

CARE OF THE HIV-INFECTED TRANSGENDER PATIENT

What's New – January 2012 Update

The World Professional Association of Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, has recently updated the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Since its first release in 1979, the *WPATH Standards of Care* have been the most recognized standards of care for transgender patients. In addition to updated guidelines on diagnostic assessment, hormone therapy, and surgical therapy, the 7th Version of the *Standards of Care* includes updated information on addressing and promoting tolerance and equality for transgender patients.

I. INTRODUCTION

RECOMMENDATION:

Clinicians providing services to HIV-infected transgender patients should integrate transgender treatment recommendations and standards of care into their practice. (AII)

Clinicians caring for HIV-infected patients may encounter individuals whose *experienced* gender does not conform to his/her natively assigned sex. These guidelines use the term *transgender* to refer to a broad range of nonconforming gender identities.

Some patients may be unsure of their gender identity and may not have had opportunities to discuss their concerns with a medical professional. Others may have a highly developed gender identity and may request hormone therapy or may already be receiving hormones that are obtained either by prescription or illicitly without a prescription.

Many HIV-infected transgender patients avoid healthcare providers because they fear insensitive treatment or have perceptions of being judged. Some of these patients also may have had poor interactions with previous providers. Providing a spectrum of care may help patients overcome resistance to treatment if these services are provided in a nonjudgmental manner. These services include:

- HIV-related medical care that includes HIV prevention and harm reduction counseling
- Mental health and substance use screening and services
- Transgender-specific care, such as hormone therapy and case management services

As part of transgender-specific care, clinicians should integrate treatment recommendations and standards of care for transgender patients into their practice. For information regarding transgender standards of care, see Section X: *Transgender-Related Standards of Care and Referral Resources*.

Provision of transgender-related services in one setting is optimal. However, if such treatment integration is not possible, the clinician should make appropriate referrals for necessary specialized services, including transgender-related healthcare, community resources, and legal services (see Section X: *Transgender-Related Standards of Care and Referral Resources*).

II. EPIDEMIOLOGY

Specific epidemiologic data for HIV-infected transgender individuals are lacking. However, a review of available data reported a mean HIV prevalence of 27.7% in male-to-females (MtFs) in four studies where HIV testing was performed in this population.¹ Seroprevalence was highest among black MtFs, with a mean estimate of 56.3%.¹ An HIV prevalence rate of 68% among MtF sex workers was also reported in a small sample population.¹ Limited data suggest that HIV prevalence rates among female-to-males (FtMs) is low, but their self-reported sexual risk behaviors suggest an increased risk for HIV infection compared with the general population.¹

III. TRANSGENDER-RELATED TERMINOLOGY

Knowledge of transgender-related terminology is important for awareness and effective communication with transgender patients. Table 1 provides an overview of commonly used transgender-related terms.

TABLE 1
TRANSGENDER-RELATED TERMINOLOGY

Transgender: An umbrella term for people whose gender identity extends beyond the conventional paradigms of birth-assigned sex, behavior, or appearance. The term may include, but is not limited to, people who identify as male-to-female (MtF) or female-to-male (FtM), cross-dressers, androgynous, and bi-gender individuals.

Male-to-Female (MtF) Transgender or Transfemale or Transwoman: An individual born with male anatomy whose gender identity is that of a woman. A MtF transgender person may or may not choose feminization enhancement treatments or may choose specific, instead of complete, enhancements. For example, the individual may choose to enlarge breasts but maintain male genitalia.

Female-to-Male (FtM) Transgender or Transmale or Transman: An individual born with female anatomy whose gender identity is that of a man. A FtM transgender person may or may not choose masculine enhancement treatments or may choose specific, instead of complete, enhancements.

Transsexual: An antiquated term that originated in the medical and psychological literature to describe someone who identifies as a member of the opposite anatomical sex. Many transgender people prefer the term *transgender* instead of *transsexual*, and, unlike *transgender*, *transsexual* is not an umbrella term to describe gender variation in an individual.

Intersex: A term applied to various conditions resulting from chromosomal anomalies and developmental disorders (e.g., androgen insensitivity syndrome and congenital adrenal hyperplasia) that result in impaired fertility, mixed sex characteristics, and, although rare, ambiguous genitalia. Intersex conditions are currently being redefined in the medical literature as *disorders of sex development*.^{2,3}

Cross-dresser: An individual who dresses as the opposite sex and may or may not seek physical changes. People may cross-dress for a variety of reasons, including for entertainment or theatrical purposes (e.g., *drag queens* and *drag kings*) or because dressing in clothes of the opposite sex provides self-gratification.

Androgynous: An individual who may appear to have few gender-defining characteristics or who may have characteristics of both sexes (e.g., *bi-gender*).

Table 1 continues

Table 1 continued

Bi-gender: An individual whose gender identity includes both sexes. Bi-gender individuals may switch between masculine and feminine gender roles.

