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Best Practices for Rehab Professionals When Caring for Patients Across the Gender Identity Spectrum

1. **Which of the following is the correct way to ask a patient about the patient's preferred method of being addressed?**

   A. "What is your preferred name and pronoun?"
   B. "Do you go by Sarah or something else?"
   C. "I noticed you are transgender, can you tell me more about the best way for me to refer to you?"
   D. "I'm so sorry, it's just habit, but I will have to call you (insert the pronoun for the gender the patient appears to be here)."

2. **Which of the following is NOT a reason that healthcare providers need to be informed regarding ideal transgender and nonbinary care?**

   A. To avoid perpetuating trauma
   B. There are some potential differences in care to most ideally care for these individuals compared to those who identify as cisgender.
   C. Healthcare providers have a responsibility to be aware and sensitive to the needs of all of the patients who may seek out their services
   D. In order to understand which patients need to be referred to a therapist who is a transgender specialist, since those who aren't cannot help these patients

3. **Which of the following is the correct way of handling accidentally mis speaking and using the wrong pronoun or name?**

   A. Apologize
   B. Apologize along with a lengthy explanation of why use of the correct pronoun is difficult for you to remember
   C. Ignore it and move on, correcting it from there on out
   D. Turn bright red and loudly correct yourself, stating "I can't believe I did that! I was trying so hard!"

4. **Which of the following is the best method of documenting the use of a pronoun that doesn't match the patient's listed biologic sex for insurance purposes?**

   A. Use the pronoun associated with the person's biologic sex, along with an explanation at the beginning of care that you are doing so to prevent any insurance issues, but will be using the preferred pronoun when interacting with the individual
   B. Make a note in the patient's documentation that "patient identifies as _____ and prefers to use the pronouns _____ "
   C. Use the patient's preferred pronoun regardless of what biologic sex is listed for insurance purposes
   D. Explain to the patient that grammar is very important to you and so you can't use they/them pronouns and need them to choose either he/him or she/her

5. **Which of the following is NOT an impact of estrogen use?**

   A. Loss of skeletal muscle mass
   B. Change in body fat distribution
   C. Hot flashes
   D. Suppression of body hair growth

6. **Which of the following is NOT a correct statement about hormone use in transgender individuals?**

   A. May take 18-24 months for impact of estrogen to become fully apparent
   B. Testosterone impact is usually quickly apparent, within 3 months
   C. Testosterone is more likely to cause challenges with vaginal dryness, while estrogen is more likely to cause challenges due to changes in skeletal muscle mass
   D. For best effect, hormones should be started before the individual becomes pubescent

7. **Which of the following statements are true regarding vaginoplasty?**

   A. A colonic transplant can create a neovagina that is self-lubricating, but may not provide as much pleasure as a penile inversion procedure
   B. No aftercare is needed to maintain the neovaginal width and depth
   C. Patients will begin to experience menstrual cycles within the first 6-9 months following vaginoplasty
   D. This procedure is typically covered by insurance

8. **Which of the below is NOT a true statement regarding phalloplasty?**

   A. There is not currently medical consensus regarding the best technique for surgeons to use
   B. Standard of care is to perform a hysterectomy & oophorectomy simultaneously if they have not already been performed
   C. Surgeons are able to move the urethra to allow for standing urination in some cases
   D. Patients need physical therapy assistance to maintain the length of the neophallus

9. **What is the purpose of using a binder?**

   A. Prevent penile erection
   B. Prepare for top surgery
   C. Prevent bloating during menstruation
   D. Minimize the appearance of the breast tissue for those who have not had top surgery.

10. **What is(are) the primary focus of pelvic floor physical therapy following bottom surgery?**

    A. All of the below
    B. Neuromotor retraining of muscles in the area
    C. Patient education regarding management of the healing tissue and health for life
    D. Scar/soft tissue mobility work

Best Practices for Rehab Professionals for Gender Affirming Care

Jennifer Stone, PT, DPT, OCS, PHC

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Clinical Manager, Rehabilitative Services, Mizzou Therapy Services, Columbia, MO

Pronouns: She/her

Special thanks to Mason Aid, pronouns they/them

Learning Outcomes

After this course, participants will be able to:

