did not inform family physician they were transgender

Reviewing Terminology

Sexual Orientation
- Whom you are physically and emotionally attracted to
- Whom you have sex with
- How you identify your sexuality



Gender Identity
- What your internal sense tells you your gender is

Sex
- Refers to the presence of specific anatomy. Also may be referred to as 'Assigned Sex at Birth'

Gender Expression
- How you present your gender to society through clothing, mannerisms, etc.

Vulnerability to Poverty

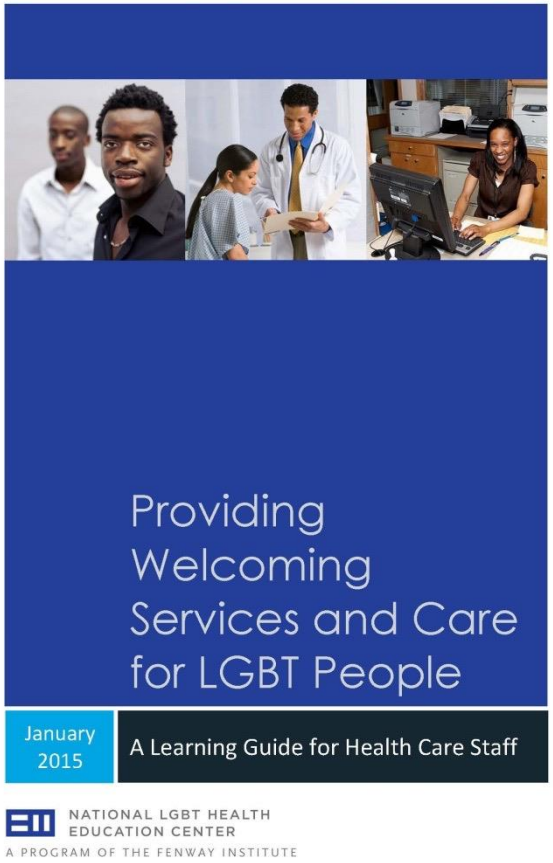
- While children generally have higher rates of poverty than adults, children of LGB parents are especially vulnerable to poverty
  - African American children in gay male households have the highest poverty rate (52.3%) of any children in any household type
  - the rate for children living with lesbian couples is 37.7%
- Transgender respondents to the National Transgender Discrimination Survey (NTDS) were 4 times more likely than the general population to have a household income of less than $10,000

http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf

Creating a Welcoming and Inclusive Environment for Caring, Working and Learning

On the Front Lines of Health Care

- A visit to a health care facility can make people nervous
- Difficult to talk about personal, intimate issues
- All must be prepared to serve a diverse patient population
- When people have a bad experience they may hide important information or not return for care.



Language

- It is also important to use the right pronouns when talking about a patient.
  - For example, most transgender women want you to say “she” or “her” when talking about them.
  - Ask for a preferred name or pronoun when records do not match a patient’s name or gender.
  - Some people may use words or pronouns which are unfamiliar to you so they can separate themselves from the gender binary, such as “they”, “zie”, and others.
- Obvious “don’ts” include the use of any disrespectful language, or gossiping about a patient’s appearance or behavior.

Avoiding Assumptions

- Each individual is unique: If you know one LGBT person, you only know one LGBT person
- You cannot know a person's sexual orientation or gender identity until they tell you
- How a person identifies their sexual orientation does not always tell you who they have sex with, and vice-versa
- Listen to how people describe their own identities and partners--use the same terms, if comfortable

Avoiding Assumptions, cont.

- You cannot always correctly guess someone's gender based on their name, or how they look or sound
- To avoid assuming gender with new patients:
  - *Instead of*: "How may I help you, sir?"
  - *Say*: "How may I help you?"
  - *Instead of*: "He is here for his appointment."
  - *Say*: "The patient is here in the waiting room."
  - *Instead of:* "Do you have a wife?"
  - *Say:* "Are you in a relationship?"

Developing Trust and Rapport

- Avoid asking unnecessary questions to satisfy own curiosity (what you need to know vs want to know)
- Pay attention to your body language and facial expressions
  - Check in with yourself: Are you wrinkling your nose? Shaking your head “no”? Raising your eyebrows?

Using Preferred Names and Pronouns

- Transgender people should be identified with their preferred name and pronoun
- This is the pronoun that corresponds to their gender identity and expression
- Even when the patient is not present, always use preferred names and pronouns

Using Preferred Names and Pronouns, cont.

- If you are unsure about a patient's preferred name or pronoun
  - *"I would like be respectful—what name and pronoun would you like me to use?"*
- If a patient's name doesn't match insurance or medical records
  - *"Could your chart/insurance be under a different name?"*
  - *"What is the name on your insurance?"*
- If you accidentally use the wrong term or pronoun
  - *"I'm sorry. I didn't mean to be disrespectful."*

Create an Environment of Accountability

- Creating an environment of accountability and respect requires everyone to work together
- Don't be afraid to politely correct your colleagues if they use the wrong names and pronouns, or if they make insensitive comments
  - *"My understanding is that the "Patient Name" field indicates that this person prefers to be called referred to as 'Jane', not 'John' which is on some of the old records."*
  - *"Those kinds of comments are hurtful to others and do not create a respectful work environment."*

Keeping Up with Terminology

- "**Queer**" – traditionally an insult. However, some people (especially youth) use this term with pride to identify their sexual orientation as non-heterosexual.
- "**Genderqueer" or "gender fluid**" – used by some youth to describe their gender identity and expression as both male and female, or neither male or female.
- **No labels** – Some do not like to use any terms

Managing Expectations

- You are almost certainly not the first health care staff person an LGBT individual has met.
- If the patient has experienced insensitivity, a lack of awareness, or discrimination, he or she may be on guard, or ready for more of the same from you.
- Don't be surprised if a mistake, even an honest one, results in an emotional reaction.
- Don't personalize the reaction
- Apologizing for uncomfortable reactions, even if what was said was well intentioned, can help de-fuse a difficult situation and re-establish a constructive dialogue about the need for care.

