Leeds and York Partnership
NHS Foundation Trust

Primary care approach for a new patient taking hormones: Leeds GIS

GPs are faced with difficult clinical decisions, when transgender, non-binary and gender diverse people request prescription of hormone treatment, sometimes outside of NHS specialist pathways or while facing a long wait for assessment within an NHS specialist pathway. It can be difficult for a busy primary care clinician to unpick where this person is on their journey.

NHS Gender services are not commissioned or set up for lifelong care of transgender and non-binary individuals. We are not commissioned to prescribe, administer or monitor hormones. Following specialist assessment by our team, we work collaboratively with GP's and ask that primary care support with blood monitoring and prescribing under our guidance, until stabilisation is achieved.

There are different scenarios that you may face when meeting a new patient in primary care who is transgender, non-binary or gender diverse; many patients may have been seen by an NHS clinic, stabilised and discharged back to primary care. Individuals may move or transfer their care to another area or country and present with hormone dilemmas after they have been started on hormones. The hormones may have been started by an NHS gender service, a private gender service, or by another GP practice while waiting for further assessment. At Leeds GIS, we appreciate that for our primary care colleagues it takes time to understand hormone regimens and navigate some of these difficult decisions.

The aim of this document is to support and guide health professionals with a framework for making decisions for patients who have moved surgery, or moved country and are receiving hormone treatment.

We understand that GPs may feel that they have limited experience with cross sex hormones and feel uncertain about prescribing them. We aim to offer support, advice and guidance for GPs who are looking after transgender, non-binary and gender diverse patients. We have created a **'Healthcare Professional Hormone Support Hub'** on our website to establish a framework for collaborative working and developing expertise and confidence in hormone prescribing:

https://www.leedsandyorkpft.nhs.uk/our-services/gender-identity-service/

General Principles for Continued Prescribing

When considering prescribing for a new patient to your practice who has been started on hormones, the key question is if this individual has a diagnosis from an NHS gender clinic of Gender Dysphoria/Gender Incongruence and who has started the hormones. Seeking appropriate documentation from the relevant provider will give you crucial information to help make your decisions.

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No Diagnosis of Gender Dysphoria:

If they do not have a diagnosis of gender dysphoria from an NHS gender clinic, Leeds GIS staff cannot advise a GP if their patient has had an appropriate assessment for gender dysphoria, as diagnosis requires a lengthy, comprehensive holistic assessment and no swift diagnostic test exists. Without a clear diagnosis, it is impossible for Leeds GIS to offer a clinical opinion regarding continuation of hormone treatment. Leeds GIS staff cannot know if treatment would be likely to be beneficial or harmful. GPs must make an assessment themselves, before deciding on a management plan.

If approached, Leeds GIS staff can only give general advice and guidance in these circumstances, which will not be specific to a particular patient or constitute a recommendation. Such advice and guidance might relate to factors to consider in assessment and potential strategies, but we cannot confirm a diagnosis, formulate a treatment plan for the patient or take any shared responsibility for interventions delivered in primary care in this way. These approaches lie outside specialist pathways and the treatment decisions lie with the prescribing GP.

Previous Diagnosis of Gender Dysphoria:

If a diagnosis of gender dysphoria has been made, it would be appropriate to contact the clinic where this diagnosis was made to receive further documentation of this assessment and plans for follow up or if discharged for their hormone guidance. If the diagnosis of Gender Dysphoria was made overseas, it would be appropriate to refer the patient to a GIS for assessment and diagnosis. Each service within the UK operates their waiting lists in a different manner and not all services have a priority waiting list. Further exploration of this scenario is included below.

Hormone Prescribing:

The most difficult decision is often around starting hormones. **If the patient has already been receiving an NHS prescription for hormones from their previous GP, stopping hormones can often be of more harm to the patient.**

The General Medical Council's Good medical practice guidance states that *"as a good doctor you will:*

- *make the care of your patient your first concern*
- *be competent and keep your professional knowledge and skills up to date"*

It would be appropriate for the GP to seek further information to inform your professional knowledge and we hope that our website and this information will provide you with a framework to improve your skills in the care of transgender, non-binary and gender diverse individuals to increase confidence in providing the patient with appropriate care.

GPs may not feel familiar with prescribing hormones but many of these hormones are used in regular practice for other indications and GPs are generally familiar with their use.

A harm minimisation approach could be used where the risks and benefits are clearly discussed with the individual and there is clear documentation of consent to these risks.

