

et al., 2018). All 8 studies clearly demonstrated individuals were very satisfied with their surgical results (between 72% and 100% of individuals). Additionally, individuals were significantly more satisfied with the appearance of their face compared with individuals who had not undergone surgery. One prospective, international, multicenter, cohort study found facial GAS significantly improves both mid- and long-term quality of life (Morrison et al., 2020). The results were direct and consistent, but somewhat imprecise because of certain study limitations. While gender-affirming facial surgery for AFAB individuals is an emerging field, current limited data points toward equal benefits in select patients. Future studies are recommended.

Additional procedures and/or interventions such as hair removal (prior to facial and/or genital surgery) may be required as part of the pre-operative process. See Chapter 15—Primary Care. Furthermore, consultation with pelvic floor physical therapy may be important (or required) both before and after surgery.

Representative surgical interventions include (for complete list, see appendix E and the end of this chapter):

AMAB: facial feminization surgery (including chondrolaryngoplasty/vocal cord surgery), gender-affirming breast surgery, body contouring procedures, orchiectomy, vagino/vulvoplasty (with/without depth), aesthetic procedures, and procedures designed to prepare individuals for surgery (i.e., hair removal).

AFAB: facial masculinization surgery, gender-affirming chest surgery, hysterectomy/oophorectomy, metoidioplasty (including placement of testicular prosthesis), phalloplasty (including placement of testicular/penile prostheses), body contouring procedures, aesthetic procedures, and procedures designed to prepare individuals for surgery (i.e., hair removal).

It is important surgeons understand the indication(s) and the timing for GAS. This is especially important when caring for adolescents (see Chapter 6—Adolescents).

It is important the surgeon and the patient participate in a shared decision-making approach that includes 1) a multidisciplinary approach; 2) an understanding of the patient's goals and

expectations; 3) a discussion regarding the surgical options and associated risks and benefits; and 4) an informed plan for aftercare (see Chapter 5—Assessment for Adults). These recommendations are designed to facilitate an individualized approach to care.

Appropriate aftercare is essential for optimizing outcomes (Buncamper et al., 2015; Lawrence, 2003), and it is important patients are informed about postoperative needs (including local wound care, activity restrictions, time off from work or school, etc.). In addition, it is important the surgeon is available to provide and facilitate postoperative care, refer to specialty services, or both as needed. This may include the need for ongoing support (i.e., both from the caregiver as well as the primary care provider, mental health professionals (MHPs), or both), as well as the need for routine primary care (i.e., breast/chest cancer screening, urologic/gynecologic care, etc.).

With the increase both in public interest and in the number of gender-affirming surgical procedures (Canner et al., 2018; Ross, 2017; Shen et al., 2019), additional training, tracking of outcomes, and continuing medical education for surgeons are necessary (Schechter et al., 2017).

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

Statement 13.1

We recommend surgeons who perform gender-affirming surgical procedures have the following credentials:

- a. **Training and documented supervision in gender-affirming procedures;**
- b. **Maintenance of an active practice in gender-affirming surgical procedures;**
- c. **Knowledge about gender diverse identities and expressions;**
- d. **Continuing education in the field of gender-affirmation surgery;**
- e. **Tracking of surgical outcomes.**

Surgeons offering GAS may have a variety of surgical specialty training and backgrounds. The most common surgical specialties include plastic surgery, urology, gynecology, otolaryngology and oro-maxillofacial surgery (Jazayeri et al., 2021). Consistent with other surgical domains, we recommend only surgeons who are certified or eligible to be certified by their respective national professional boards offer GAS. Furthermore, it is recommended surgeons offering care for TGD people have received documented training in gender-affirming procedures and principles of gender-affirming care (Schechter et al., 2017; Schechter & Schechter, 2019). The latter includes, but is not limited, to knowledge about gender diverse identities and expressions, and how those affect patient goals, expectations, and outcomes. It is important surgeons offering GAS be familiar with the available procedures and can provide informed consent. If surgeons do not offer a requested procedure, they may offer a referral for a second opinion. Surgeons offering GAS are expected to participate in continuing education activities in the field of GAS (i.e., meetings, conferences, seminars, etc.) to maintain current knowledge. We further recommend surgical outcomes be tracked and communicated to the patients as part of the informed consent (Schechter et al., 2017).

In addition, hospitals, institutions, and physician offices that offer GAS need to be knowledgeable regarding cultural competencies (i.e., language, terminology, etc.). This may require ongoing and regular staff education.

Statement 13.2

We recommend surgeons assess transgender and gender diverse people for risk factors associated with breast cancer prior to breast augmentation or mastectomy.

Prior to breast augmentation or mastectomy, individuals need to be informed about and assessed for breast cancer risk factors, including genetic mutations (i.e., BRCA1, BRCA2), family history, age, radiation, exposure to estrogen, and the amount of breast tissue anticipated to remain after surgery (Brown, Lourenco et al., 2021; Brown & Jones, 2015; Colebunders et al., 2014; Gooren et al., 2013; Salibian et al., 2021; Weyers et al., 2010). Breast cancer screening balances the

identification of cancer with the selection of appropriate imaging, tests, and procedures. Currently, evidence-based screening guidelines specific for TGD individuals do not exist (Salibian et al., 2021), however, recent guidelines have been proposed by the American College of Radiology (Brown, Lourenco et al., 2021). Because the risk of cancer in individuals seeking gender-affirming breast augmentation or mastectomy is similar to that in the general population (even in the setting of hormone use), existing cancer screening guidelines need to be followed (Brown & Jones, 2015; Gooren et al., 2013; Salibian et al., 2021; Weyers et al., 2010). Professionals need to be familiar with updates to these guidelines as they are subject to change. Individuals who undergo gender-affirming surgery of the chest should have ongoing breast cancer surveillance, which should be overseen by their primary care providers.

Statement 13.3

We recommend surgeons inform transgender and gender diverse people undergoing gender-affirming surgical procedures about aftercare requirements, travel and accommodations, and the importance of postoperative follow-up during the preoperative process.

Details about the timing, technique, and duration of the aftercare requirements are shared with patients in the preoperative period such that appropriate planning may be undertaken. This includes a discussion regarding the anticipated staging of surgical procedures (and associated travel requirements). Given the small number of surgeons who specialize in GAS, it is common for patients to travel for their procedures. Prior to surgery, surgeons should provide patients with a postoperative follow-up schedule. The surgeon should discuss the duration of the patient's travel dates, the anticipated inpatient versus outpatient stay, and the potential need for flexibility in travel arrangements (especially if complications occur). Given the complexity and cost of travel and lodging, changes in the care plan should be shared with the patient as early as possible. Surgeons should facilitate continuity of care with a local provider upon returning home.

Aftercare and postsurgical follow-up are important. Gender-affirming surgical procedures

often have specific aftercare requirements, such as postsurgery resources (stable, safe housing; resources for travel and follow-up care), instructions in health-positive habits (e.g., personal hygiene, healthy living, prevention of urinary tract infections (UTIs) and sexually-transmitted infections (STIs) (Wierckx, Van Caenegem et al., 2011)), postsurgery precautions or limitations on activities of daily life (e.g., bathing, physical activity, exercise, nutritional guidance, resumption of sexual activity) (Capitán et al., 2020), postsurgery resumption of medications (i.e., anticoagulants, hormones, etc.), and detailed postsurgery self-care activities (e.g., postvaginoplasty dilation and douching regimens, activation of a penile prosthesis, strategies to optimize postphalloplasty urination, recommendations for hair transplant care) (Capitán et al., 2017; Falcone et al., 2018; Garcia, 2018; Hoebeke et al., 2005). Some aspects of postsurgery self-care activities may be introduced prior to surgery and are reinforced after surgery (Falcone et al., 2018). As issues such as wound disruptions, difficulty with dilation, and UTIs may occur (Dy et al., 2019), the follow-up period provides an opportunity to intervene, mitigate, and prevent complications (Buncamper et al., 2016; Garcia, 2021).

