

## **Recommendations of the Polish Sexological Society on medical care in transgender adults – position statement of the expert panel**

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### **Summary**

Attempts at unifying the diagnostic and therapeutic procedures for transgender individuals experiencing gender dysphoria were first undertaken in Poland in the 1980s. Since then, there has been a change in the perception of transgenderism, almost paradigmatic, expressed in subsequent editions of the diagnostic systems (DSM, ICD), which is also associated with the fundamental changes in the principles of conducting trans-specific healthcare. This triggered the need to formulate recommendations for specialists practicing in Poland, which would

at least partly reflect the evolution of views and guidelines on clinical care in transgender adults seeking help due to gender dysphoria.

**Key words:** gender dysphoria, gender incongruence, transsexualism

## Introduction

The understanding of transgenderism has gone through dynamic changes in the last several years. This can be seen in the subsequent editions of the diagnostic systems such as DSM-5 and ICD-11 [1, 2]. In the first one, published in 2013, the transgender identity *per se* loses its psychopathological meaning and the attention of clinicians is directed towards a state of chronic discrepancy between the experienced identity and the pronounced gender expression and the social and/or physical characteristics of a given person, such as sexual dysphoria [1]. The ICD-11 classification goes even further. A new diagnostic entity is being proposed – gender incongruence, which is assigned to a new class of issues requiring clinical attention, namely problems related to sexual health. A significant issue is the fact of placing them outside the area of psychiatry and abandoning the diagnostic criterion of suffering or distress. The state of persistent incompatibility is the subject to diagnosis and the interventions are to alleviate this condition [2].

At the same time, the subsequent editions of the Standards of Care (SOC) of the World Professional Association for Transgender Health (WPATH) are evolving. At present, the seventh edition from 2012 is still valid [3], but the eighth edition is soon to be released. However, already in the current version, the diagnostic premise (in terms of clinical diagnosis) was abandoned as a criterion for initiating gender affirming medical interventions (GAMIs), and the symptomatic premise in the form of persistent gender dysphoria was adopted<sup>1</sup>. The importance of informed consent expressed by the patients was also emphasized. However, a significant share of mental health specialist in the process of assessing readiness to start GAMIs was retained. The upcoming eighth version of SOC will further simplify the whole process by bringing it closer to the model of informed consent, in which the weight of the decision to initiate GAMIs lies with the patient and the role of the clinician is to provide grounds and to enable the patient to make an informed decision [4–6].

In the above-presented context, updating and unifying the guidelines on clinical care in transgender adults in Poland reporting gender dysphoria is of utmost importance. The current procedures, which were developed, among others, in the Department of Sexology and Pathology of Interhuman Relationships of the Medical Centre of Post-graduate Education in Warsaw in the 1980s are nowadays out of date. Apart from this, they have never been officially published anywhere. In the meantime, the everyday practice has gone through chaotic changes, and it seems that there are nowadays several parallel incompatible approaches basing on the old and outdated recommendations, or by following arbitrary and subjective views and decisions of the practicing clinicians,

<sup>1</sup> However, the border between the persistent signs of gender dysphoria and diagnostic category of gender dysphoria, which was created based on the existence of this central symptom, is usually blurred.

and not taking into account the latest guidelines. This gives rise to disinformation and causes additional suffering of patients as well as disorientation among specialists who often face decision-making dilemmas in both clinical practice as well as in the role of expert witnesses in courts.

The premise for the development of these recommendations was a desire to at least partially harmonize the principles of diagnostic and therapeutic procedures for individuals with gender incongruence (transgender individuals) referring to the health-care providers in order to initiate the process of medical and legal transition (court proceedings aimed at reconciliation of gender) in Poland. Additional reasons were: an attempt to partially approximate these recommendations to those proposed in the seventh version of the WPATH SOC and obtaining a consensus between specialists representing different medical areas and views, taking into account the specific local context (legal situation and current practice in the area).

These recommendations were formed upon discussions between specialists representing various professions (medical doctors, psychologist, psychotherapist, and lawyers), various medical specializations (psychiatrists, sexologists, gynecologists, endocrinologists, clinical psychologists, clinical sexologists) and having diverse experience (clinical, in providing support, organizational, and legal) in the care of transgender individuals.

