

Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria

6 November, 2006

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The Royal College of Psychiatrists invites your comments on the latest draft document of the proposed standards of care for patients with gender dysphoria receiving support and medical care in the UK (version 8.3b). This is a document that has been developed in conjunction with representatives from a number of sources including the medical Royal Colleges, professional societies and Associations and representatives from user groups and other interested parties. The list of core representatives is listed in the appendix of the document.

The document now has the broad support of the substantial majority of the representatives on the core committee. It is to be circulated now as part of a wider consultation. At this stage we realise that there are still many comments to receive and consider and the document is not to be considered as the definitive or final document. We have received some feedback during a recent consultation through the medical colleges which will be considered with all other comments received after the three month consultation. We appreciate that this specialty of medicine has a strong divergence of opinion about aetiology, limitations of traditional medical care and the need for greater patient led ownership of the transition pathway. We see the standards as a minimum and so some parts are less specific than others. The document is written in such a way that core concepts form the main document and specific details which may vary over short periods of time are appendices to the document which may be updated and changed on a more frequent basis depending on need.

Please send your comments or suggestions to Candace Gillies-Wright at the Royal College of Psychiatrists (17 Belgrave Square, London SW1X 8PG; email cgillies-wright@rcpsych.ac.uk). This consultation will close on 16 February 2007. After the consultation the committee will reconvene to look at, consider and discuss all of the responses received before issuing a final document.

Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria

An intercollegiate document

Key words: *Good practice*
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This version is made available for open consultation for a three month period. Recent commesnt from representatives on the committee have not been incorporated into this document but are held until the committee next meet. Comments should be passed in writing or by e-mail to Candace Gillies-Wright (cgillies-wright@rcpsych.ac.uk) Committee Manager, The Royal College of Psychiatrists, Tel: 020 7235 2351 ext 234 at the RCPsych by 16th February 2007.

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Executive summary.

This section will be completed by the Committee once all comments and changes from the consultation period have been incorporated.

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Preface

Kevan Wylie, Chairman, MD DSM FRCPsych

The provision of care for patients experiencing gender dysphoria is an excellent example of an area where multidisciplinary and interdisciplinary care is not only good practice but ensures that a wide choice of treatment pathways is offered, tailored to the needs of the individual service user. This intercollegiate document provides guidelines which we hope will optimise the clinical care pathways for patients who may need to access several medical and allied health professionals.

We herald a new approach to care which has evolved from a linear progressive sequence to multiple pathways of care which recognise the great diversity of clinical and presentation needs. Central to the new way of working for health care professionals is the recognition of patient centred care which we hope will result in increased adherence to agreed treatment protocols, reduced morbidity, and improved quality of life for patients. The joint participation in goal setting, 'management of care' and regular follow-up is crucial to winning the support of both service users and clinicians. We recognise that as practitioners our duty of care is to ensure that individuals make competent informed decisions and choices.

Our recommendations are clearly enshrined in the principles of accessibility of services without undue and unnecessary long waits, the provision of high quality services with proper co-operation and working practices between a number of clinicians, with clear recognition of the diverse needs of patients and a recognition of a variety of needs depending on the patients particular gender transition. For some, this means helping individuals achieve real harm reduction which has caused considerable conflict between parties in the past. We strongly emphasise the establishment of clinical partnerships between both patient and clinician and between clinicians. With this in mind clinical governance processes must be set up in accordance with current National Health Service good practice guidelines.

By the adoption of these patient centred recommendations within this publication we hope that patients will feel less need or inclination to avoid seeking professional medical assistance throughout their process of transition. There are already examples of good clinical practice where such recommendations are part of standard practice. The endorsement by all of the relevant medical Royal Colleges, allied medical professionals and user groups sends a strong signal for the need for change where such ways of working remain and is necessary for full implementation.

Disclaimer – for advice from college as to whether this needs to be added, and in particular for the appendices that do not necessarily reflect the opinion of all members of the committee.

Abbreviations

GD	Gender Dysphoria
GRS	Gender Reassignment Surgery
MDT	Multidisciplinary Team
RLE	Real Life Experience
SLT	Speech and Language Therapy

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Part 1. Introduction

1. Establishment of the group

- 1.1. In 2003 the Royal College of Psychiatrists established a working group with the remit of developing good practice guidance for the delivery of professional standards of care, within the UK and the Republic of Ireland, for individuals whose phenotype is inconsistent with their gender identity. Because of the multiplicity of the specialist roles it was decided to convene representatives from other Colleges and related disciplines. Representation from service user groups was invited. The full list of representatives is in table 1. The Group held eight meetings and consulted with a large number of individuals and agencies involved in this area.
- 1.2 This document is not a commissioning document. It may be used in conjunction with the commissioning guidelines prepared under the auspices of current national and local guidelines including those prepared by the Parliamentary Forum on Transsexualism.
- 1.3 The process of treatment aims to achieve an improved quality of life. As such all procedures including surgery should be viewed as possible steps within a unique patient centred process.
- 1.4 After transition or surgery further professional input may be needed, but it is not the remit of this document to cover this in detail.

2. Definitions

- 2.1. Atypical gender development is given a clinical label. In a profound and persistent form, this is known as transsexualism (World Health Organisation, 1993, International Classification of Diseases 10 (ICD), [F64.0]) which is further defined as follows: “the desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment. The transsexual identity has been present persistently for at least two years”. The same state is called Gender Identity Disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR, American Psychiatric Association, 2000), where it is described as “the strong and persistent cross-gender identification and a persistent discomfort with the sex and a sense of the inappropriateness of the gender role”. It is a relatively rare condition in which individuals experience their ‘gender identity’ (the psychological experience of oneself as male or female) as being incongruent with their phenotype (the external sex characteristics of the body).
- 2.2 The experience of this dissonance between the sex appearance, and the personal sense of being male or female, is termed gender dysphoria. The diagnosis should not be taken as an indication of mental illness. Instead, the phenomenon is most constructively viewed as a rare but nonetheless valid variation in the human condition, which is considered unremarkable in some cultures.

3. Terminology

- 3.1. Language, in the field of gender dysphoria and transsexualism, is constantly evolving as understanding and perceptions of these conditions change. Different usage exists between communities, and even side by side within communities. The clinical description 'Gender Identity Disorder' also referred to as gender dysphoria is a personal experience of dissonance between the gender identity and the phenotype (paragraph 2.1.). The term 'transgender' is sometimes understood as an umbrella term to cover a wide variety of atypical gender experiences which may or may not lead to a permanent change of gender role and will not necessarily lead to surgical intervention.
 - 3.1.1 Although widely used in medical literature, the terms disorder and disease in this context are widely perceived by trans people as offensive and stigmatising. The use of these terms should therefore be avoided in clinical practice.
- 3.2 Throughout this document, with the exception of material contained in "quotes", the terms trans woman (male to female individual) and trans man (female to male individual) are used, in accordance with representation made to this committee by service users. An individual who has been assigned as a female at birth on the basis of genital appearance, but who later identifies as male, may be described as a trans man; similarly, an individual who has been predicted to have a male gender identity, having been assigned as a male at birth, but who later identifies as female, may be described as a trans woman. It is important to note that many people, after receiving the appropriate medical care do not identify as trans, but simply as men and women.
- 3.3 A person who is transitioning, or who has transitioned, to live according to the gender other than that which was assigned at birth, should be addressed according to the name and title (Mr, Mrs, Miss or Ms) which is deemed to be correct by the person concerned. So, if personnel, whether medical or administrative, are in any doubt as to the correct title, they should ask the individual discreetly how he or she wishes to be addressed.
- 3.4 When the word transsexual is used, it is preferable to use it as a descriptive term, e.g., transsexual individual, transsexual people, or someone who is transsexual.

4. Prevalence

- 4.1. Estimates of the prevalence of transsexualism (in the population over fifteen years old) vary considerably. Discrepancies may be due to a range of factors. Secrecy and stigma may lead to the perception of an apparently smaller trans population than in those parts of the world where there is greater tolerance. Easier access to treatment and a more benign legal setting may also affect the outcomes of studies. In Europe, the most recent studies are the Scottish study (Wilson et. al., 1999) which yielded an incidence of 0.00818% (1:12,225) and the Netherlands study (Van Kesteren et. al., 1996), 0.00472% (1:21,186). Ratios of trans men to trans women are usually found to be approximately 1:3 or 1:4. In the UK these statistics suggest that there are between 5-6,000 transsexual people in the adult population as a whole (a figure supported by Government research); support groups also estimate that trans men make up 1,500-1,800 of this total
- 4.2. Gender variant people are themselves very diverse and it would be wrong to assume that there is a "typical trans woman or man". Increasing numbers of individuals now present at an earlier stage in life; equally there are many who may have lived with their dysphoria for decades before feeling confident enough (or having the opportunity) to seek to resolve their issues. Gender variance knows no social, ethnic, religious or socio-economic boundaries.

Part 2. Good Practice

Good Practice – Availability, Accessibility and Choice

5. Availability and Accessibility of Services

- 5.1 Regardless of location there should be a competent and effective gender identity service which is readily accessible within the geographic region or reasonable travelling time thereof. The waiting times for access to such service should be in line with those of other tertiary clinics in the region.

6. Commissioning

- 6.1 Commissioners of health care should ensure that their population has access to comprehensive gender identity services, which includes multidisciplinary input from primary care, specialist clinicians working within a team or network, endocrinology and surgical specialities. Locally agreed pathways of care are required to ensure that services are provided at the appropriate level of clinical intervention. In establishing specialised services (for example in setting up a gender clinic), it is essential to obtain appropriate service user representation in conjunction with the relevant commissioning group, and to ensure that service users are offered a choice of pathways.
- 6.2 Gender treatment should be established on a multi-disciplinary basis and may include input from psychology, psychiatry, psychotherapy, nursing, speech and language therapy, endocrinology, dermatology, surgery, social work and other related professions. Working in co-operation with other specialist practitioners or colleagues, even if on a different site and affiliation with peer review and supervision networks should be the goals of all clinicians. In addition to involving service users, clinicians should facilitate or provide information about assistance available to partners and families as part of their remit, with the agreement of the trans person.