Statement 13.4

We recommend surgeons confirm reproductive options have been discussed prior to gonadectomy in transgender and gender diverse people.

Infertility is often a consequence of both gender-affirming hormone therapy (temporary) and GAS (permanent), and fertility preservation is discussed prior to medical interventions, surgical interventions, or both (Defreyne, van Schuylenbergh et al., 2020; Jahromi et al., 2021; Jones et al., 2021). Surgical interventions that alter reproductive anatomy or function may limit future reproductive options to varying degrees (Nahata et al., 2019). It is thus critical to discuss infertility risk and fertility preservation (FP) options with transgender individuals and their families prior to initiating any of these interventions and on an ongoing basis thereafter (Hembree et al., 2017).

For specific recommendations regarding reproductive options, see Chapter 16—Reproductive Health.

Statement 13.5

We suggest surgeons consider offering gonadectomy to eligible* transgender and gender diverse adults when there is evidence they have tolerated a minimum of 6 months of hormone therapy (unless hormone replacement therapy or gonadal suppression is not clinically indicated or the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity). For supporting text, see Statement 13.6.

Statement 13.6

We suggest health care professionals consider gender-affirming genital procedures in eligible* transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated).

GAHT leads to anatomical, physiological, and psychological changes. The onset of the anatomic effects (e.g., clitoral growth, vaginal mucosal atrophy) may begin early after the initiation of therapy, and the peak effect is expected at 1–2 years (T'Sjoen et al., 2019). Depending upon the surgical result required, a period of hormone treatment may be required (e.g., sufficient clitoral virilization prior to metoidioplasty/phalloplasty) or preferred for psychological reasons, anatomical reasons, or both (breast growth and skin expansion prior to breast augmentation, softening of skin and changes in facial fat distribution prior to facial GAS) (de Blok et al., 2021).

For individuals who are not taking hormones prior to surgical interventions, it is important surgeons review the impact of this on the proposed surgery.

For individuals undergoing gonadectomy who are not taking hormones, a plan for hormone replacement can be developed with their prescribing professional prior to surgery.

Statement 13.7

We recommend surgeons consider gender-affirming surgical interventions for eligible* transgender and gender diverse adolescents when there is evidence a multidisciplinary approach that includes mental health and medical professionals has been involved in the decision-making process.

Substantial evidence (i.e., observational studies (Monstrey et al., 2001; Stojanovic et al., 2017), literature reviews and expert opinions (Esteve de Antonio et al., 2013; Frey et al., 2017; Hadj-Moussa et al., 2019; Pan & Honig, 2018), established guidelines (Byne et al., 2018; Chen, Fuqua et al., 2016; Hembree et al., 2017; Karasic & Fraser, 2018; Klein, Paradise et al., 2018; Weissler et al., 2018), and a thematic content analysis (Gerritse et al., 2018), support the importance of a multidisciplinary (i.e., medical, mental health, and surgery) approach to transgender health care.

A multidisciplinary approach is especially important in managing mental health issues if these are experienced by a TGD person undergoing GAS (de Freitas et al., 2020; Dhejne et al., 2016; van der Miesen et al., 2016). In addition, primary care providers and medical specialists can help support decisions regarding the timing of surgery, surgical outcomes and expectations, perioperative hormone management, and optimization of medical conditions (Elamin et al., 2010; Hembree et al., 2017).

For specific recommendations regarding pre-surgical assessment in adolescents, see Chapter 6—Adolescents.

Statement 13.8

We recommend surgeons consult a comprehensive, multidisciplinary team of professionals in the field of transgender health when eligible* transgender and gender diverse people request individually customized (previously termed “non-standard”) surgeries as part of a gender-affirming surgical intervention.

Gender identities may present along a spectrum, and the expression of a person’s identity may vary quite widely amongst individuals (Beek et al., 2015; Koehler et al., 2018). While the overall goal of a particular procedure usually includes

reduction of gender dysphoria (van de Grift, Elaut et al., 2017) or achieving gender congruence, gender diverse presentations may lead to individually customized surgical requests some may consider “non-standard” (Beek et al., 2015; Bizic et al., 2018). Individually customized surgical requests can be defined as 1) a procedure that alters an individual’s gender expression without necessarily aiming to express an alternative, binary gender; 2) the “non-standard” combination of well-established procedures; or 3) both.

This is designed to help counsel and inform the patient as well as to ensure their goals can be achieved. The patient and their surgeon need to work together to ensure the patient’s expectations are realistic and achievable, and the proposed interventions are safe and technically feasible. The patient and their surgical team need to engage in a shared decision-making process (Cavanaugh et al., 2016). This informed consent process needs to address the irreversibility of some procedures, the newer nature of some procedures, and the limited information available about the long-term outcomes of some procedures.

Statement 13.9

We suggest surgeons caring for transgender men and gender diverse people who have undergone metoidioplasty/phalloplasty encourage life-long urological follow-up.

Postoperative complications following metoidioplasty/phalloplasty comprise the urinary tract and sexual function (Kang et al., 2019; Monstrey et al., 2009; Santucci, 2018; Schardein et al., 2019). Reported urethral complications (related to urethral lengthening) include urethral strictures 35–58%, urethral fistulae 15–70% (Monstrey et al., 2009; Santucci, 2018; Schardein et al., 2019), diverticulae, mucocele due to vaginal remnant, and hair growth within the neourethra (Berli et al., 2021; Veerman et al., 2020). Complications related to sexual function include limited to absent tactile and/or erogenous sensation, difficulties with orgasm function, and complications with penile prosthetics (Kang et al., 2019; Santucci, 2018). Penile prosthesis-related complications are estimated to involve infection (incidence 8–12%),

malfunction, urethral erosion, skin extrusion, and dislocation of its bone fixation (Falcone et al., 2018; Kang et al., 2019; Morrison et al., 2016). Although most urethral and prosthetic complications occur in the immediate and intermediate postoperative period, complications can occur at any time. Early detection may reduce morbidity (e.g., urethral strictures resulting in fistulae, pending erosion of a penile prosthetic leading to infection and requiring total explant) (Blecher et al., 2019).

Routine follow-up to assess for early evidence of urethral stricture (or other urinary issues) includes bladder ultrasound measurement of post-void residual volume (to screen for and stage neourethral stricture), fluoroscopic urethrography (to identify and stage neourethral strictures, fistulae, and diverticulae), and cystourethroscopy to examine the urethra and bladder. TGD men may also have routine urologic issues that need not be related to gender transition (urinary calculi, hematuria, and genitourinary malignancies; fertility preservation) (Sterling & Garcia, 2020a, 2020b).

Statement 13.10

We recommend surgeons caring for transgender women and gender diverse people who have undergone vaginoplasty encourage follow-up with their primary surgeon, primary care physician, or gynecologist.

Vaginoplasty is a safe procedure (Hontscharuk, Alba, Hamidian Jahromi et al., 2021). While complications may occur, most are self-limited or can be treated with minor interventions (Hontscharuk, Alba, Hamidian Jahromi et al., 2021). Minor complications include issues such as the formation of granulation tissue, intravaginal hair growth, delayed wound healing or wound disruption (or both), aesthetic concerns, and introital stenosis (Ferrando, 2020; Kloer et al., 2021). While these complications are usually self-limited, they may impact patient well-being after surgery. Additionally, these issues may go either undiagnosed or may be misdiagnosed if patients are not able to access care provided by professionals with expertise in the field of transgender health. We recommend patients be followed by their primary surgeon in person

and at regular intervals—for example at two weeks, three months, six months, and one year after surgery—although more follow-up may be indicated for some individuals.

