Best Practices for Providing Transgender Care

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Learning Objectives

1. Describe health disparities faced by transgender people
2. List 5 ways you can make your practice more inclusive to transgender patients
3. Understand when to initiate gender affirming hormone therapy
4. Describe special considerations for HIV prevention and care for transgender people
5. Recall online trans health resources

I have no disclosures to report

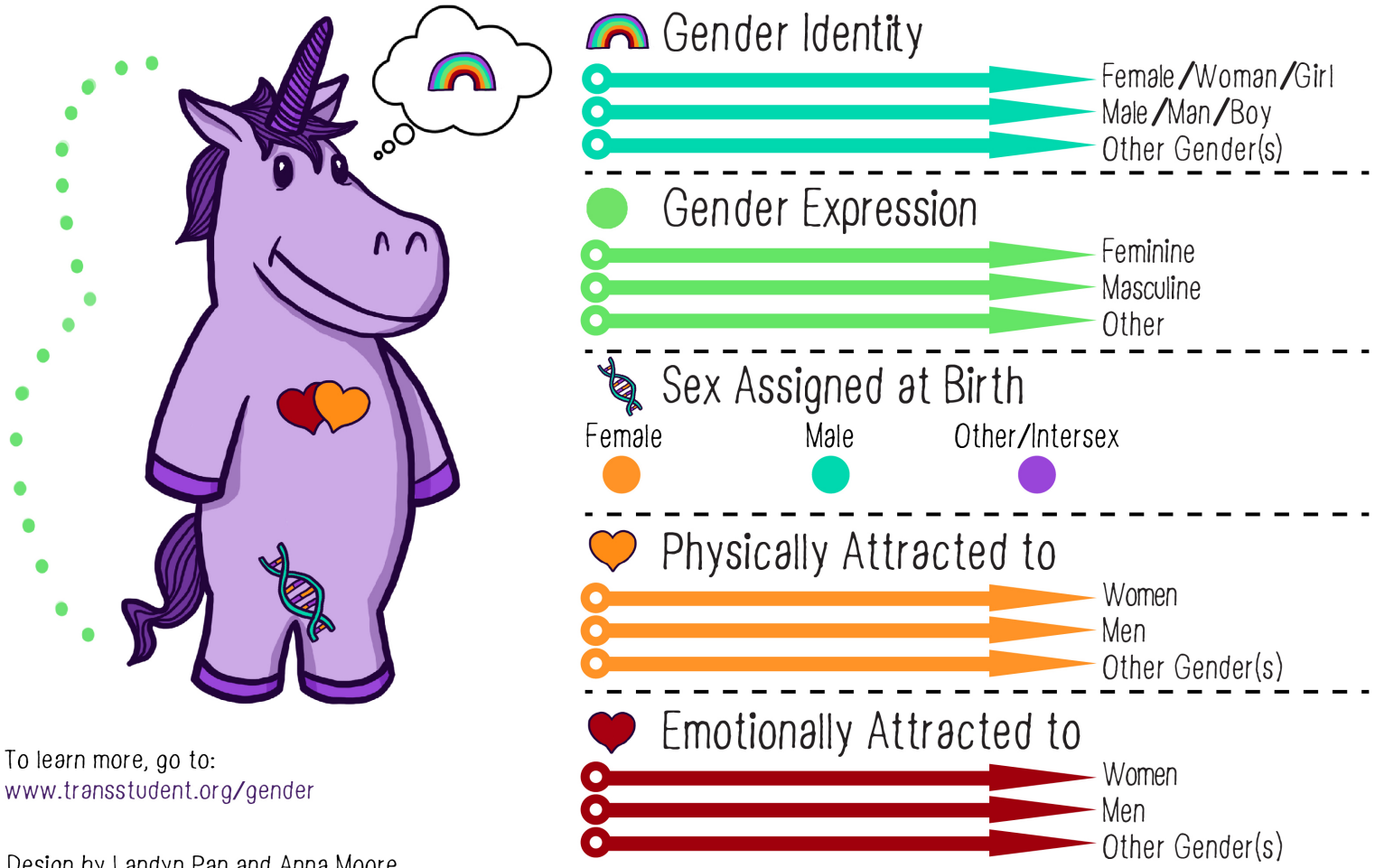
Meet Jolene

Jolene is a 25 yo transgender woman who you meet at a local Pride event where you have a booth with information on your local clinic which offers PrEP. She shows great interest however has concerns about setting up an appointment at the clinic.

I've had some really bad experiences at the doctor…. I'm pretty nervous to come.

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



To learn more, go to:
www.transstudent.org/gender

Design by Landyn Pan and Anna Moore

Transgender: Gender identity opposite as assigned at birth

Cisgender: Gender identity same as assigned at birth

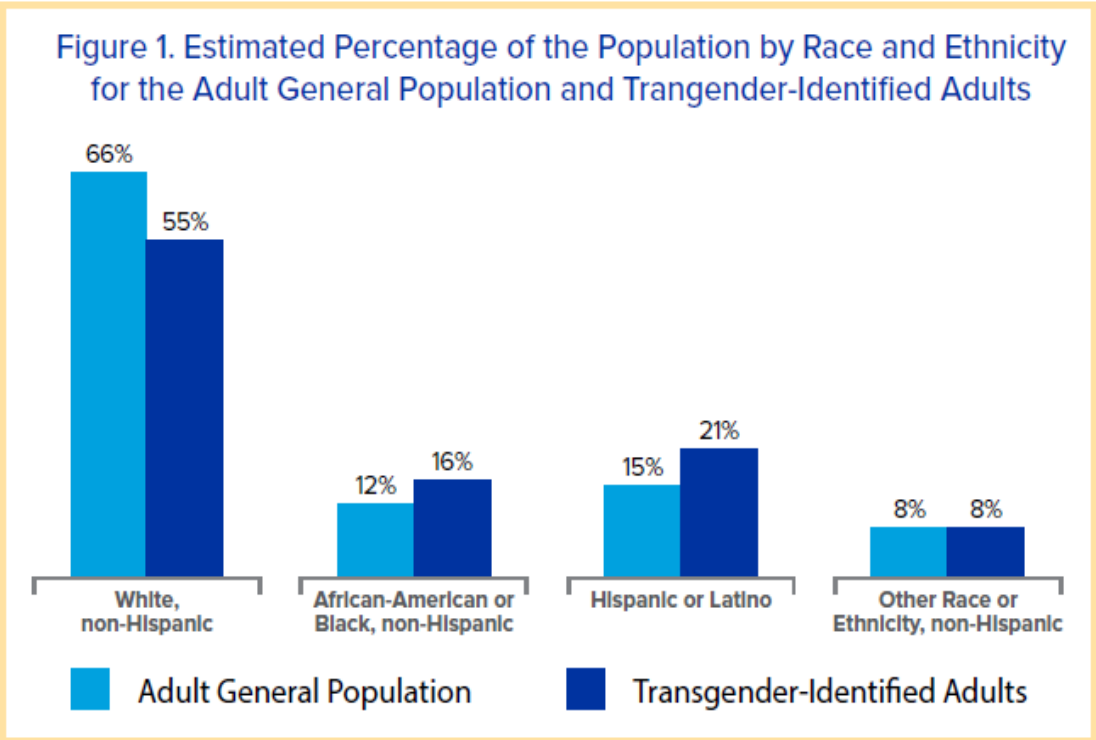
Gender Non-Binary/Gender Queer: Gender identity not male or female

