

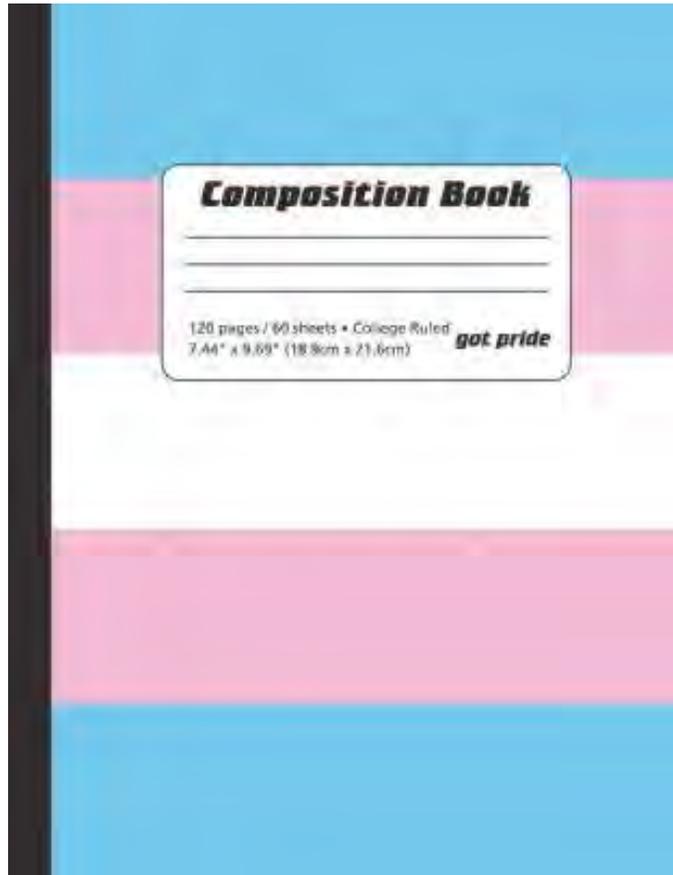
GENDER-AFFIRMING HEALTH INTERVENTIONS FOR CHILDREN AND ADOLESCENTS: FROM CLINICS TO THE COMMUNITY

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IF YOU REMEMBER 3 THINGS



- Multidisciplinary model of care for TGD youth
- Diversity of affirmation journeys
- Positive impact of parental support and affirming environments

CARE GUIDELINES

www.wpath.org

The World Professional Association for Transgender Health

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People

1th Edition

CLINICAL PRACTICE GUIDELINE

Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

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*Cosponsoring Associations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society-appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

0891-7620/18/27(11):1889-1903. © 2018 American Association of Endocrinologists and Endocrine Society. All rights reserved. DOI: 10.1210/clinem.2018-01121

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J Clin Endocrinol Metab. November 2018; 102(11):1889-1903. <https://academic.oup.com/jcem> 1889

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

Center of Excellence for Transgender Health
Department of Family & Community Medicine
University of California, San Francisco

2nd Edition – Published June 17, 2016

Editor – Madeline B. Deutsch, MD, MPH

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

Jason Hafferty, MD, MPH, FACP, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON ADOLESCENCE, SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS

As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill-equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

INTRODUCTION

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.^{1,2} Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.³

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research.

Downloaded from www.aappublications.org/ by guest on October 1, 2018

FROM THE AMERICAN ACADEMY OF PEDIATRICS



GENDER AFFIRMATION MAY INCLUDE

- Psychosocial affirmation
- Puberty blockers
- Gender-affirming (cross sex) hormone therapy
 - Integrated with comprehensive and gender-affirming primary care
- Gender-affirming surgeries
- Legal affirmation

DIVERSITY OF AFFIRMATION JOURNEYS



PSYCHOSOCIAL AFFIRMATION

- Social
 - Pronouns
 - Name
 - Social gender role
- Psychological
 - Addressing psychosocial health concerns
 - Having support in transition process
 - Addressing internalized stigma and transphobia