Additional gynecologic care is conducted throughout the TGD person's lifetime and can be managed in many settings. A speculum exam to check for granulation tissue, hair, and lesions can be performed by the primary care provider, gynecologist, or GAS surgeon and may be necessary outside of the immediate postoperative period (Grimstad, McLaren et al., 2021; Suchak et al., 2015; van der Sluis et al., 2020). After confirmation by laboratory testing, UTIs, STIs, and other fluctuations in the vaginal microbiome may be treated following relevant guidelines formulated for cisgender populations (Hooton, 2012; Sherrard et al., 2018). Manual prostate checks are performed based on relevant guidelines formulated for cisgender populations via the vaginal canal, as the prostate is located on the anterior wall of the vagina (Carter et al., 2013).

Other complications include issues such as stenosis of the neovaginal canal, rectovaginal fistulae, and inflammation (intestinal vaginoplasty) (Bustos et al., 2021). These require a combination of nonsurgical and surgical treatment with consultation and possible referral back to the primary surgeon with other surgical consultants (i.e., colorectal surgeon), if required. In addition, as pelvic floor dysfunction may affect 30–40% of patients both prior to and following vaginoplasty, the availability of pelvic floor physical therapists is an important adjunct in the postoperative period (Jiang et al., 2019).

Statement 13.11

We recommend patients who regret their gender-related surgical intervention be managed by an expert multidisciplinary team.

The percentage of individuals who regret their GAS is very low (between 0.3% and 3.8%) (De Cuyper & Vercruyssen, 2009; Defreyne, Motmans et al., 2017; Hadj-Moussa et al., 2019; Hadj-Moussa, Agarwal et al., 2018; Hadj-Moussa, Ohl et al., 2018; Landén et al., 1998; Narayan et al., 2021; van de Grift, Elaut et al., 2018; Wiepjes et al., 2018). The highest incidence of

regret was reported at a time when surgical techniques were less refined, the role of multidisciplinary care was less established, and the *Standards of Care* did not exist or were not widely known (Landén et al., 1998). Regret can be temporarily or permanent and may be classified as (Narayan et al., 2021) social regret (caused by difficulties in familial, religious, social, or professional life), medical regret (due to long-term medical complications, disappointment in surgical results or inadequate preoperative decision-making), and true gender-related regret (mostly based on patient experienced misdiagnosis, insufficient exploration of gender identity, or both). This classification is in accordance with previously discussed positive and negative

predictive factors (De Cuypere & Vercruysse, 2009; Gils & Brewaeys, 2007; Pfäfflin & Junge, 1998).

A multidisciplinary team can help identify the etiology of regret as well as the temporal stability of the surgical request (Narayan et al., 2021). Following this evaluation and in consideration of the individual's circumstances, medical and/or surgical interventions with the intent of either continuing transition or performing surgical procedures to return anatomy to that of the sex assigned at birth may be indicated. For further information see Chapter 5—Assessment of Adults.

**For eligibility criteria for adolescents and adults, please refer to the Assessment for Adults and Adolescent chapters and Appendix D*

GENDER-AFFIRMING SURGICAL PROCEDURES

As the field's understanding of the many facets of gender incongruence expands, and as technology develops which allows for additional treatments, it is imperative to understand this list is

not intended to be exhaustive. This is particularly important given the often lengthy time periods between updates to the SOC, during which evolutions in understanding and treatment modalities may occur.

FACIAL SURGERY

Brow	<ul style="list-style-type: none"> • Brow reduction • Brow augmentation • Brow lift
Hair line advancement and/or hair transplant	
Facelift/mid-face lift (following alteration of the underlying skeletal structures)	
Facelift/mid-face lift (following alteration of the underlying skeletal structures)	<ul style="list-style-type: none"> • Platysmaplasty
Blepharoplasty	<ul style="list-style-type: none"> • Lipofilling
Rhinoplasty (+/- fillers)	
Cheek	<ul style="list-style-type: none"> • Implant • Lipofilling • Upper lip shortening • Lip augmentation (includes autologous and non-autologous) • Reduction of mandibular angle • Augmentation • Osteoplastic • Alloplastic (implant-based) • Vocal cord surgery (see voice chapter)
Lip	
Lower jaw	
Chin reshaping	
Chondrolaryngoplasty	
BREAST/CHEST SURGERY	
Mastectomy	<ul style="list-style-type: none"> • Mastectomy with nipple-areola preservation/reconstruction as determined medically necessary for the specific patient • Mastectomy without nipple-areola preservation/reconstruction as determined medically necessary for the specific patient
Liposuction	
Breast reconstruction (augmentation)	<ul style="list-style-type: none"> • Implant and/or tissue expander • Autologous (includes flap-based and lipofilling)
GENITAL SURGERY	
Phalloplasty (with/without scrotoplasty)	<ul style="list-style-type: none"> • With/without urethral lengthening • With/without prosthesis (penile and/or testicular) • With/without colpectomy/colpocleisis
Metoidioplasty (with/without scrotoplasty)	<ul style="list-style-type: none"> • With/without urethral lengthening • With/without prosthesis (penile and/or testicular) • With/without colpectomy/colpocleisis • May include retention of penis and/or testicle • May include procedures described as "flat front"
Vaginoplasty (inversion, peritoneal, intestinal)	
Vulvoplasty	
GONALECTOMY	
Orchiectomy	
Hysterectomy and/or salpingo-oophorectomy	
BODY CONTOURING	
Liposuction	
Lipofilling	
Implants	<ul style="list-style-type: none"> • Pectoral, hip, gluteal, calf
Monsplasty/mons reduction	
ADDITIONAL PROCEDURES	
Hair removal: Hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process. (see Statement 15.14 regarding hair removal)	<ul style="list-style-type: none"> • Electrolysis • Laser epilation
Tattoo (i.e., nipple-areola)	
Uterine transplantation	
Penile transplantation	

CHAPTER 14 Voice and Communication

Human beings engage in communication practices not only to exchange ideas about the outside world, but also to present themselves as socio-cultural beings and to negotiate forms of address, referral and treatment by others that allow them to feel safe and respected (Azul et al., 2022). The human voice is widely regarded as one of the key modalities that contributes to the communication of gender as one of the dimensions of human diversity. However, other aspects and ways of communicating (e.g., articulation, word choice, gesture, listener perceptions and attributions) need to be considered as well (Azul, 2015; Azul & Hancock, 2020). Throughout this chapter “voice and communication” is used as a phrase encompassing the meaning-making practices in which each of the participants of a social encounter engage according to their own needs, wishes, identifications, and capacities.

While a binary understanding of gender has dominated the research literature in this area, the approach recommended in this chapter implies a broadly inclusive view of gender identification (e.g., trans feminine, trans masculine, gender fluid, nonbinary, genderqueer, agender) and the understanding that gender does not exist in isolation, but intersects with other aspects of human diversity (e.g., First Nation status, ethnicity/race, sexuality, dis/ability, faith/religion/spirituality). The recommendations in this chapter apply to all transgender and gender diverse (TGD) people who are seeking professional voice and communication support, including children, adolescents, younger and older adults, and people who wish to transition or detransition, irrespective of their intervention choices.

Not every TGD person experiences challenges with or wants professional support for their voice and communication, but those who do often encounter barriers in accessing care. Although the percentages vary by country and TGD sub-population, the statistics support the concern TGD people are not able to access voice and communication services when and how they desire (Eyssel et al., 2017; James et al., 2016; Oğuz et al., 2021; Södersten et al., 2015; Veale et al., 2019). In these studies, the percentage of TGD people wishing to receive voice and

communication training or voice surgery is generally higher than the percentage of people who have undergone these interventions. With few exceptions, access to voice training is usually greater than access to voice surgery. Groups of TGD people who are further marginalized in their societies, such as TGD people of marginalized race/ethnicity, experience discrimination and limited access to care at even greater rates (James et al., 2016; Xavier et al., 2005).

