Trans* Healthcare

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October 16, 2017

Disclosures

- Financial: none
- Self-taught and still learning!

Objectives

- Appreciate the importance of trans* health issues
  - Including in context of HIV
- Describe components of building a safe/queer friendly practice
- Approach a patient disclosing they think they are transgender
- List requirements for diagnosis of gender dysphoria
- Approach learning resources in your city/province works for trans* patients
- Describe hormone prescription
- Describe surgical procedures and which are covered for trans* patients
- Describe some health maintenance/health promotion for trans* patients
- Make special considerations in HIV treatment in a trans* patient
- Visit reference websites for patient education (sex, transitioning, risk factors to be aware of)

Outline

- Context
  - Psychological impact
  - HIV in trans* population
- Supporting a trans* person
- Therapy
  - Medications
  - Surgery, coverage
  - Preventive screening
- Resources

Psychological impact

- High prevalence of suicide and suicidal behavior in gender dysphoria population
- No strong studies yet on reduction of suicide rates and suicidal behavior following transition
- Need for psychological care before, during & after transition
  - Recommended in town by Dr. Bellows: Beve Gartner @ Lebell
  - Dr. Bellows (psychiatrist) & nurse Kelly
- Hormonal treatment → better psychological quality of life
- Discrimination, destigmatization

HIV in the trans* population

- Behaviours related to homelessness, discrimination/abuse, sex trade and negotiating sex
- Some studies (such as qualitative study by Trans PULSE) found discrimination and lack of trans-specific resources were barriers to HIV care and testing
- Lancet systematic review/meta-analysis (Baral et al, 2013): 19.1% HIV prevalence in trans women worldwide (n=11,066)
  - Highest at 21.6% in high-income countries
  - Caveat: high-risk subgroups, such as sex trade workers
  - Mix of lab testing & self-report
- 1.4% self-reported HIV prevalence is 2015 US Transgender Survey
  - 3.4% in trans women
  - 0.3% in trans men
  - 0.4% in nonbinary people
- Canadian AIDS Society Trans Needs Assessment Report (n=460, Sept 2013-Jan 2014)
  - 0.8% self-reported HIV+
  - 39% never tested + 35% not tested in past 1 year

HIV in the trans* population, ctd.

- Trans Youth Health Survey
  - n=923, ages 14-25, across Canada, surveyed Oct 2013-May 2014
  - 10% of trans* youth traded sex in their lifetime
  - 6-17% of trans* youth used some type of illicit substance from Ritalin to prescription opiates
- Trans PULSE study
  - Ontario, n=433, published 2012
  - 19% of trans women & 7% of trans men participated in “high risk” sexual activity in the past year (oral or genital sex with no barrier method)
  - 0.8% used injection drugs (besides hormones) in past year
  - 3% of trans women & 0.6% of trans men had HIV
  - 46% never tested for HIV
- No database data on how many people with HIV identify as trans* in Canada

Components of trans* friendly practice

- Ask, don't assume
- Use patient's own terms: trans*, transgendered, trans man/trans woman, male/female, transsexual, genderqueer, nonbinary, other
- Also ask about gender of partners when asking about sexual activity
- Train admin staff & colleagues to address by preferred name & pronouns
- Make chart note (on my EMR, in Demographics tab) to address by preferred pronouns
- Address "gender" on EMR
    - Pt's presentation vs. what's on their health card

A patient discloses they think they're transgender

- Open-ended, gentle
- How long they've had thoughts like this
- Behaviours, such as tucking, dressing, play
- If thinking of transitioning / ready to
  - Hormones?
  - Surgery?
- Mood (depression/mental health screen)
- Partner(s)
- Supports
- Anticipated challenges to transitioning
- Physical: assess puberty (if applicable)
- Labs: consider liver function, CBC, renal, lipids, diabetes screen
- Plan: psychiatrist +/- counselor, gamete banking

Gender dysphoria Dx

Children

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Adolescents/Adults

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Trans* network

- Officially, under development in SK
- Ask around - once you know one provider who works with trans* patients, ask them who they know
  - In Regina
    - Psychiatrist: Dr. Anne Bellows @ 2110 Hamilton - retiring :(
      - Now: Dr. Sarah Dungavell in Saskatoon
    - Internist: Dr. Tom Perron @ Queen City Medical Specialists
- Advocate: ask other providers (Ex. plastic surgeons) if they'd be willing to provide services for trans* patients