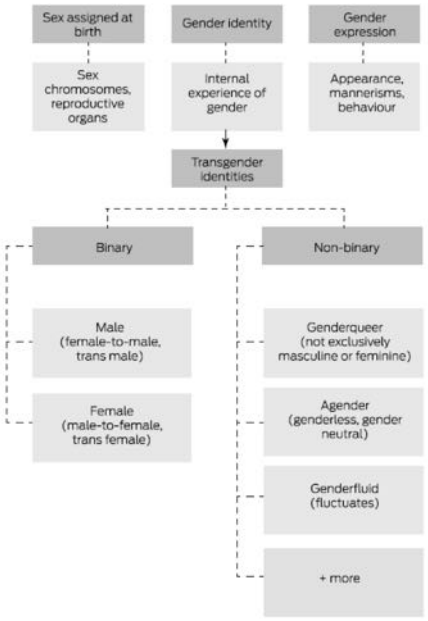
- Least three commonly used terms when describing genders and individuals who identify in different ways across the gender spectrum.
- Identify at least two reasons why using preferred pronouns is important and how to incorporate this into medical documentation.
- Identify at least three impacts of hormone therapy on the musculoskeletal system.
- Describe at least three rehabilitative considerations post-surgically based on different types of gender affirmation surgery.

Definitions

- Gender
- Sex
  - Sex assigned at birth
- Transgender man
- Transgender woman
- Nonbinary
- Cisgender
- Gender dysphoria

Definitions

- Gender divergent
- Gender affirming care
- Transition
  - Social
  - Medical
  - Surgical
- Microaggression
- Heteronormative
- Cisnormative
- Sexuality/sexual orientation



Importance

- Exact prevalence is not known, due to lack of accurate large scale studies
  - Varies per country
  - Estimated 0.7% of American young people identify as gender divergent in some way
  - Nearly 1 million adults in the US are transgender
  - Survey found 12% of millennials identify as gender diverse
- Vulnerable population
  - Increased likelihood of depression, anxiety, self harming behaviors, and suicide, especially among transgender youth
  - Frequently encounter prejudice
  - High risk for verbal, physical, and sexual abuse

Importance

- 85% of PTs report tolerance vs respect
- 1% of PTs report full respect
- 68% report very low to average knowledge about transgender/nonbinary care
- High reported rates of:
  - Depression (44%)
  - Suicidal ideation (54%)
  - Suicide attempts (31%)
  - Excessive drinking (22%)
  - Illicit drug use (36%)

Importance

- Transgender youth who socially transition and are supported in their choices have age-normative rates of anxiety and depression
- Gender dysphoria has been proven to improve with gender affirmative care
  - Satisfaction with care is high (80+%)
  - Only approximately 2% report regretting the decisions they have made to adjust their presentation

Importance

Texas leads the nation in transgender murders. After the latest attack, the Dallas trans community ask why.

Transgender woman's murder underscores problem of partner violence: Advocates

Anti-LGBT hate crimes are rising, the FBI says. But it gets worse

Killings of transgender people in the US saw another high year

Trans and non-binary health and wellbeing report reveals severe inequities

After a transgender woman's death at Rikers, calls for justice and answers

Pronouns

- "What's your pronoun?"
  - Not "preferred pronoun"
- Common ones:
  - She/her
  - He/his
  - They/them
  - Zhe/ze
  - Zhir/zir
  - Zhim/mer
  - One

Gender Neutral Address

- Mx-pronounced “mix” or “mux”
- Ind-abbreviation of individual
- M
- Misc-abbreviation of miscellaneous
- Mre-abbreviation of mystery, pronounced “M’ree”
- Msr-combination of miss and sir, pronounced “miser”
- Myr-pronounced “meer”
- Pr-abbreviation of “person”, pronounced “per”
- Sai-pronounced “sai”

Gender neutral job titles

- Police officer vs police man/woman
- Server vs waitress or waiter
- Flight attendant vs stewardess or steward
- Salesperson vs salesman/woman

Gender Identity

Social Development

Gender identity development

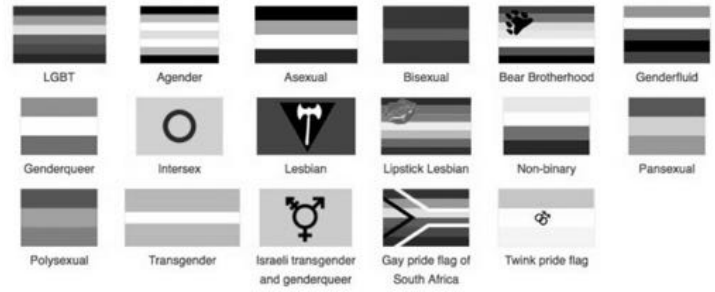
- Important to remember-transgender is an identity, gender dysphoria refers to distress or degree of social challenges presented by the distress
- Gender identity can present very strongly from a young age or be expressed later in life due to social context & other factors
- Gender and sexuality are not binary, but rather a spectrum

Gender as a social construct

It's a Girl!

