About These Slides

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Please contact ASHM Sexual Health Project Officer Sabdy Ma at education@ashm.org.au if you have any enquiries.
ASHM SSHC Journal Club
Transgender Health

DASH GRAY, AMAN BEDI, JOE COTTER CLINIC 16
5/8/2020

We acknowledge the traditional custodians of the land on which we live and work and pay our respects to Elders past, present and emerging
Transgender Health

- Team presentation
- Case
- Concerning issues – psychosocial, medical
- Journal articles - 6
- Questions

Case:

- LB (pronoun he/him), 22, AMAB, referred by psychologist for gender affirming care
- Gender dysphoria since childhood
- Anxiety, depression – suicide attempt 1/2020 – ED
- Headspace – counselling
- Came out to mum as trans → counsellor → psychologist → Clinic 16
- Felt a bit lighter after coming out

- PMHx: ADHD – psychiatrist, aware of depression but not gender dysphoria
- Nil personal/FHx of VTE
- Meds: Vyvance
- Not sexually active
- Non-smoker, minimal EtOH, previous uni studies – dropped out, unemployed
- Minimal exercise, diet – mostly take-aways, some home-cooked meals
Case:

- Lives with parents and siblings
- Parents, sister – aware of gender dysphoria, supportive of GAC
- 2 brothers: unaware, 1 at home, 1 lives away
- Brother at home: hx of being verbally abusive and aggressive, worse since losing sight (age 23 due to Leber’s hereditary optic neuropathy), previous police attendances for ‘throwing things’ ?transphobic
- ‘No friends’ – only social contacts via online gaming
- Social transitioning – growing hair, name

Goals:
- Maximally feminising – good knowledge of hormone therapy
- Does not want to have children
- GRS, ‘uterine transplantation’

Medical – physical exam/baseline bloods NAD. MSE: withdrawn, normal thought form but has chronic low-level suicidality due to gender dysphoria, no perception/cognition/judgement concerns

Dietetics – dietary advice

Counselling: no longer seeing psychologist ‘deregistered’, further psychological evaluation

Concerns
- Physical safety at home during transition
- Social isolation
- Support during transition
- Compliance and willingness to engage with services and ongoing medical reviews
Case

Management:
Informed consent model
Further counselling, peer group
Family meeting – mum

Commenced on spironolactone (start low, go slow) – aftertaste but tolerable. BP/mood stable. 3/12 ly K+ stable

Commenced on oestradiol valerate

Follow-up 3 months post commencing oestradiol:
Happier, more engaging, breast development

Issues:
Gender diverse – suicide risk
Family/sibling violence/experience in GAC
Barriers to GAC – Covid
Spironolactone – 3/12 ly K+ check – ?necessary
Uterine transplantation
Suicidality, self-harm, and their correlates among transgender and cisgender people living in Aotearoa/New Zealand or Australia

Gareth J. Treharne, Damien W. Riggs, Sonja J. Ellis, Jayde A. M. Flett & Clare Bartholomaeus

*International Journal of Transgender Health, DOI: 10.1080/26895269.2020.1795959*

Published online: 23 Jul 2020

**Background:**

Transgender and gender diverse – high rates of suicidality and self-harm

Past research – range of correlates of suicidality in this group:

- gender-related discrimination, psychological distress, resilience and social support

Little known about whether these correlates are similar for trans and cisgender people

**Aim:** to test whether demographic and psychosocial correlates hold for both trans and cisgender people living in Aotearoa/NZ and Australia
Suicidality, self-harm, and their correlates among transgender and cisgender people living in Aotearoa/New Zealand or Australia

Method:
Design – cross-sectional survey

15/1/2017 to 15/12/2017

Info on survey – community organisations (eg LGBTQI Health Alliance, Gender Diversity Australia), professional organisations (eg Beyond Blue), paid advertisement on Facebook

Inclusion - > 18 yrs living in Aotearoa/NZ or Australia.
- quotas set in both countries