Why is providing transgender inclusive healthcare important?

You will care for transgender patients!

- 1º source: The Williams Institute, UCLA
  - June, 2016, report: used CDC Behavioral Risk Factor Surveillance System
- 1.4 M adults (0.6% U.S. population)

Prevalence of Type 1 DM in USA:
0.55% or 1.3M



Flores, A. R, et al. The Williams Institute. October, 2016 pp.1-15.

Question

What is the estimated HIV infection prevalence among trans women?

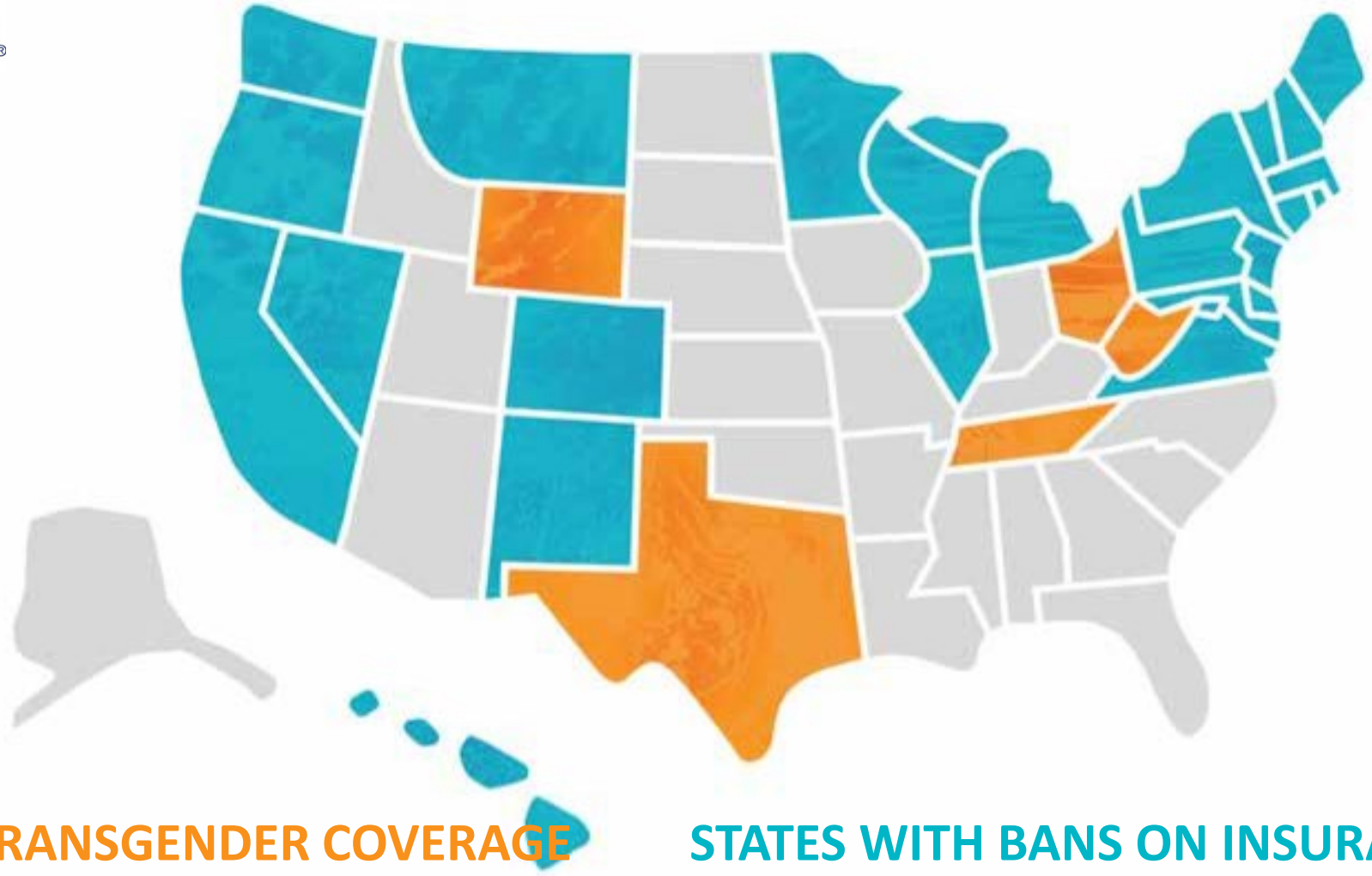
A. 14%
B. 44%
C. 26%
D. 7%

- **81%** report workplace harassment or mistreatment
- **78%** report harassment, **41%** reported physical assault at school
- **40 %** reported attempting suicide at some point in their life
- Transwomen HIV prevalence **14%**, Black Transwomen **44%**

National Transgender Discrimination Study, 2015
Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS Behav. 2008;(12):1-17.

- **55%** of those who sought coverage for transition-related surgery in the past year were denied
- **25%** of those who sought coverage for hormones in the past year were denied
- **33%** of those who saw a health care provider in the past year reported having at least one negative experience
- **23%** of respondents did not see a doctor when they needed to because of fear of being mistreated

National Transgender Discrimination Study, 2015



STATES WITH TRANSGENDER COVERAGE EXCLUSIONS IN MEDICAID

STATES WITH BANS ON INSURANCE EXCLUSIONS FOR TRANSGENDER HEALTHCARE

Words matter!

