TREATING TRANSGENDER & NON-BINARY PATIENTS

A Manual For Clinical & Non-Clinical Staff in Primary Care Settings

Spirit Level Transgender Support Group
spiritlevel.org.uk
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Spirit Level

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Treating Transgender Patients Presenting Problems

Gender Incongruence/Confusion and the symptoms of Gender Dysphoria may be a chronic condition but it is likely the patient has reached a crisis or turning point in their lives and will be desperate for help.

More and more people are starting to understand that they maybe gender incongruent - to a greater or lesser degree - but many will not be aware of this possibility and present with problems of depression, anxiety, anger management issues and so on. Part of the challenge to GPs is to take the time to drill down into why the patient is experiencing these symptoms and act accordingly.

a) The Transgender (Transitioning) Patient

Some patients, especially younger patients, will come to the practice seeking a referral to a Gender Identity Clinic as the first step to transitioning physically, to obtain gender-affirming treatment and - eventually - surgery.

- Explore counselling options (but be aware of long waiting times). Recommend peer-to-peer support. Advise on talking therapies.
- Discuss possibility of social transitioning and support networks (if any) as an interim step.
- Proactively consider bridging or gender-affirming hormones as a therapeutic regime and as a palliative while waiting for a GIC consultation.
- Discuss any parenthood or fertility issues. Hormone treatment cannot start until after sperm donation and storage of gametes and waiting times at local fertility clinics can be very long so an early referral may be indicated.
- Refer EARLY to Gender Identity Clinic (GIC). You will find a list of NHS and community GICs with their waiting times here.
- If the patient is self-medicating, ensure regular blood and endocrine tests and advice on disease prevention programmes (e.g. prostate cancer for transwomen).
- Don’t manage the GIC’s waiting list by questioning a patient’s need for or commitment to transitioning.

NHS Guide For General Practicioners:
www.nhs.uk/Livewell/Transhealth/Documents/gender-dysphoria-guide-for-gps-and-other-health-care-staff.pdf

b) Help To Cope With Gender Incongruence & Confusion

Patients will seek help with the symptoms that arise from gender incongruence, usually mental health issues (depression and thoughts of self-harm and suicide) and resultant negative behaviours e.g. self-harm, alcohol and drug abuse, risk-taking, risky sexual behaviours etc.

- Refer for counselling and talking therapies (but be aware of waiting times).
  Advise about on-line therapies, crisis centres and helplines (e.g. The Samaritans)
- Recommend accessing peer support where available but be aware of the limitations of this assistance
- Consider prescribing (low level) HRT for therapeutic reasons (sense of well-being, stabilising emotions, decreasing symptoms of gender dysphoria, reducing harmful triggers)

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c) Help With Socially Transitioning

Because waiting times for clinical services such as diagnosis, development of a care plan, prescribing and surgery can be so long, one of the primary roles of a GP and their practice can be to support 'social transitioning'. Social transitioning is the process of living a gender congruent life without chemicals or surgery (at least initially).

Social transitioning, counselling and/or bridging hormones are the primary tools a GP has in dealing with the symptoms of gender dysphoria. And it can start in the doctor's surgery.

Remember: The NHS is currently applying the principle of 'informed consent'.
The patient knows best what their condition is and the most appropriate form of treatment.
They just need your help getting it.

General Approaches To Treating Transgender Patients

The role of the General Practitioner (GP)

"A supportive GP can be crucial to the longer-term health of people with Gender Dysphoria, with some patients requiring more support at the primary care level than others might. It is not acceptable for a GP to block or withhold treatment from dysphoric individuals on the basis of their own religious, cultural or other doctrinal beliefs around gender. GPs as well as other clinicians should recognise that surgery is not always wanted or needed and that hormone therapy may be sufficient for some people"

Source: www.nhs.uk/Livewell/Transhealth/Documents/gender-dysphoria-guide-for-gps-and-other-health-care-staff.pdf

a) Be Accepting and Open To The Transgender Condition

Confessing to or confiding a trans condition and describing the symptoms of gender dysphoria can be very stressful. Clinicians should do their best to put the patient at ease, be reassuring and welcoming. Treat the trans condition as a commonplace, matter-of-fact kind of condition. Ask:

a) Would the patient like to be seen by a doctor with more experience or training in this field?
b) How would the patient like to be addressed?
c) Would the patient feel more comfortable with a differently gendered doctor?
d) Would the patient feel more comfortable presenting in their acquired or presenting gender?

b) Don't Diagnose

Some doctors believe that they have a right and/or duty to try to diagnose whether a patient is truly 'transgender' or suffering from gender incongruence or dysphoria. **DON'T**.

