

# Meeting the Health Care Needs of Transgender People

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Boston, MA

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NATIONAL LGBT HEALTH  
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# Continuing Medical Education Disclosure

- Program Faculty: Julie Thompson, PA
- Current Position: Physician Assistant, Fenway Health
- Disclosure: No relevant financial relationships. All hormone use for transgender patients is off-label.

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# Learning Objectives

*By the end of this session, learners will be able to:*

1. Define terms and concepts related to transgender people
2. Discuss the major health disparities facing transgender people
3. Describe strategies for creating a gender-affirming environment for transgender patients
4. Review the general principles of primary care for transgender people, as well as hormone therapy



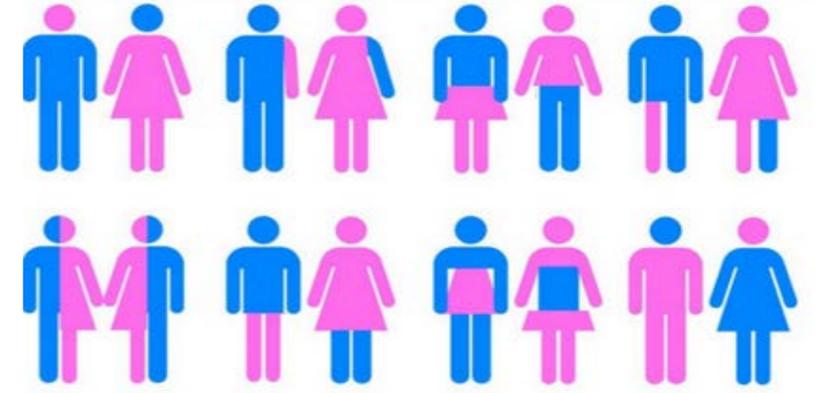
# 1. Key Terms and Concepts

# Definitions

- Sex and gender are distinct concepts
- Sex
  - Biologic sex, comprised of a person's genetic make-up and its phenotypic expression. Refers to the presence of specific anatomy.
    - Also may be referred to as 'sex assigned at birth'. At birth, infants are typically assigned male or female
- Gender
  - The perception of a person's sex on the part of society. Refers to attitudes, feelings, and behaviors that a culture associates with either males or females



# Definitions



- Gender identity
  - A person's internal sense of their gender (am I male, female, both, neither?)
  - All people have a gender identity
  - Usually develops by the age of 3 and remains relatively stable over the lifetime
- Gender expression/role
  - How one presents themselves through their behavior, mannerisms, speech patterns, dress, and hairstyles
  - May be on a spectrum - masculine or feminine, or neither
- Gender variant/non-conforming
  - Refers to people whose gender expression is different from what society expects for conventional male or female norms

# The T in LGBT: Transgender



- **Transgender:** Refers to a person who is born with the genetic traits of one gender but has the internalized identity of another gender
  - Many diverse identities and expressions — no one way to be trans
  - Many (but not all) seek some degree of medical or surgical intervention to align their minds and bodies
  - **Gender Minority** - a person who identifies as transgender or gender nonconforming, and/or whose gender identity or expression differs from conventional gender binary
  - **Transgender woman** - Male-to-female (MTF), assigned male at birth, lives female/feminine/affirmed woman, transfeminine spectrum
  - **Transgender man** - Female-to-male (FTM), assigned female at birth, lives male/masculine/affirmed man, transmasculine spectrum



# Definitions



- Other identity terms include:
- Transsexual
  - A Medical term which has historically referred to a sub-set of individuals who have undergone medical/surgical treatment to transition to the “opposite” gender. Many now find this term too specific and clinical
- Genderqueer, gender fluid
  - Someone who rejects the gender binary and blurs the distinction between male and female. Relatively new term used to describe falling somewhere on a gender spectrum.
- Cis-gender = non-transgender
  - Identifying with or experiencing a gender the same as one’s assigned sex at birth, e.g. both male-gendered & male-sexed



# Alternative Constructs of Gender Identity:

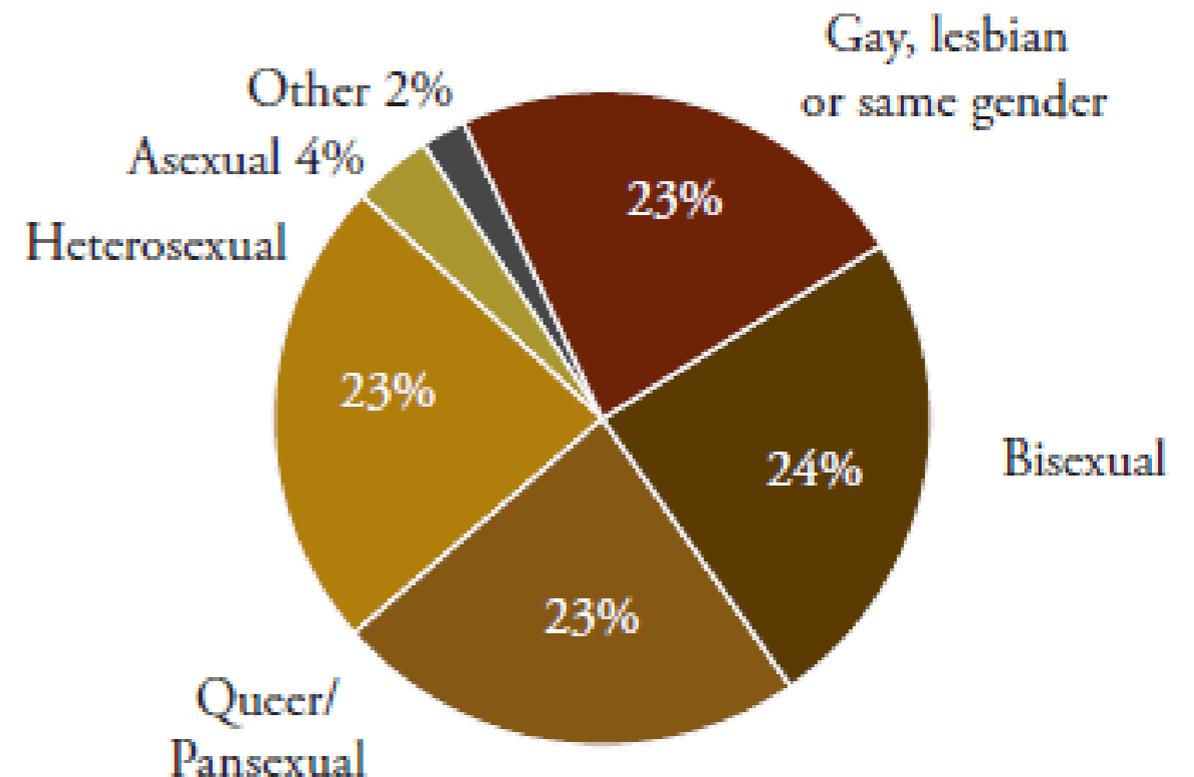
- If gender is determined by anatomic sex or the genitals
  - Then binary understanding of gender: gender “reassignment” or “transition”
- If gender is determined by the brain or one’s internal identity
  - Then spectrum of gender identity: gender “affirmation”