Pronouns ➡ Patient Centered Care

- Don’t make words your barrier to providing Transgender care
- Be patient centered and **ASK or Collect at Check In** –
  - What name do you prefer?
  - What pronouns do you prefer?
- **To err is human**….it is okay if you mess up, just apologize and **get it right the next time**

Examples

- "What pronouns do you use?"
- "How would you like me to refer to you?"
- "How would you like to be addressed?"
- "Can you remind me which pronouns you like for yourself?"
- "My name is Dr. Nall and my pronouns are he, him, and his. What about you?"

1. What is your current gender identity? (Check an/or circle ALL that apply)

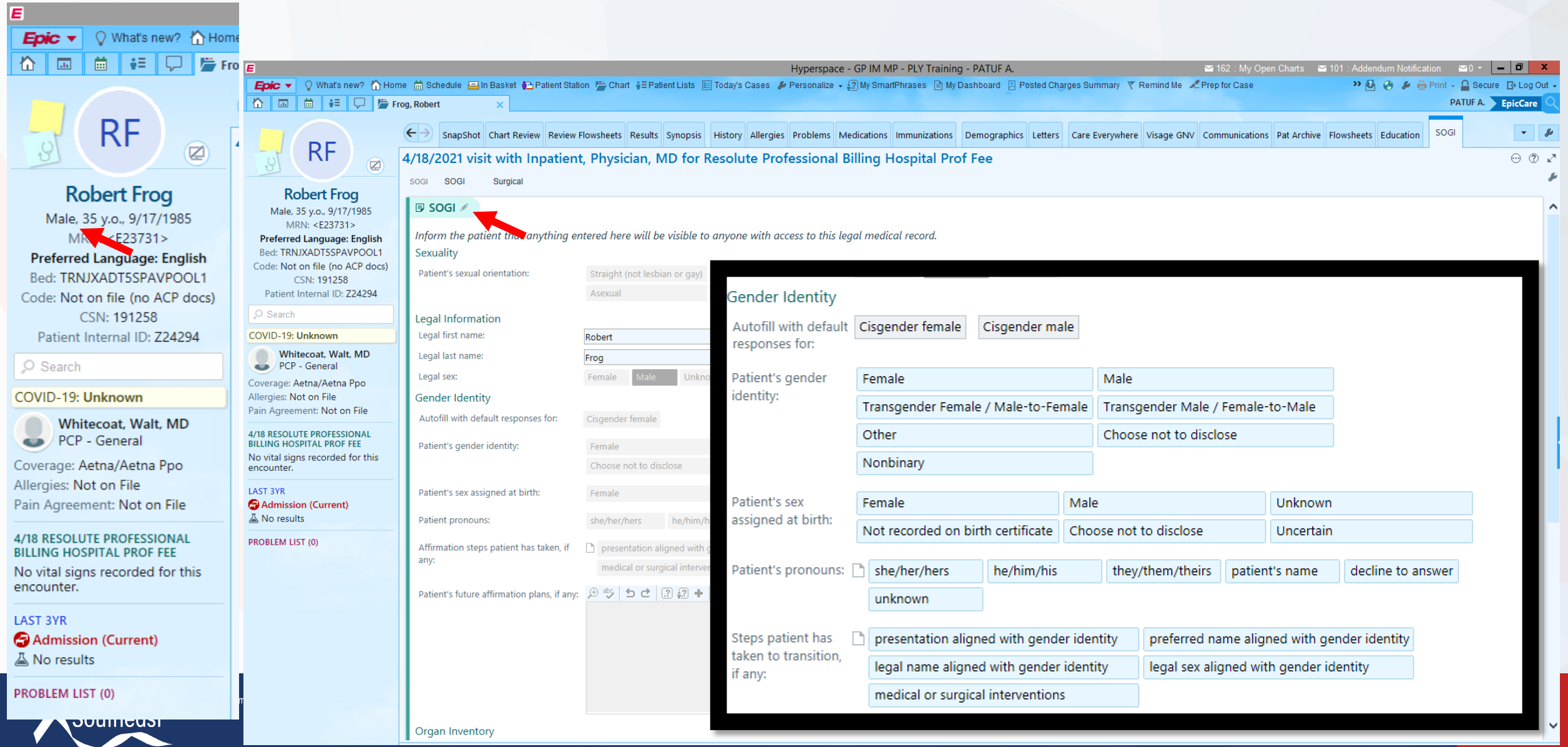
- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/FTM
- ☐ Transgender Female/Trans Woman/MTF
- ☐ Genderqueer
- ☐ Additional category (please specify): _____
- ☐ Decline to answer

2. What sex were you assigned at birth? (Check one)

- ☐ Male
- ☐ Female
- ☐ Decline to answer

3. What pronouns do you prefer (e.g., he/him, she/her)? _____

SOGI: Sexual Orientation and Gender Identity in EPIC



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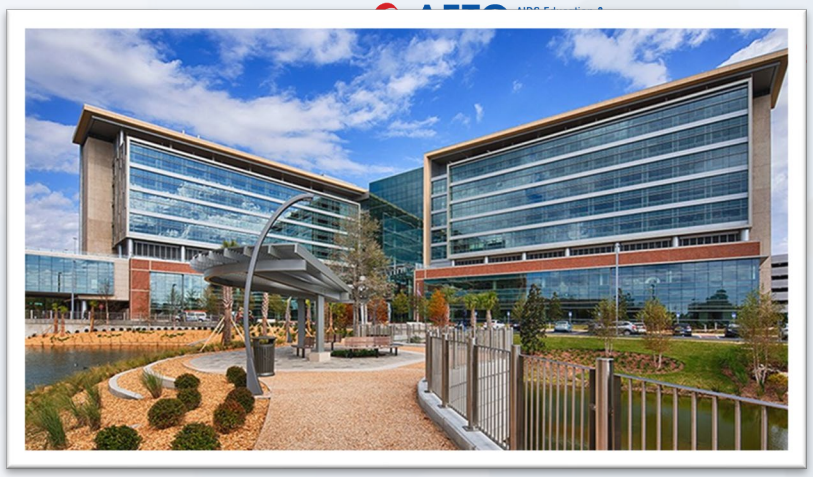
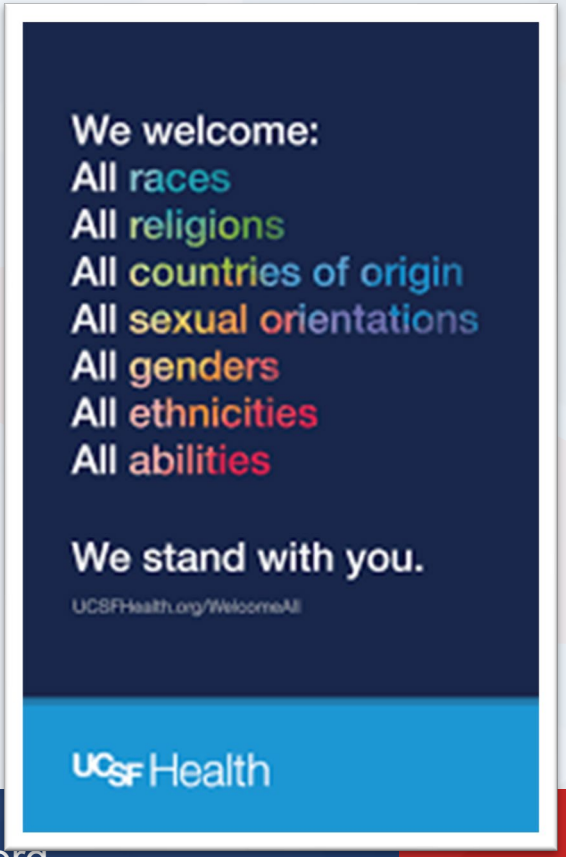
ways to make your practice more inclusive of transgender patients