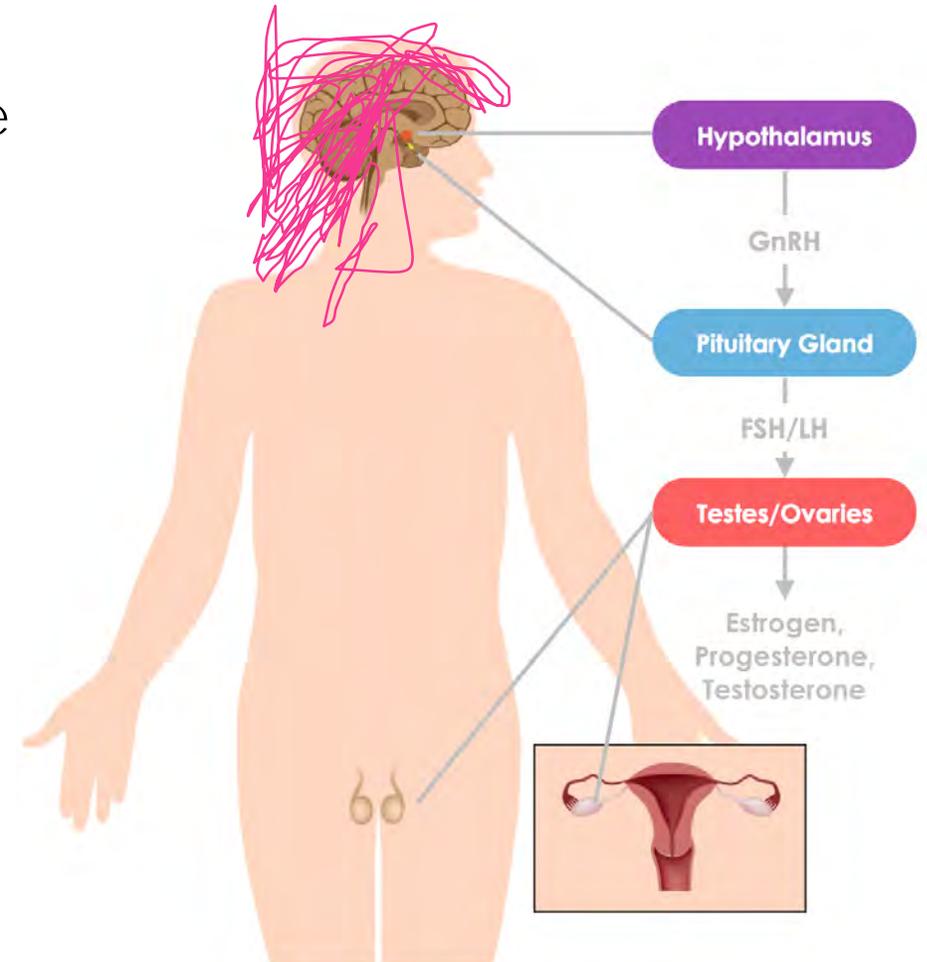


ELICITING GENDER IDENTITY

- Kids: “Some kids tell me they think of themselves as girls, some as boys, some as part girl and boy, or something entirely different. How do you think about yourself?”
- Teens: “There are lots of ways people describe their gender identity, how do you think of yours?”
 - “Tell me what that term means to you?”
- Role of diagnostic evaluation

