Providing Care for Gender Non-Conforming and Non-Binary Patients

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They/them/theirs

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Prevalence Studies

Only 2 population studies have aimed to estimate the prevalence of non-binary identified people

Overall around 10% of people reported an 'ambivalent' or 'incongruent' gender identity

Another study showed a prevalence of 'gender ambivalence' or non-binary gender of 1.8% in AMAB people and 4.1% in AFAB people

When specifically looking at LGBTQ population: 5% of youth identified as neither male nor female; in another study, 13% of trans people surveyed were 'a gender not listed here'

When you get a form you have to fill and it only has two genders you can select.

- Up to 1/3 of the transgender population identify as nonbinary

M ☐
F ☐
X ☑

Towards Better Data Collection and Visibility

Update intake forms to include gender-neutral language

Use two-step method (1. identify gender identity, 2. identify sex assigned at birth)

Social media data source mining

Twitter

Social media data sources can expand the range of what can be easily measured and provide new information for mining health-related knowledge

Potential to provide a comprehensive snapshot of the language used by trans* individuals

Provider Attitudes

- Often non-binary identity is dismissed by providers as "confusion"
- Not all non-binary people identify as TG
- Medical heterosexism and ignorance

Patient Experiences

PROVIDERS' INABILITY TO SEE BEYOND THE TRANSGENDER BINARY

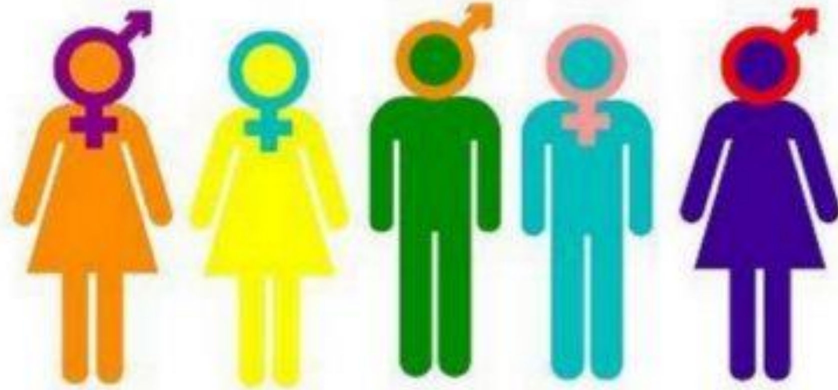
LACK OF CULTURAL COMPETENCE IN PROVIDING GQ/NB CARE

"BORROWING" THE TRANS LABEL

EVEN TRANSGENDER-SPECIFIC SERVICES FALL SHORT

Best Practices for Medical Staff

- Avoid gendered terminology
- Collect information on names, gender identity, and pronouns
- Allow "fill in the blank" and "choose not to disclose" options
- Document sex assigned at birth in addition to gender identity so that insurance will cover screening and treatment related to sex characteristics



Informed Consent Model

Gender Affirmative Model

Facilitating	Facilitating an authentic gender self
Alleviating	Alleviating gender stress or distress
Building	Building gender resilience
Securing	Securing social supports

Considering Physical Interventions

Means for achieving overt masculinization or feminization are established

Have to creatively rely on principles of treatment in trans men or women

The physical intervention needs of non-binary individuals are diverse

When Considering Hormone Treatment...