It's a Boy!

Gender & Sexuality Spectrum



Development of Gender Identity

- Social & behavioral development, occurs in stages
  - Approximately age 2-become conscious of physical differences between boys & girls
  - By 3rd birthday-most can easily label themselves
  - Age 4-most have stable sense of identity
  - Also learn “gender behaviors”
  - Crossover play is normal for cisgender children, but may be socially discouraged
  - Research says genderdiverse children typically have this same timeline, but may be taught to suppress

Children & Gender Identity

- Some methods of expression for children
  - Hair & clothing style
  - Preferred name
  - Social behaviors
  - Mannerisms that are seen as more feminine/masculine
- Children and youth who identify as gender diverse are likely to be faced with bullying, social pressures, and prejudice
- Resources: https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/Support-Resources-for-Families-of-Gender-Diverse-Youth.aspx

Social Stigma

- Minority stress model-stigma and prejudice result in added stress beyond that experienced by non gender diverse individuals, which can cause an increase in mental and physical disorders
  - Hypertension
  - Asthma
  - Substance abuse
  - Depression/anxiety

Social Stigma

- Wagner et al, 2019

Health Risk Experiences	Transgender Youth	Cisgender Women	Cisgender Men
Unsafe at or traveling to/from school	26.9	7.1	4.6
Threatened or injured with a weapon	23.8	4.1	6.4
Forced to have intercourse	23.8	20.7	4.2
Bullied at school	34.6	20.7	14.7

Social Stigma

Health Risk Behaviors	Transgender Youth	Cisgender Women	Cisgender Men
Cigarette use	32.9	22.0	23.2
Alcohol use	70	62.8	53.3
Marijuana use	43.8	38	34.1
Felt sad/hopeless	53.1	39.3	20.7
Considered suicide	43.9	20.3	11
Made a suicide plan	39.3	16	10.4
Attempted suicide	34.6	9.1	5.5

Minority Stress Processes

- Distal processes
  - Experiences of rejection and discrimination
  - Non-affirmation of gender identity
  - Verbal & physical abuse
  - Employment & housing discrimination
  - Difficulty with access to medical care
- Proximal processes
  - Stress as a result of the internalization of prejudice and stigma
  - Internalized transphobia
  - Expectation of being rejected

Gender Affirming Medical Care Model

How do you create an environment that is welcoming and healing to individuals across the gender & sexuality spectrum?

First, do no Harm!

- Medical discrimination can cause significant harm
  - Multiple documented instances of care providers using incorrect pronouns or names in care episodes shortly prior to an individual's death by suicide
  - Can worsen anxiety and depression
  - Can lead to incorrect diagnosis (assumption that every issue is due to hormone use)
  - 20% of transgender/nonbinary (compared to cisgender matched group) have been denied medical care
  - 23% avoided seeking medical care due to past experience

Broken Arm Syndrome

- Assumption that mental health challenges are just due to being transgender (vs brain chemical imbalance)
- Treating the person as transgender/nonbinary first, then a person second (different care plan than a cisgender individual)

Non-Affirming Behaviors

- "Outing" people in waiting rooms (why do we call people by their listed first name when bringing back for appointments?)
- Refusal (explicit or implicit) to use preferred names and/or pronouns
- Binary language during patient education
- Dismissal of concerns based on the person's gender expression
- Buying into/expressing stereotypes (ex: transgender men do not need to discuss birth control)

Non-Affirming Behaviors

- Assumption of cisgender & heteronormative status
- "Counseling" people away from their gender expression
- Refusal to facilitate care for desired outcomes
- Conversion "therapy"
  - Use of counseling or extreme measures (shock therapy, inducing N/V, inducing paralysis) to stop people from expressing their gender identity or sexual orientation

What Difference can a Healthcare Provider Make?

