



**SYDNEY NORTH**  
Health Network



**phn**  
NORTHERN SYDNEY

An Australian Government Initiative

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**SYDNEY NORTH**  
Health Network



**WELCOME**

**Transgender Care in General Practice**  
**Gender Affirming Care**

**Tuesday 2 November, 2021**

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## ACKNOWLEDGEMENT OF COUNTRY



The Sydney North Health Network wishes to acknowledge Australia's Aboriginal peoples – the traditional custodians of the land on which we meet and work.

We pay our respects and recognise their continued connection to land, water and community and honour their ancestors, Elders past, present and emerging.



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## Housekeeping



Before we begin, please familiarise yourself with the following housekeeping items:

- Your microphone and video will be disabled during this webinar
- **To change your displayed name**  
Click on the 'participants' icon at the bottom of your screen, then click the 'more' option next to your name, then click 'rename'
- **Q&A**  
Please use the Q&A box in the panel at the bottom of your screen to submit questions to the presenters  
In the event we do not have time to answer all the questions, we will endeavour to respond in a follow-up email.
- This meeting **will be recorded** and will be available on the SNHN website in a few weeks
- If your screen freezes - your WiFi connection may be limited, try moving closer to your WiFi router
- **An Evaluation** will be available at the completion of this webinar and will be emailed to you the next day.



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## POLL 1



### Questions

How many patient requests for gender affirmation care have you received in the past year?

How confident do you feel managing the primary care needs of trans patients



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## POLL 2



Which of the following statements are TRUE

- *Gender affirming medical therapy increases the risk of cancer in trans women*
- *Gender affirmation can be life saving*
- *All patients are required to have a psychiatric evaluation prior to commencing medical affirmation*
- *Serum monitoring of hormone levels is not required*

This poll will be repeated later in the webinar



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## SPEAKER INTRODUCTION



### ◆ **Teddy Cook**

Acting Director, Community Health – ACON, Adjunct Lecturer – Kirby Institute, UNSW Sydney, Vice President – Australian Professional Association for Trans Health (AusPATH)

### ◆ **Dr Catriona (Treeny) Ooi**

Director, Northern Sydney Sexual Health Service

### ◆ **Dr Nicole Gouda**

GP and SNHN AOD Clinical Lead



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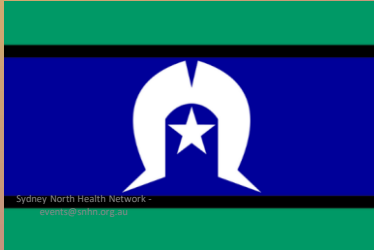
## GENDER AFFIRMING HEALTHCARE AND TRANS-AFFIRMING PRACTICE FOR GPs

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# Tedd



## Teddy Cook

HE/HIM  
TCOOK@ACON.ORG.AU

I live in Alexandria, Gadigal Sydney. My mum's family are from Wonnarua Maitland, my dad's are English, Irish and French.

I have an identical twin who is non-binary. I am a man of trans experience.

I'm

- ACON's Acting Director, Community Health;
- Manager, Trans Health Equity;
- Vice President, Australian Professional Association for Trans Health; and
- Adjunct Lecturer, UNSW Kirby Institute's Sexual Health Program

Over 15 years of experience in community health and non-government sectors.

Joining ACON in 2012, I currently oversee Client Services, LGBTQ Community Health Programs, Pride Training and Trans Health Equity +/- 50 staff.

I <3 community development, policy, health promotion and program delivery, and am the architect of TransHub.

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ACON is Australia's largest health organisation specialising in community health, inclusion and HIV responses for people of diverse sexualities and genders.

Established in 1985, our early years were defined by community coming together to respond to the HIV/AIDS epidemic in NSW, and we remain committed to ending HIV for everyone in our communities.

ACON Health Ltd  
Main Switch: 02 9206 2000  
Website: [www.acon.org.au](http://www.acon.org.au)



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# TRANS



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# TRANS MOB

First Nations people who are trans in Australia might use the term Sistergirl and Brotherboy. Trans people are likely part of every Aboriginal and Torres Strait Islander community.