7. Legal Rights of Transgendered People

- 7.1 Case law confirms the obligation for Health Authorities to make treatment available for trans individuals (A, D & G v North West Lancashire Health Authority, Court of Appeal, 1998). Issues are considered further in Appendix A.
- 7.2 In cases where a trans person is referred to a clinic, care should be taken to ensure that privacy is maintained at all times and persons addressed according to their wishes. Whether or not an individual has a Gender Recognition Certificate, clinicians should ensure that they comply with the privacy requirements of the Gender Recognition Act (2004).

8. Referral Process

- 8.1 Gender dysphoria services are specialist services. The support of a General Practitioner who is prepared to enter into shared care arrangements is essential.
- 8.2 The patient should have access to local mental health services for non-gender care, including if they are in prison.
- 8.3 Specialist clinicians and gender clinics should provide patients and referrers with details about clinic services and protocols.
- 8.4 Certain groups will have additional specialist requirements - such as patients with learning disabilities (see Appendix B).
- 8.5 Adults with gender dysphoria should have equal access to the full range of available help and services irrespective of ethnicity, cultural background or disability.

9. Collaborative working

- 9.1 Primary care and general practice continue to be central to the delivery of medical and psychological care to a majority of patients and clients and GPs have a role in collaboration with other care givers to ensure that patients get optimum care. Practice based commissioning provides an opportunity or vehicle for delivering collaborative care with other agencies that are involved in the management of gender dysphoria. Collaborative methods could include use of integrated care pathways and use of shared care guidelines and protocols.
- 9.2 In the context of Patient Centred Care, the central point of contact is in fact the service user and their GP. The goal of collaboration should be the effective sharing of information between all the parties involved.
- 9.3 Treatment in this field is particularly holistic in the degree to which different specialties may be involved. There is no inherent necessity for specialists to work together under the same roof. Indeed, patients may not experience the full benefits of choice and emergent expertise if their options are constrained in such a fashion. Nevertheless it is highly desirable that practitioners should establish protocols for working together in the interest of the service user, unless the service user explicitly requests otherwise.
- 9.4 It is desirable for a single practitioner to adopt the lead role to facilitate co-ordinated care.

10. Waiting times

- 10.1 As a matter of good practice, service providers should take all reasonable steps to provide the service user with a realistic understanding of the timescales involved. Service users should have confidence that their treatment will progress in the agreed timescale unless circumstances alter. Service providers should also continually seek ways in which to help guarantee deadlines.
- 10.2 This is medical treatment as any other treatment and patients should not wait unreasonable times.

Good Practice – Patient Focus and Flexibility

11. Informed Consent

- 11.1 Care should be taken to respect the patient's autonomy for decision making at all times.
- 11.2 The idea of empowering people to make informed choices about their own healthcare is a strong principle within modern healthcare thinking. It is embodied throughout current health and social care legislation.
- 11.3 Treatment should be patient-centred and should recognise the individual's preferences, needs, and circumstances. Treatment should not be prescriptive but should allow choices for individuals with regard to their treatment which are clinically safe. It is imperative that those experiencing this condition are accorded a substantial role in determining the kind of treatments that are appropriate for them, the pace at which treatment should progress and the duration and sequencing and where practicable providers of its individual elements. A relevant specialist, should support the individual in coming to those decisions. A flexible approach to treatment, meeting as nearly as possible each individual's needs, is likely to be successful.
- 11.4 Treatment involving a combination of hormone administration and usually some combination of gender confirming surgical procedures, following psychiatric/psychological assessment and accompanied by psychological support, is deemed to lead to excellent outcomes. Although there is a paucity of large scale, long term follow-up studies, one study found that the success rate was 97% in female to male individuals and 87% in male to female individuals (Green & Fleming, 1990). Another study showed that 98% expressed no regrets after surgery (Smith et al, 2005) 91.6% were satisfied with their overall appearance and the remaining 8.4% were neutral; no patient was dissatisfied. This study did indicate that those trans women who had lived as heterosexual men before transitioning to live as women, were at risk of less satisfactory outcomes. This was particularly the case where physical appearance and psychological functioning were unfavourable and the gender dysphoria experienced was inconsistent. Those with added difficulties were at greater risk of dropping out of treatment altogether and those that continue may need additional therapeutic guidance up to and even after surgery. Lawrence (2003) which examined factors associated with satisfaction or

regret following sex reassignment surgery (SRS) in 232 male to female transsexuals. They found that dissatisfaction was most strongly associated with unsatisfactory physical and functional results of surgery. However, not all these elements of treatment will be necessary or desirable in every case, nor will their sequencing conform rigidly to a standard pattern. For some people extensive surgery may not be appropriate or possible. Treatments which are partially or wholly reversible (except hair removal), should usually precede those which are irreversible. Hair removal, especially facial hair in trans women, is an exception to this guidance and may be undertaken at any stage.

- 11.5 Best practice involves informed consent by the individual concerned, at every stage of treatment. The clinician has a responsibility to inform service-users of the treatment options, benefits, potential unwanted side effects and health risks of the treatment, in terms that can be readily understood. The advantages and disadvantages of not undertaking treatment should also be discussed. Patient Information documentation should be provided at least two weeks before consultations so that individuals have the opportunity to consider their options and discuss issues with others.
- 11.4. In cases of disagreement between the clinician and the service user there is an automatic right to the provision of an independent second opinion by another specialist working in the field.

12. Children and Adolescents

- 12.1. Under current guidelines, it is highly unlikely that wholly irreversible treatments (surgical procedures) will be sanctioned by the clinician for a young person under the age of 18 years old but each case should be decided on its own merits and not automatically ruled out on the basis of age alone. Attention should be paid to the development in other countries of treatment services for adolescents, which recognised the intense distress experienced at that age if treatment is not available.
- 12.2 Treatment services should be well integrated; clinicians should consult with each other in all cases and liaise appropriately with family, school and social networks. Partnership with local child and adolescent services (a network model) is recommended good practice (Di Ceglie 2000). See also College report CR63.
- 12.3 If and when the young person is to move on to adult services (ideally in a facility agreed by the young person) the clinician(s) involved should liaise with the adult services, preferably at a joint meeting, to ensure smooth transition from one service provider to the next. Ongoing liaison between the adult services and the previous service-providers may benefit the individual concerned.

13. Clinical Governance

- 13.1 Where specialist gender clinics are established as a pathway for the provision of services, they should operate to the principles outlined in this document

and follow clear protocols in their delivery of service. As with other health care providers, clinics will be required to adhere to the principles of clinical governance, including regular clinical supervision of staff, audit and continuous professional development including service user involvement in the governance of delivery of care. All staff should be able to demonstrate regular appraisal of their professional practice in accordance with their regulatory bodies.

Good Practice – Harm Reduction

14. Harm reduction

- 14.1 Individuals may choose to alter their gender presentation at any time. Practitioners need to be aware of and respect the fact that some people experiencing discomfort with their original gender role may have completed some or all of the steps involved before even approaching medical practitioners for clinical treatment. Such autonomous action may be considered an indicator of the individual's strength of purpose.

Part 3. Recommended Procedure Overview

Recommendations – Initial Referrals, Assessments and Support

15. GP Consultation and Overview

- 15.1 Initial assessment by a general practitioner or any member of the primary care team should use the holistic model. The GP should take a full history, including a brief mental state assessment. Any distress experienced by the service user should be acknowledged by the assessor. The GP has the additional advantage of possessing other medical information about the patient, which should be reviewed. Once a provisional diagnosis is reached, the GP should follow the local protocol/guidelines available in order to refer swiftly for further assessment.
- 15.2 With the current changes in the general practice contract and training in the UK some primary care organisations (PCO) and deaneries, in consultation with the specialist gender dysphoria services, may wish to develop GPwSI (General Practitioners with Special Interest) in this area and where this is the case, these should be actively supported. Where PCO have GPwSI in GD, these GP should serve as a local resource to support other primary care colleagues.

Specialist Assessment

16. Initial Assessment

- 16.1 Initial assessment of patients with possible gender dysphoria includes a general medical and mental health interview with specific attention to psychosexual history and current functioning. A record is required of lifelong mental functioning including any history of disorder. Recollections of childhood gender-typed behaviours, childhood and adolescent cross-gender dressing with possible erotic accompaniment are elicited. Attempts to conform to cultural gender expectations are described. The current marital and/or relationship status and extended family situation is discussed. Steps already taken are noted. Drug use is recorded. Information is provided to the patient. The treatment approaches for gender dysphoria includes reversible steps before the irreversible, and implementation of the Real Life Experience (RLE) of full-time living in the chosen gender role prior to eligibility for surgical intervention. Discussion should be had with the client on how they intend to conduct their transition. Whilst reversible treatments should be administered before irreversible treatments, it should be understood that a change of social gender role is not a step which can easily be reversed, nor may it be as trouble-free without having started hormone therapy.
- 16.2 At first presentation patients may already have changed their social gender role, commenced hormone treatment or had surgery. This should be recognised and individual circumstances accommodated in the overall treatment programme if possible.

