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**PRESCRIBING AND MONITORING FOR TRANSWOMEN ON ORAL OR TRANSDERMAL ESTROGEN**

**Recommended starting doses;**

1. **Transdermal estradiol – patch 25–50mcg twice weekly or gel 0.5- 1.5mg daily**
2. **Oral estradiol – 1 or 2mg daily**

**Consider lower starting doses in older patients or those with CV risk factors**

**Oral estrogen may increase VTE risk.**

**Transdermal estradiol should be first line option for patients;**

1. **over 40**
2. **with risk factors for VTE (including BMI >30)**
3. **with risk factors for CVD**
4. **T2DM**

**Current smokers should not exceed maximum conventional HRT doses**

The following should be measured 6 monthly for the first year and then annually thereafter:

1. **Estradiol (E2)** –
   * Target 350-750 pmol/l if aged < 40; 300-600 pmol/l if aged 40-50 – dose range oral E2 up to 8 mg od, E2 patch up to 400 micrograms twice weekly, E2 gel up to 6 mg daily.
   * Target 200-400 pmol/l if aged > 50 or younger and significant CV risk factors particularly smoking – use transdermal route E2 administration for this group and do not exceed conventional HRT doses.

Discuss with specialist if target range not achieved within these parameters.

1. **Prolactin** – if persistent hyperprolactinaemia (>1000 mU/l or lower levels with symptoms/signs of hyperproactinaemia) refer to local endocrinologist for further evaluation.
2. **Blood pressure** – may increase – treat as appropriate and discuss with specialist regarding estrogen dose adjustment.
3. **LFTs** – refer back to specialist if three times greater than upper limit of normal reference range.
4. **Full lipid screen** including fasting triglycerides – oral estrogen can increase triglycerides. Treat raised triglycerides as per local guidance.
5. **HbA1c** if diabetes or pre-diabetes.

The following should be performed according to usual screening protocols:

1. **Breast cancer screening**

**Testosterone –**

* No need to check testosterone post orchidectomy unless signs of virilization.
* Pre-orchidectomy monitoring will be advised by the GIS and the target will be dependent on the anti-androgen treatment used – usually suppressed into the female reference range on a GnRH agonist and should certainly be < 5 nmol/l; on oral anti-androgens levels may drop below male reference range but not a consistent outcome.