Adolescent Visit Guide: Gender-Affirming Care

For Transgender and Gender Diverse Adolescents

Guidelines

This guide is for use in day-to-day practice of a pediatric & adolescent provider. It does NOT cover every scenario. We recommend these in-depth resources.

Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Comprehensive guidelines for hormone management and titration.* https://bit.ly/EndoSoc2017

Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. WPATH SOC8. *Overarching discussion of the scope of gender-affirming care, and establishes standards for readiness for blockers or hormones. Many insurance companies follow these guidelines to determine coverage requirements.* https://bit.ly/WPATH_v8

Seattle Children's Gender Clinic Gender-Affirming Hormone Protocol. *Detailed dosing and monitoring recommendations.* https://bit.ly/SeattleProtocol

Transline: Transgender Medical Consultation Service. *Clinician-facing consultation line for care of TGD patients. Providers can submit questions which are answered by experts.* https://bit.ly/TranslineConsult

Trauma-Informed Tanner Staging. *Examination of 2º sex characteristics may cause distress for TGD children and adolescents. Strategies to limit iatrogenic trauma include involving a Child Life specialist or using self-Tanner staging tools, such as:* https://bit.ly/self-Tanner

Additional Resources

WPATH Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in US: [excerpt] https://bit.ly/WPATH_2023

"The Standards of Care state that, 'the goal of gender affirming care is to partner with TGD people to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity. Gender-affirming care supports TGD people across the lifespan—from the very first signs of gender incongruence in childhood through adulthood and into older age.' … the **only gender-affirming care for children recommended in SOC-8 is social support or social transition, in which a TGD child would be able to use a name, pronouns, and gender expression (including haircut or clothing) that aligns with their gender.** At no point does SOC-8 recommend transition-related care or medical intervention for children before the age of puberty." [emphasis added]

Check for medical care bans in your state at: https://bit.ly/GAHT_MAP

Download this Visit Guide at:

https://bit.ly/TGD_visit

GAHT Dosing Guide available at:

https://bit.ly/TGD_dosing

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American Academy of Pediatrics

https://bit.ly/AAP_TGD

Ensuring Comprehensive Care & Support for TGD Children & Adolescents

"The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends…that youth who identify as TGD have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space."

In 2023, "The AAP Board of Directors voted to reaffirm the [above] 2018 policy statement and authorized development of an expanded set of guidance for pediatricians based on a systematic review of the evidence." (https://bit.ly/AAP-23)

Expected time course of ESTRADIOL (+ androgen blockade)

Effect	Expected onset	Expected max. effect
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/strength	3-6 months	1-2 years
Softening of skin/decreased oiliness	3-6 months	Unknown
Decreased sexual desire	1-3 months	Unknown
Decreased spontaneous erection	1-3 months	3-6 months
Decreased sperm production	Unknown	2 years
Breast growth	3-6 months	2-5 years
Decreased testicular volume	3-6 months	Variable
Decreased terminal hair growth	6-12 months	> 3 years
Increased scalp hair	Variable	Variable
Voice changes	None	None

Expected time course of TESTOSTERONE

Effect	Expected onset	Expected max. effect
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	6-12 months	>5 years
Scalp hair loss	6-12 months	>5 years
Increased muscle mass/strength	6-12 months	2-5 years
Body fat redistribution	1-6 months	2-5 years
Cessation of menses	1-6 months	1-2 years
Clitoral enlargement	1-6 months	1-2 years
Vaginal atrophy	1-6 months	1-2 years
Deepening of voice	1-6 months	1-2 years

Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, at https://bit.ly/WPATH_v8

Definition of Gender Dysphoria

In Children and in Adolescents

DSM-5 DEFINITIONS OF GENDER DYSPHORIA

A marked incongruence between one's experienced/ expressed gender and assigned gender, lasting **≥6 months**, as manifested by…

Pediatric (6 or more of the following, one of which must be #1): *

1. **A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)**
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
7. A strong dislike of one's sexual anatomy
8. A strong desire for the physical sex characteristics that match one's experienced gender

Adolescent/Adult (2 or more of the following): *

1. A marked incongruence between one's experienced/expressed gender and 1º and/or 2º sex characteristics (or in young adolescents, anticipated 2º sex characteristics)
2. A strong desire to be rid of one's 1º and/or 2º 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 2º sex characteristics)
3. A strong desire for the 1º and/or 2º sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
6. 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)

*AND condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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VISIT OUTLINE

Making a diagnosis of gender dysphoria may require several visits and a multidisciplinary assessment. Suggested follow-up schedules range from q3m-q6m depending on pubertal stage and individualized medical treatment.

Initial Visit(s)

[ ] Collect a gender history from patient and parents/guardians, including:
- [ ] history of gender identity development,
- [ ] history of disclosure/social transition,
- [ ] presence of dysphoria and current management,
- [ ] interest in future fertility

[ ] Screen for depression (PHQ-A/PHQ-9), anxiety (GAD-7 or SCARED score).
[ ] Perform full H&P, including
- [ ] assessment of pubertal stage & development
  (see "Trauma-Informed Tanner Staging" in Table: Guidelines)
- [ ] social history (HEADDS assessment)

[ ] Assess for diagnosis of gender dysphoria (see Table: DSM-5 Definitions)
[ ] If no current mental health provider, refer for assessment and co-mgmt if desired[1]
[ ] Assess the patient's family, school and other relevant settings (HEADDS) that may be impacted by gender expression, behavior, and identities.

Follow-Up Visits

Pre-pubertal care

[ ] Re-evaluate patient at least every 6 months for psychosocial distress, mental health concerns, social affirmation, and signs of puberty.
[ ] lab monitoring PRN to detect puberty onset: LH (ped)[2], FSH, E, total T, & 25OH-vit D

Pubertal and Post-pubertal care

[ ] Reassess gender dysphoria & patient goals.
[ ] Reassess pubertal stage & development.
[ ] Reassess interest in future fertility
[ ] Screen for depression (PHQ-A/PHQ-9), anxiety (GAD-7 or SCARED score).
[ ] Offer support/guidance for social transition when appropriate
[ ] Monitor non-medical interventions such as binding or tucking for health impact
[ ] Gender-affirming medical tx (blockers/hormones) may be considered ONLY IF:
- [ ] diagnosis of gender dysphoria AND
- [ ] the patient has reached at least Tanner stage 2 of puberty AND
- [ ] patient demonstrates emotional & cognitive maturity required to provide informed consent/assent for the treatment AND
- [ ] parents consent (required for patients younger than 18 years old). If there is dissent between parents, we recommend working to achieve consensus/ acceptance, while supporting adolescents' developing autonomy.

[ ] If currently on medication for puberty suppression, menstrual suppression, or puberty induction, routine monitoring is outlined here: https://bit.ly/TGD_dosing

[1]WPATH SOC8 states: "We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner."
[2]For baseline measurements, use ultrasensitive aka "pediatric" LH. Level >0.3 mIU/mL = puberty starting.