How to Approach Vaginal Bleeding for Transmen and Non-Binary Individuals on Testosterone Treatment

Considerations:

There are several things to consider when a transman or non binary individual has new or changed vaginal bleeding. It is important to remember that vaginal bleeding in a transman or non-binary individual can cause significant distress and further exacerbate their dysphoria. Engaging with a health practitioner to discuss these matters and have a vaginal examination can be difficult and very confronting especially when there is dysphoria around their genitals. We would suggest a frank discussion around this with the individual to find what may make this more comfortable and less stressful for them. This could include for example; allowing extra time, having a range of speculums available, allowing the patient to try self-insertion at home to understand what this may feel like.

The aim of this document is to provide a framework to sensitively assess the significance of the bleeding, examine and investigate appropriately. There is an absence of clear guidelines in this area and cases should be considered on an individual basis.

Causes of Bleeding:

1. **Pregnancy:**
   A discussion around the possibility of pregnancy must be ascertained in a sensitive manner and consideration of a pregnancy test to rule this out. No assumptions on sexuality can be made from gender identity. Although this may be a less common cause of bleeding it is the most important to rule out complications of early pregnancy such as an ectopic pregnancy. Testosterone treatment is not a contraceptive so pregnancies can and have occurred in people using it. Note testosterone is teratogenic so prompt consideration of this is important.

2. **Testosterone levels:**
   - Vaginal bleeding can take six months to settle after commencing testosterone. During this time bleeding can be erratic and infrequent but does not need any further investigation unless there is a dramatic change/additional symptoms or concern. In approximately 10% of individuals receiving Testosterone, bleeding may persist beyond 6 months. At this time, it would be appropriate to add either a GnRH agonist or progestogen and reassess after a further 4-6 months. GnRH agonists and progestogens are discussed further below.

- Inadequate testosterone levels can cause problem bleeding and we would recommend checking Testosterone levels at the appropriate time. We normally recommend trough level (immediately before injection or if not possible within two days prior to injection) on **Sustanon/ Enanthate**; mid-way between injections on **Nebido** (although can be a trough sample of logistically easier); 4 to 6 hours after application of **gel** if applied in morning/first thing in the morning if gel applied in evening.
- Target levels are in the lower third reference range for trough level on injection; middle third reference range on gel or mid-way between Nebido injections.
- If outside target range, increase/decrease as appropriate: injection frequency by 1 week for Sustanon, 2 weeks for Nebido; or gel dose by 10mg and recheck levels at 3-6 months to review.
- Further information can be found on our website on our hormone regimens and monitoring.

3. **Infection:**
   Consideration should be given to common infections such as sexually transmitted infections; chlamydia and gonorrhoea. If there is significant dysphoria around their genitals it may be that a self-taken swab would be considered preferential. If a sexually transmitted infection is found a full sexual health screen would be recommended through a local sexual health clinic.

   Many sexual health clinics offer trans specific health care. Contact your local clinic https://www.nhs.uk/service-search/sexual-health to ask if they have a specific service.

4. **Atrophy:**
   Testosterone changes the vaginal epithelium in a similar way to post-menopausal changes in cis gender women. The proliferation of the epithelial cells slows and becomes thinner and more fragile causing bleeding or vaginal discharge. As a result, vaginal examinations can be distressing not just due to dysphoria but also due to discomfort and pain. Consideration can be given to using vaginal estrogens to treat the atrophy before a full examination of the vaginal vault is possible.

   The recommendations are not limited to the below. If atrophy is suspected and the individual is unable to tolerate a full examination, we would suggest treatment for 4-6 weeks before another attempt at vaginal examination is made. In some severe cases it may necessitate more frequent and prolonged application of topical Estradiol than in post-menopausal females.

   - Vagifem/Vagirux: 10mg tablet daily for 2 weeks then 1 tablet twice per week (if still symptomatic at 2 weeks it would be appropriate to continue with application for 4-6 weeks).
   - Ovestin cream 0.1%: 1 application per day for 2-4 weeks then reduction based on symptoms down to a maintenance dose of one application twice per week.

