Task Coverage hints for Gender Affirming Hormone Therapy in GIM

Recommended quick reference for triage: UCSF Transgender Care and Treatment Guidelines

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People | Transgender Care (ucsf.edu)

Transmasculine hormone therapy:

https://transcare.ucsf.edu/guidelines/masculinizing-therapy

Testosterone levels: goal is physiologic range (400-700 ng/dL)

If > physiologic range:

- you can ask when drawn (ideally should be mid-cycle between doses)
- if midcycle timing, you can go down on dose or increase time between doses;
- please note this is often a bit of a negotiation with patients; so, if they do not need an immediate refill you could let them know it is high and that their PCP will discuss next steps with them upon their return

If < physiologic range:

- you can offer to increase dose based on patient preference
- please note, some non-binary and gender queer patients may not want to be in physiologic range. I will often state something like "Your testosterone is below physiologic range. We can go up on your dose if you like or keep it stable. Just let me know."

HCT: Monitoring for 2/2 polycythemia Use male reference range

- testosterone will increase hgb/hct levels
- work up other causes: i.e. sleep apnea, TOB, obesity
- If > 55 % need to get it down (while also seeing if there are other causes). If covering would hold a dose of testosterone while awaiting return of PCP; ultimately treat underlying causes, decrease dose, can consider phlebotomy
- If > 50 and <55, workup possibly other causes; consider dose testosterone dose change

From UCSF guidelines: Transgender men with true polycythemia should first have their testosterone levels checked, including a peak level, and have dose adjusted accordingly. Changing to a more frequent injection schedule (maintaining the same total amount of testosterone over time) or transdermal preparations may limit the risk of polycythemia. Phlebotomy or blood donation may be an appropriate short term solution depending on the level of elevation; in all cases other pathologic causes of polycythemia should be excluded. In addition to neoplasms and cardiopulmonary disease, specific conditions of concern in transgender men include obesity-related obstructive sleep apnea, and tobacco use.

Transfeminine hormone therapy:

https://transcare.ucsf.edu/guidelines/feminizing-hormone-therapy

Estrogen levels: goal is mid-cycle range for cis-gender women (100-200 pg/mL)

If > physiologic range:

- if on IM dosing, you can ask when drawn (ideally should be mid-cycle between doses)
- If midcycle or oral or patch, you can go down on dose;
- please note this is often a bit of a negotiation with patients; so, if they do not need an immediate refill you could let them know it is high and that their PCP will discuss next steps with them upon their return

If < physiologic range:

- you can offer to increase dose based on patient preference
- please note, some non-binary and gender queer patients may not want to be in physiologic range. I will often state something like "Your estrogen is below physiologic range. We can go up on your dose if you like or keep it stable. Just let me know."

Testosterone levels: goal is <55 nl/dl:

- If on spironolactone for suppression of testosterone can increase up to 200 mg BID to reach goal of suppressing testosterone; make sure patient is tolerating the medication and lytes are wnl.
- If on finasteride or dutasteride, these do not suppress testosterone levels (may increase actually). They block the action of testosterone but not productions

CMP: primarily checking lytes for spironolactone

Other considerations:

Can place e-consult to endocrine

See attached referral resources developed by UChealth Transgender Clinic