### **The core of the recommendations**

#### I. Goals of the diagnostic process:

- A. Making the diagnosis using the diagnostic entities available in F64 class according to ICD-10 (and not just limited to F64.0 categories), as to reflect the real and already known to the specialists today diversity of incoming patients, as well as the widest possible consideration of the approach proposed in the form of new diagnostic entities of gender dysphoria (DSM-5) and gender incongruence (ICD-11).
- B. confirmation of the ability to make informed consent, which includes:
  1. Assessment and confirmation of the relative mental stability (exclusion of mental state decompensation of such character and severity that would affect cognitive and intellectual functions and emotions, making it impossible to accurately assess the persistence and stability of the sense of gender identity and the presence of persistent gender dysphoria).
  2. Psychoeducation and assessment of the patient's knowledge in the field of:
    - a) the actions of sex hormones (also in relations to fertility and the possibility of its preservation),
    - b) psychosocial consequences of the transition,
    - c) legal aspects related to the transition,
    - d) making the transition expectations more realistic,
    - e) coming-out and benefits resulting from functioning in a role consistent with the perceived gender identity,

- f) the possibility of undertaking supportive psychotherapy in the transition process,
- g) normalization of transgender experience,
- h) indicating social resources and non-governmental organizations that can provide support.

**Important: Polish Sexological Society recommends not to prolong the diagnostic process excessively. Usually, meeting the above objectives takes several months of regular diagnostic meetings and should be a condition for GAMIs (hormone replacement and/or surgical interventions)**

I. Requirements for making a diagnosis covering the category of F64 class according to ICD-10:

- A. Medical history aimed at:
  - 1. Confirmation of persistent dysphoria/gender incongruence.
  - 2. Exclusion of secondary causes of gender dysphoria or symptoms which can resemble them, i.e., delusions (Note: persistent gender dysphoria/incongruence may coexist with other mental conditions, including personality and psychotic disorders, which does not exclude the possibility of its diagnosis and initiation of GAMIs. However, in this case it is permissible and often desirable to prolong the diagnostic process and to recommend parallel psychiatric treatment and/or psychotherapy).
  - 3. Ensuring that the patient's psychological situation is stable enough to enable assessment and diagnosis, as well as the implementation of treatment.
- B. In individual and justified by the medical history and physical examination cases it is reasonable to evaluate the karyotype.
- C. In clinically justified cases it is also reasonable to perform additional medical tests including imaging of the central nervous system.

**Important: In the diagnostic process, the cooperation of at least two specialists who can perform a medical and psychological assessment is recommended. The team should include a physician who is a specialist in psychiatry or sexology and a psychologist who has the certificate in clinical sexology (preferentially) or a specialist in clinical psychology or psychosexology. It is recommended that the diagnosing specialists have experience in the care of transgender individuals with gender dysphoria and/or have the opportunity to consult with such experienced specialists. In justified cases (i.e., lack of availability of appropriate specialists, unambiguous clinical situations, such as in the case of highly functioning patients, without co-occurring problems) it is allowed that the participation of one of the two specialists is limited to a minimum (i.e., to make a formal diagnosis) provided that they have the appropriate competences and experience of clinical work with transgender individuals. This solution applies only to the qualification for hormone replacement and surgical interventions within the chest (mastectomy or breast augmentation).**

- III. Comments on the psychologist's assessment:
- A. The main tool in the psychological assessment of transgender individuals is the psychological examination (psychological interview/history).
  - B. In justified cases it can be supplemented with psychological testing or questionnaires.
- IV. Medical examinations preceding the initiation of hormone replacement:
- A. Required:
    1. Patient's history (including family history)
    2. Physical examination, including anthropometric measurements (height, weight and waist circumference), blood pressure and pulse measurement.
    3. Laboratory tests: blood count, serum lipids, fasting glucose, liver function tests (ALT, AST, GGTP and bilirubin), as well as serum creatinine, prolactin, LH, FSH, testosterone and 17 $\beta$ -estradiol concentrations.
  - B. Recommended (note: if the patient refuses to undergo the following examinations it is not a contraindication to the initiation of hormone replacement. However, this fact should be recorded in the patient's file or/and a written consent should be signed for the initiation of hormone replacement despite not being examined<sup>2</sup>):
    1. Gynecological examination in transgender men including the transvaginal (TV) or transabdominal (TA) ultrasonography (USG), vaginal smear and breast USG.
    2. Urological examination in transgender women and in the case of future procreation plans also a semenogram.
  - C. Medical examinations during hormone replacement:
    1. During the first year of hormone replacement, measurement of sex hormone concentrations: testosterone (in transgender men) and 17 $\beta$ -estradiol (in transgender women) every 3 months. In the subsequent years of hormone replacement, measurement of sex hormone concentrations 1–2 times per year.
    2. In the case of transgender men, apart from the measurement of testosterone concentrations, also total blood count due to the risk of polyglobulia (every 3 months in the first year of testosterone replacement and 1–2 times per year in subsequent years). In the case of transgender women,

