




D P C
SUMMIT



Gender Affirming Care for Primary Care Docs

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1



- ▶ Navigate to <https://aafp1.cnf.io/> and tap the session titled "Gender Affirming Care for Primary Care Physicians"
- ▶ OR just point your phone's camera at the QR code to join directly



2

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3

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4

Learning Objectives

- 1 Describe the care processes, documentation considerations, and team roles involved in supporting patients receiving gender-affirming hormone therapy in primary care settings.
- 2 Identify best practices for monitoring workflows, laboratory coordination, and follow-up systems that promote patient safety and continuity of care for transgender patients.
- 3 Apply strategies for addressing common operational and care-coordination challenges and integrating preventive health and health-maintenance considerations into ongoing care for transgender patients.



5

Resources

World Professional Association for Transgender Health (WPATH)

- Standards of Care 8th edition
- Published 2022
- Clinical departures from the SOC may come about because of:
 - a patient's unique anatomic, social, or psychological situation;
 - an experienced health care professional's evolving method of handling a common situation;
 - a research protocol;
 - lack of resources in various parts of the world;
 - or the need for specific harm-reduction strategies.

Boston University

<https://www.bumc.bu.edu/endo/clinics/transgender-medicine/guidelines/>

University of California San Francisco

<https://transcare.ucsf.edu/guidelines>



6

Terminology

- **Transgender and Gender Diverse (TGD):** inclusive, legal, thorough
- **“Trans Folx”:** a common informal term
- **AFAB/AMAB:** assigned female/male at birth
- **Trans Man:** an AFAB person whose authentic gender is male
- **Trans Woman:** an AMAB person whose authentic gender is female
- **Cisgender:** a backwards working term created when someone needed a term meaning “not trans” that did not imply normality; derived from organic chemistry

GOLDEN RULE:

Use the language your patient uses.
If unknown, uphold safety, dignity, and respect.



7

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: You have started a DPC practice and you’re a straight, cis, white man but you really want to help transgender people in your community with gender affirming care. Which of these is the most important first step to preparing your clinic to care for these patients?

8

Inclusive Marketing

- Welcoming statements on website, signage, paperwork
- Hidden language of LGBTQ+ patients – “we are an inclusive practice”
- Rainbows (subtle or overt)
- Pride flags
- Participation in local Pride events
- Sponsorship of LGBT organizations
- Recognition of Pride Month (June!)
- Model good practices that help both trans and cis patients, such as:
 - using your and your staff members’ pronouns so you are normalizing sharing pronouns;
 - intentionally using gender-neutral language in describing patients served and services offered
- You can hire people to audit your language and make recommendations for gender inclusivity



9

Inclusivity Examples



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10

Practical Office Considerations

- “First, do no harm...”
- **Pronouns:** are they available in your EMR, messaging, billing software?
- **Legal vs. Preferred/Chosen Names:** often need to send orders and insurance info (when needed) using the legal name; how will you manage this?
- **Staff:** is your staff comfortable, welcoming, and inclusive?
- **Lab Reference Ranges:** be aware that gender markers are often incorrect!

Medical Equipment:

Syringes:

1 cc Luer Lock syringes without needles

Needles:

21G 1.5 inch needles to draw;
28-30G 5/8 inch needles to inject

Sharps disposals to give to patients



11

Patient Considerations

- Financial reality of trans folk — payment is often an issue, job instability, housing issues, and lack of family support (direct financial support and/or removal from insurance plans)
- Gender issues and mental health issues almost always coexist
- Lots of issues with communication and outreach
- Gender issues are often studied, discussed, and understood by the young; as a physician, it’s important to have some humility (and grace)
- If needing to make referrals to other providers, do the footwork to vet providers for their experience and desire to care for trans (and all LGBTQ+) patients



12

Coding and Insurance Considerations

CODING

Gender Dysphoria (GD) F64.0 remains in the DSM-5-TR

Gender Incongruence is no longer seen as pathological or a mental disorder... but there is still an ICD-11 code for it HA60.

MED NEC

“Gender incongruence that causes clinically significant distress and impairment.”

“Gender incongruence is marked and sustained.”



13

Live Content Slide

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Poll: According to WPATH Standards of Care 8th Edition (2022), which of these is most necessary before starting gender affirming care with a patient?

14

Everybody Wants Hormones

But first...