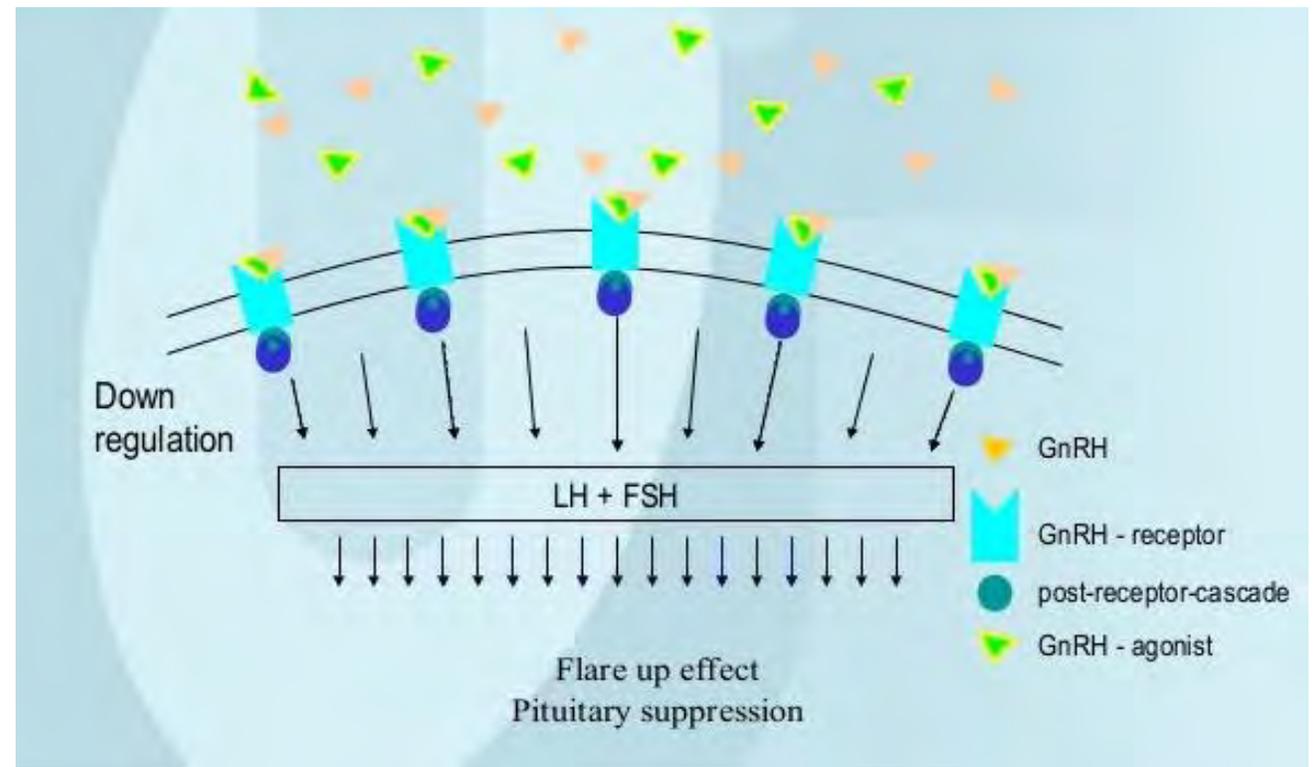
PUBERTY BLOCKERS

- Blockers are gonadotropin releasing hormone (GnRH) agonists
- GnRH
 - Pulsatile release from the hypothalamus
 - Stimulates pituitary release of luteinizing and follicle stimulating hormones (LH and FSH)
- LH and FSH
 - Stimulate the gonads to produce sex steroids (estrogen, progesterone and testosterone)



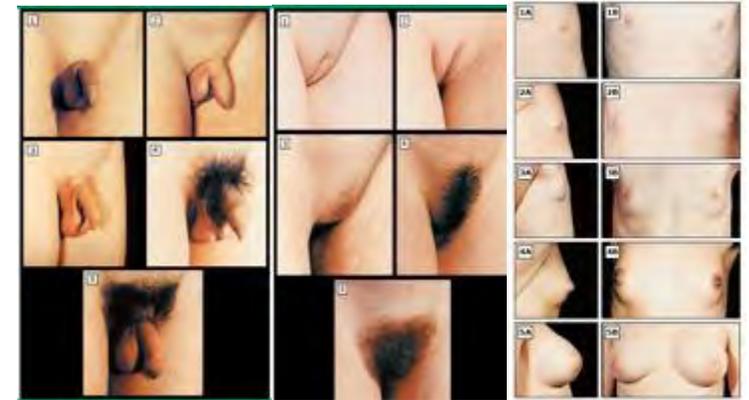
MECHANISM OF ACTION OF BLOCKERS

- Large non-pulsatile dose of GnRH agonist floods the pituitary
- Initial release of FSH and LH
- Initial surge of sex steroid hormones
 - Menstrual bleeding 14-28 days after injection
 - Followed by amenorrhea
- End result
 - Suppression of
 - FSH and LH secretion
 - Testicular release of testosterone
 - Ovarian release of estrogen and progesterone



GNRHA TREATMENT

- When?
 - At least Tanner (sexual maturity rating) stage 2
 - Mean age for the first signs of puberty
 - 10.5 years in ovary-bodied people, range 8 to 12 yrs
 - 11.5 years in testicle-bodied people, range 9 to 13 yrs
- What
 - Intramuscular leuprolide acetate (Lupron)
 - Histrelin Implant (Supprelin LA or Vantas)



CLINICAL EFFECTS OF GNRHA

- Will slow down
 - Pubertal development
 - Bony changes of puberty
 - Androgen-dependent hair growth
 - Deepening of the voice, enlargement of larynx
 - BMD does not increase as expected but is believed to catch up with subsequent sex steroid administration
- Completely reversible
 - If immediately followed by cross-sex hormones patient *will be not be fertile*
 - No effect on fertility if discontinued

CLINICAL EFFECTS OF GNRHA

- May
 - Improve psychological function
 - But has not been found to improve gender dysphoria
 - Increase adult height in affirmed males
 - Decrease adult height in affirmed females

WHY USE PUBERTY BLOCKERS?