Sistergirl - trans woman / trans femme  
Brotherboy - trans man / trans masc

“ Back then... they would see that Sistergirl and know that she wasn't a boy. So that Sistergirl would go with the women and do women's dancing and ceremony...  
Bree, Sistergirl

“ In Arrente, they call us 'gwarre gwarre' and Luritja mob say 'kungakunga' meaning 'girl girl'  
Bree, Sistergirl

“ We're part of a culture that's been going for thousands of years. You can't say that's not impressive.  
Taz, Brotherboy

“ I knew that I had a boy spirit inside...although I did not fully understand the term 'transgender'.  
Kellum, Brotherboy

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# GENDER EXPERIENCES

# TRANS CIS

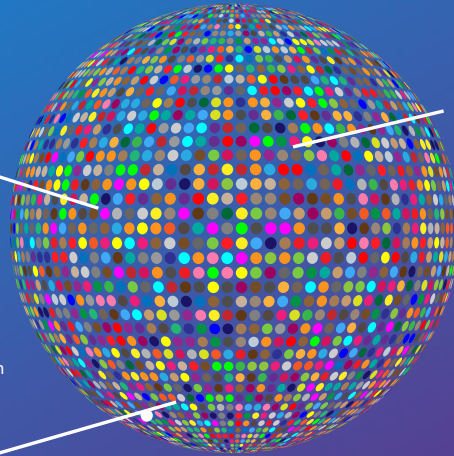
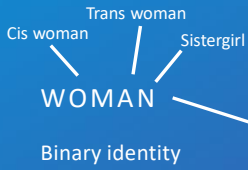
Gender is different to what was presumed at birth

Gender is the same as what was presumed at birth



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# GENDER IDENTITY

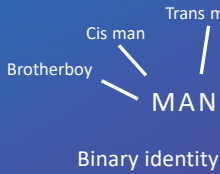


## NON-BINARY



Umbrella term for identities other than man and woman.

- Genderfluid
- Genderqueer
- Trans feminine
- Trans masculine
- Sistergirl
- Brotherboy



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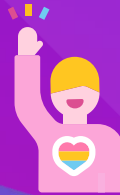
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# TRANS PEOPLE

2-4% of the population is trans



Can be straight, gay, queer, lesbian, asexual, etc.



Affirm who we are socially, medically and/or legally



Have surgeries and many don't



Are women, men and non-binary



Take hormones and many don't



Experience gender euphoria, not always gender dysphoria

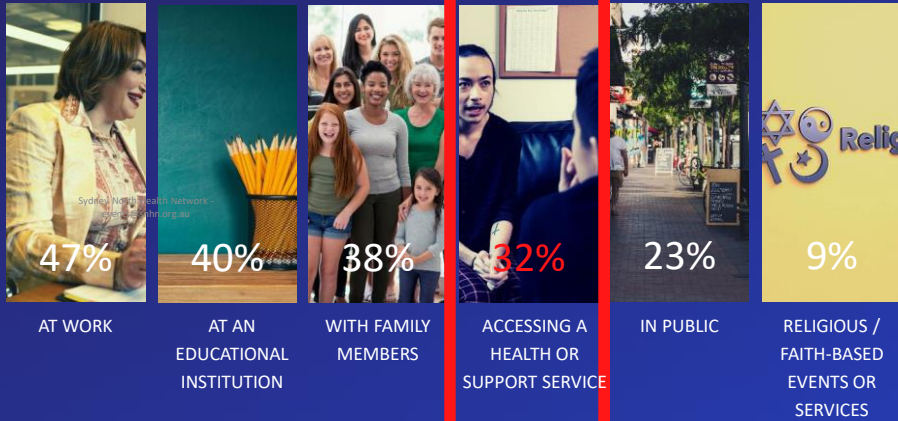
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# TRANS ACCEPTANCE

% of people that currently feel accepted "a lot" or "always" in the following situations:

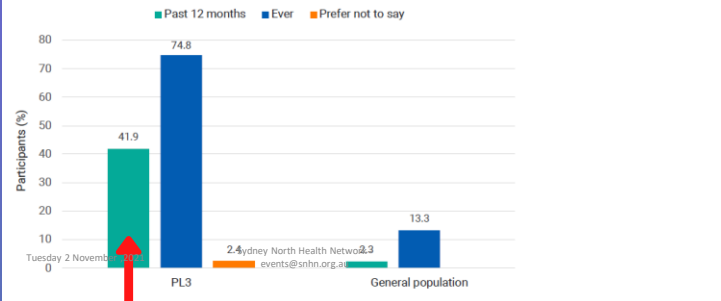


Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

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# SUICIDE

Figure 16: Suicidal ideation (n = 6,799) in the past 12 months and ever among PL3 participants and the general Australian population



1 in 4 participants reported considering attempting suicide in the previous 12 months. This is 25 times higher than the general population.

