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Healthcare for Trans Adults

Practical Guidance for GPs

Transgender patients may present to general practice at various stages of their transition.
GP care plays a vital role in ensuring support, referrals, and access to safe treatment.
This guide provides practical, evidence-based advice for GPs.

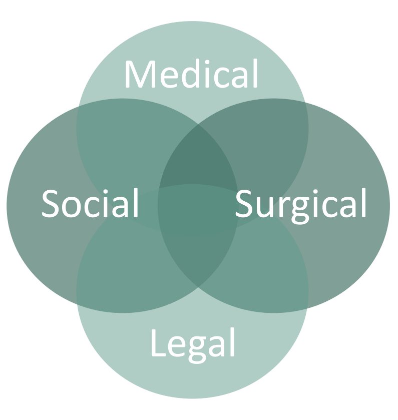
First presentation - key considerations:

Create a welcoming environment:	Check correct pronouns and name. Update records as appropriate. Trans people may be avoidant of accessing healthcare, so making the contacts we have positive, helps to foster a relationship and may improve future health outcomes[1]
Conduct a holistic assessment:	Explore physical, psychological, and social needs (see WPATH Standards of Care[1])
Screen for mental health concerns:	Depression and anxiety are common and should be sensitively explored. Check for self-harm and suicidality as this population is at high risk[2]
Ascertain what support they want:	Not all transgender people will want medical or surgical transition.

People might be considering, or have embarked on, any, or all, of the different types/elements of transitioning.

People may need their GP's support with different aspects of this. For example:
- Changing gender markers and updating names on medical records (see NHS gender reassignment advice[d])
- Supporting access to hormone therapy and surgical treatment via referrals, prescriptions and monitoring.
- Supporting documentation for patients applying for Gender Recognition Certificates.

Types of transition:



Referrals:

In an ideal world, transition-related care for transgender patients would be supported with input from specialised gender services (e.g. a Gender Identity Clinic). These are referral centres which provide evidence-based care with multidisciplinary input from Endocrinologists, Psychologists, Psychiatrists, Nurses and Speech and Language Therapists.

Elegibility: Any patient expressing gender incongruence, who would like assessment, support or any associated medical care. Patients do not need to undergo psychological assessment before referral.

How to refer:
This will vary depending on the GIC you are referring to. A list can be found here. You do not need to refer to the closest GIC. Some GICs will also accept patient self-referral. You will need to
1. Complete referral form (find via their website or in Emis documents search) *Note: these are often long, so you can ask the patient to complete as much as possible themselves and bring back to you.*
2. Attach referral letter with medical history, current/past medications, baseline bloods (see below section on "Safe Prescribing" for a list).

In London you may also need to complete a referral via eRS.

Ideal timeline:

Initial GP appointment and referral → Specialist input from a GIC (Eg. hormone therapy, surgery, mental health support) → Discharged back to GP for ongoing care with support for hormone advice.

Current NHS timeline:

Initial GP appointment and referral → Long waiting lists (4+ years). GPs left to manage in the interim. Risk of deteriorating mental health deteriorating, self sourcing unregulated medications etc. → Eventual specialist input from GIC

It is during this long wait for specialist input that **bridging or harm reduction hormone prescriptions** may be required.

Hormone Prescriptions:

There are two main situations in which GPs might prescribe hormone therapy:
- Continuing prescriptions initiated by a GIC.
- Prescriptions for those awaiting GIC input – these are often referred to collectively as "***bridging prescriptions"*** in guidance but encompass both ***"bridging"*** and ***"harm reduction"***.

Prescribing for Patients Not Under a GIC
There are four situations in which you might consider this:

Bridging	Taking Over	HARM REDUCTION: Continuing	HARM REDUCTION: Initiating
Taking over gender affirming hormones after a diagnosis of gender incongruence **from abroad**, for those who have been safely established on therapy.	Taking over gender affirming hormones after a diagnosis of gender incongruence in the **private sector**, for those who have been safely established on therapy.	Continuation of gender affirming hormones for someone who is self-medicating while they await GIC assessment.	Initiating gender affirming hormones for someone who whose mental health is at significant risk due to gender incongruence while they await GIC assessment.

The balance of risk and expertise required increases across these situations*
**Note: The risk of taking over depends on the reputability of the private provider*

Benefits:

Prescription provides desired phenotypic changes for the person, aiming to improve wellbeing and mental health.