16.3 A routine general and sexual health screen should be offered.

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17. Counselling and psychotherapy

- 17.1 Self-assessment should be facilitated by Psychotherapists or Psychologists. Effective psychotherapy should be seen as an essential intervention to support self-assessment and should be used prior to and during the person's treatment programme. It should enable people, through a variety of approaches, to be clearer about their gender identity including whether they want to commence or reverse treatment.
- 17.2 Aside from information from GPs, input from self help organisations, counsellors, psychotherapists, or psychologists can help people work through any distress and become clearer as to their future courses (for example, through exploration of their thoughts, feelings, the unconscious and behaviour).
- 17.3 The intention of the service is to help people understand and appropriately accept responsibility. The service should be confidential and can be independent of medical services and prior to, during or after a medical approach.

18. Clinical Care Procedures – Therapeutic support

The following situations require consideration of psychological interventions for trans people (for example, from psychologists or psychotherapists).

- 18.1 Assessment prior to gender transition, hormone and surgical treatment should include a psychological assessment and formulation including a development history, an account of psychological attitudes to gender and sexuality and an understanding of any other psycho-social issues that may be responsive to psychological interventions.
- 18.2 Trans people wishing to consider gender transition but hampered in the decision making process by psychological defences such as ambivalence and guilt should have the opportunity for exploration of these issues either directly with a gender identity specialist or through a consultation/referral to a psychological therapist.
- 18.3 Some patients with gender dysphoria may have widespread issues beyond gender. Such individuals may require in depth exploration of these wider issues. These issues are sometimes related to an additional mental health diagnosis which may or may not interrupt the gender treatment process.
- 18.4 In the course of gender transition, patients may become depressed or have to face psychosocial issues, in reaction to external factors, as well as to being a function of medication or transition itself. As with any other individual, they may benefit from psychological interventions in any of a number of different models of psychotherapy.
- 18.5 Some patients referred to a gender identity service should be encouraged to explore their gender identity issues within a psychotherapeutic process. This may occur at any stage of a patient's treatment in the gender identity service

and such individuals should have the opportunity of psychotherapy or psychological intervention outside a gender identity service. If such service is not available locally, provision should be available from the gender identity service.

- 18.6 Post-operatively transsexual people may wish to have emotional support or psychotherapy. This may be appropriate within a gender identity service or in a psychotherapy or psychology service.
- 18.7 In considering psychological interventions and therapy clinicians should pay attention to their patient's perceptions of the value and the meaning of the intervention. When this takes place within the gender identity service the implications for the different roles and functions of staff must be taken into account.

Recommendations – The Real Life Experience

19 The Real Life Experience (RLE)

- 19.1 The progression from one gender role to the other usually requires support from specialist services during progression through changes in social, family, domestic and work life.
- 19.2 The real life experience (RLE) is a period of time, a minimum of 12 months and typically between 12 and 24 months living continuously in the gender role with which the individual identifies. The aim is to assist the patient and the professionals in decisions about how to proceed. There will be occasions where in certain circumstances the RLE may need to be extended. The reasons for this must be discussed with the individual.
- 19.3 The quality of the real life experience (RLE) is assessed through discussions about the patient's ability to consolidate their gender role in areas such as employment, voluntary work, education and training or some other stable, social and domestic lifestyle; formally adopt a gender-appropriate first name and to demonstrate that society is aware that they are living in their new role.
- 19.4 There may be occasions when clinicians request verifiable documentation or evidence of the gender change.
- 19.5 Where verifiable evidence exists of successful real life experience before attending the service, this should constitute part of the overall real life experience (RLE).
- 19.6 During the real life experience(RLE) there should be early consideration of obtaining a second opinion for suitability and eligibility and potential readiness for surgery. Once this is obtained a surgical opinion should be sought speedily, and surgery offered without undue delay thereafter depending on national waiting list directives (Mate-Kole et al 1990).

Recommendations – Use of Medical Opinions

20. Opinions for progression through treatment pathways

Opinions are required at the crucial stages of commencing hormonal therapies and referral for surgical procedures

- a. The decision to proceed with hormonal treatment for the individual will involve an opinion, in writing, from a psychiatrist or chartered psychologist working in the speciality of gender dysphoria, the case having been discussed within a multidisciplinary team or network.
- b. A second opinion to proceed with surgery is necessary and will normally be obtained after completion of the real life experience (RLE) from a psychiatrist or chartered psychologist working in the speciality of gender dysphoria.
- c. The purpose of the second opinion is to confirm diagnosis, the reasonableness of the plan to refer for surgery and to respond to any additional specific questions raised by the referrer. This may not necessarily require referral to another specialist team or network.
- d. At least one medical practitioner must provide an opinion for surgery.
- e. Second written opinions are necessary for all trans people who require the following procedures to be undertaken as part of gender confirmation.

Trans men

Mastectomy; Hysterectomy; Vaginectomy; Salpingo oophorectomy; Urethroplasty; Phalloplasty; Metoidioplasty; Testicular prosthesis; Scrotoplasty

Trans women

Penectomy; Orchidectomy; Vaginoplasty; Clitoroplasty; Labiaplasty; Augmentation Mammoplasty

- f. In the case of mastectomy, an opinion may be sought earlier than the above where the trans man has been known to the clinic for 12 months, has started androgenisation with hormones and is unable to progress with the full RLE because of the presence of large breasts. In this case the opinion will be applicable exclusively for the mastectomy.
- g. Whilst no further second opinion is necessary for surgery additional to gender reassignment surgery, local protocols for this may need to be satisfied.
- h. If surgery has not occurred within 2 years of obtaining the second opinion, the provider of the first opinion must consider arranging a further opinion.
- i. It is important that surgeons responsible for major irreversible surgeries, do not merely rely on referrals but, in addition, satisfy themselves that this is an appropriate proposed procedure for the person concerned.

Recommendations – Factors Conducive to Successful Outcomes

21. Peer Support & Mentoring

Societal prejudice can impair overall health and wellbeing. Peer Support can reduce social isolation and reduce distress. Peers can play an important role in providing support and encouraging the use of helpful organisations and resources. Because many trans people may be more comfortable talking to those who have been through similar experiences, they are more likely to trust their help and accept their advice.

Clinicians should provide information on local and national resources.

22. Family Support

There is evidence that for many trans people, family support is an important aid to successful transition. Clinicians should provide information about accessing family support. Regional clinics could facilitate setting up of family workshops. (see appendix C)

23. Hair treatments

Facial and body hair removal, hair transplantation and provision of hairpieces where appropriate may help a trans woman live more successfully. (See appendix D)

24. Image in the new social gender role

It is important for those experiencing gender dysphoria to have confidence in their ability to succeed in the new social gender role. The chances of success, especially during the early stage of RLE, will be considerably reduced where there is a poor self-image. This factor may have a negative impact on decisions about future treatment.

25. Speech and language therapy with trans people

Speech and Language Therapists working with trans people aim to develop voice and communication skills that are congruent with age, physical appearance and consistent with the expectation of both the individual and society for that person's core gender identity. Speech and Language Therapists may be involved in the care of both trans women and trans men. (See appendix E)

26. Facial Feminisation Surgery

Facial Feminisation Surgery is considered by some to be an essential part of the transition process by trans women.

This procedure involves aggressive cranial surgery and depending on the amount of work undertaken, can take anything from five to twelve hours. Surgery can encompass scalp advancement, brow repositioning, removal of brow bossing on the forehead, re-contouring the orbital rim, cheek surgery, rhinoplasty, upper lip lift and the re-shaping of the jaw & chin.

Recommendations – Hormonal Interventions

27. Guidelines for hormone therapy for gender dysphoria

27.1.1 Accepting the desire for the guidelines to be evidence based, there is a great paucity of such evidence. Hormonal support management is based on traditional patterns of treatment. Only recently are treatment programmes being introduced based on the management of patients with endocrine gonadal disorders unrelated to gender dysphoria. (Futterweit 1998; Moore et al 2003; Levy et al 2003)

27.1.2 Hormone support for trans people should be carried out as part of the care from a multi-disciplinary network, supervised by a clinical endocrinologist or using clearly developed protocols (see appendix F, G and H) with access to an endocrinologist if necessary. Endocrinologists involved should be conversant with the management of patients with gonadal disorders not due to gender dysphoria such as is encountered in patients with chromosomal, pituitary, adrenocortical or gonadal diseases.

Full discussion of fertility issues should precede hormonal treatment. There should be no differentiation between gamete storage in trans patients and the general population. (See appendix I)

27.1.3 There should be awareness of the recently described complications of excessive and prolonged gonadal steroid replacement in menopausal women especially if given in non-physiological and excessive amounts. Wherever possible physiological end organ response should be the aim of any hormonal treatments. This should be based on management of circulating hormone levels to allow accurate and individual dose titration together with suppression of the hormone effects, associated with the undesired gender. Treatment should be flexible and patient led as far as is consistent with clinical safety accompanied by a full explanation of the principles behind the replacement regimen and taking account of the individuals' views of their needs. Some of their effects can be reversed so that a trial of the effects of treatment may be offered, once the diagnosis is confirmed, to the trans person before more permanent decisions are made. A trial of hormone therapy does not confirm or refute a diagnosis.

27.1.4 Close liaison between the specialist clinician and General Practitioner should be maintained at all times. Physical assessment and on going haematological, endocrinological and biochemical monitoring is essential under agreed shared care protocols. Breast awareness will be required for trans women taking estrogen therapies.

- 27.1.5 All patients receiving hormonal therapies should be regularly reviewed to ensure that clinical well being is maintained.

Choice of hormone preparation, method of delivery and dosage should be in line with current understanding of minimum health risks and maximum efficacy. The hormone treatment protocols outlined below are designed to deliver optimum results, in the safest way, and should be suitable for the majority of trans service-users.

However, research in this area is limited. Therefore, since the aim is to achieve greater comfort for the trans person, clinicians should respond flexibly to the individual's response to treatment, and it may be necessary to vary products and dosages accordingly. If necessary, this may be under specialist care.

