TRANSGENDER HEALTHCARE – WORLD RUGBY

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LEARNING OUTCOMES

- Describe gender incongruence
- Recall the referral process
- Recall current NHS funding arrangements
- Recall treatment options including cross sex hormone treatment, gender affirming surgeries and non-hormonal/surgical treatments.
- Discuss testosterone and any potential challenges
- Discuss the ethical considerations
GENDER INCONGRUENCE
GENDER INCONGRUENCE

- ICD 11: Moved from ‘mental, behaviour and neurodevelopmental disorders’ to chapter 17: ‘Conditions related to sexual health’.

- HA60: Gender Incongruence of Adolescence and Adulthood: is characterized by a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which often leads to a desire to ‘transition’, in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual’s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.
THE REFERRAL PROCESS
REFERRALS

- Referrals can come from:
  - GP or other healthcare professional. (mostly from GP)
  - Transfers of care from other transgender healthcare service. (UK or abroad)
  - Transfers of care from Tavistock Gender Identity Service. (GIDS) – Child and Adolescent service.
REFERRAL

- Significant waiting lists (average 2 years across clinics but varies)
- Currently in the UK it is the patient’s choice as to which clinic they attend.
FUNDING STRUCTURE
FUNDING AND STRUCTURE (ADULT)

• Within England, funded by NHS England
• Similar for NHS Wales and NHS Scotland
• National funded
• 7 Gender Identity Clinics in England
• 2 Gender Identity Clinics in Scotland (two satellites)
• 1 Gender Identity Clinic in Wales
• Variety of funding agreements exist
PRE-TREATMENT CONSIDERATIONS
ASSESSMENT

• Normally 2
• 1 by a ‘Named Professional’
• 1 by a ‘Lead Clinician’
• Treatment recommendations by ‘Lead Clinician’
• Follow up by either ‘Named Professional’ or ‘Lead Clinician’
GENERAL PHILOSOPHY OF TREATMENT

- To reduce distress related to the gender dysphoria/incongruence, increasing function and personal wellbeing.
- To assist transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment (WPATH, V7, 2012)
Exploring social domains/social gender role expression.

Online, offline.

Safe spaces: LGBTQ; social clubs; gaming/social media; Cosplay; etc.

May formalise by social gender role transition including changing documents.
CAPACITY

• Capacity is foremost in transgender healthcare and patients should know sufficient details of the effects of treatment, including the potential adverse effects to be able to consent to what they feel is the needed treatment.

• It is important that every reasonable adjustment is undertaken to provide the information in an understandable and accessible format.
PRE-TREATMENT SUGGESTED BASELINE TESTS IN THE UK

- Body mass index (BMI).
- Blood Pressure (BP).

- Bloods:
  - LH, FSH, SHBG, Testosterone, Oestradiol, Prolactin.
  - FBC, U+Es, LFTs, TFT, Fasting Lipids, HbA1C and Glucose.

- Smoking status.

- There is no indication for a physical/genital examination!
Hormone treatments can affect fertility and gender affirming surgical treatment will affect fertility.

It is important for patients to think about and consider future fertility options if they may want treatment in the future.

Further information about preserving fertility can be accessed via the National gamete donation trust info@ngdt.co.uk and The fertility network UK info@fertilitynetworkuk.org
TREATMENT OPTIONS – HORMONES & SURGERY
CROSS SEX HORMONES TREATMENT

- Treatment is life long (if wished).
- Some of the effects are at least partially reversible.
- Some are irreversible.
- Most changes take 3 years to complete – but every person’s experience will be different in terms of rate and order.
CROSS HORMONES TREATMENT

- Trans males - Testosterone
  - Gels.
  - Short term injections.
  - Long term injections.

- To achieve cis male levels of testosterone
  - Lower 1/3 at trough for injectables.
  - Upper half for gels.

- Trans females - Oestrogen
  - Tablets.
  - Gels.
  - Patches.

- Anti-Androgen (GnRH primarily).
  - To achieve mid range levels of oestrogen.
NON-BINARY

- Generally individualistic:
  - The treatments needed for non-binary patients are generally individualistic. This is for many reasons including but not limited to non-binary being an umbrella term to describe many gender identities which then may result in different treatments but different groups and also individuals.
  - May be no treatment.
  - Can be low dosage testosterone in those assigned female at birth (or higher).
  - Can be lower dosage oestradiol in those assigned male at birth (or higher).
  - Anti-androgens (to partially or completely suppress testosterone or oestradiol).
  - Combination (could include some or all the above).
EFFECT OF CROSS SEX HORMONES

**Testosterone**
- Skin changes.
- Voice Drop.
- Body Fat redistribution.
- Increased muscle mass.
- Clitoral growth.
- Increased/changed libido.
- Facial and bodily hair.