Not everything's about gender. A person's gender identity isn't relevant for a lot of patient health concerns so take care not to assume that a patient's health concern is related to their transition or to transition-related health care.

Don't ask intrusive questions about sexual preferences, masturbation, how they dress or anything else. Many will also make a referral for psycho-sexual counselling as a way of either getting rid of or parking the client or even to try disprove they are transgender.

Transgender patients believe in 'informed consent', that a patient has the ability to decide for themselves if they are gender incongruent. Informed consent is beginning to be adopted as the best basis for treatment of transgender and non-binary patients across the NHS.

See GenderGP 'What Is Informed Consent', May 2020

c) Don't Be Intrusive

Don't ask questions about:

- Sexuality, sexual preferences or fantasies
- Clothes or lifestyles except as behaviours may impact on prescribing
- Genitals

d) Trans Is Not A Mental Illness

Don't insist on some form of counselling or referral to psycho-sexual services before offering help and treatment. Living with gender incongruence and dysphoria can cause depression and that in turn can lead to harmful behaviours. Patients may show signs of discomfort or distress which you as the GP will need to explore and offer solutions to e.g. counselling or anti-depressants. **These may include:**

- Low self-esteem
- Becoming withdrawn or socially isolated
- Depression or anxiety
- Taking unnecessary risks
- Neglecting themselves

www.nhs.uk/conditions/gender-dysphoria/

e) Be Professional

All patients should be listened, to treated with respect and given good person-centred care. And the fear of being mis-gendered, treated disrespectfully or even discriminated against has prevented many trans people from accessing health care.

f) Ask, Don't Assume

Ask about someone's gender identity, don't try to guess or just assume. Don't assume its a 'binary' thing. Some trans patients will be transitioning from an assigned gender to being non-binary. Always ask about which hospital ward your patient would prefer to be on.

g) Adopt a Person-Centred Approach

- Discuss the goals of the patient. Do they just want a better understanding of their condition and help to cope?
- Are they seeking gender-affirming hormones?
- How are they feeling emotionally and psychologically?
- What is their family situation? Can they come out, if not out already?
- Do they wish to medically/surgically transition?
  If so, discuss a) waiting times; b) the clinical pathway; c) potential issues which will need to be addressed (for instance obesity, heart disease, smoking etc)

- Discuss potential fertility issues and if the patient is interested in storing gametes, refer to the local clinic immediately (since hormone treatments can be delayed while waiting for a consultation and outcome)

Across The Practice

All parts of the service you provide (receptionists, admin staff, nurses, nurse practicioners and doctors) must not only accept but must proactively embrace and support the new gender identity. Using the correct names and pronouns, being welcoming, being pleased to see the patient and interested in their health and progress are vitally important and being a champion and advocate with other services will help the patient enormously.

Your Role And Your Obligations

- Respect how difficult it might have been to seek treatment
- Be proactive about changing personal details in records if asked
- Advise about gender-specific disease prevention, including opting out
- Discuss future family plans and fertility treatment options. If needed, make immediate referral due to waiting times
- Get informed about (reputable) private services e.g. Gendercare and GenderPlus
- Get informed about prescribing medicines you are not familiar with e.g. HRT for transwomen.

Be Welcoming & Inclusive

The practice can do a lot to create a positive relationship with transgender patients by:

- Displaying positive messages in reception areas, waiting rooms and surgeries
- Training staff to ASK the patient their preferred names, pronouns and titles
- Adopting procedures to always update records to reflect the patient's choices about name etc.
- Training staff to cope with service-users who may verbally disapprove of or harass trans patients or complain to you about them

What The BMA Says

The BMA offers sound advice which the trans community generally supports.
You can find useful guidance here:

www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/managing-patients-with-gender-dysphoria

www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/lgbtplus-equality-in-medicine/inclusive-care-of-trans-and-non-binary-patients

Social Prescribing

Social Prescribing aims to alleviate some of the social circumstances that can affect a person's health.