# Sexual Orientation

- Gender identity ≠ sexual orientation
- Sexual orientation
  - How a person identifies their physical and emotional attraction to others
  - Dimensions include: desire/attraction, behavior, and identity (Straight, gay, lesbian, bisexual, queer—other)
- All people have a sexual orientation and a gender identity

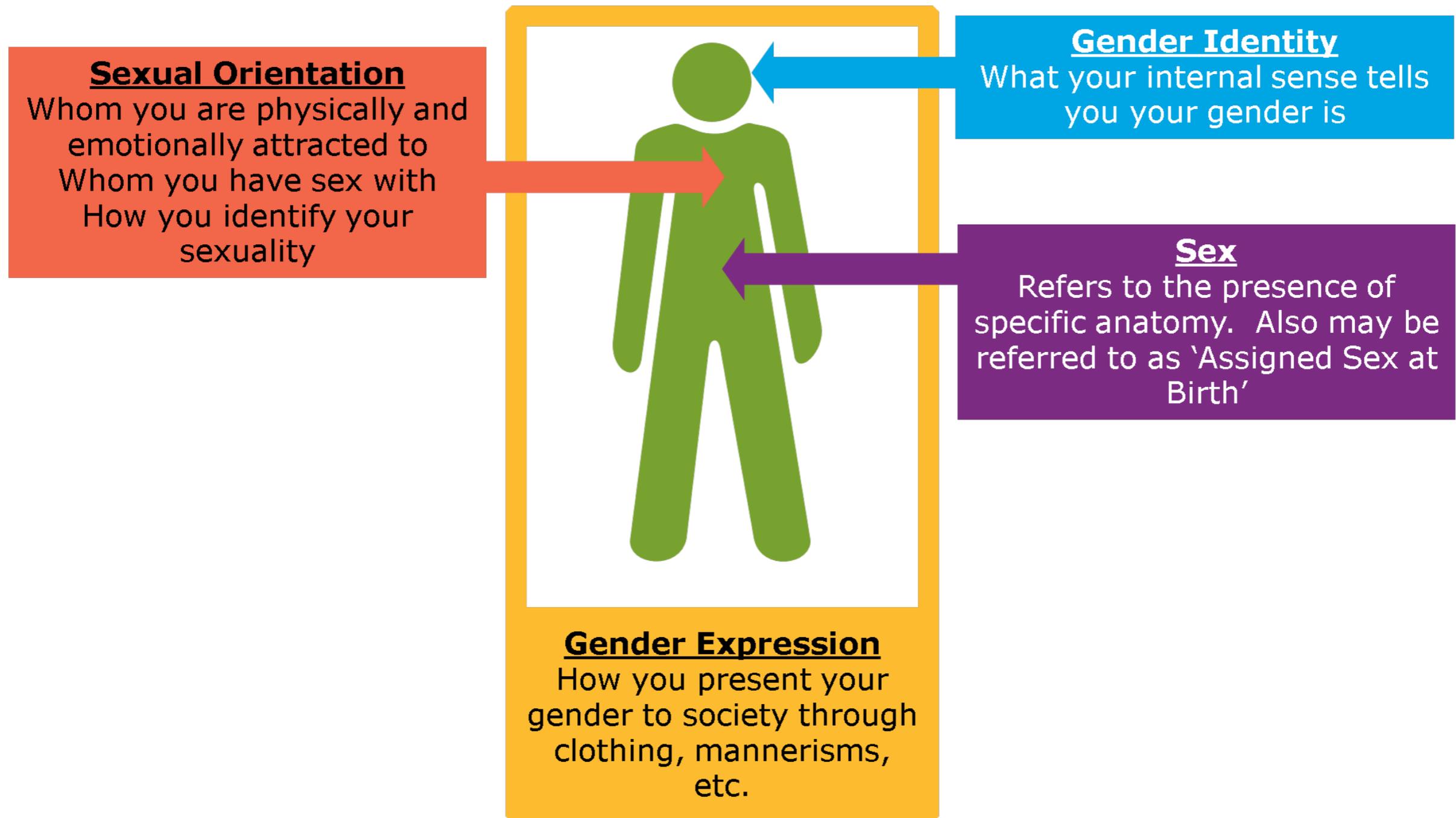
- Transgender people can be any sexual orientation



(Grant et al. (2011). Injustice at Every Turn:  
[http://www.thetaskforce.org/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf)

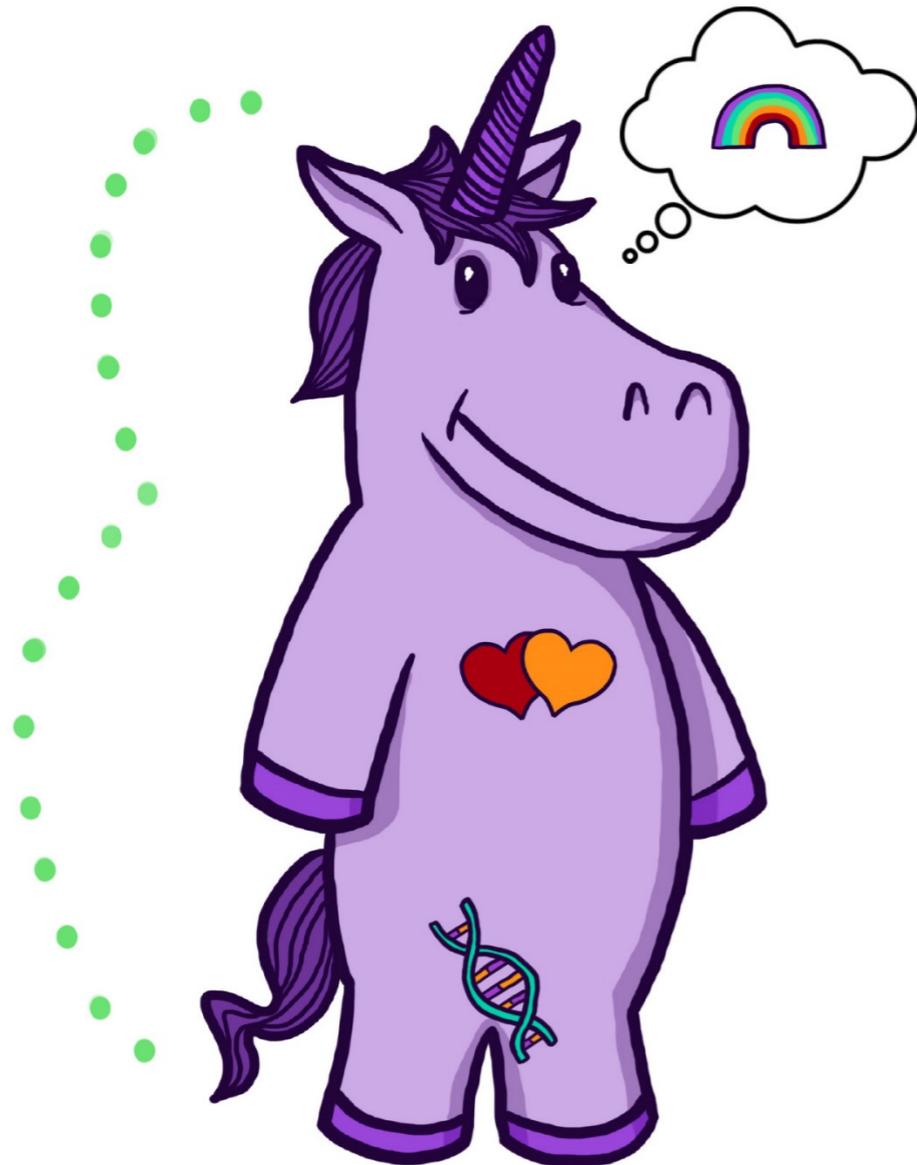


# Reviewing Terminology



# The Gender Unicorn

Graphic by:  
**TSER**  
Trans Student Educational Resources



## Gender Identity

-  Female/Woman/Girl
-  Male/Man/Boy
-  Other Gender(s)