Counsel the patient about what hormonal therapy is able to achieve

Align with the patient's expectations and goals

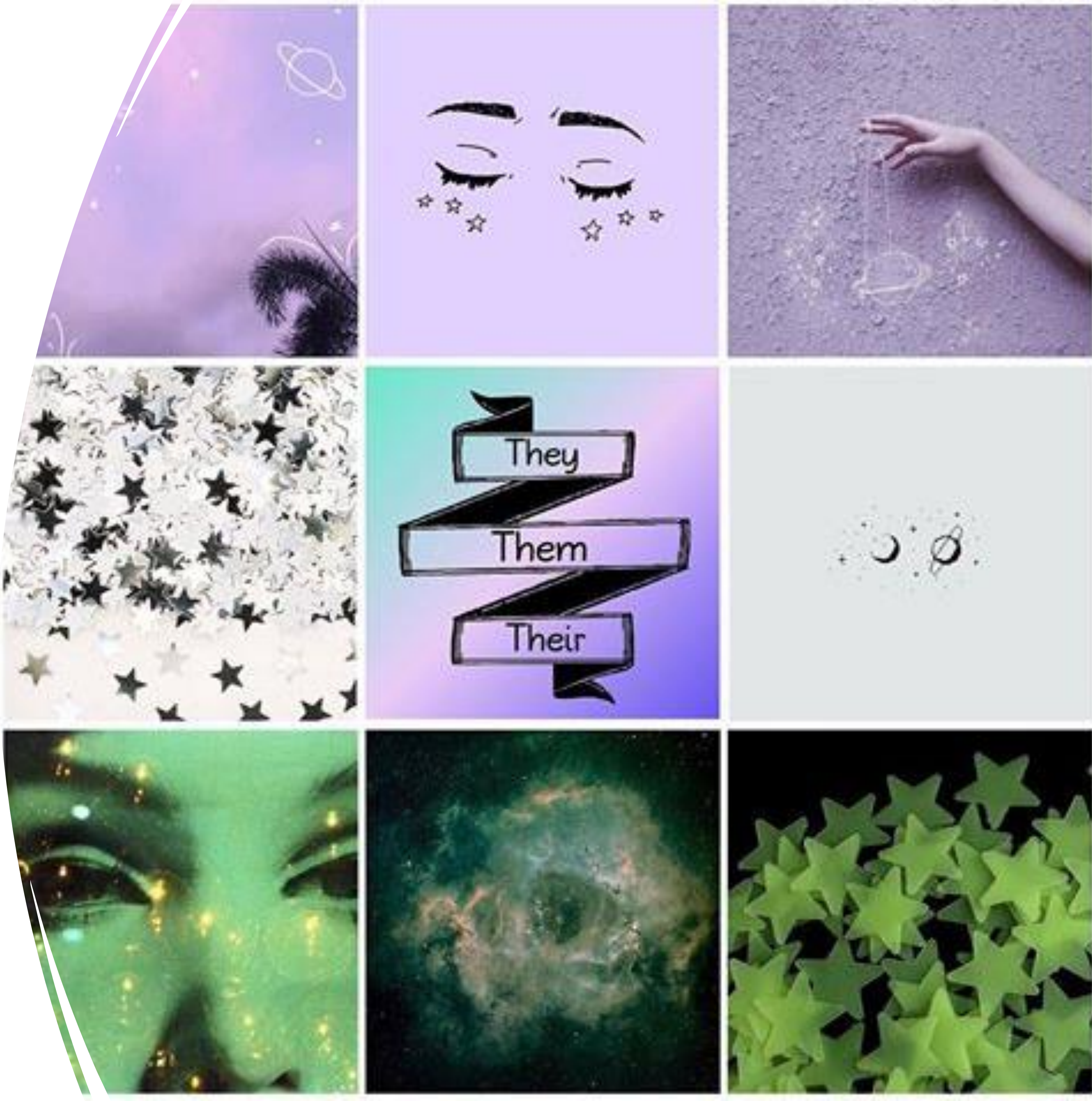
So I found the Gender I now identify as

Microdosing

- "Microdosing" refers to taking a lower dose of gender-affirming hormone therapy.
- On lower doses of hormone therapy, the physical changes are more subtle and happen gradually.
- There are several situations in which microdosing may be helpful.