These might be low income, poor or inappropriate housing, financial problems, stress, social isolation, low mood and so on. It depends on being able to provide signposting and referral to appropriate agencies to provide focussed help.

Adopt A Whole-Person Approach

Don't just address the health problems and don't just address the circumstances that may be directly contributing to ill-health but try to understand how all these issues interact with each other and may be making things worse.

Refer To A Local Support Group

Do some research into local transgender and non-binary support groups or - if none exist - to a local LGBT+ group. A good place to start is the Live Well Directory: **www.thelivewelldirectory.com** (apply trans gender as a filter).

Sahir House, a local HIV/AIDS charity, is leading the way in offering all kinds of support to LGBTQ+ people, including running a gender-diverse group at its city centre location.

In-Trust: peer to peer support, social, provides training to public sector organisations. Chiefly in north of Liverpool and Sefton but open to all, has a close connection to Trans Health Merseyside and CMagic

Spirit Level: peer to peer support, advice, listening service, social, meets twice monthly

Trans Support Service

People may be referred (or may refer themselves) to TSS for specialist support BUT THERE IS A SIGNIFICANT WAITING TIME. The TSS therapist may be able to make referrals to support agencies to assist with difficulties relating to housing, employment, addiction or substance use; or relationship or sexual problems. They may also support GPs with any onward referral to a gender identity clinic and associated funding application if appropriate and with signposting to other local Trans-specific support agencies.

www.merseycare.nhs.uk/our-services/liverpool/trans-support-service-tss

Axess Sexual Health

The Axess service to LGBT people (its 'Butterfly' Clinic) seems to focus solely on physical sexual health and is not particularly trans-focussed. For instance, it says it can offer access to cervical screening for lesbians and bisexual women but doesn't mention trans men (who might still have a cervix after all).

www.nhs.uk/common-health-questions/sexual-health/should-trans-men-have-cervical-screening-tests

There are also national groups and agencies supporting transgender and non-binary people such as:

The Beaumont Society: www.beaumontsociety.org.uk

GIRES: www.gires.org.uk
GIRES also provides training in trans healthcare to primary care teams.

Mermaids: mermaidsuk.org.uk
Mermaids provides help and advice to young people and their families

Switchboard: LGBT+ helpline

Spectra: spectra-london.org.uk
Although London-based, Spectra does run regular on-line groups for trans people.

Transunite: www.transunite.co.uk
Although not a support group, it does list various local groups which might be suitable.

Advice About Good Health, Wellbeing and Mindfulness

Although an all-round, all-inclusive approach should be adopted, emphasize groups and initiatives around smoking cessation, losing weight, exercise and eating well since related conditions may be a barrier to gender reassignment/affirmation. Well-being and mindfulness can help with issues such as stress, low mood and depression which are bad in themselves but may also be preventing the person achieving their goals or finding solutions to other problems. If necessary, refer to the axess, the local sexual health clinic: **www.thelivewelldirectory.com/Services/1204**

Housing & Personal Finances

Advice about housing issues on Merseyside can be obtained from the Citizens Advice Bureau, Shelter, The Whitechapel Centre and The Merseyside Law Centre.

Advice about personal finances can be obtained from the Citizens Advice Bureau and the Greater Merseyside Money Advice Project: **www.gmmap.org.uk**

Names and Records

a) Language Matters

Use your patient's preferred name, title, gender and pronouns when talking to them and avoid labels like 'boyfriend' or 'girlfriend' - just say 'partner'. You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.