Figure 20: Suicide attempts in the past 12 months and ever by gender (n = 5,263)

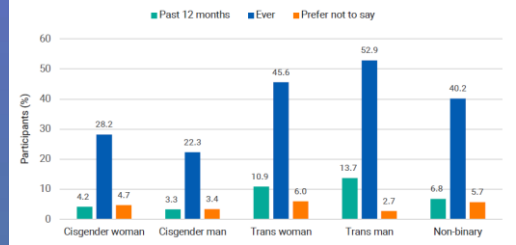
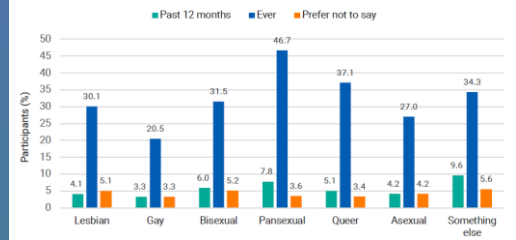


Figure 21: Suicide attempts in the past 12 months and ever by sexual orientation (n = 5,291)



Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

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# CISGENDERISM

- Social, cultural, systemic ideology of gender experience, gender identity, expression and bodies
- ...suggests trans people aren't real
- ...delegitimises people's own understanding of their bodies and genders
- ...labels bodies as male or female
- ...assumes that people can only be men or women
- ...enforces strict binary gender roles (masculine and feminine)
- ...pathologises the trans experience as disordered
- ...is an ideology that rejects the validity of non-binary genders
- ...insists gender can be based on genitals
- ...insists gender is the same as what is recorded on someone's first birth certificate.

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**TRANS VITALITY IS HERE**  
WWW.TRANSVITALITY.ORG.AU

Trans Vitality | acon HERE FOR HEALTH

Trans-Affirming Clinical Language

TRANS-AFFIRMING LANGUAGE GUIDE

WHAT DO TRANS PEOPLE SOUND LIKE?

HERE & NOW  
Trans Care After a Sexual Assault

Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables

FREDERICKA PERKINS

pride in sport

RUGBY AU | netball | Hockey Australia | unisport | Water Polo | CRICKET AUSTRALIA | AFL | tennis

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www.TransHub.org.au

**TRANSHUB IS HERE**  
 FOR TRANS & GENDER DIVERSE PEOPLE, THEIR LOVED ONES, ALLIES & HEALTH PROVIDERS  
 WWW.TRANSHUB.ORG.AU

**EVERYONE DESERVES TO FEEL SAFE AND SUPPORTED BY THEIR DOCTOR.**

Going to the doctor is a necessary part of life for most of us. For trans and gender diverse people, medically affirming our gender involves hormones and/or surgical intervention, so building relationships with doctors and health professionals becomes critically important. TransHub offers resources to support us as we medically affirm who we are.

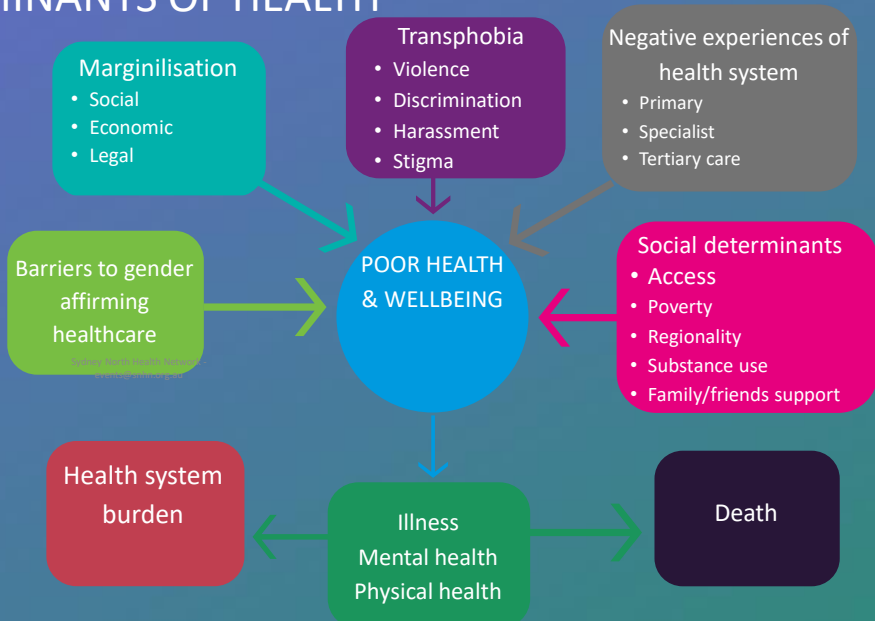
FOR MORE INFORMATION WWW.TRANSHUB.ORG.AU



Over to Treeny...