- 27.1.6 Some patients may obtain hormones from the Internet or other agencies. The clinician should discourage patients from using such sources but may offer monitoring and advice on the effects of such agents. The clinician should assist patients in obtaining hormones from properly authorised sources when clinically safe and appropriate.

- 27.1.7 When patients move between clinical services, appropriate hormonal treatment should continue to be offered providing that the patient has had this prescribed from a bona fide medical gender practitioner as stated in 20(a).

27.2 Trans women

The mainstay of therapy is estrogen therapy and suppression of androgen secretion and action. See Appendix F.

27.3 Trans men

The mainstay of therapy is androgen therapy. See appendix G.

27.4 Aftercare

Long term monitoring should be offered once the patient is stabilised at the agreed end stage of the gender transition. Endocrinological monitoring should be directly available to the client, without psychiatric or psychological involvement unless requested.

A summary of commonly used preparations is listed in Appendix H.

Recommendations – Surgical Interventions

28. Gender Reassignment Surgery (GRS)

- 28.1 This is also termed Gender Confirmation Surgery, Sex Reassignment Surgery, and Gender Realignment Surgery etc.
- 28.2 It is the surgeon's responsibility to determine that a referred patient's physical and mental wellbeing is sufficiently robust to undergo such a major irreversible procedure. The surgeon must see copies of both opinions confirming that GRS should be offered. If in doubt the surgeon should enter into additional dialogue with the referrers before undertaking any procedure.
- 28.3 The evaluation of GRS is summarised in Appendix J.

29 The Role of the Nurse in the Community

- 29.1 The role of the nurse working with patients with gender dysphoria includes pre and post operative care. Ideally contact should be made prior to surgery to establish a professional relationship between both parties. Information should be shared on aftercare.
- 29.2 Post operative care consists of wound and physical care. Support of patient, relatives, friends and carers may be offered. This may only be for a short period of time until the patient is recovered both mentally and physically and ready to resume normal life.
- 29.3 It is important that the nurse has knowledge of the needs of patients with gender dysphoria and of the surgery that is involved. It is desirable for the nurse to be able to liaise with the other disciplines.

30. Genital Surgery for trans women

- 30.1 Within the UK, feminising vaginoplasty (penectomy and bilateral orchidectomy with construction of a sensate clitoris, labia majora and vaginal formation) is in most cases performed as a single stage procedure using tissue obtained from the penis and scrotum. When there is insufficient skin available (e.g. micro-penis or more commonly, long term hormone therapy) the vagina may be constructed from bowel segments, usually the sigmoid colon. Patients who lack sufficient functional depth following an inversion penilesrotal skin vaginoplasty may be also candidates for salvage colonic vaginoplasty. (see appendix K)
- 30.2 Hair removal from the donor site may be needed in many types of GRS.

31. Genital surgery for trans men

- 31.1 Patients may request genital surgery as the final stage of reassignment. There are many options that can be tailored according to the patient's request. Patients who wish to have penetrative intercourse will need a total phalloplasty to house a penile prosthesis. Some patients do not wish to have a urethra and are content to sit to void and therefore this will reduce complications and the number of operations required.
- 31.1.1 Patients should have an in depth discussion with regards to the current techniques and should be shown photographs of typical results and if possible be able to speak to patients who have had the desired operation. Patients should have the opportunity to choose any of the clinically appropriate techniques even if this means referral to another centre. (see appendix L)

32. Breast Surgery - Trans Women

- 32.1 With estrogen treatment a degree of breast enlargement will occur in trans women, for many this is slow and disappointing. It may take at least two years for the optimum effect of estrogen on breast development after gonadectomy or pharmacological equivalent to plateau. Breast augmentation can either be timed prior to GRS or after. In many cases the latter timing is chosen by the patients. (see appendix M)

33. Breast Surgery - Trans Men

- 33.1 Once a patient has started on masculinising hormones then nearly all of the androgenous changes are irreversible. In the early months of treatment with androgens patients will be living totally in the male role and as they masculinise their breasts are totally inappropriate. Mastectomy may be undertaken early in the patient's treatment (see 24(b)). (see appendix N)

Recommendations – Follow-up and General Medical Care

34. General Medical Care

- 34.1 Trans men and women must be offered information on breast awareness and screening as advised by current national guidelines.
- 34.2 Trans women must be offered advice as appropriate in relation to prostatic disease.
- 34.3 Trans men must be offered ongoing screening for cervical disease (if relevant) as advised by current national guidelines and remain on the cervical cytology recall service.
- 34.4 The risk of developing ovarian carcinoma if the ovaries remain in site once androgen therapy commences is unknown but unlikely to be different to that of nulliparous women whose lifetime risk is slightly greater than that of women who have been pregnant in the past.
- 34.5 Access to all other medical services should be on an equitable basis with those offered to non-trans individuals in similar settings.

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Appendices

Appendix A - *Legal Rights of Transgendered People*

- A1 A Health Authority (now Primary Care Trust) is still permitted to accord any treatment 'low priority'. This must not be interpreted, however, in such a way that transsexualism, (or any condition) without being individually considered on its merits, becomes barred from treatment by a 'blanket policy'. It should be noted that the Court of Appeal in Madrid (*Katia v IMSALUD*, 2004) found that, as an intersex condition, transsexualism should be treated on an equal basis with other 'corrective' intersex surgery.
- A2 There is an obligation to treat trans people in accordance with current best practice and in the light of the most up-to-date research in the field. Failure to meet the demonstrable medical needs of trans individuals may result in legal challenges.
- A3 Principle 3 of the NHS Plan (2000) also expresses the need for non-discriminatory practices and comprehensive involvement of individuals with their own treatment plans. Implicit in this Principle, which is strongly reinforced by the Human Rights Act 1998, is the overriding need for properly informed consent of the person concerned before each stage of treatment.
- A4 "The National Health Service of the 21st Century must be responsive to the needs of different groups and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have greater say in the NHS, and the provision of services will be centred on patients' needs" (Principle 3, NHS Plan, 2000).
- A5 No individual can give or withhold consent to treatment on behalf of another person (unless mental health legislation applies). The requirement for a trans person to divorce before medical intervention may be accessed, is not regarded as acceptable practice.
- A6 Treatment waiting times should conform to NHS guidelines. Health care practitioners should be aware that unnecessary, non-clinical delay in administering hormones or moving to the surgical stage of treatment could result in legal challenges. There is little research in this area but some studies indicate that those who have undergone expedited gender confirmation surgery have improved psychosocial outcomes, compared with those who are being held on a waiting list for surgery, for two years or more (Mate-Kole et al., 1990; Lawrence, 2001; 2003). Access to treatment should not be delayed because the person concerned has only recently moved into the geographical catchment area of the service.
- A7 The European Court of Human Rights, in *Goodwin v UK* and *I v UK* (July 2000, under Articles 8 & 12) gave a strong indication to the UK government and all other agencies that they are under a positive obligation to treat trans people, in all areas of their lives, with respect and dignity, and to accord them

equal rights and status with all other citizens. Legislation now enables trans people to obtain legal recognition of their new gender status, for all purposes, after they have undergone transition which does not necessarily include genital surgery (Gender Recognition Act, 2004). It should never be regarded as an impediment to access to, and provision for, treatment services, that an individual, for whatever reason, chooses not to seek a Gender Recognition Certificate.

- A8 It should be borne in mind that, even after medical treatments to effect harmonisation of physical sex characteristics with the gender identity, trans individuals may have mixed biological characteristics. This factor should determine the actual treatment services made available to them. For example, a trans woman should not be denied screening for prostate cancer or access to appropriate fertility services, upon confirming her legal status as female through the acquisition of a Gender Recognition Certificate.
- A9 The Civil Partnership Act (2004) imposes specific legislation (section 3, schedule 3) on people acquiring a Gender Recognition Certificate which will need to be fulfilled.

Appendix B - The needs of people with Learning Disabilities who have Gender Dysphoria

Author – Daniel Wilson

Within this section, the needs of people with an additional diagnosis of learning disability will be identified. For clarification, a learning disability will be defined as an individual with an I.Q. of 70 or below, as outlined by the World Health Organisation (1994) ICD-10 publication. Alternatively, where a health or social care learning disability service has recognised the need for involvement.

This document has clearly outlined the process required for assessment and access to treatment for individuals requiring gender reassignment treatment. However, the needs of people with learning disabilities are often greater, not only in accessing services but understanding the condition, treatment and consequences can be difficult, as outlined by DOH (2001) and often require additional support to access treatment by learning disability services.

Individuals referred should have the opportunity of the following:

- A person centred plan implemented by the learning disability service which would outline their holistic needs including the gender need.
- Access to counselling prior to referral to a gender clinic. With further counselling provided if not accepted for treatment
- Access to counselling will be required if accepted for treatment. This may not need to be a constant service. However, it would be needed prior and during the real life experience, prior and at the start of hormone treatment and pre and post any surgical treatment.
- Counselling should be provided, where possible, by a professional who has experience of both learning disability and gender identity issues. Where this is not possible, supervision should be sought from a suitable source where the experience is available.
- A support network will be required for the individual which might be identified from the person centred planning group to support the individual throughout the gender treatment process. This support network should include community learning disability nurse and/or social worker and an advocate support worker. This support will be around the whole gender reassignment process.
- Where learning disability services are involved the individual's capacity to consent to treatment should be considered and assessed by the multidisciplinary team. Lack of capacity to consent is not a reason to stop the referral process. However, a decision to act in the individual's best interest should be considered.
- Gender clinics that have concerns about an individual having a learning disability, and their ability to understand and consent, should refer the individual to their local learning disability service for assessment of learning disability. If diagnosed with a learning disability the above requirements should be implemented.