Understanding Diversity of Expression

- Be aware that there are a wide range of sexual and gender identities and expressions, and that these can change over time.
  - For example, some people “come out” as gay later in life, after having been in a long-term heterosexual marriage.
  - For any number of cultural or personal reasons, some patients may identify their sexuality in a way that does not tell you who their sexual partners are.
- Learning to make patients feel comfortable and trust you enough to reveal such personal information will take time. Practicing and apologizing as you learn will help you develop these skills.

Clinical Care of Transgender Patients

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Health Care of Transgender People

- Goal of care is to facilitate affirmation and, if present, alleviate gender dysphoria
- Two categories
  - Issues specific to transgender people varying emotional, behavioral, medical, surgical and ethical issues
  - General health concerns
- WPATH - Caregiver need not be an endocrinologist
- Increasing amount of care provided by primary care — working as part of a team or collaborative effort

Gender Dysphoria

- Refers to a range of discomfort or distress that is caused by this discrepancy between a person's gender identity and their sex assigned at birth and associated gender roles and secondary sex characteristics
  - curiosity suicide 
- The focus of health care engagement is determining needs and goals with a plan for alleviating distress.

Coleman, SOC, V 7 p168

Terminology: "Transition" or "Affirmation"

- The process of changing from living as, and being perceived as, the gender assigned at birth, to living and being perceived as the individual sees and understands themselves
- Goes beyond medical treatment with mental health, medical and surgical treatment and includes social affirmation, and legal changes.
- Many prefer the term "gender affirmation" or "gender confirmation" over "transition"

Transgender Standards of Care

September 2011 WPATH Standards of Care

- The criteria for hormone therapy are as follows:
  - Persistent, well-documented gender dysphoria
  - Capacity to make a fully informed decision and to consent for treatment;
  - Age of majority in a given country (if younger, follow the Standards of Care outlined in section VI);
  - If significant medical or mental health concerns are present, they must be reasonably well controlled

Standard Vs. Informed Consent Model (WPATH SOC7)

Standard

- Psychotherapy not required
- Initiation of hormone Rx after psychosocial assessment by "qualified mental health professional"
- Recommendation for team care or collaborative model
- Experienced hormone prescribing medical provider may meet requirement

Informed Consent Model

- Rx initiated by prescribing MD
- Based on clinical judgment
- Lack of contraindications
- Pt. capacity to give informed consent
- Pt with clear understanding of information they are consenting to
  - expectations, knowns, unknowns

Informed Consent Model

- Requires healthcare provider to effectively communicate benefits, risks and alternatives of treatment to patient
- Requires healthcare provider to judge that the patient is able to understand and consent to the treatment
- Informed consent model does not preclude mental health care
- Recognizes that prescribing decision ultimately rests with clinical judgment of provider
  - Informed consent is not equivalent to treatment on demand

(Deutsch, 2012)

Importance of Autonomy and Informed Consent

- Who needs extra help to give informed consent
  - Language and cultural differences
  - Cognitive impaired (e.g. dementia, developmental disability)
  - Low literacy / low health literacy
  - Neurodiverse spectrum
  - Severe Mental Health Disorders (e.g schizophrenia, delusional disorders, other psychotic disorders, , dissociative identity disorder)
  - Severe substance use disorder / intoxicated

Initial Visits

- Review history of gender experience
- Document prior hormone use
- Obtain sexual history
- Review patient goals
- Address safety concerns
- Assess social support system
- Assess readiness for gender transition
- Review risks and benefits of hormone therapy
- Order screening laboratory studies
- Provide referrals

Initial Visits

- Obtain informed consent
  - Reproductive Rights - freezing sperm/eggs, ability to get pregnant despite testosterone therapy
  - Permanent vs transient changes
  - Goals of short-term and long-term
  - Short and long-term risks, screenings … unknowns!
  - Social implications
    - supports
    - job/career
    - sex

… Also Consider…

- Many patients have already taken/are taking non-prescribed hormones
  - 2013 Ontario survey: 25% had ever used and 6.4% were currently using
  - 2009 NYC study: 23% of transwomen currently using
  - 2007 Virginia Trans Health Initiative Survey: 60% of transwomen and 23% of transmen had ever used
  - 2001 San Francisco Study: 29% of transwomen and 3% of transmen in the past 6 months
  - 2000 Washington, DC Transgender Needs Assessment Study: 58% had used at some time in the past