- ▶ Provide time to explore gender incongruence
- ▶ Prevent sex characteristics that are difficult or impossible to reverse
 - Adam's apple
 - Male pattern hair growth
 - Voice deepening
 - Breast development

BLOCKERS *AFTER* PUBERTY

- Prevent menstruation
- Prevent further androgen effects
- Give parents a chance to catch up
- Used post puberty will NOT cause regression in
 - Penis, beard, body hair, Adam's apple, shoulders, jaw
 - Breast or hips
- Allows use of lower doses of affirming hormones

GENDER AFFIRMING HORMONES

- Typically initiated between age 14-16 (widely variable)
 - Number of years living stably in affirmed gender role
 - Number of years of pubertal suppression
 - Degree of dysphoria
 - Distress because physical development is out of sync with peers
- ▶ Puberty is 2-3 year process – mimic this in patients who started blockers in early puberty
 - Those who present later in adolescence have already experienced near-full puberty so hormone regimens may be increased to full replacement doses over a shorter interval
 - Ideally continue blockers until gonadectomy

MASCULINIZING HORMONES

Testosterone injections, patch, or gel

Partially reversible effects

- Increased lean muscle mass / decreased subcutaneous fat
- Masculine pattern hair growth
- Chest tissue atrophy possible
- Irreversible effects
 - Deepened voice
 - Clitoromegaly
- Adverse effects
 - Acne
 - Polycythemia, transaminitis
 - Dyslipidemia, weight gain, hypertension
 - Mood lability



Video from Seattle Children's:
<https://www.youtube.com/watch?v=dmjSEf2og1A>

FEMINIZING HORMONES

Androgen blockade

- Continuing blockers
 - Allows lower doses of estrogen; even higher doses may not block effects of testosterone
- Spironolactone
- Bicalutamide

Decreased height possible

- With administration of estrogen growth plates will close



Video from Seattle Children's:
https://www.youtube.com/watch?v=8_gdLCXKI5Y

FEMINIZING HORMONES

17 beta estradiol pills, patch or injections

- Partially reversible
 - Decreased facial and body hair
 - Fat redistribution
 - Decreased spontaneous erections
 - Softened skin
- Irreversible
 - Breast tissue growth
 - Closure of growth plates
- Adverse effects
 - Thromboembolic disease
 - Liver dysfunction, cholelithiasis
 - Hyperprolactinemia, hypertension



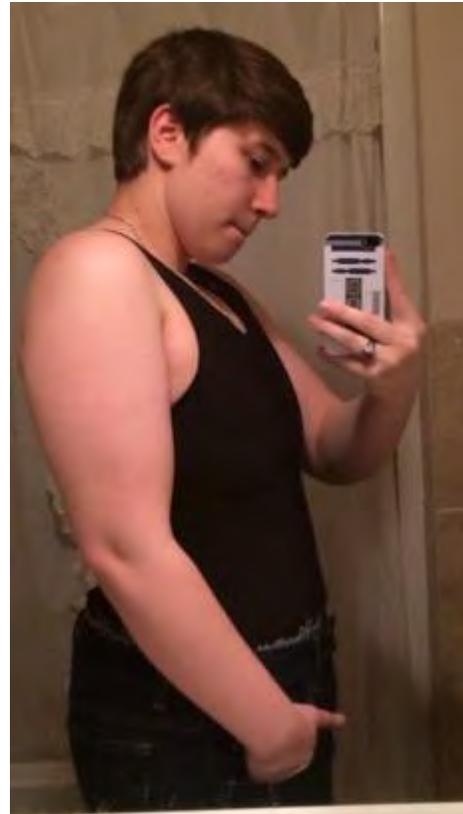
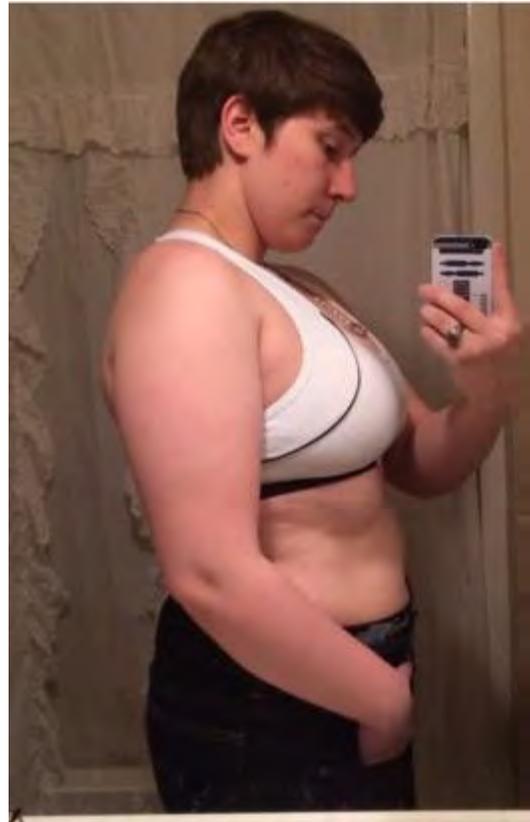
Video from Seattle Children's:
https://www.youtube.com/watch?v=8_gdLCXKI5Y

