APPENDIX E:
accompaniment to the preventive care checklist for transfeminine patients

EXPLANATIONS FOR TRANS-SPECIFIC RECOMMENDATIONS

Note: This form has been adapted with permission from Dr. V. Dubey from the CFPC-endorsed Preventive Care Checklist Form©. The use of these trans-specific forms assumes familiarity with the original forms and their explanations. The original form contains graded evidence-based recommendations,[1] which may or may not be applicable to transgender patients. Unbolded recommendations should be followed as per the original forms. The specific recommendations herein represent an effort to incorporate expert opinion and limited trans-specific evidence with standard National and Provincial primary care practices in a practical format that can be accessed at the point-of-care.

MEDICAL TRANSITION HISTORY

Establishment of a patient's status regarding gender-related treatments and timing of these treatments at the outset of a preventive care assessment allows for patient-centred tailoring of counselling, education, physical examination, and screening recommendations.

LIFESTYLE/HABITS/PSYCHOSOCIAL

An effort should be made to assess the impact of transition/trans identity, experiences of transphobia and impact on employment, housing, family, relationships, and economic well-being.

Social Supports – specific attention should be given to assessing the extent of a patient's social supports, creating an opportunity to suggest additional resources if needed.

Sexual History – delineating the types of sex that a patient is having and with whom will direct the indicated type and frequency of STI screening.

Family Planning/Contraception – transfeminine patients planning to undergo hormonal treatment and/or gonadectomy should be counselled regarding the option for fertility preservation, those who have not undergone gonadectomy and are on hormonal therapy should be counselled regarding the variable effect on fertility and the need for contraception if sexually active with a partner who may become pregnant. (See *Guidelines for gender-affirming primary care with trans and on-binary patients, Part 1*, and *RHO's Reproductive Options Fact Sheet*[2] and the LGBTQ Parenting Network's 'Fertility Preservation for People Who Produce Sperm'[3])

Name change/identification – assess patient need/desire to change name and/or sex marker on identification and offer support for this process (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part I*, and *Appendices P and Q*)

Alcohol – estrogen affects the metabolism of alcohol by the liver and has been associated with elevation in liver enzymes, thus we suggest using the same safe-drinking guidelines for transfeminine individuals as for cis women (i.e. max 10 drinks a week with no more than 2 drinks a day most days, see Canada's Low-risk Alcohol Drinking Guidelines).[4]

FUNCTIONAL INQUIRY

An effort should be made to use language consistent with a patient's gender identity; if unsure - consider asking the patient how they refer to their gendered body parts.

Mental Health – inquire re: experiences/impacts of transphobia; screen for depressive symptoms, anxiety (particularly social anxiety), and self-harm; suicidal ideation and attempts are particularly high in the trans population[5] and should be specifically inquired about; inquire re: current level of gender dysphoria and body image, (re-)assess patient interest in transition-related surgeries if not undergone.

Breasts – inquire re: breast pain (can be normal in early phases of feminization), and nipple discharge (bilateral/non-bloody discharge can be considered normal in early phases, otherwise may be indicative of hyperprolactinemia or local breast disease); if implants present consider inquiry re: symptoms of capsular contracture or rupture (pain, loss of contour, deflation).

GU – inquiry re: urinary symptoms is relevant regardless of genital operative status: spironolactone can cause urinary frequency; the prostate remains post-vaginoplasty; vaginoplasty may lead to urinary complications including increased frequency of UTIs, stricture, fistula; if post-op vaginoplasty; inquire re: vaginal discharge, pruritus, pelvic pain. Odour/discharge is most frequently due to sebum, dead skin, or keratin debris (skin graft) – routine douching with soapy water is usually adequate to maintain hygiene. Imbalances in neovaginal flora may also occur – cleansing/douching with a solution of 25% povidine iodine in water for 2-3 days may be helpful and if symptoms persist; a 5-day course of vaginal metronidazole is reasonable;[6] STIs, granulation tissue, and other neovaginal lesions should also be considered in the differential.

Sexual Function – if patient has not undergone vaginoplasty, inquire re: erectile dysfunction and if present, whether this is of concern for the patient (PDE-5 inhibitors may be considered in patients wishing to maintain erectile function); if the patient has undergone vaginoplasty, inquire re: problems with dilation, dyspareunia, post-coital bleeding, and ability to achieve orgasm (also see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Sexual Function and Fatigue*).

Constitutional Symptoms – fatigue in the absence of other associated symptoms suggesting another cause may be due to testosterone levels below the physiologic female range (also see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Sexual Function and Fatigue*).

EDUCATION/COUNSELLING

Review S/Sx DVT/PE/Stroke – consider periodic review of the signs and symptoms of DVT, PE, and stroke for transfeminine patients on hormone therapy who have additional risk factors.

