SUMMARY

GOALS

- Assess transgender patients for Gender Dysphoria (GD).
- Monitor patient’s psychological well being and functioning.
- Maintain sex hormone levels that are safe and appropriate for the desired gender when hormones are prescribed for GD.

DIAGNOSTIC CRITERIA

Introduction: The term “transgender” is generally used to describe a diverse group of individuals whose gender identity differs from their sex assigned at birth. 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. Not all transgender individuals will have GD. DSM-5 Gender Dysphoria diagnostic criteria include:

A. A marked incongruence between one’s experienced/expressed gender and assigned (natal) gender of at least six months duration as manifested by at least two of the following:
   - A marked incongruence between one’s experienced/expressed gender and primary (1°) sex characteristics
   - A strong desire to be rid of one’s 1° and/or secondary (2°) sex characteristics b/c of a marked incongruence w/one’s experienced/expressed gender
   - A strong desire for the 1° and/or 2° sex characteristics of the other gender
   - A strong desire to be of the other gender (or some alternative gender different from one’s designated gender)
   - A strong desire to be treated as the other gender (or some alternative gender different from one’s designated gender)
   - A strong conviction one has typical feelings/reactions of the other gender (or alternative gender different from one’s designated gender)

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

EVALUATION

MENTAL HEALTH (MH)
- Assess self-identified transgender patients for GD (Pg. 4); enter the GD diagnosis on the Problem List.
- Rule out co-occurring MH disorders and/or mimics of GD.
- If the patient desires gender affirming hormones, refer to the primary care provider (PCP), if not previously completed.
- Encourage the patient to join a transgender support group, if available.

MEDICAL
- Perform history - focus on past medical history and history of GD hormones/surgery, include review of MH assessment (Pg. 5).
- Perform physical exam (PE) - focus on special considerations (Pg. 6).
- Order baseline labs and manage conditions, if present, before starting hormone therapy (Pg. 6).
- Screen for HIV and HCV; consider risk assessment and screening for asymptomatic sexually transmitted infections (STIs) based on behavioral history/sexual practices.
- Ensure the World Professional Association for Transgender Health (WPATH) criteria are met to be eligible for hormone therapy (Pg. 7).

TREATMENT

PRE-HORMONE THERAPY (for patients who request hormones)
- Discuss realistic goals and expectations of hormone therapy.
- Evaluate for contraindications to therapy (Transwoman Pg. 10, Transman Pg. 21).
- Inform the patient of the risks/benefits of hormone therapy (Transwoman Pg. 15, Transman Pg. 27) and obtain informed consent using a CDCR 7528 (Transwoman) or CDCR 7528-1 (Transman).

SOCIAL/ENVIRONMENTAL/HOUSING
- Refer to a MH clinician if available, advise patient to submit a request for housing to be forwarded to the PREA Compliance Manager (PCM), and contact a Correctional Counselor for gender appropriate allowable clothing and personal property (Transwoman Pg. 11, Transman Pg. 22).

HORMONE MEDICATIONS
- Transwoman: Estrogen/Androgen blockers (Pg. 13). Transman: Testosterone (Pg. 24).

GENDER AFFIRMING SURGERY
- Referral if patient requests and referral criteria met per guidelines (Pg. 29)

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Initial Presentation of Patient – Pg. 4

- If the patient newly identifies and wishes to pursue hormone therapy, refer to MH for a GD assessment.
- If the patient arrives at CDCR on hormones, continue hormones at current doses if in line with current National Guidelines and refer to MH for GD assessment.
- For questions please email m_MSDDetransgenderSupport@cdcr.ca.gov.

Initial Evaluation for Hormone Therapy

1 | Pg. 4  
MH Assessment
- Rule out co-occurring MH disorders and/or mimics of GD
- Assess for GD
- Refer the patient to the PCP if the patient has GD and wishes to be on hormones
- Encourage the patient to join a transgender support group, if available

2A | Pg. 5  
Medical Provider History
- Perform History - Focus on past medical history, history of GD hormones/surgery, etc.
- Review MH Assessment - GD diagnosis and psychiatric history

2B | Pg. 6  
Medical Provider Physical Exam
- Unless an immediate medical need, sensitive elements of the exam (breast, pelvic, and rectal) can be delayed until provider-patient rapport has developed
- Perform a routine physical examination - Focus on special considerations, etc.

3 | Pg. 6  
Baseline Labs
- Order labs and manage conditions, if present, before starting hormone therapy
- Screen for HIV, HCV, HBV, if clinically indicated
- Consider risk assessment and screening for asymptomatic STIs based on behavioral history and sexual practices

4 | Pg. 7  
Eligibility For Hormone Therapy
- Ensure the patient is eligible for hormone therapy using WPATH criteria

Reference Below When Indicated

Transwoman Pg. 18  Transman Pg. 27
Special Circumstances
See recommended treatment for patients with special circumstances

Transwoman Pg. 19  Transman Pg. 28
Refer to Specialist
Refer patient to a Transgender Specialist or Endocrinologist, as clinically indicated

Treatment and Monitoring

5 | Transwoman Pg. 8  Transman Pg. 20
Goals & Expectations
- Review the realistic goals of hormone therapy
- Help the patient understand that changes are individual

6 | Transwoman Pg. 9  Transman Pg. 21
Baseline Labs
- Review baseline labs to determine any current or previous health problems that may pose risk to therapy

7 | Transwoman Pg. 10  Transman Pg. 21
Contraindications & Risks
- If any absolute contraindications are present, do not continue with hormone therapy
- Review potential risks with patients that are at very high or moderate to high risk of adverse effects

8 | Transwoman Pg. 10  Transman Pg. 22
Adverse Effects & Consent
- Discuss the potential risks and benefits of hormone therapy
- Obtain consent using CDCR 7528 (Transwoman) or CDCR 7528-1 (Transman)

9 | Transwoman Pg. 11  Transman Pg. 22
Social/Environmental
- Offer referral to an MH clinician
- Inform the patient to work with a Correctional Counselor to obtain appropriate housing and accommodations

10 | Transwoman Pg. 12  Transman Pg. 23
Order Medications
- Review common approaches and titration of hormones
- Use appropriate Transwoman/Transman PowerPlan

11 | Transwoman Pg. 15  Transman Pg. 25
Monitoring and Follow-Up
- Monitor physical, labs, and hormone levels
- Follow-up on the patient’s hormone effects, lifestyle, and psychosocial impacts

12 | Transwoman Pg. 17  Transman Pg. 27
Preventive Screening
- Conduct preventive screening, as clinically indicated

Transwoman Pg. 29
Consideration for Gender Affirming Surgery
Referral if desired and referral criteria meet per guidelines
# CCHCS/DHCS Care Guide: Transgender

## Summary

### Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Assigned at Birth</td>
<td>GLAAD Media Reference Guide: The designation of a person as male, female, or intersex. At birth, infants are often assigned a sex, usually based on the appearance of their external anatomy (this is what is written on the birth certificate). A person's sex, however, is actually a combination of bodily characteristics including: chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>Male, Female, Non-Binary</td>
</tr>
<tr>
<td>Gender Expression or Role</td>
<td></td>
</tr>
<tr>
<td>Gender Non-Conforming</td>
<td></td>
</tr>
<tr>
<td>Transgender (adj.)</td>
<td></td>
</tr>
<tr>
<td>Transgender man/ transman</td>
<td>A person whose sex assigned at birth was female, but understands oneself to be male.</td>
</tr>
<tr>
<td>Transgender woman/ transwoman</td>
<td>A person whose sex assigned at birth was male, but understands oneself to be female.</td>
</tr>
<tr>
<td>Transition</td>
<td>GLAAD Media Reference Guide: Altering one’s birth sex is not a one-step procedure; it is a complex process that occurs over a long period of time. Transition can include some or all of the following: personal, medical, and legal steps; telling one's family, friends, and co-workers; using a different name and new pronouns; dressing differently; changing one's name and/or sex on legal documents; hormone therapy; and possibly (though not always) one or more types of surgery. The exact steps involved in transition vary from person to person. Avoid the phrase &quot;sex change&quot;.</td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>WPATH: 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 1° and 2° sex characteristics).</td>
</tr>
<tr>
<td>Cisgender</td>
<td>GLAAD Media Reference Guide: A term used by some to describe people who are not transgender. &quot;Cis-&quot; is a Latin prefix meaning &quot;on the same side as,&quot; and is therefore an antonym of &quot;trans-.&quot;</td>
</tr>
<tr>
<td>Non-binary and/or Genderqueer</td>
<td>GLAAD Media Reference Guide: Terms used by some people who experience their gender identity and/or gender expression as falling outside the categories of man and woman. They may define their gender as falling somewhere in between man and woman, or they may define it as wholly different from these terms. The term is not a synonym for transgender and should only be used if someone self-identifies as non-binary and/or genderqueer.</td>
</tr>
<tr>
<td>Intersex</td>
<td>CDCR DOM: An individual born with external genitalia, internal reproductive organs, chromosome patterns, and/or endocrine systems that do not seem to fit typical definitions of male or female. A morphological and physiological anomaly where an individual is born with &quot;congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical&quot;. In essence, the reproductive organs differ from those typically associated as being male or female (e.g., ambiguous genitalia) AKA Disorders of Sex Development (DSD). Hermaphrodite is an outdated term.</td>
</tr>
</tbody>
</table>

## Decision Support

## Patient Education/Self Management
### INITIAL PRESENTATION OF PATIENT

Many transgender people may avoid seeking or continuing care due to prior discrimination or disrespect in a clinic setting. As such, it is essential to provide a welcoming clinic environment to ensure CCHCS transgender patients are comfortable seeking care when issues arise and also when returning for scheduled follow-up visits. Often, transgender patients will first present to medical for treatment of GD by requesting hormone therapy.

- PCPs should refer to transgender patients by the name and pronoun that the patient indicates is correct for them (Transwoman: She, her, hers; Transman: He, him, his, etc.; Non-binary gender identity: they, them, theirs, etc.). If unsure, ask the patient, “What pronoun is correct for you?”

- Not all individuals identifying as transgender have GD. That said, many clinicians report that most transgender individuals experience some degree of dysphoria in the absence of treatment. Without treatment, this population may experience higher rates of depression, anxiety, and suicidality.

- If a patient newly self-identifies as transgender, an initial referral to MH is done to evaluate for GD, then a referral to the PCP for evaluation for hormone therapy, if desired. The patient’s PCP can typically complete the evaluation and order labs and is able to start and manage hormone therapy. Alternatively, the patient can be referred to a contracted provider (typically an endocrinologist) via telemedicine.

- For questions please email m_MSDTransgenderSupport@cdcr.ca.gov.

### STEP 1: MENTAL HEALTH ASSESSMENT

The patient should receive an MH assessment for GD before considering starting gender affirming treatment. Typically the following areas are covered:

- **HISTORY** - The MH clinician rules out co-occurring MH disorders that may complicate GD treatment. In addition, the MH clinician rules out mimics of GD, including factitious disorder, borderline personality, malingering and psychosis, and will assess the patient for the following:
  - Patient’s history of MH diagnoses (past and present)
  - Presence of MH diagnoses that mimic GD or contribute to the patient’s dysphoria
  - Relevant background information on GD
  - Abuse and neglect history
  - Substance Use Disorder (past and present)
  - Trauma/PTSD
  - Psychological conditions which may preclude medical treatment of GD
    - Self-injurious behaviors
    - Suicidal behaviors (including ideation, gestures, or attempts)
    - Potential sexual violence or related violent behaviors

- **DIAGNOSIS** - According to the American Psychiatric Association (APA), the name change to GD, rather than Gender Identity Disorder “remove(s) the connotation that the patient is ‘disordered’.” The change…“offer(s) a diagnostic name that is more appropriate to the symptoms and behavior…”

  - **DSM-5 Gender Dysphoria** diagnostic criteria include:
    - A marked incongruence between one’s experienced/expressed gender and assigned (natal) gender of at least 6 months in duration, as manifested by at least 2 of the following:
      - A marked incongruence between one’s experienced/expressed gender and 1° and/or 2° sex characteristics
      - A strong desire to be rid of one’s 1° and/or 2° sex characteristics because of a marked incongruence with one’s experienced/expressed gender
      - A strong desire for the 1° and/or 2° sex characteristics of the other gender
      - A strong desire to be the other gender (or some alternative gender different from one’s designated gender)
      - A strong desire to be treated as other gender (or some alternative gender different from 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)
    - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- Following the MH assessment, if the patient is found to have GD and wishes to pursue treatment, refer the patient to the PCP for evaluation for hormone use.

- Encourage the patient to join a transgender support group, if available.
INITIAL EVALUATION FOR HORMONE THERAPY

STEP 2A: MEDICAL PROVIDER - HISTORY

Transgender patients are evaluated much like any other patient. Below are some targeted history elements that should be obtained for these patients. These patients frequently had challenging experiences attempting to obtain health care and may be understandably sensitive when staff do not address them with their correct name and/or pronouns. Many patients have experienced trauma in their lives and utilizing the five guiding principles of trauma informed care (safety, choice, collaboration, trustworthiness, and empowerment) can help the patient feel safer in the health care setting and result in a better patient-provider interaction.

History is focused on determining the safety of prescribing (or continuing) gender affirming hormones as well as identifying and treating any existing STIs.

**HISTORY** – The PCP rules out medical mimics of GD, and conditions that preclude hormone therapy. Otherwise, the approach to taking history is similar to that of non-transgender patients, but should specifically include:

- **Detailed past medical history (PMH),** assessing for coronary artery disease or cerebrovascular disease, arterial or venous thromboembolism (VTE)/pulmonary embolism, liver disease, hypertension, diabetes (DM), breast or uterine cancer, erythrocytosis (transman), pituitary adenomas (transwoman), Human Immunodeficiency Virus (HIV) testing and/or infection with other STIs.
- **Gender-related hormonal and surgical interventions**
  - Past hormone use or body modifications:
    - Medically supervised or unsupervised (from internet or street)
    - Injectable silicone
  - Current status. Enter all GD-related surgeries in “Procedures” - EHRS, if not already noted.
  - Plans to pursue gender affirming hormone therapy or gender affirming surgery
- **Reproductive history** (can be a sensitive issue for GD patients)
  - GYN and OB histories are important in transmen (pregnancy is a contraindication to testosterone use)
  - Fertility and birth control
    - Transmen who are sexually active with partners w/sperm; review contraceptive options (progesterone-only oral contraceptive or IUD)
    - Transwomen sexually active with partners who may become pregnant; consider barrier methods, etc.
  - History of polycystic ovarian syndrome (PCOS) and hyperandrogenism prior to transitioning
- **Sexual history** (can also be a sensitive issue for patients and should be initiated gradually)
  - Sexual history should cover:
    - Sexual function, unprotected receptive, both consensual and nonconsensual, anal intercourse
    - STIs (including HIV, Human Papillomavirus, etc.)/sex work
    - Unintended pregnancy (transman)
- **Sexual risk assessment**
  - Current or previous male, female, or transgender partners
  - Assess current STI status and if possible, future STI risk
- **Social History**
  - Substance abuse (can lead to high-risk sexual behavior resulting in HIV and STIs)
  - Refer to MH clinician for:
    - Social isolation, rejection by family or community of origin
    - Harassment or discrimination; ensure the patient works with custody if there are any safety concerns
- **Family History**
  - Any cancer, cardiovascular disease, DM, blood clotting disorders, or liver disease
  - Transmen with known or suspected genetic mutations for breast or ovarian cancer should be referred for genetic counseling
- **CDCR 7385, Authorization for Release of Protected Health Information (ROI)**
  - Ensure continuity of care from the community by obtaining applicable health records, when appropriate.

**REVIEW MH EVALUATION**

- **Diagnosis of GD:** Confirm the patient has a diagnosis of GD (if requesting hormone therapy).

**Note:** Be sure to enter GD-related diagnoses in the Consolidated Problems section of the EHRS PCP Workflow, if not already done. See page 7 for diagnoses.
INITIAL EVALUATION FOR HORMONE THERAPY

STEP 2B: MEDICAL PROVIDER - PHYSICAL EXAM

PHYSICAL EXAM – Regardless of the gender identity of the patient, PEs should be based on the external and internal sex organs present and the patient’s presenting symptoms. Transgender patients may be uncomfortable with their bodies and find aspects of the Physical Exam (PE) traumatic.

- Unless there is an immediate medical need, sensitive elements of the exam (particularly breast, pelvic, and rectal exams) can be delayed until the provider-patient rapport has developed.
- A complete PE, breast, and genital exam is not required for the initiation of hormone therapy, but its importance in screening for health problems and a plan for a future examination/evaluation should be discussed. The PE should always follow a patient-centered approach, keeping in mind that some patients may have extreme discomfort with their bodies and find some elements of a PE traumatic.
- Patients who have undergone gender affirming surgery may have varying PE findings depending on the procedures performed, approaches used, and occurrence of complications.
- In addition to a routine PE, please note the following:

  ⇒ Transwoman Special Considerations: Genitourinary:
    - Tucking of testicles and penis - May lead to hernias/other complications at the external inguinal ring or skin breakdown at the perineum. A thorough history and education is recommended for all transwomen.
    - Vaginal exams in post-surgical transwomen - The anatomy of a neovagina created in a transwoman differs from a natal vagina in that it is a blind cuff, lacks a cervix or surrounding fornices, and may have a more posterior orientation. As such, using an anoscope may be a more anatomically appropriate approach for a visual examination. The anoscope can be inserted, the trocar removed, and the vaginal walls visualized collapsing around the end of the anoscope as it is withdrawn.

  ⇒ Transman Special Considerations: Genitourinary:
    - Conducting a pelvic examination with transmen - The pelvic exam may be a traumatic and anxiety inducing procedure for transmen and other trans-masculine persons. Transmen patients are less likely to be up to date on cervical cancer screenings and have a higher rate of inadequate cytologic sampling.
    - Should the patient express distress or concern about the examination, it may be deferred until a later date once a trusting relationship has been developed.
    - Various techniques can be used to make a pelvic examination (including bimanual and/or speculum exam) less uncomfortable such as:
      - Discuss procedures with the patient beforehand including the order in which steps will occur and reminding the patient that the exam can be stopped at any time at their request.
      - If the patient experiences pain during examination, an estradiol vaginal cream can be prescribed for 2 to 3 weeks prior to the examination and discontinued after the examination.
    - When appropriate and indicated, findings suggestive of intersex conditions (e.g., ambiguous genitalia) should be evaluated by an endocrinologist (e.g., clitoromegaly patient with female phenotype). Transwoman Page 19, Transman Page 28

STEP 3: ORDER BASELINE LABS

Laboratory tests should reveal any existing health problems such as liver dysfunction, high cholesterol, or DM. If present, these conditions should ideally be managed prior to starting hormones. The values will also provide a useful baseline to help with future monitoring for endocrine changes.

- Screen all transgender patients at least once for HIV. After initial screening of all patients, a repeat screening is based on HIV risk assessment. **Effective risk assessment requires the ability to obtain an accurate sexual history that includes anatomy-specific sexual behavior.**
- Screen for the hepatitis B virus (HBV), gonorrhea, chlamydia, and syphilis.
- Screen for the hepatitis C virus (HCV) risk factors and do antibody screen per current guidelines.
- Consider risk assessment and screening for asymptomatic STIs based on behavioral history and sexual practices. Screening intervals should be based on risk, with screening every three months in individuals at high risk (multiple partners, condomless sex, transactional sex/sex work, sex while intoxicated).

### Baseline Labs In Addition To Above

<table>
<thead>
<tr>
<th>All Patients</th>
<th>Transwoman Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC, serum creatinine and potassium</td>
<td>Fasting lipid panel</td>
</tr>
<tr>
<td>Liver function tests (LFTs)</td>
<td>Total testosterone level</td>
</tr>
<tr>
<td>A1C (if diabetic)</td>
<td>Estradiol level</td>
</tr>
<tr>
<td>Fasting glucose (if family history of DM)</td>
<td>Thyroid Stimulating Hormone (TSH)</td>
</tr>
<tr>
<td></td>
<td>Prolactin level</td>
</tr>
</tbody>
</table>
Although the decision to implement treatment with hormones for a transgender person is individualized, there are common guidelines. These guidelines are designed to maximize the safety of the patient, fulfill the legal and ethical requirements of the PCP, and reduce the possibility of inappropriate treatment.

**WPATH Criteria:** Identifies four eligibility criteria for hormone therapy but also emphasizes the need for individualized treatment plans that may include hormone therapy in selected cases that do not meet all four criteria. The WPATH criteria are as follows:

1. Gender Dysphoria that is persistent and documented
2. Medical and/or mental health conditions, if present, are reasonably well-controlled
3. Legal age of majority (18 years in California)
4. Informed consent

The presence of coexisting mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to, or concurrent with, treatment of GD.

Ensure the absence of absolute contraindications to hormone therapy. Transwoman Page 10, Transman Page 21

### Diagnoses in EHRS

The following “Diagnoses” are available in the EHRS to help document the patient’s condition/status, in addition to GD that would typically be listed.

<table>
<thead>
<tr>
<th>Term</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrine disorder in female-to-male transgender person</td>
<td>61491908</td>
</tr>
<tr>
<td>Endocrine disorder in male-to-female transgender person</td>
<td>61491873</td>
</tr>
<tr>
<td>Female-to-male transgender person</td>
<td>61491874</td>
</tr>
<tr>
<td>Hormonal imbalance in transgender patient</td>
<td>1525569</td>
</tr>
<tr>
<td>Male-to-female transgender person</td>
<td>61491875</td>
</tr>
<tr>
<td>Transgender</td>
<td>10067958</td>
</tr>
<tr>
<td>Transgender with history of sex reassignment surgery</td>
<td>68837711</td>
</tr>
<tr>
<td>Transgender, S/P sex reassignment surgery</td>
<td>68837718</td>
</tr>
<tr>
<td>Transgender, status post sex reassignment surgery</td>
<td>68837739</td>
</tr>
</tbody>
</table>

**Note:**

Thus far the evaluation of the patients has been the same for Transwomen and Transmen.

