Trans Reproductive and Sexual Health Considerations for SK Prevention Institute

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Disclosures

- Financial: none
- Self-taught and still learning!

Objectives

- Appreciate the importance of trans health issues
- Describe components of building a safe, queer friendly practice
- List requirements for diagnosis of gender dysphoria
- Approach resources in your city/province for trans patients
- Describe aspects of social, medical and surgical
- Discuss unique considerations for trans people in:
  - Fertility preservation
  - Pregnancy
  - Contraception
- Describe screening processes for trans patients
- Direct patients to reference websites and local resources

Outline

- Context
  - Psychological impact
- Supporting a trans person
- Trans-related medical care
  - Medications
  - Surgery, coverage
  - Preventive screening
- Resources

Psychological impact

- 0.5-1.2% of youth identify as transgender (CPATH pre-conference training)
  - 0.3-0.6% of adult population may be trans per US surveys
- Suicide
  - TransPULSE (n=433, Ontario, 2009-10): 57% of those not supported by parents attempted suicide in past 1 yr
    - 93% reduction in suicide attempts in past 1 yr among trans youth who were supported by their parents
- Need for psychological care before, during & after transition
  - Celeste Selferling @ Monarch Mental Health (UR Pride) @ Family Service Regina (free)
  - Sherry Rapley @ Ranch Ehrlo (sliding scale)
  - Dr. Sara Dungavell in Saskatoon, Dr. Samra Sahlu in Regina
- Hormonal treatment → better psychological quality of life
- Discrimination, destigmatization, depathologization
- Regret: 1-2% per Sherbourne guidelines
  - Not necessarily regret about starting hormone therapy, possibly regret about life circumstances/impacts of medical transition

caring for kids
.cps.ca
Information for parents from Canada's paediatricians

Pregnancy & Babies | Healthy Bodies | Keeping Kids Safe | Growing & Learning | Illnesses & Infections | Immunization | Behaviour & Parenting | Teen Health

home » growing & learning » gender identity

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In this section:

- Growing bodies
- Healthy development
- Media & Literacy
- Learning

Gender identity

Although we often associate gender development with puberty and adolescence, children begin showing interest in their gender early in life.

This article discusses how gender identity typically develops and how parents and caregivers can promote healthy gender development in children. It's important to remember that each child is unique and may develop at a different pace.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

AAP Statement in Support of Transgender Children, Adolescents and Young Adults

7/27/2017

by: Fernando Stein, MD, FAAP, President, American Academy of Pediatrics, and Karen Remley, MD, MBA, MPH, FAAP, CEO/Executive Vice President, American Academy of Pediatrics

Canadian Family Physician

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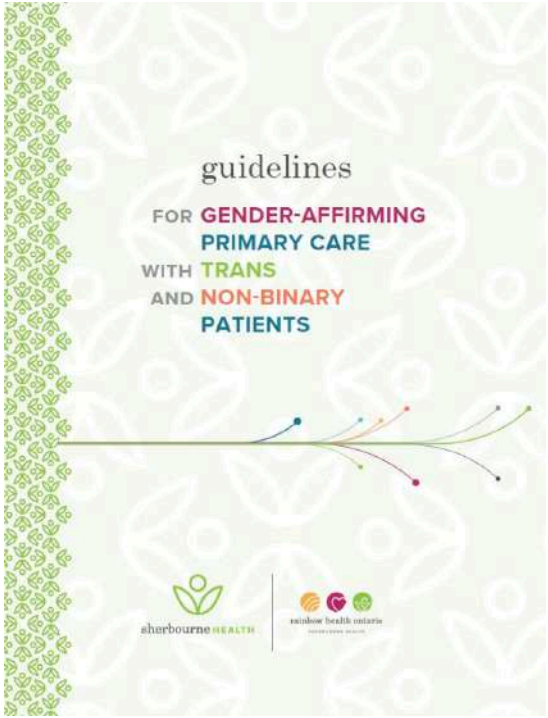


