



**Department of Public Health  
Transgender Health Services**

50 Lech Walesa Street  
San Francisco, CA 94102  
Telephone: (415) 355-7498  
FAX: (415) 355-7407

[transgenderhealthservices@sfdph.org](mailto:transgenderhealthservices@sfdph.org)  
[www.sfdph.org/transgenderhealthservices](http://www.sfdph.org/transgenderhealthservices)

**EDWIN M. LEE**  
MAYOR

**Primary Care of Transgender People**

**General**

**Important Information**

Most of the health care needs of transgender people are not specific to gender issues. The goal of care for individual patients is to assist them to live in good health. Unfortunately - due to the frequent experience of discrimination, isolation and shame, and for some patients an understandable pre-occupation and urgency to obtain hormone therapy and surgery – patients often do not receive recommended preventative care and care for medical conditions. Transgender people in our community have been found to be at particular risk for HIV and other sexually transmitted infections, suicidal ideations and acts, and criminal justice involvement. Like other marginalized and stigmatized groups, transgender patients may present with histories of trauma, with histories of negative experiences with institutions, and with multiple vulnerabilities. Family and social support and connection within transgender communities has been found to be protective. Building rapport with patients may take several visits. There is no reason to believe that given accessible and sensitive care that transgender people cannot have good health outcomes comparable to non-transgender people.

Prepared by Barry Zevin MD  
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Tom Waddell Urban Health Clinic  
San Francisco Department of Public Health

**Best Practices**

- Deliver medical care and preventative services that are relevant to the patients anatomy and risk factors
- Provide health maintenance and prevention interventions according to established standards based on patient age, anatomy, and risk factors.
- Obtain relevant medical history: In addition to standard health history this will include history of gender experience, prior hormone use, prior surgical history, sexual history, patients goals related to health and gender transition.
- Obtain psycho-social needs assessment including mental health history, information about family and other social support or estrangement, alcohol and drug use history, criminal justice involvement, history of past and current suicidality, and support from and knowledge about the TG community
- Be mindful in physical exam of previous trauma and abuse. Assess patient's comfort with physical exam; perform exam appropriate to patient's health conditions and relevant preventative exam.
- Use harm reduction principles in addressing substance use, sexual practices, occupational sex work and destructive unhealthy relationship.

**Practices to Avoid:**

- Avoid breast, rectal and genital exam on initial visits. Unless there is an urgent necessity for this part of the exam it is best delayed until trust has been established between the provider and the patient.

## **Health promotion / disease prevention**

### **Part 1: HIV, STI, and sexual violence Prevention**

#### Important information

Prevention services have been developed for transgender populations, especially those living in poverty in cities, due to the high prevalence of HIV infection, STI's, survival sex, involvement in sex work, and high risk of being a victim of abuse, sexual assault, hate crimes, and murder. Preventative services need to be customized to individual patients in particular communities. Various interventions have been developed to reduce the risks of acquiring HIV infection and sexually transmitted diseases. Counseling received as part of primary care for transgender people has not been evaluated but as part of a package of services including HIV testing and treatment, STI screening and treatment, provision of condoms and sterile syringes, and other services this intervention is consistent with CDC recommended high impact hiv prevention. The policy of SFDPH STD control division is to recommend screening transgender people for STI every 3-6 months. Some primary care providers prefer to ask patients at every visit, "Do you need STD screening?" and have found this effective when applied consistently. The best option for STI screening will depend on the capacity and population seen at a primary care setting and the preferences of individual patients. There has not been adequate study of strategies for individuals to reduce the risk of being victimized in vulnerable sexual situations. One suggested strategy has been working with patients to safely disclose their anatomy to potential sexual partners in a way that will reduce risk of violence. If this strategy is pursued it must be done in a sensitive manner, balancing any safety advantages of disclosure against peoples right to privacy and avoiding any suggestion that victims are responsible for the bigotry of others.