"Of all the things that could offend a trans person or lead them to feel misunderstood, excluded and distrustful, mistakes involving forms of gender-related speech are perhaps the most upsetting. Potentially they are also easiest to pay attention to getting right"

b) Procedures To Be Followed

There is no need for any evidence e.g. a Gender Recognition Certificate to change a name on a medical or other records. If the patient requests a gender change on records, you must:

- Notify Primary Care Support England
- Register them as a new patient but do not update the old record with the new NHS number
- Create a new medical record for that patient, transfer in all previous medical information but not the patient's previous identity
- Complete registration process within 5 days to avoid interruption to care

IMPORTANT: The personal details of trans patients e.g. previous names or gender status are protected by equalities legislation. Disclosing the personal details of a trans patient (e.g. their former name or gender status is a criminal offence).

pcse.england.nhs.uk/help/patient-registrations/adoption-and-gender-re-assignment-processes/

Advice To Trans Patients About How They Can Change Their Own Records

Helping a patient move forward in their journey towards expressing and living their true gender identity can bring benefits to their mental health and your relationship with the patient. So what forms of identity can be changed?

Without a Gender Recognition Certificate

- Name (by deed poll or statutory declaration)
- Passport (requires a doctors letter)
- Driving Licence (gender markers can also be changed)
- DWP details (name, title)
- Bank Accounts etc

With A Gender Recognition Certificate

- Birth Certificate
- DWP details (gender, NI number, pension entitlements etc)

Disclosing the personal details of a trans patient e.g. former name or gender status is a criminal offence

Social Transitioning

‘Social Transitioning’ is the process by which a person begins to express and live their true gender identity without physically transitioning.

This may involve changes in appearance and behaviours which have to be accommodated and respected across the practice, for instance by changing names and gender markers not just in the surgery but also with other parts of the NHS. It may involve prescribing gender-affirming hormones, counselling and the help of local trans/non-binary or LGBT+ support groups.

Social transitioning may include changed names/pronouns, appearance and behaviour

- For transwomen this includes hair removal, breast forms, hair styling, padding, voice feminization
- For transmen this may include binding breasts, wearing a ‘packer’, masculine haircuts, beard dye (as hormones begin to change appearance)

If a patient is socially transitioning, you may need to keep track of how the process is going:

- If the patient has come out to friends and family as transgender or non-binary, how did it go? Does the patient have the support they need?
- How does the patient feel if they are being mis-gendered (people are not using the patient’s preferred pronouns though inadvertence or as a form of disrespect or bullying)
- If the patient has adopted a different name, has that been accepted by friends, family and people at college or work? If not, how does that make the patient feel?
- If the patient is dressing/grooming differently, is that being accepted by other people. And how does it feel to dress/groom in the way that feels best for them?
- If the patient has adopted other gender-affirming behaviour (for instance using their voice differently), what has been the response?

All of this change can be life-affirming but also very stressful. Discuss a care plan that includes exploring likely responses from family, school and work and puts in place support arrangements.

Trans and non-binary people strongly support social transitioning and it is increasingly the choice of transgender and non-binary young people who do not wish to and may never pursue physical transitioning.

Clinical Services To Transitioning Patients

GIC waiting times are so long, social transitioning may be the only option for trans people embracing a new gender identity

- **Refer EARLY to Gender Dysphoria Clinic (GDC)**. Refer to the closest GDC but offer the full range of choices. Research waiting times at individual GDCs (see Appendix). **How To Find A Gender Dysphoria Clinic:** www.nhs.uk/nhs-services/how-to-find-an-nhs-gender-identity-clinic/
- Don't manage the GDC's waiting list by questioning a patient's need for or commitment to transitioning.
- Don't try to be a gate-keeper. Most GPs aren't trained to diagnose gender incongruence or dysphoria or make decisions about what would be in the patient's best interests. Also respect the fact that non-binary and gender non-conforming patients may still be transgender and treat them accordingly.
- Explore counselling options (long waiting times). Recommend peer-to-peer support. Advise on talking therapies.
- Discuss possibility of social transitioning without surgery
- Consider bridging hormones for therapeutic purposes. If self-medicating, ensure regular blood and endocrine tests and advise on disease prevention programmes (e.g. prostate cancer for transwomen)
- Discuss fertility and gamete storage if indicated