In the following pages, the steps for the treatment and monitoring of transgender patients are divided into two sections: Transwoman (Pages 8-19) and Transman (Pages 20-28).
TREATMENT AND MONITORING (INDIVIDUALIZED PATIENT APPROACH)

STEP 5: TRANSWOMAN THE GOALS AND EXPECTATIONS OF HORMONE THERAPY

Transwoman: A person whose sex assigned at birth was male, but understands oneself to be female.

The PCP should cover the following topics when discussing gender affirming hormone therapy with patients.

♦ What are the goals of hormone therapy?
Patients need to have realistic goals of what may be accomplished with hormone therapy. In the past, some patients have had the mistaken belief that changes will occur quickly and have had unrealistic expectations of what changes will occur. When disappointed with the timing or degree of changes, some patients have wanted to increase the dose of their hormone beyond what is considered to be a safe dose range.

Expected Effects of Feminizing Hormones (Estrogen and Androgen Blockers)

<table>
<thead>
<tr>
<th>General effects include:</th>
<th>Sexual and gonadal effects include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suppress endogenous birth-gender hormone production</td>
<td>• Reduction in erectile function</td>
</tr>
<tr>
<td>• Induce secondary sex characteristics of new gender</td>
<td>• Changes in libido</td>
</tr>
<tr>
<td>• Breast development (usually to Tanner stage 2 or 3)</td>
<td>• Reduced or absent sperm count and ejaculatory fluid</td>
</tr>
<tr>
<td>• Redistribution of facial and body subcutaneous fat</td>
<td>• Reduced testicular size</td>
</tr>
<tr>
<td>• Reduction of muscle mass</td>
<td></td>
</tr>
<tr>
<td>• Reduction of body hair (and to a lesser extent, facial hair)</td>
<td></td>
</tr>
<tr>
<td>• Change in sweat and odor patterns</td>
<td></td>
</tr>
<tr>
<td>• Arrest and possible reversal of scalp hair loss</td>
<td></td>
</tr>
<tr>
<td>• Changes in emotional and social functioning</td>
<td></td>
</tr>
<tr>
<td>• Feminizing hormones do not affect the pitch of the voice in transwomen</td>
<td></td>
</tr>
</tbody>
</table>

♦ What is the expected timing of the response?
Help the patient understand that changes are individual and will take place over months to years, with most changes being complete by 3 years of treatment.

Increased doses beyond max recommended dose is not indicated and will not result in additional changes.

<table>
<thead>
<tr>
<th>Time Needed To See Feminizing Effects Of Medication (Estrogen &amp; Androgen Blockers)11</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect</td>
<td>Onset</td>
</tr>
<tr>
<td>Redistribution of body fat</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Decrease in muscle mass and strength</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Softening of skin/decreased oiliness</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Decreased sexual desire</td>
<td>1-3 months</td>
</tr>
<tr>
<td>Decrease spontaneous erections</td>
<td>1-3 months</td>
</tr>
<tr>
<td>Male sexual dysfunction</td>
<td>Variable</td>
</tr>
<tr>
<td>Breast growth</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Decreased testicular volume</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Decreased sperm production</td>
<td>Unknown</td>
</tr>
<tr>
<td>Decreased terminal hair growth</td>
<td>6-12 months</td>
</tr>
<tr>
<td>Scalp hair</td>
<td>Variable</td>
</tr>
<tr>
<td>Voice changes</td>
<td>None</td>
</tr>
</tbody>
</table>
### CCHCS/DHCS Care Guide: Transgender

**TREATMENT AND MONITORING (INDIVIDUALIZED PATIENT APPROACH)**

#### STEP 6: TRANSWOMAN REVIEW BASELINE LABS

Obtain the following baseline labs to determine the patient’s current health and identify any health problems that may pose immediate or future risk to estrogen therapy.

| **CBC, Serum Creatinine, and Potassium** | • Estrogens inhibit erythropoiesis; hemoglobin and hematocrit (H&H) may drop after initiating estrogen therapy.  
• For patients using spironolactone, serum potassium and renal function should be monitored for development of hyperkalemia. |
| **Liver Function Tests (LFTs)** | • Estrogen use may be associated with transient liver enzyme elevations and rarely clinical hepatotoxicity.  
• Seek consultation if increase LFTs ≥ 3x baseline.  
• Estrogen use increases the risk of cholelithiasis and subsequent cholecystectomy. |
| **A1C (If diabetic)** | • The effect of hormone therapy on DM risk/disease course is unclear.  
• A study of the effects of gender affirming hormones on insulin resistance found that transwomen may experience some increase in markers of insulin resistance.  
• WPATH Standards of Care recommend that conditions such as DM be “reasonably well controlled” prior to initiating hormone therapy. |
| **Fasting Glucose (If family history of DM)** | • Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.  
• Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol. |
| **Fasting Lipid Panel (Based on USPTF Guidelines)** | • Estrogen is known to increase serum thyroid-binding globulin concentration which may cause reduction in free thyroxine available for hormone activity. This will lead to an increase in serum TSH. |
| **Thyroid Stimulating Hormone** | • The normal range of total testosterone levels is 250-1000 ng/dL in sex at birth males age 18-69.  
• The goal for transwoman is to suppress testosterone level to less than 50-55 ng/dL. |
| **Estradiol Level** | • For adult sex at birth male, estradiol level is between 25-50 pg/mL.  
• The goal for transwoman is 100-200 pg/mL. |
| **Prolactin Level** | • Normal sex at birth male level is 2-25 ng/mL.  
• Estrogen therapy can increase the growth of pituitary lactotroph cells.  
• If increased, consult with an Endocrinologist whether to continue estrogen or not.  
• If persistently elevated, consider possible pituitary adenoma; obtain an MRI.  
• **Note:** Psychotropic meds can increase prolactin. |
STEP 7: TRANSWOMAN CONTRAINDICATIONS AND POTENTIAL RISKS OF HORMONE THERAPY

**Absolute contraindications:**
Psychiatric conditions which limit the ability to provide informed consent.

The following patients are at a very high risk of adverse effects:
Consider referral to a contracted provider (typically an endocrinologist) via telemedicine.

- Unstable ischemic cardiovascular disease
- Estrogen-dependent cancer
- End stage chronic liver disease
- Hypersensitivity to one of the components of the hormone formulation
- History of thromboembolic disease
- History of or current hormone-sensitive cancer, such as prostate cancer

The following patients are at a moderate to high risk of adverse effects:
Proceed with caution considering risks versus benefits and utilizing shared decision-making.

- History of prolactinoma
- History of breast cancer (non-estrogen dependent)
- Significant liver disease (transaminases increase > 3 X)
- History of or current hormone-sensitive cancer, such as prostate cancer
- History of cerebrovascular disease
- History of coronary artery disease
- History of severe migraine headaches

STEP 8: TRANSWOMAN POTENTIAL ADVERSE EFFECTS & INFORMED CONSENT

Estrogen has a more serious risk profile as compared to other medications used in transgender individuals. Although each hormone will have its own specific considerations and precautions, it is worthwhile to address general considerations and precautions with hormone use.

Estrogen should be used with **CAUTION**, after risks/benefits discussion with the patient if:

- Obese
- Smokes cigarettes, tobacco, other nicotine
- Migraines or seizures
- High cholesterol
- High blood pressure (BP)
- Has a strong family history of breast cancer or other estrogen sensitive cancers
- Heart disease, heart valve problems, or tendency to have blood clots, kidney or liver disease

Estrogen can:

- Increase risk of blood clots that can cause heart attacks, strokes, lung/leg blood clots
- Increase fat around internal organs which can increase risk for DM and heart disease
- Increase BP
- Increase risk of getting gallstones or cause nausea and vomiting
- Cause damage to liver
- Cause headaches or migraines
- Increase the risk of prolactinomas
- Cause temporary or permanent loss of fertility

PCPs should use the **CDCR 7528, Feminizing Hormone Therapy Consent** form and ensure the patient understands the risks associated with use of estrogen and androgen blockers and all questions are answered.

Hormone therapy is expected to be life changing and may result in some irreversible effects. The process of sharing in the decision-making involves developing a partnership, exchanging information about the available options, deliberating while considering the potential consequences of each one, and making a decision by consensus. The informed consent for hormone therapy is a decision aid that includes the before mentioned information to help patients make a well-informed decision that reflects their values and goals with their PCP.
During the course of treatment, a patient’s housing may be reevaluated and the patient may be transferred to a different facility.

A request from the patient via Gender Identity Questionnaire, Form 22, note, etc., to be housed consistent with their gender identity, shall be forwarded to the PCM.

Advise the patient to work with a Correctional Counselor to obtain gender appropriate accommodations per the DOM.

Offer referral to an MH clinician if GD continues or patient reports social or other challenges due to transitioning.

In designated male institutions, transwomen are typically allowed the following personal items, which may vary with custody level and security status or may vary somewhat between institutions.

Sample List of Allowable Clothing (Varies by institution and other security factors)

<table>
<thead>
<tr>
<th>General Population Levels I, II, III, IV</th>
<th>SHU / PSU</th>
<th>ASU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brassieres</td>
<td>Brassieres</td>
<td>Brassieres</td>
</tr>
<tr>
<td>Panties</td>
<td>Panties</td>
<td>Panties</td>
</tr>
<tr>
<td>Sandals</td>
<td>T-Shirts</td>
<td></td>
</tr>
<tr>
<td>T-Shirts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking Shoes</td>
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</tr>
</tbody>
</table>

Sample List of Allowable Hygiene Items (Varies by institution and other security factors)

<table>
<thead>
<tr>
<th>General Population Levels I, II, III, IV</th>
<th>SHU / PSU</th>
<th>ASU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Splash</td>
<td>Foundation</td>
<td></td>
</tr>
<tr>
<td>Blush</td>
<td>Hair Gel, Spray, Gel Curl, Braid Spray and Lock Gel</td>
<td>Facial Cleanser</td>
</tr>
<tr>
<td>Cotton Balls</td>
<td>Hair Rollers</td>
<td>Feminine Hygiene Wash</td>
</tr>
<tr>
<td>Emery Board</td>
<td>Lip Gloss/Lipstick/Lip Liner</td>
<td>Hair Gel, Spray, and Gel Curl, Braid Spray and Lock Gel</td>
</tr>
<tr>
<td>Eyebrow Pencil/Eyeliner</td>
<td>Mascara</td>
<td></td>
</tr>
<tr>
<td>Eye Shadow Kit</td>
<td>Pumice Bar/Sponge</td>
<td></td>
</tr>
<tr>
<td>Fabric Softener</td>
<td>Scrunchies</td>
<td></td>
</tr>
<tr>
<td>Face Powder</td>
<td>Shower Bag</td>
<td></td>
</tr>
<tr>
<td>Facial</td>
<td>Shower Cap</td>
<td></td>
</tr>
<tr>
<td>Facial Cleanser</td>
<td>Shower Puffs/Loofahs</td>
<td></td>
</tr>
<tr>
<td>Feminine Hygiene Wash</td>
<td>Tweezers</td>
<td></td>
</tr>
</tbody>
</table>
Prescriber: Prescribing gender affirming hormones is well within the scope of a range of PCPs including medical doctors, nurse practitioners, physician assistants, obstetricians-gynecologists, and endocrinologists. Most medications used in gender affirming hormone therapy are commonly used substances with which most prescribers are already familiar due to their use in the management of menopause, hirsutism, prostatism, or abnormal uterine bleeding. There have been no well-designed studies of the role of progestogens in feminizing hormone regimens.

Estrogen
- The primary class of estrogen used for feminizing therapy is 17-beta estradiol (estradiol), which is a “bioidentical” hormone in that it is chemically identical to that from a human ovary.
- The general approach is similar to estrogen replacement in agonadal (i.e., Turner syndrome) or menopausal states, with some dosing modifications.
- Estradiol is most commonly delivered to transwomen via a transdermal patch, oral or sublingual tablet, or injection of a conjugated ester (estradiol valerate or estradiol cypionate). In CCHCS, injectable estradiol valerate is the preferred agent.

Androgen Blockers – Common Approaches
- Suppression of testosterone production and blocking of its effects contributes to the suppression/minimization of male secondary sexual characteristics. Unfortunately, many of these characteristics are permanent upon completion of natal puberty and are irreversible.
- Androgen blockers allow the use of lower estradiol dosing.
- Spironolactone is the most commonly used androgen blocker in the U.S. Spironolactone is a K+ sparing diuretic, which in higher doses also has direct anti-androgen receptor activity as well as a suppressive effect on testosterone synthesis.
  - Doses of 200-400 mg daily have been reported without negative effect.
  - Hyperkalemia is the most serious risk but is very uncommon when precaution is taken to avoid use in individuals with renal insufficiency, and used with caution/frequent monitoring in those on angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blockers (ARBs).
  - Due to its diuretic effect, patients may experience self-limited polyuria, polydipsia, or orthostasis.
- Finasteride blocks 5-alpha reductase type 2/3 mediated conversion of testosterone to potent androgen dihydrotestosterone.
  - Finasteride 1 mg daily is FDA-approved for male pattern baldness, while the 5 mg dose is approved for management of prostatic hypertrophy.
  - Since these medications block neither the production nor action of testosterone, their antiandrogen effect is less than that encountered with full blockade.
  - 5-alpha reductase inhibitors may be a good choice for those unable to tolerate, or with contraindications to the use of spironolactone.

Titration
- Titration upwards of dose should be driven by patient goals, clinical response, hormone level monitoring, and safety monitoring (e.g., presence of risk factors such as smoking, renal function and K+ in patients using spironolactone).
- A general approach for titration would include increasing of both estrogen and antiandrogen dosing until the estrogen level is in the female physiologic range.
  - Once this has been achieved, titration efforts can focus on increasing androgen blockade.
  - Starting dose of estrogen can be maintained for 1-2 months after which a dose increase can be considered barring any concerning effects.
  - Physical changes related to androgen blockade and estrogen may take months to appear and are generally considered to be complete after 2-3 years on hormone therapy. Many patients eager to begin maximal feminizing hormone therapy are opposed to the idea of slow upward titration.
    - Weak evidence suggests that initiation of estrogen therapy at lower doses and titrating up over time may result in enhanced breast development in transwomen.
    - The estrogen receptor agonist activity of spironolactone may play a role in reduced breast development due to premature breast bud fusion.
    - As such, an escalating regimen beginning with low dose estrogen only, and titrating up over several months, and then adding spironolactone may be an alternative approach. Upward titration of spironolactone can also help minimize side effects such as orthostasis or polyuria. It is recommended that PCPs discuss these considerations with patients before initiation of hormones in order to make an informed decision.
**TREATMENT AND MONITORING (INDIVIDUALIZED PATIENT APPROACH)**

<table>
<thead>
<tr>
<th>Summary</th>
<th>Decision Support</th>
<th>Patient Education/Self Management</th>
</tr>
</thead>
</table>

**STEP 10: TRANSWOMAN ORDER MEDICATIONS**

- To order medication(s), use the Transgender Feminizing Therapy PowerPlan.
- In order to achieve adequate suppression of androgens, estrogen alone would need to be administered in higher doses, with associated increased risks. Thus, the combination of an androgen blocker and estrogen is the preferred approach.
- Note that parenteral (IM) administration, typically with estradiol valerate, is preferred.
- For patients over 50 years old who have been on estrogen for several years, doses may be reduced to those administered to post-menopausal non-transgender women (i.e., 0.025-0.05 mg patch). For transwomen starting transition over 50 years old, an ‘active period’ of treatment with suggested doses used for younger transwomen may be considered following a thorough assessment and discussion of relative risks and benefits. See Page 18 - Special Circumstances.

### Medication Class

<table>
<thead>
<tr>
<th>Medication*</th>
<th>Effects / Adverse Effects / Drug Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
</table>

#### Estrogen

**Parenteral**

- Estradiol valerate (Delestrogen®)
  - 20 mg/mL, 40 mg/mL
  - **$-$-$-$-$**

  Estradiol cypionate (IM only)
  - 2.5-10 mg IM every 2 weeks
  - **Initial Dose:** 2.5 mg IM every 2 weeks
  - **Maximum Dose:** Typically 5 mg IM every 2 weeks

  Estradiol cypionate (IM only)
  - 5 mg/mL in oil for injection
  - **$-$-$-$-$**

**Oral Estradiol**

- (Estrace®)
  - 0.5 mg, 1 mg, 2 mg
  - **$-$-$-$-$**

**Transdermal Estradiol Weekly Patch**

- (Climara®, Vivelle dot®, Minivelle®)
  - 0.025 mg/24h, 0.0375 mg/24h, 0.05 mg/24h, 0.06 mg/24h, 0.075 mg/24h, 0.1 mg/24h
  - **$-$-$-$-$-$**

#### Effects / Adverse Effects / Drug Interactions*

- Estradiol levels/effects may be ↓ by:
  - Erythromycin, clarithromycin, azole antifungals, calcium channel blockers (verapamil, diltiazem), Lisoniazid, vitamin C,
  - fluoxetine, fluvoxamine, paroxetine, nefazodone, sertraline, some HIV medications (efavirenz, indinavir, saquinavir, atazanavir, cimetidine)

- Estradiol levels/effects may be ↑ by:
  - Anticonvulsants (carbamazepine, oxcarbazepine, phenytoin, phenobarbital, topiramate), rifampin, rifapentine, etravirine, dexamethasone, some HIV medications (lopinavir/ritonavir, ritonavir, tipranavir, darunavir, nevirapine)

#### Adverse Effects:

- Abdominal pain, back pain, headache, n/v, diarrhea, fluid retention, pruritus, skin irritation, weight gain, breast pain/tenderness, URI, DVT, VTE, pulmonary embolism, rash, urticaria.

**Black Box Warning for Estradiol:**

- Estrogens increase the risk of endometrial cancer; monitor for abnormal vaginal bleeding. Estrogens with or without progestins should not be used for the prevention of cardiovascular disease. Increased risks of myocardial infarction, stroke, invasive breast cancer, pulmonary embolism, deep vein thrombosis in postmenopausal women (50 to 79 years of age) have been reported. An increased risk of developing probable dementia in postmenopausal women 65 years of age or older has also been reported.

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*See prescribing information for complete description of contraindications/precautions, adverse effects and drug interactions. The cost scale $-$-$-$-$-$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.*
<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Medication*</th>
<th>Effects / Adverse Effects / Drug Interactions</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Androgen Blockers</td>
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</table>

**Spironolactone (Aldactone®)**

- **Dose:** 100-200 mg orally twice daily
- **Initial Dose:** 50 mg orally twice daily
- **Standard Dose:** 100 mg orally twice daily

**Renal Impairment:**

- CrCl ≥ 10 mL/min: No dosage adjustment needed. Monitor renal function closely as hyperkalemia is more likely to occur in patients with renal impairment.
- CrCl < 10 mL/min: Avoid use

**Heart Failure Patients:**

- CrCl 30-49 mL/min: Clinical practice guidelines recommended 12.5 mg orally once daily or every other day for the first 4 weeks followed by 12.5 to 25 mg orally once daily.
- CrCl < 30 mL/min: Avoid use

**Hepatic Impairment:**

- Per mfg. labeling initiate in the hospital

- **Adverse reactions:** gynecomastia, breast pain, diarrhea, fever, nausea, vomiting, GI bleeding, gastritis, gastric ulcer, somnolence, hyperkalemia - may be severe, hyponatremia, hyperuricemia, electrolyte imbalance, metabolic acidosis, gout, lethargy, muscle cramps, headache, abdominal cramps, confusion, dizziness, rash, blood dyscrasias / agranulocytosis, gastritis, hypersensitivity reactions, anaphylaxis, vasculitis, renal failure, hepatotoxicity, Stevens-Johnson syndrome, SLE, severe dermatologic conditions, dehydration

- **Drug Interactions:** concomitant triamterene, eplerenone and/or amiloride (contraindicated), ACEIs, ARBs, heparin, lithium, NSAIDs, corticosteroids, digoxin, trimethoprim, MAOIs, amikacin, lofexidine, warfarin, chlorofarabine

- **Black Box Warning:** Shown to be a tumorigen in chronic toxicity animal studies. Avoid unnecessary use

- **Contraindications:** Acute renal insufficiency and/or potassium > 5.5 mEq/dl, anuria, Addison’s disease, concomitant eplerenone, amiloride, and/or triamterene use, hypersensitivity to spironolactone or any component of the product

- **Avoid use in patients who are receiving digoxin, ACE inhibitors, potassium sparing diuretics**

- **Use caution:** in patients with cirrhosis, heart failure, renal impairment, adrenal vein catheterization, volume depletion, diabetes, hepatic impairment, gout

**Finasteride (Proscar®/Propecia®)**

- **Dose:** 1-5 mg orally daily
- **Initial Dose:** 1 mg orally daily
- **Max Dose:** 5 mg orally daily

**Hepatic Dosing:** Initiate with caution.

**Renal Dosing:** Specific guidelines for dosage adjustments are not available. Appears no dosage adjustments are needed.

- **Adverse reactions:** gynecomastia, breast pain, neoplasms of male breast, prostate cancer (high-grade), hypotension, orthostatic hypotension, peripheral edema, pruritus, urticaria, rash, constipation, diarrhea, asthenia, dizziness, headache, testicular pain, somnolence, depression

- **Drug Interactions:** Terazosin, Saw palmetto, St. John’s wort

- **Contraindications:** Hypersensitivity to finasteride or any component of the product

- **Use caution:** with hepatic impairment, increased risk of high-grade prostate cancer has been reported, serum PSA levels may be decreased, monitoring recommended

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**Bold = CCHCS Formulary** *See prescribing information for complete description of contraindications/precautions, adverse effects and drug interactions.