Gender Identity Disorder: A *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM IV-TR)* term that is used for the provision of transgender-related care and replaces the older term *gender dysphoria*. However, *gender identity disorder* is a controversial term within the transgender community, and clinicians should be sensitive to the negative effects that can result from classifying gender identity as a disorder.

Gender Transition: The process of bringing the body and mind into alignment. There are many aspects of transition that may occur simultaneously or sequentially. Transition includes physical (hormones, surgery), social, psychological, linguistic, intellectual, and spiritual aspects of self. The term *transition* should be used in place of *sex change*, *pre-operative*, or *post-operative*, because these latter terms inaccurately suggest that one must have surgery to truly change one's sex.⁴

Defamatory Terms: The terms *transvestite*, *hermaphrodite*, *she-male*, *he-she*, *tranny*, and *gender-bender* may be considered derogatory if used by someone who is not transgender.⁴ (Note: although providers should not use these terms, transgender persons will sometimes use these terms as slang.)

Key Point:

Gender identity is distinct from sexual orientation. Sexual orientation involves sexual attraction, whereas gender identity involves the individual's natal sex in relation to the gender that he/she experiences.

Like all people, transgender individuals present with a variety of sexual orientations and behaviors. The terms *gay*, *straight*, *lesbian*, *homosexual*, and *heterosexual* may be defined differently by transgender individuals, depending on whether they are using their natal anatomy or their gender identity as a reference point. As with all people, these terms may be more about identity than behavior. Therefore, assessment of a patient's gender identity is distinct from assessment of his/her sexual behavior (see Section VIII: *Risk- and Harm-Reduction Approach for HIV-Infected Transgender Patients*).

IV. BASELINE HISTORY AND PSYCHOSOCIAL ASSESSMENT

RECOMMENDATION:

As part of the routine management of HIV-infected patients, clinicians should perform a psychosocial assessment at baseline and at least annually in HIV-infected transgender patients. (AIII)

A psychosocial assessment is used to identify not only the transgender patient’s basic psychosocial information but also circumstances that may require transgender-related case management services (see Table 2). Some patients may feel stigmatized or victimized by family members, coworkers, or employers. Such negative experiences often destabilize patients and can be barriers to HIV treatment.

A patient’s responses to a psychosocial assessment may also increase the clinician’s awareness of transgender-related culture, advocacy organizations, and social networks.

**TABLE 2
TRANSGENDER-FOCUSED PSYCHOSOCIAL ASSESSMENT**

- Support network
 - Family and partner contacts, including level of knowledge and support of patient’s gender identity
 - Social connections and community networks (e.g., *house ball* community^a)
 - Stability in relationships
- Transgender-related discrimination or violence
- Housing status
- Employment and insurance
 - If employed, are the patient’s employer and coworkers accepting of the patient’s gender identity?^b
 - If insured, can the patient be reimbursed for transgender-related care?
- Educational level
- Legal issues
 - Living will and healthcare proxy
 - Permanency planning for dependents
 - Potential obstacles to legal gender change and name change

^a The house ball community is based primarily on communal support among gay and transgender individuals. The majority of members are black and Hispanic.⁵ Approximately 40 *houses*, which often comprise a large extended *family*, exist in New York City.⁵ The houses organize events, or *balls*, that include a variety of performances and competitions between houses. For some individuals, membership to a house may provide support and encouragement and may be a source of relief from social isolation.

^b Employer support may lead to assistance in obtaining required documents to change gender identity on insurance and other legal documents.

For more information about psychosocial assessment, refer to the [Mental Health Quick Reference Card](#).

V. ROUTINE SCREENING AND LABORATORY ASSESSMENTS FOR HIV-INFECTED TRANSGENDER PATIENTS

RECOMMENDATION:

Routine medical screening of HIV-infected transgender patients should be performed according to standards of care, as determined by clinical judgment and according to the patient’s level of comfort. (AIII) For recommendations on cancer and cardiovascular screening for patients receiving hormone therapy, see Section VI.A: *Hormone Therapy*.