Monitoring of Transgender Hormone Therapy

Male To Female
Evaluate the patient every 2–3 months in first year, then 1–2 times per year
Measure serum testosterone and estradiol every 3 months during the first year, then twice-yearly, then yearly. **Goal:** testosterone level should be < 50 ng/dL and estradiol < 200 pg/mL. Prolactin should be checked at baseline and then at least annually during the transition and then every 2 years
If on spironolactone: check serum electrolytes every 3 months for the first year and then yearly
Check Complete Blood Count and Liver Function at baseline and follow-up visits
Lipid panel test: based on recommendations

Female To Male
Evaluate the patient every 2–3 months in first year, then 1–2 times per year
Measure testosterone every 2–3 months until level in normal physiologic range, then every 6 months during the 2nd year, then yearly; check prolactin if patient has any symptoms
Measure estradiol level during first 6 months of treatment or until no bleeding for 6 months
Check Complete Blood Count and Liver Function at baseline and follow-up visits
Lipid panel test: based on recommendations

The Clinical Pathway

Before referral to a GIC gather the following information:

- A description of the individual's experience of gender dysphoria, including duration and previous care
- The individual's clinical needs and expectations
- A summary of significant physical and mental health history including any history of substance misuse together with any significant social history or developmental issues
- A risk assessment covering current (self-) medication and biometrics (height, weight etc)

Stages

- Referral to a specialist Gender Dysphoria Clinic (self-referral or by primary, secondary or tertiary care)
- Assessment for gender dysphoria, and diagnosis
- Individuals who meet the criteria for diagnosis of gender dysphoria related to gender incongruence are accepted on to the NHS care pathway and an individualised treatment plan is agreed
- Therapeutic interventions delivered by the specialist Gender Dysphoria Clinic; and / or referral for interventions with other providers
- Ongoing review and monitoring during and after interventions
- Conclusion of contact: discharge to primary care

Risks Associated With Prescribing Gender-Affirming or Bridging Hormones

To avoid excess risk, the goal is to maintain hormone levels in the normal range for the target gender. Risks or complicating factors include:

Risks

Complications of feminizing hormone therapy might include:

- Osteoporosis - there are increased risks for transgender women on gender-affirming hormones but no increased risk for transgender men
- Deep vein thrombosis or pulmonary embolism
- High triglycerides, a type of fat (lipid) in your blood

- Weight gain
- Infertility - talk to the MTF patient about storing sperm and explore feelings associated with loss of libido and potency
- High potassium (hyperkalemia)
- High blood pressure (hypertension)
- Type 2 diabetes
- Cardiovascular disease - oestrogen may reduce the risk of cardiovascular disease and there is no difference between transgender males and cisgender males of cardiovascular disease risk
- Excessive prolactin in blood (hyperprolactinemia)
- Stroke
- Increased risk of breast cancer compared to cisgender men

Other Issues

Transgender people may have underlying or associated conditions relating to their lifestyle. Studies show that transgender people are more prone to:

Avoid Accessing Health Care
Transgender persons may avoid medical care for fear of being rejected.

Cancer
Trans men who still have a uterus, ovaries, or breasts are at risk for cancer in these organs. Trans women are at risk for prostate cancer though this risk is low. Transgender persons should be screened for cancers of the reproductive organs. www.nhs.uk/common-health-questions/sexual-health/should-trans-men-have-cervical-screening-tests

Depression and Anxiety
Transgender persons have high rates of depression and anxiety especially if they do not have adequate social support or who are unable to express their gender identity. Transgender patients should be screened for signs and symptoms of depression and anxiety and should seek appropriate mental health services provided as needed.

The Royal College of Psychiatrists suggests that GPs may prescribe a bridging prescription to cover the patient's care until they are able to access specialist services. **The GMC advises that GPs should only consider a bridging prescription when:**

- the patient is already self-prescribing, or seems highly likely to self-prescribe, with hormones obtained from an unregulated source (online or otherwise on the black market)
- the bridging prescription is intended to mitigate a risk of self-harm or suicide, and
- the doctor has sought the advice of a gender specialist and prescribes the lowest acceptable dose in the circumstances.