The cost scale $-$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
STEP 11: TRANSWOMAN MONITORING AND FOLLOW-UP

**Monitoring:** Standard monitoring of estrogen administration should be done at baseline, 3 months, 6 months, 9 months, 12 months, and then twice a year once hormone levels have reached target range. This should include an assessment of the patient’s adjustment to therapy, targeted PE, bloodwork, and health promotion/disease prevention counselling as indicated. The suggested tasks for each of these follow-up visits are summarized and expanded upon below.

- While laboratory monitoring of hormone levels may seem complex, it is of similar difficulty to the monitoring of other complex lab-monitored conditions managed by PCPs, such as thyroid disorders, anticoagulation, or DM.
- Once hormone levels have reached the target range for a specific patient, it is reasonable to monitor levels yearly, or only as needed or clinically indicated (see below).

The interpretation of hormone levels for transgender individuals is not yet evidence based; physiologic hormone levels in non-transgender people are used as reference ranges.

- However, estrogen levels in non-transgender women may not be associated with specific secondary sex characteristics (i.e., higher estrogen levels in non-transgender women are not necessarily associated with larger breasts), and specific phenotypical end points are likely multifactorial and particularly dependent on genetics and the age at which gender affirming hormone therapy is begun.

### Target Hormone Levels

**Serum Estradiol:** Should not exceed the peak physiologic range 100-200 pg/mL (exogenous)

**Serum Testosterone:** Should be < 50 ng/dL (endogenous)

**Prolactin:** Should be monitored at least yearly, and more frequently if elevation is noted

<table>
<thead>
<tr>
<th>3 MONTHS*</th>
<th>6 MONTHS*</th>
<th>9 MONTHS*</th>
<th>12 MONTHS*</th>
<th>TWICE A YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight, Waist and Abdominal Circumference</td>
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<td></td>
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<tr>
<td>Hormone Effects</td>
<td></td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Social/Environmental</td>
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<tr>
<td>Education/Lifestyle</td>
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</tbody>
</table>

**BLOODWORK**

<table>
<thead>
<tr>
<th>BUN/Creatinine/ Potassium ‡</th>
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<th>✓</th>
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</thead>
<tbody>
<tr>
<td>HbA1C§ or glucose †</td>
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<td></td>
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</tr>
<tr>
<td>Lipids</td>
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</tr>
<tr>
<td>Prolactin</td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

* In first year of therapy only
† See Page 16 for details
‡ Only if on spironolactone
§ Only if diabetic
‖ Only if family history DM
## Blood Pressure
Estrogen may increase BP, but the effect on incidence of overt hypertension is unknown. Estrogen increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Spironolactone reduces BP and is recommended for at-risk or hypertensive patients desiring feminization.

## Weight, Waist and Abdominal Circumference
Estrogen causes the body to redistribute fat. Fat will begin to collect around the hips and thighs. The muscles in arms and legs will become less defined and have a smoother appearance as the fat just below skin becomes thicker. Estrogen does not have a significant effect on abdominal fat.

## Hormone Effects
The goal of therapy is to reduce the hormonally induced male secondary sex characteristics, complete elimination is not possible. The initial changes (over the first three to six months) include a possible decrease in sexual desire along with decreased rates of growth of facial and body hair. There will also be some initial growth of breast tissue, a decrease in oiliness of the skin, and early redistribution of fat mass.

- **Hair** – Adult male beard growth is very resistant to inhibition by combined hormonal intervention, especially in individuals with European ancestry.
- **Breast development** – Breast formation starts almost immediately after initiation of estrogen administration and decreased androgen levels; breast development is typically maximal at two - three years. Some transwomen may report nipple tenderness and discomfort during the period of breast growth.
- **Skin** – Androgen deprivation leads to a decrease activity of the sebaceous glands and may result in dry skin.
- **Body composition** – Following androgen deprivation, there is an increase in subcutaneous fat and a decrease in lean body mass. Body weight usually increases.
- **Testes** – Atrophy of the testes occurs over many years. Lacking gonadotropic stimulation, the testes become atrophic and may occasionally enter the inguinal canal, which may cause discomfort.
- **Prostate** – Atrophy of the prostate also occurs over many years.
- **Voice** – Antiandrogens and estrogens have no effect on the properties of the voice.
- **Sexual function** – Feminizing hormone therapy may reduce sexual desire, reduce erectile function, and decrease ejaculation among transwomen. Some transwomen choose to reduce hormone doses to balance the degree of feminization with the level of sexual function, while others report no need for dose adjustments.

## Mental Health
- Screen for depressive symptoms (including suicidality) and anxiety disorders.
- Inquire regarding symptoms of hypomania, mania, or psychotic symptoms.
- Inquire regarding current level of GD and body image.
- Screen for disordered eating.

## Social/Environmental
- Assess the impact of transition/trans identity on housing, relationships, and safety concerns.
- Social Supports – specific attention should be given to assessing the extent of a patient’s social supports, creating an opportunity to suggest additional resources if needed.

## Education/Lifestyle Counselling
- Adequate calcium: recommended a minimum of 1200 mg of calcium daily (total: diet plus supplements).
- Adequate Vitamin D: recommended 1000 IU of vitamin D daily.
- Hormone adherence: missed doses of estrogen impacts bone health if post-orchiectomy, while extra doses may lead to risks associated with supraphysiologic levels of estrogen.
- Review the signs and symptoms of Deep Vein Thrombosis (DVT) and Pulmonary Embolism and advise immediate medical attention should these occur.
- Adherence with screening recommendations (See Page 17).
### General approach to screening
The appropriate screening of transgender patients should generally follow the recommendations for their assigned sex at birth. If an individual has a particular body part or organ and otherwise meets criteria for screening based on risk factors or symptoms, screening should proceed regardless of hormone use.

### Breast Cancer Screening
- It is recommended that screening not commence in transwomen until after a minimum of 5 years of feminizing hormone use, regardless of age. Note that transwomen over age 50 do not meet screening criteria until they have at least 5 years of feminizing hormone use.
- It is recommended that screening mammography be performed every 2 years, once the age of 50 and 5-10 years of feminizing hormone use criteria have been met.
- Breast Cancer: Discuss screening in pts > 50 years old with additional risk factors (Estrogen therapy > 5 years, family history (FH), BMI >35).

### Prostate cancer
- PCPs should remain aware of the possibility of prostate cancer in transwomen, even those who have undergone gonadectomy.
- Perform routine screening for prostate cancer as for sex at birth males. If a prostate exam is indicated, both rectal and neovaginal approaches may be considered.
- Transwomen who have undergone vaginoplasty have a prostate anterior to the vaginal wall, and a digital neovaginal exam may be more effective.
- It should be noted that when prostate specific antigen testing is performed in transwomen with low testosterone levels, it may be appropriate to reduce the upper limit of normal to 1.0 ng/mL.

### Testicular cancer
- There is no evidence to perform screening in transwomen.
- Transwomen adherent to therapeutic doses of estrogen plus an androgen blocker, and with persistent testosterone elevations, should be evaluated for testicular tumors by PE, as well as human chorionic gonadotropin (hCG), alpha-fetoprotein (AFP) and lactic dehydrogenase (LDH) levels, and possibly a scrotal ultrasound.

### Cardiovascular Disease
- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors.
- The risk of DM type II is possibly increased, particularly with the presence of additional risk factors.
- While there is minimal impact on LDL and HDL, there is likely a significantly increased risk of hypertriglyceridemia with oral estrogen, so if hypertriglyceridemia is an issue do not use oral estrogen.
- It is recommended to aggressively manage vascular risk factors prior to and during estrogen administration. (UCSF Center for Excellence in Transgender Health) recommends to maintain systolic BP ≤130 mmHg and diastolic BP ≤90 mmHg and cholesterol should also be aggressively managed.
- Spironolactone should be used preferentially for androgen blockade in clients whose BP is of concern.
- Individuals at high risk for developing cardiovascular disease should be offered aspirin as primary prevention.
- Cardiovascular Disease: Screen for risk factors.
- DM: On estrogen: increased risk.
- Hyperlipidemia: On estrogen: annual lipid screening.

### Osteoporosis
- Testes intact: Routine screening as for sex at birth males.
- Post orchiectomy: Screen all patients > 65 years old.
- Screen patients age 50-65 years old if off hormones for > 5 years.
### Transwomen ≥ 50 years old
- Older transwomen initiating therapy may have less rapid/degree of changes.
- Due to higher levels of co-occurring conditions in older individuals, there may also be higher risk of adverse effects.
- There is no evidence to support continuation or cessation of hormones for older transwomen.
- Since the mean age of menopause in the U.S. is 49, it is reasonable in transwomen who have undergone gonadectomy to consider stopping hormone therapy around age 50.
  - Expected effects of this may be similar to non-transgender women experiencing menopause.
- Transwomen who retain their gonads but withdraw hormone therapy may experience return of virilization. A discussion of the pros and cons of this approach, with individualized and shared decision-making is recommended.

### Pituitary adenoma
- Prolactin increase and growth of pituitary prolactinomas are theoretical risks associated with estrogen therapy.
- With the administration of physiologic doses of estrogen, there is no clear basis for an increased risk of prolactinomas in comparison to the population background rate in non-transgender women.
- Additionally, Endocrine Society guidelines for the management of incidental prolactinomas are expectant management only, in the absence of suggestive visual or other symptoms (headache/galactorrhea).
- The inmate population is likely to take higher doses of estradiol than the civilian population. As such it is recommended that routine screening with serum prolactin levels is done annually.
- It is noted that some transwomen experience a minimal amount of galactorrhea early in their hormone therapy course. The presence of non-bloody minimal galactorrhea from more than one duct and/or bilateral is almost certainly physiologic and would not warrant further evaluation.

### Chronic HCV and hormone therapy
- Chronic HCV is not a contraindication to hormone therapy.
- Both estrogen and testosterone undergo hepatic metabolism, and routine monitoring of hepatic function has been recommended.
- Monitoring of liver function in patients with chronic HCV infection should proceed as routinely recommended by disease stage and risk factors for progression dictate.
- Non-oral forms of hormone therapy avoid first pass through liver metabolism and may be preferred for patients with liver disease, though there is no specific evidence to support this recommendation.
## TREATMENT AND MONITORING (INDIVIDUALIZED PATIENT APPROACH)

### STEP 13: TRANSWOMAN SPECIAL CIRCUMSTANCES

#### Perioperative use of feminizing hormones

- Many surgeons insist that transwomen discontinue estrogen for several weeks before and after any gender affirming procedure. These recommendations may appear as benign to the surgeon; however, to the transgender woman undergoing a life and body altering procedure simultaneous with gonadectomy, sudden and prolonged complete withdrawal of estrogens can have a profound impact.
- Postoperative depression is a nontrivial concern and may have some basis in the drastic hormone shifts, including cessation of estrogens, experienced in the perioperative period.
- There is no evidence to suggest that transwomen who lack specific risk factors (smoking, personal or family history, excessive doses or use of synthetic estrogens) must cease estrogen therapy before and after surgical procedures, in particular with appropriate use of prophylaxis and an informed consent discussion of the pros and cons of discontinuing hormone therapy during this time.
- Possible alternatives include using a lower dose of estrogen, and/or changing to a transdermal route if not already in use.

#### Venous thromboembolism

- Several studies have demonstrated an increased risk of VTE in transgender individuals receiving hormone therapy, particularly transwomen on estrogen.
- Risk factors for venous thrombosis in those who had a VTE included immobilization after surgery, smoking, or a hypercoagulable disorder.
- Routine VTE prophylaxis with aspirin in unselected transgender populations is not recommended.
- Routine screening for prothrombotic mutations is not recommended in the absence of risk factors.
- Regardless of the circumstances, estrogen therapy is very risky in patients with significant risk factors for, or history of, VTE who continue to smoke tobacco.
- The incidence of thrombophilias appears to be the same in the transgender population as the general population. Therefore, routine pretreatment screening for thrombophilias is not suggested.
- When thrombophilias are detected, it has been suggested that treatment with anticoagulants be administered if estrogen therapy is to be continued.

### STEP 14: TRANSWOMAN WHEN TO REFER TO A SPECIALIST

Care for the transgender patient can be accomplished by a PCP. Consider referring patients to a contracted provider (typically an endocrinologist) via telemedicine in the following cases:

1. Patients that are at a very high risk for adverse effects from Estrogen treatment:
   - Unstable ischemic cardiovascular disease/cerebrovascular disease
   - Estrogen-dependent cancer
   - End stage chronic liver disease
   - Hypersensitivity to one of the components of the formulation
   - Have a history of thromboembolic disease
   - Had or have a hormone-sensitive cancer, such as prostate cancer

2. Findings suggestive of intersex conditions (e.g., ambiguous genitalia)

3. Patients that did not achieve expected clinical response despite treatment with maximum estrogen dose.
STEP 5: TRANSMAN GOALS AND EXPECTATIONS

Transman: A person whose sex assigned at birth was female, but understands oneself to be male.

The PCP should cover the following topics when discussing gender affirming hormone therapy with patients.

- **What are the goals of hormone therapy?**
  Patients need to have realistic goals of what may be accomplished with hormone therapy. In the past, some patients have had the mistaken belief that changes will occur quickly and have had unrealistic expectations of what changes will occur. When disappointed with the timing or degree of changes, some patients have wanted to increase the dose of their hormone beyond what is considered to be a safe dose range.

**Expected Effects of Masculinizing Hormones (Testosterone)**

<table>
<thead>
<tr>
<th>General effects include:</th>
<th>Sexual and gonadal effects include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Suppress endogenous birth-gender hormone production</td>
<td>- Increase in libido</td>
</tr>
<tr>
<td>- Induce secondary sex characteristics of new gender</td>
<td>- Clitoral growth</td>
</tr>
<tr>
<td>- Development of facial hair</td>
<td>- Vaginal dryness</td>
</tr>
<tr>
<td>- Virilizing changes in voice</td>
<td>- Cessation of menses/ovulation (anovulatory state)</td>
</tr>
<tr>
<td>- Redistribution of facial and body subcutaneous fat</td>
<td>- It is common, though not absolute that ovulation stops. Long-term fertility may be affected,</td>
</tr>
<tr>
<td>- Increased muscle mass</td>
<td>though some transmen are able to discontinue testosterone and achieve a successful pregnancy</td>
</tr>
<tr>
<td>- Increased body hair</td>
<td>- The effects of prenatal testosterone on fetal or childhood development has not been studied</td>
</tr>
<tr>
<td>- Change in sweat and odor patterns</td>
<td></td>
</tr>
<tr>
<td>- Frontal and temporal hairline recession</td>
<td></td>
</tr>
<tr>
<td>- Possibly male pattern baldness</td>
<td></td>
</tr>
</tbody>
</table>

- **What is the expected timing of the response?**
  Help the patient understand that changes are individual and will take place over months to years, with most changes being complete by 3 years of treatment.

  Increased doses beyond max recommended dose is not indicated and will not result in additional changes.

<table>
<thead>
<tr>
<th>Time Needed To See Masculinizing Effects Of Medication (Testosterone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect</td>
</tr>
<tr>
<td>Skin oiliness/acne</td>
</tr>
<tr>
<td>Facial/body hair growth</td>
</tr>
<tr>
<td>Scalp hair loss</td>
</tr>
<tr>
<td>Increased muscle mass/strength</td>
</tr>
<tr>
<td>Fat redistribution</td>
</tr>
<tr>
<td>Cessation of menses</td>
</tr>
<tr>
<td>Clitoral enlargement</td>
</tr>
<tr>
<td>Vaginal atrophy</td>
</tr>
<tr>
<td>Deepening of voice</td>
</tr>
</tbody>
</table>
### TREATMENT AND MONITORING (INDIVIDUALIZED PATIENT APPROACH)

#### STEP 6: TRANSMAN: BASELINE LABS

Obtain the following baseline labs to determine the patient’s current health and identify any health problems that may pose immediate or future risk to testosterone therapy.

| CBC | • An expected potential side effect of testosterone treatment is polycythemia, an increased level of red blood cells, which manifests as increases levels of H&H.  
• Because it is theoretically plausible that high hematocrit levels may increase risk for cardiovascular events, stroke and blood clots, regular monitoring of hematocrit during testosterone therapy is important.  
• Goal is to keep hematocrit less than 50 mg/dl. |
| Liver Function Tests (LFTs) | • Testosterone is metabolized by the liver.  
• Transient elevations in liver enzymes may occur with testosterone therapy.  
• Regular blood tests for liver function are recommended. |
| A1C (If diabetic) | • The effect of hormone therapy on DM risk or disease course is unclear.  
• WPATH Standards of Care recommends that conditions such as DM be “reasonably well controlled” prior to initiating hormone therapy. |
| Fasting Glucose (If family history of DM) | • Testosterone may increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events (typically treat if triglycerides > 500)  
• Testosterone may also lower HDL. |
| Fasting Lipid Panel (Based on USPTF Guidelines) | • Sex at birth women age 19 and up, normal testosterone level range from 8-60 ng/dL.  
• Sex at birth men age 18-60, normal range of total testosterone levels is 250-1000 ng/dL.  
• The goal “total testosterone” level for transmen is 400-700 ng/dL. |
| Testosterone Level (Total) | • Serum estradiol is monitored during the first six months of testosterone treatment or until there has been no uterine bleeding for six months.  
• Levels of estradiol for menstruating women range 15-350 pg/mL and for postmenopausal women, normal levels should be lower than 10 pg/mL.  
• The goal for transmen is <50 pg/mL. |

#### STEP 7: TRANSMAN CONTRAINDICATIONS AND POTENTIAL RISKS OF HORMONE THERAPY

**Absolute contraindications:**
- Pregnancy or breastfeeding
- Poorly controlled psychosis or acute homicidality
- Psychiatric conditions which limit the ability to provide informed consent

**The following patients are at a very high risk of adverse effects:**
Consider referral to a contacted provider (typically an endocrinologist) via telemedicine.
- Androgen-sensitive cancer
- Unstable ischemic cardiovascular disease
- Endometrial cancer
- Hypersensitivity to one of the components of the formulation
- Polycythemia/Erythrocytosis (Hct > 50%)
- History of breast or uterine cancer

**The following patients are at a moderate to high risk of adverse effects:**
Proceed with caution considering risks versus benefits and utilizing shared decision-making.
- Significant liver disease (transaminases > 3 upper limit of normal)
- History of coronary artery disease or history of cerebrovascular disease
The medical effects and safety of testosterone are not completely known and there may be long-term risks that are not yet established. As with most medical interventions, a number of health risks have been postulated to be related to testosterone therapy. Several pre-existing medical conditions and risk factors may increase the risks associated with testosterone administration. When these are present, a careful evaluation of risks and benefits should be completed and fully discussed with the patient.

Testosterone can:
- Increase risk of heart disease, which includes:
  - Less good cholesterol (HDL)
  - More bad cholesterol (LDL)
  - Higher BP
  - Increase risk of liver disease and increased LFTs
  - Increase risk of DM
  - Increase aggression or depression
  - Increase red blood cell count and hemoglobin to the level that is normal for a man and would have no health risks; however, higher increases can cause problems that can be life-threatening, including stroke and heart attack
  - Turn into estrogen, and it is not known if this could increase the risks of cancers of the breasts, ovaries, or uterus
  - Cause thinning to the tissue of the cervix and the walls of the vagina which can lead to tears or abrasions during vaginal intercourse, which can raise the risk of getting a sexually transmitted infection, including HIV
  - Cause headaches or migraines

PCPs should use the CDCR 7528-1, Masculinizing Hormone Therapy Consent form and ensure the patient understands the risks associated with use of testosterone and all questions are answered.

Hormone therapy is expected to be life changing and may result in some irreversible effects. The process of sharing in the decision-making involves developing a partnership, exchanging information about the available options, deliberating while considering the potential consequences of each one, and making a decision by consensus. The informed consent for hormone therapy is a decision aid that includes the before mentioned information to help patients make a well-informed decision that reflects their values and goals with their PCP.

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**STEP 9: TRANSMAN POSSIBLE SOCIAL/ENVIRONMENTAL CHALLENGES**

- During the course of treatment, a patient’s housing may be reevaluated and the patient may be transferred to a different facility.
- A request from the patient via Gender Identity Questionnaire, Form 22, note, etc., to be housed consistent with their gender identity, shall be forwarded to the PCM.
- Advise the patient to work with a Correctional Counselor to obtain gender appropriate accommodations per the DOM.
- Offer a referral to a MH clinician if GD continues or the patient reports social or other challenges due to transitioning.

Transmen are typically allowed the following personal items, which may vary with custody level and security status or may vary somewhat between institutions.

<table>
<thead>
<tr>
<th>General Population Levels I, II, III, IV</th>
<th>SHU / PSU</th>
<th>ASU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athletic Supporter</td>
<td>Athletic Supporter</td>
<td>Binders/Compression Tops</td>
</tr>
<tr>
<td>Binders/Compression Tops</td>
<td>Binders/Compression Tops</td>
<td></td>
</tr>
<tr>
<td>Briefs/Boxers</td>
<td>Briefs/Boxers</td>
<td></td>
</tr>
<tr>
<td>After Shave</td>
<td>After Shave</td>
<td></td>
</tr>
</tbody>
</table>

Sample List of Allowable Clothing/ Hygiene Items (Varies by institution and other security factors)
Prescriber: Prescribing gender affirming hormones is well within the scope of a range of PCPs, including medical doctors, nurse practitioners, physician assistants, obstetricians-gynecologists, and endocrinologists. Medication used in transmen gender affirming hormone therapy (testosterone) is commonly used in treating low testosterone levels in older sex at birth males and most prescribers are already familiar with its use.