UCSF Transgender Care

For Patients ▾ For Providers ▾ Our Team ▾ Schedule an Appointment

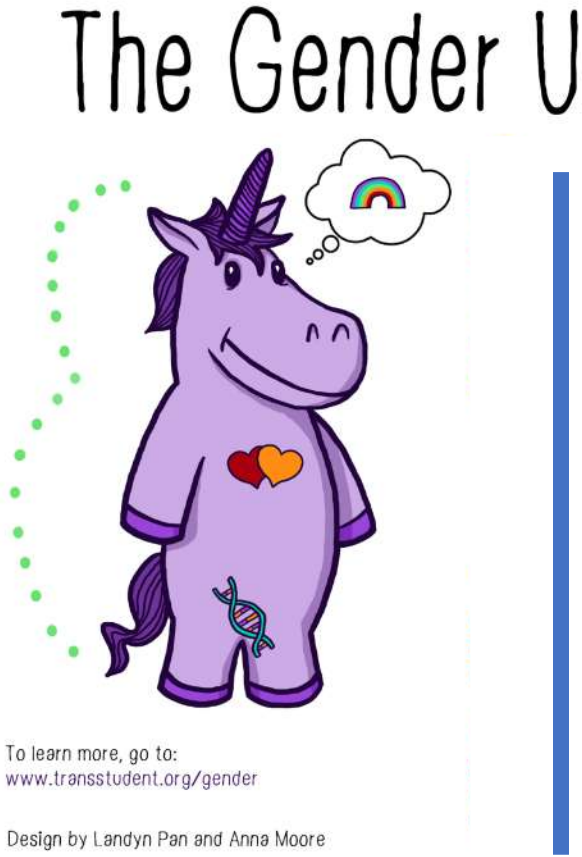
For Providers » Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

- Welcome
- Place a Referral
- e-Consults (Internal to UCSF Medical Center only)

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

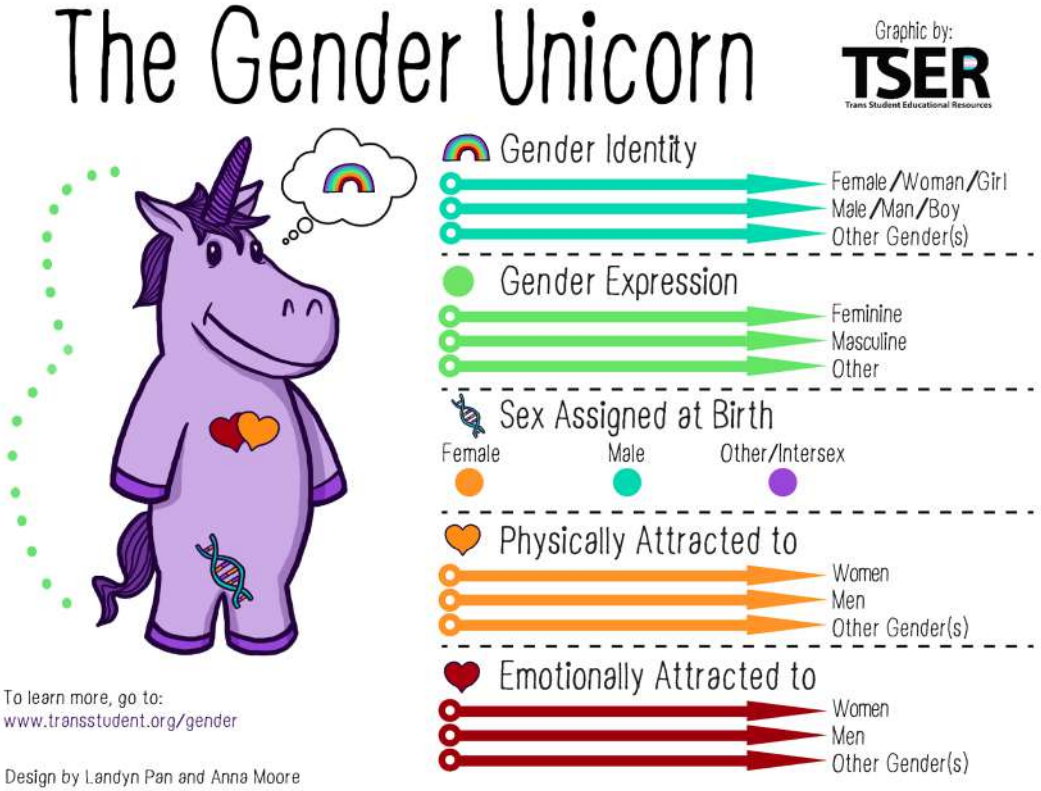
Publication Date: *June 17, 2016*

Gender identity definitions - Matching game!



