

Treatment Guidelines for MTF Transition

Philosophy of Care:

- i. Since the inception of the Harry Benjamin guidelines, there have been changes in the definition of "gender", both socially and generationally. Gender expression no longer needs to be divided along rigid masculine/feminine lines in American society. Transgender and questioning youth appear to range on a spectrum of gender identity never addressed by the Harry Benjamin guidelines. We recognize the right of each patient to define their own gender identity independent of our preconceptions. We do not discriminate or withhold hormones on the basis of gender identity definition.
- ii. A transgender identity is not a psychiatric illness. Many youth do have mental health needs, regardless of gender identity. If we do not define a transgendered person as mentally ill, it would be discriminatory on the basis of diagnosis to force such clients to undergo evaluation and/or treatment by mental health personnel. However, if anyone in the Dimension team feels that a mental health evaluation is needed, hormonal treatment may be postponed until this evaluation is done and any mental health issues are resolved. We do not withhold general medical services from patients who refuse to see a therapist or psychiatrist. All youth at Dimensions are routinely offered appropriate mental health services and/or referrals.
- iii. The Dimensions team cares for our patients as a team. The team will make decisions on appropriate care for each transgender patient, with adequate input from medical, nursing, mental health and social services staff. If a conflict exists among the team regarding appropriate care for an individual, then further evaluation will be pursued to resolve this conflict.

Treatment

- I. Discussion of patient goals and expectations. Assess desire and readiness for gender transition. Assess connection with transgender community and exposure to persons who have completed transition.
- II. Screening:
 - A. Complete physical, HCM
 - B. Labs ordered for:
 1. CBC w/differential
 2. Liver Panel
 3. Lipid profile
 4. Renal Panel
 5. Hormonal studies indicated by findings in history and physical
 - C. Assess individual medical issues
- III. Discussion and signing of Informed Consent.
- IV. Treatment options
 - A. Non-hormone options
 - B. Estrogens: Available forms

- a. Premarin 0.625 – 5 mg qd or estradiol 1-10 mg qd (Occasional occurrences of allergies to Premarin have been reported. If this occurs, synthetic estrogens can be substituted.)
 - b. Injectable estradiol in oil, 10-20 mg q 4 week.
 - c. Estradiol patch 0.05 - 0.3 mg 7d (check for latex allergy)
 - C. Antiandrogens: Spironolactone 25 – 50 mg po bid (benefits may include: modest breast development, softening of facial hair. Risks of use include; hyperkalemia, hypotension, drug interactions).
 - D. The use of Propecia (Finasteride) is currently being explored, but there is little data on its use and effectiveness in this population. (Finasteride is a competitive and specific inhibitor of Type II 5 α -reductase, an intracellular enzyme that converts the androgen testosterone into DHT.)
 - E. Progesterone- not recommended
- V. Follow up
- A. Monitor labs 3 months after start of estrogen then every 6-12 months
 - 0. CBC
 - 1. ALT or Liver panel
 - 2. Lipid profile
 - 3. Renal panel (if taking sprinolactone)
 - 4. Testosterone level if needed
 - 5. Prolactin level (may discontinue after 3 years of normal values; level between 25-100 may indicate improper use of estrogen)
 - B. Review medication use
 - C. Assess feminization
 - D. Monitor mood cycles and adjust medication as indicated
 - E. Complete forms for name/gender change, if desired.
 - F. Review CAD risk factors
 - G. Continue routine HCM (including breast exam, STD screening, prostate screening, and mammograms after age 40).