Changing the Way We Work Community of Practice for Ontario Family Physicians

Infectious Disease & Gender Affirming Care

January 17, 2025

Dr. Daniel Warshafsky
Dr. Tehmina Ahmad

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians

Infectious Disease & Gender Affirming Care

Moderator:

- Dr. Ali Damji, Division Head, Primary Care, Trillium Health Partners and Family Physician, Credit Valley Family Health Team, Mississauga, ON

Panelists:

- Dr. Daniel Warshafsky, Toronto, ON
- Dr. Tehmina Ahmad, Toronto, ON

Host:

- Dr. Jobin Varughese, Brampton, ON

The Changing the Way We Work Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits.

Please note that due to changes to the Cert+ platform, there will be delays in credits being applied to your account.

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

Changing the way we work

A community of practice for family physicians

At the conclusion of this series participants will be able to:

- Identify the current best practices for delivery of primary care and how to incorporate into practice.
- Describe point-of-care resources and tools available to guide decision making and plan of care.
- Connect with a community of family physicians to identify practical solutions for their primary care practice under current conditions.

Disclosure of Financial Support

This CPD program has received in-kind support from the Ontario College of Family Physicians and the Department of Family and Community Medicine, University of Toronto in the form of logistical and promotional support.

Potential for conflict(s) of interest:
N/A

Mitigating Potential Bias

- The Scientific Planning Committee has full control over the choice of topics/speakers.
- Content has been developed according to the standards and expectations of the Mainpro+ certification program.
- The program content was reviewed by a three-member national/scientific planning committee.

Planning Committee: Dr. Jobin Varughese (OCFP), Dr. Ali Damji (DFCM), Dr. Eleanor Colledge (DFCM), Dr. Harry O'Halloran, Julia Galbraith (OCFP), Pavethra Yogeswaran (OCFP), Marisa Schwartz (DFCM)

Previous webinars & related resources:

https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Dr. Daniel Warshafsky – Panelist

Associate Chief Medical Officer of Health at the Office of the Chief Medical Officer of Health

Dr. Tehmina Ahmad – Panelist

Medical Consultant – Endocrinology & Metabolism, Toronto Western Hospital, UHN

Speaker Disclosure

- Faculty Name: **Dr. Daniel Warshafsky**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: N/A
  - Others: N/A

- Faculty Name: **Dr. Tehmina Ahmad**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Shoppers Drug Mart (hired consultant for Transgender Module development for Pharmacists), Ontario College of Family Physicians
  - Others: N/A

Speaker Disclosure

- Faculty Name: **Dr. Jobin Varughese**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Toronto Metropolitan University, School of Medicine (Interim Assistant Dean of Primary Care Education), William Osler Health System (Associate Vice President of Academics)

- Name: **Dr. Ali Damji**
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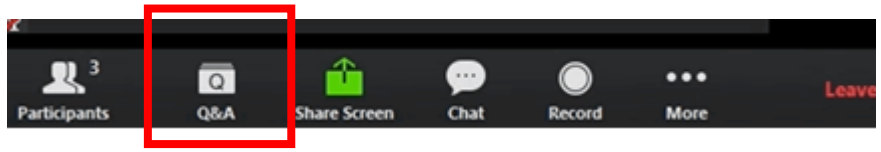
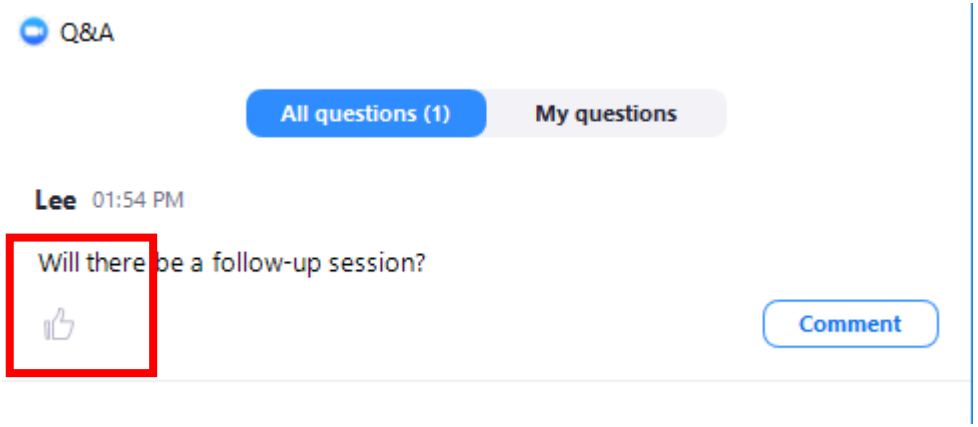
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario Medical Association Section of General & Family Practice, Trillium Health Partners, Canadian Mental Health Association Peel Dufferin, Center for Effective Practice, GSK
  - Advisory boards: Medical Post Advisory Board, Foundation for Advancing Family Medicine, Center for Effective Practice
  - Others: N/A

How to Participate

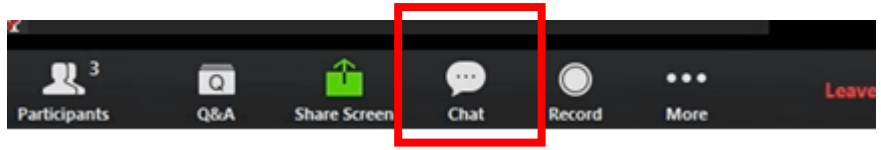
- All questions should be asked using the Q&A function at the bottom of your screen.



- Press the thumbs up button to upvote another guest's questions. Upvote a question if you want to ask a similar question or want to see a guest's question go to the top and catch the panels attention.



- Please use the chat box for networking purposes only.



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Respiratory Season Updates

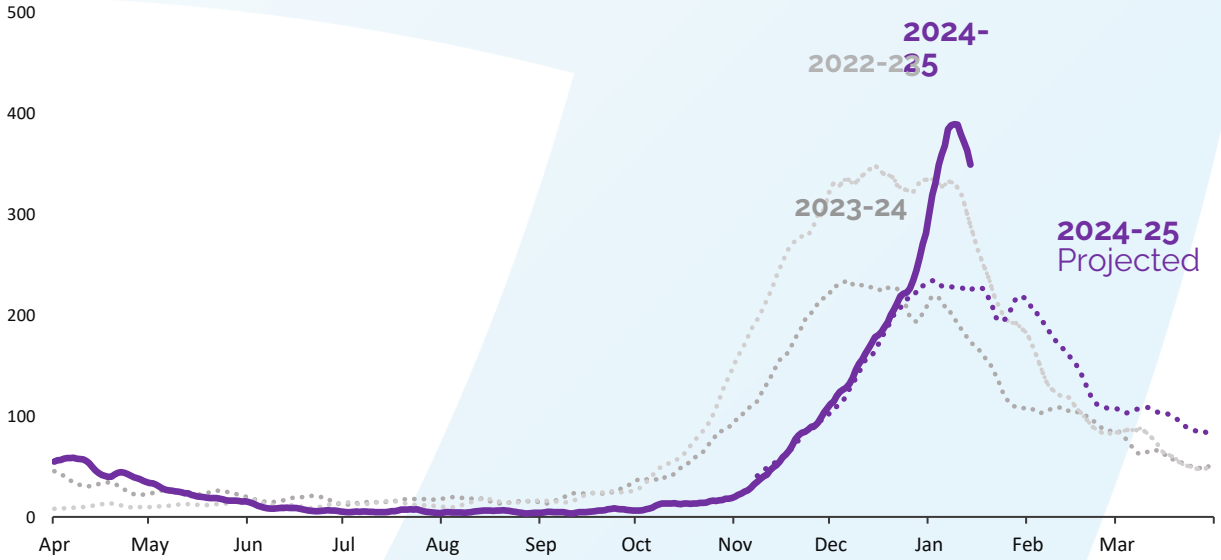
Office of the Chief Medical Officer of Health
January 2025

Ontario

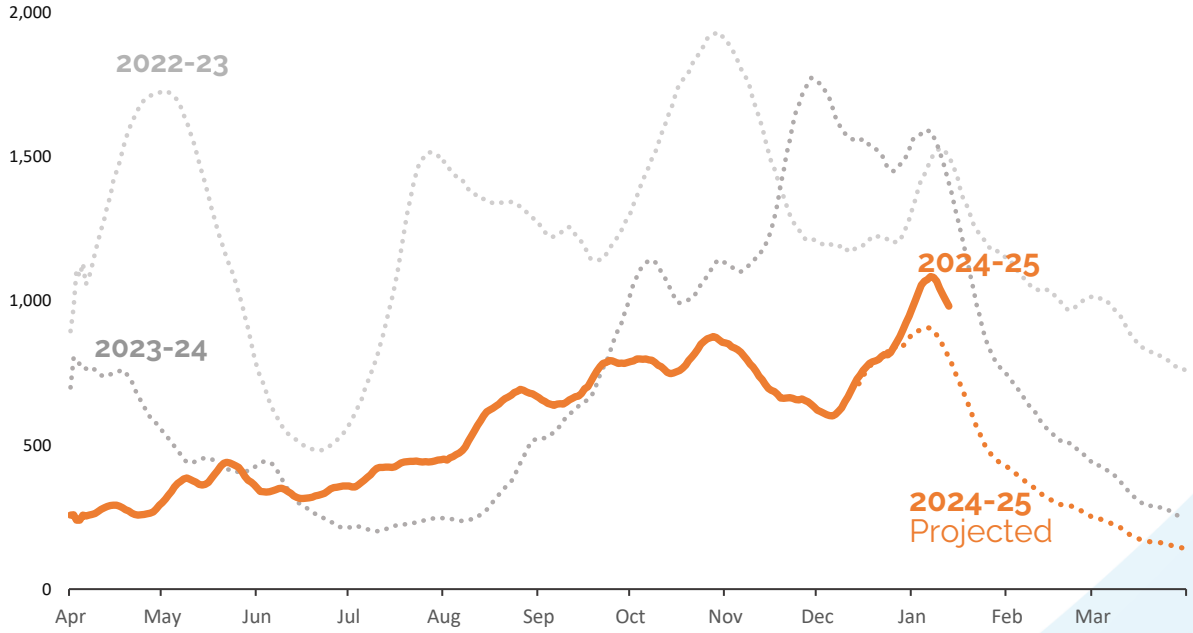
Ontario 2024-25 respiratory season hospitalizations to date vs. previous years

- **RSV** total hospitalizations have surpassed peak levels in 2022-23 and 2023-24 driven by seniors, although seem to be plateauing. Pediatric RSV hospitalizations peaked in mid-December and are slowly declining.
- **Influenza** hospitalizations are increasing at a steeper rate than the previous 2 years, currently running at about 1 week behind last year's wave. Hospitalizations are expected to be nearing peak levels.
- **COVID-19** hospitalizations had expected post-holiday surge, but are decreasing already and at lower levels than prior years.

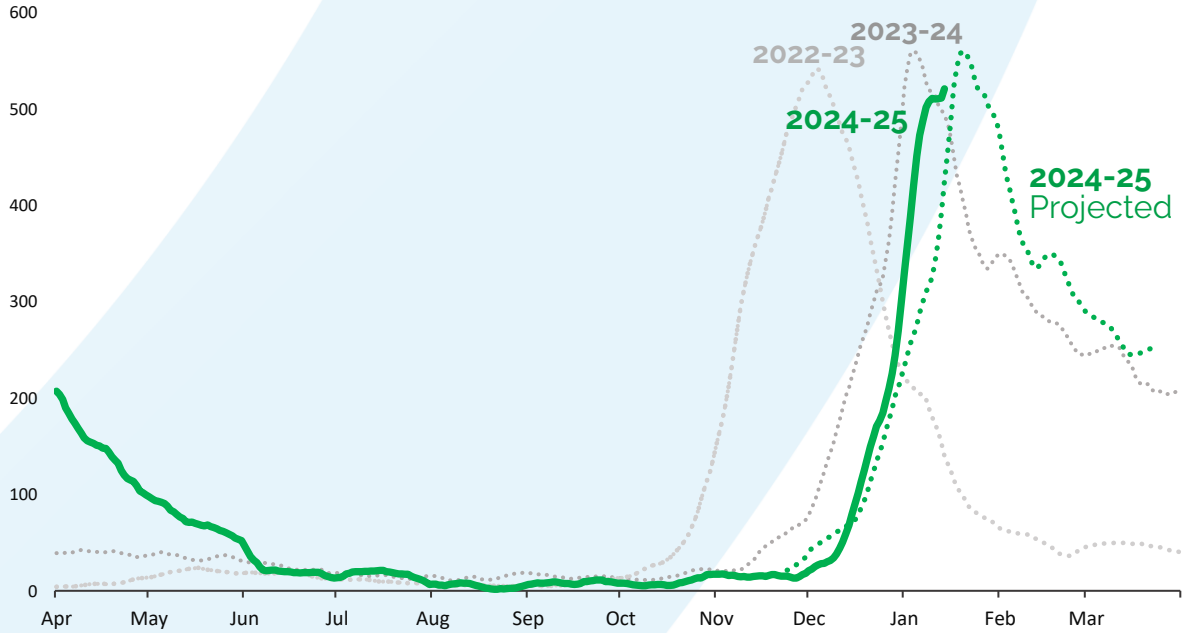
RSV inpatients



COVID-19 inpatients



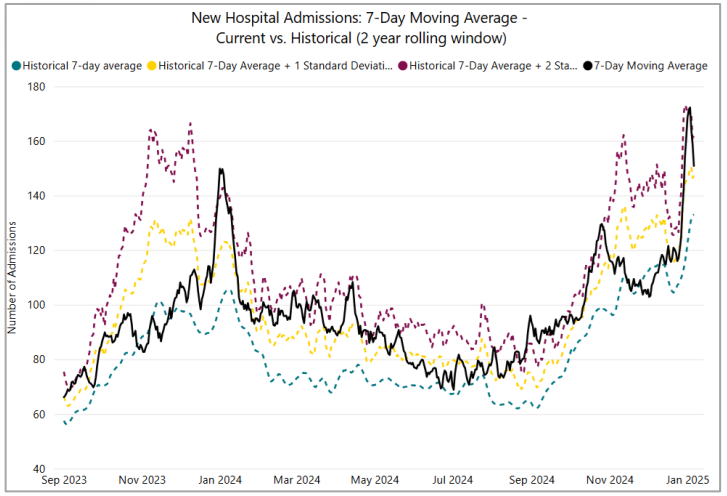
Influenza inpatients



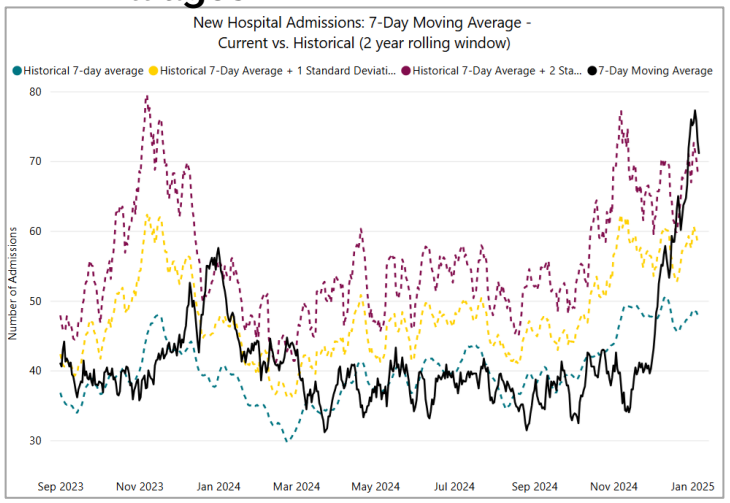
Data: I9 hospital census data as of January 13

