HRT & TransCare Coordination

An intro the art of gender-affirming care

Welcome to the world of transcare

What will this lecture help you to do?

- Give you an overview of the process of medical transition (HRT & surgery)
- Give you an idea of what's involved, even if you don't prescribe HRT, so you can work with your transgender patients.
- Gives you the basics of prescribing HRT
- Gives you the basics of referring for gender-affirming surgeries

This is an evolving field

- Standards & protocols are there however
- Network with the larger medical community that cares for transgender folks – MDs, DOs, ARNPs, Pas (some) – also MHP
- References and guidelines – Fenway, Lyon-Martins, Kaiser-Permanente
- Transhealth.ucsf.edu – gold standard (IMHO)
- *Lesbian, Gay, Bisexual and Trasngender Healthcare* Eckstrand, Ehrenfeld (Springer, 2016)
- http://www.cedarriverclinics.org/transtoolkit/

This doesn't cover basics of gender dysphoria, pronouns, etc.

Resources provided after the lecture as needed.

Overview For all genders:

what brings you here today?

Preferred name, pronouns, and how do they describe their gender.

Full history & PE

- active & past medical conditions,
- medications & supplements,
- sexual hx, family hx.
- PE – height, weight,
- BP,
- cardiac (murmur, edema, carotid bruit).

Info about the gender journey:

Tell me how you came to this decision

How do you identify?

When did you first notice that you didn't identify with the assigned gender?

How long have you been thinking about HRT?

Goals for transition:

- Body
- Social
- Emotional

Psychosocial assessment

- Employment/job
- Housing
- Partner, roommates, friends – support
- Working with therapist? if not, ask about a referral to one
- STI testing – discuss and protection
- Fertility: discuss. If desired, refer for egg harvesting, sperm banking.

Therapy or not?

WPATH standards – patient sees therapist before starting HRT; to aid in decision making; historically diagnosed patient with gender dysphoria

Informed Consent – patient may or may not see a therapist. Patient makes decision on their own.

The "Just In Case" approach – patient makes decision, has therapist on hand for support during transition.

Gatekeeper? Empower-er?

What's your role?

Who knows the patient's gender identity? They do. We listen. They'll tell us.

Determine if there are any medical contraindications and cautions, how to support them.

Assess (as you would any patient) for ability to give informed consent.

While the patient knows their gender identity… as providers we have to verify that they have that 'Diagnosis".

Can be binary, non-binary, gender-fluid.

Informed consent:

- **Even if patient has seen therapist, go over benefits and risks.**
- **I cover and send home – sign next time**
- Different forms online – look for Fenway's forms, reliable

Contraindications for HRT:

Feminizing: VTE, active hormone-sensitive cancers (if hx consult oncologist), actively suicidal.

Masculinizing: Active hormone-sensitive cancer, out of control diabetes, active unstable coronary artery disease.

Comorbidities that are of concern:

Feminizing: DM, HTN, tobacco use, obesity, gallstones, hypotension, hypertriglyceridemia, mood disorders

Masculinizing: tobacco use, obesity, DM, HTN, OSA, mood disorders; sometimes AI, migraine

Comorbidities that are of concern:

CVD: does not appear to increase in TG men, may be more prevalent in TG women, but studies have not controlled for other factors.

Diabetes: recommended be controlled prior to HRT, but no guidelines, patients often improve after HRT initiation.

Now is a good time to find out the payor's policy for HRT

- Some payors have policies that patient MUST see a therapist for a minimum length of time before starting HRT.
- Only way to know is to call, find out. You may be able to google and find that particular policy.
- WA state Medicaid does not require therapy prior to HRT.
- You can however still run labs and address other health issues.
- This is a GREAT time to get people to quit smoking, use safer sex, and get a move on a better diet and exercise program.
- However, don't refuse hormones unless CI is present. (Note that hx of VTE + current smoking is probably a CI or close to it.)