Risks and Benefits of Continuing to Prescribe

The risks of stopping hormones may well be greater than the risks of continuing a prescription.

The risks of stopping hormones include:

- Psychological harm and increasing gender dysphoria impacting on mental health
- Regression of reversible changes associated with cross sex hormones
- Possibility of hypogonadism as a result of receiving prolonged hormone treatment or blockers
- Return of menses in transmen or emergence of dysfunctional uterine bleeding
- Risk of the individual sourcing unregulated hormones or other preparations over the internet
- Further damage to the doctor-patient relationship - research suggests transgender and non-binary individuals are less likely to seek help for health-related conditions and screening than their cis counterparts

Harm Minimisation, Prescribing and Monitoring

In this approach, the GP assesses the need for hormone treatment and balances this against the potential risks for the patient and the possibility of the patient continuing to take unregulated hormones. If there is no diagnosis of gender dysphoria, the assessment of gender dysphoria being made is not specialist, may be incorrect and could lead to harm secondary to prescribing hormone treatment but these challenges should be acknowledged by the GP and the patient.

Considerations for treatment

- Explain that this approach is dependent on the patient **not taking any unregulated hormone treatment** in addition to prescribed treatment.
- Explore the risks and benefits of treatment, as far as possible, using our **consent** forms.
- Discuss **fertility**, both the risk of infertility (which may be irreversible) and the importance of contraception due to potential teratogenicity.
- Progesterone only **contraception** can be used for female birth assigned people, to achieve amenorrhoea and provide contraceptive protection.
- Consider any pre-existing conditions that may complicate treatment.
- Check monitoring investigations, as outlined on our website.

Prescribers are advised to discuss their response to a request to prescribe from a patient with a colleague, at a practice team meeting or with pharmacy colleagues and to document the decision made, with reasons, clearly in the patient notes and communicate this to the patient.

Exploration of Scenarios

There are a number of scenarios that we will attempt to address, however it is not possible to cover every eventuality. We suggest that you use these suggestions as a framework to aid decision making with your patient.

1. **Continuing prescribing hormones for a patient with a diagnosis of Gender Dysphoria from an NHS clinic who has been stabilised and discharged back to primary care.**

In this scenario the individual has been discharged from our hormone clinic (Leeds GIS or another gender service) although they continue to receive care from other health professionals within the gender service while they await further gender affirming treatments such as surgery; or they have been fully discharged from our service. They were established on hormones and were transferred from the hormone clinic back to your care.

The GMC guidance outlines ongoing care responsibilities:

"Once the patient has been discharged by a GIC or gender specialist, the prescribing and monitoring of hormone therapy can be carried out in primary care without specialist input. From the patient's perspective, management in primary care is far easier, and there is no specific expertise necessary to prescribe for and monitor patients on hormone therapy."

We would strongly recommend continuing hormones in this scenario.

2. **Continuing prescribing hormones for a patient with a diagnosis of Gender Dysphoria from a Private Provider or with a diagnosis from an NHS provider who has then seen a private provider for hormones.**

If the diagnosis is from a private provider, then the following document may be helpful which is available on our website: 'Prescribing on the request of a private provider': https://www.leedsandyorkpft.nhs.uk/our-services/wp-content/uploads/sites/2/2023/10/Info-Re-Prescribing-on-the-Request-of-a-Private-Provider-Leeds-GIS-v3.pdf

3. **Continuing prescribing hormones for a patient with no diagnosis of Gender Dysphoria who has been referred to an NHS Gender service, is on a waiting list for assessment and has been started on hormones while waiting by another GP practice as a bridging prescription in a harm minimisation approach.**

If the patient has been started on hormones by another GP practice then the following document may be helpful: ''Bridging' Prescriptions': https://www.leedsandyorkpft.nhs.uk/our-services/wp-content/uploads/sites/2/2023/10/Info-Re-Bridging-Prescriptions-Leeds-GIS-v4.pdf

4. **Continuing prescribing hormones for a patient with a diagnosis of Gender Dysphoria from overseas who has been referred to an NHS Gender service, is on a waiting list for assessment and has been started on hormones while waiting by another GP practice as a bridging prescription in a harm minimisation approach.**

Requests to prescribe from a GIC outside the UK, or from patients who have started treatment overseas, can be difficult to manage and, wherever possible, such patients should be referred to a UK GIC for assessment, but in some situations a GP may decide it is in the patient's best interests to prescribe prior to be seen by a UK specialist.