Trans* medical therapy

- Puberty blockers: GnRH analogues: fully reversible
- Hormones: partially reversible
  - Risks
    - MTF: liver/kidney dysfunction, venous thromboembolism, cardiovascular
    - FTM: cardiovascular, mood, liver dysfunction, polycythemia, uterine bleeding
    - Both: infertility
- Surgery: irreversible

Medications: Puberty blockers

- Puberty blockers: reversible, for <14-16 yo (16 per WPATH guidelines), Tanner stage 2+
- Leuprolide (Lupron) IM injections q1mo

Medications: Hormones: Male-to-female (MTF)

Source: Endocrine Therapy for Transgender Adults in British Columbia, transhealth.phsa.ca

+/- progestins
- ?nipple development

	Estrogen			Androgen antagonist				
Agent	17β-estradiol			spironolactone	***and/ or***	finasteride	***and/ or***	Cyproterone acetate
Administration	Transdermal	***or***	oral	oral		oral		oral
Brand name	Estradot®, Estraderm®, Oesclim®		Estrace®	Aldactone®		Proscar®		Androcur®
Pre-orchiectomy	*Use transdermal if >40 yrs or at risk for DVT* start at 0.1 mg/24 hrs, applied twice per week; gradually increase up to maximum of 0.4 mg/24 hrs, applied twice per week		*Oral is an option if <40 yrs and low risk for DVT* start with 1–2 mg qd; gradually increase up to maximum 6 mg qd	start with 50–100 mg qd; increase by 50–100 mg each month up to average 200–300 mg qd (maximum 500 mg qd) *modify if risks of adverse effects: see below§*		2.5–5.0 mg qd for systemic anti-androgen effect; 2.5 mg every other day if solely for androgenic alopecia		25-50 mg qd
Post-orchiectomy	0.025–0.1 mg/24 hrs, applied twice per week		1–2 mg qd	25–50 mg qd		2.5 mg qd		0 mg qd

Medications: MTF

Monitoring

- Incr estrogen & spironolactone until testosterone suppressed
  - Check estrogen level if not achieving desired results with suppressed testosterone
  - 3 mo after dose change, then q3-6mo
- Adverse effects: renal panel, liver panel, prolactin, cholesterol, diabetes screen

Expected changes

- 1-6 mo: body fat redistribution
- Anorgasmia, decr erections, decr ejaculate
- Testicular volume ↓ 25% in 1st year, 50% over time
- 3-6 mo: breast buds
  - Max breast development at 18-24 mo

Medications: Hormones: Female-to-male (FTM)

Source: Endocrine Therapy for Transgender Adults in British Columbia, transhealth.vch.ca

	Intramuscular injection (esterified testosterone)		Transdermal gel	Transdermal patch
Agent	Testosterone cypionate	Testosterone enanthate	Testosterone crystals dissolved in gel	
Brand name	Depo-Testosterone®	Delatestryl®	AndroGel®	Androderm®
Pre-oophorectomy	40-50 mg every week; adjust after one month to ensure blood testosterone is in the middle of the normal male range. Thereafter, adjust as needed to suppress menses and acheive visible secondary masculine characteristics (voice change, and body/facial hair, upper body muscle mass). (typically 50–100 mg every week, or 100–200 mg every 2 weeks) *ensure patient knows how much to inject – there are 100 mg/mL (cypionate) and 200 mg/mL (enanthate) preparations*		5–10 g qd; start with 2.5 g qd if there are comorbid conditions that may be exacerbated by testosterone (see discussion below)	5–10 mg/24 hours, applied daily; start with 2.5 mg patch if there are comorbid conditions that may be exacerbated by testosterone (see discussion below)
Maintenance (after 2 years)	Reduce to level needed to keep serum testosterone within the male reference interval (page 14). Monitor risk of osteoporosis.			

