

Appendix E: Accompaniment to the Preventive Care Checklist for Transgender Women

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 recommendations¹, which may or may not be applicable to transgender clients. 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 client'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/transgender identity on employment, housing, family, relationships, and economic wellbeing

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

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 trans women 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 Guidelines²)

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

Family Planning/Contraception – trans women planning to undergo hormonal and/or surgical treatments should be counselled regarding the option for sperm banking (see RHO Fact Sheet 'Reproductive Options for Trans People'),³ those who have not undergone GAS 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

Name change/identification – assess client need/desire to change name and/or sex marker on identification and offer support for this process (see Appendices P, Q and the related RHO Fact Sheets).^{4,5}

Functional Inquiry

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

Breasts – inquire re: breast pain (may be normal in early phases of feminization), skin changes, lumps & bumps, and nipple discharge (latter may indicate hyperprolactinemia or local breast disease), if implants present consider inquiry re: symptoms of capsular contracture or rupture (pain, loss of contour, deflation)

GU – inquire re: urinary symptoms regardless of genital operative status (prostate remains post-vaginoplasty, while vaginoplasty itself may lead to urinary complications including increased frequency of UTIs, stricture, fistula), if post-op GAS inquire re: vaginal discharge, pruritus, pelvic pain; STIs and imbalances in neovaginal flora (particularly bacterial vaginosis) may occur, and can be treated as in cis women

Sexual Function – if client has not undergone GAS, inquire re: erectile dysfunction and if present, whether this is a problem for the client (PDE-5 inhibitors may be considered in trans women wishing to maintain erectile function), if the client has undergone GAS, inquire re: problems with dilation, dyspareunia, post-coital bleeding, and ability to achieve orgasm

Mental Health – screen for depressive symptoms and anxiety disorders (particularly social anxiety); suicidal ideation and attempts are particularly high in the trans population⁶ and should be specifically inquired about; inquire re: current level of gender dysphoria and body image, (re-)assess client interest in surgical treatments if not accessed

Constitutional Symptoms – fatigue in the absence of other associated symptoms suggesting another cause may be due to testosterone levels below the physiologic female range (occurring more frequently post-orchietomy); cautious supplementation of compounded testosterone gel to bring testosterone levels into the female range have anecdotally been successful at treating fatigue in this circumstance

Education/Counselling

Review S/Sx DVT/PE – review the signs and symptoms of DVT and PE for all trans women on feminizing hormone therapy, and advise immediate medical attention should these occur

Adequate Calcium Intake – all trans women on estrogen should ensure a minimum intake of 1200 mg of Calcium daily (total: diet + supplements)

Adequate Vitamin D – all trans women on estrogen should take 1000 IU of vitamin D daily

Hormone Adherence – missed doses of estrogen impacts bone health if post-orchietomy, while extra doses may lead to risks associated with high serum levels of estrogen

Regular, moderate physical activity – some trans women 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; a sedentary lifestyle increases thrombosis risks associated with estrogen therapy

Obesity – obesity significantly increases the thromboembolic risks associated with estrogen therapy, weight loss counselling should be emphasized

Underweight - Screen for Disordered Eating – persistent gender dysphoria 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 may be helpful

Alcohol and other substances – substance use is more prevalent in members of the LGBT community; inquire re: problematic use of substances including alcohol, cannabis,

cocaine, opioids, hallucinogens, ketamine, ecstasy, and non-prescribed hormones; if referral to substance abuse program is indicated, consider an LGBT-specific or LGBT-positive program such as Rainbow Services at CAMH

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

STI Prevention – transgender women may be at high risk of STIs depending on behavioural factors; safer sex counselling and frequent screening (i.e. every 3 months) for those at high risk is imperative (for client-centred handout materials, see Brazen: a Trans women's Safer Sex Guide⁷)

Injection safety – for clients who self-inject estrogen: confirm dose, review aseptic injection technique, inquire re: injection site reactions, 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