Testosterone
- All testosterone preparations currently used in the U.S. are "bioidentical" meaning they are chemically equivalent to the testosterone secreted from the human testicle.
- Prior use of oral methyltestosterone and other synthetics commonly encountered in bodybuilding communities has resulted in unsubstantiated concerns about negative hepatic effects of testosterone use in transmen.
- Testosterone is available in a number of injected and topical preparations, which have been designed for use in non-transgender men with low androgen levels. In CCHCS, Parenteral (IM) administration of Testosterone cypionate is preferred.

Titration
- Titration upwards of dose should be driven by patient goals, clinical response, hormone level monitoring, and safety monitoring (i.e., H&H).
- Clinical response can be measured objectively by the presence of amenorrhea by 6 months.
- Once total testosterone is greater than the midpoint value in the lab reported reference range, it is unclear if an increase in dose will have any positive effect on degree of virilization or perceived slow progress, or on mood symptoms or other side effects.
  - Titrate dose upwards based on testosterone levels measured at 3 and 6 months.
  - Once hormone levels have reached the target range for a specific patient, it is reasonable to monitor levels yearly.
  - As with testosterone replacement in non-transgender men, annual visits and lab monitoring are sufficient for transmen on a stable hormone regimen.

Ordering Medication
- To order medication use the Transgender Masculinizing Therapy PowerPlan.
- Route of injection (intramuscular vs. subcutaneous): While testosterone for injection is labeled for the intramuscular route, many PCPs have administered testosterone using the subcutaneous route with good efficacy and patient satisfaction, and without complications. Benefits of subcutaneous administration include a smaller and less painful needle, and may avoid scarring or fibrosis from long term (possibly > 50 years) intramuscular therapy.

See the medication table on the following page.
### SUMMARY

TREATMENT AND MONITORING (INDIVIDUALIZED PATIENT APPROACH)

### STEP 10: TRANSMAN ORDER MEDICATIONS

#### TESTOSTERONE

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Medication*</th>
<th>Effects/Adverse Effects/Drug Interactions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenteral</td>
<td>Testosterone cypionate 50-200 mg IM every 2 weeks Initial Dose: 50-100 mg IM every 2 weeks Standard Dose: 100-200 mg IM every 2 weeks</td>
<td>Adverse reactions: Injection site reaction, headache, hypertension, edema, DVT, pulmonary embolism, erythrocytosis, cerebrovascular accident (CVA), cholestatic hepatitis, n/v, neoplasms of liver, increased LFTs, MI, depression, suicidal thoughts, unstable angina, acne, alopecia, erythrocytosis, increased hemoglobin/hematocrit, paresthesia, dyslipidemia, increased glucose levels, aggressive behavior/hostility</td>
<td>Parenteral (IM) administration is preferred in CCHCS</td>
</tr>
<tr>
<td></td>
<td>Hepatic Dosing: Severe dysfunction: Contraindicated Mild to Moderate dysfunction: Initiate with caution</td>
<td></td>
<td>During the first 3 to 9 months of testosterone treatments total testosterone levels may be high although free testosterone levels are normal due to high sex hormone binding globulin levels in some biological women</td>
</tr>
<tr>
<td></td>
<td>Renal Dosing: Specific guidelines for dosage adjustments are not available. Appears no dosage adjustments are needed.</td>
<td></td>
<td>15% of patients on testosterone will experience transient elevations in liver enzymes (if increase &gt; 3X stop and seek expert consultation, e.g., endocrinologist)</td>
</tr>
<tr>
<td></td>
<td>Testosterone enanthate 50-200 mg IM every 2 weeks Initial Dose: 50-100 mg IM every 2 weeks Standard Dose: 100-200 mg IM every 2 weeks</td>
<td></td>
<td>Do not use cypionate and enanthate interchangeably due to differences in duration of action</td>
</tr>
<tr>
<td></td>
<td>Hepatic Dosing: Severe dysfunction: Contraindicated Mild to Moderate dysfunction: Initiate with caution.</td>
<td></td>
<td>Test hormone level (total testosterone) midway between injections</td>
</tr>
<tr>
<td></td>
<td>Renal Dosing: Specific guidelines for dosage adjustments are not available. Appears no dosage adjustments are needed.</td>
<td></td>
<td>Titrate the testosterone dose to result in a serum testosterone level between 400-700 ng/dl</td>
</tr>
<tr>
<td></td>
<td>Testosterone enanthate Black Box Warning: Testosterone enanthate can cause blood pressure increases that can increase the risk of major adverse cardiovascular events (MACE), including non-fatal myocardial infarction, non-fatal stroke and cardiovascular death. Before initiating testosterone enanthate, consider the patient’s baseline cardiovascular risk and ensure blood pressure is adequately controlled. Periodically monitor for and treat new-onset hypertension or exacerbations of pre-existing hypertension and reevaluate whether the benefits of testosterone enanthate outweigh its risks in patients who develop cardiovascular risk factors or cardiovascular disease on treatment. Due to this risk, use testosterone enanthate only for the treatment of men with hypogonadal conditions associated with structural or genetic etiologies.</td>
<td></td>
<td>Use caution in the following: cardiac disease, coronary artery disease (CAD), hepatic disease, renal disease, hypertension</td>
</tr>
</tbody>
</table>

**Bold = CCHCS Formulary**

*See prescribing information for complete description of contraindications/precautions, adverse effects and drug interactions.

The cost scale $-$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
Monitoring: Standard monitoring of testosterone administration should be done at baseline, 3 months, 6 months, 9 months, 12 months, and then twice a year once hormone levels have reached target range. This should include an assessment of the patient’s adjustment to therapy, targeted PE, bloodwork, and health promotion/disease prevention counseling as indicated. The suggested tasks for each of these follow-up visits are summarized and expanded upon below.

- While laboratory monitoring of hormone levels may seem complex, it is of similar difficulty to the monitoring of other complex lab-monitored conditions managed by PCPs, such as thyroid disorders, anticoagulation, or DM.
- Once hormone levels have reached the target range for a specific patient, it is reasonable to monitor levels yearly, or only as needed or clinically indicated (see below).

The interpretation of hormone levels for transgender individuals is not yet evidence based; physiologic hormone levels in non-transgender people are used as reference ranges.

- Testosterone levels can be difficult to measure in non-transgender men due to rapid fluctuations in levels, relating to pulsatile release of gonadotropins.
- Free testosterone represents the portion of testosterone unbound to serum proteins and depends on levels of Sex Hormone Binding Globulin (SHBG).
- Consensus is lacking on the role of free vs. total testosterone levels; total testosterone levels are reliable and readily available, however they do not describe the actual bioavailable testosterone level.
- For transgender care, the Endocrine Society recommends monitoring of the total testosterone level.

**Target Hormone Levels:**

- **Total Testosterone:** Target level is 400-700 ng/dL (exogenous)
- **Estradiol:** Should be < 50 pg/mL (endogenous)

<table>
<thead>
<tr>
<th>3 MONTHS*</th>
<th>6 MONTHS*</th>
<th>9 MONTHS*</th>
<th>12 MONTHS*</th>
<th>TWICE A YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess At Each Visit †</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight, Waist and Abdominal Circumference</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cessation of Menses</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hormone Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mental Health</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Social/Environmental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education/Lifestyle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BLOODWORK**

| Lipids | | | | ✓ |
| HbA1C‡ or fasting glucose§ | ✓ |
| Hemoglobin & Hematocrit | ✓ | ✓ | ✓ | ✓ | ✓ |
| Total Testosterone | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Estradiol | | | ✓ | | |

* In first year of therapy only
† See Page 26 for details
‡ Only if diabetic
§ Only if family history of DM
### Blood Pressure
Testosterone therapy at normal physiologic doses may increase BP, but does not appear to increase the risk of significant hypertension. Patients with risk factors for hypertension, such as obesity, family history, or PCOS may be at increased risk, and BP should be monitored while on testosterone therapy.

### Weight, Waist and Abdominal Circumference
Testosterone therapy leads to a reduction in subcutaneous fat but increases in abdominal fat. The increase in lean body mass is on average 4 kg, and the increase in body weight may be greater.

### Cessation of menses
Menses usually stop within a few months of starting testosterone. However, in some individuals, bleeding may continue. The recommended approach is to increase the testosterone dose modestly. Another approach is to add an oral progestin such as medroxyprogesterone acetate (MPA; 5 to 10 mg daily continuously) or treatment with a gonadotropin-releasing hormone (GnRH) agonist to stop the menstrual bleeding. (Patients requiring these additional therapies are typically referred for expert consultation, e.g., Endocrinologist).

### Hormone Effects
Testosterone causes male-pattern hair growth and an increase in lean body mass, muscle mass, and fat mass. It also causes growth in midline structures like the larynx and clitoris.

Monitor the following hormone effects:
- **Hair** – The development of hair follows the pattern observed in pubertal boys: first the upper lip, then chin, then cheeks, etc. The degree of hair growth might be predicted from the pattern in male members of the same family. The same applies to the occurrence of androgenetic alopecia, "male-pattern baldness."
- **Voice** – Deepening of the voice may occur due to oropharyngeal growth and may be irreversible.
- **Acne** – Acne occurs in approximately 40 percent, similar to that observed in hypogonadal men starting androgen treatment past the age of normal puberty.
- **Clitoral enlargement** – Clitoral enlargement occurs in all, but the degree varies.
- **Sexual desire** – Most subjects will note an increase in sexual desire.
- **Breasts** – Androgen administration may cause a decrease in glandular tissue.

The relatively lower height and the broader hip configuration of transmen compared with cisgender men does not change with testosterone treatment.

### Mental Health
- Screen for depressive symptoms (including suicidality) and anxiety disorders.
- Inquire regarding symptoms of hypomania, mania, or psychotic symptoms.
- Inquire regarding current level of GD and body image.
- Screen for disordered eating.
- Inquire regarding libido/changes in libido.

### Social/Environmental
- Assess the impact of transition/trans identity on housing, relationships and safety concerns.
- Social Supports – specific attention should be given to assessing the extent of a patient’s social supports, creating an opportunity to suggest additional resources if needed.

### Education/Lifestyle Counselling
- Hormone adherence: missed doses of testosterone.
- Adherence with screening recommendations (See Page 27).
General approach to screening

The appropriate screening of transgender patients should generally follow the recommendations for their assigned sex at birth. If an individual has a particular body part or organ and otherwise meets criteria for screening based on risk factors or symptoms, screening should proceed regardless of hormone use.

Breast Cancer Screening

- Transmen who have not undergone bilateral mastectomy, or who have only undergone breast reduction, should undergo screening according to current guidelines for non-transgender women.

Cervical Cancer

- Cervical cancer screening for transmen including interval of screening and age to begin and end screening follows recommendations for non-transgender women.

Pelvic pain and persistent menses

- **Pelvic Pain**: Pain less than 6 months of duration is considered acute. Chronic pelvic pain, which is continuous or episodic pain in the lower abdomen or pelvis lasting more than 6 months, has a large differential. History is a critical component to assessment/diagnosis. Key to history is a detailed description of pain including onset, precipitating/palliating features, quality, radiation, severity and timing.
  - The general approach to the workup of pelvic pain in transmen is similar to that for non-transgender women. An anatomic approach to history gathering that considers urological, gynecologic, GI, musculoskeletal, and psychological components is critical. Specific etiologies may be multifactorial, such as post-op adhesions +/- GI surgery, or endometriosis and/or pelvic floor muscle dysfunction.
  - **Persistent Menses**: Transmen with a history of abnormal cycles prior to initiating testosterone (e.g., frequent cycles, heavy irregular bleeding) may have underlying pathology, which could result in a prolonged or complicated path to cessation of menses once on testosterone. Therefore, in patients with risk factors for endometrial hyperplasia and a degree of clinical suspicion, evaluation for and elimination of known causes of irregular bleeding should be considered concurrent with testosterone administration; those with pre-existing amenorrhea or oligomenorrhea may require evaluation for endometrial abnormalities prior to initiating testosterone.

Osteoporosis

- Screen all patients > 65 years old
- Screen patients age 50-65 years old if off hormones for > 5 years

Diabetes Mellitus

- Routine screening (Transmen with PCOS should be screened for DM)

Hyperlipidemia

- On testosterone: Annual lipid screening

Erythrocytosis/polycythemia

- H&H values in transmen should be interpreted in the context of the dose of testosterone used and menstruation status.
- Transmen with physiologic male testosterone levels and who are amenorrheic would be expected to have H&H values in the male normal range.
- Patients with persistent menses or on lower doses of testosterone should have their H&H interpreted accordingly. Transmen with true polycythemia should first have their testosterone levels checked, including a peak level, and have dose adjusted accordingly.
- Changing to a more frequent injection schedule (maintaining the same total amount of testosterone over time) or transdermal preparations may limit the risk of polycythemia.
- Phlebotomy or blood donation may be an appropriate short term solution depending on the level of elevation; in all cases other pathologic causes of polycythemia should be excluded. In addition to neoplasms and cardiopulmonary disease, specific conditions of concern in transmen include obesity-related obstructive sleep apnea (OSA), and tobacco use.

Older Transmen

- No upper age limit exists for testosterone replacement in non-transgender men.
  - As such, there is no age recommendation for the termination of testosterone therapy in transmen.
  - It is reasonable to consider discontinuing hormone therapy at or around age 50, the age at which non-transgender women undergo menopause. Regardless of the presence of gonads at this age, withdrawal of testosterone will result in reduced muscle mass, body hair, and libido.
## Chronic HCV and hormone therapy
- Chronic HCV is not a contraindication to hormone therapy.
- Both estrogen and testosterone undergo hepatic metabolism, and routine monitoring of hepatic function has been recommended.
- Monitoring of liver function in patients with chronic HCV infection should proceed as routinely recommended by disease stage and risk factors for progression dictate.
- Non-oral forms of hormone therapy avoid first pass through liver metabolism and may be preferred for patients with liver disease, though there is no specific evidence to support this recommendation.

## Metabolic syndrome and related conditions (obesity, hyperlipidemia, impaired glucose tolerance, PCOS)
- Cardiovascular and DM considerations are covered elsewhere in these guidelines.
- PCOS can manifest with any combination of impaired fasting glucose, dyslipidemias, hirsutism, obesity, and oligo- or amenorrhea with anovulation.
- Some of these features (hirsutism, oligo- or amenorrhea) may be welcomed by transmen and present prior to testosterone administration.
- Testosterone administration is not contraindicated in the presence of PCOS, but patients should be monitored for hyperlipidemia and DM.
- Transmen with amenorrhea in the presence of testosterone are not believed to be at elevated risk of endometrial hyperplasia, due to the atrophic effects of testosterone on the endometrium. It may be prudent to pursue endometrial evaluation prior to initiation of testosterone in transmen with a current history amenorrhea/oligomenorrhea.
- Testosterone replacement in non-transgender men is associated with an increased risk of OSA. It is unknown whether OSA is increased in transmen after the initiation of testosterone therapy may result in positive lifestyle changes that reduce obesity, disorders of glucose metabolism, or hyperlipidemia.
- In all but the most severe cases (DM out of control, active unstable coronary artery disease), transmen should be informed of risks, and if testosterone therapy continues to be desired, it should be continued with concurrent conventional management of metabolic disorders and their sequelae.

## STEP 14: TRANSMAN WHEN TO REFER TO A SPECIALIST
Care for the transgender patient can be accomplished by a PCP. Consider referring patients to a contracted provider (typically an endocrinologist) via telemedicine in the following cases:

1. Patients that are at a very high risk for adverse effects from testosterone treatment:
   - Unstable ischemic cardiovascular disease/cerebrovascular disease
   - Androgen-sensitive cancer
   - Endometrial cancer
   - Polycythemia / Erythrocytosis (Hct > 50%)
   - History of breast or uterine cancer
   - Significant liver disease (transaminases > 3 times upper limit of normal)

2. Findings suggestive of intersex conditions (e.g., ambiguous genitalia)

3. Patients that did not achieve expected clinical response despite treatment with maximum testosterone dose.
Background:
- Individuals may live successfully as transgender persons without surgery. Gender affirming surgery may be considered for those individuals who are diagnosed with Gender Dysphoria and demonstrate significant distress not attributable to conditions of confinement, mental illness or other factors, but are due to lack of reasonable response to available nonsurgical treatments and there are no available, additional treatments other than surgery that are likely to improve or alleviate their symptoms.
- Most individuals seeking gender affirming surgery have been previously treated with hormone therapy. If the patient is unable to take hormone therapy due to medical contraindications, a request for gender affirming surgery may still be submitted.
- Each referral is considered on a case-by-case basis.
- Surgery is not required for legal changes in California (e.g., gender change, birth certificate, name change). Other states and countries may have different requirements.

Criteria:
- In addition to the eligibility and readiness criteria for hormone therapy, general criteria for consideration of surgery includes participation in psychotherapy as clinically indicated and consolidation of gender identity.
- The patient must request consideration for and demonstrate a practical understanding of gender affirming surgery including, but not limited to, permanence, potential complications, and short- and long-term treatment plans.

CRITERIA FOR GENDER AFFIRMING SURGERY

1. Persistent, well-documented Gender Dysphoria
2. Legal age of majority (in California, 18 years old)
3. For hysterectomy, salpingo-oopherectomy, orchietomy, metoidioplasty, or vaginoplasty: 12 months of continuous gender affirming hormone therapy (unless there is a medical contraindication to such therapy, or the patient is otherwise unable or unwilling to take hormones).
4. For metoidioplasty, phalloplasty, vaginoplasty: Continuous full-time living in the new gender role for 12 months.
5. If significant medical or mental health concerns are present, they must be well controlled

Procedures Which May Be Authorized for CCHCS/DHCS Patients Requesting Gender Affirming Surgery

<table>
<thead>
<tr>
<th>Transwoman</th>
<th>Transman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginoplasty: Create a vagina</td>
<td>Vaginectomy: Remove vagina</td>
</tr>
<tr>
<td>Clitoroplasty: Create a clitoris</td>
<td>Hysterectomy: Remove uterus</td>
</tr>
<tr>
<td>Labioplasty: Construct labia</td>
<td>Salpingo-oopherectomy: Remove tubes/ovaries</td>
</tr>
<tr>
<td>Vulvoplasty: Construct vulva</td>
<td>Metoidioplasty: Create a penis from clitoris, enlarged from testosterone use</td>
</tr>
<tr>
<td>Orchietomy: Remove testicles</td>
<td>Phalloplasty: Create a penis using tissue from elsewhere on the body</td>
</tr>
<tr>
<td>Penectomy: Remove penis</td>
<td>Urethroplasty: Create/repair urethra</td>
</tr>
<tr>
<td></td>
<td>Scrotoplasty: Create a scrotum</td>
</tr>
<tr>
<td></td>
<td>Placement of testicular prostheses</td>
</tr>
<tr>
<td></td>
<td>Mastectomy and reduction mammoplasty</td>
</tr>
</tbody>
</table>

For questions please contact: m_MSDTransgenderSupport@cdcr.ca.gov
For GAS submissions please contact: CDCRCCHCSGASRC@cdcr.ca.gov
## REFERENCES


Hormone Therapy: Transwoman

- Changing your gender is a serious and possibly dangerous process.
- There are many things you can do to get the safest and best results for your body and mind like:
  - Not smoking
  - Not drinking alcohol or taking illegal drugs
  - Keep a healthy weight
  - Exercise regularly
- You should only trust information you get from your medical and mental health clinicians.

What You Need To Know About Estrogen Therapy

- The feminizing effects of estrogen can take months to be noticed and years to be complete.

### TIME NEEDED TO SEE EFFECTS OF ESTROGEN & ANDROGEN BLOCKERS

<table>
<thead>
<tr>
<th>Effect On Your Body</th>
<th>Starting</th>
<th>Maximum Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less stomach fat/More fat on butt, hips, thighs</td>
<td>3-6 months</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Less muscle and strength</td>
<td>3-6 months</td>
<td>1-2 years</td>
</tr>
<tr>
<td>Softer skin/Less oily skin</td>
<td>3-6 months</td>
<td>Unknown</td>
</tr>
<tr>
<td>Less sexual desire</td>
<td>1-3 months</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Less spontaneous erections</td>
<td>1-3 months</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Male sexual dysfunction</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Breast growth</td>
<td>3-6 months</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Smaller testicles</td>
<td>3-6 months</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Make less sperm</td>
<td>Unknown</td>
<td>&gt;3 years</td>
</tr>
<tr>
<td>Less hair growth</td>
<td>6-12 months</td>
<td>&gt;3 years</td>
</tr>
<tr>
<td>Head hair</td>
<td>Variable</td>
<td>----</td>
</tr>
</tbody>
</table>

- Some changes to your body will be permanent, even if you stop taking estrogen, including:
  - **Breast development**: You will need to do monthly breast self-examinations, have an annual medical exam,
  - **Less sperm production**: Even if you stop estrogen, the ability to make healthy sperm

- Taking estrogen will **not** protect you from sexually transmitted infections (like HIV).
- Dangerous side effects of taking Estrogen can include:
  - Blood clots
  - Feeling depressed
  - Breast cancer
  - Stroke
  - Heart Attacks
  - Liver disease

- Estrogen may raise your risk of heart disease, just like smoking cigarettes. If you choose to smoke, your doctor may not prescribe estrogen or may prescribe lower doses. It is important to reduce other risk factors for heart disease, like high cholesterol and being overweight.

- You can choose to stop taking estrogen at any time. Your doctor can also stop your treatment for medical reasons. If you stop taking estrogen, you must follow a plan to reduce the dose gradually to avoid harmful side effects.