#1 - It Starts at the Front Door!

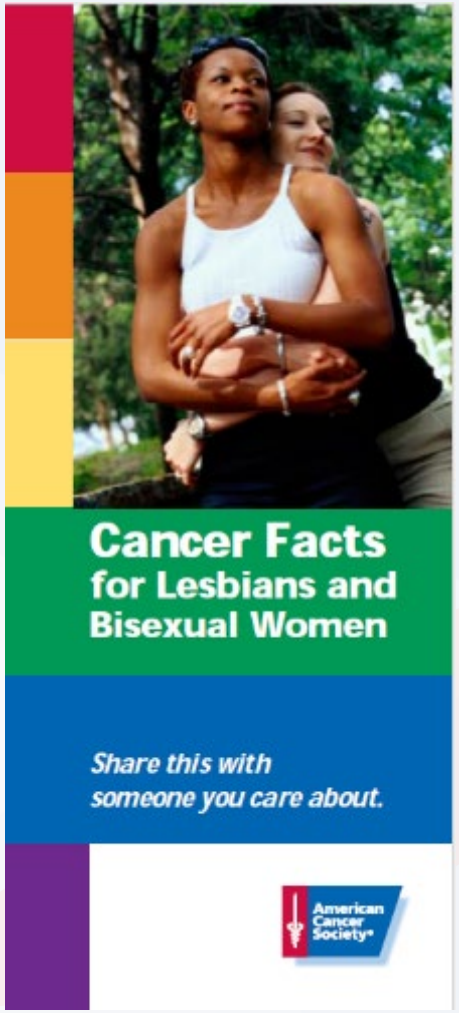


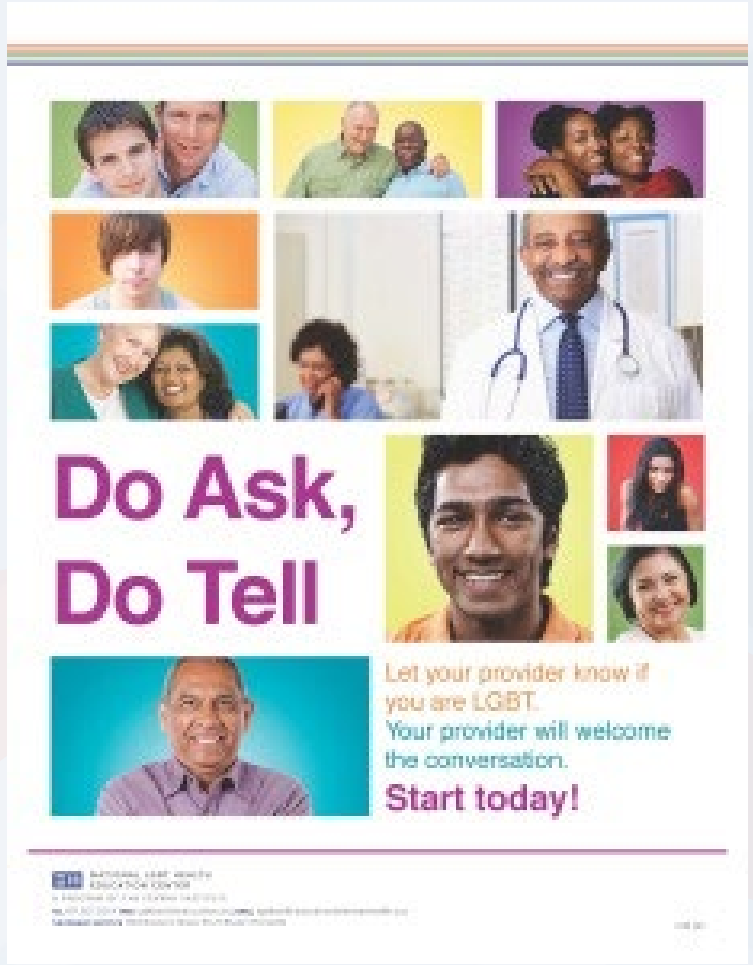
- Inclusive language on website
- Training for ALL staff
- Welcoming waiting room, provides privacy
  - Chairs facing away from door, trees/plants, TV
- Openly display non-discrimination statement



#2 – Do patients see themselves in your clinic?

- Inclusive brochures/signage
- Inclusive intake forms
- Pictures on walls
- Diverse staff





Signal you are safe

#3- Reduce Stigma (WALLS)

- **W**atch your language: avoid stigmatizing language/actions
- **A**sk questions: learn from LGBTQ+ patients
- **L**earn more: reduce misunderstandings
- **L**isten to experiences: listen to patients' experiences
- **S**peak out: speak out when others stigmatize