- Inclusive PCP=50% reduction in rates of anxiety and depression
- When gender divergent youth have 1 person in their lives who is supportive, distress & associated comorbidities significantly decrease

Gender Affirmative Model of Care

- Recognizes gender diversity as a normal part of human development (not pathologized)
  - Views gender identity as one's view of oneself, separate from biologic sex, and which may be fluid or stable over time, and which occurs across a spectrum
  - Components listed on the next few slides
  - Additionally requires psychologic concepts

Nonpathologizing

- Transgender and gender diverse identities are not mental disorders
- These identities are a normal part of human development and diversity

Culturally Sensitive

- Recognition that gender expressions may vary across cultures, thus gender identity should be understood through a cultural lens

Fluid, Nonbinary, Multifaceted

- Understanding that:
  - Gender expression may be fluid over time
  - Gender expression may occur across a spectrum vs being binary
  - Gender emerges as an interplay of biology, development, socialization, and culture

Conceptualizing Mental Health

- Mental health challenges (if they arise) are likely due to trauma and/or social stigmatization vs being as a result of the person's gender

Psychologic Concepts for Gender Affirmative Care

- Empathy
  - Capacity to imagine oneself in another's life, used to appreciate struggle and experience different from one's own
- Containment
  - Atmosphere created in a therapeutic relationship that conveys a sense of safety, allowing processing of difficult emotions

Psychologic Concepts for Gender Affirmative Care

- Psychologic Safety
  - Environment, team, or relationship of support-encourages authenticity and risk taking without fear of consequences or retaliation-potential to promote learning, development, and growth
- Zone of proximal development
  - In the process of learning, there are concepts that are too challenging and concepts that are too easy. Providers find this zone as the "middle ground" that promotes enough challenge for growth, but not so much as to shut down or traumatize

So What Can You Do?

- Ask for pronoun & preferred name…and USE them!
- Document in a way that reflects respect for that person's desires (again, ask them!)
- Consider your waiting room processes
- Ask open ended questions about relationships and sexuality, if relevant to your care
  - We shouldn't be making heteronormative monogamous assumptions about cisgender individuals either
- Ask for preferred body part names, if relevant to your care

So What Can You Do?

- See the person first, gender expression second
- Be cognizant that research says there may be some unconscious bias at play, so constantly examine yourself to see if you are allowing this to influence your care decisions
- Educate yourself and others (the burden to educate should not be on this already marginalized community)
- Use trauma informed care principles

What About When You Mess Up?

- You probably will at first/as you are still learning
- Don't apologize, because that places the person in an awkward position-do they then have to tell you it's okay?
  - "Thank you for correcting me, I will do better in the future."
  - Or correct yourself… "She, I mean they…"
- Commit to doing better

Trauma Informed Care

- Understanding that trauma can trigger a patient into perceiving a threat to life, mental, or bodily integrity
  - Event doesn't have to "make sense"
- Establishing a therapeutic relationship that allows the patient to progress without being triggered into a regression through environmental or verbal triggers

Trauma Informed Care

- Connect with your patients!
- Body language! (yours and theirs)
- "Open door" to share about past trauma
- RESPECT
- Check in
- What is informed consent?
- Mindfulness
- Create a safe space

Documentation

- Ask your patient what pronouns they wish to have used in their documentation
- Then, to ensure there will be no issues with insurance paying, document something like the following:
  - "Patient states preferred name is Jo, patient is transgender and uses he/him pronouns despite biologic sex remaining female at this time."
  - "Patient's preferred name is Terry, patient identifies as nonbinary uses they/them pronouns. Current biologic sex is male."

Transition/Affirmation

Social, medical, surgical

We will use the term "transition" but anywhere you see it, you could replace with the word "affirmation"

Transition/Affirmation

- The process of doing something to make one's body more accurately reflect one's internal experience/expression of gender
- Individuals make a wide range of choices here
  - Most have some version of side effect, so as with any medical decision, the individual must weigh the cost/benefit ratio
- Our role is to support their choices and be aware of the options they may choose

Social Transition

- Reversible process
- Affirming one's gender through:
  - Preferred name and pronoun use
  - Clothing choices
  - Hairstyle choices
  - Participation in gendered spaces (bathrooms, sports teams)
  - Use of devices to change one's bodily appearance or behaviors

Social Transition

- Binder-minimize the appearance of breasts
- Padding-add appearance of breasts
- Tucking-minimize the appearance of a crotch bulge-common method: tuck penis between legs, push testicles up into inguinal canal, wear tight undergarments
- Packing-wear padding or phallic device in order to simulate appearance of a penis
- Stand-to-pee devices-held under the vulva, captures urine, then flows through a lower opening, may be phallus shaped

Legal Affirmation

- Changing one's name and/or gender marker on legal documents (driver's license, birth certificate, passport, medical insurance cards, etc.)