Clinical Services For Non-Transitioning Patients

There is no need for the patient to be assessed by mental health services prior to referral to a GIC or prescribing a course of hormone treatment. GPs do not need prior approval from their Clinical Commissioning Group or Integrated Care System

- **Consider referral for counselling** (but be aware of waiting times):
  Talk Liverpool www.talkliverpool.nhs.uk
  CMAGIC www.cmagic.org.uk/counselling
  TSS www.merseycare.nhs.uk/our-services/liverpool/trans-support-service-tss
  Useful advice can be found at: genderkit.org.uk/article/support-services/
  and genderkit.org.uk/article/counselling/
- If there are issues relating to sexual health, consider a referral to the Axess sexual heath service, particularly the **Butterfly Clinic**: www.axess.clinic/services/butterfly-clinic/
- Social prescribing to promote well-being etc
- Recommend accessing peer support but be aware of the limitations of this assistance

Resources to point patients to:

- **Gender Trust** – support group for signposting patients
- **Gendered Intelligence** - resources for the trans community
- **GIRES** - transgender experiences: information and support
- **LGBT Foundation** – health-related resources lgbt.foundation/trans-resources
- **MindLine Trans+** - national confidential helpline
- **TransUnite** – find a local support group

- **Consider prescribing (low level) HRT** for therapeutic reasons (sense of well-being, stabilising emotions, decreasing symptoms of gender dysphoria, reducing harmful triggers)

Under 18s

Treatment of gender incongruence in the under 18s should be left to specialist services

- Refer to CAMHS and GIDS (not Tavistock & Portman NHS Trust but NHS Arden and Greater East Midlands on behalf of planned regional provision)
- May be prescribed puberty blockers at age 15 and with at least one year's history of gender dysphoria*
- May be prescribed gender-affirming hormones if 16+ and on puberty blockers*
- Likely to be dealing more with AFAB patients that AMAB
- Help to socially transition likely to be more important than hormones so knowledge of safe spaces, family therapy and counselling, local support networks e.g. YPAS etc is important.

This can be helped by:

- family therapy
- individual child psychotherapy
- parental support or counselling
- group work for young people and their parents
- regular reviews to monitor gender identity development
- referral to a local Children and Young People's Mental Health Service (CYPMHS) for more serious emotional issues
- referral to a specialist hormone (endocrine) clinic for puberty blockers for children who meet strict criteria (at puberty)*

YPAS/GYRO: Part of the CAMHS partnership, provides support to children and young people up to 25 with wellbeing or other issues. Has a specific LGBTQ support service (GYRO)

* Following the publication of the Cass Review, GPs should check the latest guidance from NHS England, the BMA, RCGP and GMC

Appendices

Appendix 1 - GIC Waiting Times (June 2022)

Information derived from genderkit.org.uk/resources/wait-times/#west-of-england-specialist-gender-identity-clinic-fulldetail

GIC	To Be Seen	To Get Hormones	Transfers Prioritised	Notes
Belfast	<47 months	?	?	NI Only
Cardiff	24-28 months	?	?	Wales GP Only
Exeter	71 months	12 months	No	Not seeing any first appointments
Glasgow	48 months	?	?	Scotland GP only
Leeds	44 months	16 months	?	
London GIC (Tavistock)	52 months	18 months	?	
London GIDS	31 months			
London TransPlus	?	Immediate		Only accepts referrals from other GICs
Manchester Indigo	?	?	?	Very limited access, no new referrals
Merseyside CMagic	?	?	?	Very limited access, no new referrals
NCTH East of England	?	?	?	Only accepts referrals from other GICs
Newcastle	50 months	39 months	?	
Northants	49 months	8 months	No	
Nottingham	27 months	6 months	No	
Sheffield	49 months	18 months	No	

www.nhs.uk/nhs-services/how-to-find-an-nhs-gender-identity-clinic/

Waiting Times At Private Gender Clinics In The UK

Service	To Be Seen	To Get Hormones	Notes
Harley Street GC	6 months	Immediate	
Dr Lenihan	10 months	Immediate	
GenderCare	9 months	Immediate	
GenderDoctors	2 months	Immediate	
GenderGP	Online Only	Immediate	Some clinicians hate GenderGP and will not assist patients using GenderGP
London Transgender Clinic	6 months	Immediate	
Northern Gender Network	5 months	Immediate	
YourGP	NO	NO	Not accepting new referrals
Kelly Psychology	NO	NO	Not accepting new referrals

Appendix 2 - Bridging or Gender-Affirming Hormones

Endocrine and other pharmacological interventions may be recommended by a GP:

- where they are essential for the purpose of harm reduction;
- where they are in the individual's best interest for reducing gender dysphoria; and
- when assisting the individual in achieving gender expression congruent with their identity and consistent with their treatment goals.