## Gender Expression/Presentation

-  Feminine
-  Masculine
-  Other

## Sex Assigned at Birth

-  Female
-  Male
-  Other/Intersex

## Sexually Attracted To

-  Women
-  Men
-  Other Gender(s)

## Romantically/Emotionally Attracted To

-  Women
-  Men
-  Other Gender(s)

To learn more go to:  
[www.transstudent.org/gender](http://www.transstudent.org/gender)

Design by Landyn Pan

# 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
  - The focus of health care engagement is determining needs and goals with a plan for alleviating distress
  - The goal of treatment for transgender people is to improve their quality of life by facilitating their transition to a physical state that more closely represents their sense of themselves

# Terminology: “Transition” Or “Affirmation”

- The process of recognizing, accepting, and expressing/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.



# How Many People Are Transgender?

- The number of transgender people is unknown; population-based studies are limited
- Massachusetts Behavioral Risk Factor Surveillance Survey
  - 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

# Ending Stigma and Discrimination: Clinicians Can Help

- Many transgender individuals do not discuss their gender with caregivers
  - MN Study: **45% did not inform their family physician** they were transgender
  - NTDS: 28% of respondents said they were out to all their medical providers, 18% said they were out to most, 33% said some or a few, and **21% were out to none**
  - Many transgender persons have experienced discrimination and poor treatment in health care settings
  - Many transgender people maintain their assigned gender role for fear of stigmatization
- Improving health outcomes relies on changes in our understanding and clinical practice to decrease stigma and improve communication and and quality care

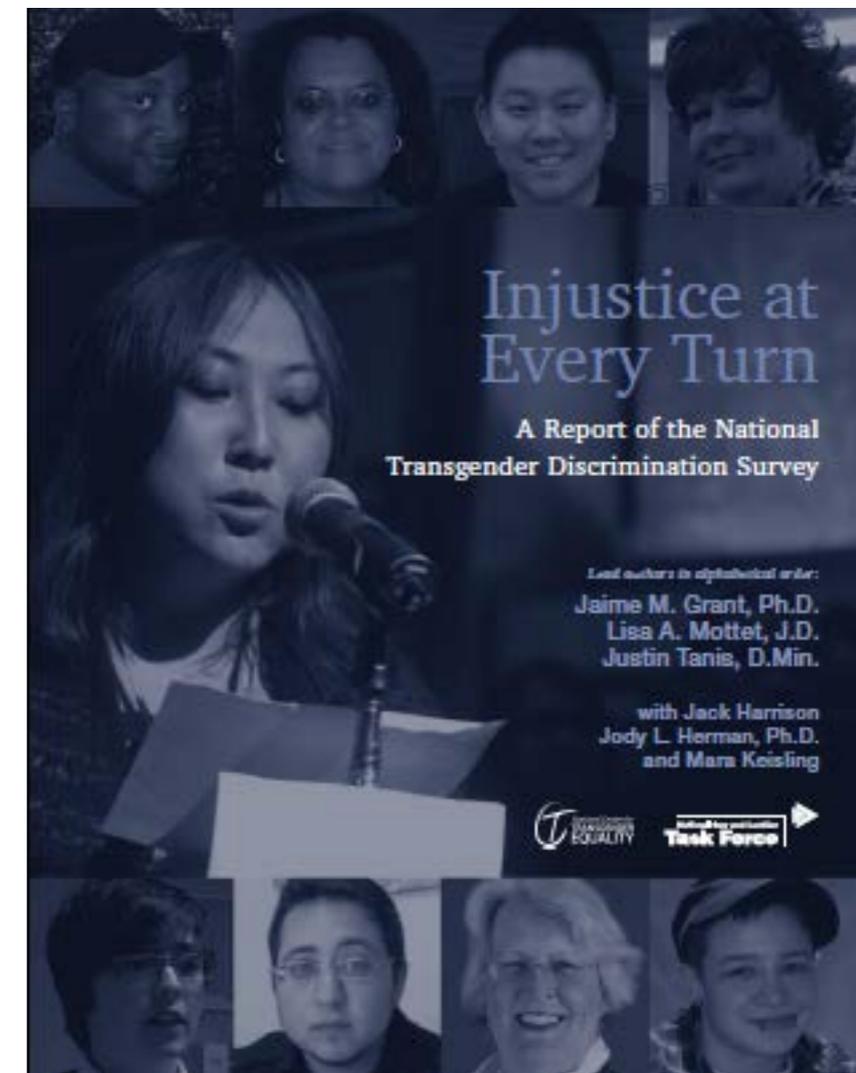


## 2. Major Health Disparities for Transgender Individuals



# Stigma & Discrimination of Transgender People

- Transgender people experience very high rates of stigma and discrimination
- The National Transgender Discrimination Survey, 2011 (6450 transgender respondents):
  - 57% family rejection
  - 53% verbally harassed or disrespected in a place of public accommodation (e.g., hotel, restaurant, bus, etc)
  - 40% harassed when presenting ID
  - 26% lost a job
  - 19% refused a home or apartment
  - Income: 4x more likely to live on <\$10,000 annually compared to average American
  - Unemployment: 2x the rate of unemployment compared to U.S. rate



# WPATH SOC 2011

“The latest 2011 revisions to the SOC realize that transgender, transsexual, and gender nonconforming people have **unique health care needs to promote their overall health and well-being, and that those needs *extend beyond hormonal treatment and surgical intervention.***”

Eli Coleman, PhD, SOC Committee Chair, Professor and Director at Program in Human Sexuality, University of Minnesota.