Most aspects of routine medical screening in transgender patients are similar to those in the general population. However, transgender patients, regardless of their surgical status, may find aspects of a physical examination distressing or traumatic, particularly breast, genital, pelvic, and rectal examinations. When immediate examination is not clinically indicated, examination deferral can be offered until the patient expresses readiness. Deferral of examinations to increase patient comfort should be documented in the medical record. An ongoing dialogue about the patient’s concerns, as well as offering examination deferral when appropriate, may convey respect for the patient. Patients who perceive respect and encouragement from their care providers may be more proactive about their health and remain in care (see Table 3).⁶

TABLE 3 STRATEGIES TO HELP ALLEVIATE A PATIENT’S CONCERNS ABOUT PHYSICAL EXAMINATION
<ul style="list-style-type: none">• Address the patient’s fears• Explain each step of the examination prior to performing it• Use the smallest, clinically indicated speculum for Pap tests and pelvic examinations• Use urine-based gonococcal/chlamydial testing for male-to-female patients• <i>For extreme cases of anxiety</i> (particularly in patients with a history of physical or sexual abuse):<ul style="list-style-type: none">○ Consider a referral for psychotherapy to decrease post-traumatic stress-type symptoms prior to physical examination○ Consider administration of a low-dose anxiolytic prior to physical examination

A. Pelvic Examination

RECOMMENDATION:

Clinicians should perform routine pelvic examinations in HIV-infected FtM patients and MtF patients who have undergone complete sex reassignment surgery according to HIV care guidelines for natal females. Before performing a pelvic examination in transgender patients, clinicians should explain the medical reasons for the examination. (AIII)

HIV-infected FtM patients remain at risk for gynecologic complications that can be detected by routine pelvic examinations (see [Primary Care Approach to the HIV-Infected Patient](#)).

B. Cytologic Screening

RECOMMENDATIONS:

Clinicians should perform routine cervical Pap tests in any HIV-infected FtM patient with cervical tissue; patients who are uncomfortable receiving a Pap test should be educated about the importance of obtaining cervical cytology. (AIII)

Clinicians should notify the pathologist when submitting a Pap test sample from a FtM patient who is receiving testosterone therapy because testosterone-related atrophy of the cervix may mimic cervical dysplasia.⁷ (AIII)

Anal Pap tests should be performed in HIV-infected transgender patients according to guidelines for natal males and natal females (see [Neoplastic Complications of HIV Infection](#)). (AIII)

Neovaginal Pap tests are not indicated for HIV-infected MtF patients. (AIII)

FtM patients should receive routine cervical Pap testing if cervical tissue is present, regardless of whether they have undergone a hysterectomy.

Key Point:

FtM patients receiving testosterone therapy may experience atrophy of the cervix, which can mimic cervical dysplasia.⁷ Notifying the pathologist of the patient's testosterone treatment status can increase accuracy of Pap test results.

For transgender patients, the smallest, clinically indicated speculum may be necessary for a Pap test. For information regarding Pap screening, refer to [Neoplastic Complications of HIV Infection](#).

C. Screening for Gonococcal and Chlamydial Infections

RECOMMENDATIONS:

Clinicians should screen HIV-infected transgender patients at baseline for gonorrhea and chlamydia; screening should also be performed at least annually thereafter for sexually active HIV-infected transgender patients. (AIII)

Clinicians should obtain an accurate sexual history and test all possible sites of exposure when screening for gonorrhea and chlamydia, including the urethra, rectum, and pharynx. (AIII)

For additional information regarding gonococcal and chlamydial infections in HIV-infected patients, refer to the [Gonococcal and Chlamydial Infections](#) guidelines.

VI. CROSS-GENDER THERAPY FOR HIV-INFECTED TRANSGENDER PATIENTS

Cross-gender therapy is used to physically transition transgender patients and may include hormone therapy alone or hormone therapy and physical enhancements, such as breast enlargement or complete gender reassignment surgery. Cross-gender therapy provides the opportunity to greatly increase quality of life for transgender patients by physically affirming their gender identity. For clinicians caring for HIV-infected transgender patients, cross-gender therapy may also facilitate retention in HIV care. However, both hormone therapy and gender reassignment surgery require careful consideration, as well as patient education, to optimize safety and reduce health risks associated with these forms of treatment, including infertility.

A. Hormone Therapy

RECOMMENDATION:

Clinicians should educate HIV-infected transgender patients about the possible health risks associated with hormone therapy. (AIII)

Although several small retrospective cohort studies suggest hormone therapy is generally safe, particularly over the short- and midterm,⁸ limited data exist on the long-term effects of cross-gender hormone therapy. Clinicians should inform patients that hormone therapy may increase the risk for:

- **Cardiovascular disease**—particularly venous thromboembolism
- **Certain cancers**—including breast, ovarian, and uterine cancers
- **Hepatic complications**—due to disturbances in liver metabolism caused by elevated liver enzymes
- **Erectile dysfunction**—due to increased circulating estrogen, which may also increase the risk for HIV transmission as a result of condom slippage or reduced condom use

Hormone treatment for transgender patients is most effective when clinicians provide therapy according to the fundamental principles listed in Table 4.

