Primary Care for the Transgender and Gender Nonconforming Patient

Frederic M. Ettner, MD

KEYWORDS

• Transgender • Gender nonconforming • Gender affirming • Mental health

KEY POINTS

- With knowledge of gender-affirming models of care, surgeons will be equipped to safely treat transgender/gender nonconforming (TGNC) patients with respect and purpose.
- Due to a variety of factors, many TGNC patients lack access to health care and, therefore, are at increased risk for common medical conditions.
- Collaboration with mental health care and primary care professionals is fundamental to healthy outcomes.
- By providing complete and compassionate health care, positive surgical outcomes will follow.

INTRODUCTION

As physicians, *primum non nocere* (first, do no harm) is more than a motto. It defines a responsibility to all patients who seek services. Primary care physicians (family medicine, pediatricians, internists, and obstetrician/gynecologists), physician assistants, and nurse practitioners are the vanguard of medical practice. Gender is an integral part of humanity and one of the more misunderstood foundations of human behavior. This is especially true for transgender individuals. The health care system has been largely indifferent to the needs of people with unique gender identities and presentations, causing health disparities, stigmatization, and minority stress.[1] This article introduces the surgeon, the "captain of the ship," to primary care for the transgender/gender nonconforming (TGNC) patient. The protocols discussed have been developed through years of patient encounters, extensive review of the medical literature, and the guidance provided by the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC).

PATIENT ENCOUNTER

A generalist is usually the first physician to see the patient. This may be the first time the patient has visited any physician. The current accepted prevalence of TGNC people is 200 to 700 per 100,000.[2] Therefore, a primary care physician working a 40-hour week may have seen, knowingly or unknowingly, 10 to 35 gender diverse patients in a year. The encounter begins when the patient makes an appointment. Gathering appropriate demographics, that is, sex assigned at birth, self-described gender identity (nonbinary, fluid, or queer), and preferred pronouns can be a demonstration of respect, if office staff have been appropriately trained. Creating an environment conducive to lessening the stress for these persons is crucial to establishing a trusting relationship. Within this context, medical and social history taking, physical examination, and treatment can proceed.

Many TGNC individuals lack access to health care or fear discrimination, and thus are at increased risk for common medical conditions. Promoting well-being is the goal of the primary

The author has nothing to disclose.
Department of Family Medicine, University of Chicago Pritzker School of Medicine, 7126 North Lincoln Avenue, Lincolnwood, IL 60712, USA
E-mail address: fmettnermd@gmail.com

Clin Plastic Surg ∎ (2018) ∎–∎
https://doi.org/10.1016/j.cps.2018.03.001
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care provider, regardless of a patient's gender identity or presentation. The recognition that gender nonconformity is not synonymous with gender dysphoria is important in consulting with all TGNC patients. Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular gender. Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth and the associated gender role and/or primary and secondary sexual characteristics. Only some TGNC people experience gender dysphoria.[3]

Familiarity with and knowledge of primary medical care, hormonal treatment, and regular follow-up are essential in providing care to this population. Collaboration with other professionals, such as mental health providers, contributes to ensure optimal care. TGNC patients encompass all age groups—pediatric, adolescent, adult, and geriatric. Each age group brings challenges medically, surgically, psychologically, and socially. There are no algorithms, and each patient needs to be treated as an individual.

With the initial consultation, or face-to-face encounter, between medical provider and patient, the expectations of patient and provider are discussed, and the process of obtaining informational consent begins. There are no diagnostic physical findings, laboratory tests, imaging studies, psychological profiles, or questionnaires to assess TGNC patients. The TGNC person is self-diagnosed, and the initial encounter confirms the patient's self-disclosure. After this initial consultation, a subsequent visit includes a complete history and physical examination. Baseline laboratory tests are scheduled after the initial consultation. The purpose of this evaluation is to discuss the patient's gender identity and assess gender dysphoria and the presence of morbid conditions that may contraindicate or have impact on hormonal therapy.

Medical History

The initial complete medical history should include

- History of patient's realization of gender identity and gender dysphoria, desire for cross-sex hormone therapy and expectations, and/or gender-affirming surgical goals (facial, breast, and genital)
- A detailed past medical history, with emphasis concerning cardiovascular disease (hypertension, coronary artery disease, cerebrovascular disease, and thromboembolic phenomena), hepatic disease (hepatitis and cirrhosis), alcohol/drug use, metabolic diseases (diabetes, thyroid, and kidney), myeloproliferative disease (erythrocytosis, leukemia, lymphoma, and bone marrow dyscrasias), cancer (breast, uterine, and genital), hormonal abnormalities (hypothyroid, pituitary adenomas, and congenital adrenal hyperplasia), genital/urinary abnormalities (gravida/para, menarche, menstrual cycle, days of flow, last menstrual period, Pap smear with human papilloma virus screening, HIV, and sexually transmitted infection testing), sexual health history (fertility, preferred partners, asexual, sensuality, experienced expected sexual response, and abuse), substance abuse (tobacco, alcohol, and illicit drugs), nutrition (note weight-positive problems of hormonal treatment), activity (maintain ideal body mass index [BMI])
- Family history of chronic disease (cardiovascular, hypertension, diabetes, blood clotting disorders, liver disease, kidney disease, and unusual anesthetic problems) and familial diseases
- Medication history—documentation of all medications, especially previous hormonal therapy either prescribed or acquired (nonprescribed)
- Surgical history, including silicone injections or other body modifications
- Social history—family dynamic, support, discussion of transitioning and/or pre/intra/post-operative care, alcohol/tobacco use (CAGE questionnaire—alcohol-dependence surveillance tool), illicit drugs, and harms (suicidal ideation, plan, or attempt)
- Mental health history—major disorders (psychosis, bipolar, depression, impulse control disorder, and substance abuse); administer depression questionnaire (ie, 9-item Patient Health Questionnaire)
- Education/occupation—explore potential difficulties transitioning in these settings
- Review of systems—skin, musculoskeletal, cardiovascular, respiratory, digestive, genital (review sexual history emphasizing change in sexual response and possible infertility with hormonal treatment and permanence of gonadal surgeries with resultant infertility), and neurologic

Physical Examination

The examiner should be cognizant of the disdain, fear, and anxiety that a physical examination may provoke in a TGNC patient. Creating a safe environment by discussing the rationale for examination and the information it yields is essential. This is especially evident in a trans male without any

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