The principles for decision making in this area would be very similar to the above framework for prescribing on the request of a private provider. An overseas patient may be referred to a UK gender identity service for an NHS assessment and diagnosis but this may take years for an assessment and diagnosis. .

5. **Requests to take over a prescription for an individual with or without a diagnosis of Gender Dysphoria who is 'self prescribing' or sourcing hormones online.**

If the individual has been sourcing their own hormones or purchasing hormones over the internet then you might find the following document helpful: 'Self Prescribing' which is available on our website: https://www.leedsandyorkpft.nhs.uk/our-services/wp-content/uploads/sites/2/2023/10/Info-Re-Self-Prescribing-Leeds-GIS-v3.pdf

6. **An individual with a diagnosis of Gender Dyphoria has had a pause from hormone therapy and requests to restart hormones.**

Sometimes patients have a 'pause' from hormones for many reasons such as while they are accessing other health care, seek fertility treatment or have difficulty with their mental health. They come to their GP with a request to 'restart' their hormones and this opens up difficult decisions and complexity for the GP. You might find the following document helpful: 'Restarting' Hormone Prescriptions: https://www.leedsandyorkpft.nhs.uk/our-services/wp-content/uploads/sites/2/2023/11/Info-Re-restarting-hormones-Leeds-GIS-v2-Nov-23-FINAL.pdf

Ongoing Hormone Treatment:

We suggest you consult our website 'hormone support hub' which contains information for health professionals on hormone prescribing including advice, frequently asked questions and some support with trouble shooting.

If the website information does not answer your question and you would like some further advice from our informal advice and guidance service, we can arrange this on receipt of a written request from yourselves via email to gid.lypft@nhs.net including:

- an update on the problems they are experiencing with their hormones and your query.
- an up-to-date medical summary detailing their current problems, medication and any allergies.
- recent weight and blood pressure measurements
- their most recent blood test results including a full hormone profile (**U&E's, LFT's, Calcium, Cholesterol:HDL Ratio, Triglycerides, Prolactin, FSH, LH, HbA1c, Oestradiol, Testosterone, Full Blood Count, TFT's and SHBG) – please be aware to time the blood test to the appropriate timing depending on their medication as per the table below.**

We cannot arrange to review these patients in clinic, but we may be able to offer you some further advice and support.

Deciding not to Prescribe:

A GP may decline to accept responsibility for prescribing, but the GP must also be satisfied that declining responsibility would not pose a significant clinical risk to the individual. If the patient is distressed, or the GP believes them to be at risk from self-harm, the GP should offer them support and consider the need for referral to local mental health services. A referral to an NHS gender service should be made if the individual does not have an NHS diagnosis of gender dysphoria or has received a diagnosis of gender dysphoria overseas if this is acceptable to the patient.

If an NHS clinician does not feel able to prescribe a medication, the reasons for this should be shared with the patient as soon as possible and an alternative course of action discussed, considering the patient's preferences and possible risks from not prescribing.

In conclusion:

None of these decisions are easy or without risk, and there can be difficulty in communicating this risk and uncertainty with an individual. We hope this can provide support for clinicians and patients when making these decisions together.

The reality of the current service is that there are long waiting lists across the country for gender services. It is not possible to expedite a referral for these individuals. We appreciate that this results in difficult decisions being made in primary care, but we hope this document can support you and your patient making decisions together on their ongoing care.

Considerations of other aspects of ongoing care:

Feminising Treatment:

- **Blood tests:** Estradiol, SHBG, testosterone, U&E's, LFT's, Lipid profile including Triglycerides, and Prolactin should be done six monthly for a year and then annually. Estradiol levels are ideally between 350-750 pmol/l if aged < 40; 300-600 pmol/l if aged 40-50; 200-400 pmol/l if aged > 50 or younger with significant CV risk factors particularly smoking or high BMI (> 40 kg/m^2).