Adequate Calcium Intake – all transfeminine patients on hormone therapy should ensure a minimum intake of 1200 mg of Calcium daily (total: diet + supplements).

Adequate Vitamin D – all transfeminine patients on feminizing hormone therapy should take 1000 IU of vitamin D daily.

Hormone Adherence – poor hormone adherence may impact bone health if post-orchiectomy, while extra doses may lead to risks associated with high serum levels of estrogen.

Regular, moderate physical activity – some transfeminine individuals may tend to avoid exercise for fear of unwanted muscle development; encourage aerobic exercise as well as high-repetition weight-bearing exercise for osteoporosis prevention.

Safe sex practices/STI counselling - transfeminine patients may be at high risk of STIs depending

on behavioural factors; inquire re: sexual practices and risks including sex work; safer sex counselling, frequent screening (i.e. every 3 months) and an assessment of indications for HIV PrEP[7] are indicated for those at high risk. For patient-centred handout materials, see *Brazen 2.0: Trans women's Safer Sex Guide*.[8]

Overweight/Obese – obesity may increase the thromboembolic and metabolic risks associated with estrogen therapy, weight loss counselling should be emphasized; screen for eating disorders (more prevalent in LGBT2SQ populations, particularly amongst youth).

Underweight - screen for disordered eating – persistent gender dysphoria/incongruence may be associated with a desire to maintain a thinner body habitus in order to hide indicators of natal sex, which may have negative health impacts; strategizing around other ways to address persistent gender dysphoria/incongruence may be helpful.

Smoking – smoking greatly increases the thromboembolic risks associated with estrogen therapy, smoking cessation should be emphasized.

Alcohol and other substances – substance use is more prevalent in members of the LGBT2SQ community; inquire re: problematic use of substances including hormones without a prescription; if referral to a substance abuse program is indicated, consider an LGBT2SQ-specific or LGBT2SQ-positive program such as Rainbow Services at CAMH. Offer safer smoking and injection kits when indicated for harm reduction. A naloxone kit and instructions on use should be offered to all patients who are at risk of opioid overdose, as well as friends and family of those at risk.[9]

Advanced care planning – A discussion regarding advanced care planning is recommended at least once for Canadians ≥65.[10] Trans and gender diverse patients may have particular needs in ensuring that their gender identity and expression are respected and a respectful decision-maker is chosen (See '*Creating End of Life Documents for Trans Individuals: An Advocate's Guide*').[11]

Injection safety – for patients who self-inject estrogen: confirm dose, review aseptic injection technique, inquire re: rotating injections sites, injection site reactions, and pre-injection anxiety; consider review of route options (IM vs. SC injectable, oral, transdermal), ensure safe sharps disposal; counsel re: risks of injecting non-medical silicone (i.e. 'pumping' to enhance body shape) including chronic inflammation, disfigurement, pulmonary complications, sepsis, and death.

Bathroom safety - finding a bathroom that feels comfortable and safe can frequently be a source of stress for trans individuals. Resources such as *Refuge Restrooms*[12]can assist trans people in locating gender neutral bathrooms. For those who may be experiencing urinary frequency due to spironolactone, timing of administration can be adjusted if safe bathroom access is a concern.

PHYSICAL EXAMINATION

Breasts – Evidence to date suggests that the risk of breast cancer in transfeminine individuals is not higher than in cis women and may potentially be lower than in cis women, however both benign and malignant breast disease can occur in transfeminine patients on hormone therapy (also see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Breast Cancer*); annual routine clinical breast exams in transfeminine patients with or without implants are of questionable utility but may be useful to assess the degree of breast development or to detect implant complications respectively. Transfeminine patients should receive counselling around breast self-awareness as is recommended for cis women.

For those who may have interest in MOHLTC-covered breast augmentation surgery, **breast inspection** at baseline and 12 months following hormone initiation is recommended, with particular attention to Tanner stage. **Measurements** such

as chest circumference at the fullest part of the breast and nipple-areolar diametre may be helpful in determining the presence or absence of breast growth, or may be of interest to some patients (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part I: Physical Exam and Baseline Investigations*).

Genitourinary – In patients who have not undergone orchiectomy, testicular examination may reveal testicular atrophy in the setting of feminizing therapy but is not routinely needed. For those who have undergone vaginoplasty, we do suggest annual (starting 1 year post-op) neovaginal speculum examination to detect any abnormalities such as granulation tissue (which may be treated with silver nitrate), active hair follicles (which may be tweezed or if extensive, cauterized under local anesthetic), warts, abnormal discharge, or malignancy; vault smears are not generally recommended as their utility in detecting dysplasia or metaplasia in keratinized epithelium is not established; neovaginal tissue created from colon can be screened for malignancy by direct visual inspection; in the extremely rare case that a neo-cervix has been surgically created, Pap guidelines may be followed as for cis women; if examination of the prostate is indicated, the prostate may be palpated along the anterior wall of the neovagina by digital examination in the lithotomy position.