Measures: demographics, Multi-Dimensional Scale of Perceived Social Support (MSPSS), Everyday discrimination Scale (EDS), K10, Brief Resilience Scale (BRS), Suicidal Ideation Attributes Scales (SIDAS), recent/lifetime suicidal ideation and suicide attempt, Deliberate Self Harm Inventory (DSHI)

Analysis:
SPSS
Chi-square/Fisher's/ANOVs – bivariate ass between suicidality and self harm
Logistic regression – multivariate analyses

Suicidality, self-harm, and their correlates among transgender and cisgender people living in Aotearoa/New Zealand or Australia

Table 1. Differences in demographics, suicidality, self harm, and psychosocial variables by country of residence and gender identity.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Gender identity</th>
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<td></td>
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<td>Cisgender</td>
<td>Brute difference</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
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<td>18.7</td>
<td>0.771, 0.554, p = 0.591</td>
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<td></td>
</tr>
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<td>103.0</td>
<td>0.715, 0.495, p = 0.680</td>
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<tr>
<td>Income</td>
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<td>103.0</td>
<td>0.715, 0.495, p = 0.680</td>
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<tr>
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<td>103.0</td>
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<tr>
<td>Employment</td>
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<td>103.0</td>
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<tr>
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<td>Living with family and partner</td>
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<td>103.0</td>
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<tr>
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<td>103.0</td>
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<td>Living with family, partner, and friend</td>
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<tr>
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<td>103.0</td>
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Suicidality, self-harm, and their correlates among transgender and cisgender people living in Aotearoa/New Zealand or Australia

Discussion:
- This study provides preliminary insights into correlates of suicidality and self-harm for trans and cisgender people in Aotearoa/NZ and Australia.
- Significant differences in prevalence of suicidality and self-harm based on gender modality, trans>cisgender (2x as likely to have recently attempted suicide).
- Identifies factors:
  - distress in both groups
  - discrimination, lower level of social support in transgendered participants
  - living alone – less likely to self-harm in transgendered participants
  - resilience – not widely a factor

Prevention of suicide in transgender people – reduce discrimination, distress, and provide increased social support.
Suicidality, self-harm, and their correlates among transgender and cisgender people living in Aotearoa/New Zealand or Australia

Limitation:
Sample – self selecting
Recruitment – over-representative of younger participants, engaged with community, social media
Not enough intersex
Recall bias – retrospective accounts

Conclusion:
Strong relationship between self-harm and discrimination (as a risk factor) and social support (as a protective factor)

Article 2

Understanding more about how young people make sense of their siblings changing gender identity: How this might affect their relationships with their gender-diverse siblings and their experiences

Nicola L Wheeler, Trilby Langton, Elizabeth Lidster and Rudi Dallos

Clinical Child Psychology and Psychiatry, 2019, Vol. 24(2) 258–276

Published: 10 April 2019
Understanding more about how young people make sense of their siblings changing gender identity: How this might affect their relationships with their gender-diverse siblings and their experiences

**Background:**
- ‘The Sibling Bond’ (Bank & Kahn 1982) - ‘not minor actors on the stage of human development but rather play a complex role’
- Dunn et al (1992) - impact on relationship when change in identity – disability (supportive)
- McNulty et al (1989) - difficult feelings towards disabled siblings due to perceived differential treatment and attention
- Lamb et al (2014) - relationship impacted by other changes in a child’s identity

Changes to gender identity have not been explored.

**Aim:**
1. Develop a greater understanding of how young people make sense of, and experience, their siblings changing gender identity
2. Employ this greater understanding to identify any potential support needs siblings may have and suggest how these might be addressed.

**Method:**
Consultation: Intercom Trust (LGBT charity South West England)
Design: Intercom, Gender Identity Development Service (GIDS), young people > 12 who attended GIDS sibling group for their 2014 family day

**Design:**
Semistructured interview
Topics – suggested by sibling consultees – open-ended interviews
Thematic analysis – identify common/nuanced experience within sibling participants’ narratives, then used to suggest how support available to siblings of gender-diverse young people might address their potential needs.