Medical Transition

- Use of medication or hormones to either halt unwanted secondary sex characteristics or produce desired secondary sex characteristics
- Not needed pre puberty
- Best practices-mental healthcare providers should be involved to rule out other issues such as body dysmorphic disorder and to help manage the mental health challenges common to gender diverse individuals as well as any mood challenges presented by medications
- Contraindications: polycythaemia, history of thrombosis, liver disease, cardiac failure
- Full effects may take 2-3 years

World Professional Association for Transgender Health (WPATH) Standards for Medical Transition

- Letter from 1 mental healthcare provider
- Persistent, documented gender dysphoria
- Capacity to make an informed decision and consent to treatment
- Age of majority in country of residence
- Any comorbidities are controlled

Medical Transition- Puberty Suppression

- Relatively new, hotly debated as by definition this involves hormones for people under the age of 18
- Purpose-delay the onset of puberty, buy time for maturation and decision making
- World Professional Association for Transgender Health (WPATH) recommendation: Suspend puberty if they have undergone a psychiatric assessment and reached at least Tanner stage II of puberty
  - Biologic males-testicular enlargement to at least 4 mL
    - Mean age 11.47 years
  - Biologic females-breast bud formation and areola enlargement
    - Mean age 10.70 years
  - Both-growth spurt

Puberty Suppression

- Benefits
  - Decrease gender dysphoria that can be caused by appearance of secondary sex characteristics, menstruation, etc.
  - Allow safer exploration of identity
  - Increase likelihood of responsiveness to cross hormonal therapy if that is desired
- Concerns
  - Few studies to guide treatment or determine side effects
  - Some concern about impact to physical development

Puberty Suppression

- Thorough exploration of family and social context should ideally be done
- Often there is a very narrow window in which to intervene
- Use of drugs that simulate gonadotropin release, which ultimately desensitizes the receptors and causes production of sex steroids to decrease
- Performed until the adolescent meets criteria to receive cross sex hormones (usually 16)
- Reversible

Medical Transition- Cross Sex Hormones

- Estrogen
  - May take up to 18-24 months to see impact
  - Breast growth, increased body fat percentage, slowed growth of body and facial hair
  - Decrease in testicular size, difficulty or inability achieving erection
  - Decrease in skeletal muscle mass/strength
  - May develop musculoskeletal pain due to decrease in muscle mass and strength
- Testosterone
  - Early effects (first 3 months): amenorrhea, increased body hair, increased skeletal muscle, increased libido, increased acne
  - Later effects: deepening of voice, atrophy of vaginal epithelium, increase in size of clitoris
  - May develop vaginal pain/dryness similar to that experienced by postmenopausal women
  - Some of androgenization impact will remain even if hormones are stopped

CONTINUED

Estrogen

- Desired outcome: change body fat distribution (breasts, hips), suppress body hair growth

Route	Formulation	Dosing
Oral	Estradiol	2–4 mg daily
Parental (subcutaneous, intramuscular)	Estradiol valerate	5–30 mg every 2 weeks
Transdermal	Estradiol	0.1–0.4 mg twice weekly
Anti-androgens	Progesterone	20–60 mg PO daily
	Medroxyprogesterone acetate	150 mg IM every 3 months
	GnRH agonist (leuprolide)	3.75–7.5 mg IM monthly
	Histrelin implant	50 mg implanted every 12 months
	Spironolactone	100–200 mg PO daily
	Finasteride	1 mg PO daily

CONTINUED

Testosterone

- Desired effect: suppress female secondary sex characteristics (breasts, hips, menstruation), cause presentation of male secondary sex characteristics (facial/body hair, etc.)

