Learning Objectives

The participant will:

- Understand the prevalence and diversity of transgender, transsexual, and gender nonconforming people.
- Be prepared to implement 3 practice adaptations needed in working with this population due to high levels of discrimination.
- Gain knowledge and have access to resources to safely and successfully treat gender dysphoria.

Disclosures

- Dr. Zevin is an employee of the San Francisco Department of Public Health.
- There are no other relevant financial or personal relationships that could cause bias in this presentation.
- No medications used as feminizing / masculinizing therapy for transgender patients are FDA approved for this indication.
A Concerned Parent

Gender Galaxy

Prevalence

1:11,900 – 1:45,000 MTF
1:30,400 – 1:200,000 FTM

Conventional prevalence based on presentation to specialized centers
Prevalence

- .3% to 1.4% of the general population
  - Based on community surveys
  - % even higher if includes “ambivalent” gender identities
  - Numbers seen in healthcare settings rising

Two Question Method for Recording Sex and Gender in Health Records

What is your gender? - Check one that best describes your current gender identity.

- Male
- Female
- Trans male
- Trans female
- Not listed, please specify.
  - Declined/Not stated
  - Question not asked

What was your sex at birth? – Check one

- Male
- Female
  - Declined/Not stated
  - Question not asked

Female to male, FTM, F2M, transman, transmasculine, masculine spectrum

Male to female, MTF, M2F, transwoman, transfeminine, feminine spectrum
Data from the National Transgender Discrimination Study—online responses were obtained from 6,456 self-identified transgender and gender non-conforming adults aged 18 and over.

- 97% reported harassment, mistreatment or discrimination at work.
- 55% had lost a job due to bias.
- 53% report being verbally harassed or disrespected in public setting.
- 57% experienced rejection by their families.
- 11% evicted due to gender.

An ongoing crisis

- At least 21 transwomen killed this year, most are women of color.
- Transgender people of color were 1.6 times more likely to experience physical violence when compared to other members in the LGBT community.
Adverse Effects of Discrimination

- Nearly four times more likely to have a household income of less than $10,000/year compared to the general population.
- One-fifth (19%) reported experiencing homelessness.
- Almost half of the respondents (46%) reported being uncomfortable seeking police assistance.
- Discrimination was pervasive.
- People of color fare worse; African Americans most impacted in many dimensions.

Discrimination in Healthcare Settings

- 19%-26.7 of people refused medical care in the past. NTDS
- 51.9% are expecting to be refused Medical care. Lambda Legal
- 28% of people report harassment in medical setting. Lambda Legal
- 20.9% healthcare providers used harsh or abusive language. Lambda Legal
- 7.8% health care professionals were abusive or physically rough. Lambda Legal
- 2% of the NTDS study reported violence IN the doctor’s office.

Discrimination in Healthcare Settings

- Common Errors
  - Failure to use proper names and pronouns
  - Focus on gender when issue has nothing to do with gender status
  - Excess curiosity about a person’s gender and sex
  - Asking patients to educate providers
  - Using patients as teaching example
  - Breast, genital or rectal exams without considering patient’s past history of trauma or difficult relationship with that part of their anatomy

Adverse Effects of Discrimination on Health

- High rates of stress and trauma-related behavioral health problem
- High-risk behaviors and suicidality
- High risks of HIV infection and STDs
- Decreased rates of receiving recommended preventative care and care for medical conditions
Caring for the Trans Person part 1: addressing the results of discrimination

Adaptations in Care Pearls

- Using appropriate pronouns and language
  - Ask straightforwardly what patient prefers if unsure
  - Change chart names and gender and train front office staff
  - Avoid terms pre-op/post-op, confusing and assumes surgery is norm
- Acknowledge “years of isolation and struggle”
  - Daily stress of living in a stigmatized and marginalized status
  - Recognition of this in patient care has been reported to be more important than “transgender expertise” Lombardi 2001

Adaptations in Care Pearls

- Trauma Informed Approach
- Create Trans friendly setting by including relevant posters, magazines, etc.
- Unisex bathrooms are preferred solution to BR problems
  - If BR is gendered patients must be allowed to use BR they feel is appropriate to their identity

Adaptations in Care / Pearls

- in addition to a standard health history:
  - history of gender experience
  - prior hormone use
  - prior surgical history
  - sexual history
  - goals related to health and gender transition
Adaptations in Care / Pearls

- Preventative care / cancer screening based on anatomy
- Be mindful in physical exam of previous trauma and abuse
  - Avoid genital and rectal exams on 1st visit if possible

Caring for the Trans Person part 2: Transition related healthcare

Gender Dysphoria

- Diagnostic Terms
  - DSM5 - Gender dysphoria
  - ICD 10 – Transsexualism, other gender identity disorders, etc.
  - ICD 11 - Gender Incongruence???

Gender Dysphoria

- Practical Diagnosis and Informed Consent Standard
  - Patients will bring specific issues
  - “Dysphoria” is an understatement as emotions involved usually very intense
  - Initiating treatment in primary care setting based on informed consent is reasonable and shows good outcomes
Gender Dysphoria: Hormone Therapy

- Rx initiated by prescribing MD
  - Based on clinical judgment
  - Lack of contraindications
  - Pt. capacity to give informed consent
  - Informed consent
  - Model patient education documentation forms are available:
    https://www.sfdph.org/dph/comupg/oprograms/THS/ClinicalResources.asp

Natural History of Gender Dysphoria

- Consequences of untreated gender dysphoria
  - Suicidality / suicide
  - Neglect of health and healthcare needs
  - Resorting to black market or unscrupulous MD's
    - Unmonitored hormone therapy with adverse effects
  - High risk sexual behavior
  - Substance use
  - HIV and other infectious diseases
  - Vulnerability to victimization
  - Attempts at self surgery or surgery by unscrupulous providers
    - Silicone and other injections "pumping parties"