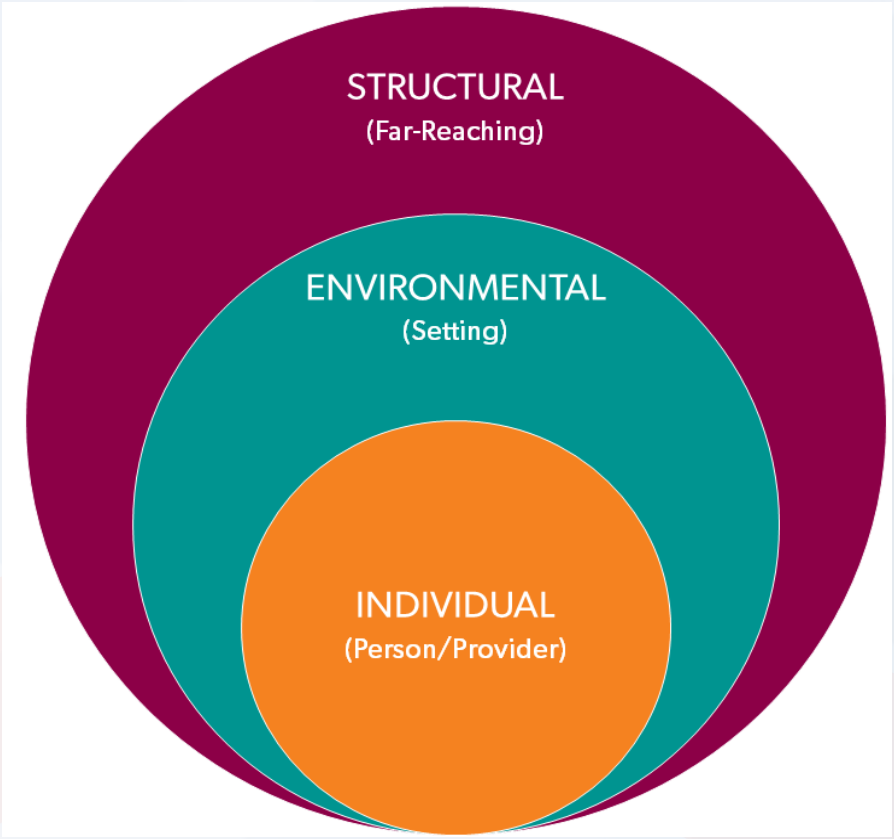


Image:https://providecare.org/how-identify-signs-symptoms-individual-stigma/

#4 – Community Outreach

#5 - Provide Gender Affirming Care

- Social/Emotional Affirmation
  - Name and pronouns
  - Dress, Binding, Tucking, Packing, Padding
  - Coming out

- Medical affirmation
  - Hormones
  - Hair removal
  - Voice Therapy
  - Surgery

- Legal affirmation
  - Identity documents

"I would like to offer a new lens, one that casts gender non-conformity in a positive light, in order not to squelch it but facilitate it"

-Diane Ehrensaft PhD

Equal Access LGBT Health Clinic at Eastside

Gender Affirming Therapy: Masculinizing (FtM)

Developed by Catherine Bielick, 2017-2018 Clinic Director, updated 2021 by Monica Rodriguez, LGBT Officer

Initial evaluation in clinic → Informed consent process started → Patient obtains baseline labs → Begin HRT after discussion of risks and benefits → Reevaluation at 3 months (with labs prior) → Reevaluation at 6 months (with labs prior) → Reevaluation at 12 months (with labs prior)

Initial Evaluation

- Baseline history and counseling
  - Mood status (PHQ-9, GAD6, Mood Disorder Questionnaire)
  - Suicidal ideation
  - Smoking status & other VTE/hypercoagulable risk factors
  - Desire for fertility – counsel on fertility options
- Set **expectations** for what changes to expect from GAT (reference)
  - Skin oiliness; 1-6 months; 1-2 years
  - Facial/body hair growth; 3-6 months; 3-5 years
  - Scalp hair loss; >12 months; variable
  - Increased muscle mass/strength; 6-12 months; 2-5 years
  - Body fat redistribution; 3-6 months; 2-5 years
  - Cessation of menses; 2-6 months; n/a
  - Clitoral enlargement; 3-6 months; 1-2 years
  - Vaginal atrophy; 3-6 months; 1-2 years
  - Deepened voice 3-12 months; 1-2 years
- Absolute Contraindications: any active testosterone-sensitive cancer
- Complete Informed Consent Form & Upload to patient chart
- Enroll patient in Gender Affirming Therapy in the Clinic Navigator

Therapeutic Options

Testosterone Cypionate IM or SQ:
- Initial 50 mg/wk; Max 100 mg/wk

•Can double each dose for q 2-week dosing

Others (for reference)
- Testosterone Enthanate IM or SQ: Initial 50 mg/wk; Max 100 mg/wk
- Testosterone topical gel 1%: Initial 50 mg qAM; Max 100 mg qAM
- Testosterone topical gel 1.62%: 40.5-60.75mg qAM; Max 103.25mg qAM
- Testosterone Patch: Initial 4 mg qPM; Max 8 mg qPM
- Testosterone cream: initial 50 mg, Max 100 mg
- Testosterone Axillary gel 2%: Initial 60 mg qAM; Max 90-120 mg qAM
- Testosterone Udecanoate: Initial 750 IM repeat in 4 weeks, q 10 weeks

Testosterone Treatment Risks

Erythrocytosis/polycythemia

•Use reference male range

Management of polycythemia

1)Check testosterone levels, including peak levels – adjust dose

2)More frequent injection schedule with lower peak dose may lower risk [59]

3) Phlebotomy or blood donation short term solution

4)Rule out pathologic causes of polycythemia (OSA, tobacco, etc)

Hair Loss
- Fronto-temporal pattern, severity based on genetics

Management
- OTC Minoxidil (Rogaine)
- 5-alpha reductase inhibitors (finasteride/dutasteride)
- Surgical approaches – scalp advancement, hair transplantation

Acne
- Peaks in first year of testosterone therapy then declines
- Treat as normal with topical skin treatments escalating with severity

Weight gain
- Must use with caution and informed consent with PCOS, obese, or hyperlipidemic patients

Labs *Baseline & Prior to Every Visit*

- CBC without diff (Hg and Hct for erythropoietic effect)
- CMP
- Serum Estradiol (not total estradiol)
- Serum Total Testosterone LC/MS/MS
- Pregnancy Test (always at baseline, follow up if pregnancy is possible)
- No evidence to support extra monitoring: lipids, A1C/glucose, cholesterol

Goals
- Titrate GAT dosing to the physiologic range of non-transgender individual of identified gender

(levels vary by lab – Quest lab ranges listed)

Physiologic range of non-transgender males ≥18yo
- Total Testosterone = 400-700 ng/dL (test code 15983)
- Serum Estradiol = can vary greatly – not great priority
  - Only 29% of 31 trans men achieved physiologic male-range estradiol levels

