The Spectrum of Transgender Identity

Transgender is a broad term used for people whose gender identity or gender expression differs from their assigned sex at birth (Box 1) (1). However, there is no universally accepted definition of the word “transgender” because of the lack of agreement regarding what groups of people are considered “transgender.” In addition, definitions often vary by geographic region and by individual (2). The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, considers transgender individuals to be individuals with a disturbance in sexual or gender identity. Any combination of sexual and gender identity is possible for transgender individuals (Box 2). The diagnosis of gender identity disorder is only established for individuals with clinically significant distress and functional impairment caused by the persistent discomfort with one’s assigned sex and primary and secondary sex characteristics. If untreated, gender identity disorder can result in psychologic dysfunction, depression, suicidal ideation, and even death (3).

Prevalence rates of transgender populations are not clearly established; however, studies suggest that transgender individuals constitute a small but substantial population (4). Additional research is needed among this population as outlined by the Institute of Medicine Report, The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (2).

The social and economic marginalization of transgender individuals is widespread. Harassment, discrimination, and rejection occur frequently within an individual’s own family and affect educational, employment, and housing opportunities. Transgender individuals, particularly young transgender individuals, are disproportionately represented in the homeless population (5). Once homeless, individuals may be denied access to shelters because of their gender or are placed in inappropriate housing. Subsequently, many homeless transgender individuals turn to survival sex (the exchange of sex for food, clothing, shelter, or other basic needs), which increases the risk of exposure to sexually transmitted infections and becoming victims of violence (6). In one small study, 35% of male-to-female transgender individuals tested positive for human immunodeficiency virus (HIV), 20% were homeless, and 37% reported physical abuse (7).

Barriers to Health Care

Within the medical community, transgender individuals face significant barriers to health care. This includes the failure of most health insurance plans to cover the cost of mental health services, cross-sex hormone therapy, or gender affirmation surgery. This barrier exists despite evidence that such treatments are safe and effective and that cross-gender behavior and gender identity issues are not an issue of choice for the individual and cannot be reversed with psychiatric treatment (8). With medical and psychiatric care that affirms transgender identity, the transgender individual can lead an enhanced, functional life (9).
The consequences of inadequate treatment are staggering. Fifty-four percent of transgender youth have attempted suicide and 21% resort to self-mutilation. More than 50% of persons identified as transgender have used injected hormones that were obtained illegally or used outside of conventional medical settings. Additionally, such individuals frequently resort to the illegal and dangerous use of self-administered silicone injections to spur masculine or feminine physiologic changes (5). The American College of Obstetricians and Gynecologists, therefore, urges public and private health insurance plans to cover the treatment of gender identity disorder.

**Caring for Transgender Individuals**

Obstetrician–gynecologists should be prepared to assist or refer transgender individuals for routine treatment...
and screening as well as hormonal and surgical therapies. Basic preventive services, like sexually transmitted infection testing and cancer screening, can be provided without specific expertise in transgender care. Hormonal and surgical therapies for transgender patients may be requested, but should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender patients (see Resources). Physical and emotional issues for transgender individuals and the effects of aging, as in all other individuals, affect the health status of this population and should be addressed. Health care providers who are morally opposed to providing care to this population should refer them elsewhere for care. For more information, a resource guide on health care for transgender individuals is available at www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=5825.

Creating a Welcoming Environment

Health care providers’ discomfort when treating transgender individuals may alienate patients and result in lower quality or inappropriate care as well as deter them from seeking future medical care (10). Excellent resources exist to facilitate the provision of culturally competent care for transgender patients (10). Adding a “transgender” option to check boxes on patient visit records can help to better capture information about transgender patients, and could be a sign of acceptance to that person (10). Questions should be framed in ways that do not make assumptions about gender identity, sexual orientation, or behavior. It is more appropriate for clinicians to ask their patients which terms they prefer (1). Language should be inclusive, allowing the patient to decide when and what to disclose. The adoption and posting of a nondiscrimination policy can also signal health care providers and patients alike that all persons will be treated with dignity and respect. Assurance of confidentiality can allow for a more open discussion, and confidentiality must be ensured if a patient is being referred to a different health care provider. Training staff to increase their knowledge and sensitivity toward transgender patients will also help facilitate a positive experience for the patient (10). It is important to prepare now to treat a future transgender patient. Additional guidelines for creating a welcoming office environment for transgender patients have been developed by the Gay and Lesbian Medical Association and can be found at http://www.glma.org/_data/in_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf.

