Transgender Health Care for Obstetricians and Gynecologists

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Background

The American Board of Obstetrics and Gynecologists defines Obgyn's as physicians who possess special knowledge, skills and professional capability in the medical and surgical care of women (and per 2014 men) related to pregnancy and disorders of the female reproductive system. They provide primary and preventive care for women (and men) and serve as consultants to other healthcare professions. Transgender or gender nonconforming patients often seek primary care in gynecological practices and obgyn's need to be familiar with the healthcare needs of these patients (1). A multidisciplinary team is ideal but not often feasible (yet) so you may become the one transgender (and GLBQIA) friendly provider in town. The American College for Obstetrics and Gynecology has called for obgyn's to assist in the care of transgender patients. Several studies have shown that need for care is high and unmet (2,3). Medical School education, residency education and CME education in GLBT+ healthcare is limited to none. Fortunately the Affordable Care Act Section 1557 prohibits discrimination based on sex in health programs receiving Federal financial assistance (4).

Methods

In March of 2014 "Rebirth Obgyn", a GLBT+ inclusive clinic in Obstetrics and Gynecology was established in Salt Lake City, UT. Sofar our EMR contains over 1400 transgender or gender nonconforming patients with 40-50+ new patients a month, ages 8 to 82. About 55% is FTM, 40% MTF and 5% desires puberty blockers or is gender nonconforming. We provide primary and preventive care, hormone therapy (and/or blockers) including pellets, pre- and postoperative care, hysterectomy and revisions after vaginoplasty. We refer to GLBT friendly therapists, surgeons and other specialties. We provide letters, lab testing and follow current Standards of Care(Wpath/Endocrine Society). The following is an incomplete list of important topics/tips from the "trenches" with some unstudied observations.

Results

. Access and Barriers to Health care; forms, emr's and insurances are "binary". Patients may not have insurance, are afraid of coming out, may lack support system. Use pronouns and preferred names, don't make assumptions about sexual orientation, educate office staff (and operating room/ postoperative ward personnel), make your office inviting (all gender bathrooms). Provide referrals to other friendly healthcare workers, provide letters and information for name and gender marker change in your state. Consider doing local injections for mtf receiving electrolysis and offer lidocaine gel and pain medication if desired.

. Hormones; obtain informed consent and/or letter from a mental health care provider. Cross hrt is often not covered by insurance. Follow SOC and Endocrine Society guidelines; no data for patients over 65 and cross hrt below age 16. Progesterone is controversial but 8 out of 10 of my patients prefer it. Hrt has effects on lipids (screen after age 20, keep ldl<135), weight (increase on T) and blood pressure (increase on T). Prolactin can be elevated in the first year on E, cross hrt can cause bone loss: vitamin D3 /calcium and bone density testing (cost/indication typically not covered). Dvt rate estrogen 0.4-2.6%(5), increase of potassium if on spironolactone (no dangerous levels). 50% of trans men has pcos (insulin resistance). T after breast cancer is okay. Puberty blockers for 10+ year olds; confirm puberty (labs); Tanner 2. These are reversible, discuss risks/benefits, communicate with parents and counselors. Discuss future fertility (no data) when considering cross hrt before age 16. Testosterone can enhance depression and anxiety.

.Surgery; offer pre- and postoperative care for GRS (or other) surgery, obtain operative report for technique used (penile or scrotal skin, bowel for neovagina), postoperative instructions differ per surgeon. Involve urology or colorectal surgeons if complications (fistula). For ftm hysterectomy (tlh or trh) discuss oophorectomy yes or no, don't shave the abdomen, pay close attention to cuff healing. Preop no need to stop T, continue same dose postop. Oophorectomy can induce vaginal dryness/uti; consider local estradiol cream. For MTF stop E 2 weeks preop and discuss estrogen dose after gonadectomy, consider dermal products (or pellets). Consider small revisions after vaginoplasty (think symmetry and function), ask about dilation (prevent stenosis), start substituting dilators for dildo's/ vibrators. Not everyone desires GRS surgery. It is a huge cost, commitment and recovery. Postop depression risk 30% (6) , support system important.

. Primary and Preventive care; testosterone treatment causes acne. Accutane requires Ipledge(7). Cancer screening: prostate cancer screening in mtf by recto(vaginal) exam, not psa)(8), breast cancer screening; mammograms after 40, breast exam one year after hrt, do chest exams after top surgery. Pap/colonoscopy per regular guidelines. Don't do ftm pelvic at first visit, offer valium. Many have never had penetrative sex. Ftm bleeding on T consider workup. My pathology findings on hysterectomy or d/c reveal inactive endometrium. Ovaries; sofar no increased risk for ovarian cancer, do pelvic exams if ovaries present. Hiv risk 2.6% in transgender population (CDC 2009) offer std testing. Gardasil and PrEP. Be aware of social issues as domestic violence, substance abuse, sex work, incarceration, homelessness, sexual abuse, eating disorders. Work with counselors. Check if the patient has a support system; family, friends or transgender peer group (often trough internet). Ask for suicidal tendencies every visit.

. Reproduction, contraception and sexuality; discuss before/during cross hrt. 50% pre- transition rates sexual life as poor/dissatisfied (9). Cross hrt does not prevent pregnancy and decreases fertility. Offer sperm and oocyte cryopreservation resources (10). Don't make assumptions about partners, ask if sexual partner(s) is/are cis/trans, think of asexuality, bisexuality and polyamory. Some trans women want to breastfeed (protocols available for induction of lactation) and long for uterus/birth experience. Offer Viagra or Cialis to trans women that desire penetrative intercourse (not all do) or lower testosterone blockers. Trans women can experience "female" orgasm also after vaginoplasty. Recommend quality lube (Sliquid) and vibrators for trans women after GRS (HSDD more common)(11). Testosterone increases sexdrive (12). Contraception and cessation of menses(13); Depo-Provera or progesterone IUD, Nexplanon implant, Nuvaring or ocp's. Pregnancy is emotionally difficult for transmen (14 and poster 14).

Conclusion/discussion

The Affordable Healthcare Act mandates obgyn's and other physicians to provide inclusive health care. We as transgender healthcare specialists need to educate our colleagues and continue asking the community how we can do better, then create evidence based healthcare by doing research with randomized controlled trials. We need to work together as transgender health care centers to provide the numbers to make this research statistically significant. I believe that excluding Gender Dysphoria from the DSM alltogether and no longer treating it as a mental disorder but as a variety of cultural norms or an endocrine disorder will aid in willingness to provide transgender inclusive care by physicians.

References; handout