Cross-Gender Hormone Therapy

Not universally desired nor necessary

FTM Hormone Therapy

Female to Male Treatment Options

- Injectable Testosterone
  - Testosterone Enanthate or Cypionate 50-200 mg q 1-2 wks IM or SubQ (20-24g x 5/8-1 ½" needles)
- Transdermal Testosterone
  - Androderm TTS 2-8mg daily
- Topical testosterone
  - Gels in packets and pumps, multiple formulations (Testim, Androgel) 5 to 10 gm applied topically daily
  - Axiron 2% pump gel for axillary application 1 pump to each axilla daily
- Testosterone Pellet
  - Testopel- implant 6-10 pellets q 3 to 6 months
- Buccal Testosterone
  - Striant 30 mg buccal system q 12 hours

Other Treatment Considerations for FTMs

- Testosterone cream in Aquaphor for clitoral enlargement
- Estrogen vaginal cream for atrophy
- Rogaine or Finasteride for male pattern baldness
- Use of Progesterone – may help to reduce estrogen levels and aid in cessation of menses before or after starting testosterone therapy.

Risks of Testosterone Therapy

- Lower HDL
- Elevated triglycerides
- Increased homocysteine levels - possible risk factory to CAD
- Hepatotoxicity
- Polycythemia
- Unknown effects on breast, endometrial, ovarian tissues
- Increased risk of sleep apnea
- Insulin resistance
- Infertility

MTF Hormone Therapy

Male to Female Treatment Options

- Antiandrogens
  - Spironolactone (aldactone) 50-400mg PO daily (can be divided into BID dosing)
  - Finasteride (Proscar) 2.5-5mg PO daily
- Oral Estrogens
  - Estradiol (estrace) 2-6mg PO or SL daily(can be divided into BID dosing)
  - Premarin (conjugated estrogens) 1.25-10mg PO daily (can be divided into BID dosing)
- Transdermal Estrogens
  - Estradiol patch 0.1-0.4mg twice weekly
- Injectable Estrogens
  - Estradiol valerate 5-20mg IM q2 weeks
  - Estradiol cypionate 2-10mg IM weekly

Cosmetic Therapies

- Hydroquinone
  - Topical treatment for pigmentation caused by estrogen therapy
- Hair Removal
  - Eflornithine (Vaniqa) cream
  - Electrolysis
  - Laser hair removal

Risks of Estrogen Therapy

- Venous thrombosis/thromboembolism
- Weight gain
- Hypertriglyceridemia
- Elevated blood pressure
- Decreased glucose tolerance
- Gallbladder disease
- Benign pituitary prolactinoma
- Breast cancer(?)
- Infertility

Follow-up Care for Trans Patients

- Assess feminization or masculinization
- Review medication use
- Monitor moods and sexual drive
- Counsel regarding sexual activity
- Discuss social impact of transition
- Assess safety
- Complete forms for name change
- Review CAD risk factors
- Review surgical options

Surgery as an Option/Surgical Options

Sex Reassignment Surgery (Srs) or Gender Confirming Surgery (Gcs)

- Not universally desired (e.g. Non-op)
- Not easily obtainable:
  - Cost/insurance coverage
  - Need to meet criteria

Gender Affirmation Surgery (Gas)
Sex Reassignment Surgery (Srs)
Genital Reconstruction Surgery (Grs)

- Surgery has proven to be an effective intervention for the patient with gender dysphoria
- Patient satisfaction following surgery is high (Lawrence 2003), and reduction of gender dysphoria following surgery has psychological and social benefits
- As with any surgery, the quality of care provided before, during, and after surgery has a significant impact on patient outcomes
- Not for everyone!
- Is someone ready?

Surgical Options for Affirmed Men

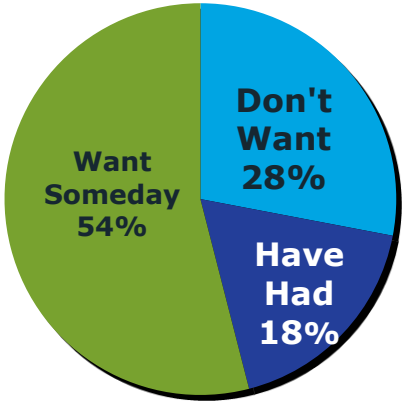
- Mastectomy with masculine chest reconstruction
- Hysterectomy and oophorectomy
- Genital reconstruction
  - Phalloplasty
  - Metoidioplasty

Surgical Options For Affirmed Women

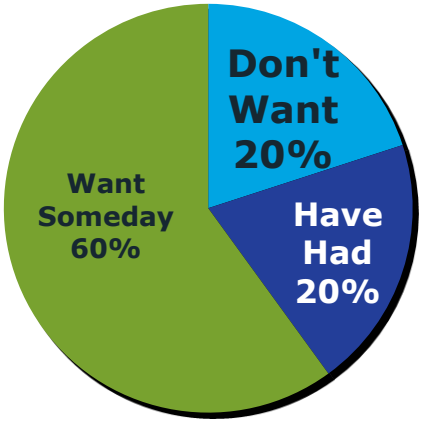
- Augmentatin Mammoplasty
- Vaginoplasty
- Orchiectomy without Vaginoplasty
- Penectomy without Vaginoplasty
- Tracheal shave
- Facial Feminizing Surgery
- Vocal Cord Surgery to elevate voice pitch
- Lipoplasty of waist/ Augmentation of hips and buttocks