What You Need To Do

- Tell your doctor if you are taking any dietary supplements, herbs, **drugs (legal or illegal) obtained in prison, other than those prescribed for you or other medications**.
- If you are in the mental health services delivery system, continue care with your mental health clinician. If you feel you need mental health services submit a CDCR 7362 or notify a staff member.
- You will be asked to sign an informed consent form before starting estrogen therapy.

☞ If you have any questions, talk to your health care or mental health provider ☞
Hormone Therapy: Transman

- Changing your gender is a serious and possibly dangerous process.
- There are many things you can do to get the safest and best results for your body and mind like:
  - Not smoking
  - Not drinking alcohol or taking illegal drugs
  - Keep a healthy weight
  - Exercise regularly
- You should only trust information you get from your medical and mental health providers.

What You Need to Know About Testosterone Therapy

- The masculinizing effects of testosterone can take months to be noticed and years to be complete.

<table>
<thead>
<tr>
<th>Effect On Your Body</th>
<th>Starting</th>
<th>Maximum Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin oiliness/acne</td>
<td>1-6 months</td>
<td>1-2 years</td>
</tr>
<tr>
<td>Facial/body hair growth</td>
<td>6-12 months</td>
<td>4-5 years</td>
</tr>
<tr>
<td>Scalp hair loss</td>
<td>6-12 months</td>
<td>-----</td>
</tr>
<tr>
<td>More muscle and strength</td>
<td>6-12 months</td>
<td>2-5 years</td>
</tr>
<tr>
<td>Less fat on butt, hips, thighs</td>
<td>1-6 months</td>
<td>2-5 years</td>
</tr>
<tr>
<td>No menstrual periods</td>
<td>1-6 months</td>
<td>-----</td>
</tr>
<tr>
<td>Bigger Clitoris</td>
<td>1-6 months</td>
<td>1-2 years</td>
</tr>
<tr>
<td>Vaginal dryness</td>
<td>1-6 months</td>
<td>1-2 years</td>
</tr>
<tr>
<td>Deeper voice</td>
<td>6-12 months</td>
<td>1-2 years</td>
</tr>
</tbody>
</table>

- Some changes to your body will be permanent, even if you stop taking testosterone including:
  - Scalp hair loss
  - Facial hair growth and more body hair
  - Deepening of your voice
- Testosterone will not protect you from sexually transmitted infections or from becoming pregnant.
- If you take testosterone for a long time, you may not be able to get pregnant in the future, even if you stop taking testosterone.
- Dangerous side effects of taking Testosterone can include:
  - Blood clots
  - High blood pressure
  - Liver disease
  - Heart Attacks
  - Feeling depressed
  - Breast and/or uterine cancer
  - Aggressive behavior/hostility
  - Stroke
- Testosterone may raise your risk of heart disease, just like smoking cigarettes. If you choose to smoke, your doctor may not prescribe testosterone or may prescribe lower doses. It is important to reduce other risk factors for heart disease, like high cholesterol and being overweight.
- You can choose to stop taking testosterone at any time. Your doctor can also stop your treatment for medical reasons. If you stop taking testosterone, you must follow a plan to reduce the dose slowly to avoid harmful side effects.

What You Need to Do

- Tell your doctor if you are taking any dietary supplements, herbs, drugs (legal or illegal) obtained in prison, other than those prescribed for you or other medications.
- If you are in the mental health services delivery system, continue care with your mental health clinician. If you feel you need mental health services submit a CDCR 7362 or notify a staff member.
- You will be asked to sign an informed consent form before starting testosterone therapy.

✔ If you have any questions, talk to your health care or mental health provider ✔
Cambiar de género es un proceso serio y posiblemente peligroso.

Existen muchas cosas que puede hacer para obtener resultados más seguros y mejores para mente y cuerpo:
- No fumar
- No ingerir alcohol ni tomar drogas ilegales
- Mantener un peso sano
- Ejercitarse regularmente
- Debe confiar únicamente en la información que le suministren su médico y proveedores de salud mental.

Lo que necesita saber sobre la terapia de estrógenos

- Los efectos de la feminización por estrógenos pueden tomar muchos meses antes de comenzar a notarse y varios años para completarse.

<table>
<thead>
<tr>
<th>Efecto sobre tu cuerpo</th>
<th>Comenzando</th>
<th>Cambio máximo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menos grasa estomacal/Más grasa en las nalgas, caderas, muslos</td>
<td>3-6 meses</td>
<td>2-3 años</td>
</tr>
<tr>
<td>Menos músculo y fuerza.</td>
<td>3-6 meses</td>
<td>1-2 años</td>
</tr>
<tr>
<td>Piel más suave/Piel menos grasa</td>
<td>3-6 meses</td>
<td>Desconocido</td>
</tr>
<tr>
<td>Menos deseo sexual</td>
<td>1-3 meses</td>
<td>3-6 meses</td>
</tr>
<tr>
<td>Menos erecciones espontáneas</td>
<td>1-3 meses</td>
<td>3-6 meses</td>
</tr>
<tr>
<td>Disfunción sexual masculina</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Crecimiento de los senos</td>
<td>3-6 meses</td>
<td>2-3 años</td>
</tr>
<tr>
<td>Testículos más pequeños</td>
<td>3-6 meses</td>
<td>2-3 años</td>
</tr>
<tr>
<td>Hacer menos esperma</td>
<td>Desconocido</td>
<td>&gt;3 años</td>
</tr>
<tr>
<td>Menos crecimiento del vello</td>
<td>6-12 meses</td>
<td>&gt;3 años</td>
</tr>
<tr>
<td>Vello de cabello</td>
<td>Variable</td>
<td>-----</td>
</tr>
</tbody>
</table>

- Algunos cambios en su cuerpo serán permanentes, aun si deja de tomar estrógenos, tales como:
  - **Desarrollo de senos**: Debe aprender a autoexaminarse los senos de forma mensual, hacerse un control médico anual y debe hacerse mamografías a partir de los 50 años de edad.
  - **Hacer menos esperma**: Incluso si se deja de tomar estrógenos, la habilidad de producir esperma sana podría volver o no volver.

- Tomar estrógenos **no** le protegerá de contraer infecciones de transmisión sexual (como el VIH).
- Algunos efectos secundarios peligrosos son:
  - Coágulos de sangre
  - Cáncer de seno
  - Ataques cardíacos
  - Depresión clínica
  - Derrame cerebral
  - Enfermedad hepática
  - Los estrógenos pueden elevar su riesgo de sufrir enfermedades cardíacas, tal como lo hace el fumar cigarillos. Si decide fumar, su proveedor de cuidados de salud podría no recetar estrógenos o podría recetar una dosis más baja. Es importante reducir otros factores de riesgo de enfermedad cardíaca, como el colesterol alto y el sobrepeso.
  - Puede decidir dejar de tomar estrógenos en cualquier momento. Su proveedor de salud también podría detener el tratamiento por razones médicas. Si deja de tomar estrógenos, debe seguir un plan de reducción progresiva de la dosis para evitar así efectos secundarios dañinos.

Lo que necesita hacer

- Avise a su proveedor de salud si usted está tomando algún suplemento dietético, hierbas, drogas (legales o ilegales) obtenidos en la cárcel aparte de los que le han sido recetados u otros medicamentos.
- Si está participando en el programa de servicios de salud mental, debe continuar viéndose con un proveedor de salud mental. Si piensa que necesita servicios de salud mental debe llenar y enviar un Formulario 7362 o indíqueselo a cualquier empleado del CDCR.
- Se le pedirá que firme un formulario de consentimiento informado antes de iniciar su terapia de estrógenos.

Si tiene alguna pregunta, converse con su médico o proveedor de salud mental 🎤
Cambiar de género es un proceso serio y posiblemente peligroso.
Existen muchas cosas que puede hacer para obtener resultados más seguros y mejores para mente y cuerpo:
- No fumar
- No ingerir alcohol ni tomar drogas ilegales
- Mantener un peso sano
- Ejercitarse regularmente
- Debe confiar únicamente en la información que le suministren su médico y proveedores de salud mental.

Lo que necesita saber sobre la terapia de testosterona

- Los efectos de la masculinización por testosterona pueden tomar muchos meses antes de comenzar a notarse y varios años para completarse.

<table>
<thead>
<tr>
<th>Efecto sobre tu cuerpo</th>
<th>Comenzando</th>
<th>Cambio máximo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piel aceitosa/acné</td>
<td>1-6 meses</td>
<td>1-2 años</td>
</tr>
<tr>
<td>Crecimiento de vello facial/corporal</td>
<td>6-12 meses</td>
<td>4-5 años</td>
</tr>
<tr>
<td>La pérdida del cabello del cuero cabelludo</td>
<td>6-12 meses</td>
<td>-----</td>
</tr>
<tr>
<td>Más músculo y fuerza.</td>
<td>6-12 meses</td>
<td>2-5 años</td>
</tr>
<tr>
<td>Menos grasa en las naglas, caderas, muslos</td>
<td>1-6 meses</td>
<td>2-5 años</td>
</tr>
<tr>
<td>Falta de periodos menstruales</td>
<td>1-6 meses</td>
<td>-----</td>
</tr>
<tr>
<td>Clitoris más grande</td>
<td>1-6 meses</td>
<td>1-2 años</td>
</tr>
<tr>
<td>Sequedad vaginal</td>
<td>1-6 meses</td>
<td>1-2 años</td>
</tr>
<tr>
<td>Voz más profunda</td>
<td>6-12 meses</td>
<td>1-2 años</td>
</tr>
</tbody>
</table>

- Algunos cambios en su cuerpo serán permanentes, aun si deja de tomar testosterona, tales como:
  - Pérdida de cabello
  - Crecimiento de vello facial y aumento de vello corporal
  - Intensificación de la voz
- Tomar testosterona no le protegerá de contraer infecciones de transmisión sexual ni de quedar embarazada.
- Si toma testosterona por un largo período de tiempo, podría quedar infértil a futuro, incluso si deja de tomar testosterona.
- Algunos efectos secundarios peligrosos son:
  - Coágulos de sangre
  - Presión arterial alta
  - Enfermedad hepática
  - Depresión clínica
  - Cáncer de seno/ó uterino
  - Comportamiento agresivo/hostilidad
  - Derrame cerebral
  - Ataques cardíacos
- La testosterona puede elevar su riesgo de sufrir enfermedades cardíacas, tal como lo hace el fumar cigarillos. Si decide fumar, su proveedor de cuidados de salud podría no recetar testosterona o podría recetar una dosis más baja. Es importante reducir otros factores de riesgo de enfermedad cardíaca, como el colesterol alto y el sobrepeso.
- Puede decidir dejar de tomar testosterona en cualquier momento. Su proveedor de salud también podría detener el tratamiento por razones médicas. Si deja de tomar testosterona, debe seguir un plan de reducción progresiva de la dosis para evitar así efectos secundarios dañinos.

Lo que necesita hacer

- Avise a su proveedor de salud si usted está tomando algún suplemento dietético, hierbas, drogas (legales o ilegales) obtenidos en la cárcel aparte de los que le han sido recetados u otros medicamentos.
- Si está participando en el programa de servicios de salud mental, debe continuar viéndose con un proveedor de salud mental. Si piensa que necesita servicios de salud mental debe llenar y enviar un Formulario 7362 o indíqueselo a cualquier empleado del CDCR.
- Se le pedirá que firme un formulario de consentimiento informado antes de iniciar su terapia de testosterona.

Si tiene alguna pregunta, converse con su médico o proveedor de salud mental.
When you were born, your body appeared to be male, female, or intersex (a natural body variation that is not male or female).

If your gender identity (your personal sense of your gender) is different from your sex assigned at birth, you may identify as transgender.

Examples:
- You were assigned male at birth and you identify as female (transwoman) or non-binary.
- You were assigned female at birth and you identify as male (transman) or non-binary.
- You were assigned non-binary at birth and you identify as male or female.

Note: Intersex newborns have generally been designated male or female at birth. More recently, some intersex newborns have been designated non-binary on their birth certificates, and they are later assigned a different gender if they develop a male or female gender identity as they grow up.

Do I have to tell anyone that I am transgender or intersex?

- You don’t have to tell anyone that you are transgender or intersex unless you want to request medical treatment, mental health treatment, or accommodations (like clothing, property, different housing, separate showers, or search procedures).
- You can ask any staff member to use the pronouns that are correct for you; staff are required to use the pronouns you say are correct for you.

Examples:
- He, him, his
- She, her, hers
- They, them, theirs

Identifying as transgender does not mean you have a mental health condition, however, it may be helpful to talk to a mental health professional about how you are feeling.

What if I want to request accommodations (like clothing, property, different housing, separate showers, or search procedures)?

- To be housed consistent with your gender identity, talk to CDCR staff such as your medical provider, mental health clinician, nursing staff, Correctional Counselor, etc., about requesting different housing.
- To request accommodations, please see your Correctional Counselor who can assist you in obtaining gender appropriate accommodations per the CDCR Department Operations Manual.
If you have thoughts or feelings related to being uncomfortable with your sex assigned at birth, or you are not sure about your gender identity, you can talk to a mental health professional about this. You don’t need to be in the Mental Health Program to ask to talk to a mental health professional.

What happens once I tell my medical provider that I am transgender, non-binary or intersex?

⇒ If you are not already housed in an institution designated to house transgender inmates, your Correctional Counselor and classification committee will decide if you should be transferred.
⇒ If you are housed in an institution designated to house transgender individuals, you can request to be issued a Transgender Access Card by submitting a Form 22 to your facility sergeant or lieutenant. Your Transgender Access Card is provided to facilitate receipt of clothing, property, and other accommodations approved for transgender individuals.
⇒ You don’t have to have any specific medical or mental health diagnosis to be transferred to a transgender designated facility.
⇒ You will not be automatically included in the Mental Health Program if you are transgender.

Can I be prescribed hormones to change my body to look more male or female?

⇒ You can tell your medical provider that you want to be prescribed hormones for the first time, or continue to take hormones previously prescribed.
⇒ Your medical provider will conduct an assessment and discuss your request with you. Your medical provider will also refer you to a mental health provider for an assessment.
⇒ If your medical provider and your mental health provider agree that hormones are a safe treatment for you, you can be prescribed hormones even if you have never taken them before.
⇒ Your medical provider may prescribe hormones, or may refer you to a specialist, called an endocrinologist, to prescribe hormones.
⇒ A patient education handout about hormone treatment is available from your medical provider. You can ask your medical provider to give you this handout.
⇒ You should only take hormones prescribed to you. Some people are not satisfied with their hormone dosage or blood level because they are not seeing the changes they want in their body. More hormones may harm you rather than making the physical changes you want. Your genetics passed down from your biological parents affect how the hormones are used in your body and how fast/much your body will change.
⇒ Discuss any concerns with your medical providers.
**TRANSGENDER HEALTH WHILE INCARCERATED**

**FREQUENTLY ASKED QUESTIONS (FAQs)**

### CAN I GET OTHER TREATMENT WHILE PRESCRIBED HORMONES, SUCH AS A MODIFIED DIET OR SPECIFIC VITAMINS OR SUPPLEMENTS?

- There are no standardized dietary recommendations for people taking hormones. Decisions about dietary and nutritional needs should be individualized based on each person’s medical assessment.

### CAN I HAVE SURGERY TO CHANGE MY BODY SO IT BETTER MATCHES MY GENDER IDENTITY (ALSO CALLED GENDER AFFIRMING SURGERY)? WHAT TYPE OF SURGERIES ARE AVAILABLE?

- You can tell your medical provider that you want to have gender affirming surgery, or revision of a prior surgery. Your medical provider will talk to you about your surgical options.
- Your medical provider will complete an electronic referral for services, which will start the process for considering your request for surgery. You can ask your medical provider if they have completed this referral, called an "eRFS."
- A mental health provider will be assigned to complete an evaluation. This should be completed within 90 days of the referral. You do not have to be part of the Mental Health Program to be evaluated for gender affirming surgery.
- The medical and mental health evaluation will be sent to a headquarters committee that includes qualified providers trained to consider requests for Gender Affirming Surgery.
- Once a decision is made, you will be informed by a mental health provider and you will meet with a medical provider to talk about next steps.
- If you are approved for surgery, you will be scheduled for an appointment with a surgeon. Some surgeries require additional evaluation and preparation.
- If you have surgery, your housing may be reevaluated to decide where you will be housed after surgery.
The headquarters committee follows guidelines set up by the World Professional Association of Transgender Health (WPATH) and CDCR/CCHCS to decide if surgery is medically necessary and safe. Some of the things considered in the decision include but are not limited to:

- Do you have a condition that might worsen if you have surgery?
- Do you have a condition or behavior that might stop you from healing properly after surgery?
- Is surgery likely to improve your health?
- Are you able to understand the risks of surgery and are you able to make independent decisions?
- Is someone else influencing your decision to have surgery or are you making the decision freely?
- If you are prescribed hormones, have you been on them long enough to benefit from them (about one year)?

**Note:** If you can’t take hormones for a medical reason or don’t want to take them, this criteria does not apply.

Since the headquarters decision takes into account many different medical and mental health factors, the committee is unable to describe for each person the decision process that led to their surgery not being approved.

If the headquarters committee decides that you should receive additional information about the decision, the committee may assign a member to contact your treatment team and communicate the information to you.

If you are not approved for surgery, you can request surgery again one year from the date of the letter from headquarters communicating that your surgery was not approved. Your mental health or medical provider will be able to give you this date.
¿QUÉ SIGNIFICA SER TRANSGÉNERO?

⇒ Cuando nació, su cuerpo parecía ser masculino, femenino o intersexual (una variación natural del cuerpo que no es masculina ni femenina).

⇒ Si su identidad de género (su sensación personal de su género) es diferente de su sexo asignado al nacer, puede identificarse como transgénero.

Ejemplos:
- Fue asignado como hombre al nacer y se identifica como mujer (mujer trans) o no binaria.
- Fue asignado como mujer al nacer y se identifica como hombre (hombre trans) o no binario.
- Fue asignado como no binario al nacer y se identifica como hombre o mujer.

Nota: Los recién nacidos intersexuales generalmente han sido designados como hombres o mujeres al nacer. Más recientemente, algunos recién nacidos intersexuales han sido designados como no binarios en sus certificados de nacimiento, y luego se les asigna un género diferente si desarrollan una identidad de género masculina o femenina a medida que crecen.

¿DEBO DECIRLE A ALGUIEN QUE SOY TRANSGÉNERO O INTERSEXUAL?

⇒ No tiene que decirlo a nadie que es transgénero o intersexual a menos que desee solicitar tratamiento médico, de salud mental o adaptaciones (como ropa, bienes, un alojamiento diferente, duchas separadas o procedimientos de registro corporal diferentes).

⇒ Puede pedirle a cualquier miembro del personal que use los pronombres que son apropiados para usted; se requiere que el personal use los pronombres que usted dice son adecuados para usted.

Ejemplos:
- Él, de él.
- Ella, de ella.
- Ellos, de ellos.

⇒ Identificarse como transgénero no significa que tenga una afección de salud mental, sin embargo, puede ser útil hablar con un profesional de salud mental sobre cómo se siente.

¿QUÉ SUCede SÍ QUIERO SOLICITAR ADAPTACIONES (COMO ROPA, BIENES, UN ALOJAMIENTO DIFERENTE, DUCHAS SEPARADAS O PROCEDIMIENTOS DE REGISTRO CORPORAL DIFERENTES)?

⇒ Para ser alojado de acuerdo con su identidad de género, hable con el personal del CDCR, como su proveedor médico, médico de salud mental, personal de enfermería, consejero correccional, etc., sobre cómo solicitar una vivienda diferente.

⇒ Para ser alojado de acuerdo con su identidad de género, hable con el personal del CDCR como su proveedor médico, clínico de salud mental, personal de enfermería, consejero correccional, etc., para solicitar un alojamiento diferente.
Si tiene pensamientos o sentimientos relacionados con estar incomodo con su sexo asignado al nacer, o no está seguro de su identidad de género, puede hablar con un profesional de la salud mental sobre eso. No necesita estar en el programa de salud mental para pedir hablar con un profesional de salud mental.

¿QUÉ OCURRE UNA VEZ QUE LE DIGO A MI PROVEEDOR MÉDICO QUE SOY TRANSGÉNERO, NO BINARIO O INTERSEXUAL?

⇒ Si aún no está alojado en una institución designada para albergar a residentes transgénero, su Consejero Correccional y el comité de clasificación decidirán si debe ser transferido.
⇒ Si está alojado en una institución designada para albergar a personas transgénero, puede solicitar que se le emita una Tarjeta de Acceso para Transgéneros enviando un formulario 22 al sargento o teniente de su prisión. Su Tarjeta de Acceso para Transgéneros se proporciona para facilitar la recepción de ropa, bienes y otras adaptaciones aprobadas para personas transgénero. 
⇒ No tiene que tener ningún diagnóstico médico o de salud mental específico para ser transferido a una prisión designada para personas transgénero.
⇒ No será incluido automáticamente en el Programa de Salud Mental si es transgénero.

¿Me pueden recetar hormonas para cambiar mi cuerpo para que parezca más masculino o femenino?