Route	Formulation	Dosing
Oral (not available in United States)	Testosterone undecanoate	160–240 mg/day
Parental (subcutaneous, intramuscular)	Testosterone enanthate, cypionate	50–200 mg/week
		100–200 mg/10–14 days
Implant (subcutaneous)	Testopel®	75 mg/pellet
Transdermal	Testosterone gel (1%)	2.5–10 g/day
	Testosterone patch	2.5–7.5 mg/day

Anti-Androgens

- Suppress testosterone, should not be used alone but always in combination with estrogen
- Oral options
  - Cypoterone acetate-12.5-25 mg
  - Spironolactone-100-200 mg

Possible Side Effects

- Should be monitored by the physician, but the rehab professional should also be aware
- DVT-5% rate reported among women who used estrogen therapy, risk greatest in the first year of treatment and in those with other risk factors
- Liver function-estrogen is poorly metabolized, no issues reported in males however
- Hyperkalemia can occur with anti-androgen use
- Elevated fasting lipids, increased insulin resistance

Possible Side Effects

- May impact fertility
- Oily skin and acne
- Libido change
- No rigorous studies on long term impact
  - Reported side effects of testosterone/estrogen blockers include bladder spasms, uterine atrophy, pelvic pain

WPATH Standards for Surgical Affirmation

- Face surgery
  - Capacity for informed consent
  - Age of majority
  - Comorbidities well controlled

WPATH Standards for Surgical Affirmation

Top Surgery

- 1 letter from mental healthcare provider
- Persistent documented dysphoria
- Capacity for consent
- Age of majority
- Comorbidities controlled

Bottom Surgery

- 2 letters from mental healthcare providers
- Persistent documented dysphoria
- Capacity for consent
- Age of majority
- 12 months of living as one's true gender
- 12 months of continuous hormone therapy
- Comorbidities controlled

Surgical Affirmation-Masculinizing Surgery

- Top surgery-bilateral mastectomy
- Facial masculinization
- Phalloplasty or metoidoplasty
  - Most patients have already had a hysterectomy and oophorectomy, if not those will be done simultaneously
  - Desired outcomes (depending on procedure chosen): able to micturate in standing, create an aesthetically pleasing phallus, preserve clitoral sensation

Top Surgery

- Subcutaneous bilateral mastectomy
- Most common procedure sought out by male transgender patients
- Breast binding can negatively influence outcomes
- Complication rates-8-25%
  - Scar tissue, infection, hemangioma, wound dehiscence
- Satisfaction is reported as high

Facial Masculinization

- Little available data
- Goal: masculinize features that are typically different between sexes (nose, forehead, chin, mandible)
- No long term studies exist, very little data on standardized approaches

Genital Surgery

Metoidioplasty

- Results in a smaller phallus
- Testosterone used to hypertrophy the clitoris, released from the pubic bone to free it
- Fewer complications
- Tissue retains the ability to become erect/normal bloodflow
- Spares sensation
- May allow standing micturition

Phalloplasty

- Results in an anatomically sized phallus
- Donor grafts taken from other sites-multiple options depending on patient's goals (some allow penetration, some allow smaller donor site scar tissue, etc.)
- Urethral lengthening to allow standing micturition
- Often a multi stage surgery
- Best option for larger patients

Surgical Affirmation-Feminizing Surgery

- Top surgery-mammaplasty
- Facial feminization
- Vaginoplasty
  - Purpose: create a neovagina (some patients want this to be functional, others do not)

Facial Feminization

- Forehead contour, chin shortening, jaw, rhinoplasty, thyroid cartilage

Top Surgery

- Mammaplasty
  - Done if chest dysphoria persists after mammary enlargement from hormone use (1-2 years after starting hormones)
  - Implant placement or (less common) fat transplant

Vaginoplasty

- Testicle removal, urethra shortened and potentially moved
- Penile inversion
  - Retains sensitivity (skin from tip to construct clitoris, prostate left in place)
  - Not self lubricating
- Skin graft
  - Typically in addition to inversion if depth is not adequate
- Bowel transplant
  - Benefit: self lubricating
  - However, not the same sensation

Physical Therapy & Gender Diversity

What is your role?