Cost, not knowing where to access services, and services not being available are amongst the most common barriers cited by research participants. According to studies in the US (Hancock & Downs, 2021; Kennedy & Thibeault, 2020), Turkey (Oğuz et al., 2021), and Aotearoa/New Zealand (Veale et al., 2019), lack of accurate information about options for voice and communication services among TGD people is a significant and ubiquitous barrier to care. Notably, in Sweden, all TGD people are offered support for their voice and communication when a diagnosis of gender incongruence is made (Södersten et al., 2015). Additionally, cultural responsiveness of providers is only slowly improving (Hancock & Haskin, 2015; Jakomin et al., 2020; Matthews et al., 2020; Sawyer et al., 2014). Hancock and Downs (2021) have conducted preliminary work to identify specific barriers to voice and communication services and develop effective means for eliminating them.

This chapter is intended to provide guidance for health care professionals (HCPs) to support and foster well-being in all TGD people who are experiencing challenges or distress regarding their own voice and communication practices and/or regarding responses and attributions they receive from others (Azul et al., 2022).

A number of different approaches TGD people can use to modify their voice and communication, either individually or in combination include self-initiated change, which may be supported by resources TGD people use to guide their voice use and communication practice; behavioral change supported by voice and communication specialists (hereafter referred to as “voice and communication training”); and change as a result of androgen hormonal treatment and/or laryngeal surgery. The currently existing research evidence

does not include self-initiated change, but is focused on the latter three approaches.

A “voice and communication specialist” is someone who has knowledge regarding the ongoing and dynamic agency of speaker and listener practices, relevant professional interventions including behavioral, hormonal, and surgical, and relevant processes related to biophysiology, socio-cultural meaning-making, and external material forces (Azul & Hancock, 2020). This specialist is capable of conducting appropriate assessments to inform the TGD person’s choice and support the exploration of goals and intervention options by providing guidance in a culturally responsive, person-centered approach. This specialist has knowledge and skills in behavioral voice and communication intervention approaches.

Practices amenable to behavioral change include: speaking and singing voice, mindfulness, relaxation, respiration, pitch and pitch range, voice quality, resonance/timbre, loudness, projection, facial expression, gesture, posture, movement, introducing self to others, describing identifications and requesting culturally responsive treatment and forms of address by others, assertive and resilient responses to misattributions, practicing implementation of voice use and communication practices with different people and in different everyday settings (e.g., Hancock & Siegfriedt, 2020; Mills & Stoneham, 2017).

Voice and communication services are offered as part of a complete and coordinated approach to health, including support for medical, psychological, and social needs (Södersten et al., 2015); however, there are no prerequisites (e.g., hormone use, pursuit of surgeries, or duration living in a gender role). The overall purposes of voice and communication support for TGD people are:

- To educate clients about the factors that influence functional voice and communication practices and the communication of the speaker’s identity (speaker, listener, professional practices, external material, biophysiological, and sociocultural factors);
- To enable clients to communicate their sense of sociocultural belonging (e.g., in terms of gender) in everyday encounters in a manner that matches the client’s desired

self-presentation and to develop, maintain and habituate voices, vocal qualities, and communication practices that support the clients’ goals in a manner that does not harm the voice production mechanism;

- To provide training in functional voice production for clients who present with restrictions of voice function (e.g., as a result of overextending their voice production mechanism);
- To support clients with developing the capacity to assertively negotiate desired forms of address and referral from others (e.g., names, pronouns, titles) and to respond to misattributions in a skillful manner that contributes to increasing and maintaining the client’s well-being;
- To support clients to develop the problem-solving skills needed to manage anxiety, stress, and dysphoria in collaboration with mental health providers; and to navigate barriers to practice or real-life use of one’s preferred voice and communication.
- To provide, or refer clients to, supportive resources that facilitate developing voice and communication skills, vocal awareness, and well-being.
- To refer clients to, or collaborate with, other specialists such as mental health practitioners, laryngeal surgeons, and endocrinologists, who may be more equipped to meet the specific needs of that client. This may be especially relevant in cases where clients face unique challenges due to multiple barriers to their health and well-being or when the client wishes to pursue laryngeal surgery or hormone therapy.

Two types of laryngeal surgeries are relevant for TGD populations: those for raising voice pitch (e.g., glottoplasty with retro-displacement of the anterior commissure, cricothyroid approximation (CTA), feminization laryngoplasty, laser-assisted voice adjustment (LAVA)) (Anderson, 2007; Anderson, 2014; Brown, 2000; Casado, 2017; Geneid, 2015; Gross, 1999; Kelly et al., 2018; Kanagalingam, 2005; Kim, 2017; Kim, 2020; Kocak, 2010; Kunachak, 2000; Mastronikolis, 2013; Mastronikolis et al., 2013; Matai, 2003; Meister,

Statements of Recommendations

14.1- We recommend voice and communication specialists assess current and desired vocal and communication function of transgender and gender diverse people and develop appropriate intervention plans for those dissatisfied with their voice and communication.

14.2- We recommend voice and communication specialists working with transgender and gender diverse people receive specific education to develop expertise in supporting vocal functioning, communication, and well-being in this population.

14.3- We recommend health care professionals in transgender health working with transgender and gender diverse people who are dissatisfied with their voice or communication consider offering a referral to voice and communication specialists for voice-related support, assessment, and training.

14.4- We recommend health care professionals consider working with transgender and gender diverse people who are considering undergoing voice surgery consider offering a referral to a voice and communication specialist who can provide pre- and/or postoperative support.

14.5- We recommend health care professionals in transgender health inform transgender and gender diverse people commencing testosterone therapy of the potential and variable effects of this treatment on voice and communication.

2017; Mora, 2018; Neumann, 2004; Nuyen et al., 2022; Orloff, 2006; Pickuth, 2000; Remacle, 2011; Thomas & MacMillan, 2013; Tschan, 2016; Van Borsel, 2008; Wagner, 2003; Wendler, 1990; Yang, 2002) and for lowering voice pitch (e.g., thyroplasty type III, vocal fold injection augmentation) (Bultynck et al., 2020; Isshiki et al., 1983; Kojima, et al. 2008; Webb et al., 2021). Reported acoustic benefits of pitch-raising surgery include increased voice pitch (average frequency (f_o)) and increased $\text{Min } f_o$ (the lowest frequency in physiological voice range). TGD people's self-rating ratings show general satisfaction with voice postsurgery, although individuals who are interested in more comprehensive changes to vocal self-presentation may need to engage in behavioral interventions with a voice and communication specialist in addition to laryngeal surgery (Brown, Chang et al. 2021; Kelly et al., 2018; Nuyen et al., 2022). Potential harms of pitch-raising surgery can be assessed and addressed in voice training by a voice and communication specialist. Reported harms of pitch-raising surgery include voice problems such as dysphonia, weak voice, restricted speaking voice range especially upper range (lowered $\text{Max } f_o$, in the physiological voice range), hoarseness, vocal instability, and lowering of frequency values over time (Kelly et al., 2018; Song & Jiang, 2017), although the rate of these outcomes is inconsistent.

Research on pitch-lowering surgeries is limited. However, studies including eight TGD people who elected to undergo thyroplasty type III after continued dissatisfaction with hormonal treatment (Bultynck et al., 2020) and one person who received injection augmentation after testosterone therapy and voice training (Webb

et al., 2020), reported statistically significant lowering of fundamental frequency, perceived as pitch.