Physical Examination

Blood Pressure – consider maintaining systolic BP \leq 130 mmHg and diastolic BP \leq 90 mmHg⁸

Breasts – it is unknown how the risk of breast cancer in trans women on feminizing hormones compares with cis women, but both benign and malignant breast disease can occur in trans women on hormone therapy;⁹ annual routine clinical breast exams in trans women with or without implants are of questionable utility but can be considered, if implants are present attention should be paid to any sign of complications

Abdo – pay particular attention to stigmata of chronic liver disease and hepatomegaly

Ano-rectum – examine the perianal region visually for any evidence of anal warts (presence in HIV-positive clients warrants referral for high resolution anoscopy) or other anorectal problems such as hemorrhoids

Genitourinary – In clients who have not undergone orchietomy, 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 neovaginal speculum examination to detect any abnormalities such as granulation tissue or active hair follicles (both of which may be treated with silver nitrate cauterization), 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

Extremities – examine for signs of DVT/thrombophlebitis

Labs/Investigations

Mammography – consider mammography in women every 2 years if aged 50-71 and on estrogen for > 5 yrs, consider initiating screening at a younger age if additional risk factors are present (i.e. estrogen + progestin for > 5 yrs, family history, BMI>35), 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

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

Yearly trans blood work – yearly investigations listed are for those currently on an androgen blocker and estrogen, and are not necessary to be done yearly if the client is not on these treatments; blood work should be tailored to the client's risk factors and hormonal milieu, re: lipid profile and CV risk – Framingham calculations will be less reliable with exogenous hormone use; given the link between feminizing hormones and cardiovascular disease, consider using high risk lipid targets for trans women on estrogen who have any other significant risk factors for cardiac disease, low-dose ASA prophylaxis should be considered for all individuals considered high risk for CVD; if the prolactin level is persistently elevated, MRI of the sella may be indicated to rule out prolactinoma (See SHC Guidelines and Protocols, Precautions and Risk Mitigation with Estrogen Therapy: Hyperprolactinemia/Prolactinoma)

Bone Mineral Density (BMD) – exogenous estrogens appear to effectively maintain bone mass in trans women although trans women may have lower BMD than age-matched cis-men at baseline;¹⁰ perform BMD testing in agonadal trans women of any age having been off exogenous hormones for any significant length of time, also consider screening agonadal trans women of any age who are or have been on lower-dose estrogen regimens, have elevated LH,¹¹ those who have been on anti-androgens without exogenous estrogen for a significant period, and those with additional risk factors

(eg. including glucocorticoid therapy, previous fracture, family history of osteoporosis). Note: frequency of BMD screening will depend on the results of the initial scan.

Immunizations

Hepatitis A/Hepatitis B – trans women may be at higher risk of Hep A/B depending on behavioural risks, if behavioural risk factors are present, the client may qualify for publically funded vaccination similarly to men who have sex with men

HPV – consider HPV vaccination x 3 doses in trans women up to the age of 45, tailor to risk; for low-income clients without private drug insurance, Gardasil® may be covered for trans women by requesting an application form from Merck Canada's Patient Assistance Program

CFPC – College of Family Physicians of Canada, RHO – Rainbow Health Ontario, GAS – gender affirming surgery - in this context referring to orchiectomy, penectomy, construction of a neovagina and female external genital anatomy, STI – sexually transmitted infection, UTI – urinary tract infection PDE-5 – phosphodiesterase-5, IU – international units, DVT – deep vein thrombosis, PE – pulmonary embolus, LGBT – Lesbian, Gay, Bisexual, Transgender, CAMH – Centre for Addiction and Mental Health, HIV – human immunodeficiency virus, GC – gonococcus, CT – chlamydia trachomatis, ASA – acetylsalicylic acid, BMD – bone mineral density, LH – luteinizing hormone, HBV – hepatitis B virus, HPV – human papilloma virus

References

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