A note about hormones

- These are bio-identical hormones. 17-beta-estradiol and testosterone USP.
- Commercially available are fine. Not necessary to compound unless shortage or sensitivity to an excipient.
- Topicals are more difficult to transition with, may work for later when lower levels are suitable.
- Do NOT use OCPs or conjugated estrogens – those are suitable for contraception, but not necessary here.
- Testosterone – oral forms are not used. Exception is buccal tabs. These are $$$$$. Patches are $$$$.
- Liver problems associated mainly with methyltestosterone (oral) and long-term use of the enanthate form.

Feminizing HRT

- Get Labs: Lipids, CMP, CBC; some add T, prolactin; HIV, STI screen
- Discuss What will change – permanent, reversible
- What won't change: Voice, hair, laryngeal prominence, frame/skeletal structure.
- Fertility: can't guarantee either absence or return (if HRT d/c)

Risks and SEs:

- **Estrogen-related: Thromboembolic disease, gallstones, possibly prolactinoma, BrCa; possibly CVA/CVD.**
- **if VTE occurs: d/c estrogen during acute VTE phase and treatment; resumption depends upon a number of factors.**
- **Spironolactone-related: hyperkalemia, orthostatic hypotension, prerenal azotemia (d/t volume depletion)**
- **Sometimes depression.**

AntiAndrogens

- spironolactone; K+ sparing, has anti-androgen receptor activity; suppresses T synthesis
- Avoid in those with renal insufficiency
- Caution & monitor if on ACE inhibitor or ARB
- May produce polyuria, polydipsia, orthostatic hypotension

Start with estradiol only? A new protocol

- "The estrogen receptor agonist activity of spironolactone may play a role in reduced breast development due to premature breast bud fusion. As such an escalating regimen beginning with low dose estrogen only, and titrating up over several months, and then adding spironolactone may be an alternative approach,[17] consistent with management practices in children with delayed pubertal onset (Grading: T O W). Upward titration of spironolactone can also help minimize side effects such as orthostasis or polyuria. It is recommended that providers discuss these considerations with patients before initiation of hormones in order to make an informed decision."
- http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy

Hormone	Initial-low	Initial	Maximum	Comments
Estrogen				
Estradiol oral/sublingual	1mg/day	2-4mg/day	8mg/day	**if >2mg recommend divided bid dosing**
Estradiol transdermal	50mcg	100mcg	100-400 mcg	**Max single patch dose available is 100mcg. Frequency of change is brand/product dependent. More than 2 patches at a time may be cumbersome for patients**
Estradiol valerate IMa	<20mg IM q 2 wk	20mg IM q 2 wk	40mg IM q 2wk	**May divide dose into weekly injections for cyclical symptoms**
Estradiol cypionate IM	<2mg q 2wk	2mg IM q 2 wk	5mg IM q 2 wk	**May divide dose into weekly injections for cyclical symptoms**
Progestagen				
Medroxyprogesterone acetate (Provera)	2.5mg qhs		5-10mg qhs	
Micronized progesterone			100-200mg qhs	
Androgen blocker				
Spironolactone	25mg qd	50mg bid	200mg bid	
Finasteride	1mg qd		5mg qd	
Dutasteride			**0.5mg qd**	

Titrate estradiol up over 3-6 months, depending on Patient response and serum hormone values, as well as comorbidities.

Monitoring from http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy

Test	Comments	Baseline	3 months*	6 months*	12 months*	Yearly	PRN
BUN/Cr/K+	Only if spiro used	X	X	X	X	X	X
Lipids	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					X
A1c or glucose	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					
Estradiol			X	X			X
Total Testosterone			X	X	X		X
Prolactin	**Only if symptoms of prolactinoma**	**depends; checked by some**					X