**Recruitment:**
Inclusion – Families had (i) at least 2 children (1 accessing GAC and sibling > 11 yrs) (ii) English speaking (no translation funds)
Focused on adolescent participants – had to lower age to 11yrs and upper age of 18yrs due to lack of participation
Infosheets given to families on GIDS open day 2015 – 2nd drive – intercom website, info distributed on advocacy worker’s caseload
Families interested – consent sought, details given to lead author
Understanding more about how young people make sense of their siblings changing gender identity: How this might affect their relationships with their gender-diverse siblings and their experiences

Participants:
10 families opted in – 3 did not meet criteria (sibling participants < 11 yrs)
Final sample – 7 families – 5 GIDS, 2 Intercom
8 sibling participants – 2 sibling from 1 family

Data collection:
Interviews
- Info about self/GD sibling
- Awareness of sibling’s GD and response to this, positive/negative experiences, fears/concerns about GD sibling’s future
65-135 minutes
None chose to have family members/friend present
Interviews conducted at home/GIDS/Intercom Trust

Post interview – debriefing, welfare check few days later
Offered 2nd interview if additional details/changes – no uptake

Analysis:
Abductive approach to thematic analysis, validity - reflexivity
Understanding more about how young people make sense of their siblings changing gender identity: How this might affect their relationships with their gender-diverse siblings and their experiences

Findings:
5 overarching themes reflecting key stages in what seemed a process of adjustment

Theme 1: confusion following finding out about, and being told of, sibling’s GD
- all 8 – confusion ‘hard to make sense of it’, upset – losing a brother’, permission to grief loss of brother when gaining a sister
- 7 GD, 7am I going to do the same
- 6 female sibling participants – sought further info

Theme 2: achieving some clarity through beginning of social transition
- new name – welcomed being involved – 3 sibling participants
- 5 sibling participants – ~3 months to adjust to new names/pronouns
- all female sibling participants – adjusting to new pronouns more challenging than new names, made efforts to use new names/pronouns and correct errors made by others
- Accidental slips – when angry etc
Understanding more about how young people make sense of their siblings changing gender identity: How this might affect their relationships with their gender-diverse siblings and their experiences

Theme 3: managing gender diverse sibling’s two identities
- 5 youngest sibling participants – much time discussing ‘coming out’, told to keep identities within family (continued to use identity assigned at birth in public) – immense pressure not to make mistakes, inadvertent outing
- interim period lasted 6 months, 12-18 months
- anxiety about slip-ups, worse for school-aged sibling participants
- battling emotions when involved in conversation that were negative about GD

Theme 4: sibling participants deepening empathy with their GD sibling
- acceptance – gradual process, trigger – marked turning point, developed deeper empathy, increasingly supportive
- relief when GD sibling decides to come out publicly
- protective of GD sibling

Theme 5: sibling participants reflection on their experiences
- increased knowledge of trans/GD through accessing info – internet, social media
- relationship with GD sibling enhanced
- 2 significant fears for GD sibling – safety, complication/Ses of treatment/meds

Limitation:
Recruitment
- hard to access siblings of GD people – sample comprising families actively seeking support → selection bias
- short time frame for recruitment 4 months
Sex bias – 6 females
Age range – older able to express complex feelings
Not generalizable
Interview focusing on impact of young person changing gender identity to identify as GD and sibling relationship – other potential aspects of life not explored

Conclusion:
1st study undertaken with siblings of GD people
Greater understanding
Seeking more info – address concerns/fears, questions
Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals

Jae A. Puckett, Peter Cleary, Kinton Rossman, Brian Mustanski & Michael E. Newcomb


Published: 04 August 2017

Background:

Transgender/Gender nonconforming individuals

Dysphoria

Barriers accessing Gender Affirming Care

Experience

-Transgender men, transgender women, TGNC
Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals

Method:
Cohort of 256 participants
- criteria
- daily diary
- online survey/open ended questions