#### Best Practices

- Assess for high-risk sexual behavior, HIV and STD risks and provide counseling to reduce risks and services such as providing condoms and teaching patients how to negotiate safer sex with sex partners.
- Perform STD screening every 3-6 months for sexually active patients, including HIV AB, and VDRL / RPR for all; pharyngeal, urine, and rectal GC and Chlamydia for MTF; and pharyngeal, rectal, and vaginal GC and Chlamydia screening for FTM.
- Ask patients if they need STD screening at every visit. This is a reasonable alternative to universal screening and good entry point to safer sex counseling.
- Counsel patients on strategies for disclosing their anatomy to potential partners as a way of avoiding violence.

## **Health promotion / disease prevention**

### **Part 2: Health maintenance**

#### Important Information

Mortality rates may be higher in transgender populations than the general population due to smoking related diseases, HIV disease, and suicide. Health care maintenance will include age appropriate interventions as done for other patients. Other specific interventions will be done based on specific risk and epidemiology seen in transgender populations. Hepatitis A&B immunity should be assured in all patients who are sexually active with men. TB screening should be done every 6 to 12 months for patients who experience homelessness. Monitoring for weight gain or weight loss is recommended for all transgender people. Weight gain and increases in blood pressure are common adverse effect of both masculinizing and feminizing hormone therapy. Weight gain or weight loss may also be a sign of depression or eating disorder which are more commonly found in transgender people. Common conditions such as diabetes, cardiovascular disease, and osteoporosis occur no more frequently in transgender people who do not take hormones. In some studies FTM transgender people had higher rates of polycystic ovarian syndrome (PCOS) and vigilance for signs of PCOS is recommended with appropriate work-up and monitoring if it is diagnosed. The impact of hormone therapy on the development of diabetes is controversial but beyond the risks of weight gain, hormone therapy at usually prescribed doses does not appear to contribute to excess diabetes. Transgender patients on hormone therapy may have increased risk of cardio-vascular events that may be preventable using standard risk reduction strategies. Cigarette smoking is notably higher in many LGBT populations. Transgender people may be more highly motivated to quit due to desire for positive outcomes with feminization or masculinization. Osteoporosis should be vigilantly monitored for in MTF patients who have not continued maintenance levels of estrogen after orchiectomy and for FTM patients who have not continued maintenance levels of testosterone after oophorectomy. Patients who continue hormone replacement therapy are at lower risk and screening should be based on presence of other risk factors. MTF patients on estrogens have a high risk of venous thromboembolism and risk of other thrombosis. Reduction of other risk factors such as smoking and sedentary lifestyle is believed to reduce this risk. Exercise counseling needs to be done in a creative and sensitive manner. Because of widespread discrimination and abuse it may not be safe for a transgender patient to go to a gym or even to go out in public. Furthermore poverty may limit many options. Nevertheless individualized planning can usually result in an acceptable plan for a motivated patient.

#### Best practices

- Assess mental health and suicide risk at every visit.
- Review health care maintenance needs including: immunizations, TB screening, safety, safer sex counseling, and cardiovascular risk reduction every 3-6 mos.
- Monitor weight and blood pressure at every visit.
- Screen for diabetes, cardiovascular disease, and bone health as for non-transgender populations.
- Provide smoking cessation screening, counseling, and assistance at every visit. Standard smoking cessation strategies may need to be adapted to the particular needs of transgender patients such as transgender specific groups and educational content related to effects on hormone effects and adverse effect risk in patients on hormone therapy.
- Provide counseling on active lifestyle and exercise to all patients. Individualize exercise advice for each patient's situation.
- Use information about risk of smoking and risk of sedentary lifestyle for patients on hormone therapy and those wishing to get surgery to motivate.