Welcoming Environment

- Educate yourself!
- Avoid microaggressions
- Actively create an environment that is equally welcoming to patients of ALL gender identities
  - Waiting room procedures
  - Asking for names & pronouns
  - Avoiding gendered verbal habits
- Educate your colleagues

Physical Therapy

- Be aware of the impact of hormones on the musculoskeletal system
  - Not everything is due to hormones
  - Remember that not all women have pain-so the fact that skeletal muscle mass is lost with estrogen therapy doesn't doom your patient to pain either
- Anything that can happen in a cis patient can happen in a transgender or nonbinary patient
- Be aware of surgical history/scar tissue
  - Ex: shoulder pain with a history of top surgery-assess the scar if given permission!

Physical Therapy

- Awareness of social transition tools and potential impact on MSK symptoms
  - Note: the answer is NOT to just stop using the chest binder, etc.
  - What can we do with this patient right now? Stretching, strengthening, etc.

Pelvic Health Physical Therapy & Gender Diversity

A few tips

Language

- All info from previous sections still apply
- Ask for preferred names for body parts-may prefer “front opening” and “back opening” vs anatomic names
- Much of our work is to help with physical comfort as much as possible
  - Many people with gender dysphoria experience extremely painful menses
  - Hormone changes may make intercourse painful or difficult to achieve, or lead to new onset incontinence, constipation, etc.

Internal Work

- Ask! Some are fine with it, for others, it may cause more harm than benefit
- Remember, there is SO MUCH pelvic floor work you can do externally/with the patient clothed
  - Exception: scar tissue management post vaginoplasty

Post-Operative Care

- Scar management
  - Dilator program
- Muscle re-education
- Vaginal estrogen use?
  - Reason? (could a moisturizer work)
  - Dysphoria with use?
  - Systemic impact potential?
  - Note: most people don't need to block estrogen when on testosterone
- Working with patients to help them toward whatever their goal is

Jiang et al, 2019

- Retrospective case series assessing pt care for women post gender affirmation surgery
- Preoperative pelvic floor PT visit x 1
- Dilator program started 10 days postoperatively
- Postoperative pelvic floor PT visit(s) post dilator program initiation
  - Pt could continue PT visits if appropriate/they wished
- PT treatment at therapist discretion & focused on dilator use, downtraining, EMG (some), muscle strength and coordination, desensitization, overall muscle strengthening

Manrique et al, 2019

- 40 patients
- Preoperative assessment
  - Assess bowel, bladder, and sexual function, discuss goals
  - Minimum 6 months of therapy if symptomatic prior to surgery
- Postoperative care
  - Followed for minimum of 1 year
  - Pts with post op symptoms received minimum 6 months of therapy after onset of symptoms
  - Manual therapy, neuromotor reeducation, exercises, patient education
- Significant reduction in symptoms seen on all measures

Questions?

Case Study 1

- Nonbinary patient with XX genetics, chief complaint of pain between the shoulder blades. Works a desk job, spends long periods of time with spreadsheets. Patient's pronouns are they/them, and they typically chest bind while at work (at home, sometimes they do, sometimes not). Patient's goals include being able to work a full day without pain.

Case Study 1

- Any additional questions you would like to ask?
- Do you think the chest binding is a factor in this case?
- What elements of treatment do you believe would be helpful for this patient?

Case Study 2

- 17 year old transgender male who has socially transitioned presents to pelvic floor PT with chief complaint of painful menses. Patient has a diagnosis of PCOS. At this time, patient has not started using hormones of any type. Patient experiences frequent abdominal pain which becomes sharp and extremely distressing for the 1-4 days around the beginning of his menstrual cycle. Patient is not currently sexually active, and prefers to use the terms “back opening” and “front opening” instead of rectum and vagina.

Case Study 2

- Any additional questions you would like to ask?
- How would you address the contribution of menstruation to pain in this patient?
- What elements of treatment do you believe would be helpful for this patient?

Resources

- PT Proud competency handbook: https://www.ptproud.org/for-clinicians-students?fbclid=IwAR2XAuI58qkmQD9Je4H_i3iK7WRW2yAwf-JcGz5ZJqiPP7uJeZpTb25hLZQ
- Trans Lifeline: https://translifeline.org/
- Blog with lots of helpful information and personal anecdotes: https://anunnakiray.com/
- Pelvic Guru has a fantastic course
- Blog, podcast, advocacy & information: https://www.themasonaid.com/?fbclid=IwAR0m-7D8da8g0vP1k2telEi098Ga6h_TTj7-mPlrv6iDog_onYcgnOEKfJc

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