Appendix C - Family Support

Author - Terry Reed

- C.1. Transsexualism within a family inevitably puts huge strains on relationships, creating a high risk of rejection of the trans person, just when support is most needed. Poor support from the family is a recognised prognostic factor for a trans person's experience of regret, following gender confirmation surgery.
- C.2. Family members themselves experience complex emotions of shock, grief, anger, bewilderment, fear, guilt, denial and embarrassment. Partners and spouses, in addition, have to face the disruption to their sexual relationships. There may be mutual accusations of selfishness as the trans individual, sometimes after years of delay, focuses on achieving all transitional goals as quickly as possible, whilst the family grapples with an entirely unanticipated situation, and may seek to delay, or even prevent, transition. The denial of contact between trans people and their children causes great suffering, but it is not unusual, despite the research indicating that such contact is not harmful to a child, whereas loss of a parent is.
- C.3. Support and education for families, in the early stages of transition, can often prevent deterioration of, or lead to significant improvements in, relationships by mitigating the experience of pain and loss. Family acceptance is an important, sometimes vital, ingredient in the successful rehabilitation of the individual in the new gender role. Engagement with the family should, therefore, form a part of the care package offered to trans individuals. However, this should only be implemented if and when the trans person is entirely comfortable with family involvement, and should not be a precondition to treatment.
- C.4. Family support may best be provided by someone other than the clinician who has the 'gatekeeper' role. A formula may be based on the workshops run by GIRES¹, assisted by DEPEND² and MERMAIDS³. The team leading the workshop should include parents, partners, a trans man and a trans woman. Families need an informal, caring and absolutely confidential setting in which to explore and share their emotions and fears with others in the same situation. The aims of the workshops are to encourage optimism about the future, to promote open discussion of the many difficulties faced by trans people, to lessen the tension between them and their families and to enable families to support the trans person.

¹ Gender Identity Research and Education Society (GIRES): Tel: 01372 801554; e-mail: bernardgi@aol.com;
website: www.gires.org.uk

² DEPEND: e-mail: info@depend.org.uk; website: www.depend.org.uk

³ MERMAIDS: e-mail: mermaids@freeuk.com; website: www.mermaids.freeuk.com; Tel: 070209 35066 (12 - 9pm)

Appendix D - Hair Treatment

Author - Andrew Messenger

- D1 Androgens stimulate the conversion of fine vellus hair into large terminal hair in many regions of the skin following puberty. The growth of pubic and axillary hair is stimulated by low levels of androgens, probably of adrenal origin. Higher levels of gonadal androgens are needed to stimulate hair growth on the beard area, trunk and limbs and, in these sites, terminal hair growth is dependent on the potent androgen dihydrotestosterone, which is derived from circulating androgens (principally testosterone) by the action of the enzyme Type II 5 alpha reductase. These changes are most pronounced in men but they also occur in some women, particularly those with hyperandrogenism. Paradoxically, androgens are also responsible for the progressive miniaturisation of hair follicles on the scalp to cause balding.
- D2 Men castrated before puberty do not show these androgen-dependent changes in hair growth. In men castrated post-puberty some reversal may be seen. The degree of reversal appears to depend on the age at androgen ablation – in young men terminal hair growth may be fully reversed by gonadectomy but with increasing age the degree of reversal becomes progressively less (1). Limited studies in male castrates suggest that androgen ablation in men aged over 30 reduces terminal hair growth by less than 50%. The same considerations apply to male balding. These observations indicate that androgens alter gene expression in androgen dependent hair follicles, which is not fully reversible in the absence of androgens. This view is supported by numerous studies on the treatment of female hirsutism with anti-androgens.
- D3 We may expect, therefore, that androgen ablation, either chemical or surgical, will produce a substantial degree of reversal of androgen-dependent hair growth in young men, although there is likely to be inter-individual variation in the response. Trans women may also be taking estrogens. In other species estrogens inhibit hair growth but very little is known about the effect of estrogens on human hair growth and we cannot assume that estrogen therapy influences terminal hair growth. Where terminal hair growth is well established androgen ablation will, at best, result in only partial reversal and other methods of hair removal may be needed. Methods such as shaving and waxing are widely used but their effect is, of course, temporary. To date there are only two methods of hair removal which have the potential to be permanent – electro-epilation (electrolysis) and laser hair removal, neither of which is readily available on the NHS.
- D4 Electro-epilation
- This is practised mainly by beauty therapists. It involves the insertion of a fine needle into each hair follicle individually; the follicle is then destroyed by thermal and/or electrolytic forces by the passage of an electric current through the needle. Electro-epilation is slow and tedious, typically requiring repeated treatments over many months or years, but good results can be obtained if done by an expert. It is most suitable for treating small areas of

unwanted hair growth, such as the chin or moustache area. It is not appropriate for treating hair growth over extensive regions of the skin, such as the chest or limbs.

D5 Laser Hair Removal

Light energy from the laser source is absorbed by melanin in the hair roots and converted to heat, which then destroys the hair follicle. The laser source is applied to the skin surface and several follicles can be treated simultaneously, meaning it is a much more rapid treatment than electroepilation. Laser hair removal is most effective in those with dark hairs and fair skin, but modern lasers are also able to treat those with racially pigmented skin. It is not suitable for treating non-pigmented hairs. Laser hair removal is expensive and treating large areas of skin is still a major undertaking. Permanency is not guaranteed and, like electro-epilation, repeated treatments may be needed. Side effects include scarring, pigment changes in the skin and, rarely, increased hair growth. Effective treatment may require access to more than one type of laser.

D6 Topical agent

A topical agent containing the ornithine decarboxylase inhibitor called eflornithine is available. It has recently been licensed in the UK for treating facial hirsutism in women. There are no published peer-reviewed studies but data presented at academic meetings suggest that it reduces hair growth by about 20%. There is no information on its use in men. Continued treatment is needed to maintain the response.

Appendix E - Speech and Language Therapy

Author - Jane Thornton

- E1 Therapeutic intervention will be mindful of the physical limitations of the client's vocal anatomy enabling change without causing vocal abuse/damage (Andrews, Dacakis, 2002). Intervention will be timely and mindful of their ability to participate in therapy (Söderpalm, 2004). It will be consistent with current research/ agreed expert opinion. Any pre-existing voice difficulty will be treated first (RCSLT, 2004). Regular therapy will commence when the client is 'living in role' or transition is imminent.
- E2 S<s should ideally work as part of a MDT and see only clients with a confirmed diagnosis of gender dysphoria. Gender dysphoria will necessarily form a small part of any S< caseload therefore access to specialist colleagues, and national support networks is vital.
- E3 Case history will include a detailed voice assessment to gain values of both perceptual and objective measures where facilities are available (Gunzburger). The amount of therapy required will be variable and take into account the client's own expectations. Therapy contracts between therapist and client are commonplace and can be re-negotiated at any point (Snap.). Therapy may be offered on an individual basis or in groups (Challoner and Povey) with use of biofeedback to support therapy. Therapists will regularly evaluate progress in line with clinical practise guidelines. It is recognised that in some locations it may be the S< who offers advice on style/ appearance and counselling however, where possible, this should be provided by appropriately trained team members.
- E4 Therapy with trans women
- E5 The introduction of female hormones will have no effect on the male voice. Therefore other factors known to mark the difference between male and female voices have to be enhanced to give the individual a more 'feminine' voice. Research has highlighted (Oates, Tanner, Glass) key communication areas where males and females differ e.g. voice quality, pitch, intonation, prosody, rate, articulation, resonance, language and non-verbal communication.
- E6 Pitch changing surgery may be offered but this should only occur after S< intervention and should be decided jointly by the consultant ENT surgeon, S< and client (Matai et al, 2003; Dacakis et al, 2003). There are various procedures of which the most preferred is cricothyroid approximation (CTA). This surgery should follow, rather than precede, other surgical procedures which involve intubation, as this could damage the laryngeal surgery. Results are variable at present (Brown, Wagner and Dacakis) and voice therapy should be offered post surgery to optimise surgical results. Thyroid chondroplasty may also be offered to reduce the prominence of the thyroid cartilage for cosmetic appearance (Conrad).
- E7 Therapy with trans men

- E8 The introduction of male hormones in trans men will lower the pitch of the voice although the degree and rate of change is variable (Van Borsel et al). Therapy should be offered at this time to help stabilise the voice and laryngeal support musculature that will have been physically altered by the male hormones. However, it is not simply lowering the pitch that will make the voice appear more masculine (see above). Other aspects of the voice/communication will determine 'maleness' to the listener and these should be addressed during therapy.

DRAFT

Appendix F - Guidelines for hormone therapy for Gender Dysphoria in Trans Women

Author - Mike Besser

- F1 Estradiol therapy. This should normally be used in association with suppression of androgen secretion.
- F1.1 Oral doses of oestradiol 1 - 4mg/day are commonly required. There should be monitoring of circulating oestradiol levels to make sure that appropriate levels are achieved and that the dose given is not excessive – levels at 24 hours after a dose of oestradiol should be in the upper part of the normal follicular phase serum oestradiol levels.
- F1.2 It is wise to check circulating lipid levels and liver function tests since occasional patients have obstructive hepatotoxic effects of oestradiol. The blood pressure should be monitored. If surgery is to be undertaken it is usual to stop estrogen replacement therapy for 4 weeks prior to surgery.
- F1.3 Estrogen replacement therapy has traditionally been given using oral equine estrogen mixtures or ethinyloestradiol. Neither of these is physiological for the human and there is a major problem in that they cannot be measured effectively in relation to physiological human circulating levels of estrogen. These adverse features are avoided if oral oestradiol is used. Oestradiol is a physiological hormone in women and the physiological levels in the circulation are well established. Different patients require different doses to achieve the female physiological level of circulating oestradiol in the upper part of the normal follicular phase of the normal menstrual cycle (for example anything from doses of 1mg to 4mg per day by mouth). Different laboratories report different normal ranges for hormonal assays depending on the methods used. Clinicians should use their local laboratory normal range for follicular phase serum oestradiol levels – a representative range for the upper half of the follicular range is 300-400 pmol/l, 80-140 pg/ml. Levels higher than this are likely to be associated with the established side effects of excessive estrogen particularly thrombo-embolism, hypertension and myocardial infarction. Physiological levels should be able to produce the desired phenotypic changes particularly if the circulating androgen levels and their effects are suppressed. Transcutaneous estrogen (50-150 mcg patches two or three times per week) can be used when monitoring of serum levels at 48 hours after patch application should be in the upper half of the normal follicular range.
- F2 Suppression of androgen secretion and action
- F2.1 It has been traditional to use the androgen receptor blocking drug cyproterone acetate to suppress the effects of circulating androgens such as testosterone, di-hydrotestosterone, androstenedione, and DHEAS. There may be problems, however, with the use of cyproterone acetate which are, at least in part, dose dependent. High doses are associated with glucocorticoid effects although this is more apparent in younger patients than adults. Hepatotoxicity is well recognised in animal models on long term therapy and indeed hepatic

tumours occur in rats. Although this has not clearly been seen in the human, hepatic dysfunction occurs rarely. Cyproterone acetate can also cause depression. There are alternative and preferable ways of suppressing secretion of endogenous androgens and their effects.