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## DETERMINANTS OF HEALTH



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# TRANS HEALTH

This infographic features a rainbow flag waving against a purple and pink background. Six circular callouts of various colors (dark grey, teal, pink, purple, grey) are arranged around the flag, each containing text about health issues. The text is as follows:

- High rates of anxiety, depression & suicidality
- High levels of sexual violence & coercion
- High levels of physical, emotional, spiritual & financial abuse
- More likely to experience stigma & discrimination
- High rates of family & domestic violence

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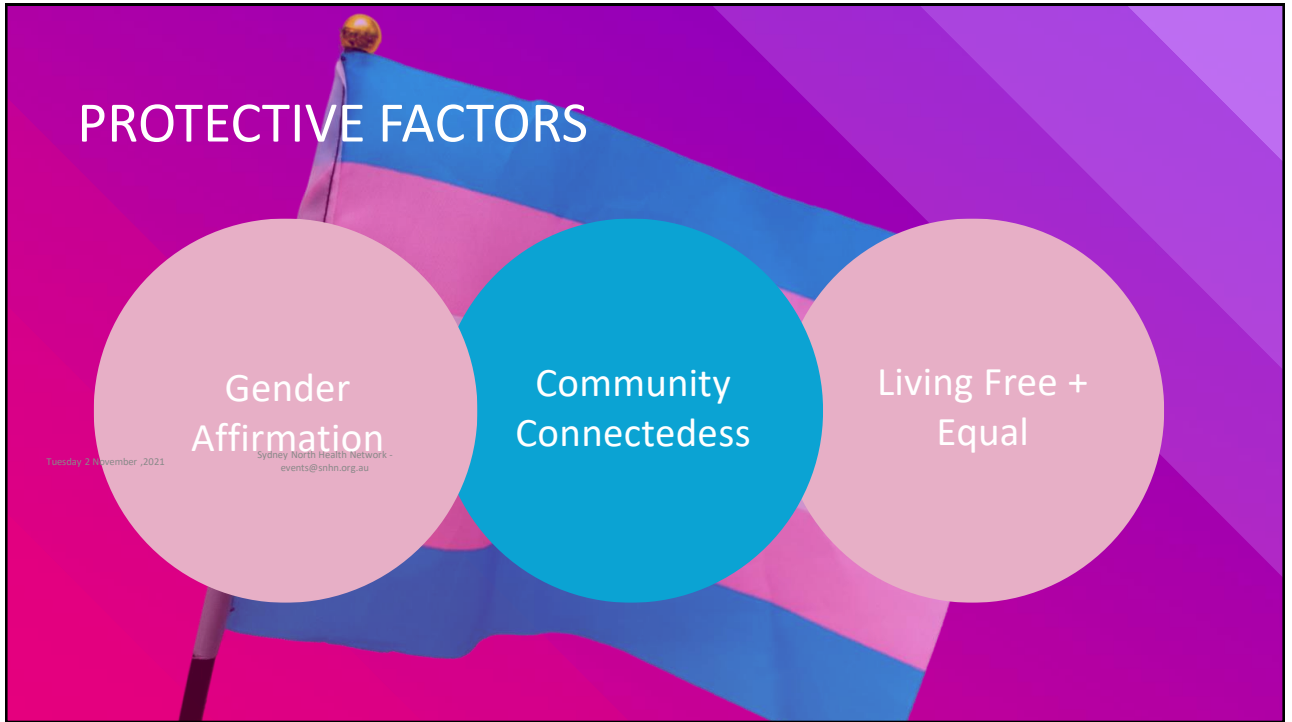
# TRANS HEALTH

This infographic features a rainbow flag waving against a purple and pink background. Six circular callouts of various colors (light blue, purple, pink, teal, dark grey, grey) are arranged around the flag, each containing text about health issues. The text is as follows:

- Barriers to gender-affirming healthcare
- Limited access to post-surgical care
- Lack of easy access to amend identity documentation
- Violence and discrimination in all areas of life
- Low rates of preventative health screening
- High rates of homelessness

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## POLL TIME



1. How confident do you feel managing the primary care needs of trans patients
2. Which of the following statements are TRUE
3. Treeny and Teddy's presentation

## THANK YOU!

 [tcook@acon.org.au](mailto:tcook@acon.org.au)

 [transhub.org.au](http://transhub.org.au)

 [/transhub\\_acon](https://www.instagram.com/transhub_acon)

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# Gender affirming care

Dr Catriona Ooi  
Director Sexual Health, NSLHD



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## Acknowledgments

- Dr Emanuel Vlahakis for slide outline
- Staff at Clinic 16, NSLHD
- Sydney North Health Network

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## Gender incongruence vs gender dysphoria

### **DSM V Definition: Gender Dysphoria in Adults and Adolescents**

A marked incongruence between experienced/expressed gender and assigned gender, >6/12 duration + at least 2 of:

- marked incongruence between experienced gender and 1<sup>st</sup> and/or 2<sup>nd</sup>ry sex characs (or anticipated 2<sup>nd</sup>ry sex charac.)
- A strong desire to be rid of 1<sup>st</sup> and/or 2<sup>nd</sup>ry sex charac. Because of a marked incongruence with one's experienced gender
- A strong desire for the 1<sup>st</sup> and/or 2<sup>nd</sup>ry sex characs of the other gender
- A strong to desire to be of the other gender (or some alternative gender to one's assigned gender)
- A strong desire to be treated as the other gender (or alternative gender)
- A strong conviction that one has the typical feelings/reactions of the other gender

