

Guide for GPs Treating Transgender Patients



This guide is written and published by TransLeeds, a support and advocacy group for the transgender, non-binary and gender nonconforming people in Leeds and the surrounding area. It is a living document and intended to be a brief guide to the treatment of transgender patients over the age of 18. An advocate from TransLeeds may attend meetings between a GP and their patient when requested. If you would like any further guidance or training, please feel free to contact TransLeeds and we will be more than happy to assist.

contact@transleeds.lgbt

Transgender Basics

For some people, their gender identity may not match the gender they were assigned at birth. These people are described as **transgender**. Many, though not all, transgender people feel a deep distress with their primary and/or secondary sex characteristics, their bodies as a whole, or how their gender is perceived by others. This is known as **gender dysphoria**. It is estimated between 1-2% of the UK population is transgender.

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Gender Dysphoria

Transgender people experiencing gender dysphoria may require hormone treatment, surgery or other treatments to align their bodies with their gender identity.

The **DSM-5** states that at least two of the following criteria for gender dysphoria must be experienced for at least six months' duration in adolescents or adults for diagnosis:

- A strong desire to be of a gender other than one's assigned gender
- A strong desire to be treated as a gender other than one's assigned gender
- A significant incongruence between one's experienced or expressed gender and one's sexual characteristics
- A strong desire for the sexual characteristics of a gender other than one's assigned gender
- A strong desire to be rid of one's sexual characteristics due to incongruence with one's experienced or expressed gender
- A strong conviction that one has the typical reactions and feelings of a gender other than one's assigned gender

Referral to Gender Identity Services

A patient with gender dysphoria should be referred by their GP to the Gender Identity Services at the earliest opportunity. There are currently seven Gender Identity Clinics for adults in the UK, and the patient should be given the choice of which ones they would like to be referred to. The closest one to Leeds is the Leeds GIC based at Seacroft Hospital.

Services provided by the Gender Identity Services

The only effective treatment for gender dysphoria is transition. The NHS provides several treatments which can help patients align their physiology with their gender identity:

- **Hormone Replacement Therapy**
- **Surgery**
 - **Top Surgery**
 - Mastectomy & chest reconstruction
 - **Lower Surgery**
 - Vaginoplasty
 - Orchiectomy
 - Penoplasty
- **Hair Removal**
 - Laser Hair Removal
 - Electrolysis
- **Voice Training**

Waiting Times

Although transgender patients have a constitutional right to treatment within 18 weeks of referral, the current waiting list for the Gender Identity Services is between 1-2 years. The NHS is working to reduce these waiting times. Meanwhile, vulnerable individuals are left with no support or treatment from the NHS.

Terminology

Transgender

A person whose gender identity does not match the one they were assigned at birth.

Sometimes abbreviated as *trans*. It is used as an adjective rather than a noun

Example : A transgender person/a transgender man or woman

Cisgender

A person whose gender identity *does* match the gender they were assigned at birth

Non-Binary

A person whose gender identity is neither male nor female. (eg, Agender, Bigender, Gender Fluid, etc)

Trans Man

A man who does not identify with the gender they were assigned at birth (They are usually assigned female at birth)

Trans Woman

A woman who does not identify with the gender they were assigned at birth (They are usually assigned male at birth)

Gender Expression

The way a person presents their gender, or how it is perceived by others

Gender Dysphoria

The distress many transgender people experience over their bodies or how their gender is perceived by others

Ways a GP Can Help

A supportive GP can be crucial to the longer-term health of people with Gender Dysphoria, with some patients requiring more support at the primary care level than others might.

-NHS Gender Dysphoria Guide for GPs

At some point in a transgender patient's transition, the GP and GP employed nurses will become solely responsible for their long term care so it is important GPs improve their knowledge and skills in this area.

