The Tavistock and Portman NHS
NHS Foundation Trust

Post Discharge Hormone Management – MALE TO FEMALE

GP	
ADDRESS	

NAME:	
D.O.B:	
ADDRESS:	
ID No:	

Date:

Dear Dr,

Your patient has recently been discharged from the gender identity clinic. Below is guidance on the ongoing hormonal management of this patient in the immediate and longer term future.

The current data suggest that long-term treatment with oestrogen in transwomen is associated with a slight increase in the standard mortality ratio. This increase in mortality appears to comprise an increase in the risk of suicide in vulnerable individuals and also an increase in cardiovascular deaths. The increase in suicide deaths appears to have been higher in the past but nonetheless psychological health should be assessed. The observed increase in cardiovascular disease, however, appears to be solely associated with the use of ethinylestradiol but not other oestrogen types and so this oestrogen type should be avoided. Breast cancer is extremely rare in this patient group and therefore hormone treatment can safely continue lifelong. If having a mammogram, patients should advise that they were assigned male at birth, otherwise there may be false positive reporting of breast abnormality.

The monitoring advice depends on the oestrogen preparation being used, the details of each being given below. In general, only annual monitoring is needed once the patient is established on a stable regimen.

Other standard health screening programme recommendations should be followed. The patient should be advised that they will get an automatic call-up to female but not male screening if they have had their gender changed on the NHS computer system.

With regards to poor energy and libido disturbance, this patient group can suffer from hypoactive sexual desire disorder (HSSD), something which can respond well to adjustment in hormone therapy, including possible use of low-dose testosterone. If this seems to be the case then contacting a specialist endocrine service for an assessment would be appropriate.

We suggest that from time to time, perhaps every five years or so, you check with the clinic's website (gic.nhs.uk) to see if there's been any change in hormonal treatment practice, as occasionally, with increasing knowledge, we do change our hormonal advice and practice.

If, in the future, you wish for the patient to be reviewed please write to us and we will be more than happy to give advice by mail or make arrangements for the patient to be seen, if that is appropriate.

Preparation	Dose	Frequency	Target range, oestradiol	Monitoring Method	Maximum Dose	How to adjust, if needed
Tablets Estradiol valerate: e.g. Progynova / Elleste Solo or Estradiol hemihydrate: Zumenon	1 & 2 mg tablets	Take all at same time, in the morning	400-600 pmol/L	Bloods 4-6 hours after taking tablets	8mg daily	Usually 2mg adjustments, 1mg if oestradiol only a little out of range
Patches (Estradiol): Estradot Evorel etc	50-200 mcg/ 24hr	Change patch/es twice a week	As above	Bloods at least 48 hours after patch application	200mcg twice weekly	Usually 50mcg adjustments, less if estradiol only a little out of range
Topical Gel Sandrena	0.5-1mg sachets	Apply in the morning, to anywhere on body except breasts	As above	Bloods 4-6 hours after application (no gel on the arms)	5mg daily	Usually 1mg adjustments, less if estradiol only a little out of range
Implants	50-100 mg	6-24 monthly	Trough value of 400-500 pmol/L	5 months after implant then repeated monthly until less than 500 (to inform secondary care)	100mg	Secondary care oversight

Blood tests that need to be requested (including safety blood tests, for monitoring):

Oestradiol, testosterone, SHBG, prolactin and LFTs. For timings, see above.

When the dose of a preparation is changed, repeat blood tests need to be taken 8 weeks after the change. Once the hormone regimen is stabilised, bloods should be taken six-monthly for two years then annually if stabilised.

Cut-offs for action with the monitoring bloods:

As well as looking to keep the oestradiol level within range, as above, there will occasionally be results from the safety blood tests that need action:

1. Testosterone:
If ovaries are still intact, usual practice is to use medication to keep testosterone suppressed, i.e. under 3nmol/L. If it rises, it may be worth checking compliance with any medication that is meant to suppress testosterone (usually a GnRH agonist). Seek advice if needed.

2. Prolactin:
Small rises in prolactin are often seen with oestrogen therapy.

a) New rise of >750 mIU/L: Repeat test
b) New rise of >1000 mIU/L: Seek advice from local endocrinology department

3. Liver function tests:
Values of greater than 3x the upper limit of normal: seek advice.

4. SHBG:
SHBG will be expected to rise on oestrogen therapy. There is no specific cut-off for action, but its value may be of use when discussing an individual case with the Gender Identity Clinic.

Please contact the Gender Identity Clinic at any time with any queries about ongoing management after a patient has been discharged.