ACES hospital admissions tracker

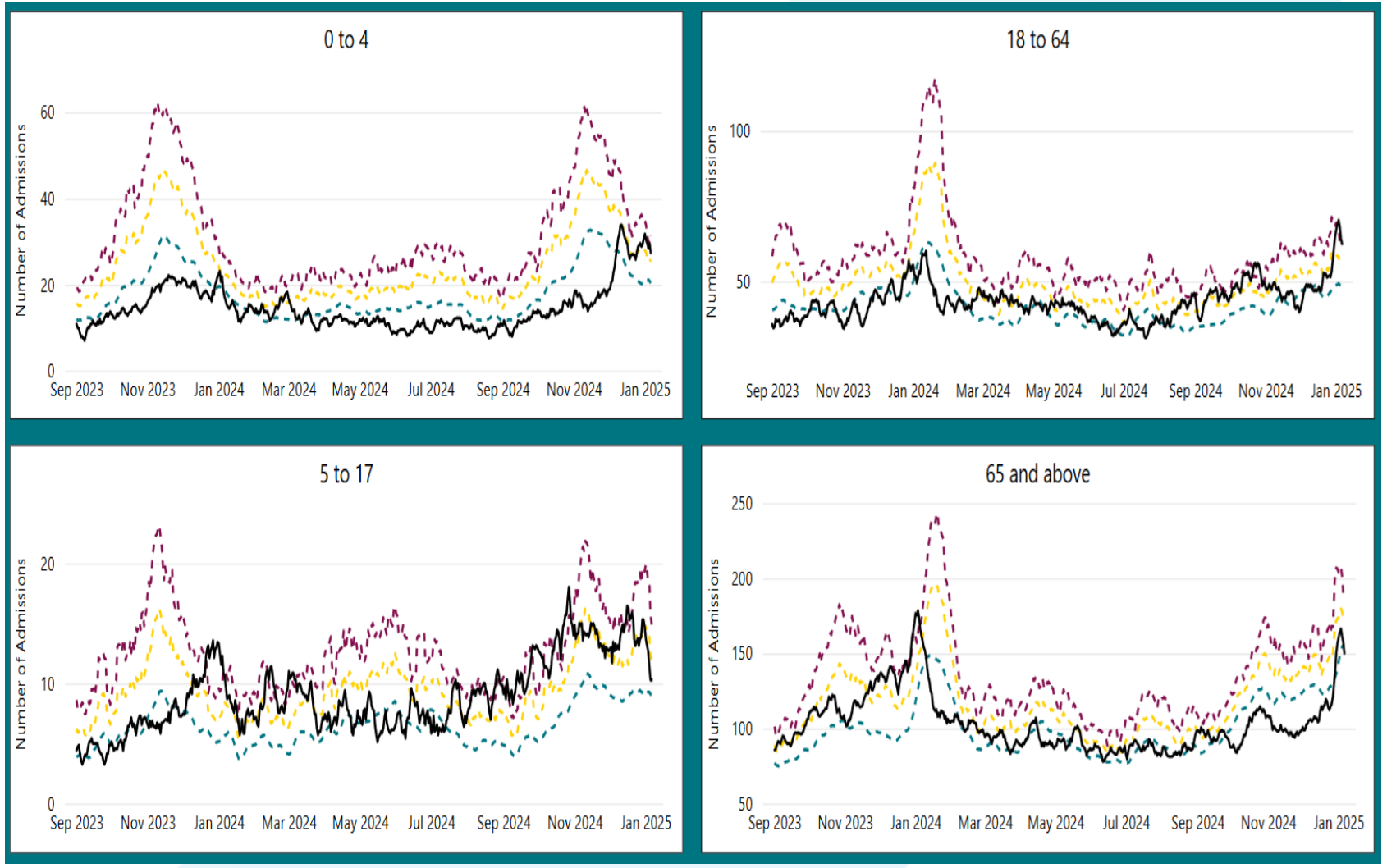
Pneumonia – All ages



ILI – All ages



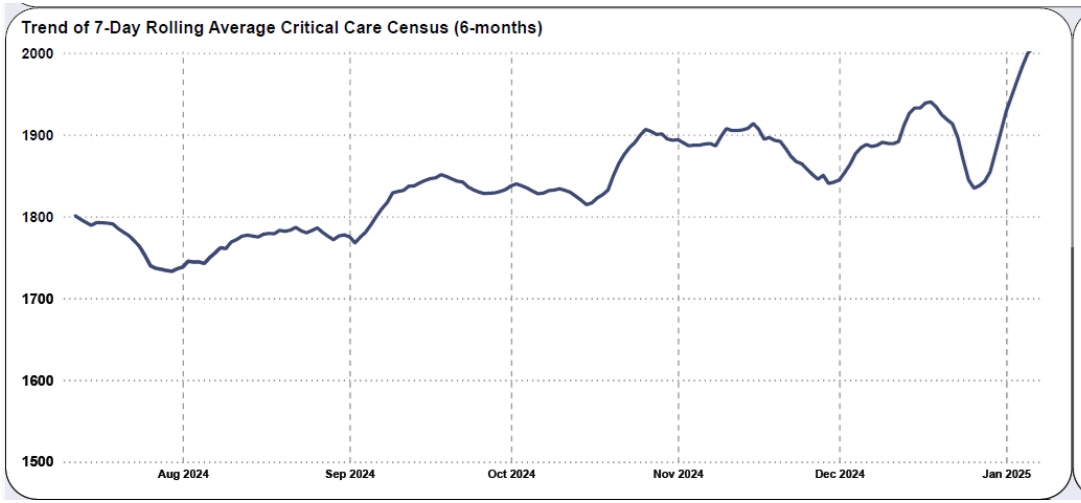
Pneumonia, ILI and COVID-19 – By age group

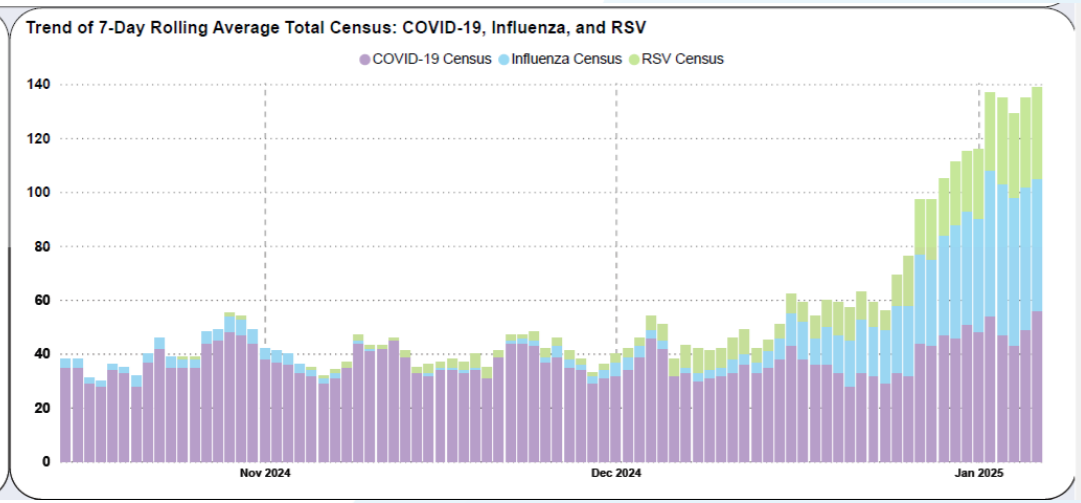


Data: KFLA PHU ACES surveillance data as of January 7

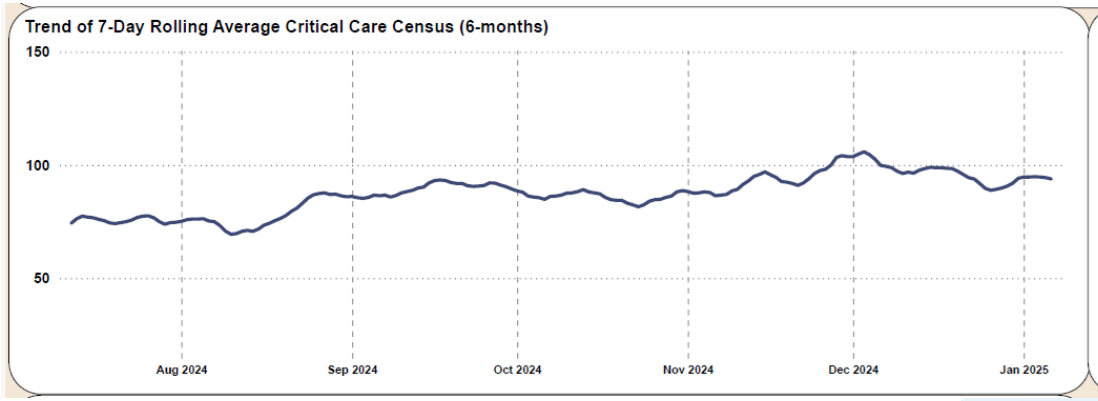
ICU census

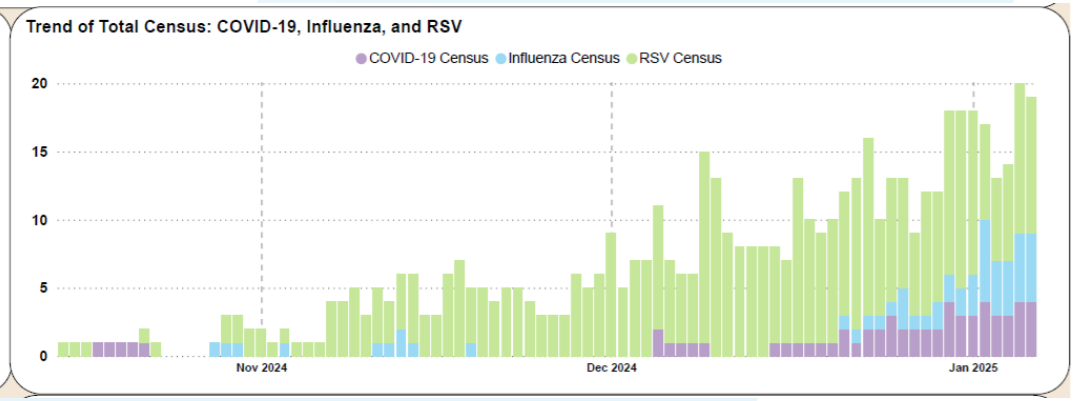
Adult ICU





Pediatric ICU





Data: CCSO (CCIS data) as of January 7

1. Weekly Summary: Ontario's COVID-19 vaccination program

43,260,944
Doses administered:
Cumulative

3,195
Doses administered:
Daily (7-day avg)

23,183
Doses administered:
This week

19,025
Doses administered:
Last week

1,599,254
People w/ Fall 2024 dose

22,166
+from
previous week

10.8%
% of population
All ages

0.15%
+ % points from
previous week

35.5%
% of population
Age 65+

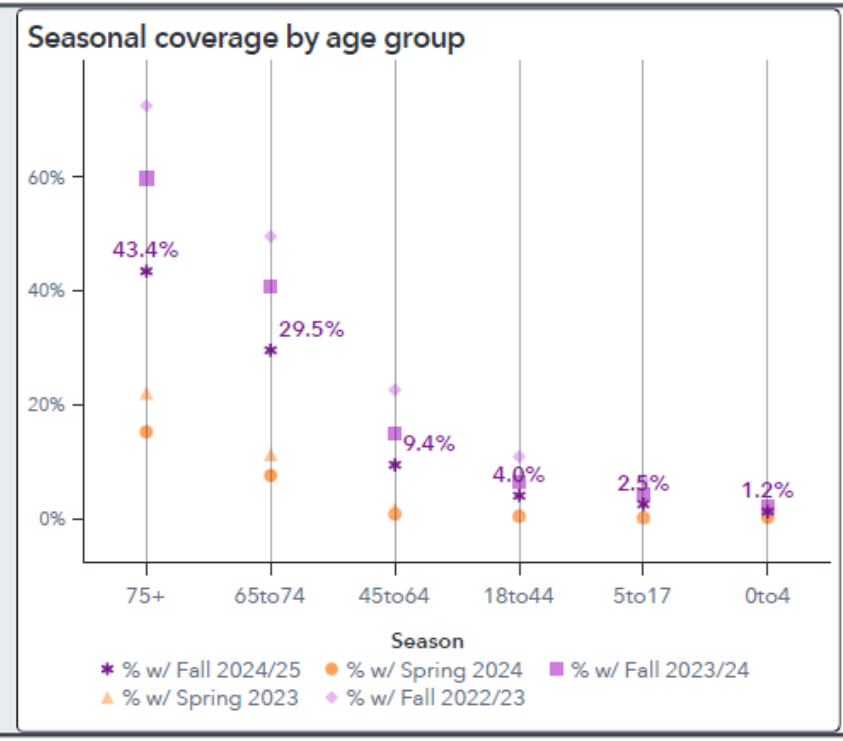
0.44% (+11,876 ppl)
+ % points from
previous week

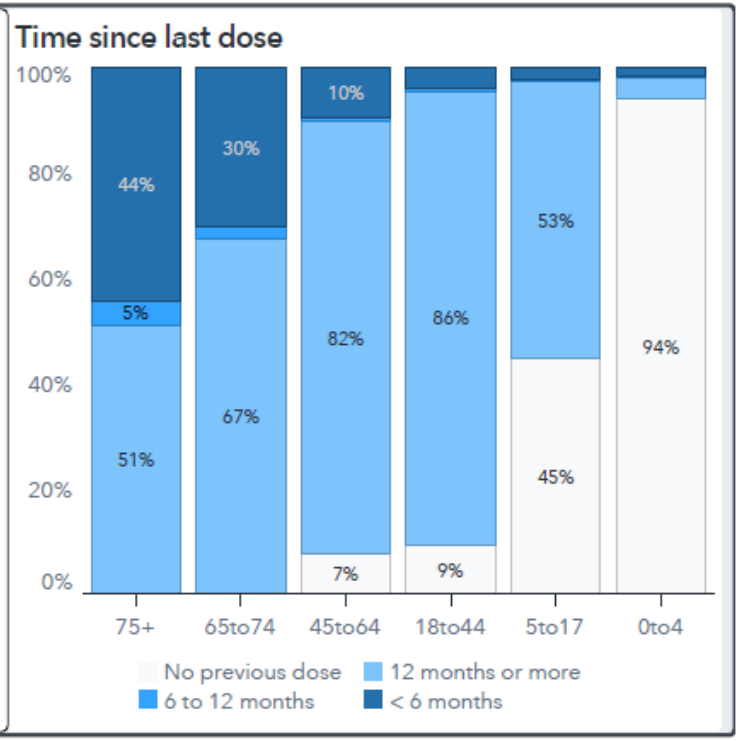
6.2%
% of population
Age 18-64

0.10% (+9,217 ppl)
+ % points from
previous week

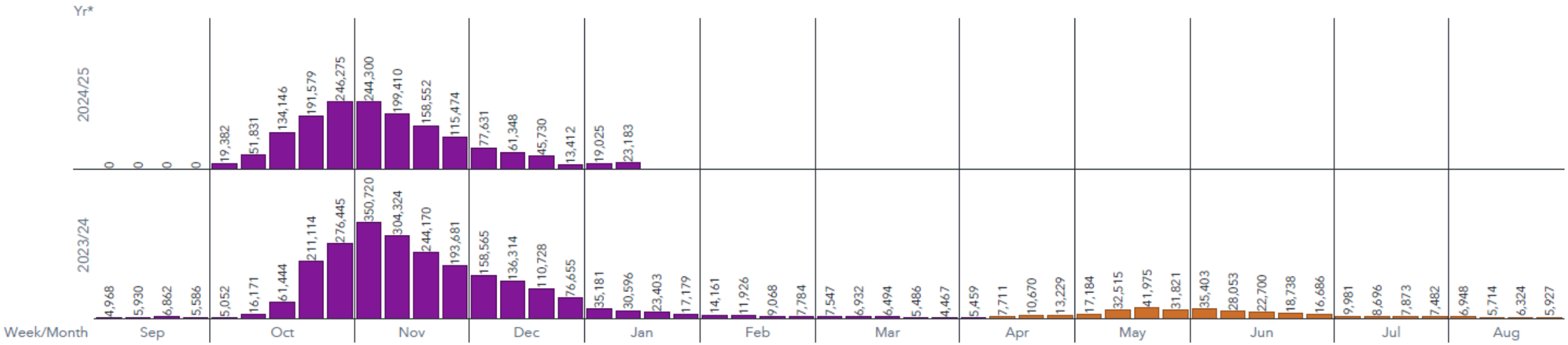
2.1%
% of population
Age <18

0.04% (+1,073 ppl)
+ % points from
previous week





Trending: Doses administered week by week



Long-Term Care (LTC) Home Residents

Total LTC residents vaccinated with fall dose

35,846

LTC residents who received a Fall 2023/24 dose (From September 12, 2023 to March 31, 2024):

45,290 (61.6%)

% LTC residents with a dose in the last 6 months

50.5%

% all LTC residents with fall dose

50.3%

Change from previous report:

592 residents

1.5 % points

Retirement Home (RH) Residents

Total RH residents vaccinated with fall dose

28,624

% all RH residents with fall dose

48.3%

Change from previous report:

363 residents

0.6 % points

RH residents who received a Fall 2023/24 (From September 12, 2023 to March 31, 2024):

37,563 (63.4%)

% RH residents with a dose in the last 6 months

48.8%

Flu Distribution in LTCH/RH

As of January 13, 2025:

144,267 (+223 since January 6) doses of publicly funded flu vaccine have been distributed to **587** (no change since January 6) LTCHs via PHUs.

36,615 (+30 since January 6) doses of publicly funded flu vaccine have been distributed to **268** (no change since January 6) retirement homes via PHUs.