⇒ Puede decirle a su proveedor médico que desea que le receten hormonas por primera vez, o continuar tomando hormonas previamente recetadas.
⇒ Su proveedor médico realizará una evaluación y discutirá su solicitud con usted. Su proveedor médico también lo referirá a un proveedor de salud mental para una evaluación.
⇒ Si su proveedor médico y su proveedor de salud mental acuerdan que las hormonas son un tratamiento seguro para usted, se le pueden recetar hormonas incluso si nunca las ha tomado antes.
⇒ Su proveedor médico puede recetarle hormonas, o puede referirlo a un especialista, llamado endocrinólogo, para que le recete hormonas.
⇒ Un folleto de educación para el paciente sobre el tratamiento hormonal está disponible de su proveedor médico. Puede pedirle que le entregue este folleto.
⇒ Solo debe tomar las hormonas que le recetaron. Algunas personas no están satisfechas con su dosis o nivel sanguíneo hormonal porque no están viendo los cambios que desean en su cuerpo. Más hormonas pueden causarle daños en lugar de realizar los cambios físicos que desea. Su genética transmitida por sus padres biológicos afecta cómo se usan las hormonas en su cuerpo y qué tan rápido y qué tanto cambiará su cuerpo.
⇒ Discuta cualquier preocupación con sus proveedores de salud.
¿PUEDO OBTENER OTRO TRATAMIENTO MIENTRAS TOMO HORMONAS RECETADAS, COMO UNA DIETA MODIFICADA, VITAMINAS O SUPLEMENTOS ESPECÍFICOS?

⇒ No hay recomendaciones dietéticas estandarizadas para personas que están tomando hormonas. Las decisiones sobre las necesidades dietéticas y nutricionales deben individualizarse en función de la evaluación médica de cada persona.

¿PUEDO SOMETERME A UNA CIRUGÍA PARA CAMBIAR MI CUERPO DE FORMA QUE ESTE COINCIDA MEJOR CON MI IDENTIDAD (TAMBién LLAMADA CIRUGÍA AFIRMATIVA DE GÉNERO)? ¿QUÉ CLASE DE CIRUGÍAS ESTÁN DISPONIBLES?

⇒ Puede decirle a su proveedor médico que desea someterse a una cirugía de confirmación de sexo, o una revisión de una cirugía previa. Su proveedor médico le hablará sobre sus opciones quirúrgicas.
⇒ Su proveedor médico completará una referencia electrónica para servicios, que comenzará el proceso para considerar su solicitud de cirugía. Puede preguntarle a su proveedor médico si ha completado esta referencia, denominada referencia electrónica para servicios (eRFS, electronic Referral for Services).
⇒ Se asignará un proveedor de salud mental para completar una evaluación. Esto debe completarse antes de los 90 días luego de la referencia. No tiene que ser parte del Programa de Salud Mental para ser evaluado para una cirugía afirmativa de género.
⇒ La evaluación médica y de salud mental se enviarán a un comité de la sede que incluye proveedores calificados capacitados para considerar las solicitudes de cirugía de afirmativa de género.
⇒ Una vez que se tome una decisión, un proveedor de salud mental le informará y se reunirá con un proveedor médico para hablar sobre los próximos pasos.
⇒ Si se aprueba la cirugía, se le programará una cita con un cirujano. Algunas cirugías requieren evaluación y preparación adicionales.
⇒ Si se somete a una cirugía, se puede reevaluar su vivienda para decidir dónde se alojará después de la cirugía.
El comité de la sede principal sigue las pautas establecidas por la Asociación Mundial de Profesionales de la Salud Transgénero (World Professional Association of Transgender Health, WPATH), por el Departamento Correccional y de Rehabilitación de California (California Department of Corrections and Rehabilitation, CDCR) y por los Servicios de Salud Correccional de California (California Correctional Health Care Services, CCHCS) para decidir si la cirugía es médica mente necesaria y segura. Algunas de las cosas consideradas en la decisión incluyen, pero no se limitan a:

- ¿Tiene una afección que podría empeorar si se somete a una cirugía?
- ¿Tiene una condición o comportamiento que podría impedirle curarse adecuadamente después de la cirugía?
- ¿Es probable que la cirugía mejore su salud?
- ¿Puede comprender los riesgos de la cirugía y puede tomar decisiones independientes?
- ¿Alguien más está influyendo en su decisión de someterse a una cirugía o está tomando la decisión libremente?
- Si le recetaron hormonas, ¿las ha tomado lo suficiente como para beneficiarse de ellas (aproximadamente un año)?

Nota: Si no puede tomar hormonas por una razón médica o no desea tomarlas, este criterio no se aplica.

Dado que la decisión de la sede toma en cuenta muchos factores médicos y de salud mental diferentes, el comité no puede describir a cada persona el proceso de decisión que llevó a que su cirugía no fuera aprobada.

Si el comité de la sede decide que debe recibir información adicional sobre la decisión, el comité puede asignar un miembro para que se comunique con su equipo de tratamiento y le comunique la información.

Si no está aprobado para la cirugía, puede solicitar la cirugía nuevamente un año después de la fecha de la carta de la sede que le informa que su cirugía no fue aprobada. Su proveedor de salud mental o médico podrá darle esta fecha.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

I. CLINICAL PROCESS

California Correctional Health Care Services (CCHCS) patients may request Gender Affirming Surgery (GAS) or revision of prior GAS. In accordance with California Code of Regulations Title 15, Section 3999.200, those who request GAS shall be referred by the institution to the Gender Affirming Surgery Review Committee (GASRC), a subcommittee of the Statewide Medical Authorization Review Team (SMART).

II. REFERRAL

When a patient submits a written or verbal request to any health care staff (or a staff member submits a request on behalf of a patient) for GAS, an appointment shall be scheduled with the primary care provider (PCP) within 14 calendar days. The PCP shall submit an electronic Request For Services (eRFS) for GAS as treatment for Gender Dysphoria (GD). If the patient has never been diagnosed with GD the PCP shall refer the patient to a mental health provider in order to assess for a diagnosis of GD. The eRFS shall state that the patient is requesting evaluation for GAS or a specific surgical procedure (listed in Section 2). The Chief Medical Executive or Chief Physician and Surgeon shall perform a secondary level review of the eRFS. Once an eRFS is submitted, appointments shall be scheduled based on local operating procedure to ensure evaluation from the treating medical provider and a written report from the mental health clinician are completed.

A. The institution shall compile and submit the above information within 90 calendar days following an appointment generated by receipt of a documented request for GAS, absent a showing of good cause for an extension, in which case an extension may be granted by GASRC.

B. The patient shall receive one random toxicology screening between the time the eRFS is submitted and the time the referral is sent to GASRC. The provider shall submit a “Quest Misc. Test” (test code 90646) and “Drug Screen Urine Panel 10-50 +ETOH w/Confirmation” (test code 2180), in the order name section, indicate “urine nicotine”. The results of the toxicology screening shall remain confidential and not be disclosed as part of a disciplinary process.

C. The institution shall neither recommend approval nor non-approval of the request for GAS at the first and second institutional levels of review.

D. The institution is responsible for reviewing and providing the following to the GASRC by submitting to CDCRCCCHCSGASRC@cdcr.ca.gov:

1. All information required by the GASRC (Section 1a for initial referrals, Section 1b for subsequent referrals, and Section 1c for surgery revisions) including the requested medical evaluation and mental health written report.

2. CDCR, 7466, Gender Affirming Surgery Request Checklist.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 1a – Initial Request for Surgery

CASE MATERIALS TO BE SUBMITTED TO INSTITUTIONAL LEVELS OF REVIEW AND TO GASRC FOR GAS CONSIDERATION

Institution staff shall prepare the following items for submission to the institutional second level of review of a request for consideration of GAS:

I. AN ELECTRONIC REQUEST FOR SERVICES

II. MEDICAL EVALUATION
   A. A complete medical history including a breast and genital exam within the past year, Body Mass Index (BMI), toxicity screening results, and identification of all medical conditions.

   B. A complete history of medical therapy for gender dysphoria including indicated laboratory monitoring and any current hormone therapy. The institution may note that the patient has not achieved 12 continuous months of hormone medication.

   C. A report of the patient’s adherence with prescribed medical therapies, diagnostic tests, appointments, etc., and patient’s ability to interact productively with providers by attending appointments and cooperating with providers during visits.

III. MENTAL HEALTH EVALUATION
   A. The mental health evaluator shall attend the Regional GAS Mental Health Evaluation Training and complete Attachment 2, Institution Evaluation for Consideration of Gender Affirming Surgery. Send training inquiries to CDCRCCHCSGASRC@cdcr.ca.gov.

   B. Personal background. A summary of the patient’s upbringing from pre-sentence report, diagnostic work-ups, and other clinical materials with any information regarding issues concerning gender identification.

   C. Complete psychological history of gender dysphoria and the patient’s experience with desired gender role inside and outside prison.

   D. Full assessment of psychiatric comorbidities and their current status/stability including:
      1. Gender dysphoria assessment. Most recent mental health evaluation of the patient’s overall mental health status with respect to symptoms related to gender dysphoria.
      2. Any history of self-injurious and suicidal behaviors, especially within the previous 12 months.
      3. Any history of substance use disorder behaviors.
      4. Evaluation to rule out malingering or coercion.
      5. Evaluation of decision-making capacity, if indicated.
      6. Summarize history of inpatient hospitalizations to include Mental Health Crisis Bed (MHCB), Department of State Hospitals (DSH), Psychiatric Inpatient Program (PIP). Identify dates of last inpatient hospitalization, if applicable, and include reason for admission.
      7. If the patient is in the Mental Health Services Delivery System (MHSDS), identify level of care, date of last Interdisciplinary Treatment Team (IDTT) and summarize the contents of the most recent Master Treatment Plan.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 1a – Initial Request for Surgery
(Continued)

E. A report of the patient’s adherence with prescribed mental health therapies, diagnostic tests, appointments, etc., and the patient’s ability to interact productively with clinicians by attending appointments and cooperating with clinicians during visits. The assessment should include all relevant information including attendance and details regarding individual appointments, group appointments, other group activities, and educational and work activities.

F. A report of the patient’s current presentation, functioning, and status of mental health symptoms. Collateral staff interviews shall be conducted.

G. Assessment of the patient’s clinically significant distress as it relates to GD.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 1b – Re-referral for Surgery

CASE MATERIALS TO BE SUBMITTED TO INSTITUTIONAL LEVELS OF REVIEW AND TO GASRC FOR GAS CONSIDERATION

Institution staff shall prepare the following items for submission to the institutional second level of review of a request for consideration of GAS:

I. AN ELECTRONIC REQUEST FOR SERVICES

II. MEDICAL EVALUATION
   A. An updated medical history including a breast and genital exam within the past year, Body Mass Index (BMI), toxicity screening results, and identification of all medical conditions.
   B. An updated history of medical therapy for gender dysphoria including indicated laboratory monitoring and any current hormone therapy. The institution may note that the patient has not achieved 12 continuous months of hormone medication.
   C. An updated report of the patient’s adherence with prescribed medical therapies, diagnostic tests, appointments, etc., and the patient's ability to interact productively with providers by attending appointments and cooperating with providers during visits.

III. MENTAL HEALTH EVALUATION
   A. The mental health evaluator shall attend the Regional GAS Mental Health Evaluation Training and complete Attachment 2 Institution Evaluation for Consideration of GAS. Send training inquiries to CDCRCCCHCSGASRC@cdcr.ca.gov.
   B. An updated history of the patient’s experience with desired gender role inside and outside prison.
   C. A full written assessment of psychiatric comorbidities and their current status/stability including:
      1. Gender dysphoria assessment. Most recent mental health evaluation of the patient’s overall mental health status with respect to symptoms related to gender dysphoria.
      2. An updated history of self-injurious and suicidal behaviors, especially within the previous 12 months, if any.
      3. An updated history of substance use disorder behaviors, if any.
      4. Evaluation to rule out malingered or coercion.
      5. Evaluation of decision-making capacity, if indicated.
      6. Summarize history of inpatient hospitalizations to include MHCB, Department of State Hospitals (DSH), Psychiatric Inpatient Program (PIP). Identify dates of last inpatient hospitalization, if applicable, and include reason for admission.
      7. If the patient is in the MHSDS, identify level of care, date of last Interdisciplinary Treatment Team (IDTT) and summarize the contents of the most recent Master Treatment Plan.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 1b – Re-referral for Surgery
(Continued)

D. An updated report of the patient’s adherence with prescribed mental health therapies, diagnostic tests, appointments, etc., and patient’s ability to interact productively with clinicians by attending appointments and cooperating with clinicians during visits. The assessment should include all relevant information including attendance and details regarding individual appointments, group appointments, other group activities, and educational and work activities.

E. A report of the patient's current presentation, functioning, and status of mental health symptoms. Collateral staff interviews shall be conducted.

F. Assessment of the patient’s clinically significant distress as it relates to GD.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 1c – Revisions to Surgery

CASE MATERIALS TO BE SUBMITTED TO INSTITUTIONAL LEVELS OF REVIEW AND TO GASRC FOR GAS CONSIDERATION

Institution staff shall prepare the following items for submission to the institutional second level of review of a request for consideration of GAS:

I. AN ELECTRONIC REQUEST FOR SERVICES

II. MEDICAL EVALUATION
   A. If not provided in a previous evaluation for GAS, complete medical history, or if previously provided, an updated medical history including a breast and genital exam within the past year, Body Mass Index, toxicity screening results, and identification of all medical conditions.
   B. If not provided in a previous evaluation for GAS, complete history of medical therapy for gender dysphoria, or if previously provided, an updated history including indicated laboratory monitoring and any current hormone therapy.
   C. Description of prior GAS and details of current surgery requested; any prior specialist recommendations for additional surgery.

III. MENTAL HEALTH EVALUATION
   A. The mental health evaluator shall attend the Regional GAS Mental Health Evaluation Training and complete Attachment 2 Institution Evaluation for Consideration of GAS. Send training inquiries to CDCRCCCHCAGASRC@cdcr.ca.gov.
   B. If not provided in a previous evaluation for GAS, personal background. A summary of the patient’s upbringing from pre-sentence report, diagnostic work-ups and other clinical materials with any information regarding issues concerning gender identification.
   C. If not provided in a previous evaluation for GAS, complete psychological history of gender dysphoria and patient’s experience with desired gender role inside and outside prison, or if previously provided, only an updated history of patient’s experience with desired gender role inside and outside prison.
   D. Full assessment of psychiatric comorbidities and their current status/stability including:
      1. Gender dysphoria assessment. Most recent mental health evaluation of the patient’s overall mental health status with respect to symptoms related to gender dysphoria.
      2. Any history or updated history of self-injurious and suicidal behaviors, especially within the previous 12 months, if any.
      3. Any history or updated history of substance use disorder behaviors, if any.
      4. Evaluation to rule out malingering or coercion.
      5. Evaluation of decision-making capacity, if indicated.
      6. Summarize history of inpatient hospitalizations to include MHCB, Department of State Hospitals (DSH), Psychiatric Inpatient Program (PIP). Identify dates of last inpatient hospitalization, if applicable, and include reason for admission.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 1c – Revisions to Surgery
(Continued)

7. If the patient is in the MHSDS, identify level of care, date of last Interdisciplinary Treatment Team (IDTT) and summarize the contents of the most recent Master Treatment Plan.

E. If not provided in a previous evaluation for GAS, a report of the patient’s adherence with prescribed mental health therapies, diagnostic tests, appointments, etc., and the patient’s ability to interact productively with clinicians by attending appointments and cooperating with clinicians during visits. If previously provided only an updated report of patient’s adherence. The assessment should include all relevant information including attendance and details regarding individual appointments, group appointments, other group activities, and educational and work activities.

F. A report of the patient’s current presentation, functioning, and status of mental health symptoms. Collateral staff interviews shall be conducted.

G. Assessment of the patient’s clinically significant distress as it relates to GD.
REFERRAL FOR CONSIDERATION FOR GENDER AFFIRMING SURGERY

SECTION 2 – Surgical Procedures

Surgical procedures which may be authorized for CCHCS/DHCS patients requesting GAS.

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<th>Transwoman:</th>
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<tr>
<td>Vaginoplasty</td>
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<td>Orchiectomy</td>
<td>Hysterectomy</td>
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<td>Penectomy</td>
<td>Salpingo-oophorectomy</td>
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<td>Clitoroplasty</td>
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<td>Labioplasty</td>
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<td>Vulvoplasty</td>
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<td>Scrotoplasty</td>
<td>Scrotoplasty</td>
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<td>Placement of testicular prostheses</td>
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<tr>
<td>Mastectomy and reduction mammoplasty</td>
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<td>Patient name</td>
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<td>CDCR number</td>
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<td>Date of birth/Age</td>
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<td>Commitment Offense</td>
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<td>CDCR sentence length (term)</td>
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<td>Arrival date to CDCR</td>
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<td>Custody classification</td>
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<td>Earliest Possible Release Date (EPRD)</td>
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<td>Current Institution</td>
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<td>Housing (Segregation, Mainline, etc)</td>
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<td>Mental Health Services Delivery System (MHSDS) Level of Care (LOC)</td>
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<tr>
<td>Academic level: Testing of Adult Basic Education (TABE)</td>
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<td>Developmental disability</td>
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<td>Work assignments</td>
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<td>Ethnicity</td>
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<td>Date of Interview for GAS evaluation</td>
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<td>Evaluator</td>
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<td>Date of final report</td>
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**Statement of Limits of Confidentiality:**
This report contains sensitive information subject to misinterpretation by persons without specialized training in psychological assessment. The information in this report should only be used by trained mental health professionals for the diagnosis and treatment of the individual named above. Written consent from the patient named above or that patient's conservator is required for the release of any information hereby enclosed. Non-consensual disclosure is limited under Section 5328, California Welfare and Institutions Code and Section 56.10-56.16 of the Government Code.

In accordance with the Psychological Association's Guidelines for Forensic Evaluation described in the Specialty Guidelines for Forensic Psychology\(^1\), Patient [X] was informed this would be a non-confidential interview and the information provided would be used to develop a report that would be forwarded to the Statewide Medical Authorization Review Team (SMART) to be used in the decision making process for approval or non-approval of GAS. Patient [X] was informed that they are not required to participate in the interview. Patient [X] was informed the evaluator is a mandated reporter, thus they are required to report if the patient is a danger to themselves or others, or if there is a child, elder or disabled person being abused. Pursuant to CDCR policy, Patient [X] was also informed the evaluator is required to report any potential threats to the safety or security of the institution as well as any reported incidents of sexual assault. Patient [X] agreed to participate in the interview.

INSTITUTION EVALUATION FOR CONSIDERATION OF GENDER AFFIRMING SURGERY

Referral Question:
This evaluation was performed in response to a request from Patient [X] that they be considered for GAS, specifically [IDENTIFY SPECIFIC SURGERY REQUESTED BY THE PATIENT]. Consistent with policy guidelines outlined in the Health Care Department Operations Manual, Chapter 4, Article 1, Section 4.1.7 Gender Dysphoria Management Policy\(^2\) and California Correctional Health Care Services (CCHCS)/Department of Health Care Services (DHCS) Care Guide: Transgender\(^3\), this evaluation was undertaken to address Patient X’s request for GAS as a medically necessary treatment for Gender Dysphoria. This evaluation was completed per CCHCS/DHCS Care Guide: Transgender, Attachment 1.

Sources of information Reviewed:
• Electronic Records Management System
• Strategic Offender Management System
• Electronic Health Record System (EHRS)
• Interview with the patient
• Other (identify sources):

Limitations of This Report:
The evaluator requested that back file records, beginning when Patient X first entered CDCR in [identify date], were scanned into EHRS [ONLY KEEP THIS STATEMENT IN IF RELEVANT]. Please note that a number of back file records were hand written illegibly, thus clinical content could not be gleaned [ONLY KEEP THIS STATEMENT IN IF RELEVANT]. The Electronic Unit Health Record (eUHR) spanned the years of 2011-2017 (the electronic platform was retired May 21, 2019). All documentation from eUHR has been scanned into EHRS, but records can be challenging to locate and review. Upon questioning, Patient X reported preferring [identify gender] pronouns, thus hence forward will be referred to as [identify gender]. Historical records and documentation refer to Patient X as [identify gender], thus both pronouns are utilized throughout this report.

\(^2\) http://lifeline/PolicyandAdministration/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch04-art1.7.pdf
\(^3\) http://lifeline/HealthCareOperations/MedicalServices/Care%20Guides%20and%20Tools/Transgender-CG.pdf
PART 1: PRE-CDCR & IN THE COMMUNITY:

Mental Health History Overview
- Summary of the patient’s childhood and upbringing to include:
  - Family history
  - Trauma history (physical, sexual, mental/emotional/verbal, domestic violence)
  - Social history to include:
    - Schooling and history of special education services, if applicable
    - Gang affiliation history
    - Juvenile criminal history (brief review)
    - History of predatory behavior
  - Substance use/abuse history
  - Summary of mental health treatment, if applicable, to include:
    - Diagnoses
    - Reasons why treatment was sought or provided
    - Psychiatric medications, if any
    - History of inpatient hospitalizations
    - History of suicide attempts or self-harming behavior

Gender Identity and Gender Dysphoria
- Summary of when the patient first recognized they did not identify as their biological/assigned gender to include:
  - Age
  - Family reaction/response
  - Patient’s reaction to noticing a difference between their internal sense of gender and their biological/assigned gender
- Identify when the patient was first assessed as transgender (if this did not occur until after incarceration in CDCR, identify)
  - Identify if any other mental health conditions were considered or ruled out
- Treatment sought for issues pertaining to gender identity, if applicable
- Summarize steps taken, if any, in the community to manage gender dysphoria and the outcomes:
  - Social transition-Experience, if applicable, living in desired gender role pre-CDCR. If yes, at what age did this begin? Was it across different settings?
    - Identify any barriers to ‘coming out’ and living as preferred gender
  - Hormone therapy, if applicable - (when, how long, from whom, impact)
  - Identify gender related surgical procedures, if any
  - Identify if the patient pursued legally changing their name or gender

Sexual and Relationship History
- Identify who the patient is sexually attracted to (their sexual orientation)
- Briefly summarize the patient’s romantic relationship history while in the community to include:
  - Have they been married?
  - Have they cohabitated with a romantic partner?
  - Do they have children? If yes, identify how the children were conceived (i.e., conceived in a loving relationship, conceived as a product of sexual assault, conceived after a brief sexual encounter, adopted, etc.)
INSTITUTION EVALUATION FOR CONSIDERATION OF GENDER AFFIRMING SURGERY

PART 2: CDCR TREATMENT:

Mental Health History Overview

- MHSDS patient placement history since being in CDCR to include:
  - Date and reason why the patient was included in the MHSDS
  - Summarize history of inpatient hospitalizations to include Mental Health Crisis Bed (MHCB), Department of State Hospitals (DSH), Psychiatric Inpatient Program (PIP)
    - Identify dates of last inpatient hospitalization, if applicable, and include reason for admission
  - Current LOC

- Summary of diagnoses while in CDCR
- Summary (brief) of treatment focus while in CDCR (i.e., mood stability, psychosis, coping skills, reducing criminal thinking)
- History of suicide attempts or self-harming behavior while incarcerated in CDCR
- Brief case conceptualization for the patient (this can be taken from the Master Treatment Plan)
- Adult social history to include:
  - Gang affiliation/Sensitive Needs Yard (SNY) status
  - Briefly summarize adult criminal history to include identification of predatory behavior as an adult
- Substance use/abuse in CDCR
- Evidence of malingering, if any
- Historical adherence with prescribed therapies, medication(s) and appointments (provide examples)

Gender Identity and Gender Dysphoria

(Please note, this section entails information ONLY pertaining to when the patient was incarcerated within CDCR. If this information was already covered in the ‘Pre-CDCR & In the Community’ section above, please do NOT replicate information here.)