Estrogen treatment in TGD people has not been associated with measurable voice changes (Mészáros et al., 2005), while testosterone treatment in TGD people has been found to result in both desired and undesired changes in gender- and function-related aspects of voice production (Azul, 2015; Azul et al., 2017, 2018, 2020; Azul & Neuschaefer-Rube, 2019; Cosyns et al., 2014; Damrose, 2008; Deuster, Di Vincenzo et al., 2016; Deuster, Matulat et al. 2016; Hancock et al., 2017; Irwig et al., 2017; Nygren et al., 2016; Van Borsel et al., 2000; Yanagi et al., 2015; Ziegler et al., 2018). Desired changes associated with testosterone treatment include lowered voice pitch, increased male attributions to voice, and increased satisfaction with voice. Reported dissatisfaction with testosterone treatment include lack of or insufficient lowering of voice pitch, dysphonia, weak voice, restricted singing pitch range, and vocal instability. These areas can be assessed and addressed in voice training by a voice and communication specialist.

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

Statement 14.1.

We recommend voice and communication specialists assess current and desired vocal and

communication function of transgender and gender diverse people and develop appropriate intervention plans for those dissatisfied with their voice and communication.

Voice and communication specialists may assess satisfaction with the presentation of socio-cultural positionings in communicative encounters, including gender and other intersecting identifications, taking into consideration that these may or may not be static over time; attributions received from others, and how these relate to the individual's identifications, wishes, and well-being; ratings of voice and speech naturalness; and voice and communication function in relation to vocal demands. Assessments may vary in nature (e.g., client-reported outcome measures, perceptual, acoustic, aerodynamic, endoscopic) according to their purpose (Davies et al., 2015; Leyns et al., 2021; Oates & Dacakis, 1983). For example, laryngeal visualization is used when individuals present with a concomitant voice problem, (e.g., muscle tension dysphonia) (Palmer et al., 2011) or experience voice difficulties, which may or may not be secondary to medical gender-affirming interventions of androgen therapy or laryngeal surgery (Azul et al., 2017).

Voice and communication specialists inform intervention-seeking TGD people who are dissatisfied with their voice and communication about available interventions that support TGD people with their voice, communication, and well-being. The nature of each option, including potential outcomes and permanence, is presented objectively to provide the TGD person respect and autonomy in decision-making. Appropriate intervention plans are individualized and feasible and should be inclusive of any professional services available. Goals may evolve over the course of the support period as the TGD person explores modifications to voice and communication, assesses their satisfaction with achieved change and refines their goals.

Statement 14.2.

We recommend voice and communication specialists working with transgender and gender diverse people receive specific education to develop expertise in supporting vocal functioning, communication, and well-being in this population.

Academic and licensing credentials of voice and communication specialists (e.g., speech-language pathologists, speech therapists, singing voice teachers, voice coaches) vary by location but typically do not specify criteria for working with specific populations. Standard curricula in formal education for these professions often do not include specific or adequate training for working with TGD populations (Jakomin et al., 2020; Matthews et al., 2020). General knowledge and skills related to the vocal mechanism and interpersonal communication are foundational but insufficient for conducting culturally responsive, person-centered care for TGD people that is effective, efficient, inclusive, and accessible (Hancock, 2017; Russell & Abrams, 2019).

Professionals in this area should receive comprehensive education that invites them to develop self-awareness, cultural humility, and cultural responsiveness in order to be respectful of and attentive to gender diversity and other aspects of a client's identifications that can take a variety of forms and imply a range of different support needs (Azul, 2015; Azul et al., 2022). Client preferences for use of names, formal forms of address, gender entry, and pronouns need to be respected in all communication with and about the client (including medical records, reports, emails). Education also needs to inform the setting up of a training space or clinic and administrative practices that are designed to be welcoming to TGD people and allow TGD people to feel safe and respected when raising concerns or issues with the voice and communication support team.

Voice and communication specialists working with TGD people will need working knowledge of applicable intervention principles, mechanisms, and effectiveness, competence in teaching and modeling voice and communication modification skills, and a basic understanding of transgender health, including hormonal and surgical treatments and trans-specific psychosocial issues. Education needs to include methodologies and practices that have been developed within TGD communities and shown to be effective and should ideally be presented by or in collaboration with TGD people with lived experience of voice and communication support.

Statement 14.3.

We recommend health care professionals in transgender health working with transgender and gender diverse people who are dissatisfied with their voice or communication consider offering a referral to voice and communication specialists for voice-related support, assessment, and training.

A voice and communication specialist is well positioned to provide information and guidance to the TGD person expressing dissatisfaction with their voice or communication when available. There is evidence voice and communication specialists provide support in such a way that a client's satisfaction with voice and communication can be achieved, thereby reducing gender dysphoria and improving communication-related quality of life (Azul, 2016; Block, 2017; Deuster, Di Vincenzo et al., 2016; Hancock, 2017; Hancock et al., 2011; Hardy et al., 2013; Kelly et al., 2018; McNamara, 2007; McNeill et al., 2008; Owen & Hancock, 2010; Pasricha et al., 2008; Söderpalm et al., 2004; Watt et al., 2018).

There is empirical evidence that behavioral voice support for TGD AMAB people is effective with regard to achieving the targeted voice changes (Oates, 2019). Seven studies prior to 2020 provide empirical evidence for the effectiveness of voice training, although it is somewhat weak (Carew et al., 2007; Dacakis, 2000; Gelfer & Tice, 2013; Hancock et al., 2011; Hancock & Garabedian, 2013; McNeill et al., 2008; Mészáros et al., 2005). Voice training methods across these seven studies were similar and indicated voice training can be effective at increasing average fundamental frequency (average pitch), fundamental frequency range (pitch range), satisfaction with voice, self-perception and listener perception of vocal femininity, voice-related quality of life, and social and vocational participation. Weaknesses of the identified studies include lack of randomized controlled trials evaluating voice training, small sample sizes, inadequate long-term follow-up, and lack of control of confounding variables. In 2021, another systematic review of the effects of behavioral speech training for AMAB people reached similar conclusions (Leyns et al., 2021).

Until recently, there was almost no research exploring the effectiveness of voice training with TGD AFAB people. There is, however, some promising, although weak evidence of effectiveness from a case study (Buckley et al., 2020) and one uncontrolled prospective study of group voice training (Mills et al., 2019).

Statement 14.4.

We recommend health care professionals working with transgender and gender diverse people who are considering undergoing voice surgery consider offering a referral to a voice and communication specialist who can provide pre- and/or postoperative support.

This statement does not intend to require TGD people receive presurgical voice training. Rather, it is recommended that every available support be offered to provide individualized informational counseling critical to person-centered care. The recommendation is for the TGD person's consideration to be informed as necessary by individualized informational counseling based on voice assessment, trial voice training, and discussion of expected voice outcomes and risks of surgery with a voice and communication specialist.

For most types of laryngeal surgery, voice training is recommended both prior to surgery to ensure preparation of the vocal mechanism for the surgical intervention and postsurgery to ensure a return to functional voice production (Branski et al., 2006; Park et al., 2021). For pitch-raising surgery in particular, another reason a trial of voice training is recommended is because there are indications certain measures improve with training but not with pitch-raising surgery (e.g., factors relevant to intonation and naturalness, such as maximum f_0 pitch in speech range; Kelly et al., 2018).

The number and quality of research studies evaluating pitch-lowering surgeries are currently insufficient, particularly with regard to comparing outcomes with and without other interventions (i.e., testosterone) (Bultynck et al., 2020). There are more techniques and studies of pitch-raising surgeries, but the quality of the evidence is still low. Outcomes from pitch-raising surgeries have been compared to outcomes from having no surgery (Anderson, 2007, 2014; Brown et al., 2000;

Geneid et al., 2015; Gross, 1999; Kim, 2017; Kocak et al., 2010; Kunachak et al., 2000; Matai et al., 2003; Meister et al., 2017; Neumann & Welzel, 2004; Orloff et al., 2006; Pickuth et al., 2000; Remacle et al., 2011; Thomas & Macmillan, 2013; Tschan et al., 2016; Van Borsel et al., 2008; Yang et al., 2002), another type of surgical technique (Mora, 2018), voice training alone (Kanagalingam, 2005; Mastronikolis, 2013; Wagner, 2003) and surgery in conjunction with voice training (Casado, 2017; Kelly et al., 2018).