Please note:

- Many LTCHs and retirement homes are partnering with pharmacies – these homes and doses are not captured

Flu Administration in Pharmacy

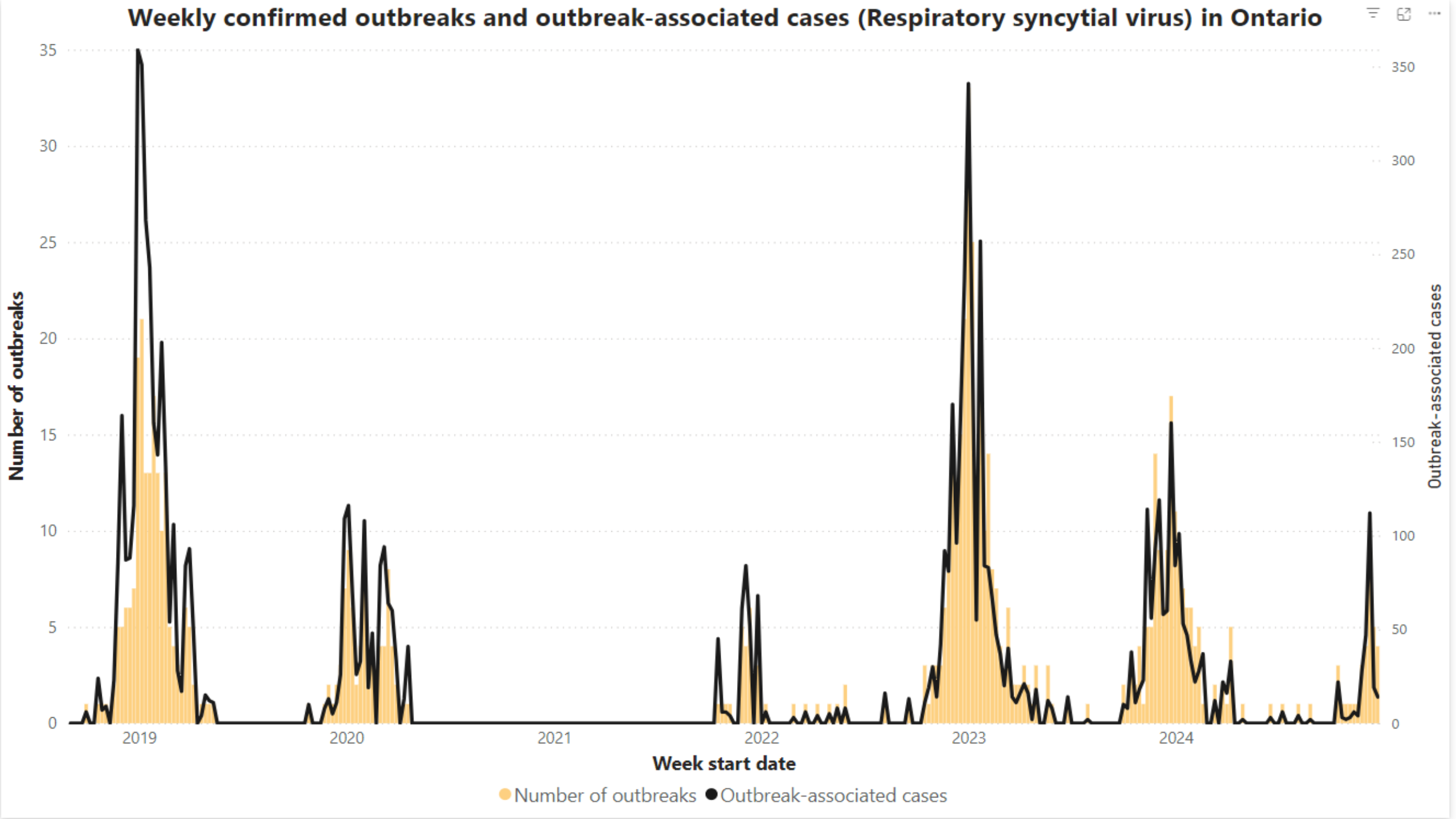
Week	2021/22	2022/23	2023/24	2024/25
	Number of doses administered by week	Number of doses administered by week	Number of doses administered by week	Number of doses administered by week
Week 1 (Oct 3-9)	13,798	3,171	25,584	191
Week 2 (Oct 10-16)	232,232	119,093	209,677	130,191
Week 3 (Oct 17-23)	198,502	238,289	258,305	236,677
Week 4 (Oct 24-30)	253,526	287,796	286,758	278,476
Week 5 (Oct 31-Nov 6)	235,578	357,353	297,034	299,635
Week 6 (Nov 7-13)	256,211	326,372	226,309	247,091
Week 7 (Nov 14-20)	161,638	261,190	167,801	189,944
Week 8 (Nov 21-27)	109,201	178,436	129,908	138,268
Week 9 (Nov 28-Dec 4)	76,491	133,519	107,329	98,707
Week 10 (Dec 5-11)	53,341	101,039	88,126	58,253
Week 11 (Dec 12-18)	34,391	73,304	62,559	52,682
Week 12 (Dec 19-25)	15,226	27,390	28,789	27,315
Week 13 (Dec 26-Jan 1)	14,413	26,201	25,334	25,368
Week 14 (Jan 2-8)	12,635	22,290	26,866	23,879
Total	**1,667,183**	**2,155,443**	**1,940,379**	**1,806,677**
Total # of doses administered for season	1,693,001	2,192,776	1,992,817	

Age	2 to 4 years old	5 to 11 years old	12 to 18 years old	19 to 64 years old	65 years and older	Total
# of doses administered	17,462	59,983	56,449	766,070	906,713	**1,806,677**
Percentage	0.97%	3.32%	3.12%	42.40%	50.19%	**100.00%**

Older Adult RSV Distribution

As of Jan. 10, 2025 (data pulled Jan. 13, 2025):

- **88,232 doses (Δ +682 doses) distributed to Public Health Units (PHU)**
  - 30,752 doses (Δ 0 doses) of Arexvy
  - 57,480 doses (Δ +682 doses) of Abrysvo
- **73,012 doses (Δ +1,067 doses) distributed to Health Care Providers (HCP)**
  - **19,445 doses (Δ +324 doses) distributed to 507 (Δ +5) Long-Term Care Homes (LTCH) via PHUs**
  - **12,800 doses (Δ +103 doses) distributed to 219 (Δ +1) Retirement Homes (RH) via PHUs**


Weekly confirmed outbreaks and outbreak-associated cases (Respiratory syncytial virus) in Ontario
Number of outbreaks
Outbreak-associated cases
0
5
10
15
20
25
30
35
0
50
100
150
200
250
300
350
2019
2020
2021
2022
2023
2024
Week start date
Number of outbreaks
Outbreak-associated cases

Infant RSV Distribution

As of Jan. 10, 2025 (data pulled Jan. 13, 2025):

- **121,832 doses (Δ +1,371 doses)** distributed to Public Health Units (PHU)
  - 50mg: 53,780 doses (Δ -46 doses)
  - 100mg: 68,052 doses (Δ +1,417 doses)

- **106,558 doses (Δ +4,120 doses) distributed to Health Care Providers (HCP)**
  - Hospitals: 38,798 doses
    - 50mg: 28,907 doses
    - 100mg: 9,891 doses
  - Primary care providers: 67,760 doses
    - 50mg: 16,712 doses
    - 100mg: 51,048 doses

Early indications of RSV uptake before discharge

~11,000 babies born every 4 weeks in Ontario

Nov 1 –Dec 31, 2024
BORN captured RSV prevention information on **11,438 newborns**
(~47% of expected birth volumes)

70% received Beyfortus (nirsevimab)
Increase from 67% in November

If not given, then why?

1) 19% - parent declining
2) 4.2% - prenatal RSV protection via maternal vaccine
3) <3% - other reasons (including preference to delay, baby unwell, etc)
4) <2% - discharge prior to provision (including to NICU),
5) <2% - in the early stages of the roll-out no supply available or program not yet initiated at

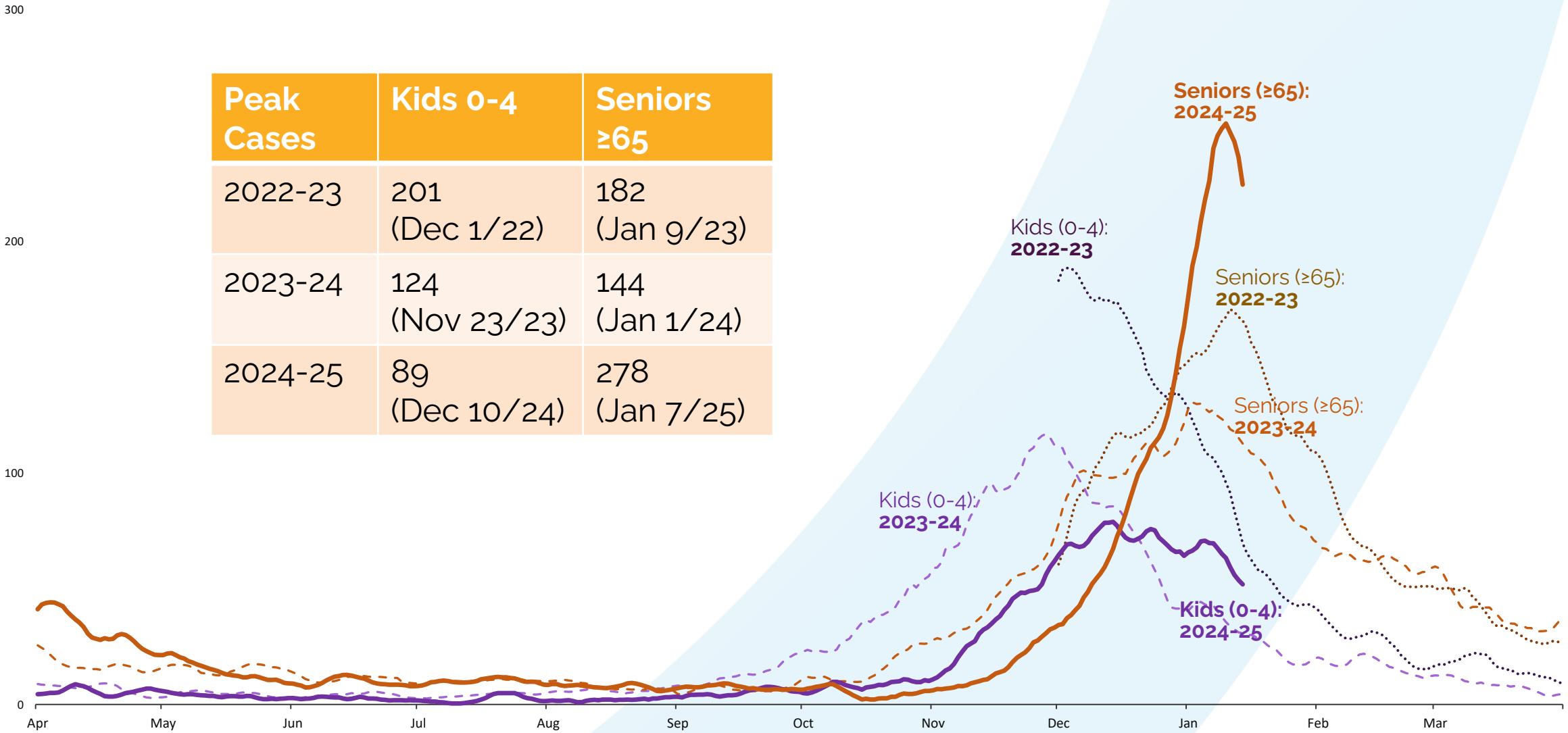
Anecdotally, clinicians share that pre-admission awareness of the program reduces hesitancy.

Due to missingness, interpret with caution and curiosity.

Comparing RSV hospitalizations by age: Kids (0-4) and seniors (≥65)

The 0-4 and ≥65 age groups make up 82% of historical average RSV hospital census.

Peak Cases	Kids 0-4	Seniors ≥65
2022-23	201 (Dec 1/22)	182 (Jan 9/23)
2023-24	124 (Nov 23/23)	144 (Jan 1/24)
2024-25	89 (Dec 10/24)	278 (Jan 7/25)



Data: I9 hospital census data as of January 13

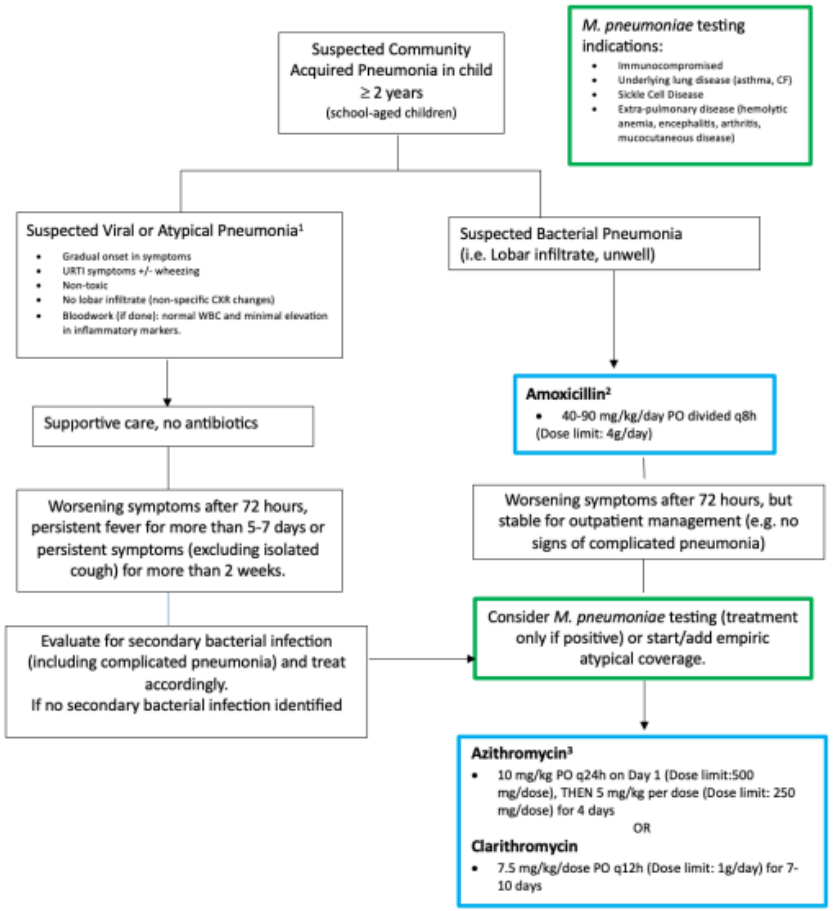
Mycoplasma pneumoniae

Diagnosis and treatment for paediatric care providers

CHEO | Children's Hospital London Health Sciences Centre | Kingston Health Sciences Centre | McMaster Children's Hospital | SickKids

Mycoplasma pneumoniae

Community Acquired Pneumonia – Outpatient Management Algorithm



Key Points:

1. Most patients with a mild *M. pneumoniae* infection will recover **without antibiotics.**
2. Either **low dose amoxicillin** (40-50 mg/kg/day) or **high dose amoxicillin** (80-90 mg/kg/day) divided 3 times a day can be used in most jurisdictions as *Streptococcus pneumoniae* susceptibility to penicillin remains high. Alternatively, if twice a day dosing is prescribed, higher dose amoxicillin should be used (45 mg/kg/dose PO q 12 h, maximum 4 g/day)
3. **Macrolides** alone should not be used alone if *Streptococcus pneumoniae* is suspected due to high resistance rates (up to 50%)

Additional Treatment Considerations

Levofloxacin and **Doxycycline** should be reserved for patients with confirmed M. pneumoniae infections where IV therapy is needed (levofloxacin), there is severe disease, or lack of response after 48-72 hours of macrolide therapy (levofloxacin or doxycycline)
Amoxicillin/clavulanate would add coverage for infections with beta-lactamase producing organisms (e.g. Haemophilus influenzae, *Moraxella catarrhalis*) as well as methicillin susceptible *Staphylococcus aureus*, but these are less common causes of pneumonia in children.

https://www.sickkids.ca/en/care-services/for-health-care-providers/clinical-practice-resources/

Human Metapneumovirus (HMPV)

- HMPV is common, on average 10% of seasonal respiratory illness in children is caused by HMPV — most people get it before they turn 5
- Causes predominantly upper respiratory symptoms
- High risk groups:
  - Are younger than 5 (especially premature infants) or older than 65.
  - Immunocompromised.
  - Have asthma or COPD.

- Recent surge in cases of human metapneumovirus in northern China
  - Within the expected range for the winter season with no unusual outbreak patterns reported

Show summary for the most recent week | Show summary for the current surveillance period

COVID-19	Influenza (all types)	RSV
Percent positivity in the most recent week **13.5%**	**Percent positivity** in the most recent week **11.8%**	**Percent positivity** in the most recent week **10.8%**
Outbreaks reported in the most recent week **78**	**Outbreaks** reported in the most recent week **11**	**Outbreaks** reported in the most recent week **4**
Hospital bed occupancy reported in the most recent week **865**	**Hospital bed occupancy** reported in the most recent week **225**	**Hospital bed occupancy** reported in the most recent week **239**
Deaths reported in the most recent week **8**	**Deaths** reported in the most recent week **Not available**	**Deaths** reported in the most recent week **Not available**
Episodes reported in the most recent week **1,655**	**Cases** reported in the most recent week **1,181**	**Cases** reported in the most recent week **Not available**

Other respiratory virus activity in the most recent week

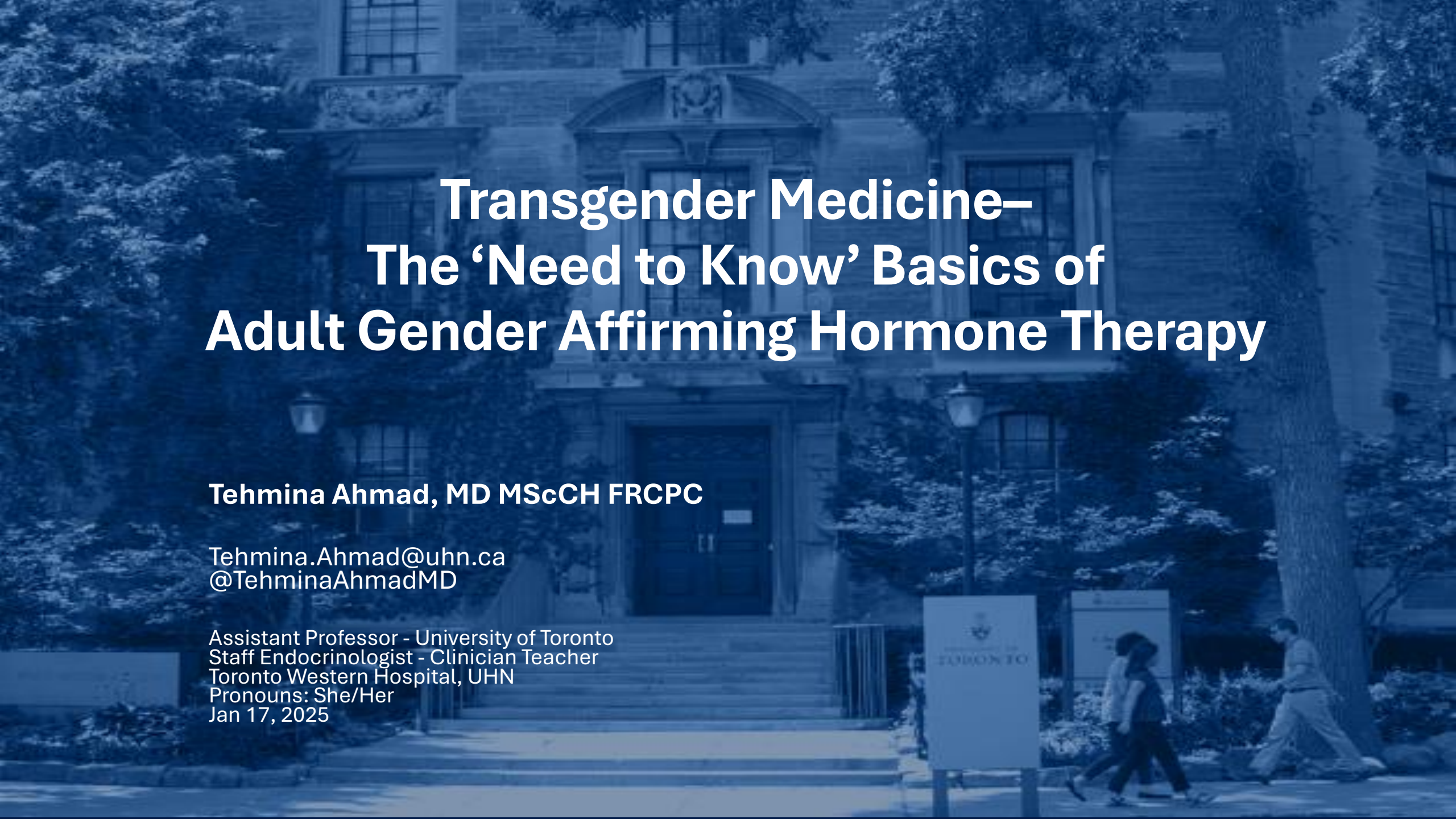
Virus	Percent positivity (%)
Adenovirus	1.0
Entero/Rhinovirus	5.9
Human metapneumovirus	0.7
Parainfluenza (all types)	1.8
Seasonal human coronavirus	1.8

Download data for the previous and current surveillance period

Cases | Outcomes

Lab testing / percent positivity | Outbreaks

Historical activity assessment | PHU influenza activity/positivity



Transgender Medicine– The ‘Need to Know’ Basics of Adult Gender Affirming Hormone Therapy

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Toronto Western Hospital, UHN
Pronouns: She/Her
Jan 17, 2025

Learning Objectives

1. Understand terminology related to sex, gender identity, gender expression, and sexual orientation.

2. Build an approach to the diagnosis of gender dysphoria/gender incongruence, gender health history, and informed consent.