Pronouns

Transgender people can experience distress if they feel their gender is not being recognised. It is important to respect and always use a transgender person's correct pronouns. Never assume a person's pronouns by their

gender expression. If you do not know the patient's pronouns it is polite to ask. You could even introduce yourself with your own pronouns before asking the patient what are theirs.

He/Him/His

Masculine pronouns usually used by men

She/Her/Hers

Feminine pronouns usually used by women

They/Them/Theirs

Gender neutral pronouns often used by non-binary people though they may also use gendered pronouns

Ze/Zir/Zirs

An example of neo-pronouns sometimes used by non-binary people

Change of Name

Many transgender people change their name to better match their gender identity. This is usually done with a deed poll but that isn't a legal requirement.

Patients should be recognised as the gender they identify and all patient records should be updated to reflect this including their name, title and gender marker.

It may not be possible to update a patient's records with a new gender marker. It is common practice to create a new record and NHS number with the correct gender for the patient and to transfer the patient's medical history to the new record. The Gender Identity Services should be made aware that the patient's record has changed. A diagnosis isn't required to make this change.

In order for transgender people to change the gender marker on their passports

they will need a letter from their GP stating that the patient is currently in transition, and this change is intended to be permanent. The wording of the letter should be as follows:

This is to confirm that my patient previously known as *[insert patient's old name and date of birth]*, is currently undergoing gender reassignment and as part of the process has changed their name by statutory declaration to *[insert patient's current name]* on *[date of the change]*. *[insert patient's current name]* now lives as *[insert patient's gender]* and this change is intended to be permanent.

Mental Health

Mental health needs to be carefully monitored.

Transgender individuals have a far higher risk of anxiety and depression than the general population which can lead to self harm or even suicide.

Anxiety and depression should be treated as with any other patient either through mental health services like IAPT and/or with medication if necessary. Additionally, studies show that transgender people with a strong support network have a lower severity of distress. Support groups like TransLeeds can assist people over 18 throughout all stages of transition through peer support and advocacy.

TransLeeds also host many social events in Leeds where transgender people can socialise and make friends in a safe environment with other transgender people.

Local Support Services

TransLeeds (18+)

A support and advocacy group for transgender people in Leeds and the surrounding area
www.transleeds.lgbt
contact@transleeds.lgbt

Non-Binary Leeds

A support group for non-binary people in Leeds and the surrounding area
nonbinaryleeds@gmail.com

Gendered Intelligence

A local support group for transgender people under 21.
www.genderedintelligence.co.uk/trans-youth/Leeds

Gender Outreach Workers

Direct support for anyone over 17 currently on the waiting list of the Gender Identity Services.
www.facebook.com/LeedsGenderOutreachWorkers
Jamie.fletcher1@nhs.net

Leeds Survivor Led Crisis Service

Support group offering a space where you can discuss the difficulties you're facing and explore coping strategies
www.lslcs.org.uk/services/group-work-2/lgbttrans-group/

Why Trans People Need Your Support

More than half (54 per cent) of trans people reported that they have been told by their GP that they don't know enough about trans-related care to provide it.

7% of trans people have been **refused medical treatment** due to their gender identity

29% of trans people who accessed mental health services say their gender identity was treated as a symptom of a **mental health issue**

41% of trans people have experienced a **hate crime** because their gender identity in the last 12 months

1 in 8 trans employees have been **attacked** by a colleague or customer in the last year

1 in 3 UK employers say they would be **uncomfortable hiring** a transgender person

More than half (55 per cent) have been diagnosed with **depression** at some point.

72% of trans people under 26 have **self harmed**

84% of trans people have **considered suicide**

48% of trans people have **attempted suicide**

Sources:

www.stonewall.org.uk/sites/default/files/trans_stats.pdf

www.stonewall.org.uk/sites/default/files/lgbt-in-britain-trans.pdf

Bridging Prescriptions

Due to the long waiting list for the Gender Services (between 1-2 years), it is becoming more common for GPs to prescribe bridging prescriptions while their patient waits to be seen by the specialist services. Hormone Replacement Therapy (HRT) is often sufficient in relieving gender dysphoria, and thus associated mental health concerns.