TABLE 4
BASIC GOALS AND EFFECTS OF CROSS-GENDER HORMONE THERAPY

Considerations Before Initiating:

- Set realistic expectations
- Emphasize the importance of medical supervision to optimize safety
- Establish health literacy^a regarding hormone therapy and possible interactions with other agents, including ART agents

Basic Goals of Hormone Therapy

- *Feminizing Therapy*
 - Provide estrogen as a feminizing agent
 - Provide androgen-blocking agents to decrease the effect of circulating testosterone
 - Maximize feminization
 - Minimize health risks
- *Masculinizing Therapy*
 - Provide testosterone as a masculinizing agent
 - Maximize masculinization
 - Minimize health risks

Basic Effects of Hormone Therapy

- *Feminizing Therapy*
 - Integument:
 - Breast growth
 - Redistribution of body fat to a more gynecoid habitus (wider hips, narrowed waist)
 - Softening of skin
 - Decrease in body hair (facial hair generally diminishes to a lesser degree)
 - Slowing or stopping the androgenic hair loss
 - Genital:
 - Decreased sperm production and testicular size
 - Loss of fertility
 - Prostatic atrophy
 - Decreased libido
 - Less frequent, less firm erections^b
 - Other:
 - Decreased upper body strength
 - Feminizing hormones generally do not affect the size of the larynx or pitch of the voice
 - Over time and depending on hormone dose, some of these changes may be permanent; breast enlargement will not completely reverse after discontinuation of treatment
- *Masculinizing Therapy*
 - Integument:
 - Redistribution of body fat to a more android habitus (loss of fat on hips, larger waist)
 - Growth of body and beard hair in accordance with the patient's genetic predisposition
 - Male-pattern hair loss in accordance with the patient's genetic predisposition
 - Minimal breast atrophy

Table 4 continues

Table 4 continued

- Genital:
 - Clitoral hypertrophy
 - Irregular menses at first, then cessation of menses
 - Atrophic vaginitis
 - Increased libido
 - Loss of fertility
- Other:
 - Deepened pitch of the voice
 - Increased upper body muscle size and strength, particularly with exercise
- Many of these changes are reversible

^a As defined by the National Network of Libraries of Medicine,⁹ health literacy includes the ability to understand prescribing instructions, appointment slips, medical education brochures, and doctor's directions and consent forms and the ability to negotiate complex health care systems. Health literacy requires reading, listening, analytical, and decision-making skills, as well as the ability to apply these skills to health situations.

^b Less firm erections can increase the risk for HIV and STI transmission due to condom slippage.

1. Concomitant Hormone Therapy and ART

RECOMMENDATIONS:

Hormone therapy for HIV-infected transgender patients who are not initiating or receiving ART should be prescribed according to the same standards of care for all transgender patients. (AIII)

Before prescribing hormone therapy for HIV-infected transgender patients who are receiving ART, clinicians should (AIII):

- **Consult with, or refer patients, to a provider who has experience in prescribing both hormone therapy and ART to select appropriate hormone treatment**
- **Educate patients about the prescribing considerations, including hormone selection and dose, for optimizing the effects of hormone therapy when prescribed in conjunction with an ART regimen**
- **Discuss the importance of adherence to ART with patients, including the risks associated with dangerously high circulating hormone levels due to ART interruption**

Clinicians should monitor hormone therapy in HIV-infected transgender patients according to established guidelines for all transgender patients. (AIII)

The clinician's selection of hormone and dose depends on whether or not the patient is also receiving ART. For ART-naïve patients who are not initiating ART, hormone therapy can be provided in the primary care setting according to standard guidelines for all transgender patients, such as the guidelines published by the Endocrine Society.¹⁰ Hormone therapy can also be provided through referral to another provider or an endocrinologist with expertise in transgender treatment. See Section X: *Transgender-Related Standards of Care and Referral Resources* for medical referral resources for transgender patients.

Hormone therapy for patients initiating or already receiving ART requires a careful approach. Some transgender patients may decline ART because of concerns about reduced hormone levels when prescribed with HIV-related medications.

Key Point:

Educating patients about how hormone selection and dose can reduce interactions between hormones and ART may encourage acceptance of ART from those who would otherwise decline it.

When hormone adjustments are made because of concomitant ART, concentrations of circulating hormone can become dangerously high if a patient does not adhere to ART. Severe cardiovascular complications, including stroke, deep vein thrombosis, and pulmonary embolism, may occur. Therefore, clinicians should consult with, or refer patients to, a provider who has experience in prescribing both hormone therapy and ART to select appropriate hormone treatment. Clinicians should also emphasize the risks associated with increased hormone levels when discussing the importance of adherence to ART.

Key Point:

Cross-gender hormone monitoring for HIV-infected transgender patients is the same as for all transgender patients. Established monitoring guidelines, such as those by the Endocrine Society,¹⁰ should be used.