3. Review common adult gender affirming hormone therapies (GAHT), dosing, monitoring, and side effects.

Outline

1. **Conceptualizing gender identity, gender expression, and sex**
2. Understanding ‘transitioning’
3. The ‘What, Who, How, and Why of gender affirming care
4. How to provide (adult) gender affirming hormone therapy
5. The one-liner on gender affirming surgeries & regret

Let’s Start with Some Definitions…

- **Transgender**: A person whose gender identity differs from the sex that was assigned at birth

WPATH SOC8
Sherbourne Health Guidelines 2022

Let’s Start with Some Definitions…

- **Transgender**: A person whose gender identity differs from the sex that was assigned at birth
- **Sex (AFAB/AMAB)**: The sex assigned at birth based on genotype or phenotypic external genitalia

WPATH SOC8
Sherbourne Health Guidelines 2023

Let’s Start with Some Definitions…

- **Transgender**: A person whose gender identity differs from the sex that was assigned at birth
- **Sex (AFAB/AMAB)**: The sex assigned at birth based on genotype or phenotypic external genitalia
- **Gender identity**: A person’s deeply felt, internal, intrinsic sense of their own gender

WPATH SOC8
Sherbourne Health Guidelines 2023

Let’s Start with Some Definitions…

- **Transgender**: A person whose gender identity differs from the sex that was assigned at birth
- **Sex (AFAB/AMAB)**: The sex assigned at birth based on genotype or phenotypic external genitalia
- **Gender identity**: A person’s deeply felt, internal, intrinsic sense of their own gender
- ~~**Transsexual:**~~ A clinical term which had historically been used to describe those transgender people who sought medical intervention (hormones, surgery) for gender affirmation **(term is no longer used!)**

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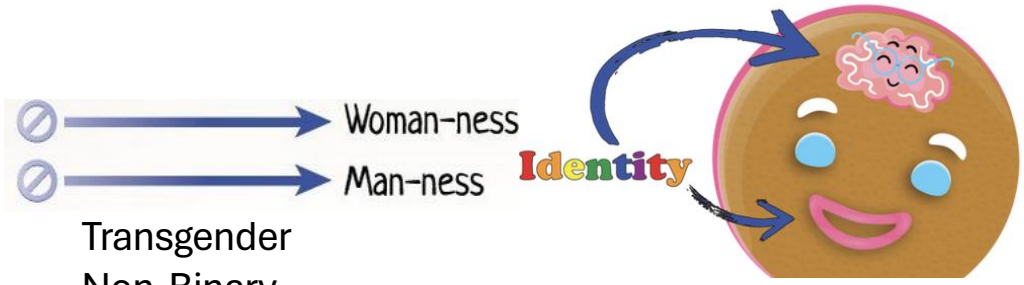
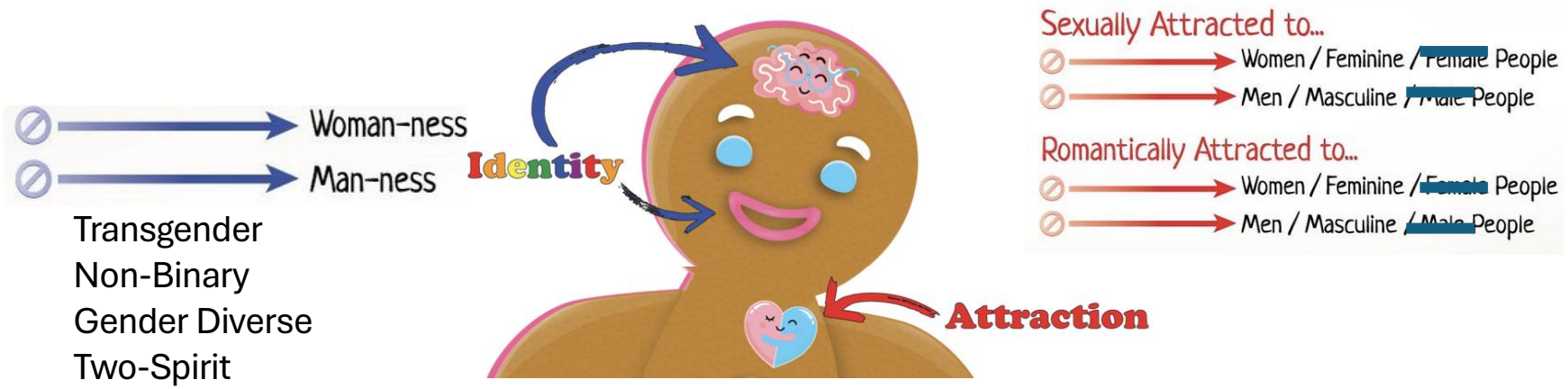
Gender Identity ≠ Sexual Orientation ≠ Sex ≠ Gender Expression



Transgender
Non-Binary
Gender Diverse
Two-Spirit
Cisgender

Adapted from: Killermann, S. 2017. The genderbread person version 4. *Genderbread. org*.

Gender Identity ≠ Sexual Orientation ≠ Sex ≠ Gender Expression



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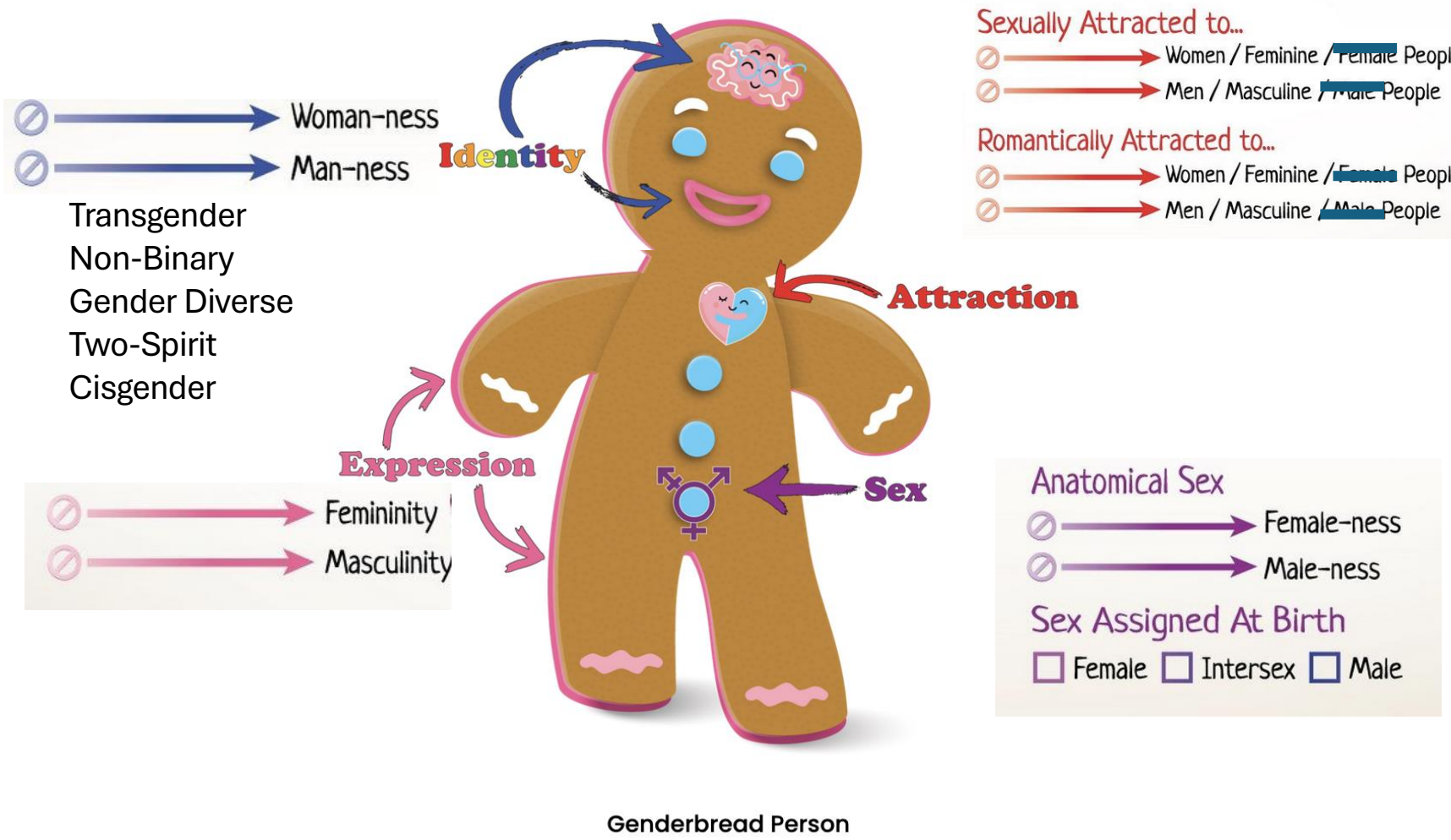
Adapted from: Killermann, S. 2017. The genderbread person version 4. *Genderbread. org*.

Gender Identity ≠ Sexual Orientation ≠ Sex ≠ Gender Expression



Genderbread Person

Adapted from: Killermann, S. 2017. The genderbread person version 4. *Genderbread. org*.

Outline

1. Conceptualizing gender identity, gender expression, and sex
2. **Understanding ‘transitioning’**
3. The ‘What, Who, How, and Why of gender affirming care
4. How to provide (adult) gender affirming hormone therapy
5. The one-liner on gender affirming surgeries & regret

What Does it Mean to ‘Transition’?

- Adopting new name and pronouns
- Altering physical appearance to align with gender identity
  - Hairstyle
  - Dress + Cosmetics
  - Body Hair Changes
- Adopting mannerisms and behaviors aligned with preferred gender role

WPATH SOC8
Targownik L. Correspondence. 2024

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- Gender affirming hormones to induce changes associated with gender identity

WPATH SOC8
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- Puberty blockers to prevent or stall secondary sex changes
- Gender affirming hormones to induce changes associated with gender identity

- Surgical removal of morphologic indicators of birth sex
- Surgical creation of morphologic features of sex associated with gender identity

WPATH SOC8
Targownik L. Correspondence. 2024

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What About the Children?!

Research Letter | Surgery

June 27, 2024

Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US

Dannie Dai, BS[1]; Brittany M. Charlton, ScD[2]; Elizabeth R. Boskey, PhD[3]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2024;7(6):e2418814. doi:10.1001/jamanetworkopen.2024.18814

Cross-sectional study

Calculated the rate of people who received GAS with a trans-related dx per 100,000 people categorized as:

- adults (18yo or older)
- minors (15-17yo, 13-14yo, <12yo)

And compared this to the proportion of gender affirming breast reduction surgeries in **cis-males** for gynecomastia

Recall, if you were born male, and identify as a man; your breast reduction was done to affirm your male gender identity

Dai et al. 2024

What About the Children?!

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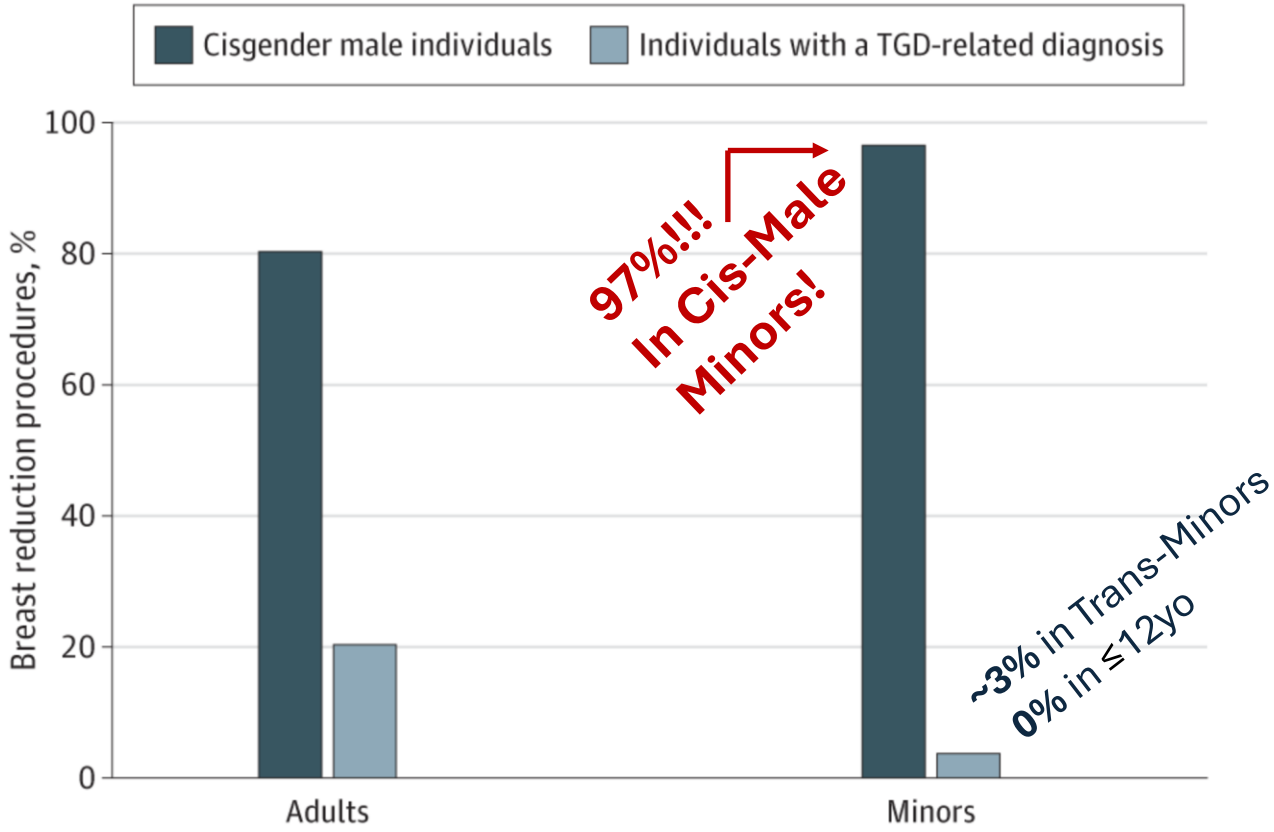


Dai et al. 2024

What About the Children?!