- Assigned sex
- Gender expression
- Gender identity
- Attracted to

Gender identity definitions



Components of trans friendly practice

- Ask, don't assume
- Use patient's own terms: trans, transgender, trans man/trans woman, male/female, transsexual, genderqueer, nonbinary, two spirit, gender fluid, other
- Ask: "what are your pronouns? Mine are __ and __"
- Also ask about gender & genitalia of partners when asking about sexual activity
- Train admin staff & colleagues to address by preferred name & pronouns
- Make chart note (on FMU EMR, in Demographics tab) to address by preferred pronouns - preferred name noted as nickname in brackets or quotations
- Address "gender" on medical record
  - Pt's presentation vs. what's on their health card
  - Can use "other" option for gender

A patient discloses they think they're transgender

- Open-ended, gentle
- "How do you describe your gender?"
- How long they've had thoughts like this
- Pronouns
- Behaviours, such as tucking, dressing, play
- If thinking of transitioning / ready to
  - Hormones?
  - Surgery?
- Mood (depression/mental health screen): SIGECAPS
  - Other mental health screen: HEADSS, psychosis, anxiety, mania
- Partner(s)
- Supports
- Anticipated challenges to transitioning

Further evaluation

- Physical: assess puberty (if applicable): Tanner stages
- Labs: consider liver function, CBC, renal, lipids, diabetes screen
- Plan: counselor +/- psychiatrist, gamete banking, support group, facilitate family conversations

Gender dysphoria Dx: DSM-5

Children

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Adolescents/Adults

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- "Gender incongruence" moved to Sexual Health chapter
  - Moved from "Mental & Behavioural Disorders"
- HA 61 Gender incongruence of childhood
  - *Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.*

- HA 60 Gender incongruence of adolescence or adulthood
  - *Gender Incongruence of Adolescence and Adulthood is characterised 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.*

Trans network

- Former psychiatrist: Dr. Anne Bellows @ 2110 Hamilton - retired Mar 2018
  - Nurse Kelly is still following patients referred to Montreal
- Psychiatrist: Dr. Sara Dungavell in Saskatoon - 2-3 yr wait
- Psychiatrist: Dr. Samra Sahlu in Regina
- Internist: Dr. Tom Perron @ Queen City Medical Specialists
- Family docs (hormone therapy, gender affirming FM care): Dr. Megan Clark & Dr. Lori Schramm @ FMU (Trans Consult service)
  - In Saskatoon, Dr. Leane Bettin @ main Community Clinic, Drs. Carla Holinaty & Ginger Ruddy @ Westwinds
  - In Moose Jaw, Dr. Kirsty Sanderson
- Plastic surgeons: Drs. Dan Kozan & Megan Lyons @ Emerald Park, Dr. Peter Chang
- Gynecologist: Dr. John Thiel

Question

What are the 3 types of transition?