2. Cancer Screening and Hormone Therapy

Exogenous hormone therapy has been linked to breast, ovarian, and uterine cancers.¹¹ Estrogen therapy may reduce the risk for prostate cancer, although the extent of the reduction is unknown.¹¹

Breast Cancer

RECOMMENDATION:

Clinicians should perform breast cancer screening in the following HIV-infected transgender patients according to clinical judgment and consideration of current guidelines established for natal females of the same age (see Appendix A):

- **FtM patients with remaining breast tissue (AIII)**
- **MtF transgender patients with breast tissue who have received hormone therapy for at least 5 years (AIII)**

MtF patients receiving feminizing hormones may be at increased risk for developing breast cancer in comparison with natal males. Although the risk is likely lower for MtF patients than it is for natal females,¹¹ clinicians should educate MtF patients receiving feminizing hormones about the increased risk for breast cancer and about breast cancer screening. Screening should be performed for MtF patients who have received hormone therapy for at least 5 years and should be based on clinical judgment and consideration of current guidelines for natal females of the same age (see Appendix A).

The risk for breast cancer is reduced in FtM patients who have undergone chest reconstruction, including reduction or mastectomy. However, clinicians should inform patients that the risk is still present when breast tissue remains and should perform screening according to clinical judgment and consideration of current guidelines for natal females of the same age (see Appendix A).

Prostate Cancer

RECOMMENDATION:

Clinicians should perform digital rectal examinations as part of routine HIV care for HIV-MtF transgender patients (see [Primary Care Approach To The HIV-Infected Patient](#)); clinical judgment and current guidelines for natal HIV-infected males should be used when considering prostate examinations in MtF transgender patients (see Appendix A). (AIII)

Feminizing hormone therapy may reduce the risk for prostate cancer; however, the extent of the reduction is unknown.¹¹ Additional data are required before a transgender-specific recommendation can be established. See Appendix A for HIV-related screening recommendations.

3. Cardiovascular Disease and Hormone Therapy

RECOMMENDATION:

When HIV-infected transgender patients choose to receive hormones, clinicians should educate them about the cardiovascular effects of hormone therapy and, when indicated, provide counseling to reduce the risk for cardiovascular disease; such discussions should take place at the time of initiation of hormone therapy and frequently thereafter. (AIII)

Both feminizing and masculinizing hormone therapies increase the risk for cardiovascular disease, including increased arterial stiffness with androgen therapy¹² and venous thromboembolism and stroke with estrogen therapy.⁸ These effects should be discussed at the time of initiation of hormone therapy and frequently thereafter. Transgender patients receiving hormone therapy who have comorbid cardiovascular risk factors require more frequent counseling and education to reduce their risk for cardiovascular disease, including smoking (see [Smoking Cessation in HIV-Infected Patients](#)).

B. Gender-Confirming Surgery

RECOMMENDATIONS:

The standards of care for gender reassignment surgery, as well as less complicated gender confirming procedures, are the same for HIV-infected transgender patients as for transgender patients who are not infected with HIV. (AIII)

Surgery, including breast implantation and gender-reassignment surgery, is not contraindicated in HIV-infected patients. (AIII)

Some HIV-infected transgender patients may elect to receive surgery as part of the transitional process. Gender-confirming surgery may involve complete gender reassignment surgery, also known as gender realignment surgery or sex reassignment surgery; or less complicated procedures, such as rhinoplasty or breast and gluteal implantation in combination with feminizing hormone therapy. In either case, the standards of care for these gender-confirming surgical procedures are the same for HIV-infected transgender patients as for transgender patients without HIV infection. Decisions regarding gender-confirming surgery should be made in consultation with a specialist in transgender surgery. See Section X: *Transgender-Related Standards of Care and Referral Resources* for referral resources for individuals seeking gender-confirming surgery.

VII. MENTAL HEALTH AND SUBSTANCE USE SCREENING

RECOMMENDATIONS:

Clinicians should perform a mental health and substance use assessment in HIV-infected transgender patients at baseline and at least annually thereafter. (AIII)

Clinicians should refer HIV-infected transgender patients requiring mental health services to a psychiatrist or psychologist with knowledge and experience in transgender treatment. (AIII)

If the HIV-infected transgender patient's substance use screening result is positive, or if the patient has a history of substance use, the clinician should re-evaluate the patient's substance use at least quarterly. (AIII)

Clinicians should offer patients with active substance use/abuse problems referral to appropriate substance use treatment programs or other substance use services. (AIII)

Comorbid mental health and substance use disorders are more prevalent among HIV-infected patients¹³ and sexual minorities^{14,15} than the general population. In addition to the baseline history and psychosocial assessment, clinicians should perform mental health and substance use screening. Identification and stabilization of mental health and substance use disorders in transgender patients can help eliminate barriers to medical care, including HIV treatment, and enable patients to pursue gender transformation in a positive manner and under medical supervision.