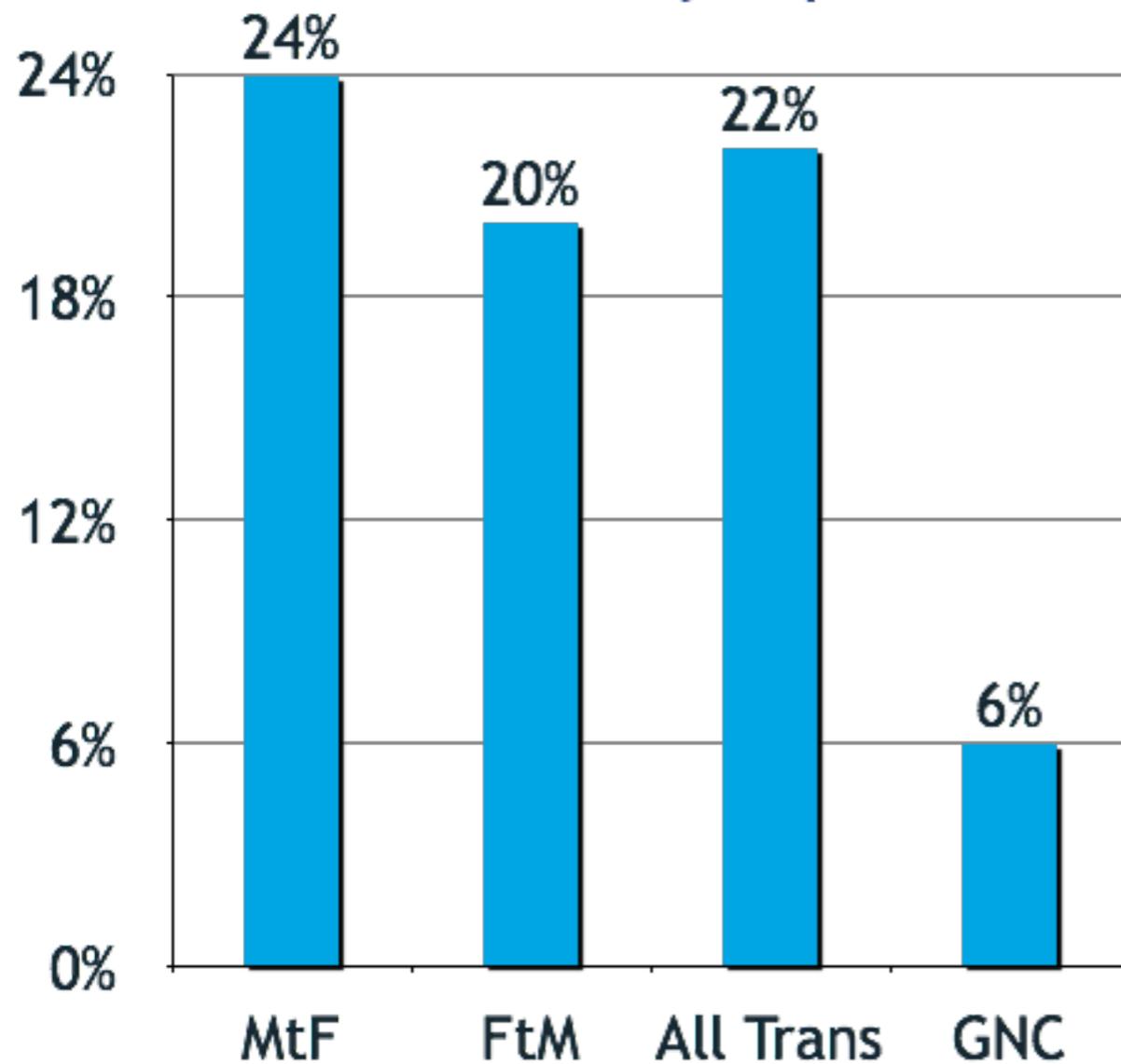
# Morbidity and Mortality in the Transgender Community

- Significant increase in mortality is seen amongst transgender individuals compared to the general population.
- **50% higher mortality rate in MTF patients**
  - 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