Transitioning

Social

- Pronouns
- Dress, appearance
- Gender marker on ID

Medical

- Puberty blockers <14-16 yo
- Hormones

Surgical

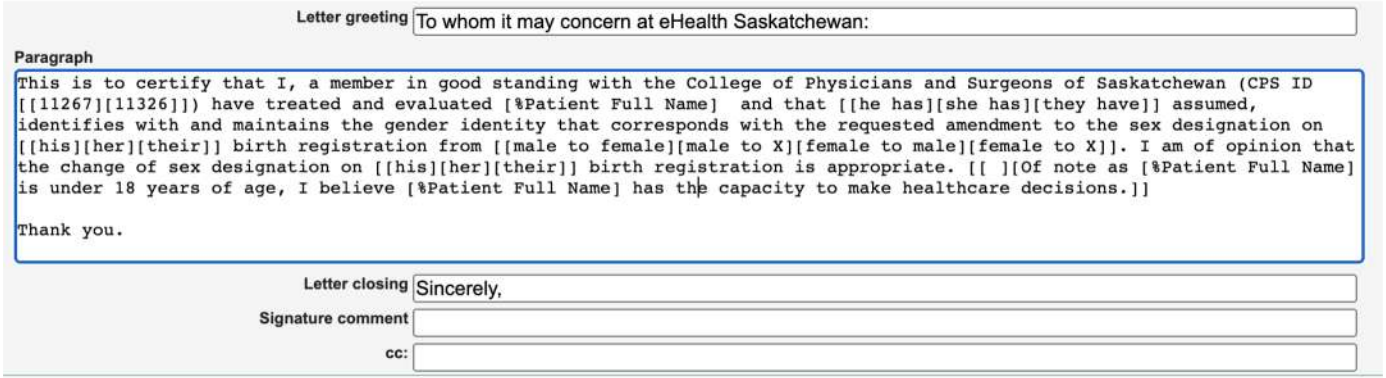
- “Top”
- “Bottom”
- Other, including:
  - Tracheal shave
  - Facial feminization

Trans medical & surgical therapy

- Puberty blockers: GnRH analogues: fully reversible
- Hormones: partially reversible
- Surgery: irreversible

Social transition: Health cards, birth certificates

- https://www.ehealthsask.ca/residents/Pages/Sex-Designation.aspx
- Pt's letter, must be notarized + $60
- MD or psychologist letter



Letter greeting: To whom it may concern at eHealth Saskatchewan:

Paragraph:

This is to certify that I, a member in good standing with the College of Physicians and Surgeons of Saskatchewan (CPS ID [[11267][11326]]) have treated and evaluated [%Patient Full Name] and that [[he has][she has][they have]] assumed, identifies with and maintains the gender identity that corresponds with the requested amendment to the sex designation on [[his][her][their]] birth registration from [[male to female][male to X][female to male][female to X]]. I am of opinion that the change of sex designation on [[his][her][their]] birth registration is appropriate. [[ ][Of note as [%Patient Full Name] is under 18 years of age, I believe [%Patient Full Name] has the capacity to make healthcare decisions.]]

Thank you.

Letter closing: Sincerely,

Signature comment:

cc:

Medications: Puberty blockers

- Puberty blockers: reversible, for <14-16 yo (16 per WPATH guidelines), Tanner stage 2+
- Leuprolide (Lupron) IM injections q1mo
- Continue until…
  - ?Start testosterone for trans boys
    - Risk breakthrough menses
  - Orchidectomy for trans girls
- Not well-studied, but may not develop enough gonadal tissue for biological pregnancy if never go into puberty of sex assigned at birth

Medications: Hormones: Feminizing

Source: Sherbourne guidelines, Dec 2019

+/- progestins

- ?nipple development
- Incr risk clot & low mood
- Not generally recommended

IM estradiol: also an option, not covered

Table 5
Formulations and recommended doses of estrogen for feminizing hormone therapy

	Starting dose	Usual dose	Maximum dose	Cost (4 weeks)
Estradiol (oral)*	1–2mg daily	4 mg daily or 2 mg bid	6 mg daily or 3 mg bid	$18–$54 (covered by ODB)
Estradiol (transdermal, patch)*[a]	50 mcg daily/ apply patch 2x/week	Variable[d]	200 mcg daily/apply patches 2x/week	$39–$76[b]
Estradiol (transdermal, gel)*[c]	2.5 g daily (2 pumps, contains 150 mcg estradiol)	Variable[d]	6.25 g daily (5 pumps, contains 375 mcg estradiol), may be limited by surface area requirements for gel application	$58–$154
Estradiol valerate** injectable	3–4 mg q weekly or 6–8 mg q2 weeks	Variable[d]	10mg q weekly	$36–$46

a Estradot® brand
b 200 mcg daily given as 2 x 100 mcg patches applied twice weekly (4 patches/week)
c Estragel® brand
d Usual doses vary significantly between individuals. Use starting doses and titrate based on patient response. Maximum doses are not often needed. Use clinical judgement in selecting optimal individual dosing.
* *Price quotes provided by* www.pharmacy.ca
** *Estradiol valerate IM must be prepared by a compounding pharmacy, commonly at the minimum concentration of 10 mg/mL. Per updated Ontario guidelines, opened multi-use vials must be discarded after 28 days. Price quote provided by Pace Pharmacy.*

The above mentioned prices are accurate as of May 2018, and represent the price for a four-week supply of a generic brand of medication unless indicated otherwise (ranging from low dose to maximum dose). Prices include a usual and customary dispensing fee of $9.99 ($10.99 for Pace), which may vary from pharmacy to pharmacy.