Guidance from WPATH, NHS, Royal College of General Practitioners, Royal College of Psychiatrists, and the General Medical Council support the use of bridging prescriptions if the patient has either already begun living as their gender identity, or if they are self medicating using illicit hormones.

If a GP isn't confident in prescribing hormones, they can refer the patient to the endocrinologist. However, the

patient's GP will be responsible for administering hormone treatment after assessment by the Gender Identity Services. Therefore, if a GP does not currently feel confident in administering hormone treatment, they will need to improve their knowledge and skills in this area.

Guidance on the suitability and administration of bridging prescriptions can also be acquired by contacting the Endocrinology Lead for Leeds Gender Identity Services, Dr Peter Hammond

Dr Peter Hammond
Harrogate and District NHS
Foundation Trust
01423 553747 Ext: 3747
gender.harrogate@nhs.net

OFFICIAL GUIDELINES ON BRIDGING PRESCRIPTIONS

WPATH

The World Professional Association for Transgender Health (WPATH) recognizes that, for optimal physical and mental health, persons must be able to freely express their gender identity, whether or not that identity conforms to the expectations of others.

[...]

Medical and other barriers to gender recognition for transgender individuals may harm physical and mental health. WPATH opposes all medical requirements that act as barriers to those wishing to change legal sex or gender markers on documents.

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008).

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these

criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use.

Guidelines for the Care of Trans* Patients in Primary Care

– Royal College of General Practitioners

Patients may opt to self-medicate with hormones and/or anti-androgens so it is useful to ask them directly about this as it can adversely impact on their health and wellbeing. They may ask you to monitor them for side effects including checking blood tests and this is something that should be negotiated between you and the patient. Under the Royal College of Psychiatrists guidelines patients presenting on illicit hormones can be issued a bridging prescription by their GP while they await assessment at a Gender Identity Service. Advice can always be sought from the Gender Service or Endocrinology.

Good practice guidelines for the assessment and treatment of adults with gender dysphoria

– Royal College of Psychiatrists

Patients frequently find it difficult to confide their feelings of gender dysphoria to their GP, often because it is the family GP or practice, and fear of ridicule, guilt or shame as well as other pressing social factors prevent them from seeking help and treatment. These factors and the anticipated delay in obtaining treatment on the NHS have led to increasing numbers of people self-medicating. Hormones and hormone-blockers are readily available via the internet. The medical practitioner or specialist must consider the risks of harm to the patient by not prescribing hormones in these circumstances. The WPATH standards of care (World Professional Association for Transgender Health, 2011) suggest the prescribing of a ‘bridging’ prescription on an interim basis for a few months while the patient is referred to a gender specialist and an endocrinologist.

[...]

The decision to proceed with endocrine treatment will usually involve a single opinion from a member of the gender identity team or network. Patients should have a written copy of this decision. However, the GP or other medical practitioner involved in the patient’s care may prescribe ‘bridging’ endocrine treatments as part of a holding and harm reduction strategy while the patient awaits specialised endocrinology or other gender identity treatment and/or confirmation of hormone prescription elsewhere or from patient records.

Gender dysphoria services: a guide for General Practitioners and other healthcare staff

- NHS Guidelines

As a general rule, the prescription of exogenous hormones (oestrogens, androgens) is not endorsed until initial assessment is completed. This will take more than one appointment unless the individual is transferring from an appropriate child and adolescent or other gender service. In these cases, hormone treatment decisions may be managed in a shared care arrangement with the other gender service until the second appointment.

If the individual is already taking hormones (having been started by a private gender specialist or through self-medication), it is generally not stipulated that they stop altogether, although there is emerging evidence that self-medication can lead to a poorer outcome. The focus is rather on safe use of hormones, and blood investigations inform this. If someone is taking doses or combinations which represent a risk, they will be advised of this and appropriate guidance given.