Research Letter

January 6, 2025

Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022

Landon D. Hughes, PhD[1]; Brittany M. Charlton, ScD[2]; Isa Berzansky, MSc[2]; et al

» Author Affiliations

JAMA Pediatr. Published online January 6, 2025. doi:10.1001/jamapediatrics.2024.6081

Cross-sectional study

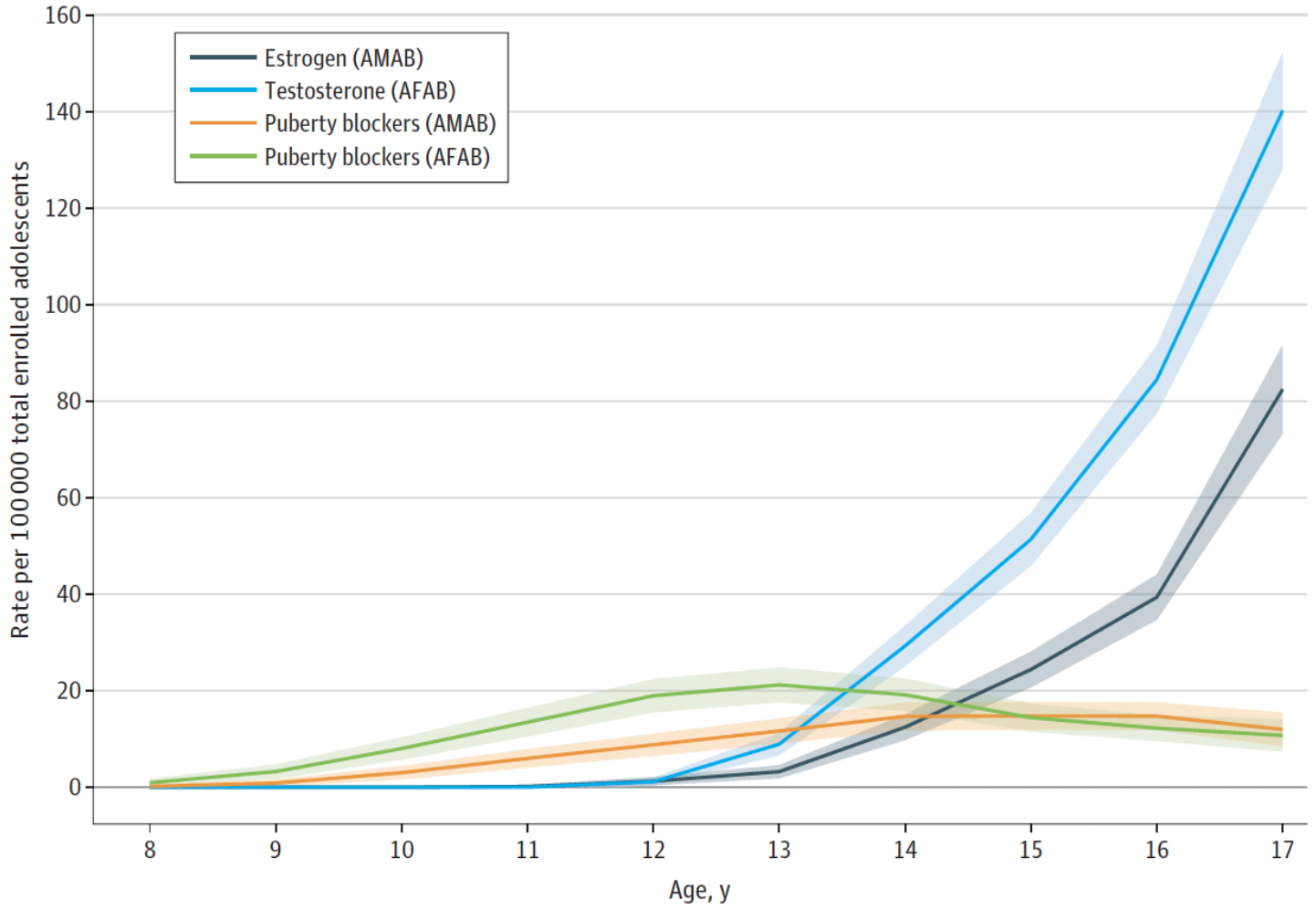
Calculated the rate of adolescents with a TGD-related diagnosis who received hormonal care per 100 000 total adolescents enrolled in insurance by age (8-17yo) and sex assigned at birth.

The sample included yielded:
11 879 766 person-years of data

Hughes et al. 2025

What About the Children?!

Figure. Gender-Affirming Medication Receipt per 100 000 Enrolled Adolescents by Age and Sex Assigned at Birth, 2018-2022



The rate of receiving *Puberty Blockers*:
AFAB – 20.81 per 100 000 adolescents
AMAB – 15.22 per 100 000 adolescents

The rate of receiving *Hormone Therapy*:
AFAB – 49.9 per 100 000 adolescents
AMAB – 25.34 per 100 000 adolescents

GAHT rates peak at age 17yo, **but still remain low:**
AFAB – 140.16 per 100 000 adolescents
AMAB – 82.42 per 100 00 adolescents

<u>NO adolescents received a hormone prescription when ≤12yo</u>

***Fewer than 1 in 1,000* adolescents receive hormones *or* puberty blockers**

Hughes et al. 2025

Is this Care *Really* Supported?

American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Nursing
American Academy of Pediatrics
American Academy of Physician Assistants
American College Health Association
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American College of Physicians
American Counseling Association
American Heart Association
American Medical Association
American Medical Student Association
American Nurses Association
American Osteopathic Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Plastic Surgeons
Endocrine Society
Federation of Pediatric Organizations
GLMA: Health Professionals Advancing LGBTQ Equality
National Association of Nurse Practitioners in Women's Health
National Association of Social Workers
National Commission on Correctional Health Care
Ontario Medical Association
Pediatric Endocrine Society
Society for Adolescent Health and Medicine
World Medical Association
World Professional Association for Transgender Health

Trans Health Project Medical Organization Statements 2024
https://transhealthproject.org/resources/medical-organization-statements/

Is this Care *Really* Supported?

"We **stand firm in our support** of gender-affirming care. Transgender and gender-diverse people deserve access to needed and often life-saving medical care.

NHS England's recent report, the Cass Review, **does not contain any new research** that would contradict the recommendations made in our Clinical Practice Guideline on gender-affirming care.

The [Clinical Practice] guideline, which cites more than 260 research studies, recommends a very conservative approach to care, with no medical intervention prior to puberty.

…Banning evidence-based medical care based on misinformation takes away the ability of parents and patients to make informed decisions.

Medical evidence, not politics, should inform treatment decisions."

Endocrine Society Press Release – May 8, 2024

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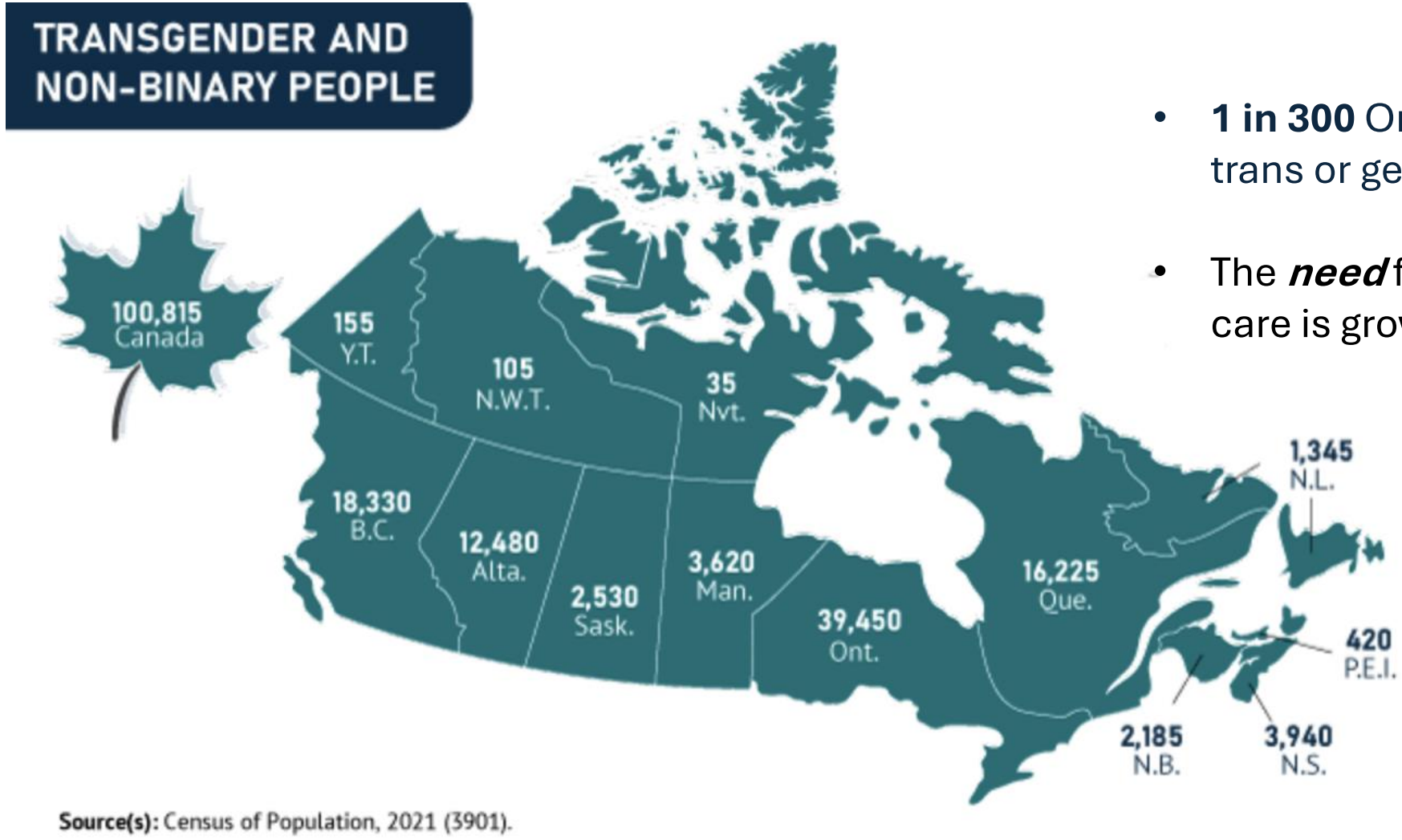
How Many People Are We Talking About?

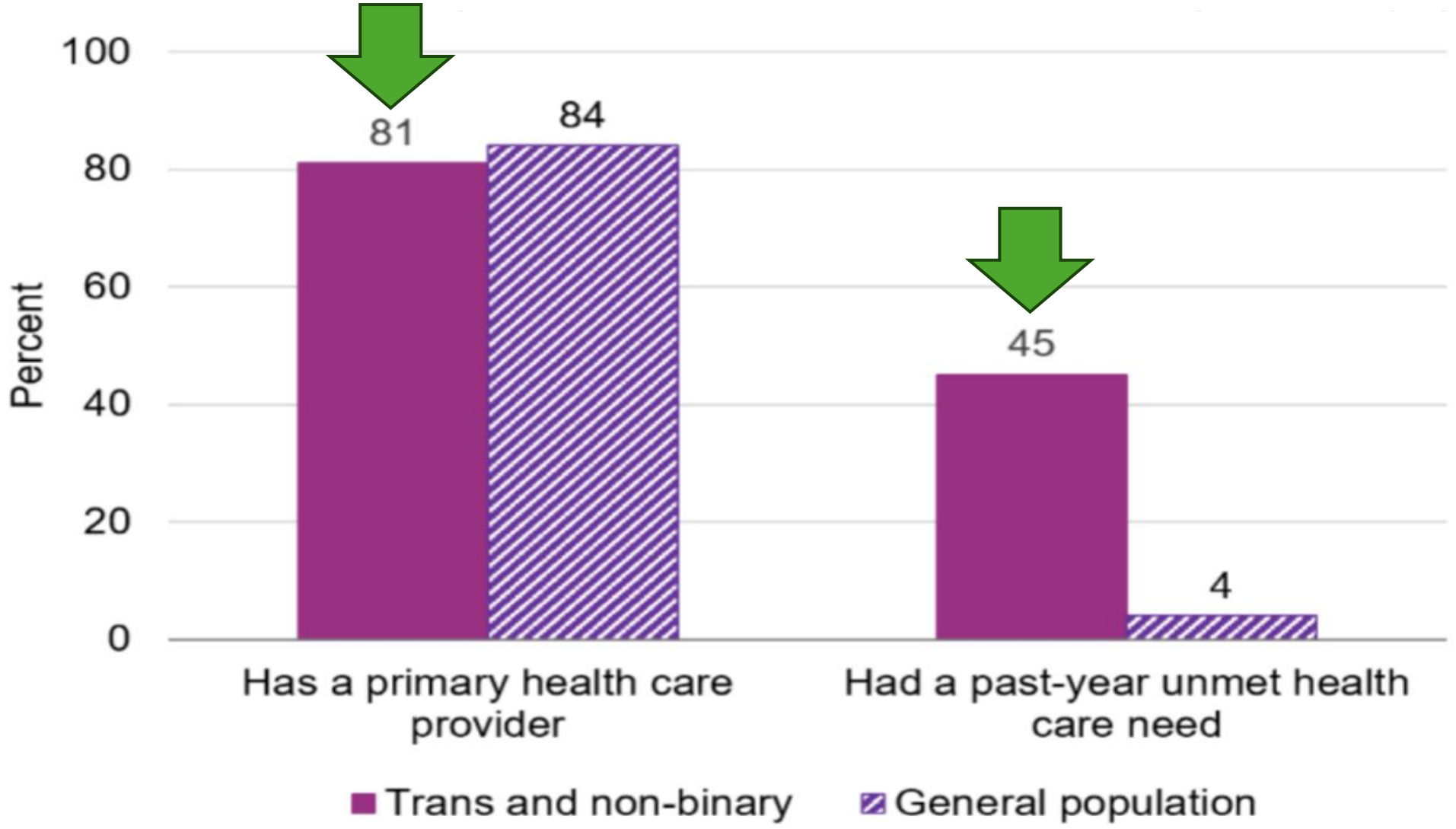


Source(s): Census of Population, 2021 (3901).

- **1 in 300** Ontarians identify as trans or gender diverse
- The ***need*** for gender-affirming care is growing

Statistics Canada 2021
Vandermorris A. & Metzger DL, 2023

How Does Trans Healthcare Access Compare to the General Population?



Bauer GR et al. 2015a

The Trans PULSE Canada Team. 2020. QuickStat #2 – Primary care and unmet health care needs

Factors Impacting Discomfort with Family Doc

Has a family doctor ever. . .	Transmasculine spectrum[a]		Transfeminine spectrum[b]	
	N = 184		n = 172	
	%	95% CI[†]	%	95% CI[†]
Refused to see you or ended care because you are trans	7.2	(1.6, 12.9)	5.0	(0.0, 10.3)
Used hurtful or insulting language about trans identity or experience	9.0	(3.5, 14.4)	12.1	(4.1, 20.0)
Refused to discuss or address trans-related health concerns	10.6	(5.3, 15.8)	13.5	(5.5, 21.6)
Told you that you are not really trans	8.2	(2.7, 13.6)	10.9	(2.8, 19.0)
Discouraged you from exploring gender	9.1	(3.4, 14.8)	6.6	(0.7, 12.4)
Told you they don't know enough about trans-related care to provide it	24.5	(15.8, 33.1)	29.1	(18.5, 39.7)
Belittled or ridiculed you for being trans	6.8	(1.2, 12.4)	8.1	(1.9, 14.3)
Thought the gender listed on your ID or forms was a mistake	6.2	(2.3, 10.1)	3.8	(0.0, 9.0)
Refused to examine parts of your body because you are trans	4.5	(1.4, 7.7)	6.2	(0.2, 12.2)
At least one of the above	37.2	(27.2, 47.1)	38.1	(26.5, 49.6)

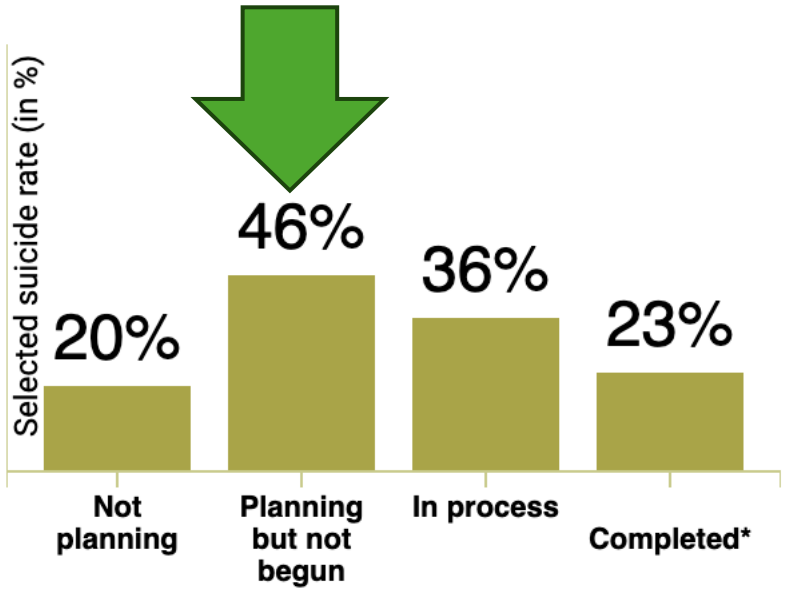
Bauer GR et al. 2015a

The Trans PULSE Canada Team. 2020. QuickStat #2 – Primary care and unmet health care needs

Why Should We Care?

