

Appendix G: Accompaniment to Preventive Care Checklist Form for Transgender Men

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 – we suggest that trans men, regardless of exogenous hormone use, follow the safe-drinking guidelines for cis women (i.e. maximum 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 men considering hormonal and/or surgical treatments should be counselled regarding reproductive options (see RHO Fact Sheet 'Reproductive Options for Trans People'³), also see potential for pregnancy/need for birth control below

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 related RHO Fact Sheets^{4,5})

Sleep – testosterone therapy may worsen or unmask obstructive sleep apnea, consider inquiring re: symptoms of sleep apnea; in those with sleep apnea, CPAP requirements may change with masculinizing hormone therapy and should be monitored^{6,7}

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 body parts.

Chest – inquire regarding skin changes, lumps/bumps and nipple discharge regardless of surgical status, if client has undergone chest reconstruction consider asking about scarring and patient-satisfaction with surgical outcome (in some cases, revisions can be considered to optimize cosmetic appearance), if client has not undergone chest reconstruction consider asking about binding and any associated MSK, dermatologic, or respiratory problems; encourage the use of a product designed specifically for the purpose of chest binding (several commercial brands are available, for a comparison see www.transguys.com) rather than the use of other products such as tensors or duct tape

GU/PV Bleeding – inquire about symptoms of vaginal atrophy (if on testosterone), vaginal bleeding, discharge, and pelvic pain. Problematic symptoms due to vaginal atrophy often respond to topical estrogen; NB: any unexplained vaginal bleeding once menstrual cessation has been achieved on testosterone warrants a full work-up for endometrial hyperplasia/malignancy

Sexual Function – inquire regarding libido/hypersexual behaviour, change in sexual attractions, dyspareunia (as indicated by surgical status and sexual activity), and post-orgasmic uterine cramping (See SHC Guidelines and Protocols, Masculinizing Hormone Therapy: Other common side effects and their management)

Derm – inquire re: acne and androgenic alopecia, both of which may be managed similarly to cisgender clients

Mental Health – screen for mood disturbances including irritability, anger, and depression, as well as anxiety disorders (particularly social anxiety); suicidal ideation and attempts are particularly high in the trans population⁸ and should be specifically inquired about; inquire regarding symptoms of hypomania, mania, or psychotic symptoms in clients on testosterone who have underlying psychiatric disorders that include such symptoms; inquire re: current level of gender dysphoria and body image, (re-)assess client interest in surgical treatments if not accessed

Education/Counseling

Adequate Calcium Intake – all trans men on testosterone should ensure a minimum intake of 1200 mg of Calcium daily (diet + supplements)

Adequate Vitamin D – all trans men on testosterone should take 1000 IU of vitamin D daily

Hormone Adherence – missed doses of testosterone impacts bone health if post-oophorectomy, while extra doses may lead to a host of problems associated with supraphysiologic levels

Regular, moderate physical activity – weight-bearing exercise helps in osteoporosis prevention; to avoid tendon rupture in trans men on testosterone weight loads used in strength training should be increased gradually with an emphasis on repetitions and stretching

Safe sex practices/STI counselling – trans men 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 Safer Sex for Transguys: A Guide for the Whole Spectrum⁹ and PRIMED: The Back Pocket Guide for Trans men & the Men Who Love Them¹⁰)

Potential for pregnancy/need for birth control – trans men on testosterone may become pregnant even if menstrual suppression has been achieved and should be counselled in this regard; given that testosterone is a teratogen, reliable birth control must be instituted where pregnancy is a risk based on sexual activity

Need for folic acid – trans men not on testosterone and in whom pregnancy is possible based on sexual activity, as well as for those who are hoping to achieve pregnancy, folic acid recommendations are the same as for cis women

Obesity - Screen for Mental Health Contributors – persistent gender dysphoria may be associated with a desire to maintain a larger 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

Smoking – tobacco use can worsen polycythemia associated with testosterone administration and increases the risk of CVD and thromboembolic events

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 anabolic steroids; if referral to substance abuse program is indicated, consider an LGBT-specific or LGBT-positive program such as Rainbow Services at CAMH

Injection safety – for clients who self-inject testosterone: confirm dose, review aseptic injection technique, inquire re: injection site reactions, ensure safe sharps disposal

Physical Examination

Blood Pressure - consider maintaining systolic BP \leq 130 mmHg and diastolic BP \leq 90 mmHg¹¹

Chest – testosterone therapy is not thought to increase the risk of breast cancer,¹² for trans men who have not undergone chest reconstruction, clinical chest (i.e. breast) exam is of questionable utility but can be considered according to a provider's common practice with cis women; trans men who have undergone chest reconstruction are at low risk and chest and axillary lymph node exam are of questionable utility but may be considered to assess for abnormalities in the remaining breast tissue; if an abnormality is noted in this case, ultrasound +/- MRI is indicated as mammography is technically impossible

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

Pelvic/Pap – follow cervical cancer screening guidelines as for cis women if the cervix is present, there is no evidence to support the performance of a bimanual exam but if uterus and/or ovaries are present this can be considered according to the clinician's routine practice with cis women; several strategies may be employed to minimize the discomfort/trauma associated with speculum examination for some trans men (see Tips for

Providing Paps to Trans men).¹² Barring contraindications, topical 2% lidocaine jelly may be applied vaginally 5-10 minutes prior to the procedure in those who find speculum examination painful due to atrophic changes.