Ano-rectum – for those who engage in receptive anal sex, visual examination of the perianal region for any evidence of anal warts or other anorectal problems such as hemorrhoids should be considered–particularly those who are HIV+. Additionally consider DRE for detection of internal lesions. HIV+ patients with physical findings consistent with warts or other HPV-related changes should also be referred for HRA.

LABS/INVESTIGATIONS

Mammography – consider mammography in transfeminine patients on hormone therapy every 2 years if aged 50-74 AND on estrogen for ≥5 years total (i.e. years do not need to be consecutive), consider initiating screening at a younger age if additional risk factors are present (i.e. estrogen + progestin for > 5 yrs, family history), consider obtaining expert opinion regarding the need for annual mammography with MRI for those aged 30-69 with family history suggestive of hereditary breast cancer; the presence of breast implants necessitates diagnostic mammography rather than routine screening mammography; additional imaging modalities (ultrasound, MRI) may be recommended by implant manufacturers or a patient's surgeon at regular intervals to detect silent rupture of silicone implants. GRS Montreal currently recommends annual ultrasounds from the 5th year onward to screen for silent rupture in silicone implants, while suggesting clinical exam only (without imaging) for monitoring of saline implants given that rupture causes visible deflation.

GC/CT/Syphilis/HIV/HBV/HCV screen – consider STI detection from the following sites as indicated: throat, urethra, neovagina, anorectum, and serum.

Yearly trans bloodwork – bloodwork should be tailored to the patient's hormone regimen, risk factors and pre-existing conditions; screening for DMII and dyslipidemia should be performed at baseline and 1 year following hormone therapy initiation, and otherwise according to routine guidelines for cis patients; Framingham calculation will be less reliable with exogenous hormone use - depending on the age of hormone initiation and duration of hormone exposure providers may choose to use the risk calculator for sex assigned at birth, affirmed gender, or an average of both;[6] for management of elevated prolactin levels see *Part II 'Hyperprolactinemia/Prolactinoma'*.

Note: For patients on anti-androgen +/- estrogen:

- Hb/Hct - use the female reference for lower limit of normal and male reference for upper limit of normal
- Cr - use male reference range for upper limit of normal

BMD screening – exogenous estrogens appear to effectively maintain bone mass in transfeminine patients although they may have lower BMD than age-matched cis-men at baseline. In accordance with national recommendations, perform bone mineral density testing in all transfeminine patients over age 65. BMD should be considered earlier in those at high risk, such as those who, for a significant period of time (i.e. >2 yrs):

- have been on low-dose or no hormones and are agonadal
- have been on anti-androgens without the co-administration of exogenous estrogen
- have been on a GnRH analogue without exogenous estrogen (See '*Part III: Osteoporosis and BMD Screening*')

Note: frequency of follow-up BMD screening will depend on the results of the initial scan.

Anal Pap screening – for those who have a history of receptive anal sex, consider anal pap every 2-3 years or yearly in those who are HIV+ (if local HRA for the follow up of abnormal results is available). See the Canadian Cancer Society's Colon cancer screening guidelines for gay and bisexual men for more information.

IMMUNIZATIONS

Hepatitis A/Hepatitis B – transfeminine patients may be at higher risk of Hepatitis A/B depending on behavioural risks, if behavioural risk factors are present, the patient may qualify for publicly funded vaccination similarly to MSM.

HPV – consider HPV vaccination x 3 doses in transfeminine patients up to the age of 45, tailor to risk; vaccination can be publicly covered in Ontario via the catch-up program for adolescents up to grade 12 and ≤26 years old for those who are sexually active with MSM.

CFPC – College of Family Physicians of Canada,
STI - sexually transmitted infection,
RHO – Rainbow Health Ontario,
GU - genitourinary,
UTI – urinary tract infection,
PDE-5 – phosphodiesterase-5,
DVT – deep vein thrombosis, PE – pulmonary embolus,
IU – international units,
HIV - human immunodeficiency virus,
LGBT2SQ - lesbian, gay, bisexual, trans, queer, and 2 spirit,
CAMH – Centre for Addiction and Mental Health,
IM - intramuscular,
SC - subcutaneous,
MRI- magnetic resonance imaging,
DRE - digital rectal exam,
HRA - high resolution anoscopy,
GC – gonococcus,
CT – chlamydia trachomatis,
HBV – hepatitis B virus,
HCV - Hepatitis C virus,
DMII - Diabetes mellitus type II,
Hb - hemoglobin,
Hct - hematocrit,
Cr - creatinine,
BMD – bone mineral density,
HPV – human papillomavirus,
MSM - men who have sex with men

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