Recruitment:
Facebook, Twitter, Tumblr, Community organisations
Online study

Sample Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
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</thead>
<tbody>
<tr>
<td>Gender identity</td>
<td></td>
</tr>
<tr>
<td>Transgender male</td>
<td>77 (30.1%)</td>
</tr>
<tr>
<td>Transgender female</td>
<td>60 (23.8%)</td>
</tr>
<tr>
<td>Male</td>
<td>35 (13.7%)</td>
</tr>
<tr>
<td>Woman</td>
<td>62 (24.4%)</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>53 (20.7%)</td>
</tr>
<tr>
<td>Agender</td>
<td>6 (2.4%)</td>
</tr>
<tr>
<td>Intermediate gender</td>
<td>5 (2.0%)</td>
</tr>
<tr>
<td>Biological sex not listed</td>
<td>2 (0.8%)</td>
</tr>
<tr>
<td>Biological sex not listed at birth</td>
<td>16 (6.3%)</td>
</tr>
<tr>
<td>Female</td>
<td>141 (55.3%)</td>
</tr>
<tr>
<td>Male</td>
<td>75 (29.7%)</td>
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<tr>
<td>Difference of sex development</td>
<td></td>
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<tr>
<td>Yes</td>
<td>7 (2.7%)</td>
</tr>
<tr>
<td>No</td>
<td>249 (97.3%)</td>
</tr>
<tr>
<td>Ethnicity</td>
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</tr>
<tr>
<td>African</td>
<td>44 (17.3%)</td>
</tr>
<tr>
<td>Asian</td>
<td>262 (96.9%)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>5 (2.0%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3 (1.2%)</td>
</tr>
<tr>
<td>Latino</td>
<td>17 (6.8%)</td>
</tr>
<tr>
<td>Native Hawaiian/Polynesian</td>
<td>0</td>
</tr>
<tr>
<td>Pacific Islander/Racial/Other Pacific Islander</td>
<td>0</td>
</tr>
<tr>
<td>Multiracial</td>
<td>37 (14.8%)</td>
</tr>
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</table>
Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals

Gender Affirming Care Procedures

Results:

201 provided response to barriers to care
Gender
- AMAB greater response rate > 87.7%
- AFAB 75%

Rates of gender affirming procedures

Hormone Therapy Access

Qualitative responses.....
Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals

Gender Affirming Care Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Total</th>
<th>Trans men</th>
<th>Trans women</th>
<th>Genderqueer</th>
<th>Non-binary</th>
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<tr>
<td>Hormone therapy</td>
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<td>13.7</td>
<td>2.0</td>
<td>1.5</td>
<td>14</td>
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<td>No, and unsure if would like in the future</td>
<td>45</td>
<td>16.6</td>
<td>20.7</td>
<td>12.7</td>
<td>8.6</td>
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<td>Yes, from a specialized gender clinic</td>
<td>47</td>
<td>16.7</td>
<td>27.5</td>
<td>13.7</td>
<td>3.6</td>
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<tr>
<td>Yes, from a general doctor's office in-person</td>
<td>100</td>
<td>39.3</td>
<td>41.5</td>
<td>20.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Yes, from friends and others in a medical setting</td>
<td>8</td>
<td>3.1</td>
<td>0.0</td>
<td>5.0</td>
<td>7.6</td>
</tr>
<tr>
<td>Top surgery</td>
<td>61</td>
<td>23.0</td>
<td>7.1</td>
<td>24.0</td>
<td>17.0</td>
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<tr>
<td>No, and unsure if would like in the future</td>
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<td>40.0</td>
<td>31.6</td>
<td>21.8</td>
<td>2.8</td>
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<tr>
<td>Yes, I have undergone top surgery</td>
<td>96</td>
<td>36.5</td>
<td>39.4</td>
<td>7.6</td>
<td>6.3</td>
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<tr>
<td>Bottom surgery</td>
<td>95</td>
<td>37.1</td>
<td>37.0</td>
<td>16.2</td>
<td>27.3</td>
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<td>29.7</td>
<td>11.3</td>
<td>5.6</td>
<td>27</td>
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<tr>
<td>Yes, I have undergone bottom surgery</td>
<td>49</td>
<td>18.0</td>
<td>23.4</td>
<td>8.8</td>
<td>0.0</td>
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<td>Puberty blockers</td>
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<td>7.2</td>
<td>6.1</td>
<td>7.6</td>
<td>100</td>
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<td>1.5</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
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<td>Yes, I am and want to take hormones</td>
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<td>0.0</td>
<td>0.0</td>
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<td>0.0</td>
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</table>

Barriers reported to care:

- 201 Participants- provided at least one response
- 166 - Pursuing hormone
- 134 - Top surgery
- 85 - Bottom surgery
- 22 - Puberty blockers
Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals

Multiple themes....