Health Maintenance

Pap smears: follow USPSTF, likely behind, based on age
- Can be traumatizing – “checkitoutguys.ca” is good patient resources for FTM’s
- MUCH higher rate of inadequate cytologic sampling (possibly due to rushing procedure from patient discomfort)[31]
- Can pre-medicate with vaginal estrogens 1-2 weeks prior to exam to decrease vaginal atrophy due to testosterone therapy
- If still refuses – offer external OR bimanual as initial step towards establishing trust

Gender Affirming Therapy: Feminizing (MtF)

Developed by Catherine Bielick, 2017-2018 Clinic Director, updated 2021 by Monica Rodriguez, LGBT Officer

Equal Access LGBT Health Clinic at Eastside

AETC AIDS Education & Training Center Program Southeast Regional Conference 2022

Initial evaluation in clinic → Informed Consent process started → Patient obtains baseline labs → Begin HRT after discussion of risks and benefits → Reevaluation at 3 months (with labs prior) → Reevaluation at 6 months (with labs prior) → Reevaluation at 12 months (with labs prior)

Initial Evaluation

- Baseline history and counseling
  - Mood status (PHQ-9, GAD6, Mood Disorder Questionnaire)
  - Suicidal ideation
  - Smoking status & other VTE/hypercoagulable risk factors
  - Desire for fertility – counsel on fertility options
- Set **expectations** for what changes to expect from GAT (reference)
  - Body fat redistribution; 3-6 months; 2-5 years
  - Decreased muscle mass/strength; 3-6 months; 1-2 years
  - Softening of skin/decreased oiliness; 3-6 months; unknown
  - Decreased libido; 1-3 months; 3-6 months
  - Decreased spontaneous erections; 1-3 months; 3-6 months
  - Male sexual dysfunction; variable; variable
  - Breast Growth; 3-6 months; 2-3 years
  - Decreased testicular volume; 3-6 months; 2-3 years
  - Decreased sperm production; variable; variable
  - Thinning and slowed growth of body and facial hair; 6-12 months; >3 years
  - Male pattern baldness; no regrowth, loss tops 1-3 months; 1-2 years
- Absolute Contraindications: any active estrogen-sensitive cancer
- Complete Informed Consent Form & Upload to patient chart
- Enroll patient in Gender Affirming Therapy in the Clinic Navigator

Therapeutic Options

Estrogen – administer FIRST [36]

- Bioidentical Estradiol Oral/Sublingual (*most typical*)
  - Initial: 2-4 mg/day
  - Maximum: 8 mg/day (BID dosing if >2 mg daily)

Others:

- Estradiol Transdermal (lower or absent clotting risk [35])
- Initial 100 mcg per [timing brand/product-dependent]
- Maximum 100-400 mcg per timing brand/product
- Estradiol valerate IM: Initial 20 mg IM q 2wk; Max 40mg IM q 2wk
- Estradiol cypionate IM: Initial 2 mg IM q 2wk; Max 5 mg IM q 2 wk
- Note: Conjugated equine estrogens (Premarin) are no longer recommended due to high risk of thrombogenicity and cardiovascular risk [38,39]

Androgen Blocker – Administer SECOND [32,36] –

- Spironolactone: Initial: 50 mg BID, Max: 200 mg BID

Optional Adjuncts (for reference)

- Finasteride 1-5 mg/day depending on desired effect
- Dutasteride 0.5 mg/day
- Progestagen
  - Micronized progesterone 100-200 mg/night
  - Medroxyprogesterone acetate (Provera), less preferred
    - Initial 2.5 mg/night; Max 10 mg/night

Estrogen Treatment Risks

Venous Thromboembolism

- VTE background rate in general pop: (1/1,000-1/10,000)
- Data on risk of oral 17-Beta estradiol (bioidentical) is MIXED – Some = no increased risk [49]
  - Some = 2.5-4 fold increase in relative risk (still low absolute risk) [50,51]
- Often quoted study: [52,53] Found 20-40-fold times risk of VTE in transgender women, BUT:
  - 1) high doses (100-200 mcg/day)
  - 2) thrombogenic ethinyl estradiol (conjugated) used and
  - 3) Mix of smokers and non-smokers in cohort
- Routine hypercoagulability screening is not recommended
- Withhold estrogen therapy when: 1) patients with significant risk factors/history of VTE and 2) who continue to smoke tobacco
- If risks are great, but manageable—consider transdermal estrogen application

Loss of erectile function

- Some do not lose, can be safely preserved with Viagra or Cialis

Libido loss

- 22% met criteria for Hypoactive Sexual Desire Disorder (HSDD), no correlation with testosterone levels [59]
- Mental health therapy – continue throughout treatment to help with body image issues and dissociative symptoms

Prolactinoma [56]

- Few case reports reporting association with estrogen therapy
  - Prolactin levels should only be checked in cases of Visual disturbance, Excessive galactorrhea, New onset headaches

Migraine

- Estrogen known association with menstrual migraines (by period cycle in non-transgender women)
- May be exacerbated with feminizing GAT

Infertility

- Sperm cryopreservation may be required

Labs *Baseline & Prior to Every Visit*

- Serum Estradiol (NOT TOTAL estradiol)
- Serum TOTAL testosterone LC/MS/MS

(free testosterone is unreliable [33])

- CMP

Goals: Titrate GAT dosing to the physiologic range of non-transgender individual of identified gender

(levels vary by lab – Quest lab ranges listed)

- Physiologic range of mid-cycle non-transgender female
  - Estradiol = 64-357 pg/mL (test code 4021 – can google to order)
  - Total Testosterone = 2-45 ng/dL (test code 15983)

No evidence to support extra monitoring: lipids, A1c/glucose, cholesterol

Other Health Concerns

Prostate Exams: follow current guidelines, prostatic atrophy may be severe if on finasteride

Hernias: If pre-operative SRS – MUST monitor – tucking genitals can cause hernias or perineal skin breakdown

If post-operative SRS and needs vaginal exam – NO cervix or fornices – pap smears unnecessary (/impossible)

Visualization of tissue may be better with an anoscope (if necessary, EAC would need WeCare referral)

Question

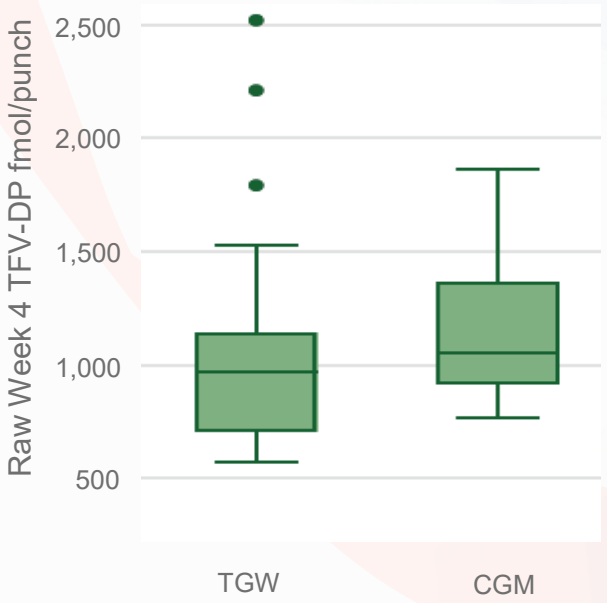
Jolene asks if she can take PrEP if she is on gender affirming hormones (estradiol). How would you respond?