**Oestrogen and anti-androgen**
- Skin softening.
- Body fat redistribution.
- Breast tissue growth.
- Decreased quantity and Quality of erections.
- Penile and testicular atrophy.
- Decrease/changed libido.
### SIDE OR ADVERSE EFFECTS OF CROSS SEX HORMONES

<table>
<thead>
<tr>
<th><strong>Testosterone</strong></th>
<th><strong>Oestrogen and anti-androgen</strong></th>
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</thead>
<tbody>
<tr>
<td>• Acne</td>
<td>• Thromboembolic (DVT/PE)</td>
</tr>
<tr>
<td>• Fertility</td>
<td>(Increased if smoking)</td>
</tr>
<tr>
<td>• Liver</td>
<td>• Fertility</td>
</tr>
<tr>
<td>• BP – increased or decreased</td>
<td>• Liver</td>
</tr>
<tr>
<td>• Appetite</td>
<td>• Raised BP</td>
</tr>
<tr>
<td>• Increased Prolactin</td>
<td>• Increased Prolactin</td>
</tr>
<tr>
<td>• ?Gynae Ca</td>
<td>• Breast Cancer (still lower than CIS female)</td>
</tr>
<tr>
<td>• Polycythaemia</td>
<td></td>
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</tbody>
</table>
NON MEDICAL/SURGICAL INTERVENTIONS

- Speech therapy
- Facial hair removal
- Psychotherapy
- Group therapy
- Couple therapy

Psychotherapy should be available for those who need it, although many will not. Undergoing psychotherapy should not be a requirement for treatment.
SURGICAL INTERVENTION

- Patients may not want any surgery (and that’s fine).
- Agreement between clinician and patient in terms of readiness.
- Chest surgery and hysterectomy require one surgical recommendation.
- Genital surgery currently requires two surgical recommendations currently.
GENDER AFFIRMING SURGERY (NHS)

**Trans males:**

- Chest Reconstructive surgery.
- Metoidioplasty.

**Phalloplasty:**

- Radial artery/pubic flap/other.
- With or without erectile potential.
- With or without urethral re-siting.

- Hysterectomy with oophorectomy.

**Trans females:**

- Orchiectomy.
- Cosmetic Vulva.
- Vaginoplasty.
GENDER AFFIRMING SURGERY – NON-BINARY (NHS)

Non-binary

- Chest Reconstructive Surgery.
- Hysterectomy with oophorectomy.
- Orchiectomy.
- Genital Reconstructive Surgery.
SURGICAL INTERVENTION (NON NHS)

- Breast Augmentation.
- Cricothyroid shave.
- Facial feminisation.
- Hair Transplantation.

- These are not funded by NHS England.
FOCUS ON TESTOSTERONE
TESTOSTERONE IN TRANS FEMALES

- Most desire an average cis female level of testosterone (<2.5-3.0nmol/L)
- This is generally easily achievable with current treatments
- In the UK:
  - GnRH (goserelin, gona/decapeptyl, leuprorelin)
  - 4 or 12 weekly, one 6 monthly prep exists
- Very effective if regular with injections (oestradiol and testosterone levels monitored initially 3 monthly, then at least yearly)
- Levels virtually always <2nmol/L
- Comparatively safe
WORLDWIDE

- Higher levels of usage of ‘others’ due to cost implications
  - Spironolactone (more variation in effectiveness; higher long term risk profile)
  - Finasteride (comparatively less effective)
  - Cyproterone (effective but high risk profile)

- Nb: a smaller % do not require anti androgen as oestradiol alone supresses

- Nb: post genital surgery; none is required and levels can be lower than cis female (<2nmol/L; <0.5-1nmol/L common)
TESTOSTERONE IN TRANS MALES

- Short to longer acting testosterone in most
- Variation in monitoring arrangements depending on preparation
- UK high % on Nebido (long acting form avg dosage interval 12 weeks; can’t self inject)
- Worldwide much higher % on Sustanon (cost)
- More self injection due to cost and convenience
- Shorter acting has higher risks of ‘peaks’ and ‘troughs’
- Supra levels increase haematocrit (sometimes to polycythaemia) and can increase oestradiol
- Small percentage (1%) can become polycythaemic on normal levels
ETHICAL CONSIDERATIONS

- Some transgender people do not wish/need medical/surgical gender affirming treatment
- Some trans females do not wish/need full suppression of testosterone
- Non-binary athletes
- Medicalisation/confirmation of gender identity
- Impact on local club/fun level sports
THANK YOU!
ANY QUESTIONS?
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