Feminizing Hormone Therapy

- Complex-there are various formulations
- Degree of irreversible reproductive effects is less known



Microdosing Estrogen

- Estrogen (used synonymously with "estradiol," which is one of three forms of estrogen found in the human body) is a feminizing hormone that many trans women, transfeminine, non-binary, and gender expansive people take to reduce gender dysphoria and/or discomfort.
- Oral Estradiol: A "typical" dose of oral estradiol is in the 2 to 8mg range per day. A microdose would be around 1mg daily. Oral estradiol is usually taken sublingually.
- Transdermal Patch: Estradiol patches come in different concentration levels, and there are different recommendations for how often a patch can be changed based on the brand. A "normal" patch dose is 100 to 400mcg per day, and a low dose estrogen patch would be around 50mcg per day.
- Estradiol Valerate: Usually injected intramuscularly, a "normal" dose of estradiol valerate would be between 20 and 40mg every two weeks. A microdose would be injecting less than 10mg every week.
- Estradiol Cypionate: Also injected intramuscularly, a "typical" dose of estradiol cypionate is between 2 and 5mg every two weeks. A low dose would be injecting less than 1mg every week. Similarly to estradiol valerate, doses can be divided in half for weekly injections.

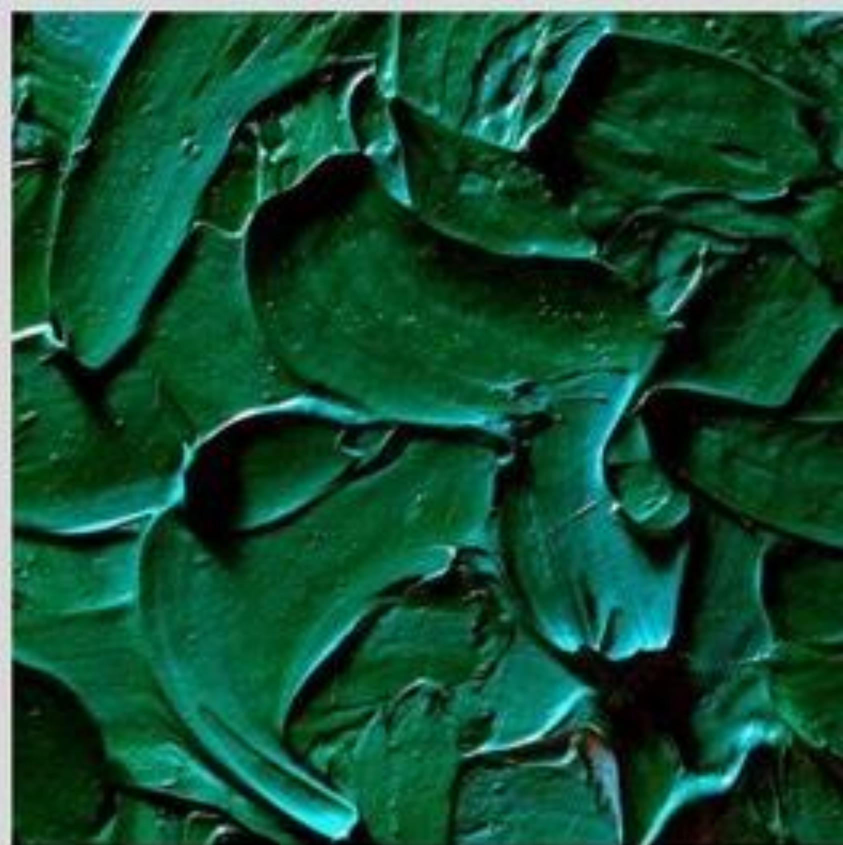
Microdosing Anti-Androgens

- For some non-binary people, the use of a testosterone blocker alone can achieve the right amount of feminization, which is generally minimal and slower. For others, the use of estrogen along with a testosterone blocker is essential. In the absence of estrogen replacement, androgen blockade may lead to unpleasant symptoms of hot flashes and low mood or energy.