- **Hormones:** If starting Estradiol over the age of 40 we would recommend conventional treatment for 10 years then reducing dosing down. If started under the age of 40 we would recommend a dose reduction between 40-50 with an aim to tailing off and potentially stopping treatment between 60 and 70. However, we would recommend an individualised approach should be employed after discussion with the individual regarding the risks and benefits. If lower gender affirming surgery is not performed, we would recommend continuing a hormone blocker.
- **Mammograms:** transwomen become eligible when they turn 50 for mammography on the breast screening programme. If she continues to take estradiol after the age of 70, she should continue to attend the breast screening programme. In addition, she should remain 'breast aware'.
- **Prostate:** If the patient develops any urological symptoms, consideration should also be given to the fact that she still has a prostate gland in situ.
- **Osteoporosis:** There is no evidence for routine DEXA scanning in trans-feminine individuals. Trans-feminine individuals may have lower bone density than matched cis-males, but they are at no greater risk of osteoporosis than matched cis-females, provided that they have not had androgen blockade or gonadectomy without estradiol treatment. We would encourage an individualised approach to DEXA scanning based on the presence of other risk factors such as low BMI, corticosteroid use, alcohol excess or medical conditions associated with reduced BMD in line with national guidelines.

Masculinising Treatment:

- **Blood tests:** Testosterone, Estradiol, LFTs, FBC, Lipid profile including Triglycerides, to be done six monthly for a year and then annually. Testosterone levels should be in the lower third of the reference range immediately before Sustanon or Nebido injections (trough levels), middle third of the reference range on Nebido (for samples taken mid-way between injections) and testosterone gel (taken 4 to 10 hours after application). The lower third of the male reference range is usually around **8-12 nmol/L** and the middle third of the male reference range is usually around **15-22 nmol/L** but does depend on the normal range for the local assay as these vary.
- **Hormones:** There is no recommendation of an upper age limit to stop masculinising treatment and we would recommend a pragmatic and individualised approach after an analysis of the risks and benefits.
- **Uterus and Ovaries:** There is currently no evidence for an increased risk of endometrial or ovarian cancer with testosterone treatment, but any symptoms which could suggest a problem with these organs, particularly vaginal bleeding, pelvic pain or abdominal bloating should be investigated further.
- **Cervical Screening:** Attendance for routine cervical screening tests should remain the same as per the NHS Cervical Screening Programme recommendations, however the invitation process and informing of results are outside the NHS Cervical Screening Programme process and should now be organised within your GP practice. If you have not already done so and your patient is registered as male, with a new NHS number, you should liaise directly with the screening lead for cervical screening who will advise on further action.
- There are challenges regarding recalls for cervical screening and we know that there is poor uptake of cervical screening in this group. Consideration should be made of what may make the individual more comfortable and less concerned about this procedure including the use of vaginal Estradiol. There is further information on our website for health care professionals regarding cervical screening.
- **Testosterone treatment is not contraceptive and is a teratogen.** Contraceptive needs should be considered if required.
- **Osteoporosis:** There is no evidence for routine DEXA scanning in trans-masculine & non binary individuals and typically they show no change or an increase in BMD as a result of testosterone hormone treatment. We would encourage an individualised approach to DEXA scanning based on the presence of other risk factors such as low BMI, corticosteroid use, alcohol excess or medical conditions associated with reduced BMD in line with national guidelines.

Timing of blood tests on hormones:

Hormone Preparation	Timing of Blood Tests
Oral estradiol	Blood test 4-6 hours after last dose of oral estradiol, or first thing in the morning if tablets are taken at night
Estradiol patch	Blood tests on day 2 after application
Hormone Gel (Estradiol or Testosterone) Estradiol Transdermal spray	Blood tests 4-6 hours after last application of treatment, or first thing in the morning if treatment is applied at night
Sustanon / Testosterone Enantate Injections	Blood tests immediately before next injection (no longer than 48rs before)
Nebido Injections	Blood tests Mid way between Nebido injections

Please be aware of the Trans & Non-Binary Sexual Health Clinic here in Leeds which is on the 3rd Monday of every month, from 4-6 pm for HIV and STI testing, Cervical smear tests, Hepatitis and HPV vaccines, Contraception, Pregnancy tests and PrEP.   For more details they can contact leeds@mesmac.co.uk or phone 0113 244420922.

Other Support:

There is often distress associated with gender dysphoria which can be very difficult for your patient to manage. You can suggest that your patient contacts our **Gender Outreach Workers (GOWs)**. They offer advice and support to trans, non-binary and gender diverse people who are on the Leeds Gender Identity Service waiting list and care pathway. They can answer questions and provide support via their information and advice line, one on one sessions and peer support and social groups. It can help to talk to someone with lived experience. Further information regarding the GOWs can be found on our website: https://www.leedsandyorkpft.nhs.uk/our-services/gender-identity-service/ under Gender Outreach Workers and other sources of help.

Leeds GIS