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<th>Financial</th>
<th>Emotions and worries</th>
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<td>Availability of care</td>
<td>Quality</td>
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<tr>
<td>Medical Mental Health fields</td>
<td>Ageing/ Timing</td>
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<tr>
<td>Interpersonal barriers</td>
<td>Other medical issues</td>
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</table>

Outcome:

Affirmation of one's gender/mental health

Improved outcomes

Sample

-need for TGNC (including non-binary, genderqueer)

Most common barrier is financial/ insurance
Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals

Recommendations

- Self educate
- Transgender friendly registration forms
- Using affirmed gender and names
- Appropriate terminology
- Family involvement
- Clear guidelines
- Access to health care

Conclusion

- Addressing disparities
- Recognising barriers to gender affirming
- Improve access to care
“You Have to Wait a Little Longer”: Transgender (Mental) Health at Risk as a Consequence of Deferring Gender-Affirming Treatments During COVID-19

Anna I. R. van der Miesen, Daphne Raaijmakers & Tim C. van de Grift

Archives of Sexual Behaviour volume 49, pages1395–1399(2020)

Published: 09 June 2020

Background:

Covid-19

Non Essential health care

Gender affirming care as a low priority

Dysphoria

Physical and mental health
You Have to Wait a Little Longer™: Transgender (Mental) Health at Risk as a Consequence of Deferring Gender-Affirming Treatments During COVID-19

Physical/Mental Health Effects:

Role of testosterone influencing course of Covid-19

Social isolation

Covid Stress, increase in Dysphoria and Suicidality

Socio-economic factors/ Transgender research

Job security

Research Initiatives

Access to services

Support networks

TGNC advocacy
You Have to Wait a Little Longer*: Transgender (Mental) Health at Risk as a Consequence of Deferring Gender-Affirming Treatments During COVID-19

Summary

“Unprecedented Scale”

Covid-19 a major barrier

Blended Care

Gender Affirming care is both medical and psychological

Article 5

The Utility of Potassium Monitoring in Gender-Diverse Adolescents Taking Spironolactone

Kate Millington, Enju Liu, Yee-Ming Chan

The Utility of Potassium Monitoring in Gender-Diverse Adolescents Taking Spironolactone

- **Background:**
  - Spironolactone – anti-androgen – promotes feminisation
    - anti-mineralocorticoid – inhibits mineralocorticoids, affects Na/K pump
    - reduced K excretion, risk for hyperkalaemia
  - *Vardeny O et al 2004* – increased incidence of hyperkalaemia with spironolactone in adults with heart failure, from 13.5% in patients taking 25 mg/d to 41.4% in those taking 50 mg/d
  - *Juurlink et al 2014* – increased incidence of hyperkalaemia with spironolactone in heart failure, no change in serum potassium in healthy volunteers
  - Guidelines recommend serial measurements

- **Hypothesis:**
  - Prevalence of hyperkalaemia in gender-diverse adolescents taking spironolactone is low, and that clinically significant hyperkalaemia is rare

- **Method/Material:**
  - Retrospective chart review – gender-diverse youth of any age, Gender Management Service Program Boston Children Hospital between 2007-2017
  - Inclusion – all patients prescribed spironolactone for purpose of gender transitioning
  - Hyperkalaemia > 5 mmol/L

- **Stats analysis:**
  - Descriptive stats – demographics, clinical characteristics
  - Categorical variables – frequencies
  - Continuous variables – mean values
  - Assn between spironolactone and risk of hyperkalaemia – logistic regression
The Utility of Potassium Monitoring in Gender-Diverse Adolescents Taking Spironolactone