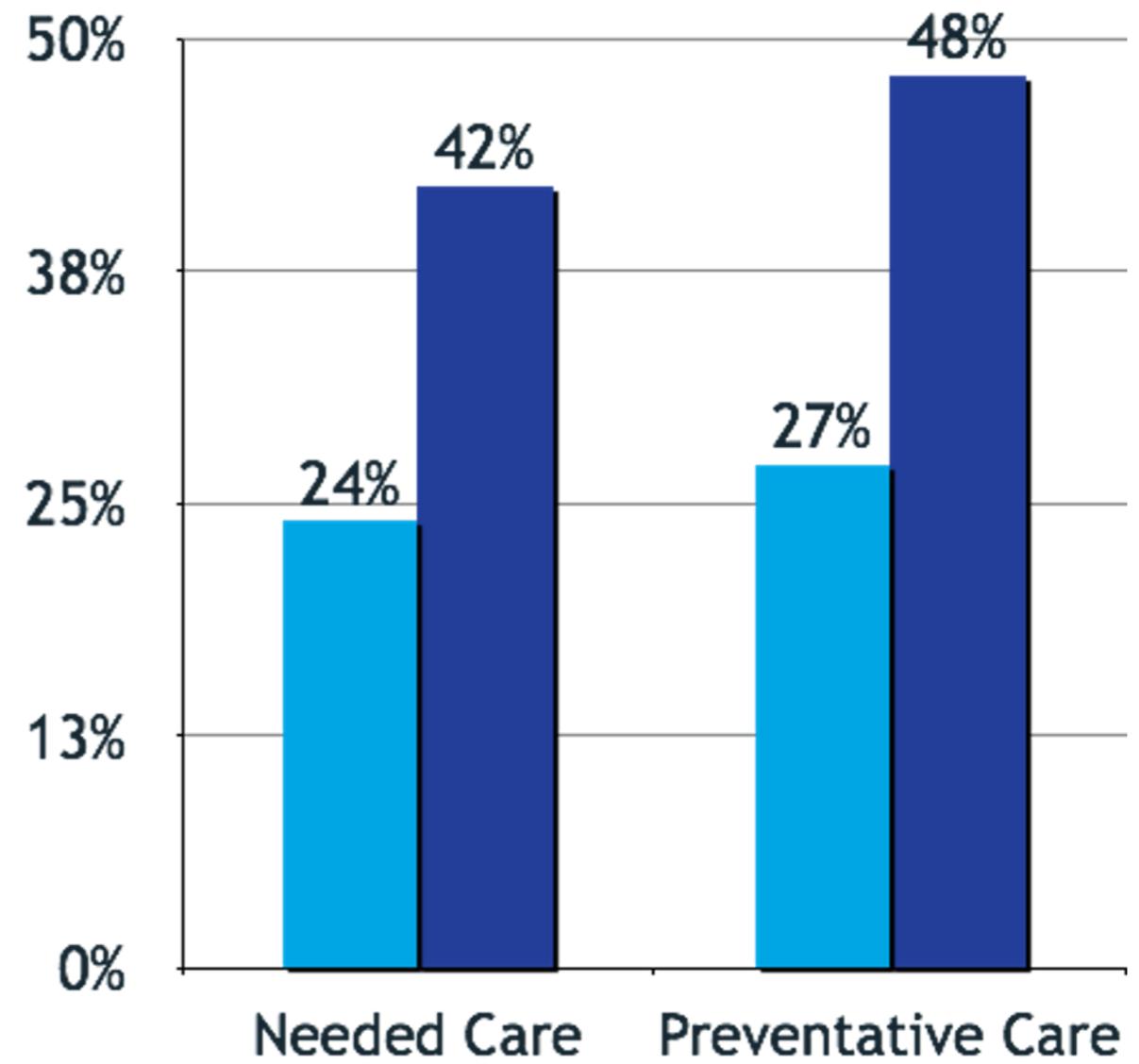


# Barriers to Primary Care: Discrimination, Abuse, and Lack of Access to Care

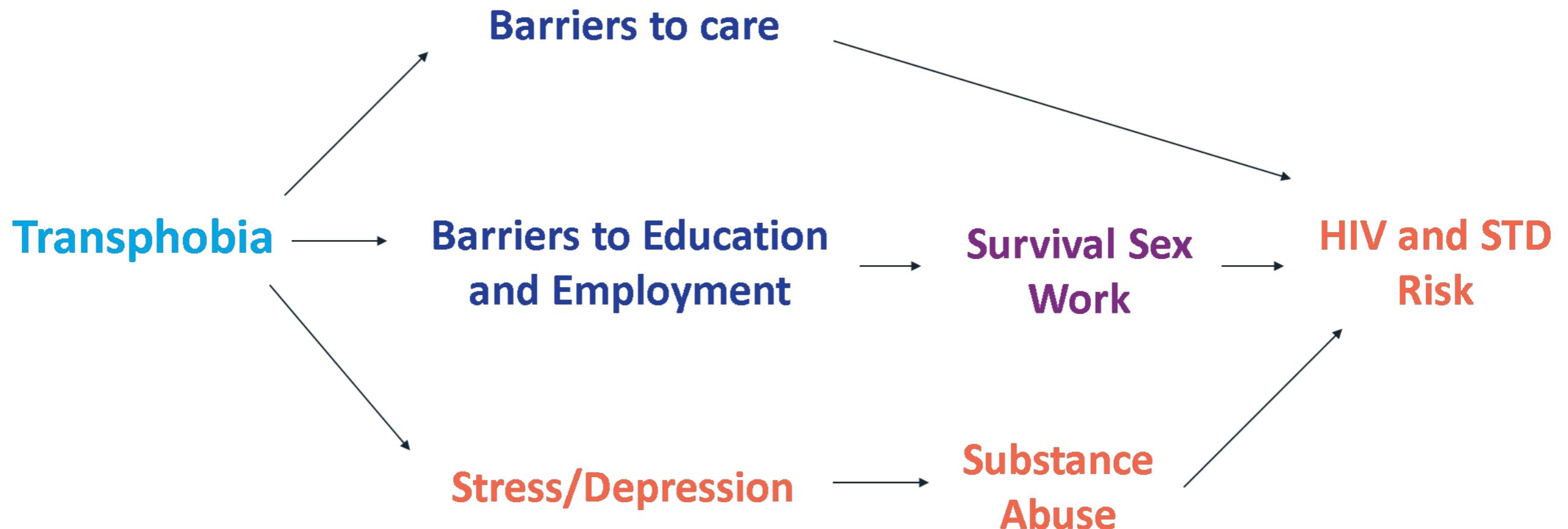
## Refusal to Provide Care by Gender Identity/Expression



## Postponement Due to Discrimination by Providers



# Negative Impacts of Transphobia



Nuttbrock 2009, Psychiatric Impact of Gender-Related Abuse Across the Life Course of Male-to-Female Transgender Persons. JSexResearch



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# HIV Infection

## NTDS – Over 4 times the national average of HIV infection

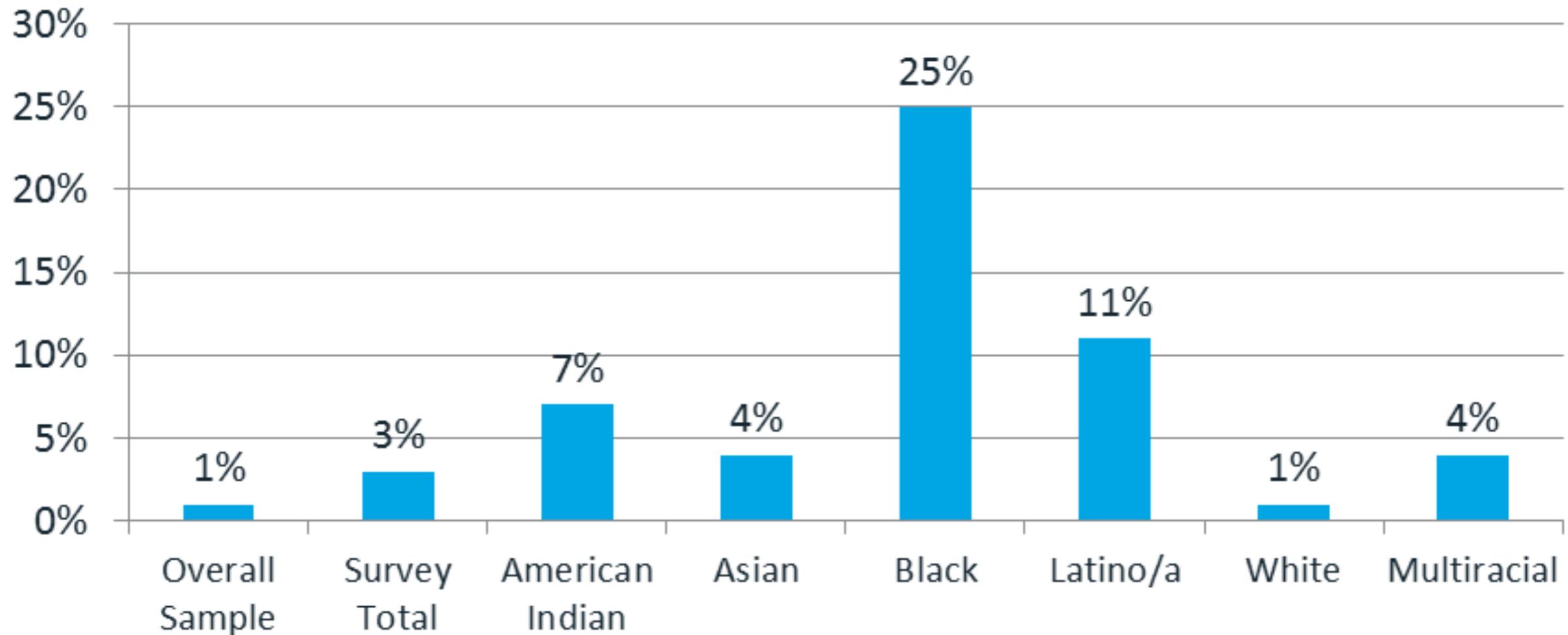
- Self-reported incidence of HIV infection was 2.64% overall, 4.28% in MtF, and 15.3% in self-identified sex workers
  - Rate of 0.6% in the general population
- HIV infection: Average rate about 27% in studies done on MTF (mostly urban) populations.
- Rates in FTM are not well-documented, seem to be 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

HIV Infection by Race, Compared to US General Population



- 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 and Trauma

- Prevalence of trauma very high in these populations
  - Extrapolation from studies of woman and other HIV patients supports need to directly address trauma issues — how these inform high-risk behaviors
  - The effect of trauma and violence on HIV risk behaviors are hard to study
- 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