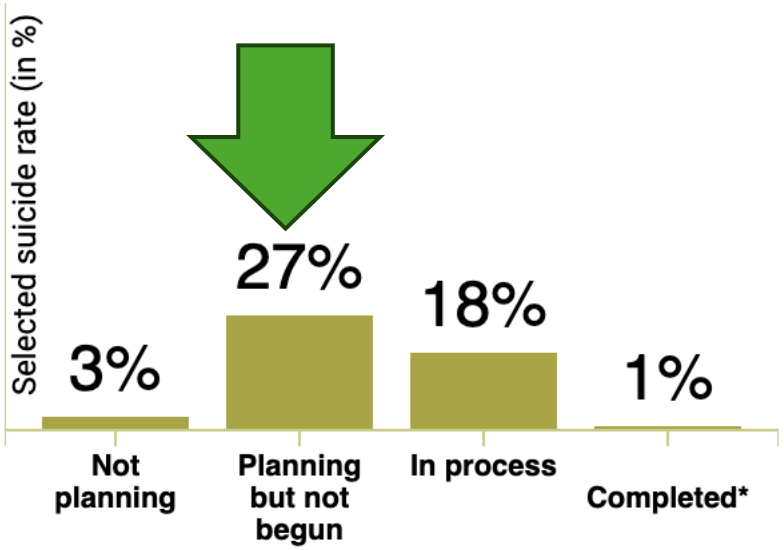
*Suicidal ideation and attempt rates of **trans** people at different stages of medical transition:*

SUICIDAL IDEATION (ACROSS LIFESPAN)



*Suicidal ideation and attempt rates of **trans** people at different stages of medical transition:*

SUICIDE ATTEMPT (PAST YEAR)



Bauer GR et al., 2015b

GAHT Improves Well-Being

www.whatweknow.info

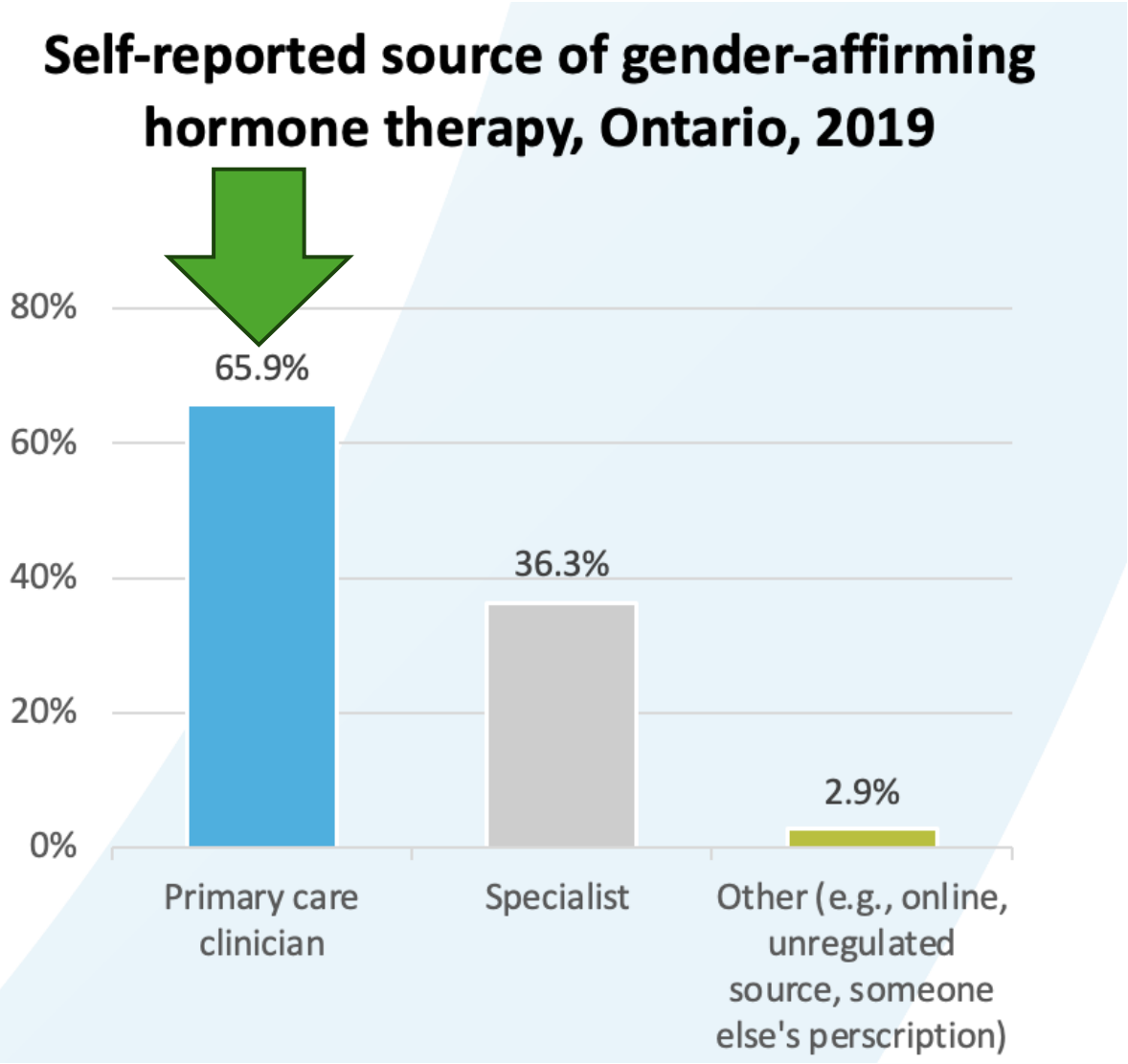
What does the scholarly research say about the effect of gender transition on transgender well-being?

Overview: We conducted a systematic literature review of all peer-reviewed articles published in English between 1991 and June 2017 that assess the effect of gender transition on transgender well-being. We identified 56 studies that consist of primary research on this topic, of which 52 (93%) found that gender transition improves the overall well-being of transgender people, while 4 (7%) report mixed or null findings. We found no studies concluding that gender transition causes overall harm. As an added resource, we separately include 17 additional studies that consist of literature reviews and practitioner guidelines.

Bottom Line: This search found a robust international consensus in the peer-reviewed literature that gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals. The literature also indicates that greater availability of medical and social support for gender transition contributes to better quality of life for those who identify as transgender.

Cornell University 2017

You Are Already at the Forefront of Care!



- 2019 Trans PULSE Canada survey found that **65.9% of respondents** on hormone therapy in Ontario were prescribed by ***primary care***
- There are *560* family medicine residency positions in Ontario
- There are *only 11* endocrinology positions each year in Ontario

Trans PULSE Canada 2019
Health Quality Ontario 2024

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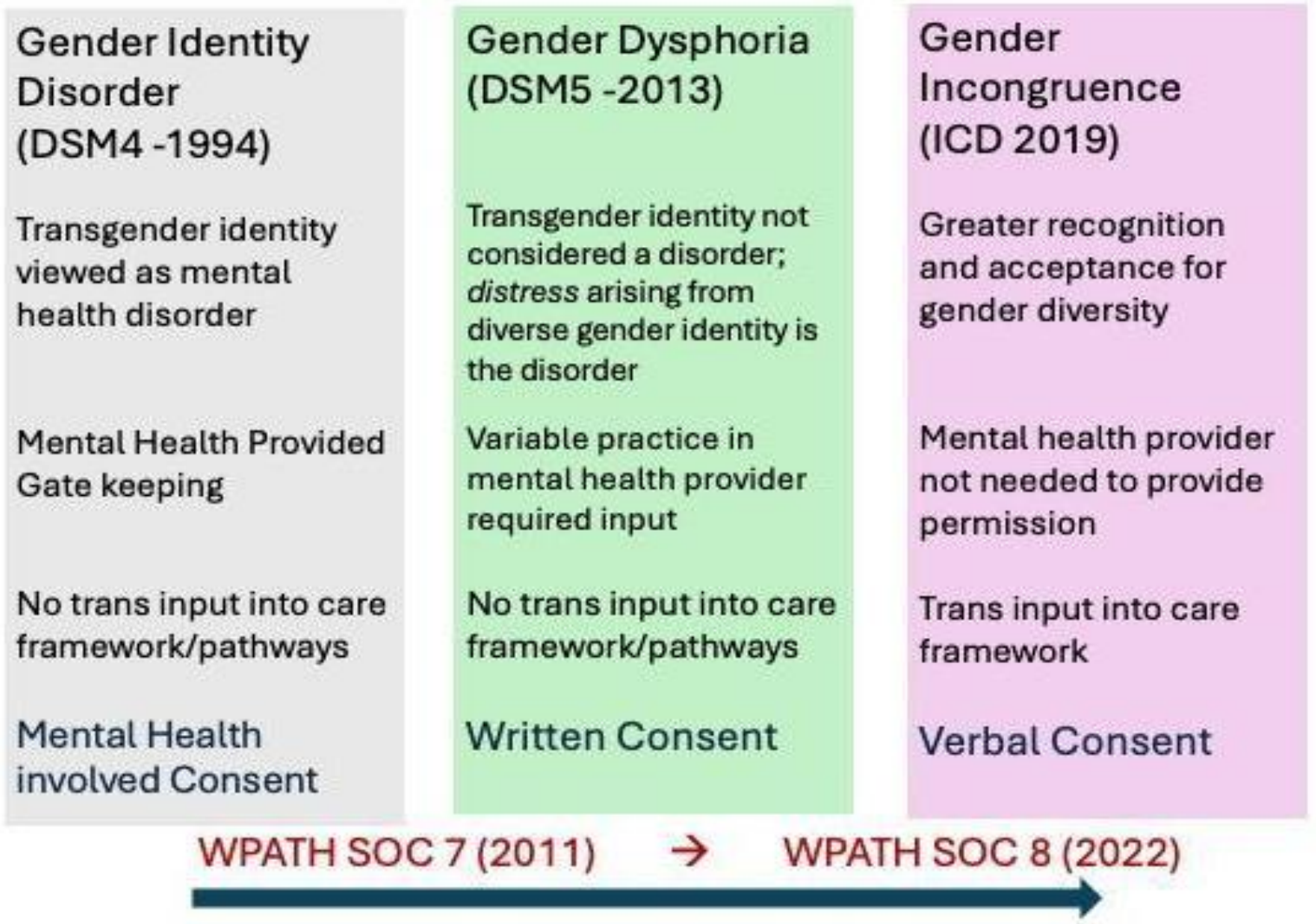
Diagnostic Terminology



Fung R. 2024. Correspondence

How to Diagnose Gender Dysphoria?

A. Marked incongruence between one's experienced/expressed gender and assigned gender, of at *least 6 months* duration, as manifested by at least TWO of the following:

A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)

A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender

A strong desire for the primary or secondary sex characteristics of the other gender

B. The condition is associated with clinically significant *distress* or *impairment* in social, occupational, or other important areas of functioning

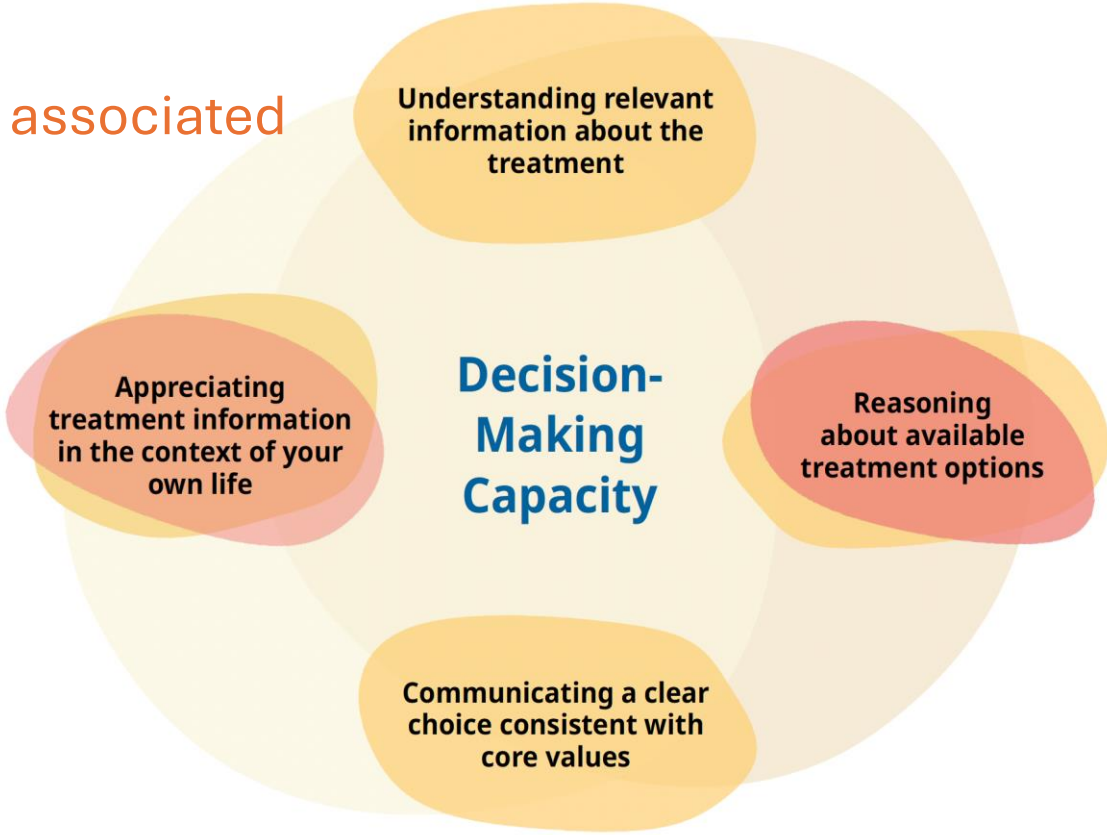
NB: There is added distress from simply living in a transphobic society.

American Psychiatric Association, DSM-5 Task Force. 2013. Diagnostic and statistical manual of mental disorders

Gender Health History & Informed Consent

Gender Identity

- In your own words, how would you describe your gender identity?
- When did you first recognize your assigned gender did not match your gender identity?
- What was puberty like? Are there parts of your body associated with gender you like/don't like?



TransCare BC Toolkit. 2023
Clark, DBA., & Virani, A. 2024

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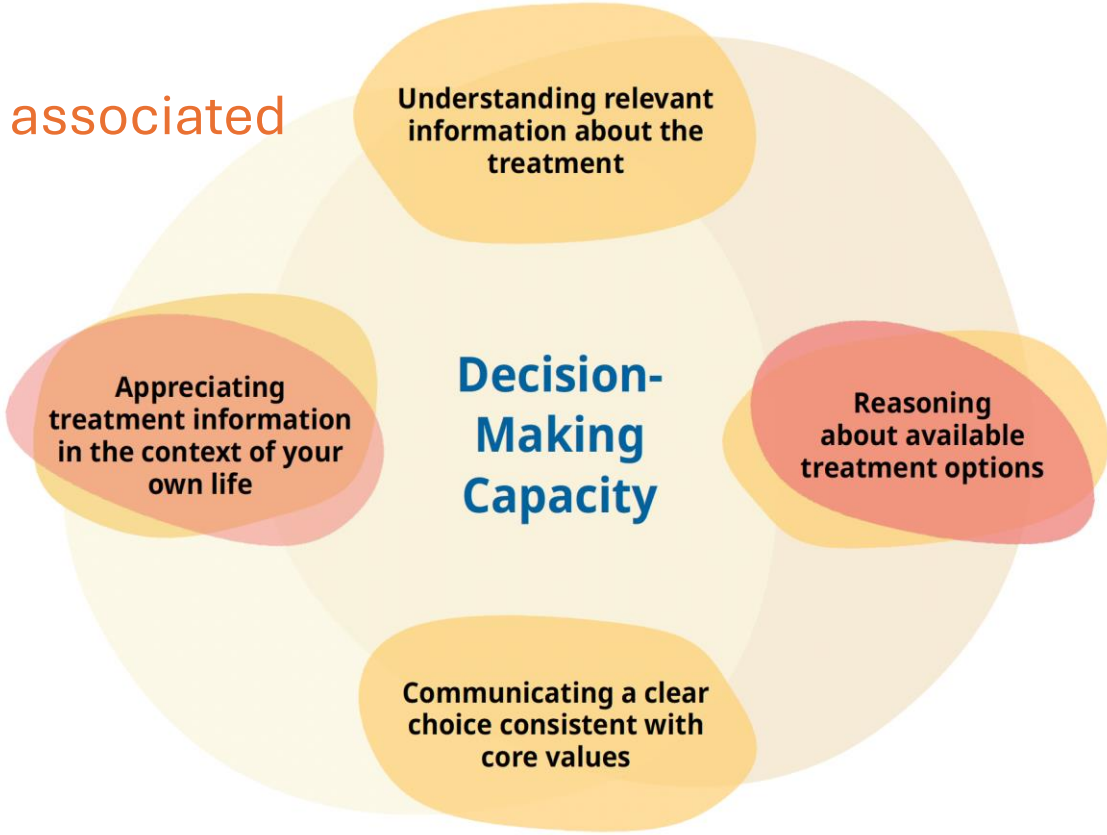
Gender Expression

- Have you started making changes to your outward appearance to more closely match who you are?



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Gender Expression

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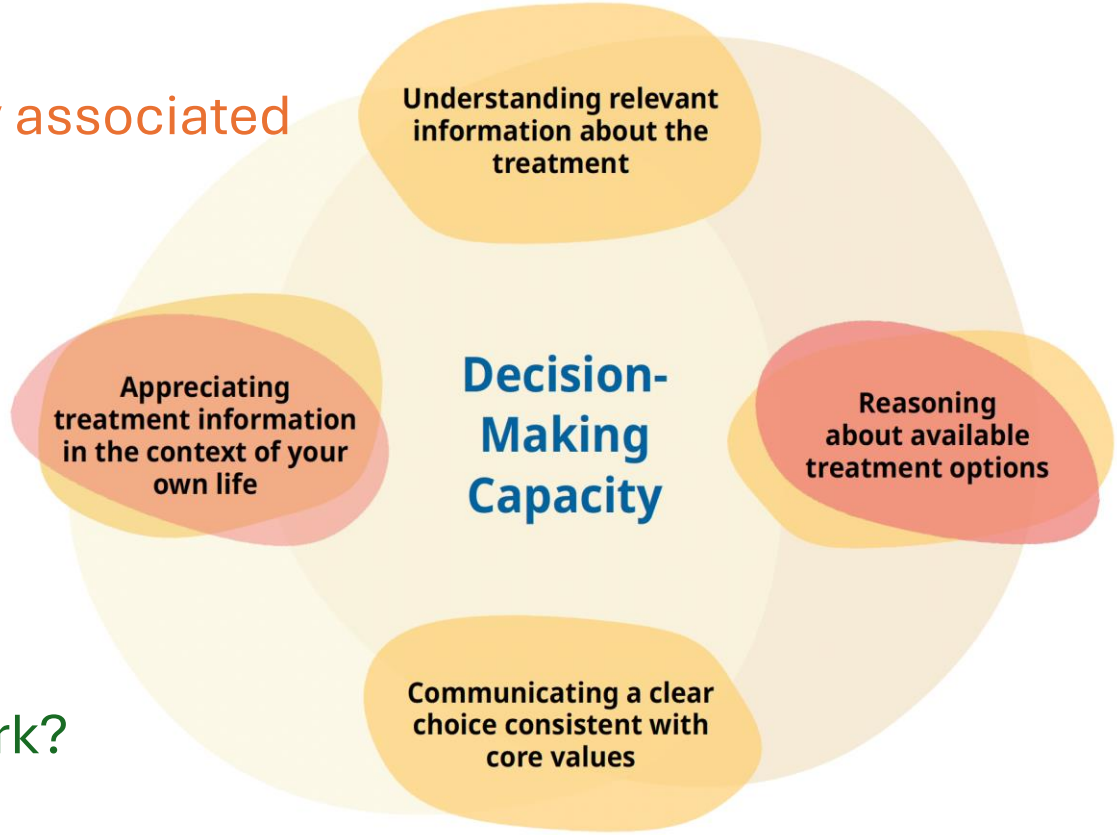
Perceptions of Others/Support

- How do you wish others would see you?
- How does your gender identity impact your life at work? Your relationships? Your family?
- Who are your supports?