**Demographics:**
- n = 85, female gender identity 82, NB: 3
- Mostly white
- 8 subjects with medical co-morbidities:
  - Asthma (n=3),
  - Migraines,
  - Eosinophilic oesophagitis,
  - Macrophage activation syndrome,
  - HTN (no prior K+ > 5mmol/L)
  - CCF secondary to left hypoplastic heart syndrome

  (started on spironolactone 25mg/d with concurrent ACE inhibitor use)

- K+: 82% measurement before initiation, 42% at least one measurement within first 3 months, 56% at least one measurement in 6 months
- Mean K+ = 4.2±1.9
- Dose of spironolactone – mean 105±85mg/d
The Utility of Potassium Monitoring in Gender-Diverse Adolescents Taking Spironolactone

**Incidence of hyperkalaemia:**
- 8 measurements in 6 subjects K+ > 5 mmol/L (2.2%)
- 1 subject – haemolysis on 2 measurements, including 1 performed prior to spironolactone initiation
- No hyperkalaemia in baseline measurements
- All hyperkalaemia measurements occurred early in course of spironolactone (<6/12)
- No K+ > 6 mmol/L

**Features of Subjects with Hyperkalaemia:**
- 5 subjects K+ > 5 mmol/L
- None were symptomatic
  - 1 subject: K+>5 1/12 after starting 50mg/d, continued normalised 2/52 later, elevated 3/12 but normalised 2/52 later
  - 2 subjects: K+>5 1/12 and 6/12 after initiation, normal after.
  - 1 subject: K+>5 1/12 after initiation, all subsequent normal, eosinophilic oesophagitis on PEG feeding and PPI.
  - 1 subject: spironolactone discontinued 5/12 after initiation due to K+>5, restarted 2/52 later after normal K.
**The Utility of Potassium Monitoring in Gender-Diverse Adolescents Taking Spironolactone**

**Discussion:**
- Low rates of hyperkalaemia (2.2%) in healthy gender-diverse adolescents
- No increased risk of hyperkalaemia despite use of larger doses (up to 400 mg/d)
- Downward trend in serum potassium concentrations over time
- Clinical context, rather than dosing alone, that predicts risk of hyperkalaemia
- Implications on care – time/financial burden adding to barriers to gender affirming care

**Hyperkalaemia:**
- Occurred early (< 6/12 of initiation)
- Up to 7 years of monitoring with no hyperkalaemia measured
- Hyperkalaemia in the early treatment, or absence thereof = no increased risk with duration of spironolactone exposure

**Renal accommodation:**
- Accommodation to mineralocorticoid antagonism - lower potassium set point, thus a lower risk for hyperkalaemia over time
- May also explain no measurable effect of higher spironolactone doses on serum potassium concentrations

**Limitation:**
- Small study size, single site – not generalisable
- Retrospective study - potential selection bias – avoiding spironolactone with previous hyperkalaemia, comorbidities
- Suggest – larger size, prospective study with real-time monitoring

**Conclusion:**
- Spironolactone – low risk for hyperkalaemia in healthy gender diverse population
- If occurs, usually early in treatment course irrespective of dosage
- Propose monitoring beyond 6/12 for those with comorbidities or on meds that may affect renal function.
Editorial: Uterus transplantation as a fertility option in transgender healthcare

Vikram G. Mookerjee & Daniel Kwan


Uterus transplantation as a fertility option in transgender healthcare

• Many trans/GD individuals want to have children – cross sex hormone therapy limits fertility and complete GRS preclude it
• Uterine Transplantation (UTx):
  • Currently considered for cis-females with Absolute Uterine Factor Infertility (AUFI) desiring pregnancy
  • Absolute Uterine Factor Infertility:
    – Infertility that is completely attributable to the uterus because of absence (congenital or surgical) or abnormalities (anatomic or functional) that prevent embryo implantation or completion of a pregnancy to term. AUFI is the primary indication for uterus transplantation
    – It is estimated that 1 in 500 women of childbearing age are affected by AUFI, defined as an absent or non-functional uterus. Models predict there are over 12,000 affected women in the United Kingdom and 150,000 women in Europe
    – Absent uterus: Uterine agenesis or Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome, Hysterectomy
    – Non-functional uterus: Adhesion deformations, intrauterine adhesions, Radiation injury, Repeated/unsuccesful implantation, Myoma not requiring hysterectomy
  • Purpose: To use the case-reasoning of applied medical ethics to suggest consideration of Uterine Transplantation for transgender women.
Ethical considerations in the era of the uterine transplant: an update of the Montreal Criteria for the Ethical Feasibility of Uterine Transplantation