## **Health promotion / disease prevention**

### **Part 3: Special Issues**

#### **Important Information**

Transgender individuals may do a number of activities and have a number of false beliefs due to gender dysphoria that have health impacts. Educating patients and offering them alternatives can mitigate the adverse or unintended consequence of these practices and beliefs or at least reduce anger and regret at a later stage. Sexual orientation and sexual activity exist along a diverse range. Many patients may be hesitant to bring up sexual functioning with medical providers and medical providers may make incorrect assumptions about patients' practices and desires. Sexual history should be done in an open-ended manner. From the point of view of sexual functioning some MTF patients wish to continue to have erections and others do not. Some FTM patients wish to have insertive vaginal penetrative sex (penis and/or toy) and some do not. Understanding these preferences can allow us to address patient expectations and assist patients. Hormone therapy for masculinization or feminization may decrease fertility but does not act as a reliable contraceptive. Many patients have misconceptions about the possibility of pregnancy and individualized education is appropriate based on the patient's sexual history. Sex reassignment surgery and to a lesser extent hormone therapy are causes of permanent infertility. It is appropriate for any patient facing loss of fertility to have a discussion about this. The ethics of this and detailed discussion about options have been published.

There have been numerous reports of severe illness and death resulting from the illicit injection of silicone and other substances by illicit providers often at group events (pumping parties) especially in the Latina MTF community. Anecdotally education about this in our primary care clinics and community awareness organizing have reduced the number of patients seen with these complications. FTM patients may practice breast binding to give the appearance of a flat chest when clothed. Long term breast binding may reduce elasticity of chest tissue and interfere with good outcomes in chest reconstruction surgery. Overly tight binding may interfere with lung function, cause rib pain or even rib fracture. Extensive anecdotal information is available online but scientific study is not available. MTF patients may push their testes into the inguinal canal and stretch their penis and scrotum posteriorly to present a more feminine appearance when clothed. This may be called tucking. Risks of tucking have not been well described in medical literature. Skin irritation and increased susceptibility to candida intertrigo have been described anecdotally. Patients who push testicles into the inguinal canal are at risk of inguinal hernia and testicular pain possibly neuropathic in origin

#### **Best practices**

- Discuss contraception issues with all patients.
- Discuss sexual functioning with all patients.
- Discuss fertility issues and options with patients considering hormone or surgical therapy.
- Educate MTF patients regarding the risk of injecting silicone or other substances by illicit providers.
- Educate FTM patients about possible risks of breast binding and strategies to reduce risks.
- Educate MTF patients about possible risks of "tucking" and strategies to reduce risks.

## **Health promotion / disease prevention**

### **Part 4: Cancer Screening**

#### Important information

Cancer screening is performed based on anatomy and risk. Unfortunately the risk of common forms of cancer is not well described for transgender patients. Patients who have not had exposure to hormone therapy or surgery should be screened as per guidelines developed for patients with their anatomy. There is no consensus among transgender health experts on best practices for breast cancer screening. Mammograms for MTF patients have no clear evidence of benefits or harms. There is no evidence that MTF patients on estrogen feminizing hormone therapy are at high risk for breast cancer. Mammographic changes are dependent on time of estrogen exposure. It is considered prudent to screen patients with significant estrogen exposure. There is no consensus among transgender health experts on who to screen. Our recommendation to screen patients who are over the age of 40 or 50 and have had 20 years or more of exposure to estrogens is an extrapolation based on our understanding of the biology of breast cancer. Mammoplasty with silicone or saline implants may make mammography technical difficulty or impossible. FTM patients with breast tissue are at risk of breast cancer that is at least equivalent to women of similar age and risk. It is uncertain to what extent testosterone increases breast cancer risk. Testosterone does not suppress ovarian estrogen production in usual doses used for masculinization and may aromatize to estrogens when given in high doses. FTM patients who have had mastectomy and chest reconstruction will usually have post-surgical residual axillary and possibly other breast tissue. They require vigilance for breast cancer (although it is not clear that screening is appropriate or what the appropriate screening modality for this would be.) Mastectomy with chest reconstruction may make mammography technical difficulty or impossible.