Diverse Utilization of Surgery: Feminizing Procedures

MtF Chest Surgery



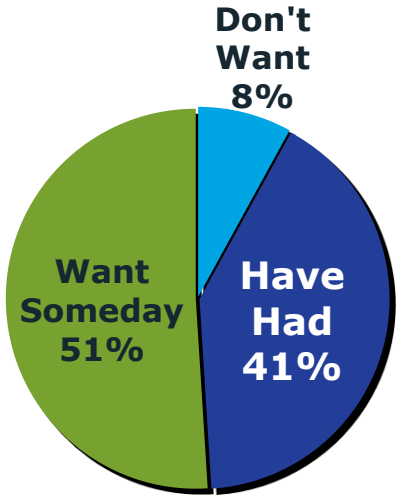
MtF Vaginoplasty



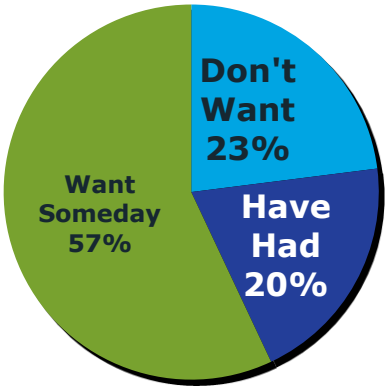
Source: Grant et al., 2010: http://transequality.org/PDFs/NTDSReportonHealth_final.pdf

Diverse Utilization of Surgery: Masculinizing Procedures

FtM Chest Surgery



FtM Hysterectomy



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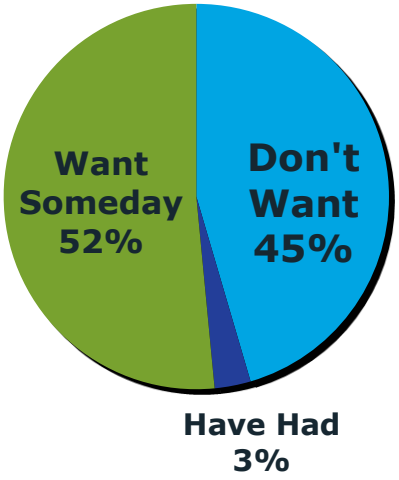
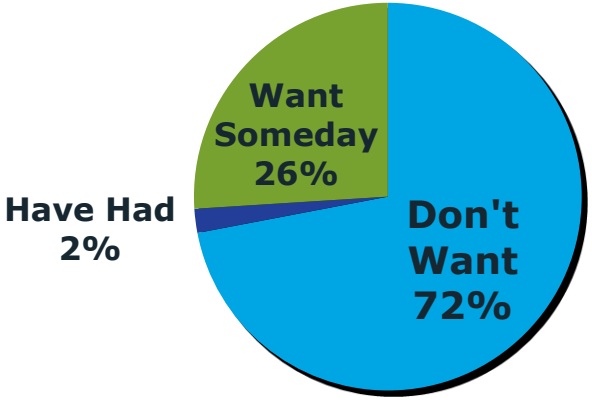
Diverse Utilization of Surgery: Masculinizing Procedures

FtM Metoidioplasty



FtM Phalloplasty



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Challenges Related to Surgery

- Access to qualified surgeons
  - limited number of surgeons with experience — low complication rates, on-site care, and proper follow up protocols
- Patient expectations
  - post-op care
  - post-op results
    - appearance
    - benefits of surgery on dysphoria

Limited Access to Surgery

- “Binding” by transmen
- “Tucking” by transwomen
- Sex work or criminal activity to pay for surgery
- Injected silicone, “pumping parties”, with potential for severe medical sequelae

Surgery by Unqualified Persons or Clinics

- In a 1984 survey of clients accessing services at a gender specialty clinic:
  - 9 % of transwomen had self-surgery on genitals
  - 2% of transmen had performed self-surgery on breasts
- In a 2013 survey of trans-identified persons in Ontario:
  - 1% had performed or attempted “procedures” on themselves