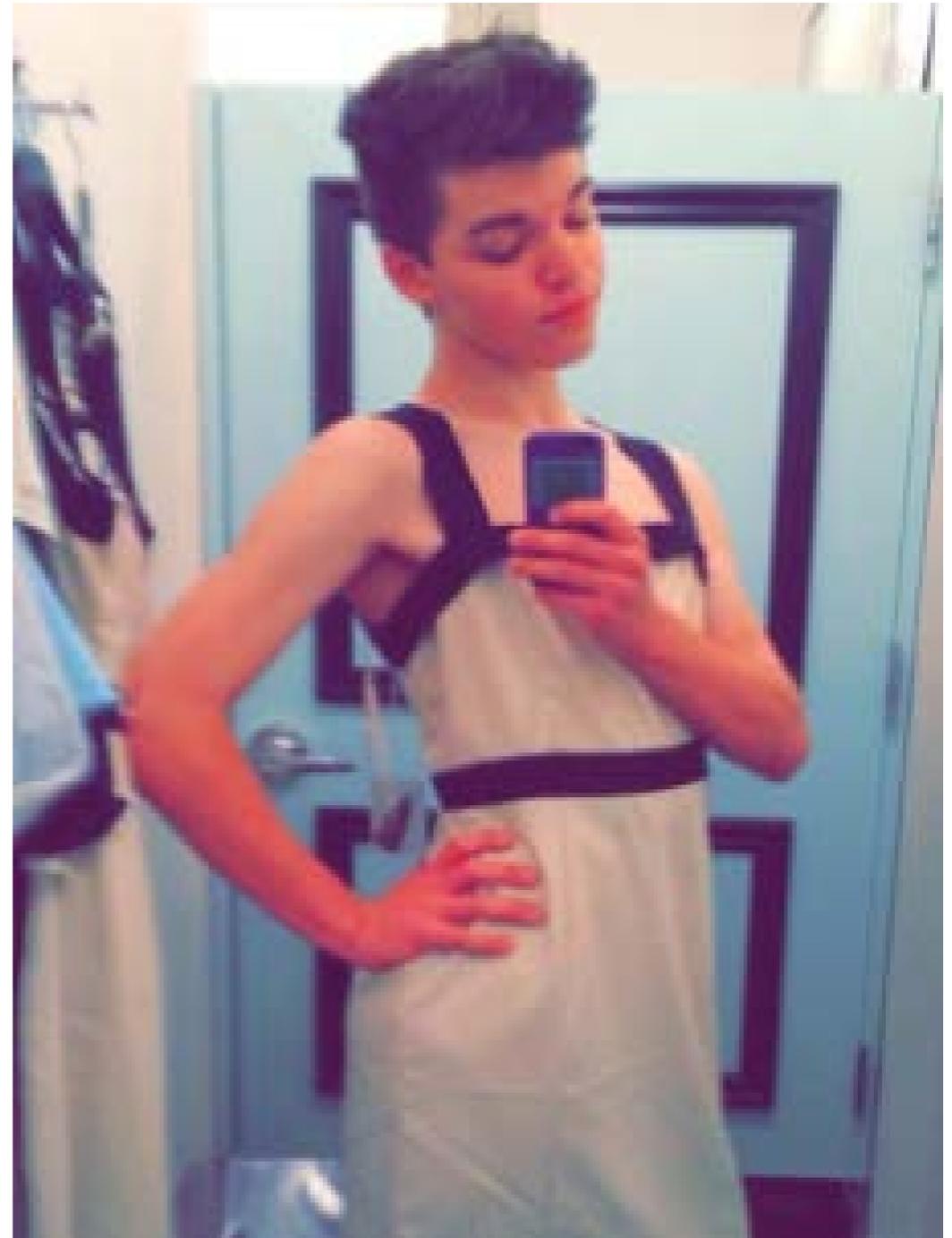
# Depression and Suicide

- 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.
- A 2009 study of 515 transgender individuals in San Francisco found that depression approaches 62% in trans women and 55% in trans men

# Leelah Alcorn's Story

- Leelah Alcorn was a transgender teen who committed suicide in 2014.
- She wrote in her suicide note:

*"The only way I will rest in peace is if one day transgender people aren't treated the way I was, they're treated like humans, with valid feelings and human rights...My death needs to mean something... My death needs to be counted in the number of transgender people who commit suicide this year. Fix society. Please."*



# 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

# 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

# 3. Creating a Gender Affirming Environment



# A Welcoming And Inclusive Environment

- Signal to transgender patients that your practice is welcoming, safe, and inclusive — mission statement, events, outreach to the community, website, etc
- Train **all staff** about transgender identity, terms, concepts



Providing  
Welcoming  
Services and Care  
for LGBT People

January  
2015

A Learning Guide for Health Care Staff

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# Consider the Environment: Caring and Working

- Train all staff to use clients' preferred names and pronouns
- Post non-discrimination policies in highly visible areas



- Include transgender, intersex, and other as options on intake forms, or ask for preferred gender
- Offer unisex bathrooms
- Listen to the terms your patients use to describe themselves and their needs



# Collecting Demographic Data on Gender Identity

■ What is your current gender identity? (check ALL that apply)

- Male
- Female
- Transgender Male/Trans Man/FTM
- Transgender Female/Trans Woman/MTF
- Gender Queer
- Additional Category (please specify) \_\_\_\_\_

■ What sex were you assigned at birth? (Check One)

- Male
- Female
- Decline to Answer

★ What is your preferred name and what pronouns do you prefer (e.g. he/him, she/her)?

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Importance of collecting data: Allows for evaluation of disparities at practice level and helps determine educational needs for clinicians and staff

# Polling Question

- A transgender client comes to your health center presenting for care. You are unsure what pronoun to use with the client (e.g., “he” or “she”). Which of the following is the LEAST preferred strategy to use in this situation?
  - ➔ Politely ask them what pronoun they prefer
  - ➔ Avoid using a pronoun at all
  - ➔ Use “it” as a neutral pronoun
  - ➔ Use “they” as a neutral pronoun

# For Front-line Staff

- Create and follow a protocol for ALL patients:
  - preferred names
  - pronouns
  - how to address mail
  - leave messages
  - when name on insurance does not match preferred name, or name on chart
- Have clear lines of referral for questions
  - Appoint a staff person responsible for providing guidance, assisting with procedures, offering referrals, fielding complaints
- Have a protocol for Ongoing training and retraining

# Avoiding Assumptions

- You cannot always correctly guess someone's gender based on their name, or how they look or sound
  - Ask straightforwardly what patient prefers if unsure. If unable to ask, use gender neutral or no pronouns at all until sure
- Use the appropriate pronouns and language
  - Change chart names and gender and train front office staff



# Using Preferred Names and Pronouns, cont.

- If you are unsure about a patient's preferred name or pronoun
  - *"I would like to 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 — Set the tone for your clinic: “See something, Say something.”
  - “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.”