Monitoring

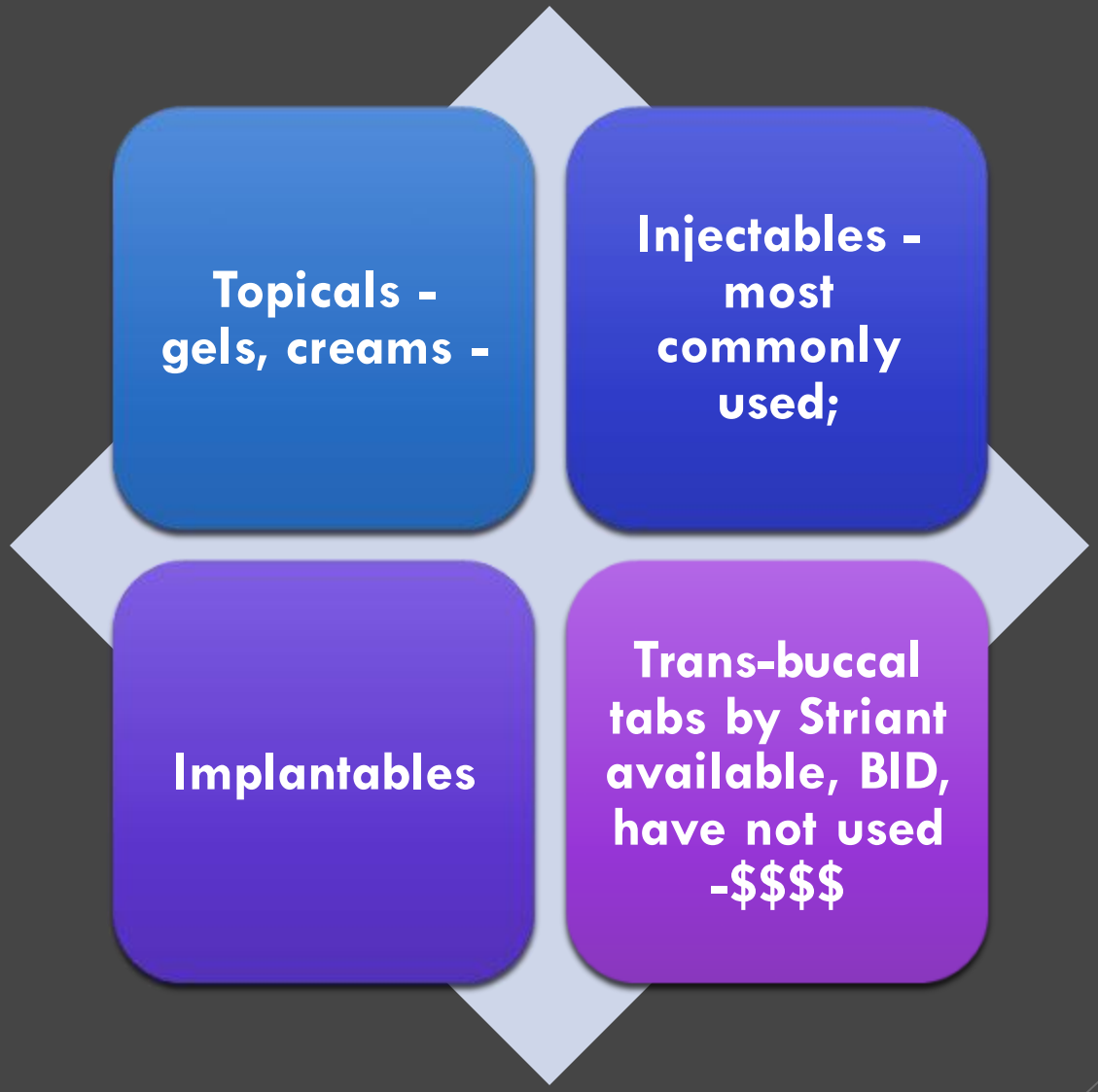
Monitoring from http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy

Aim for ~ 200 pg/ml estradiol levels. May fluctuate,. Stay within physiological menstruating female ranges
Other labs: read according to female ranges, but serum creatinine, HCt/HGb and Alk Phos use male ranges.