A. No, hormones lower FTC/TDF drug levels
B. No, FTC/TDF lowers testosterone and estrogen levels
C. Yes, but you need to double the dose
D. Yes, FTC/TDF drug levels and hormone levels are not affected

HIV Prevention

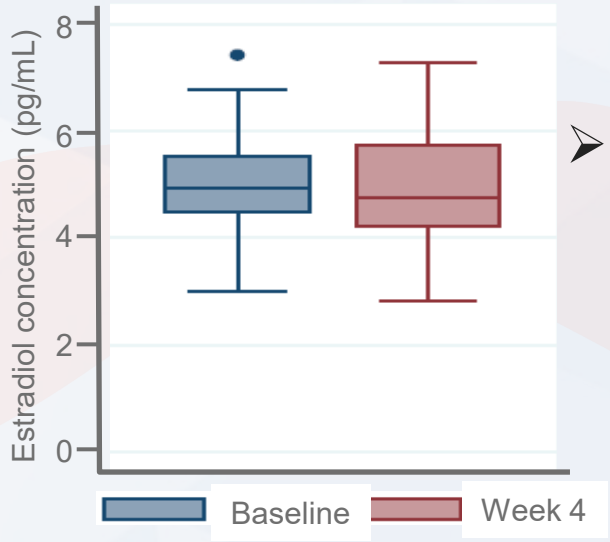
- **iBrEATHe study:** compared TFV-DP concentrations between transgender women taking estradiol (n = 24) and a control group of cisgender men (n=15)
- All taking PrEP under with directly observed therapy

TFV-DP concentrations during PrEP, TGW vs CGM



- Mean difference −12%
- 95% CI, −27% to 7%
- *P* = .21

Estradiol concentrations before and during PrEP, TGW

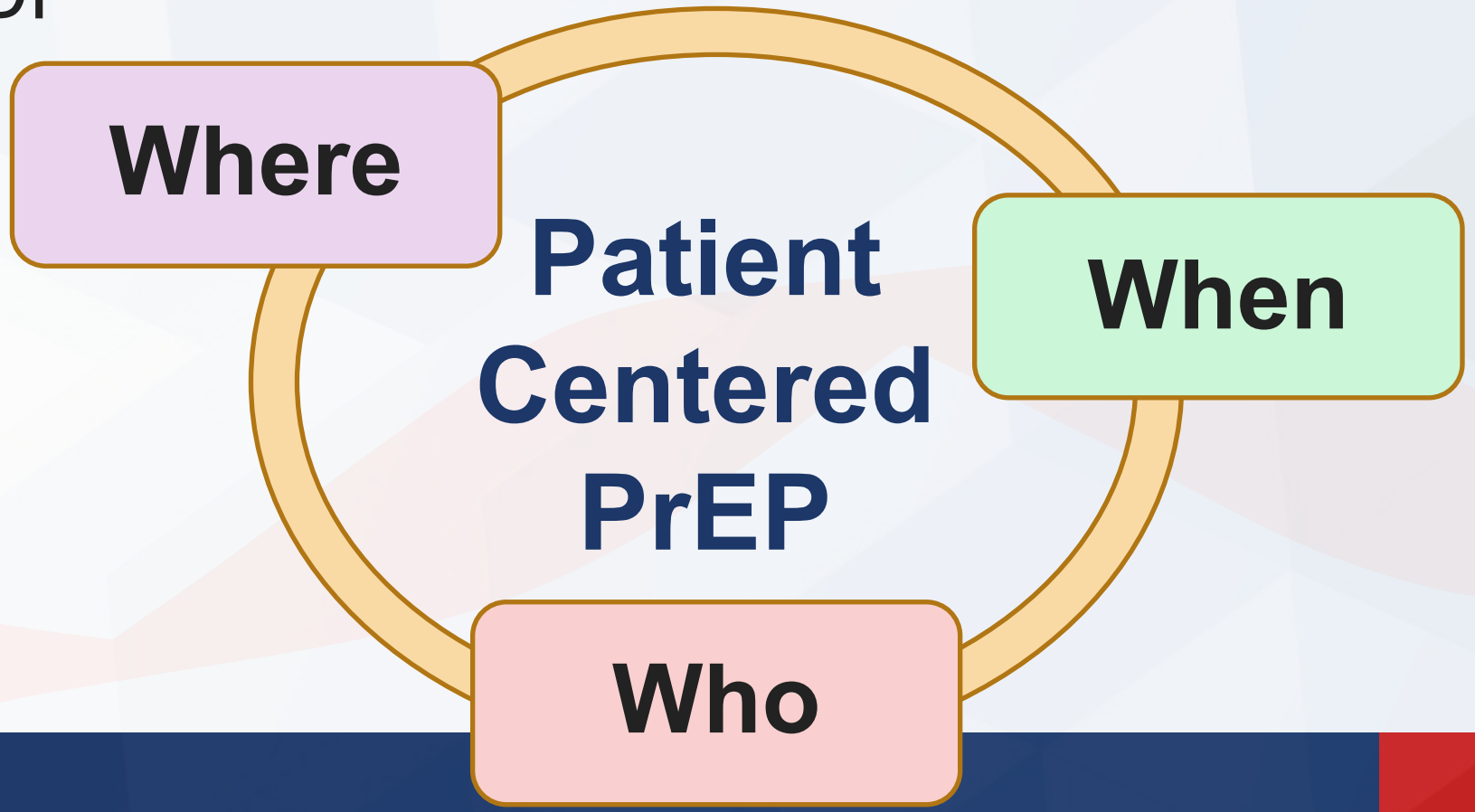


- No statistically significant difference

Deutsch MB, et al. *Lancet HIV*. 2015; 2(12):e512-e519; 109(1):e1-e8; Grant RM, et al. *Clin Infect Dis*. 2020;ciaa1160.
Image courtesy Prime Education