# 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.

# Publications



**Affirmative Care for  
Transgender and Gender  
Non-Conforming People:  
Best Practices for Front-line  
Health Care Staff**

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**Atención afirmativa para  
personas transgénero y de  
género no conformista:  
Mejores prácticas para el  
personal de atención médica de  
primera línea**

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# 4. General Principles of Primary Care



# Primary Care

- Transgender care as primary care and benefits of a multidisciplinary team and collaborative effort
- The goals of health care for transgender patients are the same as for all patients:
  - To promote and ensure physical health
  - To promote social and emotional well-being
- **Don't forget the basics!**



(Coleman et al 2012)

# Guidelines for Clinicians

- Familiarize yourself with commonly used terms and the diversity of identities
- **Listen** to how people describe their own identities, partners, and bodies; use the same terms!
  - Refer to patients by their preferred name and pronouns
  - Refer to body parts by their preferred name
- If you are not sure what terms to use, **ask** your patient what they prefer
- Realize that many have had negative experiences in the past and may perceive “slights,” even when not intended
- Avoid asking questions out of curiosity; only ask what you need to know



# Taking a History

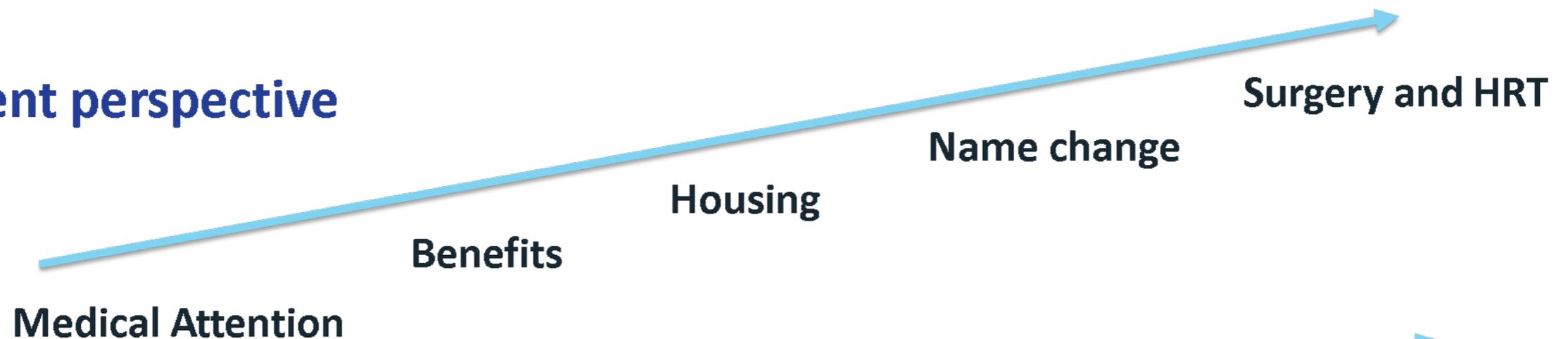
- Same as for all patients, but pay specific attention to health disparities
- Be aware of contexts that increase health risks
  - What leads people to smoke, drink, or engage in sexual risk behaviors?
- Ask about social support; be aware of possible rejection by family or community of origin, harassment, and discrimination
- Ask about use of cross-sex hormones, gender affirmation surgeries, and use of silicone

# Guidelines for Clinicians

- Recognize that the need to affirm one's gender identity can supersede other critical health concerns — Meet the patient where they are at.

## Priorities

### \*Patient perspective



### \*Provider perspective



Dr. Luis Freddy Molano, Renato Barucco. Trans-experience in the South Brox  
<http://www.nyhiv.org/pdfs/FreddyMolanoTransgenderPresentationUSCA.pdf>

# Hormone Therapy

# Advances in Treating Gender Dysphoria

- Increasingly standards of care are focused on **individualized approaches** to alleviate gender dysphoria.
  - Approaches use various combinations of psychotherapy, hormone therapy and surgery to overcome gender dysphoria



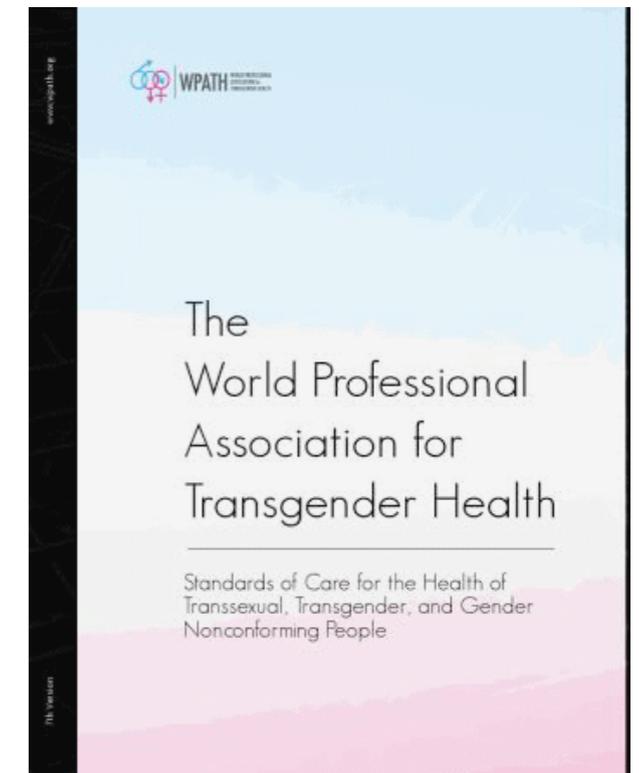
# WPATH SOC 2011

- “The previous versions of the SOC were always perceived to be about the things that a trans person must do to satisfy clinicians, **this version is much more clearly about every aspect of what clinicians ought to do in order to properly serve their clients. That is a truly radical reversal . . . one that serves both parties very well.**”
- Christine Burns, SOC International Advisory Committee Member.



# Standards Of Care

- WPATH: Standards of Care
  - [www.wpath.org](http://www.wpath.org)
- Center of Excellence for Transgender Health at UCSF
  - [transhealth.ucsf.edu](http://transhealth.ucsf.edu)
- The Endocrine Society
  - [www.endocrine.org](http://www.endocrine.org)



# 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

# Informed Consent Model

- **Effectively communicate** benefits, risks and alternatives of treatment to patient
- 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 does not preclude mental health care

# Initial Visits

- Reviewing implications and obtaining 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

# FTM Hormone Therapy

# Female to Male Treatment Options

- Injectable Testosterone
  - Testosterone Enanthate or Cypionate. IM or subcutaneous 50-200mg every 1-2 weeks
- Transdermal Testosterone
  - Androderm patch 2-8mg daily
- Topical testosterone
  - Gels in packets and pumps, multiple formulations (Testim, Androgel) daily
  - Axiron 2% pump gel for axillary application daily
- Testosterone Pellet
  - Testopel- subdermal implant every 3 to 6 months

# Masculinizing Effects of Testosterone

Effect	Onset (months)	Maximum (years)
<i>Skin oiliness/acne</i>	<b>1-6</b>	<b>1-2</b>
Fat redistribution	1-6	2-5
<i>Cessation of Menses</i>	<b>2-6</b>	
<b>Clitoral enlargement</b>	3-6	1-2
<i>Vaginal atrophy</i>	<b>3-6</b>	<b>1-2</b>
Emotional changes		
<i>Increased sex drive</i>		