Transition

- Unique to each person based on their goals and situation, health, family, identity, etc.
  - Not everyone wants or needs hormones or surgery
- Not the same starting or ending point for everyone
- Can take many years
- Move back and forth; not linear
- Life forces person back / Opportunities help people forward
- Developmental process unique to the individual

Hormone Therapy

- Feminizing Therapy
  - Anti-androgen: In US usually Spironolactone
  - Estrogen: 17β-Estradiol (oral, sub-lingual, injectable, transdermal, etc) – many brand names
    - Estradiol is strongly preferred to Conjugated Equine Estrogen or ethinyl estradiol
- Masculinizing Therapy
  - Testosterone: injectable, patch, topical
**Hormone Therapy:**
Dosing and Monitoring Guidelines

- SFDPH: [https://www.sfdph.org/dph/files/THS/HormoneTherapyRev.pdf](https://www.sfdph.org/dph/files/THS/HormoneTherapyRev.pdf)
- UCSF CoE: [http://transhealth.ucsf.edu/](http://transhealth.ucsf.edu/)

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**Surgery**

- Not every trans person wants or needs surgery
  - The terms “pre-op, post-op, non-op” are unhelpful
- Some trans individuals need surgery
  - Non-discrimination policies and health care reform are making surgery much more accessible in California and possibly across USA
  - Insurance coverage and access to these procedures is rapidly improving
  - Still numerous barriers and gaps

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**Surgeries**

- Mastectomy w/ male chest construction
- Hysterectomy/salpingo-oophrectomy
- Vaginectomy/colpocleisis
- Metoidioplasty
- Phalloplasty with Penile Implant
- Scrotoplasty
- Urethral reconstruction
- Orchietomy
- Penectomy
- Vaginoplasty
- Clitoroplasty
- Labiaplasty
- Feminizing mammoplasty
- facial feminization,
- tracheal shave,
- facial and body hair removal

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**Surgery**

- Period before during and after surgery highly stressful and traumatizing to many patients
- Excellent patient education and preparation are keys to best outcomes
- Extensive resources and information available from SFDPH Transgender Health Services [https://www.sfdph.org/dph/comupg/oprograms/THS/default2.asp](https://www.sfdph.org/dph/comupg/oprograms/THS/default2.asp)
Transgender Care Across the Lifespan

10 things to know about feminizing hormone therapy

1. Decision to start, continue, or increase hormones must include benefits, risk of adverse effects, and risk related to what will happen if a person does not get it
2. More isn’t always better / less isn’t always better
3. Importance of smoking cessation
4. Psychological benefit may be more than physical changes
5. Hormone therapy cannot get rid of hair follicles

6. Estrogen is not toxic to the liver or kidneys with very rare exceptions
7. Counsel patients on fertility impairment and offer sperm banking to interested patients prior to starting therapy
8. Patches or shots may be the safest for many patients over 40 or with other health issues
9. Ask about sexual functioning and expectations about erections before start or change
10. Changes related to any particular hormone or dose may take 3 months or longer to be noticeable
10 things to know about masculinizing hormone therapy

1. Importance of smoking cessation
2. Facial / body hair growth, voice deepening may occur quickly even at low doses and is irreversible
3. Male pattern baldness may occur quickly and is irreversible
4. Almost everyone can be taught to self inject testosterone but everyone needs to be taught
5. Libido can increase and sexual attractions can change with start of testosterone (think adolescent boys)

6. If patients have mood swings on every 2 weeks injectable testosterone may be helped by changing to every week (at ½ dose) or patch or gel
7. Testosterone usually does not cause rage, aggression, or violence (even in high doses)
8. Counsel regarding loss of fertility and possibility of ova banking
9. Uterine bleeding after being on a stable testosterone dose requires a medical work up
10. Testosterone is not a reliable contraceptive and other methods are required if patients are having vaginal sex with cisgender men
10 things to know about surgery

1. Not everyone wants or needs surgery (banish the terms pre-op, post-op)
2. Decisions about surgery require a cooperative patient-centered approach including patient, primary care, behavioral health, and surgeon
3. Vaginoplasty is a major procedure requiring several days hospitalization and extensive self care
4. Sexual functioning and orgasm are usually good after vaginoplasty but different than before
5. Phalloplasty is a major and very arduous procedure requiring multiple surgeries and prolonged recovery with a very high complication rate

10 things to know about surgery

6. Well controlled HIV infection and other well controlled chronic illness are not a contraindication to any surgeries
7. Testosterone or estrogen are required to prevent osteoporosis after surgery that removes the ovaries or testes
8. Counseling about fertility options should be given to every patient considering genital surgeries
9. Substance use disorders, mental health disorders, homelessness, cultural differences may create challenges but are not contraindications to surgery
10. Unrealistic Expectations are main barrier to good outcomes

Resources

- World Professional Association for Transgender Health http://www.wpath.org/
- SFDPH Transgender Health Services http://www.sfdph.org/transgenderhealthservices
- UCSF Center of Excellence for Transgender Health http://transhealth.ucsf.edu/
- Transline project- health.org/transline
- Vancouver Coastal Health transhealth.vch.ca

Thank you to my colleagues in the SFDPH Transgender Health Project, transgender community advocates and especially to our patients for teaching us and supporting us every day
Summary

• Every trans person can get accessible high quality healthcare if health care teams become educated
• High quality care for Trans people includes equal access to general healthcare, addressing the results of long term discrimination, and for some patients transition related medical services
• Many resources are now readily available