The condition is associated with clinical significant distress or impairment-social, occupational

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## Gender incongruence vs gender dysphoria

### **ICD-11 for Mortality and Morbidity Statistics 2019: Gender incongruence of adolescence or adulthood**

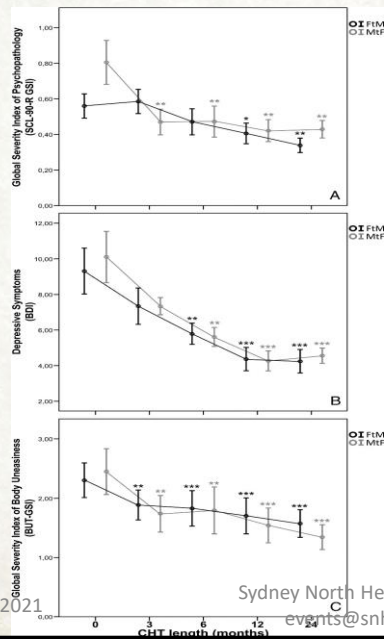
- marked and persistent incongruence between an individual's experienced gender and the assigned sex
- desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align 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.

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## Psychobiological effect of hormone treatment over time



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## First, do no harm....

- **Australian Position statement on the hormonal management of adult transgender and gender diverse individuals<sup>5</sup>**

*"Hormonal therapy is effective at aligning physical characteristics with gender identity and in addition to respectful care, may improve mental health symptoms"*

*"Gender-affirming hormone therapy is effective and, in the short term, relatively safe with appropriate monitoring."*

- Hormonal affirmation is **safe and effective**
- Can be delivered in **primary care** with specialist referral for complex cases<sup>2</sup>
- A systematic review: **no increased risk of cancer or early mortality.**<sup>1</sup>
  - Further large cohorts: ENIGI, Europe; STRONG, US; Veteran's Health, US; Trans 20, Australia<sup>3</sup>





1. Weinand JTE 2015; 2.Arora AJPH 2019; 3.Tollit BMJ Open 2019; 4.Telfer Med J Aust 2018; 5.Cheung Med J Aust 2019

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### Standards of care


|  |   |   |
|--|---|---|
| <br>November 2020<br><a href="#">Download</a> | <br>July 2020<br><a href="#">Download</a>      | <br>2019<br><a href="#">Download</a> |
| <br>June 2020<br><a href="#">Download</a>     | <br>September 2011<br><a href="#">Download</a> |   |

<https://auspath.org.au/standards-of-care/>

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SOCIAL MEDICAL LEGAL MY HEALTH 101 ALLIES CLINICIANS ABOUT





HEALTH & GENDER AFFIRMATION IN NSW




## INFORMATION FOR CLINICIANS


  
 GETTING STARTED


  
 CREATING WELCOMING ENVIRONMENTS

  
 ALL ABOUT HORMONES

  
 SURGICAL AFFIRMATION

  
 MENTAL HEALTH

  
 SEXUAL HEALTH

  
 FERTILITY & REPRODUCTIVE HEALTH

  
 SEXUAL ASSAULT

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## Initial Assessment

Aims and goals

affirmation may include:

- Psychological affirmation
- Physical affirmation
- Social affirmation
- Legal affirmation

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## Informed Consent Model

- Patient centred
- Full bio-psycho-social assessment
- Types of hormones and modes of administration
- Expected effects and side effects of hormone affirming treatments
- Competent to consent
- Age of majority is 18yrs
  - (<18 yrs. only if both parents agree + Gillick competency)

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PARADIGM SHIFT

|  |  |
|--|--|
| <p><b>OUT</b></p> <p><b>Gatekeeping</b></p> <p><b>Psychiatrist not usually needed</b></p> <p><b>Endocrinologist not usually needed</b></p> | <p><b>IN</b></p> <p><b>Informed consent</b></p> <p><b>Primary provider is the General practitioner</b></p> <p><b>Referral to sex health, endocrinologist, psychiatrist if needed</b></p> |
|--|--|

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Why Medical Affirmation?

“feminizing/masculinizing hormone therapy is a ***medically necessary intervention*** for many [trans] individuals...”

(Newfield et al 2006; Pfafflin and Junge 1998)

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## Is Medical Affirmation appropriate?