When further assessment is warranted for transgender patients, clinicians should optimally be able to refer them to a mental health or substance use provider who is experienced with transgender care. If the clinician cannot make a direct referral, then he/she should be familiar with appropriate referral services (see Section X: *Transgender-Related Standards of Care and Referral Resources*). For information about mental health and substance use screening, refer to [*Mental Health Screening: A Quick Reference Guide for HIV Primary Care Clinicians*](#) and [*Screening and Ongoing Assessment for Substance Use*](#).

VIII. RISK- AND HARM-REDUCTION APPROACH FOR HIV-INFECTED TRANSGENDER PATIENTS

RECOMMENDATIONS:

Clinicians should assess for the following behaviors in HIV-infected transgender patients:

- **Silicone use**
- **Hormones obtained without prescription, including specific hormones used**
- **Needle-sharing among those who inject hormones, silicone, and/or drugs**
- **Sexual risk behaviors**
- **Genital taping**

Clinicians should provide risk-reduction counseling and, when appropriate, harm-reduction counseling for HIV-infected transgender patients who report potentially harmful behaviors. Patients at risk for intentionally harming their genitalia require referral for psychiatric evaluation. (AIII)

A. Silicone Use

No recommendations exist for administering silicone injections as gender-confirming treatment. However, this dangerous method for altering one's appearance is often available at *silicone parties* or *pumping parties*. Many transgender patients may have friends who have received injections without major complications, but serious complications usually arise later. Clinicians and patients should discuss the possible consequences of silicone use, which are often not immediate.

In addition to the risk for HIV and hepatitis transmission and bacteriological infections, clinicians should emphasize the long-term risks that are commonly associated with silicone injection:

- Silicone can congeal over time, move to other parts of the body and cause subsequent disfigurement
- Silicone injected into the breast can interfere with the interpretation of mammograms, and may increase a patient's risk for undetected cancer in the future

Life-threatening injuries are less common but can occur. Migration of the substance outside of the injection site into the blood stream (i.e., silicone embolism syndrome) can cause respiratory failure.¹⁶ Silicone used for illicit injections may be composed of materials other than medical-grade silicone.

B. Hormone Use

Some transgender patients obtain hormones without a prescription. To reduce possible interactions with HIV-related treatment, clinicians should inquire about patients' use of nonprescribed hormones and should ask for specific information regarding the type of hormones patients are obtaining. Many clinicians will advise patients to avoid use of hormones that are obtained without a prescription and inform them of the risks associated with such behavior; however, such advice may not be acknowledged unless the provider is offering an alternative method for obtaining hormone therapy. An effective harm-reduction approach may be to encourage a reduction in the use of street hormones as the patient transitions to receiving only

prescribed hormone therapy. The following are risks associated with receiving hormones that are not obtained under the care of a clinician:

- Needle-sharing increases the risk for hepatitis B, hepatitis C, and HIV transmission
- Bacterial infections can result from non-sterile technique/supplies
- Liver damage, blood clotting problems, and deep vein thrombosis can result from inconsistent hormone dosing in illicit preparations
- Some hormones that are obtained without a prescription could be harmful in themselves (e.g., risk for disfigurement from cooking oil added to the illicit preparation)

Some providers periodically assess testosterone and estradiol levels to determine whether excess concentrations of the hormones are present (CIII). However, hormone levels may not provide a clear indication of the patient's hormone use, particularly if procurement of hormones without a prescription is inconsistent. Other laboratory markers, such as prolactin for patients receiving estrogen or hematocrit for patients receiving testosterone, may be useful for monitoring hormone effects (CIII).

C. Injection Practices

For patients who engage in high-risk injection behaviors, harm-reduction techniques can offer an effective means for modifying behaviors that place patients at risk for transmission of HIV and other diseases. For example, transgender patients who choose to continue to inject illicit hormones or silicone should be referred to [New York State's Syringe Access Resources](#). Individuals seeking syringes for hormone injections should be referred to sites that provide syringes appropriate for hormone injections and that provide education about how to safely perform these injections. For additional information on sterile syringes and safer injection techniques, see [Working With the Active User](#).

D. Sexual Risk

For all patients, a sexual risk assessment should focus on behaviors rather than the sexual orientation of the patient. In particular, the patient may not identify with the words *homosexual* or *gay*, and questions such as *Are you a homosexual?* or *Are you gay?* may not provide useful information. Clinicians should also strive to help the patient feel comfortable with providing information about his/her sexual behavior. The following could be used as part of a dialogue about sexual health:

- *I want to offer you the highest quality of care possible. Understanding your sexual practices will help me provide you with better care.*
- *Do you have anal, oral, or vaginal sex?*
- *Is this sex receptive, insertive, or both?*
- *Do you use safer sex practices, such as wearing condoms and using dental dams?*

Providers should use language that the individual patient understands. For additional information regarding risk-reduction counseling related to sexual transmission, refer to the [Prevention with Positives: Integrating HIV Prevention into HIV Primary Care](#).