   Occasionally a combination of a vaginal preparation and a vulval preparation are also required along with vaginal moisturisers such as coconut oil.

5. **Cervical Pathology:**
   There are challenges for transmen being appropriately recalled for routine cervical screening and we know that there is poor uptake of cervical screening in this population. It would be appropriate to consider bleeding from the cervix and direct visualisation of the cervix with speculum examination. A routine cervical smear can be taken if the patient is due for cervical screening. Colposcopy can be considered if there is concern from the appearance of the cervix or ongoing

bleeding with no other obvious cause. There is no increased risk of Cervical Cancer from Testosterone therapy.

Many sexual health clinics also offer cervical screening for trans and non-binary individuals. In the future it may be that there is greater up take of cervical screening from self-taken samples however there are concerns over the lack of longer term evidence to support this.

6. **Endometrial Pathology: Notes on Ultrasound Screening:**
   There are no clear guidelines for management of abnormal uterine bleeding or endometrial surveillance in this population. There is a theoretical concern of endometrial pathology based on data of increased risk with increased serum androgens in cis post-menopausal women. Current data from a trans male population suggests trans men are at no increased risk of endometrial cancer. Longer term studies are lacking. The WPATH (World Professional Association for Transgender Health) recommend health care professionals apply the same respective local screening guidelines (**including the recommendation not to screen**) developed for cisgender women at average and elevated risk for developing ovarian or endometrial cancer in their care of transgender and gender diverse people who have the same risks. Some UK services undertake a 2 yearly transvaginal ultrasound to assess endometrial thickness, but the **Leeds service does not recommend routine screening only prompt investigation if concern**.

   Considerations for investigations for the endometrium:
   Risk factors for endometrial pathology include a history of PCOS, obesity, diabetes, a history of hereditary nonpolyposis colon cancer. Other factors in the history suggestive of additional pelvic symptoms may lead you to consider this further. Consultation of local referral pathways to consider pelvic ultrasound or referral for hysteroscopy is advised where there are concerns. Endometrial thickness of under 5mm would be reassuring but if higher risk, associated symptoms or ongoing bleeding hysteroscopy may be appropriate. Communication for example via advice and guidance with local gynaecology services may be possible.

7. **Ovarian Pathology**
   There is no increased risk of ovarian cancer with Testosterone therapy. Testosterone may cause cortical and thaecal thickening similar to that seen in PCOS but there are histological differences. Additional symptoms suggestive of ovarian pathology such as bloating should lead to further investigations such as transvaginal ultrasound scanning.

Principles of Management Options

1. **Testosterone:**
   Optimising Testosterone therapy as per above with further guidance available on our website.

2. **Contraception:**
   The Progesterone options for contraception will **not** interfere with Testosterone or the process of masculinising. Decisions around contraceptive options should take into account both bleeding patterns and contraceptive needs. The progesterone only pill or LARCs (Long Acting Reversible Contraception) - such as an intrauterine system (e.g. Mirena/kyleena/jaydess), Depo-Provera injection or the contraceptive implant (Nexplanon) can be considered.

We know in cis women progestogen only contraception can cause irregular bleeding as a side effect, but we have no evidence or research in its use in the trans male community alongside Testosterone. From experience, we often find this helps to push into amenorrhoea.

3. **Blockers:**
   Consideration of a GnRH agonist as a blocker to stop bleeding such as Leuprorelin can be discussed further. We would normally use Leuprorelin 11.25mg IM every 3 months for a period of 6 months for cessation of bleeding.

In conclusion there should be an individualised approach with an understanding of the personal, societal, and systematic barriers at play.

If you had additional concerns regarding your patients' hormones or management, we would be happy to offer further advice and guidance with our hormone clinicians. We require a letter or email with full clinical details including history, examination findings and investigations including full hormone profile and additional blood testing as per our guidelines. Please ensure the timing of the blood test is at the correct time for their testosterone dose and note this within the clinical correspondence.

Leeds GIS