According to Std Of Care the criteria for hormonal therapy are:

- ✓ Persistent, well-documented gender incongruence
- ✓ Capacity to make a fully informed decision
- ✓ Age of majority in a given country (18 years in Australia)
- ✓ If significant medical or mental concerns are present they must be reasonably well controlled

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## Role Of The GP

- Gender affirmation is GP medicine
- You know these medications
- Partner with our patients: to facilitate, not diagnose
- Gatekeeper model of care is harmful to patients

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## Getting Started: the initial visit

- Introduce, reassure, explain
- Pronouns, preferred name
- Outline procedure
- Discuss patient goals
- Hx of Gender incongruence
  - Chronicity, experience (clothing, presentation, puberty etc.), connections (online/friends/groups etc.), understanding and information

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## Medical Affirmation

- PMHx:
  - General history
  - specific history: migraine, liver disease, seizures, breast lumps, irregular PV bleeding, clotting disorders
  - Mental health Hx, vaccination history (Hep A/B, HPV),
- Family Hx
  - General, breast / ovarian / prostate cancer, coagulopathy, DVT, PE, CVD
- Social Hx
  - Smoker, drug and alcohol use
  - employment, support structure, housing
- Sexual and reproductive history
  - Screening, partners, fertility control and preservation, sexual attraction, CST
- Targeted physical examination: BP, BMI, CVS appropriate secondary sexual characteristics (note genital examination not required)

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## Medical Assessment

- Baseline:
  - FBC, EUC, LFTs, testosterone, oestradiol, fasting sugar, lipids, TFT, (LH/FSH/SHBG/prolactin)
  - STI/HIV testing, HPV/Cx smear, preg testing if relevant
- Discuss
  - consent
  - Fertility, semen/egg storage
  - Hormonal options for GAC
  - Preventative care
  - Support: mental health, peer orgs, ?referral
  - expectations, reversible vs nonreversible changes

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## Next steps

- Results
- Referrals
- Hormones
- Follow-up visit and pathology

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## Feminising affirmation

2 components

- ✓ Blocking endogenous androgens
- ✓ Replacing with feminising hormones

✗ No evidence that progesterone affects final breast size (Wierckx 2014)

✗ No place for EE2-can result 6%-8% VTE (Van kesteren 1997, Wierckx 2014)

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## Oestrogen formulations

| Oestrogen                                 | Brand                                     | Route   | Starting Dose          | Max dose              | Advantages   | Disadvantages   |
|---|---|---|------------------------|-----------------------|--|---|
| Oestradiol<br>• Valerate<br>• hemihydrate | Progynova<br>Zumenon                      | PO  | 2mg OD                 | 4mg BD                | Inexpensive<br>Levels can be monitored             | Increased risk of VTE > 40 yrs.   |
| Oestradiol                                | Sandrena                                  | Transdermal (gel)                             | 1g OD                  | 2g OD                 | Avoids first pass metabolism<br>Least ass with VTE | Skin irritation<br>Risk of transfer   |
| Oestradiol                                | Climera<br>Estradot                       | Transdermal (patches)                         | 50 -100mg twice weekly | 400mg twice weekly    | Avoids first pass metabolism<br>Least ass with VTE | Patches may not adhere<br>Skin irritation   |
| Oestrogen implant                         | NOT TGA APPROVED<br>Compoundin g pharmacy | Subcutaneous (via trochar)<br>Size – 3 or 4mm | 50mg<br>6-12 monthly   | 100mg<br>6-12 monthly | Convenience<br>Presumed lower risk of VTE          | Procedure risks /scarring<br>Beware Supratherapeutic levels<br>can be expensive<br>Difficult to titrate |

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## Androgen blockers

| Androgen Blocker | Brand     | Route | Starting Dose | Max Dose | Advantages                                  | Disadvantages  |
|------------------|-----------|-------|---------------|----------|---|--|
| Spironolactone   | Aldactone | PO    | 50mg BD       | 200mg OD | Inexpensive                                 | Needs K+ monitoring<br>Antihypertensive and diuretic effect<br>Taste bad esp. BD<br>Possible effect on mood      |
| Cyproterone      | Androcur  | PO    | 25 mg OD      | 100mg OD | Inexpensive<br>Once daily<br>Well tolerated | Hepatotoxicity at high doses<br>Can affect adrenocortical function<br>May cause depression<br>Meningiomas (rare) |

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## Progesterone: yes or no??

- **little evidence** (but lots of opinions!)
  - Provera 5-10mg daily
  - Primolut 5mg BD
  - Micronised compounded progesterone 100-200mg
  - Can assist with sleep, best taken at night
  - Warn of possible mood changes
  - Probably little harm in prescribing

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## Target ranges

- Aiming for the physiological reference range.
- Titrate to clinical response:
  - Oestradiol: 250 – 700 (some guidelines <1000) pmol/L
  - Testosterone: <2 nmol/L

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## Monitoring treatment

- EUC 1 week after spiro initiation
- 6-8 weekly testosterone and oestradiol levels until target levels are achieved, then every 6-12 months
- For first 12 months quarterly FBC, UEC, LFT, lipids, BSL, weight, BP then every 6-12 months
- Annual STI/HIV testing ( or more frequent if high risk)
- Routine, age-appropriate cancer screening (breast, colon, prostate)
- Consider baseline BMD if high FRAX score otherwise at 60 yrs.