Feminizing hormone therapy monitoring
(Sherbourne guidelines)

Table 6
Recommended bloodwork for monitoring feminizing hormone therapy

In this table, smaller and lighter grey "x"s indicate parameters that are measured under particular circumstances

Test	Baseline	4–6 weeks	3 months	6 months	12 months[e]	Yearly	According to guidelines for cis patients, or provider discretion
CBC[a]	X		x	x	X	x	
ALT/AST[b]	X		x	x	X	x	X
Creatinine/lytes[c]	X	x	x	x	x	x	
Hba1c or fasting glucose	X				X		X
Lipid profile	X				X		X
Total testosterone	X		X	X	X	X	
Estradiol	X		X	X	X	X	
Prolactin[d]	X				x	x	x
Other	Hep B, C						
	Consider: HIV, syphilis and other STI screening as indicated, frequency depending on risk						

a At baseline for all, and regularly with cyproterone, for Hb/Hct use female reference for lower limit of normal and male reference for upper limit of normal

b Baseline for all and regularly with cyproterone, otherwise repeat once at 6–12 months then as needed

c Cr, lytes, should be monitored at each visit with spironolactone, but is only required at baseline and then once between 6–12 months with cyproterone unless risk factors or concerns re: renal disease are present, use male reference range for upper limit of normal for Cr

d Prolactin should be monitored at least yearly with the use of cyproterone, and more frequently if elevation is noted

e During first year of treatment only

Note: Individual parameters should be considered more frequently if concerns are identified or existing risk factors are present.

Feminizing hormone therapy expected changes (Sherbourne guidelines)

Table 4
Effects and expected time course of feminizing hormones

Effect	Expected onset[a]	Expected maximum effect[a]
Body fat redistribution	3–6 months	2–3 years
Decreased muscle mass/strength	3–6 months	1–2 years[b]
Softening of skin/decreased oiliness	3–6 months	Unknown
Decreased libido	1–3 months	3–6 months
Decreased spontaneous erections	1–3 months	3–6 months
Erectile dysfunction	Variable	Variable
Breast growth *	3–6 months	1–2 years
Decreased testicular volume *	3–6 months	2–3 years
Decreased sperm production *	Unknown	> 3 years
Thinned/slowed growth of body/facial hair	6–12 months	> 3 years[c]
Scalp hair loss stops, no regrowth	1–3 months	Variable

a Estimates represent unpublished clinical and published observations[13 14 15]
b Significantly dependent on amount of exercise
c Complete removal of male facial and body hair requires electrolysis, laser treatment, or both

Adapted from: Hembree et al. 2017, *The Endocrine Treatment of Gender Dysphoric/ Gender Incongruent Persons: An Endocrine Society Guideline*[7]

* = potentially irreversible

- Also, don't rely on feminizing hormone therapy as contraception

Medications: Hormones: Masculinizing
(Sherbourne guidelines)

Table 9
Formulations and recommended doses of testosterone for masculinizing hormone therapy

	Starting/low dose	Maximum dose	Cost per unit	Approx. cost per 4 weeks
Testosterone enanthate (IM/SC)	20–50 mg q weekly or 40–100 mg q2 weeks	100 mg q weekly or 200 mg q2 weeks	5 mL vial (each contains 200 mg/mL x 5 mL = 1000 mg): $73.50	$14–$29 (covered by ODB with EAP request)
Testosterone cypionate (IM/SC)[a]			10 mL vial (each contains 100 mg/mL x 10 mL = 1000 mg): $64	$13–$26 (covered by ODB with EAP request)
Testosterone patch (transdermal)[b]	2.5–5mg daily	5–10 mg daily	60 x 2.5 mg patches: $164 30 x 5 mg patches: $169	$76.50–$315
Testosterone gel 1% (transdermal)	2.5–5 g daily (2–4 pumps, equivalent to 25–50 mg testosterone)	5–10 g daily (4–8 pumps, equivalent to 50–100 mg testosterone)	30 x 2.5 g sachets: $67 30 x 5 g sachets: $110 2 pump bottles[c]: $175	Sachets: $62–$205 Bottles: $81–$327

