Perioperative care of the transgender or non-binary patient

Purpose and Scope

To provide background information on current preferred language in this patient group.

To highlight specific perioperative trans and non-binary issues.

The scope of this document is not specific to gender affirmation surgery but rather more generally for this patient group coming for any surgery.

Background Information

Terminology

The most important thing is to aim to be respectful by using the language that people ask you to use. Often people are scared to say the wrong thing, which is understandable, but most trans people are happy to be asked how they want to be referred to, especially as it is often a sign that the person asking is informed about caring for trans people. While some trans people may be uncomfortable when discussing their body, this is lessened by knowing that the person they are speaking to is supportive and non-judgemental.

The terminology used to describe gender identity varies over time and is still evolving. This document aims to reflect current terminology in the UK in 2023.

The term gender identity refers to an individual's sense of themselves as a man, woman, non-binary person, or other gender. "Non-binary" is an umbrella term used to refer to anyone who identifies not wholly as a man or a woman, and may feel that they are in between or outside of that spectrum altogether.

"Trans" or "transgender" are still commonly used terms to refer to people whose gender does not match the sex they were assigned at birth. Specifically, a "trans man" is a man who was assigned female at birth, and a "trans woman" is a woman who was assigned male at birth.

Cis woman or Cis man	A person who identifies with the sex that they were assigned at birth, i.e. someone who is not trans.
Trans woman	A woman who was assigned male at birth (AMAB) and identifies as a woman. This should not be written as “transwoman”
Trans man	A man who was assigned female at birth (AFAB) and identifies as a man. This should not be written as “transman”
Transsexual	A person whose gender identity that is different from that which they were assigned at birth; discourteous when used as a noun. While this is a more outdated term, some people still use it, and it is still used in some legal documents.
Transgender	The modernised term for “transsexual”
Transfeminine	A term used to describe trans people who were assigned male at birth and identify or express themselves at least partially as women, even if they may not fully identify as a woman.
Trans masculine	A term used to describe trans people who were assigned female at birth and identify or express themselves at least partially as men, even if they may not fully identify as a man.
Non-binary	An umbrella term used to refer to anyone who identifies not wholly as a man or a woman, and may feel that they are in between or outside of that spectrum altogether. While non-binary and binary trans people may have some specific and different needs, it is generally okay to refer to trans and non-binary people as a coherent group.
Transitioning	Adopting the outward or physical characteristics of the gender one identifies with, as opposed to the one assigned at birth; not all transpeople will affirm that they have ‘transitioned’.
Gender dysphoria	Distress or psychosocial discomfort associated with the individual’s sex assigned at birth
LGBTQI+	An acronym representing lesbian, gay, bisexual, trans, queer, questioning, intersex, (sometimes abbreviated to LGBT or LGBTQ+) people. Although different acronyms may be used, all generally express a unity between people of marginalised sexual orientations and gender identities. This acronym may also include intersex people, who are people born with variations in sex characteristics (such as hormones, chromosomes, reproductive organs, and genitalia) outside of the typical range of male and female, although there is some disagreement within the intersex community about their inclusion in the acronym.

Societal Context

Trans and non-binary people are at an increased risk of healthcare problems, potentially due to discrimination and inequality in healthcare provision, social exclusion, 'minority stress' and poorer mental health outcomes.

Trans populations are also reported to have poorer general health and higher rates of disability than other populations. Poor health outcomes due to social marginalisation are likely to be reinforced by other demographic factors such as ethnicity, cultural and religious background, age, disability, and socio-economic status. Protective factors against minority stress and associated negative outcomes include prompt access to gender-affirming healthcare (if desired); inclusive, non-discriminatory provision of general healthcare; and social acceptance from family, employers, education providers and the wider community.

Some, but not all, trans and non-binary people seek gender affirming medical interventions of various kinds to support a permanent change in their social gender role from that assigned at birth, and in some or all of their sex-specific physical characteristics. This might include cross-sex hormone replacement therapy or genital reconstructive surgery. Status on the pathway for assessment or treatment for gender affirming care should not be taken into account in decisions about unrelated health needs, and it is inappropriate to ask an individual about any procedures they have or have not undergone unless it is directly related to their health needs. Trans and non-binary people are still afforded legal protections regardless of whether or not they have been able to (or wish to) access gender affirming medical interventions.

<u>Pre-operative considerations</u>

Healthcare professionals should avoid asking personal information about an individual's gender history where this is not relevant to their care.