F2.2 Instead of using cyproterone acetate which has been traditionally used in doses of 50mg-100mg per day or more, a more effective alternative is to use depot injections of analogues of the gonadotrophin releasing hormone. Examples of this would be the use of goserelin or leuprorelin. A usual dose of goserelin would be the use of a subcutaneous implant of 3mg once every four weeks or of a larger dose using the three monthly preparation. This produces reversible 'chemical gonadectomy'. By super-stimulation of the pituitary, the gonadotrophin releasing hormone receptors on the pituitary are downregulated and the pituitary rapidly becomes unresponsive, leading to cessation of secretion of the gonadotrophins. LH and FSH levels fall to hypopituitary levels and testosterone and di-hydrotestosterone levels decline to very low levels equivalent to a post-gonadectomy state. If the treatment is stopped, the receptors regenerate rapidly and gonadotrophin secretion resumes. There is therefore a state of reversible hypogonadism. Gonadotrophin releasing hormone therapy may be continued until gonadectomy. Secretion of the circulating adrenal androgens, androstenedione and DHEAS are not suppressed but they have low androgen potency but may be converted to testosterone and di-hydrotestosterone. If necessary the effects may be mitigated by the use of finasteride, a drug which inhibits the conversion of testosterone to the much more active di-hydrotestosterone. In the rare event of persisting effects of androgenisation then low dose of cyproterone or spironolactone could be introduced additionally since these compounds block the androgen receptor. Suppression of the levels of androgens and their effects given this way allows the full effect of administered oestradiol to become apparent without the use of excessive dose. Circulating levels of testosterone and ideally di-hydrotestosterone levels should be monitored to ensure they are suppressed to well below the normal male range.

F3 Biochemical and Haematological Markers

See appendix H

F4 Physical Assessments

F4.1 Before commencing hormones, a full physical examination should be offered by the GP or hormone prescribing clinic. The prescribing physician should satisfy themselves that a recent clinical examination has been recorded in the medical notes.

F4.2 Genital examination may cause individual distress and may be declined by the patient: such refusals should be respected in all cases.

F4.3 Routine screening for prostate malignancy should be offered in accordance with current good practice guidelines and specifically where persistent urinary symptoms are reported.

- F4.4 Five year monitoring for breast cancer should be undertaken. Breast awareness information should be offered by the prescribing unit.
- F4.5 If gonadectomy is carried out then the use of a gonadotrophin releasing analogue must cease.

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Appendix G - Guidelines for hormone therapy for Gender Dysphoria in Trans Men

Author - Mike Besser

- G1 The use of a long acting analogue of a gonadotrophin-releasing hormone such as goserelin as detailed in appendix F will rapidly but reversibly suppress LH, FSH and ovarian function. Testosterone replacement therapy can be started at the same time. It has been usual to use depot testosterone injections such as testosterone enanthate 250mg intramuscularly each 2-3 weeks. This dose may need to be increased and most patients are maintained well on 500mg each 3-6 weeks. The basis of the dosage regimen should rely on measurement of circulating testosterone levels just before an injection is given. The ideal is to achieve a circulating testosterone level just prior to an injection at or below the lower end of the normal adult male range so that accumulation does not occur.
- G2 An alternative medication involves the transdermal gel, Testogel, which applied daily in a dose of 5g rubbed usually on to the shoulders or loins after a morning shower or bath. Transdermal patches of testosterone can be used but are frequently poorly tolerated and may induce a reaction to the medication in the patch. Another alternative is oral testosterone undecanoate in which case the dosage cannot be monitored effectively by using serum testosterone. This is because this preparation is absorbed across the gut into the lymphatic system and does not undergo 'a first pass' effect in the liver. Since the gut wall contains high levels of the enzyme 5-alpha-reductase testosterone is converted to the much more biologically active dihydrotestosterone in the gut. Circulating testosterone levels are often at or below the normal male range while di-hydrotestosterone levels are supraphysiological for men on this preparation. Sometimes the oral preparation is preferred to transdermal or intramuscular administration and if this is the case monitoring of the dosage should be based on circulating dihydrotestosterone levels in blood obtained 3-4 hours after a dose. The doses of testosterone undecanoate vary from 40mg three times a day to 80mg twice daily.
- G3 Trans men treated with androgens should have monitoring of haemoglobin and haematocrit since high haemoglobin levels may be induced with high doses. It is unusual to get liver dysfunction on these preparations.
- G4 If gonadectomy is carried out then the use of a gonadotrophin releasing analogue must cease.
- G5 Biochemical and Haematological Markers
See appendix H
- G6 Physical assessments

- G6.1 Before commencing hormones, a full examination should be undertaken. The prescribing physician should satisfy themselves that a recent clinical examination has been recorded in the medical notes.
- G6.2 Genital examination is not necessary if a pelvic ultrasound is undertaken. This should ideally be transvaginally but may be transabdominal if the patient objects to the former.
- G6.3 Breast monitoring should continue in accordance with current good practice guidelines.

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Appendix H - HORMONAL TREATMENT: GENDER DYSPHORIA: A suggested shared care protocol

[Subject to revision before final publication]

*Suggested guide to treatment (provided there are no medical contraindications or side effects)
[From: BNF (2005), Gires (2004), G.M. Besser (2004), Wylie et al (2006 National SOC)].
Contact your local endocrinologist or gender clinic for more information*

Note: Endocrine normal ranges differ between different laboratories as methods of assay are not always the same. Clinicians should use their local laboratory ranges when interpreting results as reported. Levels quoted here are indicative only. Monitoring should normally take place in a primary care setting.

Trans 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 T4, TSH, testosterone, estradiol (less than 100pmol/l), prolactin (50 – 400mU/L)

- Monitoring:

On a six monthly basis for three years and then yearly depending on clinical assessment and results. Provision of prescription is contingent on satisfactory tests, namely;

Blood pressure, full blood count, urea and electrolytes, liver function test, fasting glucose, lipid profile, testosterone, serum estradiol 24 hours after a tablet or 48 hours after application of a patch (levels should be in the upper half of the normal follicular range, 300-400 pmol/L), prolactin (less than 400mU/L).

Medication

- The specialist clinician will provide the prescription or if the GP is in agreement with shared care prescribing, this will be supervised by the gender specialist who has obtained valid consent. Typical prescriptions would be for:

- Estradiol (1mg – 4mg orally daily)

or

Estradiol patches (50mcg – 150mcg, 2-3 times per week) particularly for patients over 40 years (lower risk of thrombosis). Dosage of estrogen depends on results of circulating oestradiol levels – see above.

- Goserelin 3.6mg implant subcutaneously four weekly or 10.8mg implant twelve weekly or an alternative GnRH agonist – inhibits secretion of pituitary gonadotrophin and testosterone secretion

Additional therapies, which may be helpful, include...

- Cyproterone Acetate - (50mg – 100mg orally daily) is much less satisfactory than Goserelin
- Dianette (1 tablet daily for 21 days. Repeat after 7 gap days)
- Sprironolactone (100mg – 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 b.d.), or dydrogesterone (10mg orally b.d.) has been used.
- Finasteride (5mg orally daily) – blocks conversion of testosterone (which may derive from adrenal androgens in the absence of secreting testes) to the more active dihydrotestosterone (DHT) – can discourage male pattern hair loss and testosterone dependent body hair growth.

Surgery

- Stop hormones 4 weeks before surgery and cover with a single dose of goserelin 3.6mg stat dose. Hair regrowth can occur when the effects of goserelin wear off after four weeks.
- Hormones should be resumed four weeks post op if there are no complications namely estradiol tablets or patches for over 40 year olds (as above).
- Anti-androgen usually not required but androgens may still be significantly derived from adrenals – finasteride as above can be prescribed if androgen effects are still evident.
- Monitoring for osteoporosis, breast and prostate carcinoma required.
- Medication and tests needed for life as described above on 6 monthly basis for 3 years, then yearly if well.

Trans 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 T4, TSH, prolactin (less than 400mU/l), serum oestradiol and testosterone.

- **Monitoring:**

On a six monthly basis for three years and then yearly if well depending on clinical assessment and results. Provision of prescription is contingent on satisfactory tests, namely:

Blood pressure, full blood count (Hb & Hct), urea and electrolytes, liver function tests, fasting glucose, lipid profile, serum oestradiol (for adequacy of suppression less than 70pmol/l), 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 DHT levels 3-4 hours after a dose.