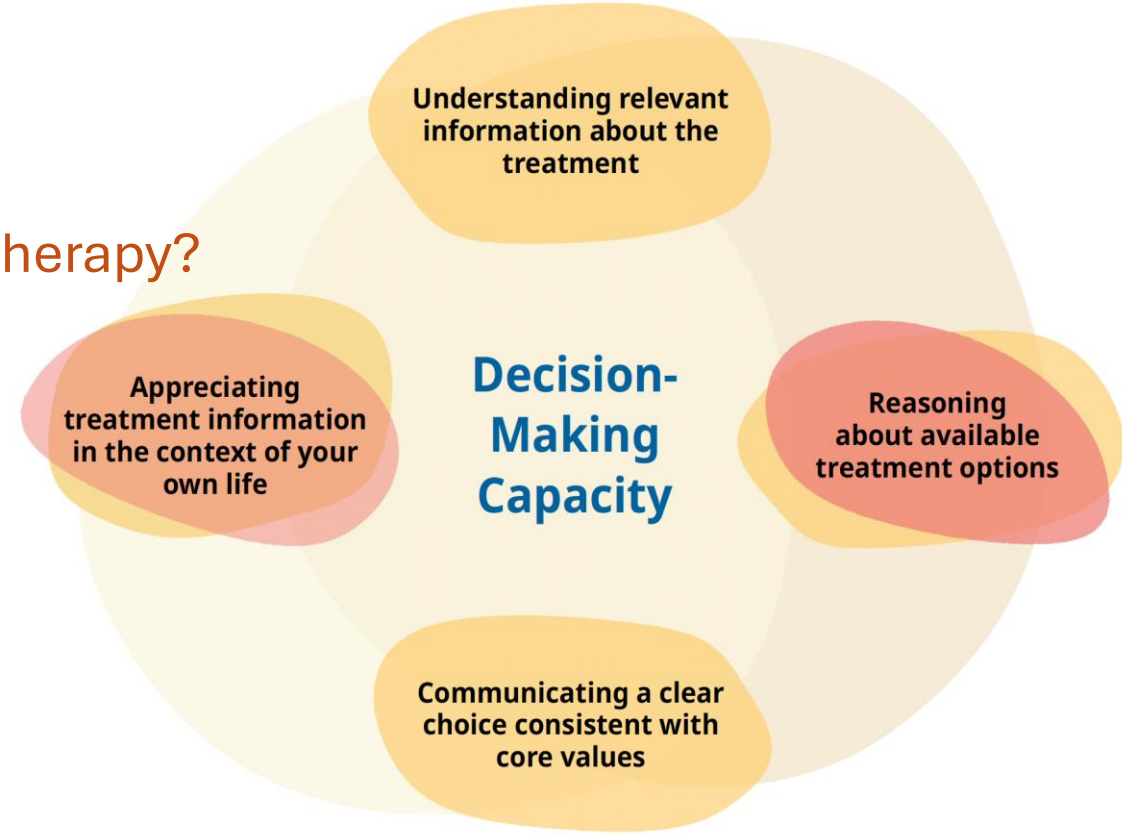


TransCare BC Toolkit. 2023
Clark, DBA., & Virani, A. 2024

Gender Health History & Informed Consent

Understanding Expectations

- Can you tell me about how hormone therapy will work for you?
- What changes you are looking forward to?
- Are there any changes that you aren't sure about?
- Have you considered any alternatives to hormone therapy?



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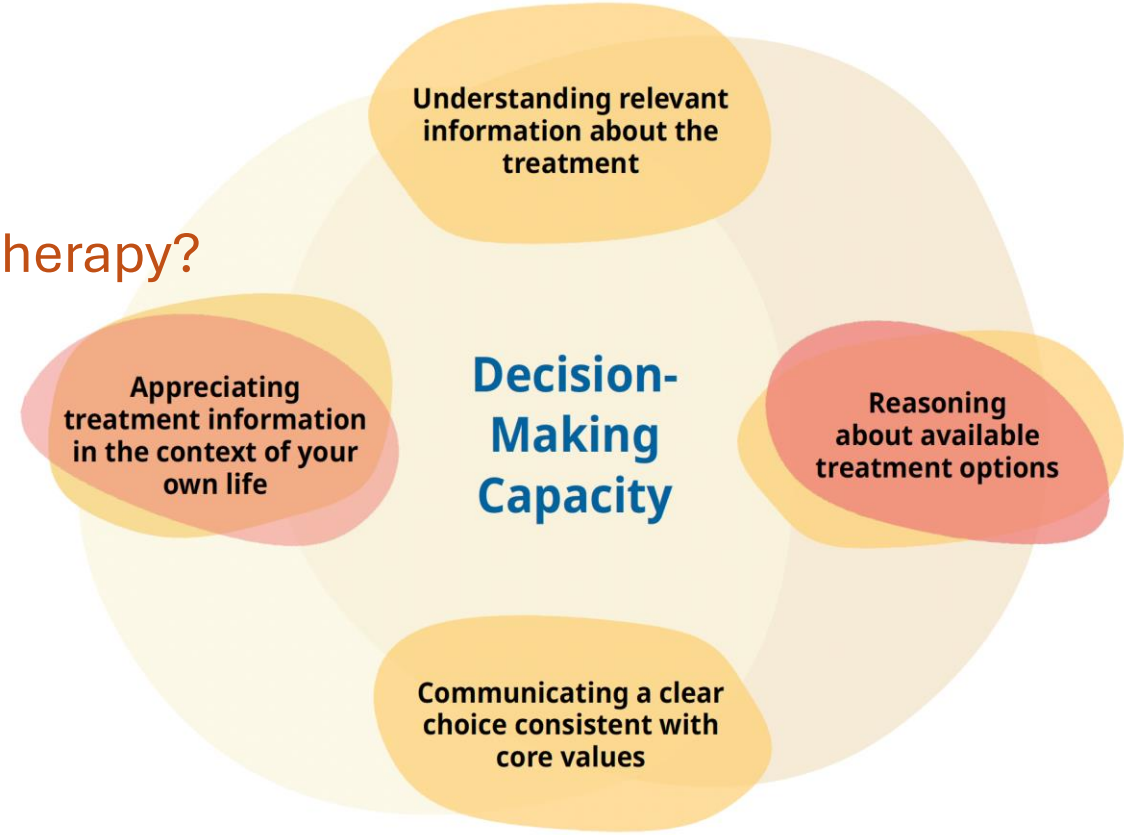


Best Practices

- *Fertility preservation referral?*
- Ask about partners/protection/contraception?
- Risk mitigation: Smoking cessation?

TransCare BC Toolkit. 2023
Clark, DBA., & Virani, A. 2024

Contraindications to Gender Affirming Hormone Therapy (GAHT)

Absolute Contraindications to Estrogen	Absolute Contraindications to Testosterone
• unstable ischemic cardiovascular disease • active, known sex hormone-sensitive cancer (e.g. breast, prostate) • end-stage chronic liver disease • psychiatric conditions that limit the ability to provide informed consent • hypersensitivity to one of the components of the formulation	• pregnancy or breastfeeding • active, known sex hormone-sensitive cancer (e.g. breast, endometrial) • unstable ischemic cardiovascular disease • poorly controlled psychosis or acute homicidally • psychiatric conditions that limit the ability to provide informed consent • hypersensitivity to one of the components of the formulation

Hembree et al., 2017

Feminizing Hormone Therapy: Estrogen +/- Anti-Androgen

Estrogen often serves as the foundation of feminizing hormone therapy (17β-estradiol)

Anti-Androgens may be used in conjunction with estrogen to reduce effects of testosterone

Spironolactone

- Peripheral Androgen receptor antagonist
- Mineralocorticoid antagonist: induces gynecomastia (intended effect)

Cyproterone Acetate

- Peripheral Androgen receptor antagonist + Central Androgen antagonist
- Progesterone activity: inhibits LH and therefore testosterone production

***Leuprolide**

- GnRH agonist, reduces GnRH pulsatility causing reversible central down-regulation of LH and FSH signalling

Sherbourne Health Guidelines 2023; TransCare BC Toolkit. 2023; WPATH SOC8 2022; Hembree et al., 2017; UCSF 2016

Estrogen +/- Anti-Androgen Formulations & Dosing

Gender Affirming Therapy	Starting dose	Usual Dose	Maximum dose
Estradiol (oral)	0.5mg to 2mg	4mg daily (or div BID)	6mg daily (or div BID)
Estradiol (transdermal patch)	50mcg patch, change 2x per week	100mcg to 200mcg change 2x per week	200 to 300mcg change 2x per week
Estradiol (transdermal gel)	2.5g daily of 0.06% estradiol gel	3.75g to 5g daily of 0.06% estradiol gel	6.75g daily of 0.06% estradiol gel
Estradiol valerate (injectable)	3mg once weekly	3 to 6mg weekly	10mg weekly
Spironolactone (oral)	50 to 100mg daily	200mg daily (or divided BID)	300mg daily (or divided BID)
Cyproterone (oral)	12.5mg q 2 days	12.5mg daily	25mg daily*

Note: Generic Oral Estradiol is covered by provincial drug coverage plans (Trillium, ODSP, OW, OHIP+)
EAP for 'transdermal' estradiol only applicable if proven that patient cannot swallow pills

Estrogen +/- Anti-Androgen Formulations & Dosing

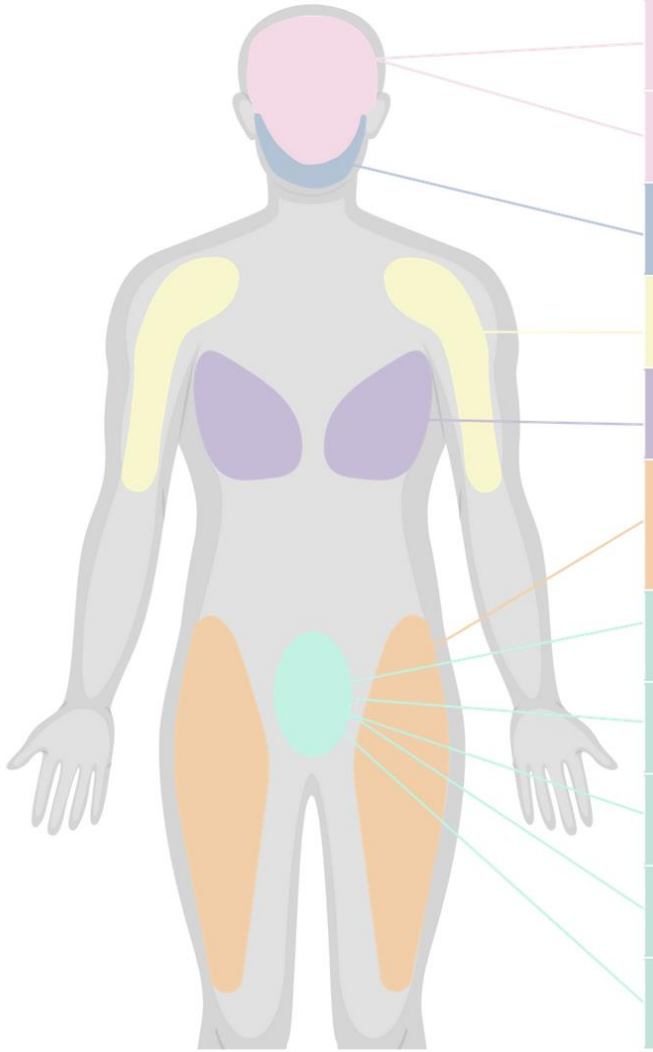
Gender Affirming Therapy	Starting dose	Usual Dose	Maximum dose
Estradiol (oral) **Do labs 4-6hrs post E2 po or SL**	0.5mg to 2mg	4mg daily (or div BID)	6mg daily (or div BID)
Estradiol (transdermal patch) **Do labs btwn patch change**	50mcg patch, change 2x per week	100mcg to 200mcg change 2x per week	200 to 300mcg change 2x per week
Estradiol (transdermal gel) **Do labs 4-6hrs post E2 application**	2.5g daily of 0.06% estradiol gel	3.75g to 5g daily of 0.06% estradiol gel	6.75g daily of 0.06% estradiol gel
Estradiol valerate (injectable) **Do labs on post injection day 3 or day 4 if q weekly** **Do labs on post injection day 7 or day 8 if q2 weekly**	3mg once weekly	3 to 6mg weekly	10mg weekly
Spironolactone (oral)	50 to 100mg daily	200mg daily (or divided BID)	300mg daily (or divided BID)
Cyproterone (oral)	12.5mg q 2 days	12.5mg daily	25mg daily*

***Target estradiol**
~200-735pmol/L
*****<735pmol/L***

***Target testosterone**
~<2nmol/L

Note: Generic Oral Estradiol is covered by provincial drug coverage plans (Trillium, ODSP, OW, OHIP+)
EAP for 'transdermal' estradiol only applicable if proven that patient cannot swallow pills

Timeline of Expected Effects – Feminizing GAHT



PHYSICAL EFFECTS	REVERSIBILITY	ONSET[a]	EXPECTED MAXIMAL EFFECT[a]
SOFTENING OF SKIN/ DECREASED OILINESS	Reversible	3-6 months	Unknown
SCALP HAIR LOSS (LOSS STOPS, NO REGROWTH)	Reversible	1-3 months	Variable
THINNED/SLOWED GROWTH OF BODY/FACIAL HAIR[c]	Reversible	6-12 months	>3 years
DECREASED MUSCLE MASS/STRENGTH[b]	Reversible	3-6 months	1-2 years
BREAST GROWTH	Irreversible	3-6 months	1-2 years
BODY FAT REDISTRIBUTION	Reversible/ Variable	3-6 months	2-3 years
DECREASED TESTICULAR VOLUME	Variable	3-6 months	2-3 years
DECREASED LIBIDO	Variable	1-3 months	3-6 months
DECREASED SPONTANEOUS ERECTIONS	Variable	1-3 months	3-6 months
DECREASED SPERM PRODUCTION	Variable	Variable	Variable
REDUCED ERECTILE FUNCTION	Variable	Variable	Variable

Sherbourne Health Guidelines 2023

Estrogen & Anti-Androgen Side Effects

	Estrogen	Spironolactone	Cyproterone
Possible side effects	VTE Cholelithiasis Hyper Tg Wt Gain Incr risk of Br Ca	High K, Cr (caution with ACEi/ARB) Polyuria/Dehydration	Liver toxicity, Depression/mood impacts, VTE Black box warning on meningioma risk with >10mg/d doses
Effects on testosterone levels	Decrease in testosterone levels	Mild/moderate decrease in testosterone levels	Effective testosterone suppression
Strength/potency	Moderate/strong anti-androgen	Weaker anti-androgen Peripheral androgen blocker	Stronger anti-androgen Peripheral and central androgen blocker
Effects on HDL cholesterol	Variable impact on HDL	HDL increases	HDL decreases
Effects on prolactin	May increase prolactin levels	Little to no increase in prolactin levels	Significant increase in prolactin levels is common

Sherbourne Health Guidelines 2023; TransCare BC Toolkit. 2023; WPATH SOC8 2022; Hembree et al., 2017; UCSF 2016

Lab Monitoring for Feminizing GAHT

	BASELINE	MONTH 3	MONTH 6	MONTH 12[e]	YEARLY	ACCORDING TO GUIDELINES FOR CIS PATIENTS, OR PROVIDER DISCRETION
EXAM/ INVESTIGATIONS	Focused Physical Exam. Include: height, weight, BP, +/- breast inspection/ measurement(s)*	BP, weight, +/- breast inspection/ measurement(s) at 12 months*			See Preventive care checklist for transfeminine patients and accompanying explanations in the full Guidelines.	
BLOODWORK						
CBC[a]	✓	✓	✓	✓	✓	
ALT[b]	✓	✓	✓	✓	✓	✓
CREATININE/ LYTESC	✓	✓	✓	✓	✓	
HbA1c OR FASTING GLUCOSE	✓			✓		✓
LIPID PROFILE	✓			✓		✓
TOTAL TESTOSTERONE	✓	✓	✓	✓	✓	
ESTRADIOL	✓	✓	✓	✓	✓	
PROLACTIN[d]	✓			✓	✓	✓

Sherbourne Health Guidelines 2023

Masculinizing Hormone Therapy: Testosterone

Testosterone serves as the foundation of masculinizing hormone therapy

Testosterone enanthate (IM/SC)

- ‘double concentrated’ 200mg/mL (less volume required for same dose)
- formulated in sesame seed oil

Testosterone cypionate (IM/SC)

- ‘single concentrated’ 100mg/mL
- formulated in cotton seed oil

Testosterone 1% gel (daily topical application)

Can apply for exceptional access program (EAP) for funding through provincial drug coverage plans (Trillium, ODSP, OW, OHIP+)

Sherbourne Health Guidelines 2023; TransCare BC Toolkit. 2023; WPATH SOC8 2022; Hembree et al., 2017; UCSF 2016