Cervical cancer screening in transmen with a cervix may be technically difficult due to vaginal and cervical atrophy. Screening may also be psychologically difficult due to anatomical discomfort as part of gender dysphoria and due to the very common occurrence of sexual abuse in this population. Usually when offered in a respectful manner PAP smear can be done but benefit should be weighed against risk if it is likely to be traumatizing. It is appropriate to ask the patient's preference for a male or female provider to perform the exam and also if a chaperone is to be used whether they prefer the chaperone to be male or female. The cytologist should be informed if the specimen comes from a patient on testosterone, as the test will need to be interpreted with this information.

Endometrial hyperplasia or uterine cancer is a theoretical risk for FTM patients on testosterone who have not had a hysterectomy with oophorectomy. Estradiol is present in these patients and testosterone may aromatize to estradiol at both the systemic and tissue level. Studies of the endometrium of patients on masculinizing therapy have been reassuring that endometrial hyperplasia is rare or does not occur. A pathological study of patients who underwent hysterectomy showed endometrial atrophy and no hyperplasia. Since there is a theoretical possibility of endometrial cancer guidelines for practice should be the same as for bleeding in postmenopausal women. Before initiating such a work up very careful history should be obtained about changes in the patients testosterone dosing over the preceding few months since this is the most common cause of bleeding.

The utility of prostate cancer screening in all populations is controversial. Hormone therapy in MTF patients likely lowers prostate cancer risk. Nevertheless prostate cancer does occur in this population and risk and screening should be discussed. PSA screening in MTF patients on hormone therapy is not useful as therapy reduces PSA levels. All types of vaginoplasty procedures leave the prostate intact. No FTM hormone therapy or surgical procedure creates a prostate and FTM patients have no risk of prostate cancer.

## Best Practices

- Perform breast cancer screening for all patients with breast tissue. Follow standard guidelines for woman and begin screening with mammograms for patients over age 40 or 50 who have been exposed to estrogen (endogenous or exogenous) for 20 years or more, or earlier if abnormal findings or family history of breast cancer.
- Continue to be aware of breast cancer risk for FTM patients who have had subcutaneous mastectomy and chest construction.
- Perform cervical cancer screening for patients with a cervix (i.e. FTM patients who have not undergone hysterectomy or had subtotal hysterectomy with preservation of the cervix). MTF patients do not require Pap smear.
- Perform screen for endometrial hyperplasia / uterine cancer for FTM with a uterus if they have bleeding after long period of amenorrhea and they have not had a change to their testosterone dose
- Perform (or withhold) prostate cancer screening according to standard guidelines in all patients with a prostate. This includes MTF who have had any type of vaginoplasty as all procedures leave the prostate intact.

Practices to Avoid:

## **Treatment of health conditions**

### Important information

Gender dysphoria and all treatments for gender dysphoria are not contra-indications for providing the full range of standard treatments for HIVD, diabetes, or any other chronic health conditions. Outcomes for the treatment of chronic health conditions can be equivalent to outcomes in other populations. Several conditions may be exacerbated by hormone therapy. These issues are treated in detail in the hormone therapy section of these guidelines. In many instances the benefits of starting hormone therapy to patients in restoring hope, improving mood, and decreasing suspicion and anger at medical institutions will outweigh any risk of harm from exacerbating medical conditions. While it has not been well studied anecdotally patient engagement in healthcare is much improved in patients who are seeing healthcare providers who are informed about transgender health. Patients receiving appropriate care for gender dysphoria show improvements in depression, self-efficacy, and quality of life that would be expected to result in improved adherence to treatments for chronic conditions and better outcomes. Anecdotally patients improve adherence, sometimes dramatically, with the intervention of starting hormone therapy. Important drug - drug or drug-street drug interactions with the currently prescribed medications for hormone therapy are not common. Those that are potentially life threatening or require changes to therapy are discussed in the hormone therapy section.

### Best Practices

- Provide standard care for HIV disease, diabetes, and other chronic medical conditions.
- Balance the risk of hormone therapy exacerbating an illness with the likely benefit of improved adherence.

### Practices to Avoid:

1. Avoid delaying or denying hormone therapy due to concerns about drug-drug, or drug-street drug interactions