Not providing these prescriptions could result in adverse outcomes:
- Adverse physical effects (e.g. loss of bone density from forced stopping post-gonadectomy, or adverse side effects from unregulated or unmonitored self-sourced medications)
- Adverse mental health impacts of ongoing gender incongruence or detransition.

Risks:

The person will not have been seen by a gender specialist and so there will always be a chance that hormone therapy is not the right course of action at this time. Unwanted irreversible physical changes could, therefore, occur, particularly in those newly commencing hormones.

There are some risks to be aware of with the use of any hormone therapy – as with any other hormone use e.g. HRT or contraception. Some of these can be partially mitigated with monitoring (*see appendix*)

Benefits and risks must be considered on an individual basis (as with all medications)

Stance of key organisations:

GMC:[2] Distinguish between prescribing on the recommendation of a "specialist service provider" who is "suitably qualified" and providing a "bridging prescription" (but are actually discussing "harm reduction".)
Suggest that GPs can consider supporting bridging prescribing with "advice from a specialist service provider or an experienced colleague" but stipulate that doctors "must recognise and work within the limits of your competence."
Support prescribing medications off-licence based on risk-benefit assessment for a particular patient (as with any other off-licence prescribing).
Reassure doctors who wish to prescribe that it is not against their guidance to do so, but do not require doctors to prescribe if they don't feel it would be beneficial or within their competencies.
State that doctors have a "You have a responsibility to make your practice inclusive and provide high-quality care to all patients."

RCGP:[3] Advise holistic risk-benefit assessment using clinical judgement. Prescribe if you feel "competent to do so". We hope that these guidelines and resources below help with this.

BMA:[4] "Prescribing in this field is not part of the General Medical Services contract for GPs and prescribing in this field may be outside the competency of some GPs. Those GPs with relevant training and knowledge in this field may be able to support prescribing prior to, or in association with, specialist gender services."

Summary criteria for "bridging" and "harm-reduction" prescriptions based on GMC guidance:
1. Clear, persistent gender dysphoria (see 'Definitions' below).
2. Unmet clinical need (e.g.. patient on long GIC waiting lists) and in significant distress or at risk (e.g. mental health deterioration, self-harm).
3. Lack of safer alternatives: The patient may otherwise self-medicate with unregulated sources.
4. Informed consent: The patient understands the benefits, risks, and limitations of hormone treatment.

We hope that this guidance helps GPs to feel competent to provide bridging prescriptions, alongside specific prescribing guidelines like this one[c]

Safe Prescribing:

Monitoring is needed for those on hormones:
Investigations are needed at baseline, during dose titration and then every 6-12 months once stabilised on treatment. *Note: Recommended reference ranges may vary slightly between services.*

Baseline blood tests prior to hormone therapy:

FBC, U&E, LFT, HbA1c , fasting lipids, bone profile, prolactin, LH, FSH, serum testosterone, serum oestradiol, SHBG, and vitamin D.

Monitoring bloods while on hormone therapy:

General:

Liver function tests: Values of greater than 3x the upper limit of normal: seek from hepatology.

Lipids/HbA1c/BP/BMI: Check Q-risk and consider statins, lifestyle changes and diabetes counselling as for anyone else.

Masculinising:

Testosterone:

Type	*Test timing*	*Target level*
Gels	4-6hrs post application	15 –20nmol/L
Short acting injections (e.g.. Sustanon)	Trough (just before next injection) or peak (7 days after injection)	8 –12nmol/L <30nmol/L
Long acting injection (e.g.. Nebido)	Trough (just before next injection)	10 –15nmol/L

FBC for Haematocrit (HCT):
>0.52 advise patient to drink 2 litres of water a day + repeat blood tests.
>0.55 seek advice from haematology but continue treatment.
>0.60 pause testosterone treatment, refer urgently to haematology for venesection. Testosterone therapy can often be resumed after a pause in treatment.

Feminising:

Oestradiol:

Type	*Test timing*	*Target level*
Tablets	4-6hrs after tablet	400-600 pmol/L
Patches	>48 hours after patch application	400-600 pmol/L
Gel	4-6hrs after application	400-600 pmol/L
Implants	5 months after implant	400-500 pmol/L

Note: Transdermal gel or patches are recommended in those at high risk of VTE e.g. people over 40 years old, BMI over 35 or smokers.