In the 11 studies reporting whether participants had voice training prior to pitch-raising surgery, most participants had prior voice training, but remained dissatisfied with voice and sought surgical intervention. Thus, most studies of surgical outcomes reflect the combined effects of voice training and surgical intervention. Attributes predicting which clients will pursue surgery after training are unknown.

Statement 14.5.

We recommend health care professionals in transgender health inform transgender and gender diverse people commencing testosterone therapy of the potential and variable effects of this treatment on voice and communication.

The research on the effects of androgen treatment on voice and communication of TGD people points to diverse and unpredictable effects on individual clients. While a number of studies have revealed effects on voice that matched TGD

people's expectations and wishes, there is high quality evidence demonstrating TGD people are not always satisfied with the vocal outcomes of testosterone therapy, and many experience difficulties such as inadequate pitch lowering, compromised voice quality, vocal loudness, vocal endurance, pitch range, and flexibility (Azul, 2015, 2016, 2017, 2018; Cosyns et al., 2014; Nygren et al., 2016; Ziegler et al., 2018). A recent meta-analysis of 19 studies examining the effects of at least 1 year of testosterone therapy estimated 21% of participants did not achieve cisgender male normative frequencies, 21% of participants reported incomplete voice-gender congruence and voice problems, and 16% were not completely satisfied with their voice (Ziegler, 2018).

For people who wish to be treated with androgens, accurate informational counseling prior to commencing treatment should enable the development of realistic expectations to avoid disappointment regarding the permanent impact of hormone treatment on voice and communication. In addition, TGD people who do not have access to or do not wish to be treated with testosterone, but want to change their voice and those who are dissatisfied with the outcomes of testosterone treatment can be advised by a voice and communication specialist of alternative and additional support options (e.g., behavioral voice and communication training; pitch-lowering surgery).

CHAPTER 15 Primary Care

Primary care is the broadest of health care disciplines and is defined as the “provision of integrated, accessible health care services by health care professionals who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” (Institute of Medicine, 1996).

Primary care providers (PCPs) encompass a wide range of health care professionals (HCPs) who deliver this care, including general and family medical practitioners, nurse practitioners, advanced practice nurses, physician associates/assistants, and internists. PCPs are represented by a variety of educational backgrounds, training, and specialties. Given the type of degree and the nature of the specialty, the scope of practice varies, and not all providers may be trained or qualified to directly provide the full breadth of transgender health care, such as mental health, genital/pelvic care, or postoperative care, following gender-affirming procedures. Physicians and other providers receive little education in transgender and gender-diverse (TGD) health at any time during their training (Dubin et al., 2018), and thus most skills are currently acquired in practice, either informally or through brief continuing education opportunities, see also Chapter 4—Education. However, if providers are competent to deliver similar care for cisgender patients, they should develop competency in caring for TGD patients. The competencies outlined below are all to be understood as being within the provider’s scope of licensure and practice. However, all PCPs should be able to manage the comprehensive health of TGD patients either directly or by appropriate referral to other HCPs, including other specialists, for evaluation and treatment. There is no evidence competency in caring for TGD patients can only be achieved through a formal or certification process. In explicitly stating recommended competencies, however, PCPs and TGD persons across all settings can share a standard set of expectations of the knowledge,

skills, and cultural competence required for the care of TGD persons.

Due to the unique medical, surgical, and social conditions faced by TGD people, PCPs need distinct competencies in the care of TGD persons, apart from what is expected of all PCPs who may otherwise care for a diverse population that includes ethnic, racial, or sexual minorities. Professional bodies from a range of generalist disciplines have issued position statements and guidelines specific to the care of TGD people (American College of Obstetricians and Gynecology, 2021; Italian Society of Gender, Identity and Health (SIGIS); the Italian Society of Andrology and Sexual Medicine (SIAMS); the Italian Society of Endocrinology (SIE), 2021; Polish Sexological Society, 2021; the Southern African HIV Clinicians’ Society, 2021). Wylie et al. (2016) state “For the most part, the general health and well-being of transgender people should be attended to within the primary care setting, without differentiation from services offered to cisgender (non-transgender) people for physical, psychological, and sexual health issues. Specific care for gender transition is also possible in primary care.” There are many examples of these services being provided safely and effectively outside of specialist care in diverse cities such as Toronto and Vancouver in Canada, New York and Boston in the US, and in Sydney, Australia, (Radix & Einfeld, 2014; Reisner, Radix et al., 2016; Spanos et al., 2021).

Hormone therapy

Whether TGD patients receive medically necessary gender-affirming hormone therapy (GAHT) from a specialist, e.g., an endocrinologist, or a PCP may depend on the availability of knowledgeable and welcoming providers and country-level factors, such as health care regulations and health services funding (see medically necessary statement in Chapter 2—Global Applicability, Statement 2.1). In much of the world, specialty services for TGD people are partly or wholly unavailable, which reinforces the need for all health providers to undertake

training in the provision of gender-affirming care. In some countries, PCPs may be required to refer TGD patients to specialist services (e.g., gender identity clinics) resulting in unacceptable delays to access GAHT (Royal College of General Practitioners, 2019).

Hormone-related therapy encompasses a range of interventions, such as puberty suppression and hormone initiation or hormone maintenance. With training, gender-affirming hormone therapy can be managed by most PCPs. Regardless of whether they serve as the primary hormone prescriber, all PCPs should be familiar with the medications, suggested monitoring, and potential side effects associated with GAHT (see Chapter 12—Hormone Therapy). PCPs should be able to make appropriate referrals to appropriate providers for all transition-related services they do not themselves provide.

This chapter supports the argument GAHT can be prescribed by PCPs or other non-specialists—“Considering barriers to health care access and the importance of GAHT to this population, it is imperative that PCPs are able and willing to provide GAHT for TGD patients.” (Shires, 2017).

PCPs are commonly called upon to provide care for a broad range of conditions and needs, including those with which they may have had limited or no prior experience. Often this involves accessing commonly used and readily available reference sources, such as professional society guidelines or obtaining a subscription to online knowledge bases. PCPs are advised to use a similar approach when asked to provide basic GAHT care by using the Standards of Care as well as other readily accessed resources (Cheung et al., 2019; Hembree et al., 2017; Oliphant et al., 2018; T’Sjoen et al., 2020). It should be noted most of the commonly used medications in gender-affirming regimens are familiar to everyday primary care practice, including, but not limited to, testosterone, estradiol, progesterone and other progestagens, and spironolactone.

Mental health

PCPs should be able and willing to assess and provide mental health support for TGD

people and GAHT that can alleviate gender dysphoria and allow gender expression. At the very least, they should be aware of these needs and consult additional specialty support if needed.

Preventive care

General practitioners are versed to provide comprehensive primary and secondary cancer prevention as a part of routine primary care. Evidence-based cancer prevention guidelines vary globally due to differences in national guidelines and levels of access to screening modalities at the local level. To date, research on the long-term impact of GAHT on cancer risk is limited (Blondeel et al., 2016; Braun et al., 2017). We have insufficient evidence to estimate the prevalence of cancer of the breast or reproductive organs among TGD populations (Joint et al., 2018). However, cancer screening should commence, in general, according to local guidelines. Several modifications are discussed in detail, below, depending on the type and duration of hormone use, surgical intervention, or both. In caring for transgender patients, the PCP should maintain an updated record of which organs are present in TGD patients so that appropriate, routine screening can be offered.