It is not a requirement for access to pharmacological interventions to undertake a change in social role.

Medication for masculinisation

- Testosterone preparations (includes testosterone injections and transdermal gels)
- Medications to suppress hypothalamic-pituitary-gonadal activity and menstruation

Medication for Feminisation

- Estradiol preparations at doses necessary to achieve serum estradiol levels typical of a pre-menopausal woman. Includes oral and transdermal estradiol as patches and gels. Transdermal estradiol preparations should be offered to people over 40.
- Medications to suppress hypothalamic-pituitary-gonadal activity and endogenous testosterone release (includes gonadotropin releasing hormone analogues and 5-alpha reductase inhibitors)
- Ornithine decarboxylase inhibitors (e.g. Vaniqa) may be prescribed as an adjunct to facial hair reduction interventions.

Risks: If Overweight

An individual's risk of thrombosis increases as their BMI increases. Individuals with a BMI of 40 or more should lose weight before using such hormone therapies.

Risks: Smoking

The risk of thrombosis is increased if they smoke, particularly if treated with estradiol. Individuals should stop smoking while using hormone therapies however smoking should not exclude access to treatment. Where BMI is over 40 and/or the patient smokes, hormone therapy should only be recommended following discussion of risk, possible adverse effects and impacts on final treatment outcome.

For Those on Hormones (Prescribed or Self-Medicating)

If hormones are prescribed or the patient is self-medicating, the doctor/clinical care practicioner should:

- Monitor the patient's weight and blood pressure and ask routine health questions focused on risk factors and medications
- Conduct directed physical examinations
- Complete blood count, renal and liver functions, lipid and blood sugar tests

Benefits of Feminizing Hormone Therapy

Feminizing hormone therapy can:

- Make gender dysphoria less severe, reducing psychological and emotional distress
- Improve psychological and social functioning
- Improve sexual satisfaction and quality of life

When Feminizing Hormones Are Not Recommended

Feminizing hormones might not be appropriate if the patient:

- Has or has had a hormone-sensitive cancer, such as prostate cancer or has a thromboembolic disease e.g. deep vein thrombosis or a pulmonary embolism
- Has uncontrolled behavioural or significant medical conditions
- Has a condition that limits the patient's ability to provide informed consent

Typical Hormone Regimes

Male To Female

Cumbria, Northumberland & Tyne & Wear NHS Foundation Trust	
Sandrena 0.1% gel	1-3mg per day
Oestrogel 0.06% gel	1.5mg-3mg/day
Estradiol Transdermal patches	50-250mcg/24h twice weekly patches

The Endocrine Society	
Estradiol Oestrogen (Oral)	2.0-6.0mg/day
Transdermal Oestrogen (patch)	0.025-2mg/day (new patch every 3-5days)
Parenteral Estradiol valerate or cypionate (intramuscular/subcutaneous)	5-30mg IM every 2 weeks or 2-10mg IM every week

Female To Male

The Endocrine Society	
Testosterone enanthate/cypionate (intramuscular/ subcutaneous injection)	100-200mg every 2 weeks or 50-100mg every week
Testosterone undecanoatec (intramuscular injection)	1000mg every 12weeks
Testosterone gel 1.6%	50-100mg/day
Testosterone transdermal (patch)	2.5-7.5mg/day

Devon NHS Partnership	
Testosterone undecanoate 1000mg intramuscular injection	First injection, second injection 6weeks after and then every 12weeks
Testosterone 2% gel (Tostran®20) 10mg per metered dose from pump	1-8 pumps per day = 10mg-80mg/

Appendix 3: Common Gender Identity Terms

AFAB: Assigned Female At Birth, common term within transmasculine community

Cisgender: Those who identify as the sex they were assigned at birth. For example, a baby born with a vulva is categorized a girl. If she sees herself as a girl throughout her life, she is considered cisgender.