Prolactin:
Small rises in prolactin are often seen with oestrogen therapy.
New rise up to 1000 mIU/L: Repeat test
Consistent rise of >1000 mIU/L: Seek advice from local endocrinology department

Note on normal ranges: Where normal range differs by sex, you can interpret tests based on the sex that the person is transitioning to if they have been on hormone therapy >12 months[5]

Considerations for other routine care:

Screening: Offer screening based on organs present (e.g., cervical smear if patient has cervix, mammography if breast tissue present). See https://outpatients.org.uk/tnbgd-screening/

Contraception: Discuss contraception needs. Important note - testosterone is not a contraceptive (despite suppressing menstruation) and is teratogenic, so contraceptive cover is key. The Faculty of Sexual & Reproductive Healthcare contraceptive guidance can be found here.

Sexual health: Offer inclusive, non-judgmental sexual health care.

Fertility: Discuss implications of treatment and offer referral for fertility preservation where appropriate.

Mental Health: Trans people often face social stigmas that can contribute to poor mental health. Transition can be a difficult time and making their GP a safe space to come for help is crucial.

Resources:

a. Transactual UK:
https://transactual.org.uk/gp-support-trans/

b. Advice for patients waiting for GIC appointment:
https://tavistockandportman.nhs.uk/services/gender-identity-clinic-gic/resources/

c. Prescribing guidelines
https://awttc.nhs.wales/files/guidelines-and-pils/endocrine-management-of-gender-incongruence-in-adults-pdf/

d. Gender reassignment/marker change processes:
https://pcse.england.nhs.uk/help/patient-registrations/gender-reassignment

References:

1. Coleman *et al.* (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI:10.1080/26895269.2022.2100644

2. https://www.gmc-uk.org/professional-standards/ethical-hub/trans-healthcare

3. https://www.rcgp.org.uk/representing-you/policy-areas/transgender-care

4. https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/lgbtplus-equality-in-medicine/inclusive-care-of-trans-and-non-binary-patients

5. https://pubmed.ncbi.nlm.nih.gov/35584132/

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Appendix 1 – Help Definitions:

Gender	Gender is a social and psychological construct, which refers to the internal sense of self and identity as a man, woman, neither, or along the gender spectrum.
Sex	Sex refers to biological characteristics, including chromosomes, hormone levels, reproductive organs.
Transgender (trans)	A person whose gender identity differs from the sex they were assigned at birth.
Cisgender (cis)	A person whose gender identity aligns with the sex they were assigned at birth.
Non-Binary	A gender identity that does not fit within the traditional categories of male or female.
Gender Dysphoria	Distress caused by a mismatch between a person's gender identity and their assigned sex. *Note, in the DSM-V defines 'Gender Dysphoria in Adolescents and Adults' as 'a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:* • *A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)* • *A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)* • *A strong desire for the primary and/or secondary sex characteristics of the other gender* • *A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)* • *A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)* • *A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)'* *In addition, in order to meet criteria for a diagnosis of Gender Dysphoria, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.*
Gender Incongruence	A difference between a person's experienced gender and their assigned sex at birth. *Note, in the ICD-11 'Gender Incongruence of Adolescence and Adulthood' (HA60) is "characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender.'*
Transition	The process a person may undertake to live as their identified gender. This can include social, legal, and/or medical steps.
Social Transition	Changing name, pronouns, clothing, etc., to match one's gender identity.
Medical Transition	Using hormone therapy to align the body with one's gender identity.
Surgical Transition	The use of surgical procedures to align the body with one's gender identity
Legal Transition	Changing gender markers and name on official documents.

Appendix 2 - Risks and possible side effects (for the purposes of consenting and awareness):

Oestrogen therapies	Testosterone therapies
Loss of fertility	Loss of fertility
Increased risk of VTE	Risk of polycythaemia
Increased risk breast cancer (compared to cis men, lower than for cis women)	Pelvic pain (particularly initially)
Cardiovascular risk + risk of hypertension or diabetes	Vaginal atrophy (leading to sexual discomfort)
Nausea and vomiting (particularly initially)	Cardiovascular risk + risk of hypertension or diabetes
Development of gallstones	Increased appetite leading to weight gain
Worsening headaches and migraines	Worsening headaches and migraines
Impact on liver function (usually transient)	Impact on liver function (usually transient)
Impact on mood and mood swings	Impact on mood and mood swings
	Increased sweating
	Hair thinning, hairline receding or male pattern baldness
	Increased risk of sleep apnoea