Access to Quality Medical Care

Morbidity and Mortality

Morbidity and Mortality in the Transgender Community

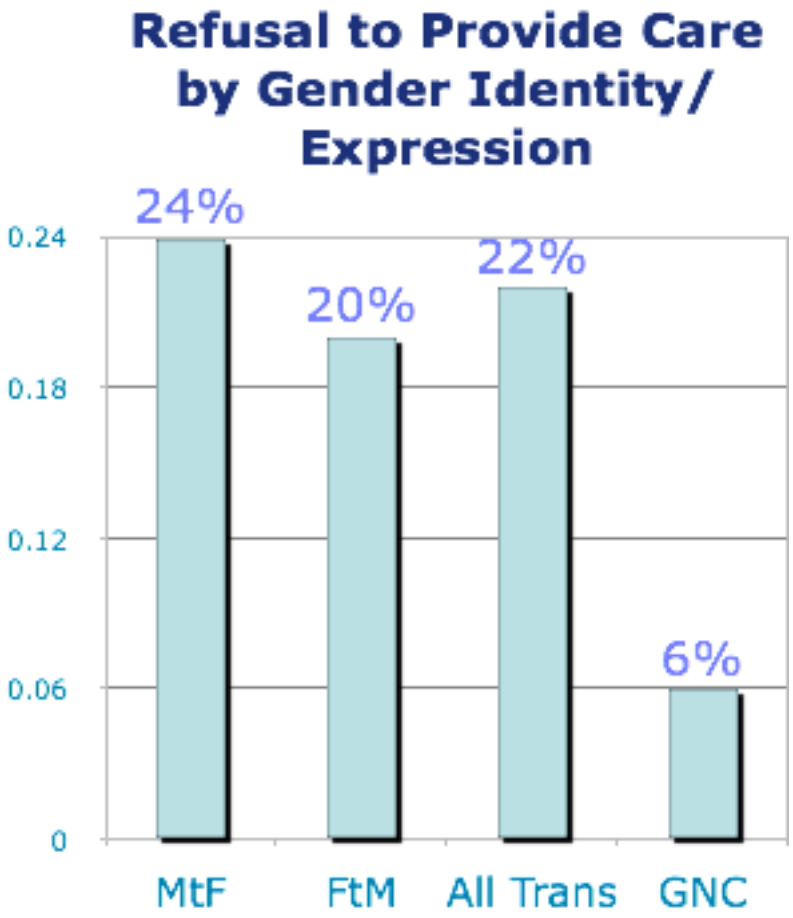
- Significant increase in mortality is seen amongst transgender individuals compared to the general population.
  - Most of the increase in mortality was due to higher rates of **AIDS, suicide, drug-related deaths**
- Asschermann's 2011 review of Dutch patient cohort: 50% higher mortality rate in MTF patients

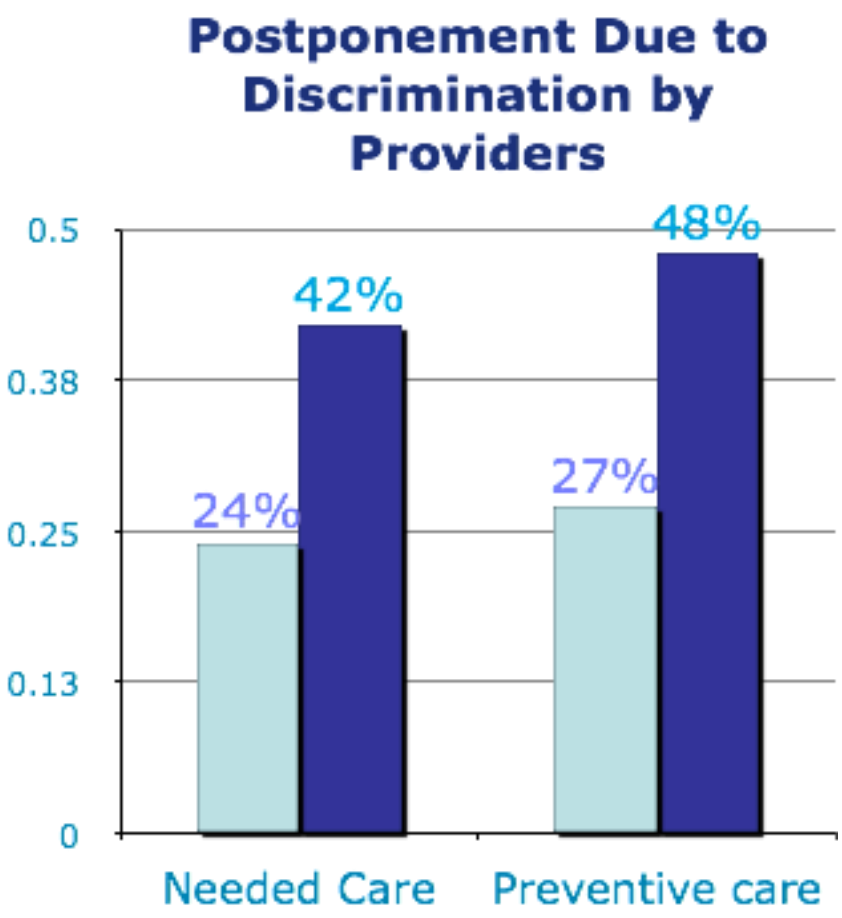
Barriers to Medical Care for Transgender Patients

- Economically disadvantaged
- Geographic and social isolation
- Lack of insurance Coverage
- Stigma of Gender Clinics
- Lack of clinical research and limited medical literature
- Provider ignorance