E. Genital Taping or Tucking

Some patients may attempt to hide their genitalia by taping or tucking. Taping increases the risk for urinary tract infections, as well as sores and damaged tissue, particularly when materials that can tear skin easily are used, such as duct tape. Patients whose long-term goals include sex reassignment surgery may reduce such behavior if they are educated about the reconstruction of natal genitalia to create new genitalia during sex reassignment surgery. If the clinician suspects that a patient may be at risk for intentionally harming his/her genitalia, then referral for a psychiatric evaluation is necessary.

IX. CASE MANAGEMENT FOR HIV-INFECTED TRANSGENDER PATIENTS

RECOMMENDATIONS:

Case managers who provide services to HIV-infected transgender patients should:

- **Develop expertise in transgender-related services, such as assisting patients with access to healthcare, assisting with adherence to medical treatment and medical appointments, and making appropriate referrals**
- **Closely monitor changes in contact information, housing, and psychosocial support for patients with unstable living situations**
- **Develop awareness of “trans-friendly” resources, including education, employment, legal aid resources, and harm-reduction programs**
- **Be familiar with the resources available to assist patients with obtaining a change of name and gender status on their identification and health insurance cards (AIII)**

Unstable living situations or difficulties with insurance reimbursement may complicate regular access to healthcare for HIV-infected transgender patients. Such challenges require proactive case management involving familiarity with transgender-related services. Case managers with such expertise can facilitate care for transgender patients by performing the following functions:

- Closely monitor changes in contact information, housing, and psychosocial support for patients with unstable living situations
- Assist with adherence to medical treatment and appointments
- Refer patients to appropriate transgender-related resources

Access to *trans-friendly* programs may facilitate referrals for housing, employment, harm-reduction programs, and legal aid resources when needed (see Section X: *Transgender-Related Standards of Care and Referral Resources*). Case managers should be able to assist with name and gender status change for transgender patients' identification cards and health insurance.

Members of the care team may find it beneficial to guide patients through the process of gender change before name change because changing the patient's gender on his/her health insurance ID card may enable reimbursement for hormone treatment. This step may help prevent patients from obtaining illicit hormones. Advocacy for coordination of transgender-related health benefits may be necessary.*

* Third-party reimbursement programs, including Medicaid, the New York State AIDS Drug Assistance Program (ADAP), and private insurers, may require female and male gender designations on insurance identification before payment can be issued for feminizing and masculinizing hormone therapy, respectively.

Case managers can develop expertise in managing the processes described above through participation in training programs and related professional development. For organizations that can assist in transgender legal issues, see Section X: *Transgender-Related Standards of Care and Referral Resources*.

X. TRANSGENDER-RELATED STANDARDS OF CARE AND REFERRAL RESOURCES

A. Standards of Care

The most recognized transgender-related standards of care are the World Professional Association for Transgender Health (WPATH) *Standards of Care*, formerly known as the *Harry Benjamin International Gender Dysphoria Association Standards of Care* (www.wpath.org).¹⁷ This publication provides clinicians who may not be familiar with transgender treatment with a framework for many clinical decisions.

The WPATH *Standards of Care* provides a comprehensive description of the “Five Elements of Treatment”: 1) diagnostic assessment, 2) psychotherapy, 3) real-life experience, 4) hormone therapy, and 5) surgical therapy. The *Standards of Care* also serve as a resource for related treatment information, including hormonal treatment and surgical options.

Other organizations have developed guidelines that expand on the WPATH *Standards of Care*; these include collaborative projects involving experts in the medical care of transgender patients and those with knowledge of the psychosocial aspects of transgender care, such as the following:

- *Principles of Transgender Medicine and Surgery*¹¹
- *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice*¹⁰
- *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia*³

B. Informational Resources

Clinicians can refer to a number of organizations for comprehensive transgender-related medical information. These organizations also provide additional transgender-related resources.

- World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association): www.wpath.org
- Transgender Health Program: www.vch.ca/transhealth
- Transsexual Women’s Resources: www.annelawrence.com
- Transgender Care: www.transgendercare.com
- Callen-Lorde Community Health Center—This organization has established a set of protocols for hormone treatment of transgender individuals. To request a copy of the protocols, refer to www.callen-lorde.org

C. Referral Resources for Transgender Care and Services

Resources are available for clinicians to connect patients with a variety of transgender-related services.