- Assess for mental and physical health conditions that could negatively affect outcome of treatment
- The first discussion
- Consent
- Reality check
- Consideration of reversible options

NOT required prior to treatment initiation:

- Psychometric assessment
- Counseling or psychotherapy
- Genital exams



15

The First Discussion

- Please share with me your journey to understand your authentic gender.
- Tell me the story of the earliest time you recognized your gender mismatch.
- What things cause you gender dysphoria?
- When do you have gender euphoria?
- When you imagine your fully realized self, what does your body look like?
- What is the closest you have come to ending your life?
- Who is in your support network?
- What goals do you have for treatment?
- What plans do you have for surgery?
- Tell me what you know about what to expect from hormone treatment?

RED FLAGS:
“figure out”
“trying to understand”



16

The Consent Discussion

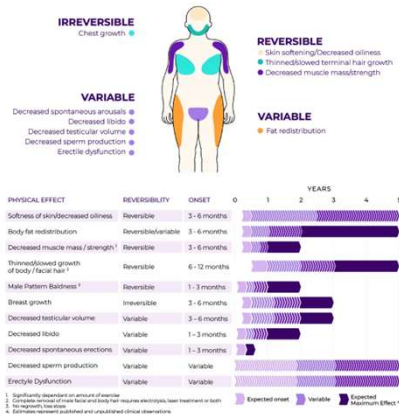
- Permanent vs. reversible changes (see next slide)
- Hormones will not...
- Risks and side effects
- Reproductive effects
- Time frames (see next slide)
- Smoking/nicotine use greatly increases risk



17

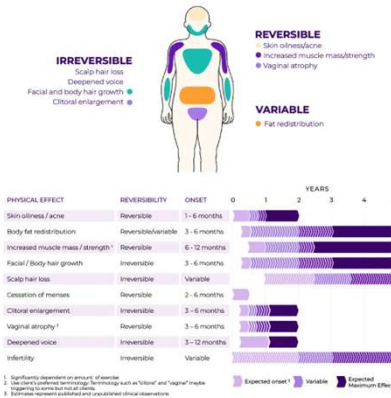
Permanent vs Reversible Changes

Expected effects timeline of using estrogen and anti-androgens for gender affirming hormone therapy



INFOGRAPHIC: <https://getplume.com/blog/timeline-estrogen-progesterone-tblockers/>

Expected effects timeline of using testosterone for gender affirming hormone therapy



INFOGRAPHIC: <https://getplume.com/blog/all-about-changes-on-testosterone/>



18

The Reality Check

If your life or financial situation will not permit...

- Taking your medicines on schedule
- Follow up bloodwork every 3 months
- Getting bloodwork done before you run out of medicines
- Follow up visits every 3 months

...then you are not ready to start GAHT



19

Completely Reversible Options

- Hair styles
- Fashion choices
- Binding
- Padding
- Tucking



20

And Now, Hormones!

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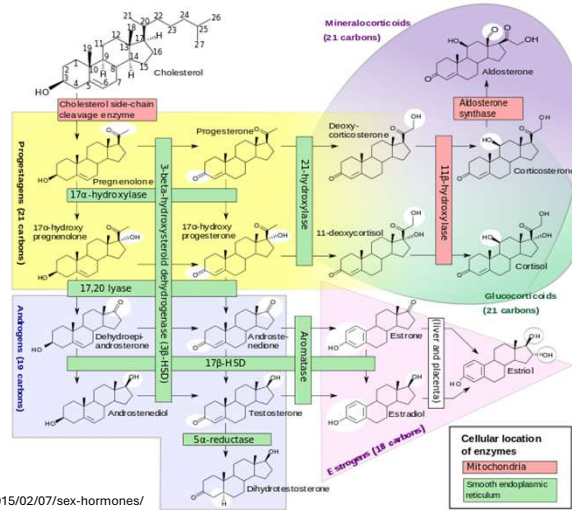
21

Live Content Slide
When playing as a slideshow, this slide will display live content

Poll: A 22 year old patient, assigned female at birth (AFAB), identifies as a man and would like to begin hormone therapy. After doing all that stuff on the other slide and deciding that hormones are the right choice, you initiate testosterone at 100 mg every 2 weeks. After 3 months, you get labs. Which of these do you expect to occur?