Testosterone Formulations & Dosing

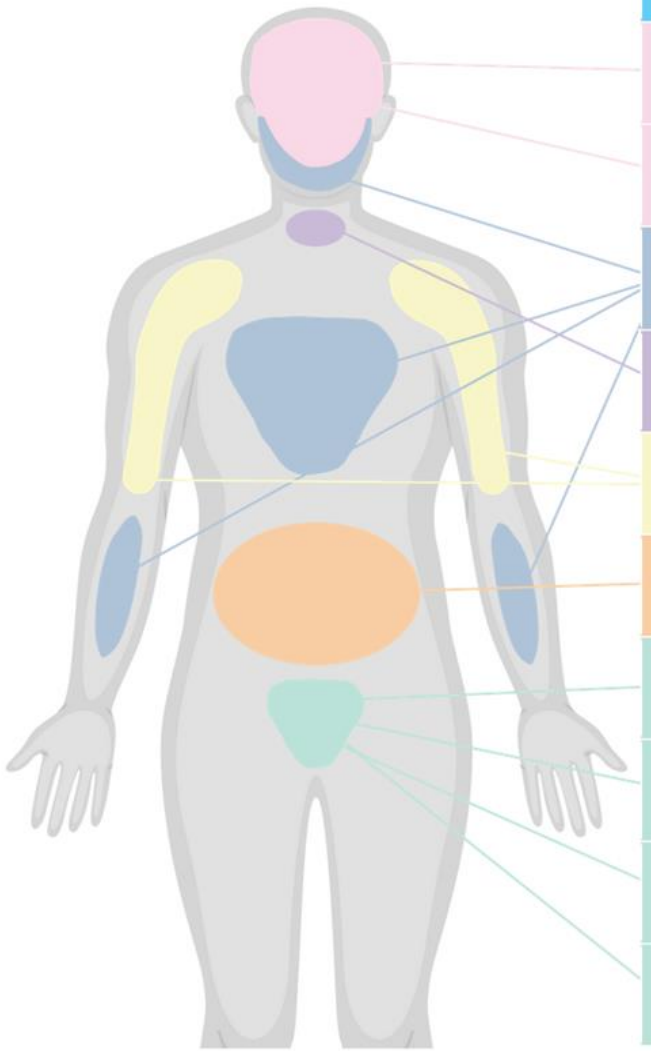
Gender Affirming Therapy	Starting dose	Usual Dose	Maximum dose
Testosterone enanthate (injectable) **or** **Testosterone cypionate (injectable)**	20mg to 40mg weekly	40mg to 80mg weekly	100mg weekly
Testosterone gel 1% (transdermal gel)	2.5g daily	5g to 10g daily	10g daily

Testosterone Formulations & Dosing

Gender Affirming Therapy	Starting dose	Usual Dose	Maximum dose
Testosterone enanthate (injectable) **or** **Testosterone cypionate (injectable)**	20mg to 40mg weekly **Do labs on post injection day 3 or day 4 if q weekly** **Do labs on post injection day 7 or day 8 if q2 weekly**	40mg to 80mg weekly	100mg weekly
Testosterone gel 1% (transdermal gel)	2.5g daily **Do labs ~ 4-6 hours post gel application**	5g to 10g daily	10g daily

***Target testosterone**
~8.5-30nmol/L

Timeline of Expected Effects – Masculinizing GAHT



PHYSICAL EFFECTS	REVERSIBILITY	ONSET[a]	EXPECTED MAXIMAL EFFECT[a]
SCALP HAIR LOSS	Irreversible	6–12 months[c]	Variable
SKIN OILINESS/ACNE	Reversible	1–6 months	1–2 years
FACIAL/BODY HAIR GROWTH	Irreversible	3–6 months	4–5 years
DEEPENED VOICE	Irreversible	6–12 months	1–2 years
INCREASED MUSCLE MASS/ STRENGTH[b]	Reversible	6–12 months	2–5 years
BODY FAT REDISTRIBUTION	Reversible/Variable	1–6 months	2–5 years
CESSATION OF MENSES	Reversible	1–6 months	n/a
CLITORAL ENLARGEMENT	Irreversible	3–6 months	1–2 years
VAGINAL ATROPHY	Reversible	1–6 months	1–2 years
INFERTILITY	Variable	Variable	Variable

Sherbourne Health Guidelines 2023

Testosterone Side Effects

	Testosterone
Possible side effects	Polycythemia (Hb/Hct) Acne Androgenic alopecia (*hereditary*) Hypertension Sleep apnea Weight gain
Effects on estradiol levels	Decrease in estradiol levels **re-assess T-dosing if estradiol is elevated**
Strength/potency	Strong anti-estrogen
Effects on HDL cholesterol	HDL decreases; LDL increases
Effects on prolactin	No impact on prolactin levels

Sherbourne Health Guidelines 2023; TransCare BC Toolkit. 2023; WPATH SOC8 2022; Hembree et al., 2017; UCSF 2016

Lab Monitoring for Masculinizing GAHT

	BASELINE	MONTH 3	MONTH 6	MONTH 12[b,c]	YEARLY	ACCORDING TO GUIDELINES FOR CIS PATIENTS, OR PROVIDER DISCRETION
EXAM/ INVESTIGATIONS	Focused Physical Exam with PAP if indicated. Include: height, weight, BP.	BP, weight			See Preventive Care Checklist for Transmasculine Patients and accompanying explanations in the Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients.	
BLOODWORK						
CBC	✓	✓	✓	✓	✓	
ALT	✓		✓[c]			✓
HbA1c OR FASTING GLUCOSE	✓		✓[c]			✓
LIPID PROFILE	✓		✓[c]			✓
TOTAL TESTOSTERONE	✓	✓	✓	✓	✓	
LH[a]	✓			✓	✓	

Sherbourne Health Guidelines 2023

Key Summary: Endocrine Society 2017 Guidelines

3.1. We recommend that clinicians ***confirm the diagnostic criteria of GD/gender incongruence*** and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⨁⨁⨁◯)

3.3. We suggest that clinicians ***measure hormone levels during treatment*** to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⨁⨁◯◯)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the ***onset and time course*** of physical changes induced by sex hormone treatment. (2 |⨁◯◯◯)

4.1. We suggest ***regular clinical evaluation*** for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels ***every 3 months during the first year of hormone therapy*** for transgender males and females and then once or twice yearly. (2 |⨁⨁◯◯)

Hembree et al., 2017

Outline

1. Conceptualizing gender identity, gender expression, and sex
2. Understanding ‘transitioning’
3. The ‘What, Who, How, and Why of gender affirming care
4. How to provide (adult) gender affirming hormone therapy
5. **The one-liner on gender affirming surgeries & regret**

What Gender Affirming Surgeries are Available?

OHIP-Funded Procedures

- Mastectomy*
- Augmentation Mammoplasty**
- Phalloplasty
- Erectile and/or testicular implant
- Vaginectomy
- Orchidectomy
- Clitoroplasty
- Scrotoplasty
- Metoidioplasty
- Labiaplasty
- Salpingo-oophrectomy
- Hysterectomy
- Vaginoplasty

* *Mastectomy includes removal of breast tissue and reconstruction, which involves removal of excess skin, reduction and proper positioning of nipple and areola, and minimization of chest wall scars.*

** *Augmentation mammoplasty is insured when no breast enlargement has occurred, following 12 continuous months of hormone therapy (unless hormones are not appropriate for the person).*

Upper Surgery (Specifically chest)

Needs 1 supporting assessment, that has to be from a **qualified** Physician or Nurse Practitioner

Lower Surgery (Genital Surgery)

Needs 2 supporting assessments:

- 1 assessment from a **qualified** Physician or Nurse Practitioner

AND

- A 2nd assessment from a **qualified** Physician, Nurse Practitioner, Psychologist or Registered Social Worker with a Masters Degree

CAMH Transition Related Surgeries FAQ 2024
Gwun et al., 2024

What Gender Affirming Surgeries are Available?

Surgery	1st Letter (MD/NP)	2nd Letter (NP/ MD/ RN/MSW/ Psychologist)	Hormones	Medical and Mental Health Coniditons	Gender Role Experience
Mastectomy	x		Not a pre-requisite	“controlled”	
Augmentation Mammoplasty	x		12 continuous months with no breast development	“controlled”	
Gonad: Hysterotomy or Orchiectomy	x	x	12 continuous months	“well controlled”	
Vaginoplasty	x	x	12 continuous months	“well controlled”	12 continuous months of living in a gender role congruent with gender identity
Phalloplasty/ Medtoidioplasty	x	x	12 continuous months	“well controlled”	12 continuous months of living in a gender role congruent with gender identity

What About Regret?

RECONSTRUCTIVE: ORIGINAL ARTICLE

Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence

Bustos, Valeria P. MD*; Bustos, Samyd S. MD†; Mascaro, Andres MD‡; Del Corral, Gabriel MD, FACS§; Forte, Antonio J. MD, PhD, MS¶; Ciudad, Pedro MD, PhD‖; Kim, Esther A. MD**; Langstein, Howard N. MD††; Manrique, Oscar J. MD, FACS††

Author Information

Plastic and Reconstructive Surgery - Global Open 9(3):p e3477, March 2021. | *DOI:* 10.1097/GOX.0000000000003477

Systematic review and meta-analysis assessing 27 studies

Of the **7,928** individuals included in the analysis, **1.0 %** expressed regret.

The most common reason for post-operative regret was:
"difficulty/dissatisfaction in life with the new gender role."

Bustos et al. 2021

What About Regret?

ELSEVIER

The American Journal of Surgery

Volume 234, August 2024, Pages 68-73

Review Article

A systematic review of patient regret after surgery- A common phenomenon in many specialties but rare within gender-affirmation surgery

Sarah M. Thornton, Armin Edalatpour, Katherine M. Gast

Percentage of patients reporting regret ranged from:

0 to 47.1 % in breast reconstruction

5.1–9.1 % in breast augmentation

10.82–33.3 % in body contouring

In other surgical subspecialties:

30 % following prostatectomy

19.5 % following bariatric surgery

Percentage of people with regret from other life choices:

16.2 % getting a tattoo

7 % having children

Percentage of patients reporting regret from:

~1 % Gender Affirming Surgery

Thornton et al. 2024

Outline

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2. Understanding ‘transitioning’
3. The ‘What, Who, How, and Why of gender affirming care
4. How to provide (adult) gender affirming hormone therapy
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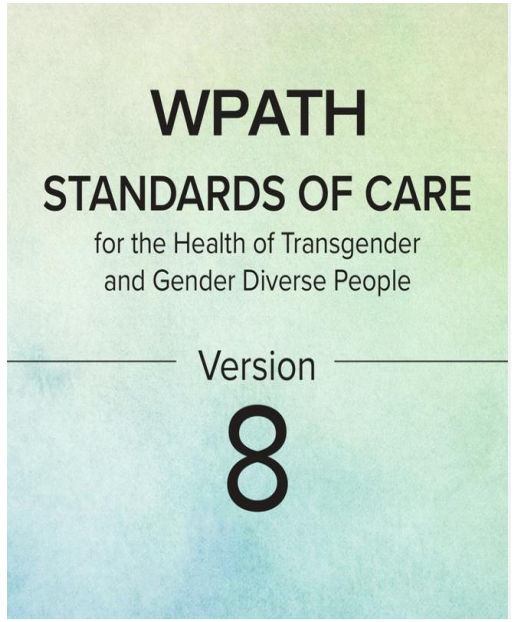
Take Home Points

- Gender Identity ≠ Sex (assigned at birth)
- Gender Affirming care is well supported by guidelines and clinical practice!
- Feminizing Hormone Therapy = Estrogen +/- Anti-Androgen therapy
- Masculinizing Hormone Therapy = Testosterone therapy
- Desired changes will take 1-6 months to initially take effect
- Baseline labs then follow up at 3, 6, and 12 months then 1-2x annually
    - Do labs at the ‘mid-point’
- Gender Affirming Surgeries exist in Ontario – many are MoH covered!

Where to Get Additional Training?

- **Project ECHO:** Trans & Gender Diverse Healthcare
  - https://camh.echoontario.ca/programs-tgdh/
- **Rainbow Health Ontario e-learning:**
  - https://learn.rainbowhealthontario.ca/learn
  - *'Mentorship Call'* (1st and 3rd Wednesday/month)
- **National LGBTQIA+ Health Education Center (USA):**
  - https://www.lgbtqiahealtheducation.org/resources/in/transgender-health/type/webinar/

Thank You for Your Time & Attention!

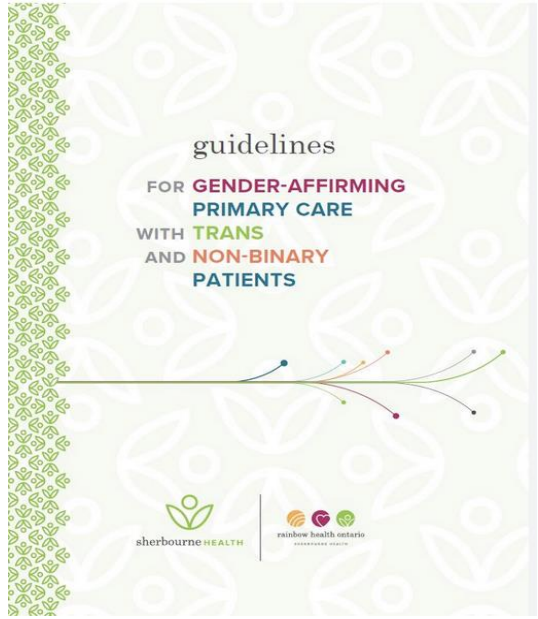


WPATH SOC 8

ENDOCRINE SOCIETY

Endocrine Society Guidelines

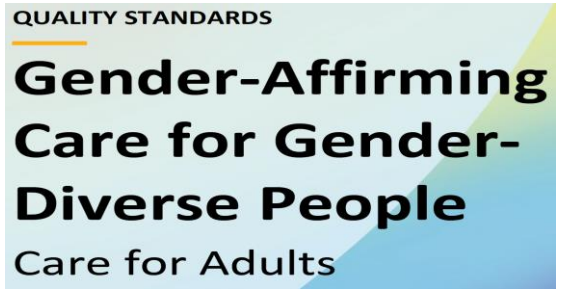
www.TransHealthTO.com



Sherbourne Health Guidelines

UCSF Guidelines

Trans Care BC



Health Quality Ontario

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Rainbow Health Ontario (RHO)

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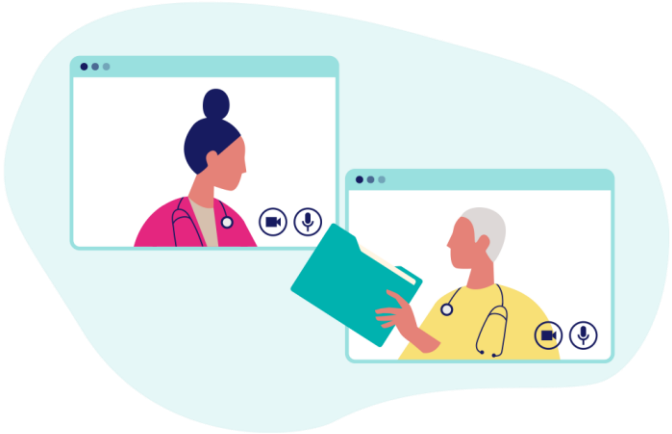

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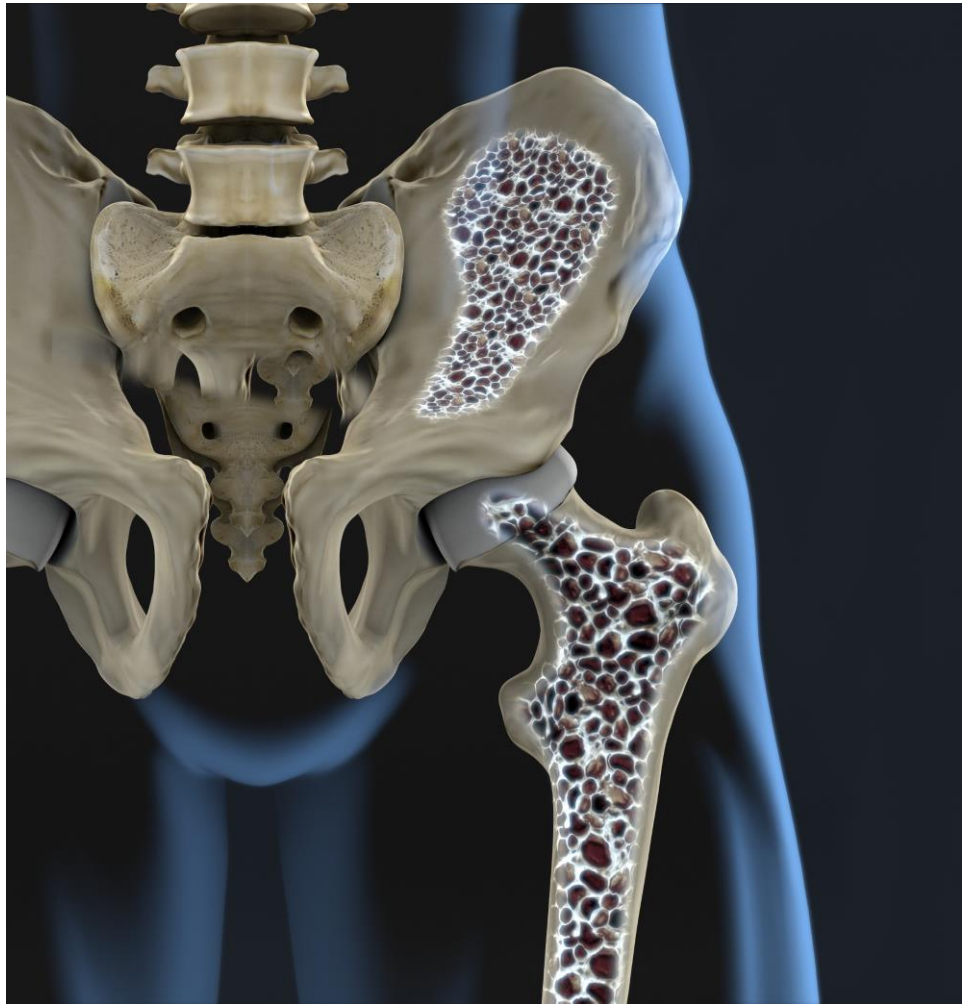

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