- If the patient was first assessed as transgender after incarcerated in CDCR, identify:
  - Date diagnosis of Gender Identify Disorder (if diagnosed under the DSM III-R or DSM IV) or Gender Dysphoria (if diagnosed under the DSM 5) given
  - Identify if any other mental health conditions were considered or ruled out
- Treatment sought for issues pertaining to gender identity while incarcerated in CDCR
- Summarize steps taken to manage gender dysphoria and the outcomes:
  - Social transition- Experience living in desired gender role while incarcerated in CDCR. Identify date this began.
    - Identify any barriers to ‘coming out’ and living as preferred gender, if any
  - Hormone therapy-(when, how long, from whom, impact)
  - Identify if the patient has pursued legally changing their name

Sexual and Relationship History

(Please note, this section entails information ONLY pertaining to when the patient was incarcerated within CDCR. If this information was already covered in the ‘Pre-CDCR & In the Community’ section above, please do NOT replicate information here.)

- Identify if sexual orientation shifted or changed since being incarcerated
- Identify if sexual orientation shifted or changed since ‘coming out’ as transgender (this question is only relevant if the patient ‘came out’ as transgender after being incarcerated in CDCR; If the patient ‘came out’ in the community, please do NOT repeat information here that was already documented above)
- Identify if sexual orientation has shifted or changed since initiation of hormone therapy (this question is only relevant if hormone therapy was initiated after the patient was incarcerated in CDCR; If the patient
INSTITUTION EVALUATION FOR CONSIDERATION OF GENDER AFFIRMING SURGERY

began hormone therapy in the community, please do NOT repeat information here that was already documented above)

- Identify if the patient is in a romantic relationship currently. If yes, identify if having GAS will impact romantic relationship

PART 3: MENTAL HEALTH ANALYSIS AND GENDER DYSPHORIA EVALUATION:

Current Level of Functioning
(If the patient is not currently in the MHSDS, please speak to the degree of stability for any mental health diagnosis they have been assigned in EHRS. Please also identify that if upon record review and clinical interview, the patient appears to meet criteria for an additional mental health diagnosis.)

- Current MHSDS LOC
- Date of last Interdisciplinary Treatment Team (IDTT) and summarize the contents of the Master Treatment Plan (MTP) to include:
  - Current diagnoses and degree of control/stability for each diagnosis
  - Medication prescribed (if any) for each diagnosis
    - Identify if the patient is medication compliant
  - Individual Plan of Care (IPOC) activated
  - Identify if the patient meets any indicators on the ‘Higher Level of Care Considerations’ tab
- Identify most recent Suicide Risk and Self-Harm Evaluation (SRASHE) risk levels (chronic and acute)
- Current presentation, functioning, and status of mental health symptoms as reported by:
  - Primary clinician
  - Psychiatrist
  - Custody staff familiar with the patient (i.e., regular block housing officers, treatment center officers, yard officers, work supervisors)
  - Other staff as relevant
  - Collateral staff interviews should query:
    - How does patient function?
    - Do they program (attend yard, dayroom, chow, etc.)?
    - Do they shower or do they tend to ‘bird bath’ in the cell?
    - How do they socialize with other inmates?
    - How do they interact with other staff?
    - Do you observe them in any distress? If yes, please explain
    - Do you observe them to be avoiding any activities? If yes, please explain
- Summarize content of any 7362 (sick call slip) submitted by the patient within past calendar year that are related to mental health
- Summary of Rules Violation Reports (RVR) for past year. If the patient was in the MHSDS, identify if the Mental Health Assessment (MHA) assessed mental health influenced the RVR
- Mental status examination during the interview for the GAS evaluation

Gender Dysphoria Evaluation Specific to the Request for GAS

- Identify if the patient meets DSM 5 criteria for Gender Dysphoria
- Identify if the patient has the capacity to make a fully informed decision and to consent for treatment
- Identify if the patient has lived full time in their desired gender role for at least 12 months (as is reasonable in the prison setting)
- Identify if the patient has received 12 continuous months of hormone therapy as appropriate to their gender goals (unless there was a medical contraindication to this therapy or the patient is otherwise unable or unwilling to take hormones)
INSTITUTION EVALUATION FOR CONSIDERATION OF GENDER AFFIRMING SURGERY

- Explore possibility that the GAS request arises from:
  - Coercion by others
  - Desire to escape from predatory or coercive inmates
  - Factitious Disorder
  - Body Dysmorphic Disorder
  - Personality Disorder
    - i.e., Borderline Personality Disorder and identity diffusion issues
  - Psychosis
  - Substance abuse (i.e., seeking opiate medication following surgery)

- Provide a summary and assessment of the patient’s relationship with their body to include the nature and degree of “clinically significant distress” as it relates to Gender Dysphoria, their understanding of physical changes and of possible changes in housing following GAS
  - Ask the patient the below questions (record patient’s answers verbatim):
    - What part or parts of your body do you find most difficult to accept?
    - What kinds of thoughts do you have around this problem?
    - In a perfect world, how would you like these body parts to be?
    - Do you avoid any activities, people or places because of your body?
    - How do you cope with your body not being the way you want it right now?
    - Why are you requesting GAS at this time?
    - What are the desired physical outcomes?
    - How do you think you will look and feel following surgery?
    - What type of institution (i.e., male or female) would you like to be housed in post-GAS?
    - How would you cope if you experienced physical complications or dissatisfaction after the GAS (identify specific coping skills)?
    - What is your plan for GAS post-surgical recovery to include physical and psychological?
    - For a Transman Patient: How do you currently cope with your breasts? (i.e., do you wear a binder? Do you wear multiple layers?)
    - For a Transwoman Patient: How do you shower in your current male institution? Do you wear a bra or covering when showering?
  - People’s experience of Gender Dysphoria often includes thoughts that can be consuming, ruminative or intrusive, and may interfere with attention, concentration, learning, task completion, and mood regulation. This is titled “Gender Dysphoria Noise.” Do you experience this? If yes, please identify the things you think about or worry about, that may impact your ability to focus, concentrate, complete tasks, or attend to other matters.
    - Identify if the patient has the psychological ability to cope and adjust with housing changes if after GAS, they are assessed to be appropriate to house in a prison that aligns with their gender identity
    - Identify if there are mental health issues that may deteriorate following GAS or potentially impede surgical recovery (i.e., anxiety, substance abuse, Post-Traumatic Stress Disorder)

Manifestation and Assessment of distress related to Gender Dysphoria
- Identify if there is distress related to the patient’s body. If distress is reported, does distress impact functioning in the below areas:
  - Living environment (housing units, showers)
  - Programming (yard, work, school, etc)
  - Relationships (familial, social and romantic)
  - Mental wellbeing
INSTITUTION EVALUATION FOR CONSIDERATION OF GENDER AFFIRMING SURGERY

- Identify if the patient avoids any activities due to Gender Dysphoria
- Per the patient’s report, identify how their life would change if they received GAS to include:
  - Life while incarcerated in CDCR
  - Life in the community upon release from incarceration
- As the evaluator, identify if you observed any outward signs of distress related to Gender Dysphoria in the patient (i.e., What is your experience of sitting in the room, as a clinician, talking about issues related to Gender Dysphoria with the patient? Does the patient seem serious, depressed, stressed, flippant, defiant?)
Gender Affirming Surgery (Feminizing)

Patient Education

Gender Affirming Surgery is a surgical procedure or procedures that changes a person’s physical appearance and/or their sex characteristics to align with their gender identity. There are several different types of gender affirming surgeries. Feminizing gender affirming surgeries make your body look more female.

WHAT TO KNOW IF CONSIDERING SURGERY

- Surgery is not needed for legal changes in California (gender change, birth certificate, name change)
- Surgery is a serious and possibly dangerous process. Some changes from surgery are permanent and cannot be reversed
- Smoking is not good for your body before and after surgery. Discuss any substance use, including nicotine or alcohol, with your doctor
- Several surgeries and procedures may be needed

The entire process can take more than a year including hair removal procedures, surgery or surgeries, and recovery time

- If you have surgery your doctor will give you instructions to follow. It is important you follow the instructions for your body to heal correctly
- Your decisions about any surgery should be carefully based on information from your doctor and mental health providers.

WHO IS ELIGIBLE FOR SURGERY?

- Patients who are diagnosed with Gender Dysphoria
- Patients of legal age (in California, 18 years old)

Patients must also:

- Be able to make their own medical decisions and agree to surgery
- Be able to understand that some surgeries cannot be reversed and that bad side effects of the surgery (if they happen) can be permanent
- Have a mental health/psychological exam to be sure that they can make it through the difficult surgery process and stick to their new lifestyle after surgery
- Have a medical history/check-up and lab tests to be sure there are no medical conditions that make surgery too dangerous to the patient

WHO CANNOT HAVE SURGERY?

In general, surgery is not recommended for patients:

- Who have serious depression or other mental health conditions not under control
- Who have a serious medical condition that is not under control
- Who smoke, abuse drugs and/or alcohol
- Who have a history of not following lifestyle, medical, or mental health interventions
- Who cannot follow instructions before and after surgery

LEARN THE TERMS

Gender Identity: A person’s feeling of being male, female, non-binary, or none of these.

Gender Dysphoria: Distress caused by a difference between a person’s gender identity and their sex assigned at birth.

Transgender: A group of people whose gender identity differs from their sex assigned at birth.

Transman: A person with a masculine gender identity who was assigned a female sex at birth.

Transwoman: A person with a feminine gender identity who was assigned a male sex at birth.

Non-binary: A term used by some people who do not identify as either male or female.
CCHCS Care Guide: Transgender

ATTACHMENT 3

Gender Affirming Surgery (Feminizing)

WHAT FEMINIZING SURGERIES ARE OFFERED THROUGH CDCR?

- **Vaginoplasty** - make a complete, functioning vagina
- **Vulvoplasty** - make all the parts of a vagina except canal (not a functional vagina)
- **Orchiectomy** - remove testicles
- **Penectomy** - remove penis
- **Clitoroplasty** - make a clitoris
- **Labiaplasty** - change size and shape of labia

_Vaginoplasty is the most common surgery requested by patients who want their bodies to look more feminine._

1. **Penile inversion vaginoplasty**
   - Use the penis skin to make a vagina
   - Cannot be reversed
   - Cause permanent infertility

2. **Intestinal vaginoplasty**
   - Use part of the colon to make a vagina
   - Cannot be reversed
   - Higher risk of complications
   - Cause permanent infertility
   - Some patients cannot have this surgery because they may have other medical conditions

_All vaginoplasty procedures require ongoing dilation (inserting a tool to stretch vagina to keep it open). Patients follow directions to do their own dilation._

The type of surgery performed is decided through discussions between the patient and surgeon of what is best for the patient.

WHAT CAN YOU EXPECT IF YOU HAVE VAGINOPLASTY SURGERY?

- Surgery is done in a hospital
- General anesthesia is used, this means patients are asleep during the procedure
- Surgery usually takes several hours and medical staff monitors for any complications
- Patients stay in the hospital for 3 days on average
- Patients will wear a urethral catheter (urinate through a tube) and vaginal bandages for 7-10 days
- It takes 12 weeks to fully heal on average

Penile inversion vaginoplasty – Results are different for each patient and may not look like the picture.

FOUR TAKEAWAYS

#1 Vaginoplasty is the most common feminizing surgery requested.

#2 If you have vaginoplasty surgery you will need to dilate (insert a tool to stretch vagina) every day and possibly for life.

#3 Results after surgery, including the look, size, depth, and shape of the new vagina are different for each patient.

#4 Recovery after vaginoplasty surgery can take 12 weeks or more.
Gender Affirming Surgery (Feminizing)

WHAT ARE THE RISKS AND COMPLICATIONS OF SURGERY?

All surgeries carry risks. The surgeon will explain all potential risks and/or complications, and answer any questions patients might have. Some possible risks and complications are listed below.

Possible Immediate Complications Include (but not limited to):

- Bleeding
- Hematoma (blood collection)
- Injury to rectum
- Injury to urinary tract
- Seroma (fluid collection)
- Infection
- Poor wound healing
- Tissue death
- Blood clots
- Fistulas (can lead to stool and urine leaking in vagina)

Possible Late Complications Include (but not limited to):

- Vaginal narrowing
- Urethra narrowing
- Abnormal urine stream
- Sexual dysfunction
- Fistulas (can lead to stool and urine leaking in vagina)

HOW TO REQUEST GENDER AFFIRMING SURGERY

- Submit a CDCR 7362 Health Care Services Request Form or tell your doctor, mental health clinician, or nurse that you would like to be considered for surgery.
- Your doctor will submit your request for surgery and perform a physical exam.
- Once your request is submitted, you will be interviewed by your mental health clinician.
- Your information including your request for surgery, your doctor’s report about your health, and your mental health interview will be sent to a committee of doctors and mental health clinicians.
- This committee, known as the Gender Affirming Surgery Review Committee, will consider many factors when making a decision (especially your health and safety) to either approve or not approve you for surgery.

WHAT CAN YOU DO TO BE A GOOD CANDIDATE FOR SURGERY?

- Don’t smoke or abuse drugs or alcohol
- Go to your doctor/mental health appointments and follow their instructions
- Consistently take your hormones (unless your doctor says you shouldn’t)
- Be at a healthy weight
- Have a good understanding of the risks and complications of surgery, the permanent changes from surgery, and the short and long-term treatments after surgery

KNOW YOUR RESOURCES

1. To obtain clothing/personal property such as bras, panties, makeup, and other items:
   - Submit a Form 22 requesting the item
2. To start hormone therapy or if you have a problem with your current hormone treatment:
   - Submit a CDCR 7362 Health Care Services Request Form
3. A Transgender Support Group may be available in your prison. Ask your mental health clinician.

FOR ANY QUESTIONS OR CONCERNS, TALK TO YOUR DOCTOR OR MENTAL HEALTH PROVIDER
Cirugía afirmativa de género (feminizante)

Educación para el paciente

La cirugía afirmativa de género es un procedimiento o procedimientos quirúrgicos que cambian la apariencia física de una persona y sus características sexuales para alinearse con su identidad de género. Hay varios tipos diferentes de cirugías afirmativas de género. Las cirugías afirmativas de género feminizantes hacen que su cuerpo se vea más femenino.

¿QUÉ HAY QUE SABER SI SE CONSIDERA LA CIRUGÍA?

La cirugía no es necesaria para cambios legales en California (cambio de género, certificado de nacimiento o cambio de nombre).

La cirugía es un proceso serio y posiblemente peligroso. Algunos cambios de la cirugía son permanentes y no se pueden revertir.

- Fumar antes o después de la cirugía no es bueno para su cuerpo. Discuta con su médico el uso de cualquier substancia, incluyendo la nicotina y el alcohol.
- Es posible que se necesiten varias cirugías y procedimientos.

El proceso completo puede tomar más de un año, incluidos los procedimientos de eliminación de vello, la cirugía o cirugías y el tiempo de recuperación.

- Si se somete a una cirugía, su médico le dará instrucciones que debe seguir; es importante que las siga para que su cuerpo sane correctamente.
- Sus decisiones sobre cualquier cirugía deben basarse cuidadosamente en la información de su médico y proveedores de salud mental.

¿QUIÉN ES ELEGIBLE PARA LA CIRUGÍA?

- Pacientes diagnosticados con disforia de género.
- Pacientes mayores de edad (18 años en California).

Los pacientes también deben:
- Poder tomar sus propias decisiones médicas y estar de acuerdo con la cirugía.
- Ser capaces de comprender que algunas cirugías no pueden revertirse y que los efectos secundarios negativos de la cirugía (si ocurren), pueden ser permanentes.
- Hacerse un examen de salud mental o psicológico para estar seguros de que pueden superar el difícil proceso de la cirugía y adaptarse a su nuevo estilo de vida después de la cirugía.
- Tener una historia médica, así como un examen médico y pruebas de laboratorio para asegurarse de que no haya afecciones médicas que hagan la cirugía demasiado peligrosa para el paciente.

CONOZCA LOS TÉRMINOS

Identidad de género: el sentimiento de una persona de ser hombre, mujer, no bina o ninguno de estos.

Disforia de género: angustia causada por una diferencia entre la identidad de género de una persona y su sexo asignado al nacer.

Transgénero: un grupo de personas cuya identidad de género difiere de su sexo asignado al nacer.

Hombre trans: una persona con identidad de género masculina a la que se le asignó un sexo femenino al nacer.

Mujer trans: una persona con identidad de género femenina a la que se le asignó un sexo masculino al nacer.

No binario: un término utilizado por algunas personas que no se identifican como hombre o mujer.
Cirugía afirmativa de género (feminizante)

¿CUÁLES CIRUGÍAS FEMINIZANTES SE OFREcen A TRAVÉS DEL CDCR?

- **Vaginoplastia**: hacer una vagina completa y funcional.
- **Vulvoplastia**: hacer todas las partes de una vagina excepto el canal (no es una vagina funcional).
- **Orquiectomía**: extirpar los testículos.
- **Penectomía**: quitar el pene.
- **Clitoroplastia**: hacer un clítoris.
- **Labioplastia**: cambiar el tamaño y forma de los labios.

La *vaginoplastia* es la cirugía más comúnmente solicitada por pacientes que deseen que sus cuerpos se vean más femeninos.

1. **Vaginoplastia de inversión del pene**
   - Se usa la piel del pene para hacer una vagina.
   - No se puede revertir.
   - Causa infertilidad permanente.

2. **Vaginoplastia intestinal**
   - Se usa parte del colon para hacer una vagina.
   - No se puede revertir.
   - Alto riesgo de complicaciones.
   - Causa infertilidad permanente.
   - Algunos pacientes no pueden someterse a esta cirugía porque pueden tener otras afecciones médicas.

**TODOS** los procedimientos de vaginoplastia requieren dilatación continua (insertando una herramienta para estirar la vagina y mantenerla abierta). Los pacientes siguen instrucciones para hacer su propia dilatación.

El tipo de cirugía a realizar se decide a través de discusiones entre el paciente y el cirujano de lo que es mejor para el paciente.

¿QUÉ PUEDE ESPERAR SI TIENE UNA CIRUGÍA DE VAGINOPLASTIA?

- La cirugía se hace en un hospital.
- Se utiliza anestesia general, esto significa que los pacientes están dormidos durante el procedimiento.
- La cirugía normalmente toma varias horas y el personal controlará cualquier complicación.
- Generalmente, los pacientes permanecen en el hospital por unos 3 días.
- Los pacientes usarán un catéter uretral (orinarán a través de un tubo) y vendajes vaginales entre 7 y 10 días.
- En promedio toma 12 semanas para sanar completamente.

**CUATRO PUNTOS IMPORTANTES**

#1 La vaginoplastia es la cirugía de feminizante más solicitada.
#2 Si se somete a una cirugía de vaginoplastia, deberá dilatarse (insertar una herramienta para estirar la vagina) todos los días y posiblemente de por vida.
#3 Los resultados después de la cirugía, incluida la apariencia, el tamaño, la profundidad y la forma de la nueva vagina son diferentes para cada paciente.
#4 La recuperación después de la cirugía de vaginoplastia puede tomar 12 semanas o más.
Cirugía afirmativa de género (feminizante)

¿CUÁLES SON LOS RIESGOS Y COMPLICACIONES DE LA CIRUGÍA?

Todas las cirugías conllevan riesgos. El cirujano explicará todos los riesgos y complicaciones potenciales, y responderá cualquier pregunta que los pacientes puedan tener. A continuación, se enumeran algunos posibles riesgos y complicaciones.

Las posibles complicaciones inmediatas incluyen (pero no se limitan a):

- Hemorragia.
- Hematoma (acumulación de sangre).
- Lesión en el recto.
- Lesión en el tracto urinario.
- Seroma (acumulación de fluidos).
- Infección.
- Curación deficiente de las heridas.
- Muerte de tejido.
- Coágulos de sangre.
- Fístulas (pueden filtrarse heces y orina a la vagina).

¿CÓMO SOLICITAR LA CIRUGÍA AFIRMATIVA DE GÉNERO?