Extra attention should be taken to ensure electronic medical records and blood bank records are up to date and aligned with the patients identity before the theatre case starts. Relying on historical records may cause delays or misinformation to be relayed intraoperatively. In addition, a pregnancy test may be required depending if the patient was assigned female at birth.

Trans and non-binary people should be allocated in-patient accommodation in line with their gender presentation, unless there is a significant reason to depart from this (e.g. the individual needs care that cannot safely be provided in other settings). If there is a reason to depart from this, this should be discussed and agreed with the individual.

Conditions that might be exacerbated by treatment with estrogen	Conditions that might be exacerbated by treatment with testosterone
Thromboembolic disease Macroprolactinoma Breast cancer Coronary artery disease Cerebrovascular disease Cholelithiasis Hypertriglyceridemia	Polycythaemia Severe liver dysfunction (transaminases threefold upper limit of normal) Coronary artery disease Cerebrovascular disease Hypertension Breast or uterine cancer

Trans women

Estradiol regimens intended to change secondary sex characteristics follow the general principle of hormone replacement treatment of hypogonadism in women and to achieve consistent estradiol values in the range 350–750 pmol/L. Typical effects include skin and scalp hair changes, reduced body hair growth, redistribution of body fat to a gynaecoid pattern, reduced upper body muscle development, breast growth, changes in sexual responsiveness (often, but not always, reduced sexual interest), less frequent or absent nocturnal erection and erectile dysfunction. Progestins are not used as a component of feminising endocrine treatment in UK specialist practice; there is no good-quality evidence that they enhance breast growth but some evidence that they increase the risk of thrombosis. Endocrine treatment of trans women is not usually discontinued in the sixth decade but, instead, continued lifelong; this is a matter of personal choice.

Trans men

Testosterone regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism, to achieve testosterone values in the reference range for a young adult man (typically 12–28 nmol/L). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions and should be avoided. Testosterone treatment in trans men may result in increased muscle mass and decreased fat mass, increased facial hair and acne, male-pattern baldness in those genetically predisposed, increased sexual desire, clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses often occurs within a few months with testosterone treatment alone. Clinicians may additionally administer Gonadotrophin Releasing Hormone (GnRH) analogues or medroxyprogesterone to stop menses prior to testosterone treatment or if it persists despite treatment.

Transfusion considerations

A key issue is whether the patient has child-bearing potential or not. If a patient does have childbearing potential [**patient has a uterus, and aged under 55**], in order to prevent sensitisation and future pregnancy complications, they should receive O Rh D negative, K negative blood in an emergency.

At certain sites in Lothian the blood bank IT system permits/restricts issue of certain blood components and registrations of pregnancies according to the CHI and gender registered in the system. At the time of writing there is ongoing consultation within Scotland with a view to a consensus approach.

In the interim, when sending transfusion blood samples **please state clearly on the request form whether the patient has child-bearing potential and follow this up with a phone call to the appropriate blood bank**. This should be done as far in advance of the operation as possible to ensure there is time to fix any potential IT issues.

Intraoperative Considerations

Airway

Some patients may have undergone vocal feminisation surgery (e.g.laryngoplasty) resulting in a narrowed airway; consider preoperative nasendoscopy to assess. Be aware that this surgery may have occurred in a non NHS setting with limited access to relevant notes.

Chest Binder

Some patients may use chest binders to flatten breast tissue and this may not be disclosed or immediately apparent. There is a theoretical risk of a restrictive lung defect under anaesthesia. Clear and sensitive discussion with the patient pre-operatively should be undertaken.

Bladder catheterisation

During surgery where bladder catheterisation is required, the choice of catheter should be made in keeping with the pelvic anatomy i.e. for laparoscopic hysterectomy in a trans man (AFAB) a female catheter should be used as this will safely empty the bladder. It is important not to make assumptions or be too afraid to ask. It can help the patient to understand the practical implications of asking sensitive questions about their bodies i.e. not simply being asked due to medical curiosity.

Post-Operative Considerations

Hormones given as part of gender dysphoria treatment should routinely be continued in the post operative phase unless there are specific reasons that doing so would increase risk to that individual, and that the additional risk cannot be ameliorated e.g. with thromboprophylaxis.

The IDL or discharge summary letter should refer to the trans related issues explicitly only if these are relevant to the elective or emergency surgery. For example, emergency laparoscopic appendicectomy would be unlikely to be relevant, whereas laparoscopic hysterectomy is much more likely to be.

References

RCOG Transgender Guideline – Public consultation version 2022.

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