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## Oestrogen effects

### Average timeline

### Effect of Oestrogen

1–3 months after starting oestrogen

- softening of skin
- decrease in muscle mass and increase in body fat
- redistribution of body fat to buttocks and hips
- decrease in sex drive
- fewer instances of waking up with an erection or spontaneously having an erection; some trans women also find their erections are less firm during sex, or can't get erect at all
- decreased ability to make sperm and ejaculatory fluid

Gradual changes (maximum change after 1–2 years on oestrogen)

- nipple and breast growth
- slower growth of facial and body hair
- slowed or stopped balding
- decrease in testicular size

Table source: Gender Affirming Hormones Prescribers Guide, Version 2, August 2019

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## Anti androgen effects

### Average timeline

### Effect of Anti-Androgens

1–3 months after starting anti-androgens

- decreased testosterone in the body
- decrease in sex drive
- fewer instances of waking up with an erection or spontaneously having an erection; some trans women also have difficulty getting an erection even when they are sexually aroused
- decreased ability to make sperm and ejaculatory fluid

Gradual changes (maximum change after 1–2 years on oestrogen)

- slower growth of facial and body hair
- slowed or stopped balding
- slight breast growth (reversible in some cases, not in others)

Table source: Gender Affirming Hormones Prescribers Guide, Version 2, August 2019

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## Feminising hormones

**Permanent:** they will not go away, even if you decide to stop hormone therapy:

- Breast growth and development. Breast size varies in all women; breasts can also look smaller if you have a broader chest.
- The testicles will get smaller and softer
- The testicles will produce less sperm, and you will become infertile (unable to get someone pregnant); how long this takes to happen and become permanent varies greatly from person to person

**Not permanent:** and will likely reverse if hormone therapy is stopped:

- Loss of muscle mass and decreased strength, particularly in the upper body
- Weight gain. If you gain weight, this fat will tend to go to the buttocks, hips and thighs, rather than the abdomen and midsection, making the body look more feminine
- Skin will become softer and acne may decrease
- Facial and body hair will get softer and lighter and grow more slowly; usually, this effect is not sufficient, and other treatments (electrolysis or laser therapy) to remove unwanted hair may be required
- Male pattern baldness of the scalp may slow down or stop, but hair will generally not regrow
- Reduced sex drive
- Decreased strength of erections or inability to get an erection. The ejaculate will become thinner and watery and there will be less of it.
- Changes in mood or thinking may occur; you may find that you have increased emotional reactions to things. Some persons find that their mental health improves after starting hormone therapy. The effects of hormones on the brain are not fully understood.

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## masculinizing affirmation

testosterone either

- Parenteral administration
- Transdermal administration

**No difference between intramuscular or transdermal delivery on anthropometric or biochemical variables**

Pelusi et al 2014

## Target range

trough total testosterone level to the lower end of the endogenous 'male' range : 10-15 nmol/L

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# Testosterone formulations

<https://www.transhub.org.au/clinicians/masculinising-hormones>

| Formulation                                | Dose              | Route                   | Cycle  | Authority number                     |
|--|-------------------|-------------------------|--|--------------------------------------|
| Testosterone undecanoate <sup>a</sup>      | 1000 mg           | intramuscular injection | 10-12-weekly (first two doses 6 weeks apart) | 10205D                               |
| Testosterone enanthate                     | 250 mg            | Intramuscular injection | 2-3 weekly                                   | Not PBS listed                       |
| Testosterone esters                        | 250 mg            | Intramuscular injection | 2-3 weekly                                   | Not PBS listed                       |
| Testosterone 2% gel                        | 23/mg actuation   | Transdermal             | Daily  | 11740X                               |
| Testosterone 1% gel sachet <sup>a</sup>    | 50 mg/5 g         | Transdermal             | One sachet daily                             | 8830R                                |
| Testosterone 5mg gel patch                 | 5mg/24 hour patch | Transdermal             | One patch daily - may cause skin irritation  | 8619P                                |
| Testosterone 1% gel pump pack <sup>a</sup> | 12.5 mg/actuation | Transdermal             | 4 x actuations daily                         | 10380H                               |
| Testosterone 5% cream <sup>a</sup>         | 2 mL              | Transdermal             | Daily  | Not PBS funded for torso application |

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## Testosterone: PBS Authority Criteria