Medication

- Testosterone enanthate 250mg-500mg intramuscularly 2-6 weekly depending on serum testosterone levels (see above)

Or

Testogel (50mg/5gm gel once daily – occasionally two doses are required) rubbed onto skin of shoulders or loins after shower or bath

Or

Testosterone undecanoate 120-160 mg/day

- Goserelin 3.6mg implant subcutaneously 4 weekly or 10.8mg pellet subcutaneously twelve weekly.

Surgery

- Hormones should be stopped four weeks preoperatively.
- Androgen (testosterone) to be resumed four weeks post op and continued for life if there are no contraindications.
- Monitoring for osteoporosis and breast carcinoma required.
- Medication and tests needed for life as described above on 6 monthly basis for 3 years, then yearly if well.

Appendix I – Storage of Gametes

Author - Mark Hamilton

I1 If a trans person seeks advice on storage of gametes then he/she should be put in touch with a fertility centre offering licensed treatment. A list of centres in the UK can be found at the web site of the Human Fertilisation and Embryology Authority (HFEA) www.hfea.gov.uk.

I2 Gametes can only be stored if the provider has given appropriate informed consent. The implications of the storage of sperm or eggs will require careful counselling. The provider will have to undergo testing for blood borne viruses including HIV, Hepatitis B & C. A support infrastructure, including hepatology services, should be available to deal with screening positive individuals.

I3 The normal maximum storage period of gametes is 10 years. However in the case of the trans person who is under 45 years of age this can be extended until he/she is 55 years of age. Centres will normally contact all individuals with gametes in storage on an annual basis to ensure that continued storage is desired. It is the responsibility of the gamete provider to ensure that the clinic is aware of his/her contact details for this purpose. The clinic may be required to destroy stored samples if the provider fails to keep in touch with the clinic.

I4 Gametes can be stored only after appropriate consent has been given. The centre offering storage will be required to register with the HFEA the fact that sperm or eggs from the named provider have been stored in accordance with statutory guidance. Gametes can be stored for use in the treatment of a named individual, in the treatment of others (sperm/egg donation) or for research. If the specimen is to be used for treatment subsequently, then further counselling and consent issues will have to be addressed before treatment can take place, including reference to the welfare of any child that might result from treatment.

I5 Hormonal therapy has the potential to disturb the endocrine control of gametogenesis. It is advisable for individuals who wish to store gametes to stop therapy before provision of sperm specimens or undergoing treatment to procure eggs.

I6 Storage of sperm

Providers of sperm will be expected to provide 5-10 ejaculated semen samples over a period of several weeks. If sperm quality is satisfactory this will allow the samples to be split and stored in separate straws or vials, allowing for 10-15 cycles of opportunity for conception through artificial insemination in the future. If sperm quality is poor then discussion may be required around the use of assisted reproduction procedures such as in-vitro fertilisation in the future. Should the individual be unable to ejaculate, the clinic may be able to offer alternative methods of obtaining sperm through surgical sperm retrieval or electro-ejaculation.

17 Storage of eggs

Egg quality, unlike sperm quality, is greatly influenced by the age of the female. Female fertility in the late 30's and beyond tails off dramatically and even IVF techniques are associated with poor success rates. In younger individuals the use of ART techniques can be considered. Providers of eggs would be required to undergo a cycle of controlled ovarian stimulation leading to egg recovery in order to obtain a reasonable number of eggs for storage. The process of stimulation can take as long as 5 weeks to complete and involves injections of gonadotrophins to stimulate the ovary to generate multiple follicular development. Under ultrasound guidance and with sedation vaginal oocyte retrieval can be performed. On average between 8-12 eggs can be obtained in this way. Egg storage as technique is not as reliable as sperm storage and pregnancy rates through the transfer of embryos derived from cryopreserved eggs are very low (<5% per cycle). If the egg provider has a male partner consideration can be given to fertilising the eggs with his sperm. The generation of embryos in this way would offer the possibility of transfer of the embryos in to a surrogate host. Embryo cryostorage is more reliable than egg storage and pregnancy rates of up to 20% per embryo transfer cycle can be anticipated with frozen embryos. Consent of the sperm provider for storage or use of embryos derived from his sperm is obligatory. Surrogacy raises further complex ethical questions, which require the input and expertise of trained counsellors in the field.

18 Storage of ovarian tissue

Freezing of ovarian tissue is experimental at present and it is unlikely that this will be available as a clinical service in the near future.

19 Changing or withdrawing consent

Any consent relating to the use and storage of gametes or embryos can be changed or withdrawn at any time by the person who gave the original consent as long as the gametes or embryos concerned have not already been used in treatment or research. The right to change or withdraw consent is an important part of effective consent in ensuring that clinics adhere to the wishes of the provider. Any consent for storage that is given to a clinic should include a statement of what should happen to the gametes or embryos in the event that an individual becomes mentally incapacitated or dies.

Appendix J - Recent report concerning gender reassignment treatment and pathways of care

Author: Dr Paul Sutcliffe

The Evidence-based Commissioning Collaboration (EBCC) works on behalf of four commissioning consortia (The North East Yorkshire & North Lincolnshire Primary Care Organisation, The North Derbyshire, South Yorkshire & Bassetlaw Commissioning Consortium, The Trent Commissioning Consortium and The West Yorkshire Primary Care Organisation) which, on behalf of PCTs in their areas, are working with the School of Health and Related Research at The University of Sheffield. The objective of the Collaboration is to share research knowledge about the effectiveness and cost-effectiveness of service interventions to inform the commissioning process. Gender reassignment surgery (GRS) was requested as a topic to be studied. The study aimed to identify the number of patients currently receiving treatment for gender identity dysphoria/gender reassignment within the EBCC region and to assess the evidence associated with key points on the treatment pathways.

Pathway of care and patient numbers:

Treatment pathways were identified for the four consortia and a consolidated pathway constructed that allowed patient numbers to be set against different stages. Four hundred and forty patients were identified across four commissioning consortia (151 NORCOM, 118 TrentCOM, 82 WYPCO, 36 NEYNL and the remainder unidentified). One hundred and seventy four patients across NORCOM, WYPCO and NEYNL are currently on the waiting list for referral. In the TrentCOM consortium the Stonebridge Centre guarantees an appointment within a set period. One hundred and sixty nine patients were identified as receiving Male-to-Female (MTF) treatment (40 NORCOM, 91 TrentCOM, 30 WYPCO, 8 NEYNL). Forty-four patients were identified as receiving Female-to-Male (FTM) treatment (7 NORCOM, 27 TrentCOM, 8 WYPCO, 2 NEYNL). Information is not available on the position of the remaining patients 227 patients identified within the region.

Literature searches of evidence around key decision points:

Ten systematic literature searches were undertaken around five key questions identified by commissioners for both trans men and trans women. These were concerned with: 1) referral/assessment/diagnosis; 2) real life experience/endocrine therapy; 3) sex reassignment surgery; 4) post surgery/reconstructive surgery; 5) other non-specific terms associated with the topic. Searches were made in five electronic databases: SSCI, Cochrane Library, Embase, Medline and Psycinfo.

a) Reviews concerning GRS:

A comprehensive summary of six earlier reviews was provided which together encapsulate over 150 individual studies. All reviews commented on the poor quality of the research evidence available; no randomised controlled trials were available. Only one controlled study was identified by Mate-Cole, Freschi and Robin (1990) which compared 20 patients having immediate surgery with 20 patients awaiting surgery for penectomy, orchidectomy and the construction of a neo-vagina. The

remaining studies reflect lower grades of evidence and had further problems in their design such as selected patient groups, retrospective analysis and losses to follow-up. Conclusions from the reviews are understandably tentative, but highlight the improvements in patients across most studies, although 10-15% of transsexual people who undergo GRS have poor outcomes.

b) Effectiveness of individual procedures for trans women:

Reviews of the following surgical procedures for trans women were undertaken: clitoroplasty; labiaplasty; orchidectomy; penectomy and vaginoplasty. There was a clear lack of randomised controlled evidence or studies which included a control group comparison. There was no evidence found concerning the effectiveness of labiaplasty and only one study concerning penectomy or orchidectomy procedures. A large amount of evidence is available reporting vaginoplasty and clitoroplasty procedures. Some complications have been reported. All the studies report, to various degrees, satisfactory outcomes in terms of being able to have penetrative sexual intercourse and achieving sexual fulfilment.

c) Effectiveness of individual procedures for trans men:

Reviews of the following surgical procedures for trans men were undertaken: hysterectomy; mastectomy; metatoidoplasty; phalloplasty; salpingo-oophorectomy; scrotoplasty / placement of testicular prostheses; urethroplasty and vaginectomy. The majority of studies report good satisfactory outcomes with few complications for each of the individual procedures. Many of the outcomes for these procedures relate to the ability to perform penetrative sexual intercourse and to be able to achieve orgasm. Another key factor requested by many patients is the ability to void whilst standing. Some of the procedures are frequently completed along with other procedures, making it difficult to assess the effectiveness of each procedure alone. Furthermore, the assessment of effectiveness is also confounded by the lack of controlled evidence, unclear outcome measures and a reliance on case studies.

There is a need for standardised measures to assess the outcome of surgery and other forms of psychological intervention. The use of QOL measures has received limited research especially in samples before and after GRS. Rakic et al. (1996) investigated several aspects of QOL after GRS in 32 transsexuals (22 MTF, 10 FTM). Four aspects of QOL were examined: sexual activity; attitude towards the patients' own body; relationships with other people; and occupational functioning. For the majority of transsexuals, QOL were improved after surgery in terms of these aspects. All patients (100%) were satisfied with their GRS. However, only 20 patients (62%) were satisfied with how their bodies looked.

In conclusion the EBCC report extended the findings from previous reviews by providing a summary of the evidence available for each of the "core" procedures for trans women and trans men. In the majority of studies a large number of transsexual people experience a successful outcome in terms of subjective well-being, cosmesis and sexual function. Like the conclusions made in previous reviews the magnitude of benefit and harm cannot be reliably estimated accurately using the current available evidence.