Derm – examine for acne and androgenic alopecia

Labs/Investigations

Mammography – for trans men who have not undergone chest reconstruction, follow guidelines as for cis women; mammography is not required following chest reconstruction; for all trans men, if a strong family history of breast cancer is present, follow the same guidelines as for cis women regarding indications for referral to a high risk screening program/genetic assessment

GC/CT/Syphilis/HIV/HSV screen – consider STI detection from the following sites as indicated: throat, urethra, vagina, ano-rectum, and serum

Cervical cytology – see Pelvic/Pap above, if patient is on testosterone, ensure to note this on the cytology requisition in order to minimize histological misinterpretation, inadequate samples are more common in clients on testosterone and repeat may be required

Yearly trans blood work – yearly investigations listed are for those currently on testosterone, and are not necessary to be done yearly if the client is not on testosterone; 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; consider using high risk lipid targets in trans men on testosterone with any other significant risk factors for CVD; low-dose ASA prophylaxis should be considered in all individuals considered at high risk of CVD

Bone Mineral Density – indications to perform BMD testing in trans men:

- At any age having undergone oophorectomy and having been off of exogenous hormones for any significant length of time
- <50 years old regardless of ovarian status if have taken testosterone for any significant length of time and have any other risk factors for osteoporosis
- >50 years old with ovaries intact and 5-10+ years on testosterone
- >50 years old post-oophorectomy and on testosterone >5 years
- >60 years old post-oophorectomy and on testosterone <5 years¹¹

BMD testing may additionally be considered in agonadal trans men with elevated LH¹⁴

Note: frequency of BMD screening will depend on the results of the initial scan

Immunizations

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

HPV – consider HPV vaccination in trans men up to age 45; for low-income clients without private drug insurance, Gardasil© may be covered by requesting an application form from Merck Canada's Patient Assistance Program

CFPC – College of Family Physicians of Canada, STI – sexually transmitted infection, RHO – Rainbow Health Ontario, MSK – musculoskeletal, GU – genito-urinary, PV – per vagina, IU – international units, CVD – cardiovascular disease, LGBT – Lesbian, Gay, Bisexual, & Transgender, CAMH – Centre for Addiction and Mental Health, BMD – bone mineral density, LH – luteinizing hormone, HPV – human papilloma virus

References

- 1 Duerksen A, Dubey V, Iglar K. Annual adult health checkup: Update on the Preventive Care Checklist Form© Canadian Family Physician, 2012 Jan; 58:43-47.
- 2 Butt, P., Beirness, D., Gilksman, L., & Stockwell, T. Alcohol and health in Canada: a summary of evidence and guidelines for low- risk drinking. Ottawa: Canadian Center on Substance Abuse; 2011.
- 3 Rainbow Health Ontario. Fact Sheet: Reproductive options for trans people [Internet]. Toronto: Rainbow Health Ontario; Feb 2012. Available from: www.rainbowhealthontario.ca.
- 4 See www.rainbowhealthontario.ca/resources/
- 5 See www.rainbowhealthontario.ca/resources/
- 6 Matsumoto AM, Sandblom RE, Schoene RB, Lee KA, Giblin CE, Pierson DJ, Bremner, WJ. Testosterone replacement in hypogonadal men: effects on obstructive sleep apnoea, respiratory drives, and sleep. Clin Endo. 1985;22(6):713-721.
- 7 Tangpricha V, Ducharme SH, Barber TW, Chipkin SR. Endocrinologic treatment of gender identity disorders. Endocr Pract. 2003; 9(1):12-21.
- 8 Bauer GR, Pyne J, Francino MC, Hammond R. La suicidabilité parmi les personnes trans en Ontario : Implications en travail social et en justice sociale. Review service sociale. 2013; 59(1): 35-62.
- 9 Cullen, J. Safer Sex for Transguys: A Guide for the Whole Spectrum [Internet]. James Cullen; 2004. Available from: <http://www.scribd.com/doc/38989522/Safer-Sex-for-Transguys-A-Guide-for-the-Whole-Spectrum>
- 10 Gay Men's Sexual Health Alliance. PRIMED: The Back Pocket Guide for Trans men and the Men Who Dig Them. Toronto: Gay Men's Sexual Health Alliance. 2009.
- 11 11-14 Center of Excellence for Transgender Health. Primary Care Protocol for Transgender Patient Care.. San Francisco: University of California, San Francisco, Department of Family and Community Medicine. April 2011.
- 12 Feldman J, Safer J. Hormone Therapy in Adults: Suggested Revisions to the Sixth Version of the Standards of Care, Intl J of Transgenderism. 2009; 11(3):146-182, DOI: 10.1080/15532730903383757
- 13 Potter M. Tips for Providing Paps to Trans Men [Internet]. Toronto: Sherbourne Health Centre; 2010, www.checkitoutguys.ca
- 14 Van Kesteren P, Lips P, Gooren LJ, Asscheman H, Megens J. Long-term follow-up of bone mineral density and bone metabolism in transsexuals treated with cross-sex hormones. Clinical Endocrinology, March 1998; 48(3): 347-54