- Indication: Androgen deficiency, patient must have an established pituitary or testicular disorder
- Criteria: Must be treated by a specialist general paediatrician, paediatric endocrinologist, urologist, endocrinologist or sexual health physician, or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists. The name of the specialist must be included in the authority application.
- Phone consultation is sufficient for the authority prescription, if the specialist agrees with the management plan.  
(PBS \$40+ / Private script \$115+)

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## monitoring

- Check HCT 1 week after initiation
- Monitor oestradiol/testosterone levels every 2-3 months until testosterone is within the normal male range
- For first 12 months quarterly FBC, UEC, LFT, lipids, BSL, weight, BP then every 6-12 months
- HPV testing and CST if cervix present
- Mammograms as appropriate
- BMD if risk factors / high FRAX score or after 60 yrs.

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## Testosterone effects

### Average timeline

### Effect of testosterone

1–3 months after starting testosterone

- decreased oestrogen in the body
- increased sex drive
- vaginal dryness
- lower growth (clitoris) - typically 1–3 cm
- increased growth, coarseness, and thickness of hairs on arms, legs, chest, back, & abdomen
- oilier skin and increased acne
- increased muscle mass and upper body strength
- redistribution of body fat to the waist, less around the hips

1–6 months after starting testosterone

- menstrual periods stop

3–6 months after starting testosterone

- voice starts to crack and drop within first 3–6 months, but can take a year to finish changing

1 year or more after starting testosterone

- gradual growth of facial hair (usually 1–4 years)
- possible male-pattern balding

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## Masculinising hormones

**Permanent:** they will not go away, even if you decide to stop hormone therapy:

- The pitch of your voice becomes deeper
- Increased facial and body hair
- Male pattern baldness may happen
- Increase in the size of the clitoris/phallus (approximately 4 - 5 cm after 2 years)

**Not permanent:** and will likely reverse if hormone therapy is stopped:

- Menstrual periods will stop, usually within a few months of starting testosterone
- Possible weight gain If you gain weight, this fat will tend to go to the abdomen and mid-section, rather than the buttocks, hips and thighs, making the body look more masculine
- Increased muscle mass and upper body strength
- Acne: May be severe and potentially require treatment

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## Potential risks. Cheung MJA 2019


| Type of therapy | Potential risks   |
|-----------------|---|
| Estradiol       | Thromboembolic disease <sup>19</sup>  |
|                 | Hypertriglyceridaemia <sup>15</sup>   |
|                 | Prolactin elevation <sup>32</sup>   |
|                 | Gall bladder disease <sup>33</sup>  |
|                 | Cardiovascular disease <sup>15, 19</sup>  |
|                 | Breast cancer <sup>†</sup>  |
| Testosterone    | Polycythaemia <sup>23</sup>   |
|                 | Acne <sup>36</sup>  |
|                 | Sleep apnoea <sup>37</sup>  |
|                 | Dyslipidaemia (increased triglyceride and LDL levels; decreased HDL levels) <sup>15</sup> |

HDL = high density lipoprotein; LDL = low density lipoprotein. \* This table provides an overview of risks associated with estradiol and testosterone therapy, some of which are extrapolated from cisgender populations. Long term data in TGD individuals are lacking. † An increased risk of breast cancer is seen with post-menopausal estrogen therapy in cisgender women, which increases with duration of use.<sup>34</sup> Owing to a lack of data, there are uncertainties regarding the risks of other hormone-dependent tumours<sup>35</sup> and cardiovascular disease.<sup>15</sup>

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## Surgical options for trans women / trans feminine people

- Breast augmentation
- Genital surgery-orchidectomy, full SRS (penectomy, vaginoplasty, clitoroplasty and vulvoplasty)
- Other-facial feminization surgery (FFS), thyroid cartilage reduction, liposuction or lipofilling

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## Surgical options for trans men / trans masculine people

- Bilateral mastectomy 'top surgery'
- 'Bottom surgery' -hysterectomy and BSO, metoidoplasty, phalloplasty, scrotoplasty
- Non-surgical body modification-binding, packing

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## What does Medicare cover?

- Psychological support-available via Mental Health Care Plan:
  - 10 visits / calendar year with eligible MHP
- Gender affirming hormones are PBS subsidized
  - trans men will need appropriate authority script (*androgen deficiency with testicular disorder*)
- Most surgery is performed in private system which can be cost prohibitive. (A few surgeries for trans women are subsidised ; for trans men mastectomy and hysterectomy attract modest rebate)

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## Being trans in Australia

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## QUESTION AND ANSWER




Please take this time to submit any questions you have using the **Q&A** box at the bottom of your screen.

**These can be anonymous if you wish.**



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**This link will also be emailed to you tomorrow.**



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