FOLLOW-UP

- Ongoing mental health support
- Medical follow-up
 - Assess clinical response
 - Monitor for undesired side effects
 - Monitor labs
- Affirming primary care and specialty services
- Voice training



BINDERS, PACKERS & STP DEVICES





GENDER-AFFIRMING SURGERIES

- "Top" surgery
 - To create a masculine chest shape or enhance breasts
- "Bottom" surgery
 - Surgery on genitals or reproductive organs
- Facial feminization
- Hair removal

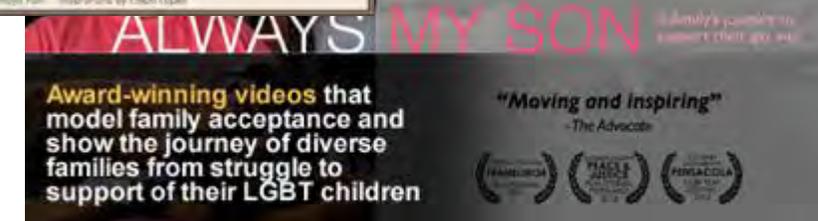
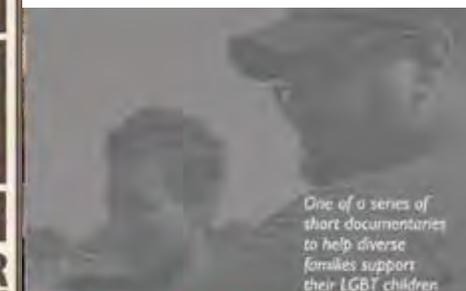
A NOTE ABOUT CONSENT

- I agree
- I disagree



FAMILY ACCEPTANCE

- Suicide rates among TGD youth are significantly lower among those with strongly supportive parents (4% vs 60%)
- TGD youth who describe at least 1 supportive person in their life report significantly less distress than those who only experience rejection
- In communities with high levels of support, non-supportive families tended to increase support over time, leading to dramatic improvement in mental health outcomes



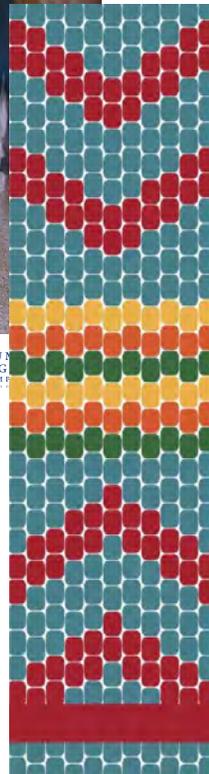
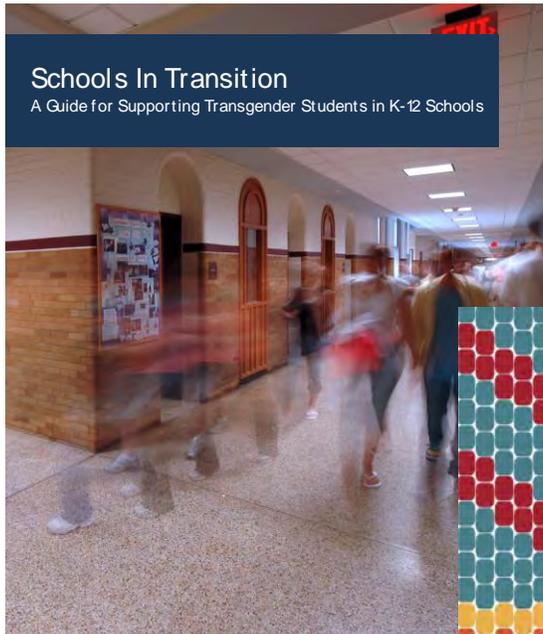
Olson, K.R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137 (3), 1-8.