This organ inventory should be updated based on the surgical history or any development that has occurred due to taking gender-affirming hormones. Not all PCPs provide care across the lifespan. However, if providers routinely care for children, adolescents, or elder cisgender persons, they should develop competency in transgender care that is applicable to these age groups. If they are unable to do so, then PCPs should be able to make appropriate referrals to other HCPs who care for these populations.

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

Statements of Recommendations

- 15.1- We recommend health care professionals obtain a detailed medical history from transgender and gender diverse people that includes past and present use of hormones, gonadal surgeries, as well as the presence of traditional cardiovascular and cerebrovascular risk factors with the aim of providing regular cardiovascular risk assessment according to established, locally used guidelines.
- 15.2- We recommend health care professionals assess and manage cardiovascular health in transgender and gender diverse people using a tailored risk factor assessment and cardiovascular/cerebrovascular management methods.
- 15.3- We recommend health care professionals tailor sex-based risk calculators used for assessing medical conditions to the needs of transgender and gender diverse people, taking into consideration the length of hormone use, dosing, serum hormone levels, current age, and the age at which hormone therapy was initiated.
- 15.4- We recommend health care professionals counsel transgender and gender diverse people about their tobacco use and advise tobacco/nicotine abstinence prior to gender-affirming surgery.
- 15.5- We recommend health care professionals discuss and address aging-related psychological, medical, and social concerns with transgender and gender diverse people.
- 15.6- We recommend health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration the length of time of hormone use, dosing, current age, and the age at which hormones were initiated.
- 15.7- We recommend health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.
- 15.8- We recommend health care professionals apply the same respective local screening guidelines (including the recommendation not to screen) developed for cisgender women at average and elevated risk for developing ovarian or endometrial cancer in their care of transgender and gender diverse people who have the same risks.
- 15.9- We recommend against routine oophorectomy or hysterectomy solely for the purpose of preventing ovarian or uterine cancer for transgender and gender diverse people undergoing testosterone treatment and who have an otherwise average risk of malignancy.
- 15.10- We recommend health care professionals offer cervical cancer screening to transgender and gender diverse people who currently have or previously had a cervix following local guidelines for cisgender women.
- 15.11- We recommend health care professionals counsel transgender and gender diverse people that the use of antiretroviral medications is not a contraindication to gender-affirming hormone therapy.
- 15.12- We recommend health care professionals obtain a detailed medical history from transgender and gender diverse people that includes past and present use of hormones, gonadal surgeries as well as the presence of traditional osteoporosis risk factors to assess the optimal age and necessity for osteoporosis screening.
- 15.13- We recommend health care professionals discuss bone health with transgender and gender diverse people including the need for active weight bearing exercise, healthy diet, calcium, and vitamin D supplementation.
- 15.14- We recommend health care professionals offer transgender and gender diverse people referrals for hair removal from the face, body, and genital areas for gender-affirmation or as part of a preoperative preparation process.

Statement 15.1

We recommend health care professionals obtain a detailed medical history from transgender and gender diverse people, that includes past and present use of hormones, gonadal surgeries, as well as the presence of traditional cardiovascular and cerebrovascular risk factors with the aim of providing regular cardiovascular risk assessment according to established, locally used guidelines. For supporting text, see Statement 15.3.

Statement 15.2

We recommend health care professionals assess and manage cardiovascular health in transgender and gender diverse people using a tailored risk factor assessment and cardiovascular/cerebrovascular management methods. For supporting text, see Statement 15.3.

Statement 15.3

We recommend health care professionals tailor sex-based risk calculators used for assessing

medical conditions to the needs of transgender and gender diverse people, taking into consideration the length of hormone use, dosing, serum hormone levels, current age, and the age at which hormone therapy was initiated.

Cardiovascular disease (CVD) and stroke are the leading causes of mortality worldwide (World Health Organization, 2018). Extensive data among racial, ethnic, and sexual minorities in multiple settings demonstrate significant disparities in the prevalence of CVD and its risk factors as well as in the outcomes to medical interventions. Structural factors such as access to care, socioeconomic status, and allostatic load related to minority stress contribute to these disparities (Flentje et al., 2020; Havranek et al., 2015; Streed et al., 2021). TGD people often experience social, economic, and discriminatory conditions similar to other minority populations with known increased cardiovascular risk (Carpenter et al., 2020; James et al., 2016; Reisner, Radix et al., 2016). TGD persons of racial, ethnic, and sexual

minorities have been shown to experience increased impact related to intersectional stress. Conversely, access to gender-affirming care, including GAHT, may buffer against the elevation of CVD risk due to the improvement in quality of life and reduction in gender dysphoria and incongruence (Defreyne et al., 2019; Martinez et al., 2018). PCPs can significantly improve TGD health through screening and prevention of CVD and its associated risk conditions—such as tobacco use, diabetes mellitus, hypertension, dyslipidemia, and obesity.

The few, primarily US based, studies evaluating the prevalence of CVD, stroke, or CVD risk in TGD persons independent of GAHT indicate an elevated CV risk, including high rates of undiagnosed and untreated CV risk factors with inadequate CV prevention when compared with cisgender populations (Denby et al., 2021; Malhotra et al., 2022; Nokoff et al., 2018). In one population-based study, TGD people had greater odds of discrimination, psychological distress, and adverse childhood experience, and these were associated with increased odds of having a cardiovascular condition (Poteat et al., 2021).

In US studies that are based on data from the Behavioral Risk Factor Surveillance System, both transgender men and transgender women show a higher prevalence of myocardial infarction (MI), stroke, or any CVD compared with cisgender men, cisgender women or both. Results vary based on the adjustment of data for additional variables, including race, income, or cardiovascular risk factors (Alzahrani et al., 2019; Caceres et al., 2020; Nokoff et al., 2018). Gender nonbinary persons also have higher odds of CVD (Downing & Przedworski, 2018). Data on hormone use was not collected in these studies, which are also limited by the use of self-reported health histories. In the US, TGD individuals presenting for GAHT may have higher rates of undiagnosed and untreated CVD risk factors compared with the cisgender population (Denby et al., 2021), although this may not be applicable globally.

A large 2018 case control study from several US centers that used 10:1 cisgender matched controls found no statistically significant difference in rates of MI or stroke between transgender women and cisgender men, and no difference in

rates of MI, stroke, or venous thromboembolism (VTE) between transgender men and cisgender men or women. There was a statistically significant hazard ratio of 1.9 for VTE among transgender women when compared with cisgender men. A subcohort of transgender women who initiated GAHT during (versus prior to) the 6-year study window did show an increased risk of stroke. Increases in rates of VTE in the overall cohort of transgender women and in rates of stroke in the initiation subcohort of transgender women demonstrated calculated numbers-needed-to-harm (not reported in the paper) between 71-123 (Getahun et al., 2018). Other studies have demonstrated no increase in CV events or stroke among transgender men undergoing testosterone therapy, although studies are limited by their small sample size, relatively short follow-up, and the younger age of the sample population (Martinez et al., 2020; Nota et al., 2019).

European and US studies in transgender women who have accessed feminizing GAHT increasingly indicate a higher risk of CVD, stroke, or both, compared with cisgender women and, in some studies, cisgender men (Getahun et al., 2018; Nota et al., 2019; Wierckx et al., 2013). Many of these studies had significant limitations, such as variably adjusting for CV-related risk factors, small sample sizes—especially involving older transgender women—and variable duration and types of GAHT (Connelly et al., 2019; Defreyne et al., 2019; Martinez et al., 2020). Furthermore, the overall increased risk was small. In many of these studies, the majority of transgender women who experienced cardiac events or stroke were over 50 years old, had one or more CVD risk factors, and were taking a variety of hormone regimens, including, but not limited, to ethinyl estradiol, a synthetic estrogen that confers significant elevations in thrombotic risk and is not recommended for use in feminizing regimens (Gooren et al., 2014; Martinez et al., 2020). Current limited evidence suggests estrogen-based GAHT is associated with an increased risk of myocardial infarction and stroke, but whether this small risk is a result of GAHT or an effect of pre-existing CV risk is unclear. There are no known studies that specifically address CVD and

related conditions in nonbinary individuals, individuals who use subphysiologic doses of gender-affirming hormones, or in adults previously treated with puberty suppression.