a Testosterone enanthate is compounded in sesame oil, and testosterone cypionate is compounded in cottonseed oil; patients with allergy to either of these compounds should use the alternative agent

b Androderm brand, per drug monograph the 12.2 mg patch delivers 2.5 mg/day while the 24.3 mg patch delivers 5 mg per day

c Each pump bottle provides 60 pumps, 1 pump = 1.25 g of gel, equivalent to 12.5 mg of testosterone

* Price quotes provided by www.pharmacy.ca. The prices listed above are accurate as of June 2018 and represent the price of the generic brand of medication unless otherwise indicated (ranging from low dose to maximum dose). Prices include a usual and customary dispensing fee of $9 99, which may vary from pharmacy to pharmacy.

Note: Testosterone (in all forms) is considered a controlled substance in Canada; prescriptions should be written in accordance with provincial requirements for controlled substances.

Masculinizing hormone therapy monitoring (Sherbourne guidelines)

Table 10
Recommended bloodwork for monitoring masculinizing hormone therapy

In this table, smaller and lighter grey "x"s indicate parameters that are measured under particular circumstances

Test	Baseline	3 months	6 months	12 months[c]	Yearly	According to guidelines for cis patients, or provider discretion
CBC[a]	X	X	X	X	X	
ALT/AST	X		X[d]			X
Fasting Glucose/ Hba1c	X		X[d]			X
Lipid profile	X		X[d]			X
Total Testosterone	X	X	X	X	X	
LH[b]	x			x	x	
Other	Hep B, C, pregnancy test					
	Consider: HIV, syphilis and other STI screening as indicated, frequency depending on risk					

a Male reference ranges should be used for Hb/Hct (lower limit of female range can be used if menstruating)
b Post-gonadectomy only: elevated LH may have implications regarding bone mineral density (See Osteoporosis and bone mineral density screening)
c During first year of treatment only
d Once at either 6 or 12-month mark

Note: Individual parameters should be considered more frequently if concerns are identified or existing risk factors are present.

Masculinizing hormone therapy expected changes (Sherbourne guidelines)

Table 8
Effects and expected time course of masculinizing hormones

Effect	Expected onset[a]	Expected maximum effect[a]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth *	3-6 months	4-5 years
Scalp hair loss *	6-12 months[b]	Variable
Increased muscle mass/strength[c]	6-12 months	2-5 years
Body fat redistribution	1-6 months	2-5 years
Cessation of menses	1-6 months	n/a
Clitoral enlargement *	3-6 months	1-2 years
Vaginal atrophy	1-6 months	1-2 years
Deepened voice *	6-12 months	1-2 years

a Estimates represent published and unpublished clinical observations[4–7]
b Highly dependent on age and inheritance; may be minimal
c Significantly dependent on amount of exercise

Adapted from Hembree et al., *The Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Guideline*[8]

* = potentially irreversible
  + Infertility is also potentially irreversible
    + but don't rely on testosterone as contraception + testosterone is also teratogenic

Risks of hormone therapy

- Feminizing: liver/kidney dysfunction, venous thromboembolism, cardiovascular
- Masculinizing: cardiovascular, mood, liver dysfunction, polycythemia, uterine bleeding
- Both: infertility

Surgical referrals

(https://www.saskatchewan.ca/residents/health/accessing-health-care-services/gender-identity-gender-diversity-and-transgender-support)

Chest surgery

- Feminizing: not covered in SK
- Masculinizing: only requires a referral to a plastic surgeon who agrees to do it, no additional documentation