Addressing Primary Care Preventive Needs

discrimination, abuse, and lack of access to care



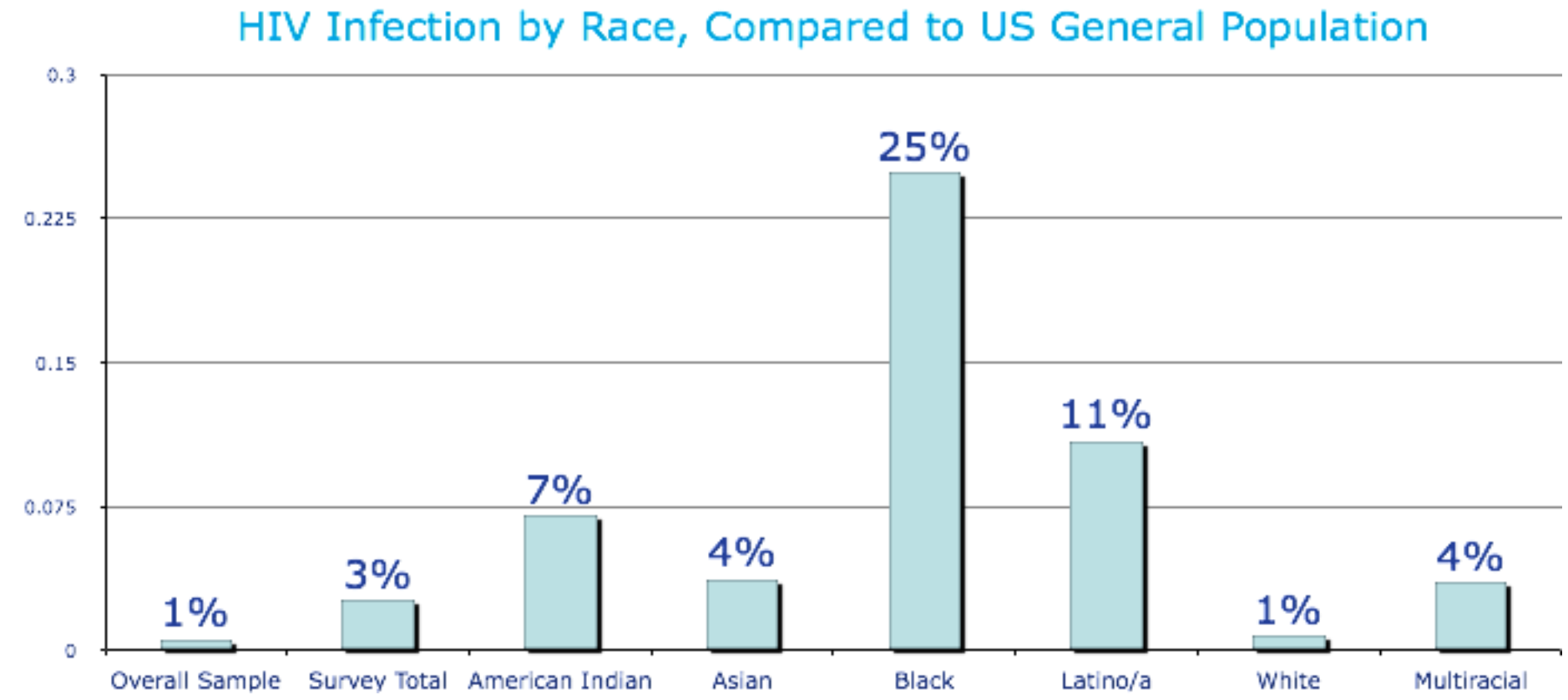


HIV Infection

- NTDS – OVER 4 TIMES THE NATIONAL AVERAGE OF HIV INFECTION
- Self-reported incidence of HIV infection was 2.64% overall, 4.28% in MtF, and 15.3% in self-identified sex workers
    - - rate of 0.6% in the general population
- HIV infection: Average rate about 27% in studies done on MTF (mostly urban) populations.
- Rates in FTM are not well-documented, seem to be low (only 0.51% in the NTDS)
    - BUT, FTM report relatively high rates of high-risk sexual behavior
- Death rate due to AIDS is 30 times higher for trans individuals

HIV Infection

- Increased health disparities for trans women of color
  - In NTDS, 24.9% of black trans women and 10.9% of Latina trans women were HIV infected



HIV Prevalence

- San Francisco details: 1997
  - MTF 137/392 (35%) HIV+
    - 65% aware of status prior to study, 20% learned their status through study, 15% failed to return
    - 50% were not receiving HIV related medical care
    - 65/104 (63%) African Americans HIV+
  - FTM 2/123 (2%) HIV+
- San Francisco 2010 (respondent driven sampling)
  - N=314 transfemales rds weighted, 40% HIV+, only 3% were unrecognized
  - Risk of HIV higher in all non-white, adjusted odds ration highest (30) for AA
  - Among HIV+: 87% have ever seen a doc for care. 71% have ever taken meds. 65% are currently taking meds

(Clements-Nolle, Marx, Guzman, & Katz, 2001)
(Rapues, et.al. 2013

Prevention Issues

- Complex and numerous causes of increased risk
- Prevalence of trauma very high in these populations
  - Effect of trauma and violence exposure on HIV risk behaviors and adherence hard to study
- Extrapolation from studies of natal woman and other HIV patients supports need to directly address trauma issues

Prevention Issues

- In a study looking at 571 trans women in the NYC Metro area, lifetime prevalence of psychological and physical abuse are 78% and 50%, respectively
- Previous and ongoing trauma stands out as significant risk factor and clinically challenging
  - 38-60% past experiences of physical violence
  - 27-46% victims of sexual assault
  - Most violence attributable to gender identity or expression

Prevention Issues

- FTM population has very similar prevalence of trauma to MTF
  - Risks of acquiring HIV in this population may be underestimated
- Persistent abuse was very high during adolescence—most often perpetrated by family or parents

Depression and Suicide

- Suicidal ideation rates as high as 64%
- In some surveys, up to 40% of transgender/gender variant individuals report having attempted suicide
- Suicide deaths 6 times higher than general population in Dutch cohort.