Microdosing Anti-Androgens

- Spironolactone: Commonly referred to as "Spiro," this testosterone blocker is the most commonly used anti-androgen in the United States.
  - A "normal" dose of Spiro usually falls in the 50 to 200 mg twice per day range.
  - A microdose would be around 25 mg per day. Spiro is taken orally and is recommended to be taken at mealtimes.
- Finasteride: A maximum dose of Finasteride is around 5 mg per day, and a low dose is around 1 mg per day.

RESPECT
GENDERQUEER
PEOPLE



Role of GnRH agonists or antagonists

Achieve absolute testosterone suppression

Could allow for tailoring the hormonal milieu without surgical interventions

THINGS THAT DON'T EXIST:

BIGFOOT

FAIRIES

UNICORNS

THE GENDER BINARY

Partial Virilization

- Different therapies depend on patient's wishes
- DHT use?
- Testosterone- intermittent or low dose treatment

Microdosing T

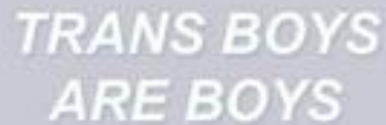
- Testosterone is a masculinizing hormone that is taken by trans men, transmasculine, non-binary, and gender-expansive people. There are many reasons why people choose to microdose and a few different ways to administer testosterone in smaller doses.
- There are many ways to administer testosterone into the body, and almost all of them have options for microdosing.

Microdosing T

- Injecting: A "normal" dose of injectable testosterone is somewhere between 50 and 100 mg every week. An injectable microdose would be around 20 mg (0.1 ml) per week. Injections are either intramuscular or subcutaneous.
- Gel: Testosterone gels come in multiple concentration levels, so make sure you understand how much to use and how often to use it based on your prescription. Generally speaking, for gels with 1% concentration, a "typical" dose is somewhere between 50 and 100 mg per day, and a microdose is in the 12.5 to 25 mg per day range. For gels with 1.62% concentration, a "normal" dose is between 40.5 and 67.5 mg per day, and a low dose is around 20.25 mg per day.
- Cream: Similar to gels, a "typical" dose of testosterone cream is somewhere between 50 and 100mg per day, and a microdose is around 10 mg per day.
- Patch: Testosterone patches come in 2 mg or 4 mg options. "Normal" doses fall somewhere in the 4 to 8mg per day range, and a low dose is around 1 to 2 mg per day.

When Considering Microdosing T

- When considering microdosing T, know that periods may not stop so exploring what dosage will be ideal for you is important
- Other considerations: reproductive health, fertility goals, surgery goals, medical hx
- Consider degree of masculinization and autonomy to adjust dosage



Stopping Bleeding FlowChart

- On T?
  - Yes--> optimize T dose/frequency
    - Still bleeding and averse to estrogen: aromatase inhibitor or progestogen
      - Still bleeding: consider GnRH analogue or SERM
    - Still bleeding and not averse to estrogen: estradiol + micronized progesterone or OCP
      - Still bleeding: consider GnRH analogue or SERM
  - No-> Progestogen
    - Norethindrone 0.35mg daily
    - Norethindrone acetate 5-15mg daily
    - MPA (po or IM)
      - Still bleeding: aromatase inhibitor
        - Still bleeding: GnRH analogue or SERM

Forever Young? A Case Study

- The article discussed here analyzed the case of a young non-binary adult requesting ongoing puberty suppression to permanently prevent development of secondary sex characteristics, as a way of affirming their gender identity
- Argument: the aim of puberty blockers is consistent with the proper goals of medicine to promote well-being, and therefore could be ethically offered to non-binary adults on principle. Consider potential benefits and harms for the specific patient.

