

Trans Youth Equality Foundation

Youth: Special Considerations

See children under 18 with their parents or guardians for treatment, not for assessment. With pre-pubertal children, the primary focus is on providing parental support and education so that a safe environment is developed for the child, and the parents and child know what the treatment options are once puberty begins.

The first visit usually involves getting a complete medical history, reviewing treatment options with the patient or the family, answering all questions and doing some baseline laboratory work. Physical exam is deferred to a second or later visit as per the patient's wishes, but is required prior to the prescribing of any medication. Social transition, in and of itself (without physical intervention), is possible, and may alleviate dysphoria, at least until puberty.

Youth under 18 are strongly advised to see a mental health professional experienced in transgender issues prior to cross-sex hormone treatment to ensure readiness to transition. Before initiating hormonal therapy with youth over 18, the primary care provider should encourage them to consult a qualified mental health professional to assist them in exploring the ramifications of gender transition, potential complications, etc.

Lack of access to mental health care should not preclude or restrict access to care when indications are favorable that transition will be well-tolerated and socially supported.

If a youth has not completed development (i.e., Tanner V), strong consideration should be given to consulting (provider-to-provider) with an expert in transgender medicine.

FAQ: frequently asked questions regarding youth, with answers from physicians at Children's Hospital Los Angeles

Is this just a phase?

This is probably the number one thing that parents and, frankly, providers will ask about. If we are to move forward with medical intervention, we want to be sure this isn't just a phase. Here's what the limited research shows: most gender variant natal boys will go on to be gay adolescents and adults, and unpublished data reveals 50% of gender variant natal girls will go on to become transgender adolescent and adult men. This data does not particularly distinguish those children who have a persistent and consistent transgender identity. What that means is that we currently have no predictors whatsoever in the research world to understand or inform the trajectory of each gender variant child. However, what the research also shows is that adolescents who present with gender variance, or a transgender identity go on to be transgender older adolescents and adults 100% of the time. Again, the data is small, but supports the notion that gender constancy is certainly in place in adolescence. The data about children (the only data available right now) is one of the main reasons that we advocate the use of GnRH analogues. Their use operates from the assumption that we are allowing those kids in the "grey zone" of early puberty to establish gender constancy.

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However, one of the flaws in this thinking is this: if we assume that gender constancy is set in place in adolescence, and not earlier, how do we know then that the presence of pubertal hormones is not playing a role in that process? Therefore, are we not blocking that process from moving forward by providing hormone blockers?

Personally, I don't believe that gender constancy is established in adolescence, I think one is born with their gender, and that it is the confusing messages from the society around an individual with a discordant body/identity that causes the question of gender constancy to arise. Anyway, the answer to how do I know this isn't just a phase is that we don't 100% know, but it is pretty clear both from the limited data and the anecdotal experience of those who work with trans youth that adolescents don't "remit" with regard to their gender identity. Where we choose to draw the age line with regard to adolescence is also interesting, and is precisely why I call this time frame the Grey Zone. It is this question that drives us to recommending the use of GnRH analogues in early puberty so that we (providers and parents) can feel more comfortable with the trans identity being permanent, and not just a phase. GnRH analogues are completely reversible, and therefore do not lead to any permanent physiologic effects.

How will treatment impact future fertility?

Ideal treatment for transgender youth is to get them onto cross sex hormones prior to the development of unwanted secondary sexual characteristics. Regardless of whether blockers are used or not, the use of prolonged cross sex hormones will make biological children very unlikely for transgender youth in the future. I say very unlikely, not impossible, because there are lots of trans folks who have stopped cross sex hormones and proceeded with the procreation process, but again, I am not familiar with each circumstance. If we treat correctly however, we would aim to feminize trans females early, and prior to the development of viable sperm. In trans males, the prolonged use of testosterone will likely render these men infertile over time. There is no data examining the length of time on cross sex hormones that solidifies infertility either for transmen or transwomen. With regard to hormone blockers, should an individual come off blockers and proceed with biologic puberty, they would still be as fertile as they would have been without blockers. There are no studies that show infertility as a side effect to GnRH analogues when used in children with central precocious puberty, which is the population most similar to our trans kids on blockers.

Under what circumstances would GnRH treatment be appropriate?

Pubertal suppression would be appropriate (with parental/guardian informed consent) for those patients who have had a persistent and consistent cross sex identity from childhood who are entering puberty and have reached Tanner Stage 2. Occasionally, there may be patients who desire halting their pubertal trajectory who

are further along in their development. For these patients, GnRH analogues may be useful, but it is important to note that side effects are more common when a person already has circulating adult levels of sex hormones .

How is GnRH prescribed?

GnRH is prescribed similarly to those pediatric patients with central precocious puberty (CPP). It is either delivered via monthly injection, or via an implant that can remain in for

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12 months, or sometimes longer. Pubertal suppression is generally achieved with 7.5 mg of leuprolide acetate monthly.

Under what circumstances is bone age testing useful?

Patients who are on hormone blockers for central precocious puberty are often on medication for several years, and while bone mineral density has been shown to be diminished while patients are on GnRH analogues, peak bone masses are not diminished compared to controls after treatment is complete, and normal puberty is resumed. There are no large studies on the effect of hormone blockers on bone mineral density in the transgender youth population who are generally started at later ages and treated for shorter time periods. Extrapolating from the CPP experience, it is likely that peak bone mineral density would not be affected in transgender youth on GnRH analogues, but research is needed to confirm this assumption. Patients with conditions that predispose them to poor bone density, i.e., osteogenesis imperfecta, anorexia, neuromuscular disease, Vitamin D deficiency, and prolonged immobilization, etc., may not be good candidates for pubertal suppression with GnRH analogues. Endocrine Society Guidelines recommend annual bone density but if cost is an issue, GnRH analogues could be used without this test.

Is it possible to override insurance exclusions?

If insurance policies specifically exclude care for GID, transgender services or other equally specific diagnoses, it is difficult to get those plans to cover GnRH analogues. However, it is always worth attempting to advocate for these medications based on the "medical necessity" model. Providers can supply insurance companies with copies of the clinical practice guidelines *Endocrine Treatment of Transsexual Persons* from the

Endocrine Society, or other scientific publications that corroborate the necessity for early treatment in transgender adolescents. More often insurance companies will require providers to obtain prior authorization for specialized medications like injectibles or implants, in which case they usually will cover them after being provided with the appropriate paperwork and supporting documentation.

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