PCPs can best address CVD risk during GAHT by assessing TGD people for CVD and modifiable CVD risk factors, such as diabetes mellitus, hypertension, hyperlipidemia, obesity, and smoking, as well as by addressing the impact of minority stress on cardiovascular risk (Streed et al., 2021). In addition, PCPs can mitigate transgender cardiovascular health disparities by providing a timely diagnosis and treatment of risk conditions and by tailoring their management in a way that supports ongoing gender-affirming interventions.

Risk assessment guidelines vary based on the national or international context and scientific affiliation of guideline developers. CVD prevention guidelines also vary in terms of the nature and frequency of the risk assessment for otherwise healthy adults under age 40 (Arnett et al., 2019; Piepoli et al., 2020; Précoma et al., 2019; Streed et al., 2021; WHO, 2007). Over age 40, when cardiovascular risk increases, guidelines clearly recommend scheduled risk assessments using a calculated prediction of ten-year total CVD risk based on risk prediction equations from large population samples. Examples of risk calculators include SCORE (recommended by the European Guidelines on CVD Prevention), Pooled Cohort Studies Equations (2013 AHA ACC Guideline on the Assessment of CVD risk), Framingham Risk scores, and the World Health Organization (WHO) Risk Prediction Charts. The WHO charts were developed based on information from the countries in each WHO subregion. In many low resource settings, facilities are not available to measure cholesterol or serum glucose, and alternative prediction charts are available without these measures.

Of note, all current cardiovascular risk calculators are gendered, using sex as a significant risk variable. There is currently insufficient data on cardiovascular risk interventions across the lifespan in TGD persons with medical and surgical interventions to adjust these predictive equations. Nonetheless, it is clear both sex assigned at birth and medical transition can affect the parameters used to calculate cardiovascular risk (Connelly

et al., 2019; Defreyne et al., 2019; Maraka et al., 2017; Martinez et al., 2020). Providers can take a variety of approaches to using cardiovascular risk calculators in TGD persons, including employing the risk calculator for the sex assigned at birth, affirmed gender, or a weighted average of the two, taking into consideration total lifetime exposure to GAHT. Although data are lacking, using the affirmed gender for transgender adults with a history of pubertal-age GAHT initiations is likely to be most appropriate. Patients with a history of submaximal GAHT use or prolonged periods of time postgonadectomy without hormone replacement before roughly age 50 may require an even more nuanced approach. Providers should be aware of the characteristics and limitations of the risk calculator in use and should engage patients in shared decision-making regarding these specific considerations.

There are currently no studies comparing the prevalence of dyslipidemia between transgender and cisgender samples, while controlling for hormone use. As noted previously, data in other populations demonstrate the presence of psychosocial stress during childhood and remote adulthood favor adiposity and abnormal lipid metabolism. Both testosterone- and estrogen-based GAHT affect lipid metabolism, although evidence is limited by the variety of hormone regimens and additional variables (Connelly et al., 2019; Defreyne et al., 2019; Deutsch, Glidden et al., 2015; Maraka et al., 2017; Martinez et al., 2020;). On balance, estrogen tends to increase high-density lipoprotein (HDL) cholesterol and triglycerides with variable effects on low density lipoprotein (LDL) cholesterol, while testosterone variably affects triglycerides, decreases HDL cholesterol and increases LDL cholesterol. The method of administration may also affect this pattern, particularly in relation to oral versus transdermal estrogen and their impact on triglycerides (Maraka et al., 2017). In general, the effect sizes of these differences are minimal, and the overall impact on cardio- and cerebrovascular outcomes is unclear. There are no studies examining hormone effects in TGD people with pre-existing dyslipidemia with hormone use starting over age 50, or investigating effects beyond 2-5 years of therapy.

Studies comparing the prevalence of hypertension between TGD and cisgender samples that controlled for hormone use are lacking. Data in other populations demonstrate chronic and acute psychosocial stress, including experiences of discrimination can mediate hypertension (Din-Dzietham et al., 2004; Spruill, 2010). In US studies that were based on the Behavioral Risk Factor Surveillance System, a large national US health survey, there were no differences in reported hypertension between transgender men or women compared with cisgender samples (Alzahrani et al., 2019; Nokoff et al., 2018).

Studies of testosterone—and estrogen-based GAHT have shown inconsistent effects on systolic and diastolic blood pressure. A retrospective study of the effects of estrogen- and testosterone-based GAHT regimens on blood pressure found a slight reduction in systolic blood pressure with the initiation of estrogen-based regimens; while there was a slight elevation (4 mm Hg) in mean systolic blood pressure on long term follow-up of testosterone-based regimens, this difference was at the margin of statistical significance and of limited clinical relevance (Banks et al., 2021). A systematic review concluded, given the limited quality of the studies, there is insufficient data to reach conclusions on the effects of gender-affirming hormone therapy on blood pressure (Connelly et al., 2021). Spironolactone, often used as an androgen blocker in feminizing GAHT, is a potassium sparing diuretic and may increase potassium when used in conjunction with ACE inhibitors or angiotensin receptor blocker medications, as well as salt substitutes. There are no studies examining hormone effects in TGD people with pre-existing hypertension with hormone use starting over age 50, or investigating effects beyond 2–5 years of therapy. Transgender persons receiving GAHT should undergo any additional blood pressure screening or monitoring indicated by WPATH guidelines for GAHT.

There are limited data comparing the prevalence of diabetes mellitus between TGD and cisgender samples independent of hormone use. Recent data from the STRONG cohort study (Islam et al., 2021) found the prevalence and incidence of type 2 diabetes was more common in the trans feminine cohort compared with cisgender females but

not cisgender male controls. No significant differences in the prevalence or incidence of type 2 diabetes were observed in the trans masculine cohort and in TGD persons overall after starting hormone therapy. However, the mean follow-up for both cohorts was 2.8 and 3.1 years, respectively (Islam et al., 2021). Data in other populations, including sexual minorities, indicates chronic and acute psychosocial stress can mediate the development and control of type 2 diabetes (Beach et al., 2018; Kelly & Mubarak, 2015).

US studies based on the Behavioral Risk Factor Surveillance System found no differences in reported diabetes between transgender men, transgender women and nonbinary persons compared with cisgender persons (Alzahrani et al., 2019; Caceres et al., 2020; Nokoff et al., 2018). Several small studies have shown a higher-than-expected prevalence of polycystic ovarian syndrome or hyperandrogenemia among transgender men (Feldman et al., 2016), conditions associated with insulin resistance and diabetes risk. While studies of both testosterone- and estrogen-based GAHT show varying effects on weight/body fat, glucose metabolism, and insulin resistance (Defreyne et al., 2019), most do not demonstrate any increase in prediabetes or diabetes (Chan et al., 2018; Connelly et al., 2019). There are no studies examining hormone effects in TGD people with pre-existing diabetes, with hormone use starting over age 50, or investigating effects beyond 2–5 years of therapy. There are currently no studies specifically addressing diabetes in adults previously treated with puberty suppression.

While intermediate-outcome studies of the effects of GAHT on blood pressure and lipids are helpful for hypothesis generation and for studying etiology, future studies should focus on cardiovascular outcomes of interest, with a specific focus on individual predictors such as age, route and dose of hormones used, and total lifetime exposure to GAHT. Interpretation of data should always consider whether cisgender controls were of the same natal sex or identified gender.

Statement 15.4

We recommend health care professionals counsel transgender and gender diverse people about