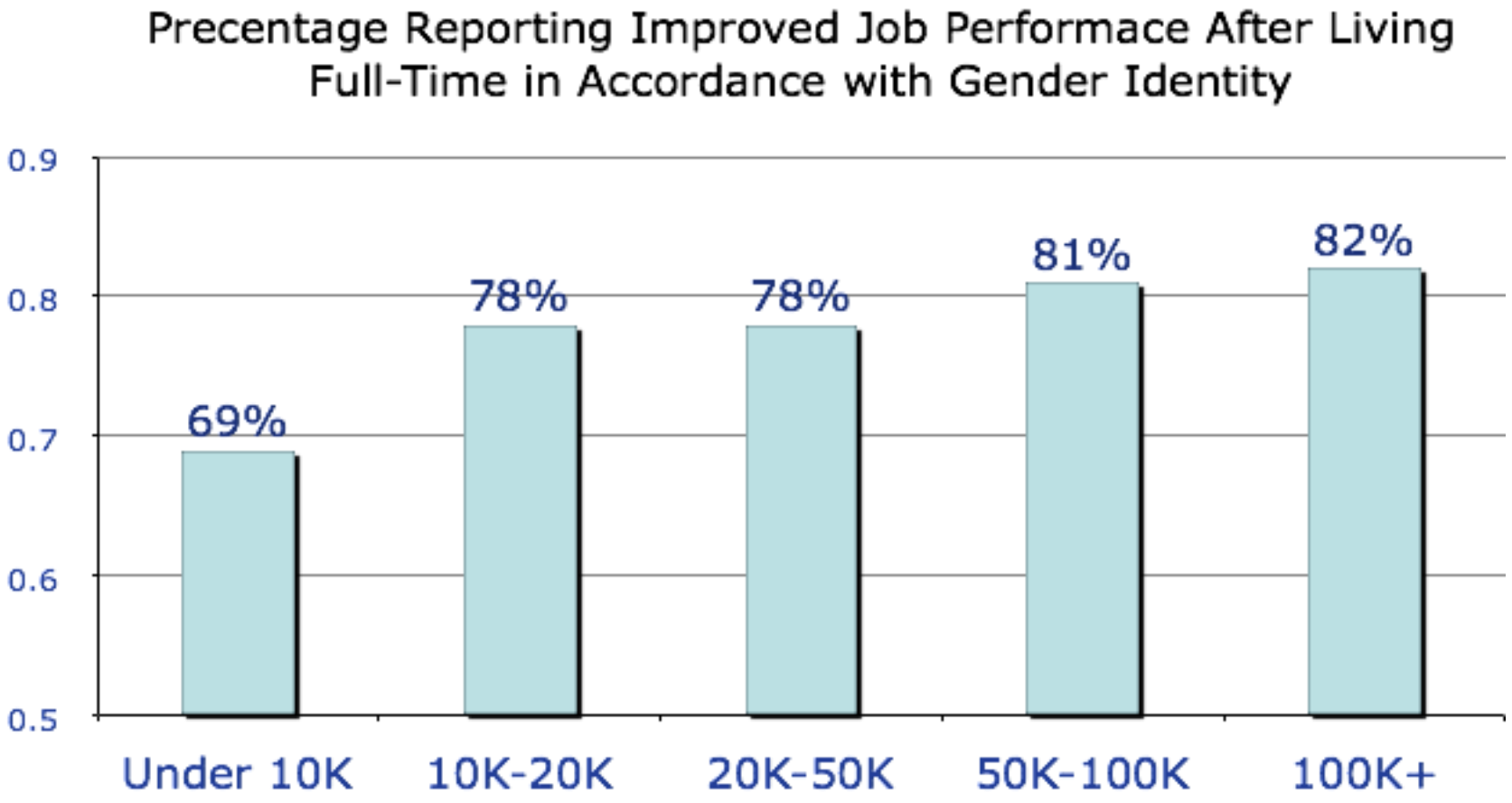
Depression and Suicide

- A 2009 study of 515 transgender individuals in San Francisco found that depression approaches 62% in trans women and 55% in trans men
- NYC metropolitan area survey found that 52–54% of trans women have a lifetime history of major depression

Depression and Suicide

- Impact of hormones on Depression and SI
- Raymond et al 2014 — Accessing transition-related medical care and impact on mental health issues, suicidal ideation, and substance use
  - High rates of physical violence due to being "visibly gender non-conforming." Suicide attempts were significantly related to experiencing physical violence
  - Suicide and engagement in HIV-related risk behaviors explained has coping responses to extreme discrimination
  - **Hormonal therapy assoc w/ higher scores in general and mental health
  - **Hormones, breast augmentation, and genital surgery all assoc w/ lower odds of SI, binge drinking, and drug use
  - African Americans and Latinas were estimated to have the lowest utilization of any transition-related medical care

Depression and Suicide



*** This is despite 51% of these same individuals reporting harassment at work**

Substance Abuse

- **Drug-related deaths in MTF were 13 times higher** than in the general population in the Dutch cohort.
- NTDS: >1/4 of respondents misused drugs or alcohol to cope with mistreatment due to gender identity or expression