Genital surgery

- Hysterectomy, orchiectomy: same as chest surgery
- GRS Montreal (grsmontreal.com): Vaginoplasty, phalloplasty
  - 1 psychiatrist + 1 surgical "approver" below
    - Dr Dungavell (psych) in Saskatoon
    - Dr Sahlu (psych) in Regina
    - Dr Clark @ FMU - can send letter or pt can phone FMU for appt
    - Drs Pask @ Saskatoon Community Clinic & Dr Schramm @ FMU - only for own patients
    - See Ministry of Health website for other Alberta approvers

WPATH criteria:

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).
6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Coverage by province

Source: CPATH, 2015

- Only GRS clinic in Montreal provides bottom surgeries for SK patients: grsmontreal.com
- Facial feminization, tracheal shave & hair removal always private
  - Local: The Face Institute in Saskatoon
- Some provinces provide funding for surgeries outside Canada

Preventive screening

- Bone mineral density over 50 yo
- Paps for trans men if they still have a cervix per routine guidelines for women
  - Some studies show decreased provider knowledge about this
- Mammography for trans women & men per routine guidelines for cis women
  - Not necessary per Sherbourne guidelines for trans men with “top” surgery
- Prostate cancer screening already not recommended generally for men anymore, but consider for trans women with strong FamHx or of African descent (same as for cis men)

Shared care

- Refer to local endocrinologist, general internist or family doctor with a special interest
  - Saskatoon
    - Dr. Leane Pask @ Community Clinic
    - Drs. Carla Holinaty & Ginger Ruddy @ Westwinds - consult service
  - Regina
    - Dr. Tom Perron (General internist)
    - Dr. Clark @ FMU - patients can self-refer by calling 306-766-0444

Cultural safety reproductive considerations: Language

Pregnant person safe(r) language: “dad”, “carrier”, “gestational parent” (Light et. al 2014)

Use (less gendered language) [1]	*Instead of (gendered language)*
People who menstruate, people who are pregnant	Female, women; pregnant women
People who produce sperm	Male, men
Not trans, non-trans, cisgender	Biologically male/female
Assigned male at birth	Biologically male
Assigned female at birth	Biologically female
Sexual or genital (gen) health	Women’s/gynecological healthcare
External genitals, external pelvic area	Vulva, clitoris
Outer parts	Penis, testicles
Genital opening, frontal opening, internal canal	Vagina
Outer folds	Labia, lips
Internal reproductive organs	Female reproductive organs
Internal organs	Uterus, ovaries
Internal gland	Prostate
Chest	Breasts [2]
Chest or breastfeeding [2]	Breastfeeding
Absorbent product	Pad/tampon
Internal condom	Female condom
Uterine bleeding	Period/menstruation
Parent or gestational parent	Mother
Hypothalamic pituitary gonadal – ovarian axis	Female gonadal steroid axis
Hypothalamic pituitary gonadal – testicular axis	Male gonadal steroid axis

Superscript number [1] The terms in these columns are offered as suggestions, but we recommend asking patients which words they use for their own body parts and experiences. *Superscript number* [2] Transfeminine persons may prefer breasts.

Krempasky. Contraception for transmasculine persons. Am J Obstet Gynecol 2020.

Key reproductive considerations

- All guidelines recommended discussion of fertility preservation prior to initiating hormone therapy as well as contraception discussion: (Bourns 2019), (Health 2011), (Hembree et al. 2017), (Amato 2016)
- Don’t rely on masculinizing and feminizing hormone therapy as contraception!
  - Up to 31% of transmasuline people believe that testosterone functions as contraception, and up to 8% reported being told so by a healthcare provider (Krempasky et al. 2020)
- Concerns that puberty blockers followed by gender-affirming hormone therapy may lead to gametes never developing
  - Not much research on this
- PubMed search for “transgender” + “pregnancy” yielded 144 articles, all in the past 14 years

Testosterone + pregnancy

- Testosterone is teratogenic: labial fusion, abnormal vaginal development, persistence of a urogenital sinus, and clitoromegaly (Krempasky et al. 2020)
  - Sherbourne guidelines (Bourns 2019) note increased risk of pregnancy loss
- Stopping testosterone prior to attempting to conceive is recommended, but duration varies/is uncertain (Amato 2016) from as little as 4-6 weeks (Krempasky et al. 2020)
- Clomiphene citrate or hCG injections may be required (Amato 2016)