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Appendix K - Genital Surgery for trans women

Author - Tim Terry

- K1 Regarding evidence that evaluates the long term risks and benefits of feminising genitoplasty for trans women, The Centre for Reviews and Dissemination, University of York, as part of the Health Technology Assessment data base, produced two documents (DARE Abstract 989743 and HTA Record 989122) reviewing the work produced by Best and Stein published under the title 'Surgical Gender Reassignment for Male to Female Transsexual People' - The Wessex Institute for Health, Research and Development 1998. These articles consider relevant literature published after 1980 and identifies one prospective controlled study comprising 40 participants and 11 non-controlled studies comprising 519 participants. All patients were over the age of 18 years. The length of follow up ranged from 0.4 years – 3.8 years in one study, to a mean of 8.2 years in another study. In the single included controlled study, controls were those on the waiting list for feminising vaginoplasty. In the case series, most data were collected retrospectively and were limited by losses to follow up and lack of validated outcome measures. In the single controlled study, after 2 years the operated group had non-validated benefits in a number of psychological, social and sexual outcome domains compared with the non-operative group. Adverse effects were not reported in this study.
- K2 Positive outcomes in the non controlled studies were reported in areas of cosmetic appearance, sexual functioning, self esteem, body image, socioeconomic adjustment, family life, relationships, psychological status and satisfaction. However, these 'benefits' were not validated. Significant risks of surgery include deep venous thrombosis, pulmonary embolism, which may be fatal (less than 1%), rectal injury (less than 1%), haemorrhage, wound infection, skin flap necrosis, urethral problems which include meatal stenosis, spraying and/or upward direction of urinary stream, prominent erectile tissue at the meatus. Vaginal stenosis/shortening, hairball formation and prolapse may occur. Request for reversal should be significantly less than 1%.
- K3 Current retrospective short and intermediate term follow up studies suggest about 80% of patients undergoing feminising vaginoplasty are pleased with the function and cosmetic outcome of their operation. The remainder are pleased that they underwent surgery but report that their pre-operative expectations have not been met with post-operative reality. The majority of these patients may benefit from secondary surgery. It is clear therefore that the vast majority of patients, at least in the short and intermediate term, derive important benefits from feminising vaginoplasty at a low risk of serious complications. (Lawrence 2003. Krege et al 2001.). Other researchers have reported excellent outcomes from feminising vaginoplasty when stringent selection criteria are used and a good surgical result obtained. (Green 1990. Eldh 1997.). However, the long term surgical, psychological, social and sexual benefits/hazards remain unquantified. As such, it is important to undertake high quality, multicentre, prospective long-term studies to determine the risks/benefits of feminising vaginoplasty. Such studies should

be restricted to specialist centres with a proven track record in gender reassignment surgery and have standardised protocols for patient selection.

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Appendix L - Genital Surgery for trans men

Author - David Ralph

The current options available in the UK are:

L1 Metatoidoplasty

This involves releasing the clitoris and bringing the urethra to its tip, thus forming a micropenis. The scrotum is fashioned and testicular prostheses inserted at a second stage. Patients will be able to stand to void but only 50% will be able to use a male urinal as the micro phallus is too small. Otherwise it is a simple one or two stage operation but penetration for sex is usually not possible due to phallus size.

L2 Total phalloplasty

a/ Pubic phalloplasty

A good size phallus is fashioned from lower abdominal wall skin that has had laser hair removal prior to the initial operation. Otherwise patients can use depilatory creams or shave the phallus. The urethra is formed from labial hairless skin in 2 stages but often the opening is 1 – 2 inches from the tip of the phallus. All scars are low down on the abdomen and under the pants line.

b/ Forearm flap phalloplasty

The phallus is fashioned from the skin of the forearm with a urethra incorporated within. The vessels and nerves of the forearm skin are divided and joined to vessels and nerves in the genital area. The phallus is sensate, is cosmetically realistic, and the patient can void from the tip of the phallus. The main disadvantage is the unsightly resulting scar on the arm that has been skin grafted. Once the total phalloplasty has been completed and urethral continuity established, patients are then offered testicular and penile prostheses and the formation of a glans. Often hysterectomy and oophorectomy can be performed at the same time as one of the stages, either by open or laparoscopic techniques.

L3 Patients must be warned that all of the surgeries involve multiple stages and complications may occur. Consent forms and information sheets, explaining all expected outcomes, including potential complications and risks, must be provided several weeks in advance of surgery.

Appendix M - Breast Surgery – trans women

Author - Dai Davies

- M1 Surgery is usually undertaken as a day case, under general anaesthetic. The incision is either placed submammary or in the axilla and a saline or silicone gel prosthesis is inserted into a submuscular pocket. Implants are designed for a female chest and therefore tend to be rather narrow for the broad male chest. Also males tend to have their nipples rather lateral in position compared with a female.
- M2 The principle complication is encapsulation or hardening around the prosthesis which occurs in 1 in 10 cases.

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Appendix N - Breast Surgery – trans men

Author - Dai Davies

- N1 In small breasted patients who have good, thick skin on their breasts, mastectomy can be achieved through a periareolar incision. Using this procedure it is difficult to achieve the correct amount of reduction. In some an overreduction is achieved which in most cases cannot be corrected as a secondary procedure.
- N2 For most patients however, a more extensive reduction is required, removing the breast as an ellipse and trying to place the scar in the submammary groove, the nipple is repositioned as a free graft. Whilst this gives a more obvious scar it is an easier and more predictable operation to undertake and the patients, on the whole, are happier with this approach.
- N3 The operations are usually done with a one night stay, as there is a slight risk of haematoma, and then managed on an outpatient basis after that. Follow-up usually continues to six months when a decision may be made as to whether any small adjustments are required. These are usually done under local anaesthetic. If a patient requires phalloplasty then there is an argument for undertaking mastectomy at the time of the phalloplasty as the spare skin can be used to resurface the forearm when a radial forearm free flap is undertaken.

Appendix O – Current UK Resources

During the consultation period the college will invite all interested parties to include contact details within this section. This will be subject to final review by the core committee following the consultation period.

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Table 1 Committee membership

Chairman:

Dr Kevan Wylie	Consultant Psychiatrist Consultant in Sexual Medicine & Consultant Andrologist	Chairman – designated by Executive & Finance Committee	Royal College of Psychiatrists
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Representatives

Name and Address	Designation	Section	Representing
Dr J Barrett	Consultant Psychiatrist	Representative	Charing Cross Hospital
Professor Mike Besser	Consultant Endocrinologist	Representative	Royal College of Physicians
Michelle Bridgman	Service User	Representative	Gender Trust
Dr Susan Carr	Consultant in Family Planning	Representative	Faculty of Family Planning and Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists
Angela Clayton	Service User	Representative	Independent Service User
Mr Dai Davies	Consultant Plastic Surgeon	Representative	Royal College of Surgeons
Tracy Dean	Vice President	Representative	Press for Change
Dr Brian Ferguson	Consultant Psychiatrist	Faculty of General and Community Psychiatry	Royal College of Psychiatrists
Prof Richard Green	Consultant Psychiatrist	Representative	Royal College of Psychiatrists
Dr M P R Hamilton	Consultant Gynaecologist	Representative	Royal College of Obstetricians and Gynaecologists

Professor Melissa Hines	Chartered Psychologist	Representative	British Psychological Society
Dr Gabriel Ivbijaro	General Practitioner	Representative	Royal College of General Practitioners
Dr Deenesh Khoosal	Consultant Psychiatrist	Representative	Royal College of Psychiatrists
Mr Alex Lawrence	Service User	Representative	FTM
Professor Del Loewenthal	Psychotherapist	UKCP Research Committee	United Kingdom Council for Psychotherapy
Mr David Ralph	Consultant Urologist	BAUS	Royal College of Surgeons
Mrs Terry Reed	Executive Committee Member	Representative	Gender Identity Research & Education Society
Mr Darren Skinner	Regional Officer	LGBT Group	Royal College of Nursing
Dr John Stevens	Consultant Psychotherapist	Faculty of Psychotherapy	Royal College of Psychiatrists
Mr Tim Terry	Consultant Urologist	BAUS	Royal College of Surgeons
Ms Jane Thornton	Speech & Language Therapist	Representative	Royal College of Speech & Language Therapists

Advisory Members

Dr Caroline Brain	Consultant Paediatrician	Consultation Only	Royal College of Paediatricians
Dr Susan Brechin	Consultant Community Gynaecologist	Consultation only	University of Aberdeen
Dr Domenico Di Ceglie	Consultant in Child and Adolescent Psychiatry	Consultation only	Royal College of Psychiatrists
Dr Jim Lucey	Consultant	Consultation Only	Royal College of

	Psychiatrist		Psychiatrists
Emma Martin	Psychotherapist	Consultation Only	National Association of Counsellors, Hypnotherapists and Psychotherapists
Andrew Messenger	Consultant Dermatologist	Consultation Only	Royal College of Physicians
Maxine Rathbone	District Nurse	Consultation only	Royal College of Nurses
Dr Russell Reid	Consultant Psychiatrist	Consultation only	Independent Sector Physician
Dr Su Sethi	Consultant in Public Health	Consultation only	Royal College of Public Health Physicians
Dr Paul Sutcliffe	Research Fellow	Consultation only	SCHARR, University of Sheffield
Daniel Wilson	Clinician	Consultation only	Consultancy, Sexuality Education and Training (CONSENT)
Walter Meyer III, George Brown & Eli Coleman	Chair	Consultation only	HBIGDA Standards of Care committee

Previous members

Michelle Ellis	Service User	Representative	Gender Trust
Vicky Williams	Service User	Representative	Gender Trust