Substance Abuse

- The Transgender Community Health Project sampled 392 trans women and 123 trans men finding that 23% have a history of substance use treatment
  - lifetime use of cannabis 90%,
  - cocaine 66%,
  - LSD 52%,
  - crack cocaine 48%, and
  - heroin 24%.
- One-third of the sample had used injection drugs, not including hormones, in the past
- Various studies have shown 26 to 62% percent prevalence of substance use disorders in transwomen

Impact of Housing Status on Drug Use in Youth

Substance	Homeless Youth on the Street	Homeless Youth in Shelters	Non-Homeless
Tobacco	**81%**	**71%**	**49%**
Alcohol	81%	67%	57%
Marijuana	**75%**	**52%**	**23%**
Crack Cocaine	26%	8%	1.4%
Intravenous Drugs	**17%**	**4%**	**1%**
Other Drugs (stimulants, hallucinogens, inhalants)	55%	34%	16%

Clearly There is a Great Need for Trans-competent Mental Health and Substance Abuse Treatment Services

Sex, Drugs, and Suicide

High rates of discrimination and overall lack of supports at home and work

+

Barriers to seeking medical care: disrespect, harassment, violence, outright denial of service

+

Widespread **lack of knowledge** in provider about the health needs to transgender and GNC people

=

Lack of access to quality health care

AND racial bias also presents a sizable risk of discrimination for TG people of color in virtually every major area of society

Health Maintenance

Preventative Care Recommendations

** Treat anatomy that is present **

Some Example Discussion Points

- Have you ever had any questions or concerns relating to your gender? Do you currently have questions relating to your gender?
- How do you identify your sex or gender?
- What pronouns do you prefer
- What name do you prefer/go by?
- Do you identify with any sexual orientation?
- Have you told any other people about your gender identity? What has been the response?
- Do you feel safe to tell your medical providers? Employers? Family? Friends? Roommates?
- Is it safe for you at home? In bathrooms? On the street?

(Bockting et al, 2006)

Some Example Discussion Points

- Have you ever pursued any changes to your appearance or body to bring it closer to your sense of self? Do you have any concerns relating to this now?
- Have you had any body modification surgeries?
- Have you ever sought to change your body through hormones/surgery? Is this something you have thought about pursuing in the future?
- Are you currently in a relationship with someone? How does your partner identify?
- Are you attracted to men, women, transmen, or transwomen?
- Do you engage in any sexual activities that involve contact with genitals, penetration, or exposure to body fluids?
- What type of protection from STIs and HIV do you use during sex? What % of the time?

(Bockting et al, 2006)

Health Maintenance FTM

- PAP smears as per natal females
  - vaginal atrophy mimicking dysplasia
  - Increased unsatisfactory pap tests
  - Discomfort with paps
- Mammograms and CBE as for natal females if no chest reconstruction. If post-op, yearly chest exam
- Assessing endometrial health/hyperplasia
  - Unexplained and prolonged vaginal bleeding should be evaluated by ultrasound or endometrial bx
  - Likely atrophy
  - SOC recommendation for hysterectomy after 5years hormone therapy
- Bone density screening should be considered over age 50 and on testosterone for >5 years

Health Maintenance FTM

- HIV and STD screening
  - Consider Hepatitis B vaccination
- Contraception
  - Testosterone does not reliably prevent ovulation
  - LARCs — Mirena IUD, Nexplanon, Depo-provera
- Smoking
  - Especially an issue with surgical procedures
- Assess cardiovascular risk
  - Increased LDL, decreased HDL
  - Increase blood pressure
  - Increase hematocrit
  - Higher rates of obesity and diabetes

Health Maintenance MTF

- Pap smears or pelvic exams s/p GRS
  - No indication for paps
  - Pelvic exams as needed — change in pH of neovagina
- Yearly prostate exam as per natal men
  - Androgen antagonists will decrease serum PSA levels
  - ?Feminizing hormone therapy decreasing risk of prostate cancer
- Mammography and CBE
  - Patients over age 50 who have been on feminizing endocrine agents over 5 years and have additional risk factors
  - Degree and duration of estrogen exposure. WHI: Protestin, with estrogen, can increase risk
- Prolactinoma screening
  - Checking prolactin levels once after 1yr of therapy. Consider annually for 3 years

Health Maintenance MTF

- Bone density screening
  - Increased osteopenia and osteoporosis compared to natal men, but bone density preserved compared to natal women
  - Decreased levels of bone turnover markers in the setting of estrogen therapy
  - Not routinely indicated prior to orchiectomy; consider if over age 60 and off estrogen therapy for longer than 5 years
- HIV rates of 20-35% in some U.S studies
- Smoking
  - Especially a concern with thromboembolic risk
- Assess cardiovascular risk
  - Higher cardiovascular mortality rate than general pop
  - Maj Factors - Estrogen types (ethinyl estradiol), cyproterone acetate, serum hormone levels, smoking status, obesity, baseline CV health

Resources

- https://transline.zendesk.com/home
- WPATH SOC v.7
  - http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf
- Endocrine Society Clinical guidelines
  - cem.endojournals.org J Clin Endocrinol Metab. September 2009, 94(9):3132-3154
- UCSF Center of Excellence for Transgender Health
  - http://transhealth.ucsf.edu/trans?page=protocol-00-00
- British Columbia TG guidelines and resources
  - http://www.vch.ca/transhealth/resources/careguidelines.html

NATIONAL LGBT HEALTH EDUCATION CENTER

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