GENDER CLINIC QUICK ORIENTATION

Gender Clinic is held at the Sunnyvale site in the **BLUE workroom on Wednesday mornings** (same place as Eating Disorder and Teen Clinic), and in the **GREEN workroom (Endo/Diab) on Friday mornings**. The first patient is scheduled for **8am**.

Gender Clinic is a multidisciplinary clinic, with members from Adolescent Medicine, Pediatric Endocrinology, Psychology, Social Worker, and occasionally Urology. Your attending for this clinic will be Dr. Avila from Adolescent Medicine.

If you're not familiar with gender terminology (ex: gender identity, gender dysphoria, sex assigned at birth, etc), please see the Resources page at the Adolescent Medicine website.

When discussing patient, remember to use patient's preferred name (not birth name) and the pronouns patient goes by. If adherence to pronouns is difficult, use patient's preferred name instead or phrases like "your child" (to parents).

You are NOT expected to counsel patients/family on gender dysphoria, gender development, gender-affirming hormonal therapy, etc. Our goal is that you become familiar with these topics as you rotate through our clinic, but it is not your responsibility to discuss them with family/patient. When families ask you a question you don't know the answer to, you can reply along the lines of, "that's a great question for us to discuss all together at the end (or with Dr. Avila)," or something along these lines.

For **new patients**, you'll be expected to review or take a ***brief*** Gender History (see below), Menstrual History (if uterus is present), major estrogen contraindications (on all patients -- migraine with aura/HTN/thrombosis/hx clotting in family), review Past Medical / Surgical / Family History (including mid-parental height) / Medications / Allergies, and do a HEADSS assessment (the HEADSS will probably be done AFTER staffing patient – ask Dr. Avila what would be the best flow). There is a template in Epic you can use for reference. Please note the "sexuality" part is a bit expanded for gender (see HEADSS below).

For **established/follow up** patients on hormonal therapy, you'll be expected to review hormone dose and frequency (if injections, any problems with administration; what sites are used for injection; any skin changes), review adherence, and any side effects. If patient has a uterus, ask about any hormones for menstrual suppression, breakthrough bleeding on hormonal methods, and LMP.

Brief Gender History

Ideally every patient already had a detailed gender history done by the social worker (Amy Valentine). Check Epic for the social worker intake. If already done, you'll **briefly review** it with patient/family. If not done, then you're expected to do a brief intake:

- how would you describe your gender identity?
- when did you realize your gender identity didn't match your sex assigned at birth?

- whom did you tell first? when did you tell your parents? what do they think?
- how about school? does the school now? What bathrooms do you use in school? How do you feel about it?
- what are your thoughts about hormones or surgeries? Why? (What do you expect hormones will do for you? What do your parents think about hormones?)
- what does yourself 10 years from look like in the mirror?
- have you ever seen counselor / therapist / psychologist or any provider in the mental health field? Have you ever discussed your gender identity with that person?

HEADSS:

The gender-focused HEADSS is as following:
"HE(A)" can be done with parents present:
H: where do you live? Who lives at home with you? (If different households, how much time is the teen spending in each household. Do parents share physical AND legal custody?) (If siblings, get age of siblings). [No need to ask about pets]
E: what grade are you? What school? [If senior: what are your plans after HS?]
(skip Activities – unless you have time and would like to use it to build rapport)
In private:

- explain this is confidential (and what that mean)

D: as usual. If using any substance, make sure to include the form (ex: vape, bong) and frequency of usage.
S: as usual (attraction? in a current relationship? ever had oral/vaginal/anal sex? → if so, which, and have you ever been tested for STDs?)
S: as usual (mood/suicide ideation/suicide attempt/self-harm). For self-harm, also ask about intentional injuries to body parts (chest, genitals)
Add safety: do you feel safe at home? at school? Any bullying at school?

The HEADSS for gender also includes gender-affirming behaviors/products:
- **for assigned F** → do you chest bind? (if no: is that something you'd like to talk about today?) If yes: What have you used to bind? How many binders do you have at home? Do you bind at night? Any issues with binding? Do you parents know you bind?
- **for assigned M** → do you tuck? (if yes: do you use something to tuck with? Do you tuck at night when you go to bed? Any swelling, redness, or other changes to your genitals because of tucking?)

Gender-affirming medical interventions brief outline (for your reference only; you're not expected to know the details of these regimens)
- **puberty blockers**: GnRH analogues/agonists. Ex: leuprolide IM q3mo (Depo-Lupron) or histrelin implant (subQ x2yrs; Supprelin, Vantas). Blockers are started at Tanner/SMR 2, ideally no later than Tanner/SMR 3. Beyond Tanner/SMR 3, blockers *can* be used, but for very specific indications (ex: to block endogenous testosterone production completely during feminization therapy) and on a case-by-case basis. Side effects (if used alone): low bone density, mood changes ("menopause").

- **masculinizing regimen**: testosterone subq/IM (other formulation exists, like daily gel or daily patch, but not used until goal dose). Testosterone is titrated up gradually, usually over 1-2 years, until goal dose. Every patient is different, but typically, "T" is started at 25mg q14days (i.e. 50mg for the month, but divided into 2 doses), and typically increased by 25mg-50mg/mo q3mo until reaching "adult"/goal dose of 50mg q7days (i.e. 200mg for the month divided into 4 weekly doses). Goal/"adult" "T" plasma level are 350-1100. Side effects to ask about: acne

    In early stages of regimen, menstrual suppression is often sought as well!

    - for **menstrual suppression**, please see Table 2 of this article by Dr. Hillard: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4075955**

- **feminizing regimen**: estrogen (Estrace, from yam extract) PO QD **+** a testosterone "blocker" (usually spironolactone QD-BID; sometimes we use GnRHa). Estrace doses often start at 0.5mg for early puberty, or at 1-2mg for late puberty. Goal doses vary and depend on serum levels, but typically falls between 2-4mg PO QD. Side effects to ask about: estrogen → any development of estrogen contraindications (migraine with aura/thrombosis/HTN). For spironolactone: (if taking pill at night) waking up at night to urinate, postural dizziness.