Ryan et al. Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. *Pediatrics*. 123-1.2009

COMMON PARENTAL CONCERNS THAT MAY DELAY ACCESS TO GENDER-AFFIRMING TREATMENT

- Fear of harassment
- Fear of rejection by peers or other family
- Fear of physical harm
- Worry about preservation of fertility options
- Worry about appropriate timing of transition
- **Grief/loss of “former” identity**
- Fear of regret regarding transition
 - *How do I know they are actually transgender?*
 - *What if this is just a phase?*
 - *Why can't we wait until they have finished puberty or they are an adult before we talk about medical transition? What if my child regrets this?*

COMMUNITY SUPPORT



Celebrating Our Magic

Resources for American Indian/Alaska Native transgender and Two-Spirit youth, their relatives and families, and their healthcare providers



- School policies to support and affirm TGD students
- Community support groups and advocacy efforts
- Inclusive insurance policies
- Anti-discrimination laws

PROMOTING SEXUAL HEALTH OF GENDER DIVERSE ADOLESCENTS

- Welcoming environments
- Visual cues
- All-gender restrooms
- Confidentiality
- Inclusive health education curricula



Q CARD



Q CARD™
Empowering Queer Youth
in Healthcare

How to use the Q Card™

1. Fill it out.
2. Bring it to your next healthcare appointment.
3. Talk to your provider about privacy & confidentiality.
4. Discuss your concerns with your provider.
5. Give this card to your provider, or keep it. It's up to you!
6. Let us know how it went at qcardproject.com.

Coming out is an intensely personal decision, and we encourage you to consider your safety and resources before taking this step.

Please call me: _____
insert name

My pronouns are: _____

My sexual orientation:
circle all that apply/ fill in the blank

GAY	LESBIAN	BISEXUAL
QUEER	PANSEXUAL	ASEXUAL

My gender identity:
circle all that apply/ fill in the blank

FEMALE	MALE
TRANSGENDER (MTF FTM)	GENDERQUEER

I would like to talk about: _____

The Q Card is tri-fold pocket communication resource designed to simultaneously empower LGBTQ youth to advocate for themselves and educate healthcare providers.

It allows youth to fill in their sexual orientation, gender identity, personal gender pronouns, and any specific concerns.



INCLUSIVE LANGUAGE

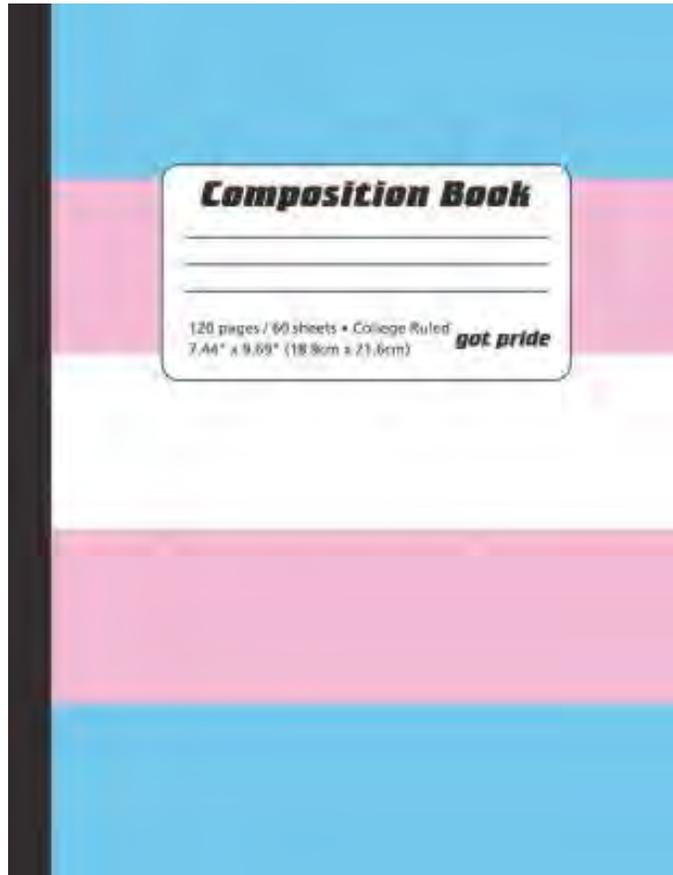
- Affirmation vs. transition
- Sex assigned at birth vs. biological/natal/real sex
- A person with ovaries/uterus/cervix vs. woman
- A person with penis/testicles vs. man
- Chest vs. breasts
- Genitals or front hole vs. penis/vagina/vulva
- Bleeding vs. menstruation
- People who menstruate/have a period vs. women
- Personal gender pronouns vs. preferred pronouns