- Envíe un formulario de solicitud de servicios de atención médica CDCR 7362 o dígale a su médico, terapeuta de salud mental o enfermera que le gustaría que se le considere para una cirugía.
- Su médico enviará su solicitud de cirugía y le realizará un examen físico.
- Una vez que su solicitud sea enviada, su terapeuta de salud mental lo entrevistará.
- Su información, incluida su solicitud de cirugía, el informe de su médico sobre su salud y su entrevista de salud mental se enviarán a un consejo de médicos y terapeutas de salud mental.
- Este consejo, conocido como Consejo de Revisión de Cirugía Afirmativa de Género, considerará muchos factores al tomar la decisión (especialmente su salud y seguridad) de autorizarlo o no para la cirugía.

¿CAMBIARÁ SU LUGAR DE DOMICILIO?

La Custodia decide la ubicación de su vivienda basándose en la protección y la seguridad.

¿QUÉ PUEDE HACER PARA SER UN BUEN CANDIDATO PARA LA CIRUGÍA?

- No fume ni abuse de drogas o el alcohol.
- Vaya a las citas con su médico y de salud mental y siga sus instrucciones.
- Tome sus hormonas sistemáticamente (a menos que su médico le diga que no debe hacerlo.
- Manténgase en un peso saludable.
- Tenga una buena comprensión de los riesgos y complicaciones de la cirugía, los cambios permanentes y los tratamientos a corto y largo plazo.

Conozca sus recursos

1. Para obtener ropa y accesorios personales como sostenes, ropa interior, maquillaje y otros artículos:
   - Envíe un formulario 22 solicitando el artículo.

2. Para comenzar la terapia hormonal o si tiene un problema con su tratamiento hormonal actual:
   - Envíe un formulario de solicitud de servicios de atención médica CDCR 7362.

3. Un grupo de apoyo para transgéneros puede estar disponible en su prisión. Pregúntele a su terapeuta de salud mental.
# Gender Affirming Surgery (Masculinizing)

## Patient Education

**Gender Affirming Surgery** is a surgical procedure or procedures that changes a person’s physical appearance and/or their sex characteristics to align with their gender identity. There are several different types of gender affirming surgeries. Masculinizing gender affirming surgeries make your body look more male.

### WHAT TO KNOW IF CONSIDERING SURGERY

- Surgery is **not needed** for legal changes in California (gender change, birth certificate, name change)
- Some people should not have surgery because the risk of bad effects is too high

*Surgery is a serious and possibly dangerous process. Some changes from surgery are permanent and cannot be reversed.*

- Smoking is not good for your body before and after surgery. Discuss any substance use, including nicotine or alcohol, with your doctor
- Several surgeries and procedures may be needed

*The entire process can take months to more than a year including surgery or surgeries and recovery time.*

- If you have surgery your doctor will give you instructions to follow. It is important you follow the instructions for your body to heal correctly

### WHO IS ELIGIBLE FOR SURGERY?

- Patients who are diagnosed with Gender Dysphoria
- Patients of legal age (in California, 18 years old)

**Patients must also:**

- Be able to make their own medical decisions and agree to surgery
- Be able to understand that some surgeries cannot be reversed and that bad side effects of the surgery (if they happen) can be permanent
- Have a mental health/psychological exam to be sure that they can make it through the difficult surgery process and stick to their new lifestyle after surgery
- Have a medical history/check-up and lab tests to be sure there are no medical conditions that make surgery too dangerous to the patient

### WHO CANNOT HAVE SURGERY?

In general, surgery is **not recommended** for patients:

- Who have serious depression or other mental health conditions not under control
- Who have a serious medical condition that is not under control
- Who smoke, abuse drugs and/or alcohol
- Who have a history of not following lifestyle, medical, or mental health interventions
- Who cannot follow instructions before and after surgery

### LEARN THE TERMS

**Gender Identity**: A person’s feeling of being male, female, non-binary, or none of these.

**Gender Dysphoria**: Distress caused by a difference between a person’s gender identity and their sex assigned at birth.

**Transgender**: A group of people whose gender identity differs from their sex assigned at birth.

**Transman**: A person with a masculine gender identity who was assigned a female sex at birth.

**Transwoman**: A person with a feminine gender identity who was assigned a male sex at birth.

**Non-binary**: A term used by some people who do not identify as either male or female.
Gender Affirming Surgery (Masculinizing)

WHAT MASCULINIZING SURGERIES ARE OFFERED THROUGH CDCR?

- Mastectomy – remove breasts
- Reduction mammoplasty – make breasts smaller
- Vaginectomy – remove vagina
- Hysterectomy – remove uterus
- Salpingo-oophorectomy - remove ovaries
- Metoidioplasty - make a penis using genital tissue
- Phalloplasty - make a penis using other parts
- Scrotoplasty – make a scrotum
- Urethroplasty – reconstruct or replace urethra
- Placement of testicular prostheses

Removal of uterus and/or ovaries can lead to permanent infertility. Removal of ovaries can lead to early bone thinning and decreased bone strength, which can lead to bones breaking.

*Mastectomy* is the most common surgery requested by transgender patients who want their bodies to look more masculine.

There are different types of mastectomy surgeries. The three most common types are:

1. Periareolar “keyhole mastectomy”
   - Small, less noticeable scar
   - Higher risk of complications

2. Buttonhole mastectomy
   - Ability to change the position of nipple (NAC)
   - More noticeable scar
   - Higher risk of additional surgeries

3. Double incision mastectomy with free nipple graft
   - Most common procedure of the three
   - Ability to resize/change position of nipple (NAC)
   - Most noticeable scar
   - Low risk of additional surgeries

The type of surgery performed is decided through discussions between the patient and surgeon of what is best for the patient.
WHAT CAN YOU EXPECT IF YOU HAVE MASTECTOMY (TOP) SURGERY?

- Surgery is done in a hospital
- General anesthesia is used, this means patients are asleep during the procedure
- Surgery usually takes several hours and medical staff monitors for any complications
- After surgery, patients will have tubes in their chest to drain fluid
- Patients will need to wear a compression vest for at least two weeks after surgery
- Patients need to sleep on their back for at least the first week and avoid heavy exercise for 4-6 weeks
- Full recovery can take several months

WHAT ARE THE RISKS AND COMPLICATIONS OF MASTECTOMY (TOP) SURGERY?

All surgeries carry risks. The surgeon will explain all potential risks and/or complications, and answer any questions patients might have. Some possible risks and complications are listed below.

Potential Complications Include (but not limited to):

- Infection
- Nipple necrosis (tissue death)
- Hematoma (blood collection)
- Seroma (fluid collection)
- Poor wound healing
- Blood clots (can lead to death)

The results of surgery are different for each patient. Your breast size and position, health of skin, and nipple size and position affect the way your chest will look after surgery.

Surgery will lead to scar tissue and can decrease skin and nipple sensitivity.

WHAT ARE YOUR OPTIONS FOR GENITAL (BOTTOM) SURGERY?

Metoidioplasty and Phalloplasty are the two most common bottom surgeries for patients who want male genitals.

Metoidioplasty — creating a penis from existing genital skin usually an enlarged clitoris after taking testosterone for a long time

- Results are approximately a penis with 1-3 inch length and width the size of a thumb
- Can often permit urination while standing (not guaranteed)
- Minimal visible scarring
- May not be capable of penetration during sex

Phalloplasty — creating a penis using skin from parts of the body

- Skin is removed from parts of the body, such as the forearm or thigh
- Often a penile prosthesis (device placed inside penis) is needed to permit penetration during sex
- Longer recovery time than metoidioplasty
- Scarring where tissue was removed
- Likely to require multiple surgeries and/or revisions
- Higher rates of complications

FOUR TAKEAWAYS

#1 Mastectomy is the most common masculinizing surgery requested.

#2 Results after surgery, including the look and size of the new chest are different for each patient.

#3 There will be scarring after having mastectomy surgery.

#4 Metoidioplasty and Phalloplasty are common procedures to create a penis. Requirements, results, and recovery are different for each procedure and should be discussed with your doctor.
Gender Affirming Surgery (Masculinizing)

WHAT ARE THE RISKS AND COMPLICATIONS OF GENITAL (BOTTOM) SURGERY?

All surgeries carry risks. The surgeon will explain all potential risks and/or complications, and answer any questions patients might have. Some possible risks and complications are listed below.

Potential Complications Include (but not limited to):

- Scar tissue can lead to narrowing of the urethra, which can lead to weak urine flow or obstruction. This can be painful, and blockage of urine can lead to permanent kidney damage.
- Fistulas (can lead to urine leaking to other places such as the skin surface)
- Vagina may not remain closed after surgery
- Poor wound healing
- Tissue death
- Blood clot and/or pulmonary embolism (blood clot in the lungs), which can lead to death

WHAT CAN YOU DO TO BE A GOOD CANDIDATE FOR SURGERY?

- Don’t smoke or abuse drugs or alcohol
- Go to your doctor/mental health appointments and follow their instructions
- Consistently take your hormones (unless your doctor says you shouldn’t)
- Be at a healthy weight
- Have a good understanding of the risks and complications of surgery, the permanent changes from surgery, and the short and long-term treatments after surgery

WILL YOUR HOUSING LOCATION CHANGE?

Your housing location is decided by Custody based on safety and security.

HOW TO REQUEST GENDER AFFIRMING SURGERY

- Submit a CDCR 7362 Health Care Services Request Form or tell your doctor, mental health clinician, or nurse that you would like to be considered for surgery.
- Your doctor may evaluate you before submitting your request for surgery.
- If your request is submitted, you will be interviewed by your mental health clinician.
- Your information including your request for surgery, your doctor’s report about your health, and your mental health interview will be sent to a committee of doctors and mental health clinicians.
- This committee, known as the Gender Affirming Surgery Review Committee, will consider many factors when making a decision (especially your health and safety) to either approve or not approve you for surgery.

KNOW YOUR RESOURCES

1. To obtain clothing/personal property such as bras, panties, makeup, and other items:
   - Submit a Form 22 requesting the item
2. To start hormone therapy or if you have a problem with your current hormone treatment:
   - Submit a CDCR 7362 Health Care Services Request Form
3. A Transgender Support Group may be available in your prison. Ask your mental health clinician.

FOR ANY QUESTIONS OR CONCERNS, TALK TO YOUR DOCTOR OR MENTAL HEALTH PROVIDER
Cirugía afirmativa de género (masculinizante)

Educación para el paciente

La cirugía afirmativa de género es un procedimiento o procedimientos quirúrgicos que cambian la apariencia física de una persona y sus características sexuales para alinearse con su identidad de género. Hay varios tipos diferentes de cirugías de afirmativas de género. Las cirugías de afirmativas de género masculinizantes hacen que su cuerpo se vea más masculino.

¿QUÉ HAY QUE SABER SI SE CONSIDERA LA CIRUGÍA?

- La cirugía no es necesaria para cambios legales en California (cambio de género, certificado de nacimiento o cambio de nombre).
- Algunas personas no deben someterse a la cirugía porque el riesgo de efectos negativos es demasiado alto.

La cirugía es un proceso serio y posiblemente peligroso. Algunos cambios de la cirugía son permanentes y no se pueden revertir.

- Fumar antes o después de la cirugía no es bueno para su cuerpo. Discuta con su médico el uso de cualquier sustancia, incluyendo la nicotina y el alcohol.
- Es posible que se necesiten varias cirugías y procedimientos.

El proceso completo puede tomar de varios meses a más de un año incluyendo la cirugía o las cirugías más el tiempo de recuperación.

- Si se somete a una cirugía, su médico le dará instrucciones que debe seguir; es importante que las siga para que su cuerpo sane correctamente.

¿QUIÉN NO PUEDE SOMETERSE A LA CIRUGÍA?

Por lo general, la cirugía se recomienda para los pacientes:

- Que tienen una depresión grave u otras afecciones de salud que no están bajo control.
- Que tienen una afección médica grave que no está bajo control.
- Que fuman, abusan de drogas o alcohol.
- Que tienen antecedentes de no seguir las recomendaciones de estilo de vida, médicas o de salud mental.
- Que no pueden seguir instrucciones antes o después de la cirugía.

¿QUIÉN ES ELEGIBLE PARA LA CIRUGÍA?

- Pacientes diagnosticados con disforia de género.
- Pacientes mayores de edad (18 años en California).

Los pacientes también deben:

- Poder tomar sus propias decisiones médicas y estar de acuerdo con la cirugía.
- Ser capaces de comprender que algunas cirugías no pueden revertirse y que los efectos secundarios negativos de la cirugía (si ocurren), pueden ser permanentes.
- Hacerse un examen de salud mental o psicológico para estar seguros de que pueden superar el difícil proceso de la cirugía y adaptarse a su nuevo estilo de vida después de la cirugía.
- Tener una historia médica, así como un examen médico y pruebas de laboratorio para asegurarse de que no haya afecciones médicas que hagan la cirugía demasiado peligrosa para el paciente.

CONOZCA LOS TÉRMINOS

Identidad de género: el sentimiento de una persona de ser hombre, mujer, no binoario o ninguno de estos.

Disforia de género: angustia causada por una diferencia entre la identidad de género de una persona y su sexo asignado al nacer.

Transgénero: un grupo de personas cuya identidad de género difiere de su sexo asignado al nacer.

Hombre trans: una persona con identidad de género masculina a la que se le asignó un sexo femenino al nacer.

Mujer trans: una persona con una identidad de género femenina a la que se le asignó un sexo masculino al nacer.

No binoario: un término utilizado por algunas personas que no se identifican como hombre o mujer.
¿QUÉ CIRUGÍAS MASCULINIZANTES SE OFRECEN EN A TRAVÉS DEL CDCR?

- Mastectomía: extirpar los senos.
- Mamoplastia de reducción: reducir los senos.
- Vaginectomía: eliminar la vagina.
- Histerectomía: extirpar el útero.
- Salpingo-ooporectomía: eliminar los ovarios.
- Metoidioplastia: hacer un pene con tejido genital.
- Faloplastia: hacer un pene con otras partes.
- Escrotoplastia: hacer un escroto.
- Uretroplastia: reconstruir o reemplazar la uretra.
- Colocar prótesis testiculares.

La extracción del útero y los ovarios puede provocar infertilidad permanente. La extracción de los ovarios puede provocar un adelgazamiento óseo temprano y una disminución de la resistencia ósea, lo que puede llevar a la fractura de los huesos.

La mastectomía es la cirugía más comúnmente solicitada por pacientes transgénero que desean que sus cuerpos se vean más masculinos.

Existen diferentes clases de cirugías de mastectomía. Los tres tipos más comunes son:

1. **Mastectomía periareolar “ojo de cerradura”**
   - Cicatriz pequeña, menos evidente.
   - Mayor riesgo de complicaciones.

2. **Mastectomía de ojal**
   - Capacidad para cambiar la posición de pezón (complejo areola – pezón, CAP).
   - Cicatriz más notable.
   - Mayor riesgo de cirugías adicionales.

3. **Mastectomía de doble incisión con injerto de pezón libre**
   - El más común de los tres procedimientos.
   - Capacidad para cambiar el tamaño y la posición del pezón (CAP).
   - Cicatriz menos notable.
   - Bajo riesgo de cirugías adicionales.

El tipo de cirugía a realizar se decide a través de discusiones entre el paciente y el cirujano de lo que es mejor para el paciente.
¿QUÉ PUEDE ESPERAR SI TIENE UNA CIRUGÍA DE MASTECTOMÍA (SUPERIOR)?

- La cirugía se hace en un hospital.
- Se utiliza anestesia general, esto significa que los pacientes están dormidos durante el procedimiento.
- La cirugía normalmente toma varias horas y el personal controlará cualquier complicación.
- Después de la cirugía, los pacientes tendrán tubos en su pecho para drenar el fluido.
- Los pacientes necesitarán un chaleco de compresión al menos por dos semanas después de la cirugía.
- Los pacientes deben dormir boca arriba al menos la primera semana y evitar el ejercicio intenso de 4 a 6 semanas.
- La recuperación completa puede tomar meses.

¿CUÁLES SON SUS OPCIONES PARA LA CIRUGÍA GENITAL (INFERIOR)?

La metoidioplastia y la faloplastia son las dos cirugías inferiores más comunes para pacientes que desean genitales masculinos.

Metoidioplastia: crear un pene a partir de la piel genital existente, generalmente un clítoris agrandado después de tomar testosterona durante mucho tiempo.
- Los resultados son un pene de 1 a 3 pulgadas de largo y del grosor de un pulgar aproximadamente.
- A menudo puede permitir orinar estando de pie (no garantizado).
- Mínima cicatrización visible.
- Puede que no sea capaz de penetrar durante las relaciones sexuales.

Faloplastia: crear un pene utilizando otras partes del cuerpo.
- La piel se extrae de partes del cuerpo como el antebrazo o muslo.
- A menudo se necesita una prótesis de pene (dispositivo colocado dentro del pene) para permitir la penetración durante las relaciones sexuales.
- Mayor tiempo de recuperación que la metoidioplastia.
- Cicatrización donde se extrajo el tejido.
- Es probable que se requiera múltiples cirugías o correcciones.
- Mayores tasas de complicaciones.

¿CUÁLES SON LOS RIESGOS Y LAS COMPLICACIONES DE LA CIRUGÍA DE MASTECTOMÍA (SUPERIOR)?

Todas las cirugías conllevan riesgos. El cirujano explicará todos los riesgos y complicaciones potenciales, y responderá cualquier pregunta que los pacientes puedan tener. A continuación, se enumeran algunos posibles riesgos y complicaciones.

Las posibles complicaciones inmediatas incluyen (pero no se limitan a):

- Infección.
- Necrosis del pezón (muerte del tejido).
- Hematoma (acumulación de sangre).
- Seroma (acumulación de fluidos).
- Curación deficiente de las heridas.
- Coágulos de sangre (pueden provocar la muerte).

Los resultados de la cirugía son diferentes para cada paciente. El tamaño y la posición de sus senos, la salud de la piel, el tamaño y la posición del pezón afectan la apariencia de su pecho después de la cirugía.

La cirugía provocará cicatrices y puede disminuir la sensibilidad de la piel y los pezones.

CUATRO PUNTOS IMPORTANTES

#1 La mastectomía es la cirugía masculinizante más solicitada.

#2 Los resultados después de la cirugía, que incluyen el tamaño y la apariencia del nuevo pecho son diferentes para cada paciente.

#3 Habrá cicatrices después de una cirugía de mastectomía.

#4 La metoidioplastia y la faloplastia son procedimientos comunes para crear un pene. Los requisitos, los resultados y la recuperación son diferentes para cada procedimiento y deben discutirse con su médico.
Cirugía afirmativa de género (masculinizante)

¿QUÉ PUEDEN HACER PARA SER UN BUEN CANDIDATO PARA LA CIRUGÍA?

- No fume ni abuse de drogas o el alcohol.
- Vaya a las citas con su médico y de salud mental y siga sus instrucciones.
- Tome sus hormonas sistemáticamente (a menos que su médico le diga que no debe hacerlo).
- Manténgase en un peso saludable.
- Tenga una buena comprensión de los riesgos y complicaciones de la cirugía, los cambios permanentes y los tratamientos a corto y largo plazo.

¿CAMBIARÁ SU LUGAR DE DOMICILIO?

La Custodia decide la ubicación de su vivienda basándose en la protección y la seguridad.

¿CÓMO SOLICITAR LA CIRUGÍA AFIRMATIVA DE GÉNERO?

- Envíe un formulario de solicitud de servicios de atención médica CDCR 7362 o dígale a su médico, terapeuta de salud mental o enfermera que le gustaría que le consideraran para una cirugía.
- Su médico puede evaluarlo antes del envío de su solicitud para cirugía.
- Si se envía su solicitud, será entrevistado por su terapeuta de salud mental.
- Su información, incluida la solicitud de cirugía, el informe de su médico sobre su salud y su entrevista de salud mental se enviarán a un consejo de médicos y terapeutas de salud mental.
- Este consejo, conocido como Consejo de Revisión de Cirugía Afirmativa de Género, considerará muchos factores al tomar la decisión (especialmente su salud y seguridad) de autorizarlo o no para la cirugía.

¿CUÁLES SON LOS RIESGOS Y LAS COMPLICACIONES DE LA CIRUGÍA GENITAL INFERIOR?

Todas las cirugías conllevan riesgos. El cirujano explicará todos los riesgos y complicaciones potenciales, y responderá cualquier pregunta que los pacientes puedan tener. A continuación, se enumeran algunos posibles riesgos y complicaciones.

Las complicaciones potenciales incluyen (pero no se limitan a):

- El tejido cicatrizante puede conducir al estrechamiento de la uretra, lo que puede ocasionar un flujo de orina débil u obstrucción. Esto puede ser doloroso y el bloqueo de la orina puede provocar daño renal permanente.
- Fistulas (pueden provocar filtraciones de orina a otros lugares como la superficie de la piel).
- La vagina puede no permanecer cerrada después de la cirugía.
- Curación deficiente de las heridas.
- Muerte de tejido.
- Coágulo de sangre o embolia pulmonar (coágulo de sangre en los pulmones) que puede provocar la muerte.

¿CÓMO SOLICITAR LA CIRUGÍA AFIRMATIVA DE GÉNERO?

1. Para obtener ropa y accesorios personales como sostenes, ropa interior, maquillaje y otros artículos:
   - Envíe un formulario 22 solicitando el artículo.
2. Para comenzar la terapia hormonal o si tiene un problema con su tratamiento hormonal actual:
   - Envíe un formulario de solicitud de servicios de atención médica CDCR 7362.
3. Un grupo de apoyo para transgéneros puede estar disponible en su prisión. Pregúntele a su terapeuta de salud mental.