

# Q&A:

Wylie C. Hembree



***Endocrine News* talks with Wylie C. Hembree, MD, chair of the task force that created the latest Clinical Practice Guideline on transgender care. He discusses why it was important for the Endocrine Society to release such a guideline on this topic now and why he thinks it will impact the care patients receive in the future.**

## In September, the Endocrine Society issued a Clinical Practice Guideline on gender dysphoria/gender incongruence, the first guideline addressing transgender patient care since 2009 and the first one to emphasize the importance of care for adolescents.

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itled “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” the guideline was published online and will appear in the November 2017 print issue of *The Journal of Clinical Endocrinology & Metabolism (JCEM)*.

Over the past few decades, there has been a rapid expansion in the understanding of gender identity along with the implications for the care of transgender and gender incongruent individuals. The new guideline establishes a framework for the appropriate treatment of these individuals and standardizes terminology to be used by healthcare professionals.

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Wylie C. Hembree, MD

*Endocrine News* spoke with Wylie C. Hembree, MD, of the College of Physicians and Surgeons at Columbia University in New York, and the chair of the task force that authored the guideline, to find out how this guideline will help dispel some of the myths that exist about treatment of this condition, as well as a closer look at treating younger patients and the differing protocols for treating adults and adolescents.

**Endocrine News: What was the main reason for the publication of the transgender guideline — what drove the decision and why now?**

**Wylie C. Hembree:** The initial 2009 Clinical Practice Guideline on Transgender Care was occasioned by the publication of a series of new clinical protocols designed to treat both adolescent and adult transgender men and women as well as by an increased number of treatment centers in the U.S. and Europe. Since that time, more than 3,000 publications have been published that clarify the natural history of gender dysphoria/gender incongruence. We are now aware that dissatisfaction with assigned gender may occur in childhood, in a small percentage, may persist into adolescence and, if not treated, will persist into adulthood. Treatment protocols for adolescents and adults are more precise, the role of mental health professionals is well defined, fertility options are available, the role of informed consent is defined, and options for gender-affirming surgery have improved and are more widely available. Laws and regulations have facilitated the social transition of transgender men and women. It is clear that a new Clinical Practice Guideline is required to aide those who participate in the transition of transgender persons.

**EN: What are your hopes for the impact of the guideline on endocrine standards of care of the patient with gender incongruence/gender dysphoria?**

**WCH:** The new guideline is designed to provide a better understanding of the presentation of gender dysphoria so that treatment protocols for adolescents and adults, their risks and benefits, and integration with surgery and social integration will be carried out more smoothly.

**A full-length feature that delves into the details of the guidelines recommendations and what it means for clinicians and patients will be published in the November issue of *Endocrine News*.**

The Guideline is designed to provide criteria for precise diagnosis as well as treatment options for use of sex steroids. Risks and adverse effects are well defined, especially with regard to protocols for suppression of endogenous sex steroids and steroid treatment to achieve complete transition to the appropriate gender.

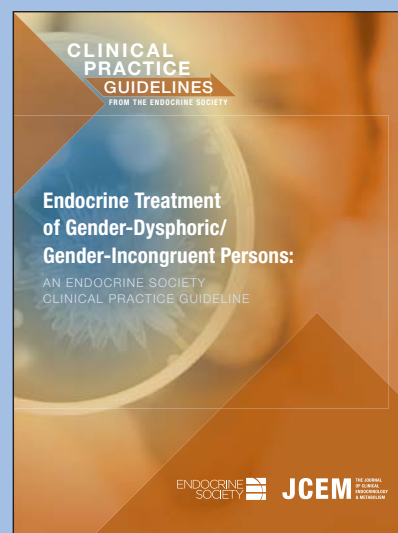
**EN: How do you expect other medical specialties to be affected by the task force's recommendations?**

**WCH:** It is hoped that the endocrine protocols can be appropriately used by non-endocrine physicians treating transgender persons and by surgeons providing procedures to aide in the transition. Furthermore, monitoring and adverse effects of this type of endocrine treatment must be understood by physicians and surgeons providing care for transgender persons. There are two aspects of the endocrine treatment for persons with gender dysphoria. The first may be designed either to prevent secretion of endogenous sex steroids at puberty or later in puberty, or in adults to suppress the sex steroid secretion that was determined by their natal sex. The second is to administer the sex steroids that achieve the body changes of the desired gender and to determine that the hormone levels are maintained within the normal physiologic range for the person's affirmed gender. In some cases, giving only one sex steroid, e.g., testosterone, may be enough both to suppress estrogen and virilize a transgender man. In transgender women, giving only estrogen may not be sufficient to suppress the testosterone secreted by their testes. An additional hormone may be required.

**EN: What are the key take-home messages for patients in this guideline?**

**WCH:** Transgender persons should understand that neither suppression nor administration of sex steroids should be given without discussions of informed consent, reversibility of treatment, and discussions of the impact upon or future options for fertility. Patients should discuss their desire for the types and timing of surgery.

Transgender persons must understand the reasons for the type of steroid hormones circulating in their bloodstream, what the risks and benefits are, and how they must be monitored. In adolescents, if the gonads that were suppressed at puberty are present, not only must the dose of the sex steroid of the desired gender be monitored, but persistent gonadal suppression must be determined. In late adolescents and adults whose gonads were suppressed, the sex steroids of the natal sex must be monitored as well as the sex steroid of the desired gender. If the gonad of a transgender person has been removed, only periodic measurement of the administered sex steroid levels is necessary and potential adverse effects should be monitored. <sup>EN</sup>



## GUIDELINE RECOMMENDATIONS

- ▶ **Hormone treatment is not recommended for pre-pubertal gender-dysphoric/gender-incongruent persons;**
- ▶ **For the care of peri-pubertal youths and older adolescents, an expert multi-disciplinary team comprised of medical professionals and mental health professionals should manage treatment;**
- ▶ **For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient;**
- ▶ **Removal of gonads may be considered when high doses of sex steroids are required to suppress endogenous secretion, and/or to reduce steroid levels in advanced age; and**
- ▶ **During sex steroid treatment, clinicians should monitor, in both transgender males (female to male) and/or transgender females (male to female), prolactin, metabolic disorders, bone loss, and cancer risks when surgical removal is incomplete.**

**The guideline was published online at [www.endocrine.org/GenderDysphoricCPG](http://www.endocrine.org/GenderDysphoricCPG) ahead of print.**