HEARING FROM YOUTH



- AHI Video (7:43m) <https://www.youtube.com/watch?v=CHN3YhMi-5A>

IF YOU REMEMBER 3 THINGS



- Multidisciplinary model of care for TGD youth
- Diversity of affirmation journeys
- Positive impact of parental support and affirming environments

RESOURCES

- <https://www.genderspectrum.org>
- <https://www.umhs-adolescenthealth.org/improving-care/spark-trainings/lgbtq-youth-series/>
- Guidelines
 - AAP: <https://pediatrics.aappublications.org/content/142/4/e20182162>
 - Endocrine Society: <https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>
 - WPATH Standards of Care: <https://www.wpath.org/publications/soc>
 - UCSF: <https://transcare.ucsf.edu/guidelines>
- <https://www.minus18.org.au/pronouns-app/>
- <http://www.impactprogram.org/wp-content/uploads/2014/12/Kuper-2014-Puberty-Blockers-Clinical-Research-Review.pdf>
- Trans Youth Project: <http://depts.washington.edu/scdlab/research/transyouth-project-gender-development/>
- Celebrating Our Magic Toolkit: http://www.npaihb.org/download/Toolkit_v6_24.pdf



THANK YOU!

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EXTRA SLIDES





MEDICAL TRANSITION FOR YOUTH IS COMPLICATED: PARENTAL CONCERNS

- How do I know they are actually transgender?
- What if this is just a phase?
- Why can't we wait until they have finished puberty or they are an adult before we talk about medical transition? What if my child regrets this?



RESILIENCE

- Many transgender youth lead normal, productive lives
- Usually develop resilient adaptations to social biases and mistreatment
- Many develop and possess remarkable strength and self-determination

EVALUATION AND MONITORING

- Height / weight / blood pressure / Tanner stage
 - baseline and every 3-6 months thereafter
- Ultrasensitive fsh / lh / testosterone / estradiol
 - baseline, 8 weeks, one year. After first year, every 6 mo and if any signs of re-emerging puberty
- Bone age / vitamin D
 - baseline and annually
- DEXA scan
 - baseline and every other year; in all patients ensure adequate calcium intake, and weight bearing activity
- Replace implant after 3 years

2017 Guidelines endorsed by Pediatric Endocrine Society

MASCULINIZING HORMONES WITH BLOCKERS

- In postpubertal patients
 - increase more rapidly up to 75 mg/2 wk for 1st 6 mo
 - then increase up to 125 mg/2 wk
- Adult dose - most patients reach normal male range of total testosterone and good clinical results at
 - 50-75mg SC Q week or
 - 50-100mg IM Q week or 100-200mg IM Q 2 weeks
 - Adjust dose to mimic physiologic testosterone levels 400-700ng/dl

Hembree. Endocrine Society Clinical Practice Guideline
2017

Olson J. LGBT Health 2014

MEDICAL MONITORING

- Every 3-6 months: ht/ wt / BP / Tanner stage
- Every 6-12 months: hemoglobin/hematocrit, lipids, testosterone, vitamin D
- Every 1-2 years bone age and DEXA (latter until 25-30 yo)

Hembree. Endocrine Society Clinical Practice Guideline
2017