Ariel Lefkomitz M.D., B.A., B.Sc., Marcel Edwards M.D., M.Sc. and Jacques Galyay M.D.

Fertility and Sterility, 2013–10–01, Volume 100, Issue 4, Pages 924–926, Copyright © 2013 American Society for Reproductive Medicine

The Montreal Criteria for the Ethical Feasibility of Uterine Transplantation

Method:

1) Reviewed criteria
- justifications for excluding transfemales - 1

2) Components of justification separated and matched to representative prima facie duties (beneficence, non-maleficence, autonomy, justice)

3) Relationship between competing prima facie duties identified.
- medical and surgical risk (non-maleficence) > right to gestate a child (autonomy)
- interrogated specific points corresponding to duty of non-maleficence
  - re-evaluate author’s claimed relationship

4) 2 paradigms constructed as comparison – case reasoning to evaluate any increased risk in the GA paradigm compared with AUF paradigm case

Uterus transplantation as a fertility option in transgender healthcare

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Uterine transplant offers the same promise of a solution for males or trans individuals wishing to gestate a child as it does for genetic females with UFI. Nevertheless, the Montreal Criteria require that the recipient be a genetic female. This warrants both justification and discussion. To date, only female recipients have been used in animal and human trials of uterine transplant. There are many interesting yet daunting theoretical medical issues concerning uterine transplant with a nongenetic female recipient, including the creation of adequate uterine vascularization de novo, the necessity for appropriate hormone replacement to sustain implantation and pregnancy, and the placement of the uterus in a nongynecoid pelvis. These unique considerations merit investigation; however, in the absence of sufficient research demonstrating safety and efficacy, uterine transplant in men and trans individuals fails to meet the first stipulation of Moore’s Criteria for Surgical Innovation, which requires that novel surgical procedures have an adequate research background. It is on this basis that the Montreal Criteria exclude nongenetic female recipients.

However, it certainly bears mentioning that there does not seem to be a prima facie ethical reason to reject the idea of performing uterine transplant on a male or trans patient. A male or trans patient wishing to gestate a child does not have lesser claim so to desire than their female counterparts. The principle of autonomy is not sex specific. This right is not absolute, but it is not the business of medicine to decide what is unreasonable to request for a person of sound mind, except as it relates to medical and surgical risk, as well as to distribution of resources. A male who identifies as a woman, for example, arguably has UFI, no functionally different than a woman who is born female with UFI.
Uterus transplantation as a fertility option in transgender healthcare

Finding:

1) Method of uterine vascularisation de novo (end-to-end anastomoses between graft vessel and recipient external iliac vessels) did not differ between AUFI and GC. Suture sites for fixing graft to pelvic location differed minimally.

2) Post transplant immunosuppression regimens identical in both cases (this was the zone of highest risk and equal between both paradigms).

3) Hormone therapy to sustain GA implantation and pregnancy did not differ significantly from AUFI or established in vitro fertilisation regimens and thus did not portend increased risk.

4) Nongynecoid pelvis (and potential for cephalopelvic disproportion during vaginal delivery) was not identified as adding increased risk to GA, since mode of delivery in both paradigm cases was by caesarean section.
Uterus transplantation as a fertility option in transgender healthcare

**Conclusion:**
Unable to identify any increases in risk, from initial assessment to delivery and subsequent hysterectomy. Propose that transgender women should not be excluded from the prima facie duty relationships recognised in cisgender females due to AMAB.

**Thank You**

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