PrEP

- Transwomen: FTC/TDF or FTC/TAF
- Transmen: FTC/TDF

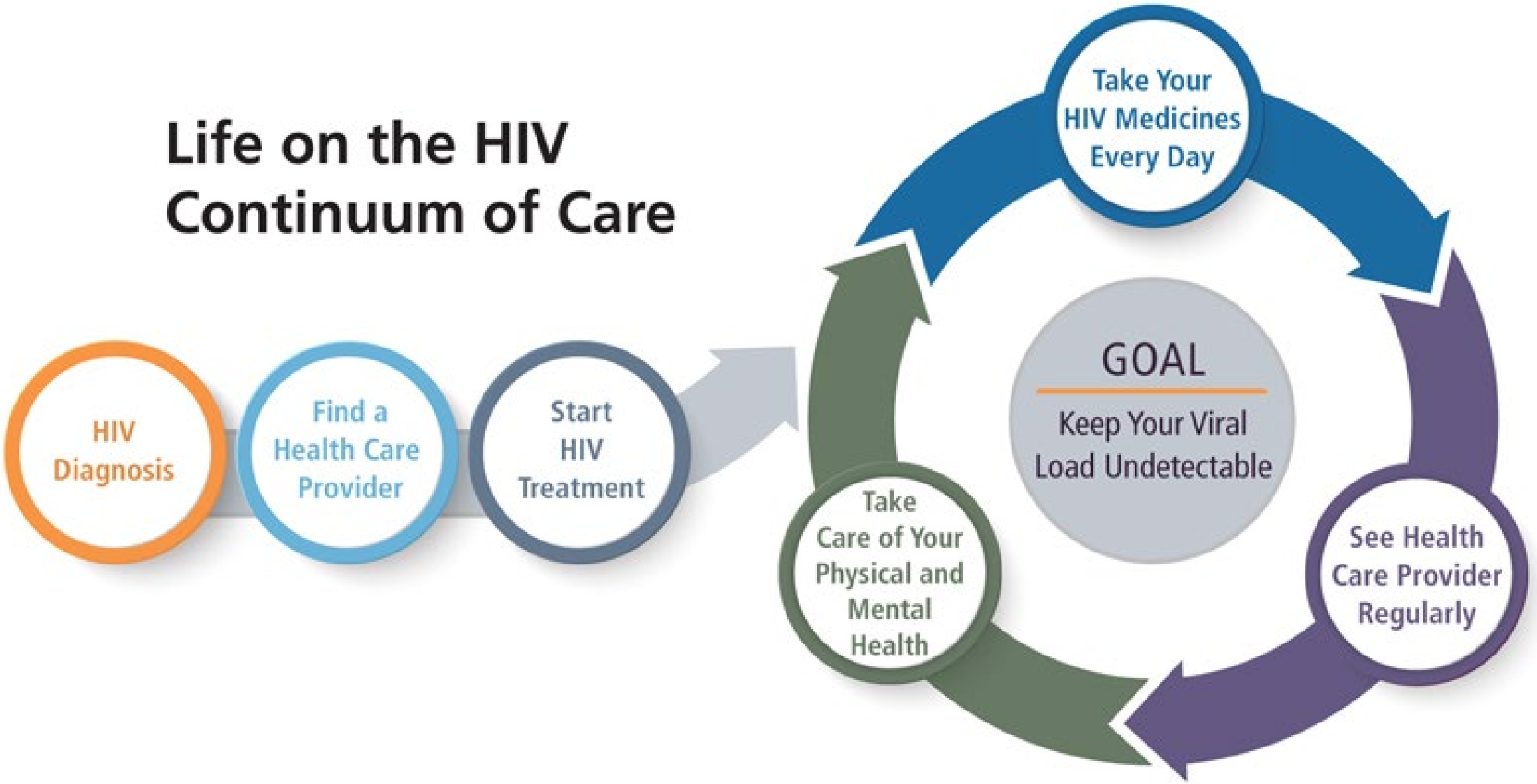


HIV Care

- **Most drugs don't interact with gender-affirming hormones**
- **Require closer hormone monitoring**
- Drugs most like to interact:

- Etravirine
- Nevirapine
- Elvitegravir (+/- cobicistat or ritonavir)
- Protease inhibitors (+ cobicistat or ritonavir)

https://clinicalinfo.hiv.gov/sites/default/files/guidelines/archive/AdultandAdolescentGL_2021_08_16.pdf.



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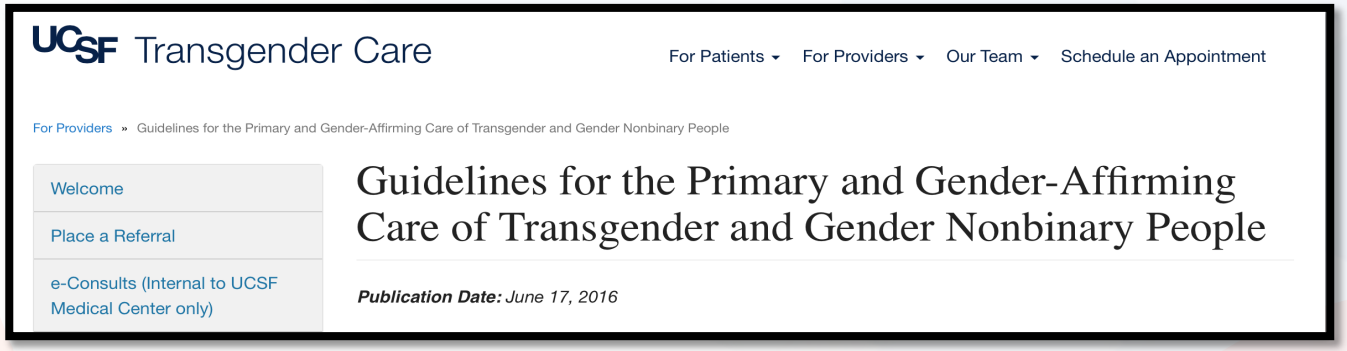

Online Resources

Practice Cultural Humility

"Proposes change through a lifelong process of learning, including self-examination and refinement of one's own awareness, knowledge, behavior and attitudes on the interplay of power, privilege and social contexts"

How can you make your practice/health system more inclusive to transgender patients?

Tervalon, M. & Murray-Garcia, J. (1998) Cultural humility versus cultural competence: A critical distinction in defining physician-training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9(2), 117.

Thank you and Questions!

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