22

Normal Physiology — It's Really Simple



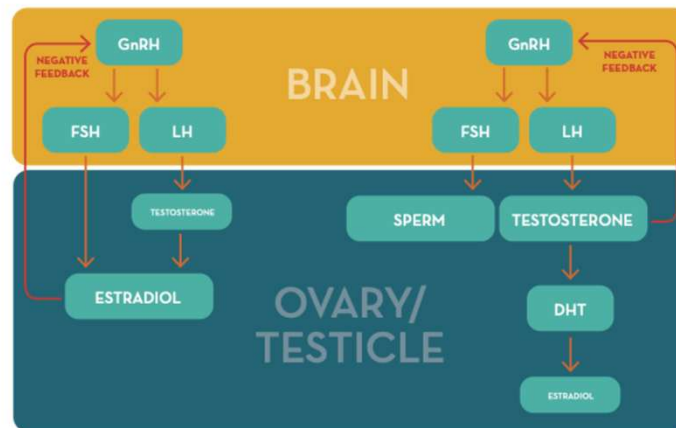
<https://pharmaceuticalintelligence.com/2015/02/07/sex-hormones/>

Haha just kidding, this is a family practice conference, not internal medicine!
Haha just kidding again!



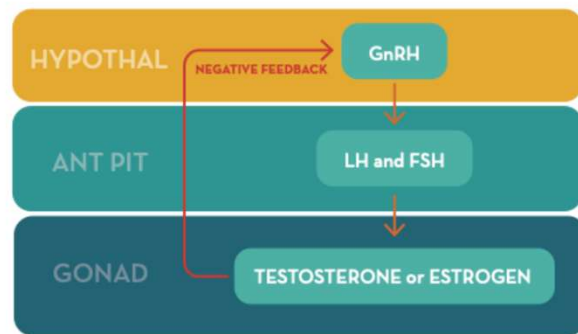
23

Normal Physiology — It's Really Simple



24

Normal Physiology — It's Really Even More Simple



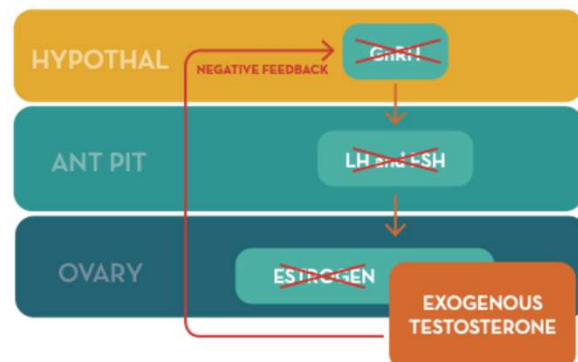
Please Note:

- Everyone has a brain
- Everyone has gonads
- The system is the same
- The hormones are different



25

Gender Affirming Hormones: AFAB

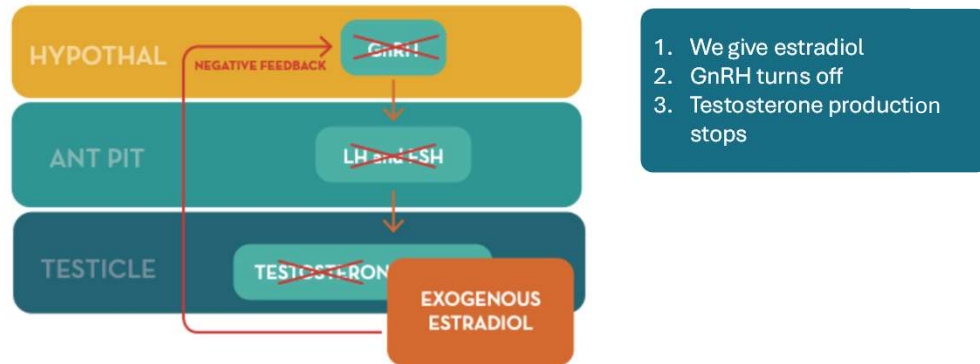


1. We give Testosterone
2. GnRH turns off
3. Estrogen production stops



26

Gender Affirming Hormones: AMAB



1. We give estradiol
2. GnRH turns off
3. Testosterone production stops



27

Initiating Masculinizing GAHT

Testosterone, or

- More Testosterone

Starting dose depends on goals

- Testosterone cypionate or enanthate 100 mg-200 mg SC or IM q 2 weeks
- Consider progestin for suppression of menses as an option depending on patient's dysphoria
- Patch or gel an option, but maybe for maintenance

Cypionate vs. Enanthate

- Cypionate: 200 mg/mL, 1 mL vial size, \$25/vial, \$0.125/mg
- Enanthate: 200 mg/mL, 5 mL vial size, \$80/vial, \$0.082/mg
- Cypionate is more commonly used because of insurance.
- Enanthate is less commonly used, and is thicker; but cheaper and vial size more convenient.