Forever Young? A Case Study II

- Puberty blockers could improve non-binary adults' well-being, increase self-esteem and interpersonal functioning, and allowing the person to feel more comfortable in their body as they navigate the social world
  - Ethically justifiable
  - Potential harms: local site reaction; exposure to sex hormones during puberty is important for bone strength so puberty blockers are likely to reduce bone density, and increase osteoporosis and bone fracture risk (therefore some limit blocker use to 2-4 years)

Forever Young? A Case Study III

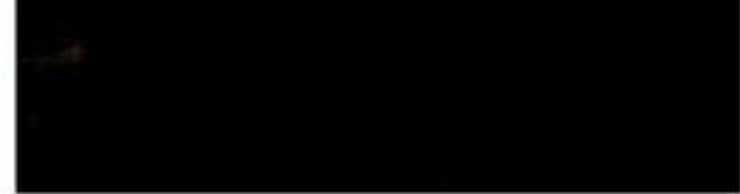
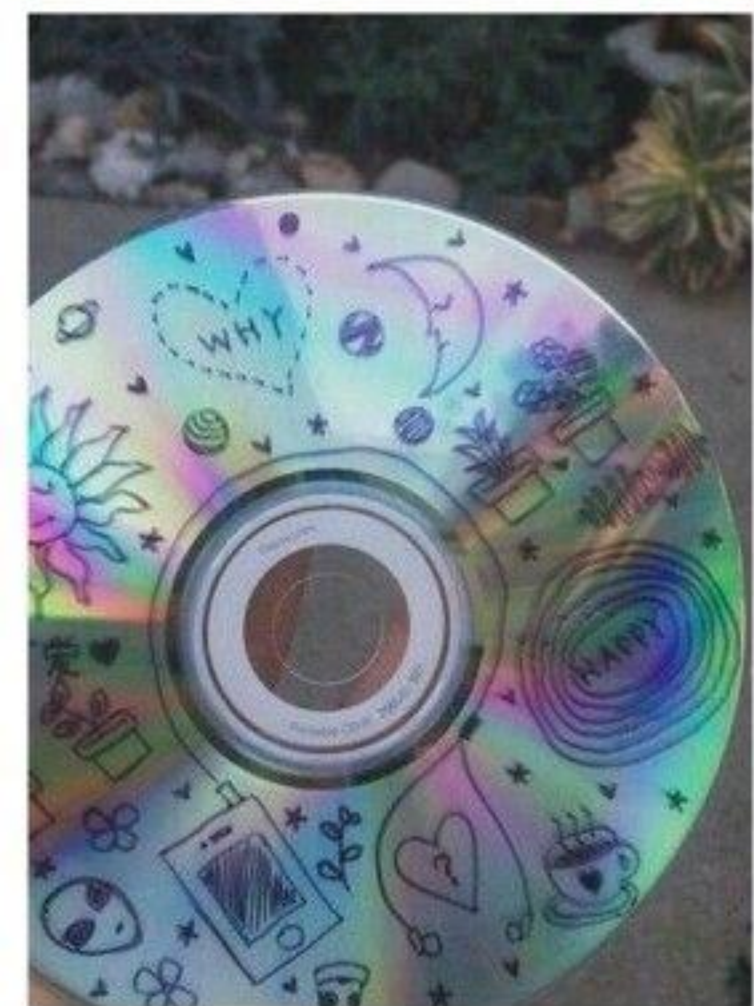
- Psychological harms
  - May have trouble finding a partner with a child-like body; social stigma
- Potential harm: fusion of bone growth plates
  - Can result in a taller-than-expected final height
- Potential harm: fertility
  - Ova/sperm unlikely to mature without sex hormones
- Another potential harm is impaired sexual function
  - Blockers may create longterm vaginal atrophy

Forever Young? A Case Study IV

- Benefits
    - Prevent development of irreversible and unwanted secondary sex characteristics
    - More reversible option than going through puberty
    - Prevents need for surgeries
    - Major improvement in gender dysphoria
    - Overall improvement in psychosocial functioning and general mental health

nice gender did your mom pick it out for you

LOVE
live
let
love



WHY

HUMAN