Cross-Dresser (sometimes shortened to CD): A person — typically a cisgender man — who sometimes wears feminine clothing in order to have fun, entertain, gain emotional satisfaction, for sexual enjoyment or to make a political statement.

Drag Kings and Queens: Performer who exaggerate gender-based behaviours and dress for the purposes of entertainment at bars, clubs, or events. Some drag kings/queens might also identify as transgender.

Gender Dysphoria: A diagnosis that describes the distress, unhappiness, and anxiety that transgender people may feel about the mismatch between their bodies and their gender identity.

Gender Fluidity: A sense that one's gender identity can change over time or even from day to day. A gender fluid person may feel male some days, female on others, both male and female or neither. A gender fluid person might also identify as 'gender queer'.

GenderQueer: People who don't identify as man or woman or whose identity lies outside the traditional gender binary (male and female). Some people use genderqueer, gender nonconforming, and non-binary interchangeably, but others don't. Many use the term to declare that their gender is non-normative in some way.

Gender 'Non-Conforming' and 'Non-Binary': When someone's gender expression doesn't fit inside traditional binary male or female categories.

Intersex: A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't fit the typical definitions of female or male and/or the gender they are assigned at birth. Some intersex people are transgender, but some don't define themselves this way.

Transgender (sometimes shortened to Trans or Trans*): A general term used to describe someone whose gender identity is different than the sex assigned at birth. Some people put an asterisk on the end of trans* to expand the word to include all people with non-conforming gender identities and expressions.

Transgender Men (Trans Man) and Transgender Women (Trans Woman)
A person whose gender identity is different to the one assigned at birth. These can be people anywhere on the TQIA* spectrum. Many trans people identify as either men or women (not trans men or trans women). **The rule is not to reach for an easy (or lazy) label but to ask how the patient regards themselves and wants to be referred to.** These identities can also refer to someone who was surgically assigned female at birth, in the case of intersex people, but whose gender identity is male. Many trans men identify simply as men.

Transmasculine is an all-inclusive term referring to:
- Transgender men
- AFAB nonbinary people who identify with masculinity
- AFAB demiboys (someone who partially identifies as a boy, man, or masculine)
- AFAB gender-fluid people who identify with masculinity, whether it's all, most or some of the time
- other AFAB people who identify with masculinity

Transfeminine, transfem or transfemme: transgender people whose identity is predominantly feminine. They may or may not identify as female. It can be a stand-alone or umbrella term including non-binary, gender-fluid, multi-gender, genderfae (gender-fluid), demigirls (partially feminine) and girlflux (a person's gender fluctuates between girl, a demigirl, genderless, and various degrees of intensity in-between.

Appendix 4: Outdated, inaccurate, or offensive Gender Identity Terms

Gender Identity Disorder (or GID): The preferred term is gender dysphoria.

Hermaphrodite: The preferred term is intersex.

Pre-operative, post-operative (also pre-op or post-op)
A set of terms to describe a transgender person who has had or not had sex reassignment surgeries. Focusing on whether someone has had surgery can be considered invasive or a violation of their privacy. Also many transgender people don't want (or don't have access to) surgeries that would change their body. Lastly, there are a variety of other ways transgender people transition besides gender-affirming surgery.

Sex Change Operation: Preferred terms are Sex Reassignment Surgery (SRS) or Gender Affirming Surgery.

Shemale: An offensive term for a transgender woman especially one who has had medical treatment for her breasts but still has a penis. This term may be used by sex-workers or within the porn industry.

Tranny (sometimes referred to as The T-word): While some transgender people use the word tranny to describe their gender, most find it highly offensive.

Transgendered: 'Transgendered' is an attempt to describe a condition rather than an acceptance of a patients gender identity. It suggests something abnormal or anomalous rather than something that is a real and fairly common condition or identity.

Transsexual: An older term for people whose gender identities don't match the sex that was assigned at birth and who desire and/or seek to transition to bring their bodies into alignment with their gender identities. Some people find this term offensive, others do not. Only refer to someone as transsexual if they tell you that's how they identify.

Spirit Level