Subcutaneous or intramuscular is equivalent; SC is much more common to use

Dosing can be every two weeks, weekly, or twice weekly; total weekly dose is easiest thing to track

Be conscious of dosing/measuring weirdness: 200 mg/mL messes with your brain. 1 unit = 0.02 mg. *Jay has made this mistake and so have his patients! Aaron always writes it for volume and rages when the EMR or refill translates it.*



28

A Note on Pharmacy Frustrations

- Testosterone is a controlled substance
- If the dose does not match to a 30 day supply, pharmacy has issues
- So:
 - Write prescription for testosterone to allow for monthly refill (eg, Testosterone cypionate 200 mg/mL, inject 200 mg/week, #4 mL)
 - Instruct patient to use according to instructions you will give (eg, 100 mg per week, or 0.5 mL weekly)
 - Have patient pick up refills on schedule; they may have surplus but it can store in fridge and that's okay



29

Initiating Feminizing GAHT

Estradiol

- 17-B estradiol Pills; less expensive (generic!): 2-6 mg/day
 - Not ethinyl estradiol (OCPs) (VTE)
 - Not conjugated estrogens (Premarin) (VTE)
- Transdermal; preferred if increased risk of VTE (Age >45): 0.1-0.4 mg 2x/week
- Injection; may not need a blocker: Estradiol valerate, 5-20 mg/2 weeks

Note: Some patients may take the pills sublingual. I don't care as long as they always do it the same way so the levels track

Testosterone blocker (not always necessary)

- Spironolactone; more monitoring, brain fog: 100-200 mg/day
- Others
 - GNRHa (osteoporosis risk if estradiol too low)
 - Finasteride; (sparse data, confusing labs)
 - Bicalutamide; (not studied, potential hepatotoxicity)
 - Cyproterone acetate; (not in US, side effects)

Progesterone (evidence lacking)

- Anecdotes say it helps breast development (but how can you test this?)
- May increase breast cancer and cardiac risks



30

Monitoring GAHT

- Target normal hormone levels for gender identity
- Labs and visit every 3 months during first year or after dose changes
- Then every 6-12 months
- Treat the patient, not the number; sometimes labs will look a little off but that's alright. *Aaron used to only test levels if the patient was frustrated, but then had a patient with blood levels super high on a low dose.*



31

A 19 year old transgender man has been on testosterone cypionate, 100 mg weekly, for 6 months. His CBC is shown on the right. What's the best next step?

| CBC With Differential/Platelet | |
|--------------------------------|--|
| ☆ WBC | 4.5 |
| ☆ RBC | 5.49 H |
| ☆ Hemoglobin | 16.3 H |
| ☆ Hematocrit | 49.5 H |
| ☆ MCV | 90 |
| ☆ MCH | 29.7 |
| ☆ MCHC | 32.9 |
| ☆ RDW | 11.8 |
| ☆ Platelets | 179 |
| ☆ Neutrophils | 54 |
| ☆ Lymphs | 33 |
| ☆ Monocytes | 7 |
| ☆ Eos | 5 |
| ☆ Basos | 1 |



32

Live Content Slide*When playing as a slideshow, this slide will display live content*

Poll: A 19 year old transgender man has been on testosterone cypionate, 100 mg weekly, for 6 months. His CBC is shown on the right. What's the best next step?

33

Monitoring GAHT Labs

Masculinizing

- Hemoglobin/hematocrit (be careful of normal range!)
- Total testosterone: halfway between shots if using injectable
- Lipids
- Testosterone, total (300-1000 ng/dL)