Masculinizing HRT

- Get Labs: CMP, CBC; some add E, prolactin; HIV, STI screen
- Discuss What will change – permanent, reversible
- What won't change: Breasts,height, hips
- Fertility: can't guarantee either absence or return (if HRT d/c)

Testosterone



Changes, Risks and SEs:

- **Voice lower, amenorrhea, muscle development, hirsutism, clitoremegaly, increased libido**
- **Hair loss, acne, oily skin, irritability (some) – many have mood improve**
- **Polycythemia/erythrocytosis – interpret in male range if amenorrheic.**
  - **Check peak level T, use transdermal; Increase dosage frequency while reducing amt given at one time (e.g. give 0.25 ml twice a week rather than 0.5 ml once a week); workup as needed. May need to reduce dose.**
  - **Address BMI, smoking, OSA as needed.**
- **Labs – increase in HCT, lipids, serum creatinine, AlkPhos. Read in male ranges generally.**

http://transhealth.ucsf.edu/trans?page=guidelines-masculinizing-therapy

Androgen	Initial - low doseb	Initial - typical	Maximum - typicalc	Comment
Testosterone Cypionate	20 mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	**For q 2 wk dosing, double each dose**
Testosterone Enthanate	20mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	"
Testosterone topical gel 1%	12.5-25 mg Q AM	50mg Q AM	100mg Q AM	**May come in pump or packet form**
Testosterone topical gel 1.62%d	20.25mg Q AM	40.5 - 60.75mg Q AM	103.25mg Q AM	"
Testosterone cream	10mg	50mg	100mg	
Testosterone axillary gel 2%	**30mg Q AM**	**60mg Q AM**	**90-120mg Q AM**	**Comes in pump only, one pump = 30mg**

"Titration upwards of dose should be driven by patient goals, in the context of clinical response, hormone level monitoring, and safety monitoring (i.e. hemoglobin and hematocrit [H&H])."

Therapy	Comments	Baseline	3 months*	6 months*	12 months*	Yearly	PRN
Lipids	No evidence to support lipid monitoring at any time; use clinician discretion	Based on USPSTF guidelines					**X**
A1c or fasting glucose	Same as lipids	Based on USPSTF guidelines					**X**
Estradiol	Aim for male ranges						**X**
Total Testosterone	Male ranges		X	X	X		**X**
Hemoglobin & Hematocrit		**X**	**X**	**X**	**X**	**X**	**X**

Monitoring: http://transhealth.ucsf.edu/trans?page=guidelines-masculinizing-therapy

How often do I increase dose?

"Titrate upwards depending on patient response"

For all genders and hormone regimes:

- You will find that you are told to increase dose in response to patient response and other factors.
- In practice, doses are increased over 3-6 months.
- Go slower if LITs, CVD, or other disorders exacerbated by the hormone exist – give body time to process it. Puberty doesn't happen overnight.
- Transmen will typically be at max dose (0.5 ml of 200 mg/ml testosterone cypionate) by 3 months, unless they are having elevated RBCs or need to go more slowly due to comorbidities.
- Transwomen may vary depending on how quickly they metabolize estrogen. Typically though 3 months is where they are at max dose.
- This really is individualized. Think making risotto, not microwave popcorn. Add hormone, evaluate, measure; adjust dosage, evaluate, measure. Takes time to see how a particular dose is doing.

Contraception - all genders

Contraception: If having penetrative sex with a partner, one partner has a penis, the other ovaries and uterus.

Contraception: typically IUD, progestin-only method, implants, injections. Condoms.

And HIV PrEP: if at risk for HIV transmission due to sexual activity – any gender.

Other medications.

Estrogens (topical/orals) - typically rings (Estring), inserts (Vagifem), creams - vaginal dryness or spotting with sexual activity

Aromatase inhibitors: if menses continue, elevated Estradiol, slow changes

Transgender Care Coordination

Surgery, therapy, other services

Surgeries – what's the role of the provider managing hormones or PCP?

- For Medicaid, you will be asked to:
- Refer the patient to the surgeon;
- Coordinate post-surgical care for the patient;
- Send a letter to Medicaid discussing what arrangements have been made;
- If the surgeon is not in network with Medicaid, you may have to preauthorize the initial surgery consult visit.
- You will also handle referrals to presurgical hair removal providers
- May need to find/locate therapists to sign off on the required letters for the surgery.
- You will have needed to have seen the patient within a certain period of time prior to writing the referral (so, ask them to come in if you haven't seen them in a while).