Dependent on whether an individual has socially transitioned in the sense of living full time in their preferred gender role (or is felt by the specialist gender clinician to be likely to do so imminently), it may be reasonable to recommend that the GP prescribe exogenous hormones- oestrogen for trans women (Male-to-Female) and testosterone for trans men (Female-to-Male)-possibly in combination with a GnRH analogue. It is important to note

that there is every indication that these are safe and effective treatments.

Tackling the risk of harm: ‘bridging prescriptions’ – General Medical Council

Patients may face a long wait before their first appointment with a gender specialist. This can be very distressing and their mental health may suffer as a consequence. The risk of self-harm and suicide for trans people is much greater than in the general population, and delay in accessing medical care substantially increases these risks. If your patient is distressed, or you believe them to be at risk from self-harm, you should offer them support and consider the need for referral to local mental health services.

Some trans people – after many years of suppression, and facing continued deterioration in their mental health while waiting for a specialist appointment – become desperate for medical intervention and may turn to self-medication with products bought on-line from an unregulated source, without prior medical assessment or supervision.

If your patient is self-medicating in this way, you should speak to them about the risks in line with [our guidance on consent](#).

Do your best to understand your patient’s views and preferences and the adverse outcomes they are most concerned about. It may well be that the risk to your patient of continuing to self-medicate with hormones is greater than the risk to them if you initiate hormone therapy before they’re assessed by a specialist.

The harm reduction approach is recommended, and endorsed by the [UK Good Practice Guidelines For The Assessment And Treatment Of Adults With Gender Dysphoria](#) (RCPsych Report CR181, October 2013) (see box).

From the UK Good Practice Guidelines For The Assessment And Treatment Of Adults With Gender Dysphoria (RCPsych Report CR181, October 2013).

These guidelines were developed by a multidisciplinary panel, including patient representatives. They are endorsed by:

British Association of Urological Surgeons,
British Psychological Society,
Royal College of General Practitioners,
Royal College of Obstetricians and Gynaecologists,
Royal College of Physicians and
Royal College of Surgeons.

The guidelines state, "...the GP or other medical practitioner involved in the patient's care may prescribe 'bridging' endocrine treatments as part of a holding and harm reduction strategy while the patient awaits specialised endocrinology or other gender identity treatment and/or confirmation of hormone prescription elsewhere or from patient records" (page 25) and, "A bridging prescription may be appropriate, and blood tests and health checks are undertaken to screen for contraindications" (page 28).

After assessing the risk and screening for medical contraindications to hormone therapy use, you should seek

advice from a GIC or gender specialist to find a hormone therapy regimen that has the lowest risk for your patient. Advice regarding a standard regimen is available in the [RCGP-GIRES Gender variance e-learning module](#).

Particular care is needed with patients who are already self-medicating and who have experienced improvement in their gender dysphoria. In these circumstances, sudden discontinuation of established hormone use may have unpredictable psychological consequences, and is not recommended.

In summary, a GP should only consider issuing a bridging prescription in cases where all the following criteria are met:

- a. the patient is already self-prescribing with hormones obtained from an unregulated source (over the internet or otherwise on the black market)
- b. the bridging prescription is intended to mitigate a risk of self-harm or suicide
- c. the doctor has sought the advice of a gender specialist, and prescribes the lowest acceptable dose in the circumstances.

How to Initiate Hormone Therapy

Good practice guidelines for the assessment and treatment of adults with gender dysphoria – Appendix 4 – Royal College of Psychiatrists

Women

Monitoring tests

Patients should be encouraged to stop smoking, take regular exercise, have a sensible diet and consume no more than 14 units of alcohol per week.