# Masculinizing Effects of Testosterone

Effect	Onset (months)	Maximum (years)
<i>Deepening of voice</i>	<b>3-12</b>	<b>1-2</b>
<b>Facial/Body Hair Growth</b>	6-12	4-5
<i>Scalp Hair Loss</i>	<b>6-12</b>	
<b>Increased Muscle Mass &amp; Strength</b>	6-12	2-5
<i>Coarser Skin/ Increased Sweating</i>		
<b>Weight Gain/Fluid Retention</b>		
<i>Mild Breast Atrophy</i>		
<b>Weakening of Tendons</b>		

# Other Treatment Therapies for FTM

- Estrogen vaginal cream for atrophy
- Finasteride for male pattern baldness
- LARC for cessation of menses/birth control

# MTF Hormone Therapy

# Male To Female Treatment Options

- Antiandrogens
  - Spironolactone (aldactone) 50-400mg daily
  - Finasteride (Proscar) 2.5-5mg daily
- Oral Estrogens
  - Estradiol (estrace) 2-6mg PO or SL daily
  - 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

# Feminizing Effects of Estrogens and Anti-Androgens

Effect	Onset (months)	Maximum (months)
<i>Decreased Libido</i>	<b>1-3</b>	<b>3-6</b>
Decreased Spontaneous Erections		
<i>Breast Growth</i>	<b>3-6</b>	<b>24-36</b>
<i>Decreased Testicular Volume</i>	3-6	24-36
<i>Decreased Sperm Production</i>	<b>Unknown</b>	<b>Unknown</b>
Redistribution of Body Fat	3-6	24-36
<i>Decrease in Muscle Mass</i>	<b>3-6</b>	<b>12-24</b>
Softening of Skin	3-6	Unknown
<i>Decreased Terminal Hair</i>	<b>6-12</b>	<b>&gt;36</b>



# Other Treatment Therapies for MTF

- Hair Removal
  - Eflornithine (Vaniqa) cream
  - Electrolysis
  - Laser hair removal

# Monitoring Recommendations and Preventive Screening

# Guidelines for Clinicians

- Treat the anatomy that is present:
  - If you have it, check it!
- Clinical care should be based on an up-to-date anatomical inventory:

- ◆ Breasts
- ◆ Cervix
- ◆ Ovaries
- ◆ Penis

- ◆ Prostate
- ◆ Testes
- ◆ Uterus
- ◆ Vagina

(Deutsch et al, 2013)



If you've never been sexually active (in any way) and have a cervix, you need regular Paps. Check out our website for more information and tips on how to make getting a Pap easier.   [checkitoutguys.ca](http://checkitoutguys.ca)



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# Risks of Estrogen Therapy

- Venous thrombosis/thromboembolism
- Increased cardiovascular risk
- Cancer risk — breast. Need to consider prostate, testicular
- Weight gain
- Decreased libido
- Increased triglycerides
- Elevated blood pressure
- Decreased glucose tolerance /risk of diabetes
- Gallbladder disease
- Benign pituitary prolactinoma
- Infertility

# Health Considerations for the Trans Feminine Spectrum

- **Venous thromboembolism**
- In the Dutch cohorts, rates of 2.6% annually in first year, falling to 0.4 % thereafter, with 1 – 2% risk of death from PE,
  - BUT all but 1 of these patients was using oral ethinyl estradiol
  - Similar to CVD rates seen on controlled natal females using OCPs with high dose (50mcg) ethinyl estradiol
- Belgian cohorts also showed increased incidence of VT (6-8%), but **ONLY** in patients treated with ethinyl estradiol

# Health Considerations for the Trans Feminine Spectrum

- **Cardiovascular disease**

- About 50 to 60% higher risk in transwomen

- Associated with smoking and higher baseline cholesterol levels

- Higher rates of diabetes may play a role

- Type of estrogen used: Ethinyl estradiol assoc w/ 3-fold increased risk of CV death

- **Recommendations:**

- Avoid prescribing ethinyl estradiol at any point
- Consider transdermal or low-dose oral estradiol in patients >40yrs old
- Lifestyle behaviors — healthy diet, smoking cessation, exercise — can reduce cardiovascular risk!



# Health Care Maintenance for MTF Patients

- Mammography and CBE
  - Patients over age 50 who have been on feminizing endocrine agents over 5 years and have additional risk factors
- Bone density screening
  - Not routinely indicated prior to orchiectomy; consider if over age 60 and off estrogen therapy for longer than 5 years
    - Increase in osteopenia and osteoporosis compared to natal men, but generally preserved compared to natal women
      - Observed lower BMD in MTFs PRIOR to start of estrogen therapy
    - Decreased levels of bone turnover markers in setting of hormone therapy
- Yearly prostate exam as per natal men
  - Androgen antagonists will decrease serum PSA levels

# Risks of Testosterone Therapy

- Lower HDL, elevated LDL
- Polycythemia
- Sexual health changes - libido, vaginal atrophy, cervical atrophy
- Effects on breast, endometrial, ovarian tissues
- Weight gain
- Increased risk of sleep apnea
- Insulin resistance?
- Infertility

# Health Care Maintenance FTM

## ■ Cardiovascular Disease

- No increased risk of cardiovascular events in short and medium-term follow ups
  - Testosterone can increase blood pressure
  - Increased LDL and decreased HDL
- 
- In Asscherman's 2011 series, only 1 MI in FTM at age 72 after 42 years of testosterone tx.

# Healthcare Maintenance for FTM

- **Diabetes**
- Slightly higher prevalence of Diabetes type 2 than control, BUT almost all diagnosis made BEFORE starting testosterone therapy
  - Increased endocrine screening prior to initiation of hormone therapy
- Higher incidence of PCOS-like changes of the ovaries after exposure to testosterone
  - Insulin sensitivity

# Healthcare Maintenance for FTM

- PAP smears as per natal females
  - Effects of T on cervical epithelium mimicking dysplasia
  - Increase in unsatisfactory paps
- Mammograms and CBE as for natal females if no chest reconstruction; if post-op, yearly chest exam
- Risk of endometrial hyperplasia
  - Unexplained and prolonged vaginal bleeding should be evaluated by ultrasound or endometrial bx
- Bone density screening should be considered over age 50 and on testosterone for >5 years
  - Overall protective: Larger cortical bone size, but not necessarily increased density overall
  - Increased muscle mass / mechanical loading

# Health Care Maintenance FTM

- **Contraception**

- Testosterone does not reliably prevent ovulation

- Consider LARCs without estrogen

- Mirena IUD
- Depo-Provera
- Nexplanon

# Reproductive Choices

- Hormones produce a potential irreversible loss of fertility. *This should be discussed prior to beginning hormone therapy.*
  - Talk about options and desire for banking of sperm or ova
- Desire and timing of hysterectomy/oophorectomy, orchiectomy, or genital reconstruction surgery
- The desire for pregnancy should be discussed in the context of the patient's gender identity and anatomy

# Patients' Perspective

- Transgender community members discussing their experiences and perspectives in the health care setting
  - Primary care
  - Sexual Health
  - HIV Prevention



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# 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](http://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>



# Questions & Answers



**HIV TAC TEAM**

Thank you for participating in this Webinar. We hope that you are able to find the information provided useful as you continue your P4C project. We ask that you take a few moments to complete the feedback survey you will receive in a message following this webinar.



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**HIV TAC TEAM**

**Thank you for participating in today's  
webinar**

Please email if you have any question(s):  
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