2013 online survey of transmasculine (TM) people who had been pregnant + delivered

- Online survey, 2013, n=41 TM who had delivered
  - Convenience sample, mostly white and living in U.S.
- 88% used own oocytes
- 80% reported resuming menses within 6 mo of stopping testosterone hormone therapy
- 5 conceived while still amenorrheic due to testosterone hormone therapy
- 17/25 on testosterone previously stopped it to become pregnant
- 7% used fertility drugs
- Most conceived in first 4 mo of trying
  - 19% in 4-6 mo
  - 10% in over 7 mo
- Only half had physician prenatal care
  - 46% had midwife care
  - 5% had no prenatal care
- More than general population delivered outside of a hospital
  - 17% home births
  - 7% birth centre
- No noted changes in pregnancy outcomes or complications from general population

Citation: Light, A. D., J. Obedin-Maliver, J. M. Sevelius & J. L. Kerns (2014) Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstetrics and gynecology,* 124**,** 1120.

Light et. al 2014: Qualitative findings

- Isolation, ?increased postpartum depression
- Gender dysphoria: some had more and some had less in pregnancy
- Interactions with healthcare professionals: good and bad
  - “Treat us as if we are normal human beings with normal bodies”
  - Safe language: “dad”, “carrier”, “gestational parent”, “chest feeding”

Emerging reproductive technologies

- Cryopreservation of ovarian tissue
- Uterine transplantation
  - WPATH virtual conference Nov 2020 oral presentation by Dr. Liza Johannesson (Johannesson 2020)
    - 31 uterus transplants done in U.S. @ Baylor, Cleveland Clinic, UPenn since 2016, all in cisgender women
      - Pregnancies: a few gestational hypertension, gestational diabetes, preterm labour/delivery
        - No fetal complications
        - All delivered by C-section
      - Immunosuppression required x 3-5 years
      - Remove the uterus after childbearing complete
      - All private and/or funded by research $

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Resources

For patients/general public

- Paps for trans men: checkitoutguys.ca
- Trans Care BC: transhealth.phsa.ca
- Sask Medical Transition Guide
- CATIE safe sex patient guide
  - Brazen, Trans Women's Safer Sex Guide
  - PRIMED^2, A Sex Guide for Trans Men into Men
- Saskatchewan Ministry of Health info page
- Transition related surgery summary sheets from Rainbow Health Ontario
- GRS Clinic in Montreal: grsmontreal.com
- Monarch Mental Health thru URPride
- Local organizations
  - TransSask: transsask.org
  - Trans Umbrella Foundation: transumbrella.org
  - University of Regina Pride: urpride.ca

For health and social service providers

- World Professional Association for Transgender Health (WPATH): wpath.org
- Canadian Professional Association for Transgender Health (CPATH): cpath.ca
- Guidelines
  - WPATH
  - Trans Care BC guidelines: transhealth.phsa.ca > Service providers
  - Endocrine Society guidelines 2017
  - Sherbourne trans health guidelines, Dec 2019
  - UCSF Centre of Excellence for Transgender Health guidelines
- Trans PULSE project (Ontario): http://transpulseproject.ca/

Nonmedical local support

- OUTSaskatoon
  - Online: Q List
- Moose Jaw Pride
- UR Pride (Regina) support groups
- Saskatchewan Trans Health Coalition Medical Transition Guide
- Trans Umbrella Foundation (TUF) support groups (Regina)
  - Adults
  - Youth
  - Parents of gender diverse people
- TransSask
  - Online: Health and Mental Health Providers List
  - Online: SK Medical Transition Guide
  - Patient support person: support.coordinator@transask.ca
  - PA support group (monthly @ Friendship Ctr)

Coming soon: TRANS navigator pilot project

- Through a SK Health Research Foundation-SK Centre for Patient-Oriented Research Sprout grant
- A person with lived experience, who provides navigation, support and education to people who are trans and gender diverse + their support people and healthcare providers
- Funding + evaluating x 1 year, with goal of securing long-term funding & refining program
- Navigators to start in March!

Questions or comments?

Thank you!

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