- **Callen-Lorde Community Health Center**—This organization has established a set of protocols for hormone treatment of transgender individuals. To request a copy of the protocols, refer to www.callen-lorde.org
- **Clinical Education Initiative**—Provides clinical education to community-based medical providers, including providers of special populations. Refer to www.ceitraining.org
- **Community Healthcare Network**—Provides transgender health care and support services. Refer to www.chnny.org
- **Gender Identity Project**—Provides a network of services for the transgender community. Refer to www.gaycenter.org/gip/services
- **Health & Education Alternatives for Teens**—Provides transgender healthcare and support services for youth. Refer to www.heatprogram.org
- **New York/New Jersey AIDS Education & Training Center**—Provides training for providers who treat HIV-infected patients, including special populations. Refer to www.nynjaetc.org
- **Sylvia Rivera Law Project**—Provides legal services to transgender individuals. Refer to www.srlp.org
- **Transgender Legal Defense & Education Fund**—Focuses on public education, direct legal services, community organizing, and public policy efforts. Refer to www.transgenderlegal.org
- **Urban Justice Center**—Provides legal services, advocacy, and community education for lesbian, gay, bisexual, and transgender youth. Refer to www.urbanjustice.org

D. Transgender-Related Conferences

A number of transgender-related conferences take place annually. Some of these conferences include:

- **Empire Conference** (New York State)—Organized by TransEvents USA. Refer to www.transeventsusa.org/empire
- **First Event Transgender Conference** (Massachusetts)—Organized by the Tiffany Club of New England. Refer to www.tcne.org
- **International Foundation for Gender Education Conference** (Massachusetts)—Organized by the International Foundation for Gender Education. Refer to www.ifge.org
- **Trans-Health Conference** (Philadelphia)—Organized by the Mazzoni Center. Refer to www.trans-health.org
- **Ct TransAdvocacy Coalition** (Connecticut)—Organized by area advocacy groups in Connecticut. Refer to <http://www.transadvocacy.com>
- **WPATH International Symposium** (locations vary)—Organized by the World Professional Association for Transgender Health. Refer to http://wpath.org/events_symposium.cfm

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APPENDIX A

Age-Appropriate Diagnostic Screening for HIV-Infected Patients

TABLE 1 AGE-APPROPRIATE DIAGNOSTIC SCREENING FOR HIV-INFECTED PATIENTS			
Screen	Recommendations	Comments	Published Guidelines for All Patients
Breast cancer	<ul style="list-style-type: none"> • Clinicians should perform routine breast cancer screening in HIV-infected women according to standard guidelines for all patients • Clinicians should discuss the risks and benefits of breast cancer screening with HIV-infected patients 	<ul style="list-style-type: none"> • Rates of breast cancer are not increased in HIV-infected women compared with the general population 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force • American Cancer Society • American College of Obstetricians and Gynecologists
Prostate cancer	<ul style="list-style-type: none"> • Clinicians should perform routine prostate cancer screening according to standard guidelines for all patients • Clinicians should discuss the risks and benefits of prostate cancer screening with patients 	<ul style="list-style-type: none"> • Rates of prostate cancer are not increased HIV-infected men compared with the general population 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force • American Cancer Society
Colorectal cancer	<ul style="list-style-type: none"> • Clinicians should perform routine colorectal cancer screening in HIV-infected patients according to standard guidelines for all patients • Clinicians should discuss the risks and benefits of colorectal screening with patients 	<ul style="list-style-type: none"> • Rates of colorectal cancer may be increased in HIV-infected patients compared with the general population; however, no HIV-specific screening recommendations have been established 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force • American Cancer Society
Bone mineral density	<ul style="list-style-type: none"> • Clinicians should perform bone density screening according to standard guidelines for all patients 	<ul style="list-style-type: none"> • Accumulating evidence suggests that HIV infection may reduce bone mineral density; further data on fracture risk in HIV-infected patients are needed 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force <p style="text-align: right;"><i>Appendix A continues</i></p>

<p><i>Appendix A continued</i></p> <p>Electrocardiography</p>	<ul style="list-style-type: none"> • Clinicians should perform electrocardiography according to standard guidelines for all patients 	<ul style="list-style-type: none"> • Although some experts suggest that increased electrocardiography may benefit select HIV-infected patients, others suggest that such screening is not beneficial • Further data on increased electrocardiography are needed before an HIV-specific recommendation can be established 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force • American Heart Association
<p>Thyroid</p>	<ul style="list-style-type: none"> • Clinicians should perform thyroid screening according to standard guidelines for all patients 	<ul style="list-style-type: none"> • For the general population, recommendations differ; some groups do not recommend routine thyroid screening, whereas others recommend routine screening in select populations • Data on the benefit of thyroid screening in HIV-infected patients are limited; further data are needed before HIV-specific recommendations can be established 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force • American Thyroid Association • American Association of Clinical Endocrinologists
<p>Abdominal ultrasonography</p>	<ul style="list-style-type: none"> • Clinicians should perform abdominal ultrasonography in men aged 65 to 75 years who ever smoked according to standard guidelines for all patients 	<ul style="list-style-type: none"> • Further data on abdominal ultrasonography in HIV-infected patients are needed before an HIV-specific recommendation can be established 	<ul style="list-style-type: none"> • U.S. Preventive Services Task Force