Medications: FTM

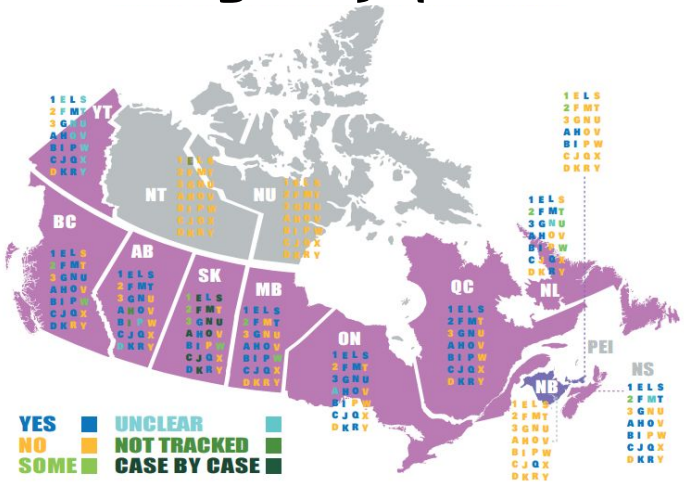
Monitoring

- Testosterone: 1-3 mo after dose change, then q6-12mo
  - Trough/midcycle if IM
- Adverse effects: CBC (Hct/Hgb), diabetes screen, cholesterol, liver enzymes q3-6mo

Expected changes

- More variable
- Clitoral growth
- Body fat redistribution / muscle mass
- Hair growth / male pattern baldness
- Voice changes
- Libido
- Amenorrhea

Coverage by province



British Columbia (BC)☑ Alberta (AB) ☑ Saskatchewan (SK)☑ Manitoba (MB)☑ Ontario (ON)☑
Quebec (QC)☑ New Brunswick (NB)☑☒ Nova Scotia (NS)☑ Prince Edward Island (PEI) ☑☒
Newfoundland & Labrador (NL)☑ Yukon (YT)☑ Northwest Territories (NT)☒ Nunavut (NU)☒

SRS coverage	1	Labiaplasty	E	Mastectomy	L	Private clinic stay	S
Surgery available in province	2	Clitoroplasty	F	Scrotoplasty	M	Travel	T
Use CAMH	3	Vaginectomy	G	Erectile and Testicular implant	N	Services outside of Canada	U
Penectomy	A	Hysterectomy	H	Clitoral release	O	Facial feminization	V
Orchiectomy	B	Salpingo - oophorectomy	I	Chest contouring/ Chest Masculinization	P	Voice and Communication Training	W
Vaginoplasty	C	Metoidioplasty	J	Assess for hormone therapy	Q	Tracheal shaving	X
Breast Augmentation	D	Phalloplasty	K	Counseling	R	Laser/hair removal	Y

Source: CPATH

- Only GRS clinic in Montreal provides bottom surgeries: grsmontreal.com
- Canadian Association of Mental Health approval required in SK & ON
  - Referrals to approved psychiatrists
- Facial feminization, tracheal shave & hair removal always private
- Some provinces provide funding for surgeries outside Canada

Preventive screening

- Regular osteoporosis screening with bone mineral density: consider earlier for adolescents on GnRH analogs
- Paps for trans men if they still have a cervix per routine guidelines for women: starting age 21, q2yrs until 3 normals, then q3yrs
- Mammography for trans men per routine guidelines for women: q2yrs >50 yo or start at 10 yrs younger than 1’ relative got breast Ca
    - Likely still have residual breast tissue even if had mastectomy
    - This tissue is difficult to evaluate on mammogram
- Prostate cancer screening already not recommended generally for men anymore, but consider for trans women with strong FamHx or of African descent

HIV meds + hormones

- No relevant drug interactions between antiretrovirals used in SK and hormones (UCSF Centre for Excellence in Transgender Health guidelines)
- Spironolactone + TMP/SMX for CD4 under 200
  - Hyperkalemia
  - Monitor renal panel q1-4weeks

Resources

For patients/general public

- Paps for trans men: checkitoutguys.ca
- Trans Care BC: transhealth.phsa.ca
- CATIE safe sex patient guides
  - Brazen, Trans Women's Safer Sex Guide
  - PRIMED^2, A Sex Guide for Trans Men into Men
- GRS Clinic in Montreal: grsmontreal.com
- Local organizations
  - TransSask: transsask.org
  - Trans Umbrella Foundation: transumbrella.org
  - University of Regina Pride Centre: urpride.ca

For service providers

- World Professional Association for Transgender Health (WPATH): wpath.org
- Canadian Professional Association for Transgender Health (CPATH): cpath.ca
- Trans Care BC guidelines: transhealth.phsa.ca > Service providers
- Canadian AIDS Society Trans toolkit for community service organizations: http://www.cdnaids.ca/trans-toolkit-practical-resources-community-based-organizations/
- Trans PULSE project (Ontario): http://transpulseproject.ca/