<sup>2</sup> This group of examinations is recommended by all means, but according to the actual state and needs. However, it should be underlined that in some transgender individuals the severity of gender dysphoria is so extreme that some are impossible to conduct, i.e., gynecological or urological examination. As severe gender dysphoria is not indifferent to health and is associated with suffering, reduced quality of life, and even an increased risk of suicide, it requires the implementation of targeted management. The possibility of such an approach despite the patient's refusal is to implement the principle of harm reduction (i.e., by preventing the intake of hormones from the 'black market' without the medical supervision) and quickly alleviate the suffering. This does not necessarily mean that the physician cannot and should not undertake to discuss the appropriateness of conducting these medical examinations in the future, after the severity of dysphoria weakens. Such situations usually take place in clinical practice. It should also be emphasized that the recommendations are intended to indicate the desired course of action and provide support for practicing clinicians, rather than forcing them to act inconsistent with the actual state of the individual situation of a given patient, which may result in the recognition of a particular examination as necessary to make a decision about the initiation of GAMIs.

apart from the measurements of 17 $\beta$ -estradiol, also serum prolactin concentrations due to the risk of hyperprolactinemia or prolactinoma in the course of estrogen use. Additionally, in the case of anti-androgen use, such as cyproterone acetate or spironolactone, liver transaminases (due to the risk of hepatotoxicity) or serum potassium concentrations (due to the risk of hyperkalemia), respectively.

3. Blood coagulation tests are not recommended before the initiation or during hormone replacement. The risk of thromboembolic complications during oral estrogen use should be evaluated on the basis of family history and the presence of other risk factors such as obesity (BMI>30), smoking and age >40 years.
  4. If vaginal bleeding occurs (in transgender men), it is necessary to perform a TV or TA USG for the assessment of the endometrium as well as the cytological examination of the cervical smear.
  5. In the case of transgender women, self-examination of the testicles is recommended until the orchidectomy. In addition, in the case of suspected prostate hyperplasia, determination of serum PSA concentrations and the ultrasound assessment of the prostate should be performed.
- V. Medical examinations preceding surgical interventions within the chest (mastectomy or breast augmentation):
- A. The same as before commencing hormone replacement (assessment made by a team of two specialists)
  - B. It should be noted that hormone replacement is not required before surgical interventions within the chest.
- VI. Medical examinations preceding panhysterectomy and orchidectomy:
- A. The same as before commencing hormone replacement (assessment made by a team of two specialists)
  - B. Additional criteria:
    1. Termination of legal proceedings aimed at reconciliation of gender  
(Note: we are aware of the fact that, despite the common practice in our country, the opinions of legal authorities in this area are not consistent, i.e., some allow the possibility of conducting surgical procedures, which also deprive fertility before the end of court proceedings, when they have the consent of the individual and the purpose is therapeutic. However, until more explicit legal solutions are formulated, we do recommend this conservative approach.)
    2. 12 months of functioning in the role consistent with the perceived gender identity.
    3. If the patient started hormone substitution, its duration should be at least 12 months (it is not additional 12 months in relation to the required time in the role consistent with the perceived gender identity).

**Important: Legal proceedings aimed at reconciliation of gender can be started immediately after completing the diagnostic process, i.e., making a formal diagnosis covering the category from F64 class according to ICD-10.**

**VII. Language and communication with the patient:**

- A. We recommend respecting the patient's identity and referring to the patient in accordance with perceived gender regardless of the state of transition. We refer to relevant publications, i.e., non-governmental organizations or recognized authorities, to learn about the principles of 'trans-affirmative' actions (i.e., Polish Trans-Fuzja Foundation, Transgender Europe, publications such as: *Language and trans health* [7]).

**VIII. Content of referrals and opinions:**

- A. Information on the diagnosis and its justification.
- B. Information about gender identity and its duration as well as about dysphoria and its persistence.
- C. Information on the ability to give informed consent.

**Important: It is recommended to limit the inclusion in the certificates and opinions (especially for the needs of court proceedings) of patient's biographical and personal information only to those that constitute the premise for formulated conclusions. This applies especially to the information on sexual functioning (behavior, fantasies, sexual orientation and preferences).**

*The recommendations were developed in Krakow on 31<sup>st</sup> January 2020 by the group of experts listed below:*

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