Baseline

Blood pressure, full blood count, urea and electrolytes, liver function tests, fasting blood glucose, lipid profile, serum free thyroxine T4, thyroid- stimulating hormone, testosterone, oestradiol (less than 100 pmol/l) and prolactin (50–400 mU/l).

Monitoring

On a 6-monthly basis for 3 years and then yearly depending on clinical assessment and results. Provision of prescription is contingent on patients understanding the risks and benefits that may result due to the need to take the following tests: blood pressure, full blood count, urea and electrolytes, liver function test, fasting glucose, lipid profile, testosterone, serum oestradiol 24 h after a tablet or 48 h after a patch (levels should be in the upper half of the

normal follicular range, 300–400 pmol/l) and prolactin (less than 400 mU/l).

Medication

In the first instance, a specialist clinician will provide the prescription or, if the GP is in agreement with collaborative care prescribing and the patient attends a gender specialist service, this will be supervised by the gender specialist who has obtained valid consent.

Typical prescriptions would be for:

Oestradiol (1–6 mg orally daily)

OR

Oestradiol gel (two to four measures daily) or patches (50–150 mcg, two to three times per week), particularly for patients over 40 years (lower risk of thrombosis). Dosage of oestrogen depends on the results of monitored circulating oestradiol levels (see p. 34)

Goserelin 3.6 mg implant subcutaneously once every 4 weeks or 10.8 mg implant once every 12 weeks, or an alternative gonadotrophin-releasing hormone agonist – inhibits secretion of pituitary gonadotrophin and testosterone secretion.

Additional therapies, which may be helpful, include:

Cyproterone acetate (50–100 mg orally daily) – it is much less satisfactory than goserelin

Dianette (1 tablet daily for 21 days; repeat after 7 gap days), which contains cyproterone acetate and an oestrogen

Spirolactone (100–400mg orally daily) may be required for additional androgen receptor blockade – long-term use associated with liver dysfunction and possibly hepatoma risk (animal data).

Progesterone is not usually indicated since no biologically significant progesterone receptor sites exist for biological males.

Medroxyprogesterone acetate (100mg orally twice daily) or **dydrogesterone** (10mg orally twice daily) has been used

Finasteride (5 mg orally daily) – blocks conversion of testosterone (which may derive from adrenal androgens in the absence of secreting testes) to the more active dihydrotestosterone. It can discourage male pattern hair loss and testosterone-dependent body hair growth.

Men

Monitoring Tests

Patients should be encouraged to stop smoking, take regular exercise, have a sensible diet and consume no more than 14 units of alcohol per week.

Baseline

Blood pressure, full blood count, urea and electrolytes, liver function tests fasting glucose, lipid profile, serum free thyroxine T4, thyroid-stimulating hormone, prolactin (less than 400mU/l) and serum oestradiol and testosterone.

Monitoring

On a 6-monthly basis for 3 years and then yearly if well, depending on clinical assessment and results. Provision of prescription is contingent on patients understanding the risks and benefits that may result due to the need to take the following tests: blood pressure, full blood count (haemoglobin and haematocrit), urea and electrolytes, liver function tests, fasting glucose, lipid profile, serum oestradiol (for adequacy of suppression less than 70pmol/l) and prolactin (less than 400mU/l).

Serum testosterone should be at or below lower end of normal range (<10nmol/L) just before next dose is due to avoid accumulation or inadequate dosage. If on oral testosterone, measure dihydrotestosterone levels 3–4h after a dose.

Medication

Goserelin 3.6mg implant subcutaneously once every 4 weeks or 10.8mg pellet subcutaneously once every 12 weeks.

Testosterone enantate or Sustanon (mixed testosterone ester) 250–500mg intramuscularly every two to six weeks depending on serum testosterone levels (see above).

OR

Testogel (50mg/5g gel once daily – occasionally two doses are required), rubbed into the shoulders or loins after shower or bath.

OR

Testosterone undecanoate 120–160mg/day orally or 1g intramuscularly every 3 months.



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