CHECK WITH INSURANCE!

- AND check with the surgeon!
- Most insurances and surgeons follow some form of WPATH for requirements
- However, they each have their own procedures/processes/paperwork.
- Surgeons sometimes have particular requirements about smoking, BMI, maybe when patient last saw you.
- Checking ahead of time will save time later.
- Yes, ask the patient to check – however I like to call the surgeon myself, find out the requirements.
- Self-pay patients – they have more leeway.

General process: getting started

- Ask about surgeries at the time you first see patient
- Document when they bring it up during other visits. This helps when it comes to time to refer, you've got a record of it.
- Usually most payors and surgeons want a year on hormones and/or living/presenting as identified gender prior to surgery, but can start process before then.
- When ready to start referral, I like to sit down with patient, document what they want, go over the surgery in general – e.g. esp. post-surgical care needs.
- Again, UCSF Center of Excellence for Transgender Health is a good guide.
- Kaiser-Permanente – SF – has good resources (patient oriented) https://mydoctor.kaiserpermanente.org/ncal/promotions/#/transgendercare

Letters

Many providers share templates. Take advantage of these.

Information required typically: how long you've seen patient, how long on hormones, any comorbidities and how well-controlled they are, general stability of mood (okay to have psych conditions, need to be stable however).

Typically discuss that patient has sufficient post-surgical care and support.

Chest surgery (transmasculine)

- For Medicaid: Alexandra Schmidek MD at Virginia Mason (local), Geoff Stiller MD out of E. WA; possibly OHSU. May be others.
- Other payors may have their preferred surgeons.
- Javad Sajan MD Seattle, Art Foley MD in Olympia, Tony Mangubat MD Renton - check for insurance coverage. Jeffrey Kyllo MD, Keith Paige MD – Polyclinic.
- Typically need one letter from therapist (must be approved by Medicaid for Medicaid patients). May be restrictions re: BMI and smoking.
- Make sure patient has help at home for a week.
- Post-surgical recovery – plan two weeks down and six weeks to get back to “normal”.

Hysterectomy

- Done less often now – less concern about uterine cancer in FTMs. Used to be considered near-mandatory.
- IS done for gender dysphoria.
- Some transmen get severe pelvic cramping, hysto resolves it.
- Typically, refer to good gynecological surgeon, but worth it to find someone who has worked with this population.
- Swedish Ob-Gyn for women and Nicki Ingresano MD; were doing hystos for FTMs before it was “cool”.
- Some types of hysterectomy may make later types of gender-affirming bottom surgery more difficult – e.g. abdominal hysto with those getting abdominal phalloplasty.

Orchiectomy

- Elected by some to stop testosterone production.
- Reduces gender dysphoria
- In Seattle, one doctor I send to is Emily Bradley MD
- Two letters needed (Medicaid, probably others)
- Should be performed by surgeon familiar with transgender surgery as a particular procedure is needed to leave sufficient scrotal skin to build a neovagina later.
- Note: you will be surprised how many of your transfeminine patients “tuck” or push their testicles into the inguinal canal.
- Emphasize these body parts can be used to build neovagina – keep them in good condition!

Vaginoplasty

- Complicated, different varieties of procedures
- This is not outpatient! Plan for several weeks of downtime.
- Start electrolysis (genital) a good year ahead of planned surgery.
- Coordinate post-op care with trans-competent MD/DO, granulation tissue may require removal (probably beyond our scope) – Linda Mihalov MD
- Start referral to surgeon for consult- call surgeon to see if they will do the pre-authorization with Medicaid (or insurer) or if you need to do so.
- Medicaid: write letter affirming that you've got arrangements made and that patient is a good candidate.

Danica Roem, VA state representative
Laith Ashley, model

Gender Affirming Care: Providing the space and care for people to be reborn into their own lives.

Few of your patients will be this famous.
All will be important.

Continue Learning!

Gender Odyssey

Swedish CE

Kaiser Permanente

We shall not cease from exploration,
and the end of all our exploring will
be to arrive where we started and
know the place for the first time.

T. S. Eliot