Gender Transition: World Professional Association for Transgender Health Guidelines

The World Professional Association for Transgender Health is a multidisciplinary professional society representing the specialties of medicine, psychology, social sciences, and law. Their published clinical guidelines about the psychiatric, psychologic, medical, and surgical management of gender identity disorders are widely used by specialists in transgender health care (11), but are not universally accepted by all members of the transgender health community because critics consider them to be overly restrictive and inflexible.

The World Professional Association for Transgender Health guidelines describe the transition from one gender to another in three stages: 1) living in the gender role consistent with gender identity; 2) the use of cross-sex hormone therapy after living in the new gender role for at least 3 months; 3) gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months. Additional clinical guidelines have been published by the Endocrine Society (12).

Female-to-Male Transgender Individuals

Hormones

Methyltestosterone injections every 2 weeks are usually sufficient to suppress menses and induce masculine secondary sex characteristics (13). Before receiving androgen therapy, patients should be screened for medical contraindications and have periodic laboratory testing, including hemoglobin and hematocrit to evaluate for polycythemia, liver function tests, and serum testosterone level assessments (goal is a mid normal male range of 500 microgram/dL), while receiving the treatment.

Surgery

Hysterectomy, with or without salpingo-oophorectomy, is commonly part of the surgical process. An obstetrician–gynecologist who has no specialized expertise in transgender care may be asked to perform this surgery, and also may be consulted for routine reasons such as dysfunctional bleeding or pelvic pain. Reconstructive surgery should be performed by a urologist, gynecologist, plastic surgeon, or general surgeon who has specialized competence and training in this field.

Screening

Age-appropriate screening for breast cancer and cervical cancer should be continued unless mastectomy or removal of the cervix has occurred. For patients using androgen therapy who have not had a complete hysterectomy, there may be an increased risk of endometrial cancer and ovarian cancer (13).

Male-to-Female Transgender Individuals

Hormones

Estrogen therapy results in gynecomastia, reduced hair growth, redistribution of fat, and reduced testicular volume. All patients considering therapy should be screened for medical contraindications. After surgery, doses of estradiol, 2–4 mg/d, or conjugated equine estrogen, 2.5 mg/d, are often sufficient to keep total testosterone levels to normal female levels of less than 25 ng/dL. Nonoral therapy
also can be offered. It is recommended that male-to-female transgender patients receiving estrogen therapy have an annual prolactin level assessment and visual field examination to screen for prolactinoma (13).

**Surgery**

Surgery usually involves penile and testicular excision and the creation of a neovagina (14). Reported complications of surgery include vaginal and urethral stenosis, fistula formation, problems with remnants of erectile tissue, and pain. Vaginal dilation of the neovagina is required to maintain patency. Other surgical procedures that may be performed include breast implants and nongenital surgery, such as facial feminization surgery.

**Screening**

Age-appropriate screening for breast and prostate cancer is appropriate for male-to-female transgender patients. Opinion varies regarding the need for Pap testing in this population. In patients who have a neocervix created from the glans penis, routine cytologic examination of the neocervix may be indicated (15). The glans are more prone to cancerous changes than the skin of the penile shaft, and intraepithelial neoplasia of the glans is more likely to progress to invasive carcinoma than is intraepithelial neoplasia of other penile skin (14).

**Conclusion**

Obstetrician–gynecologists should be prepared to assist or refer transgender individuals. Physicians are urged to eliminate barriers to access to care for this population through their own individual efforts. An important step is to identify the sexual orientation and gender identity status of all patients as a routine part of clinical encounters and recognize that many transgender individuals may not identify themselves. The American College of Obstetricians and Gynecologists urges health care providers to foster nondiscriminatory practices and policies to increase identification and to facilitate quality health care for transgender individuals, both in assisting with the transition if desired as well as providing long-term preventive health care.

**Resources**

Select clinics with expertise in treating transgender individuals:

Fenway Community Health
www.fenwayhealth.org

University of Minnesota, Center for Sexual Health
www.phs.umn.edu/clinic/home.html

Callen-Lorde Community Health Center
www.callen-lorde.org

Tom Waddell Health Center
www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransgenderHlthCtr.asp

**References**


11. World Professional Association for Transgender Health. The Harry Benjamin International Gender Dysphoria Association’s standards of care for gender identity dis-