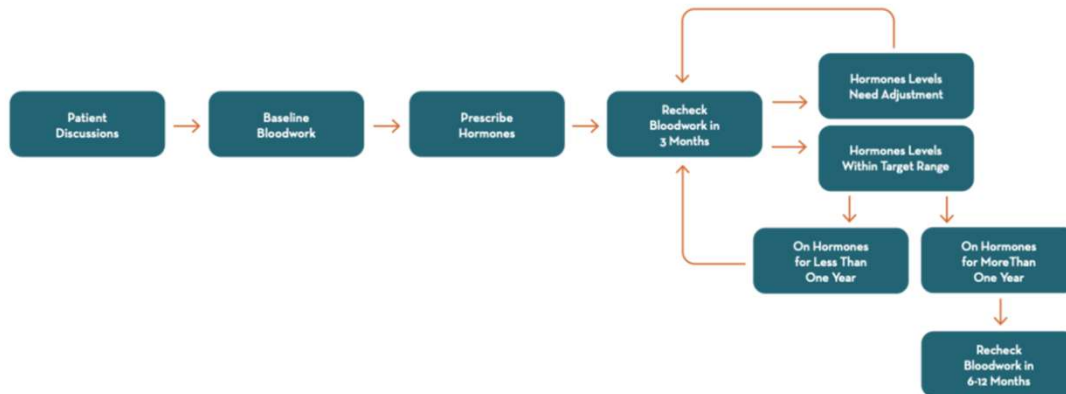
Feminizing

- Estradiol: halfway between shots if using injectable
- Total testosterone: early morning draw
- BMP if taking spironolactone
- Testosterone, total (30-100 ng/dL)
- Estradiol <200 pg/mL
- Shorthand T<55<E



34

Simple Clinical Process



35

Troubleshooting Common Issues

Masculinizing

- If patient is noticing loss of effect prior to injection day
 - Increase frequency to once weekly and halve dose
- If patient is having injection site reactions
 - Change to testosterone enanthate

Feminizing

- Adjust based on levels
- Consider changes to blocker
- If T is not falling, consider changing to injectable estradiol



36

Sex

(we included it because it sells)

Fertility

- Assess their plans for biological children at first visit
- Make plans for fertility preservation prior to initiation of GAHT
- Know who in your area provides those services

Contraceptives

- Nature finds a way
- If a patient is having PV sex they need to use contraceptives unless intending pregnancy
- All contraceptive options are available with GAHT

HIV

- Consider PreP where appropriate
- Interactions between hormones and antiretrovirals does not seem to be clinically significant



37

Things Often Not Discussed, But Really Important!

Voice Training

- Testosterone deepens voice, but patients may sound odd if they are not trained to change how they make sounds
- Estradiol is not helpful in this regard; Patients may sound odd or strain/damage vocal cords if they try to pitch up voice without training
- Comprehensive training will include how gender is communicated through movement, word choice, conversational choices
- Know your local resources

Hair Removal

- Feminizing GAHT may not reduce facial or body hair growth to desired levels
- Know your local resources for hair removal

Socialization

- Being a man vs. being a woman are very different
- Support groups are important

Therapy

- “Second puberty” is a real thing



38

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: A 42 year old transgender woman is on estradiol valerate, 10 mg injected every 2 weeks. She has been on estradiol for 18 years with satisfactory results. She is brand new to you; she says she hasn't had a doctor in 10 years, and has been getting her estradiol from Mexico. The only surgery she has ever had was an appendectomy at age 19. She has no family history of cancer. Which of these is the most appropriate screening test?

39

Longitudinal Care

- If they still have a body part, it needs screening
- Consider self-collect swabs for high risk HPV
- Long term increased risk of CVD
- Aging on hormones
 - GAHT should be considered lifelong care
 - If patient has had gonads removed, it is critical for bone health to continue hormone treatment

40

Surgical Considerations

- At least 6 months stable on regimen
- Continue hormones through surgical process
- No increased risk of VTE
- Important benefits post-gonadectomy, esp. bone density
- Regret rates; 0-4% for top surgery 0-8% for bottom surgery



41

Surgical Options

Facial Surgery

- Brow shave
- Tracheal shave
- Vocal cord procedures

Top Surgery

- Breast augmentation
- Double mastectomy with nipple grafts
- Periareolar mastectomy
- Liposuction

Bottom Surgery

- Orchiectomy
- Vaginoplasty
- Hysterectomy
- Salpingo-oophorectomy
- Vulvoplasty
- Metoidoplasty
- Phalloplasty
- Urethral lengthening



42

Post-Surgical Care

- Drain management
- Dilation of neo-vagina
- Hair growth in neo-vagina
- Penile implant care/erosion
- Lifelong risk for urethral strictures and fistulae



43

Live Content Slide

When playing as a slideshow, this slide will display live content

Social Q&A for Gender Affirming Care for Primary Care Physicians



44

QUESTIONS?

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45



46