GENDER-AFFIRMING HORMONE THERAPY INITIATION AND MAINTENANCE

GENERAL TIPS FOR PROVIDING GENDER-AFFIRMING CARE

Patient-centered Care

- Use preferred name and pronouns
- Discuss individual medical treatment goals

Medical assessment

- Discuss medications and/or conditions that might change with hormone treatment

Mental health assessment

- Discuss conditions that might compromise assessment of gender identity or treatment plan

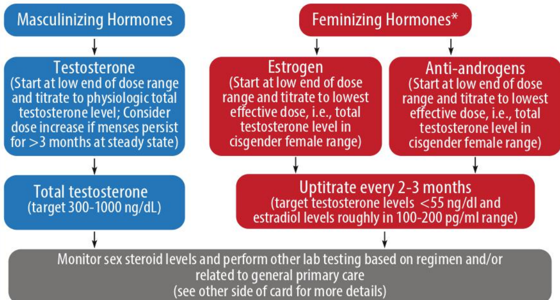
Discuss fertility

- Assess fertility preservation goals and discuss options
- Discuss pregnancy risk

Don't forget routine body part-specific screenings

- Provide bone health screenings based on guidelines
- Person with cervix: Offer Pap smear based on guidelines
- Person with breasts: Offer chest exams and mammograms based on guidelines
- Person with prostate: Offerprostate exams based on guidelines

PROTOCOL FOR TRANSGENDER AND NON-BINARY PERSONS USING HORMONE THERAPY



*Note: Progesterone is not currently recommended for feminizing therapy.

RECOMMENDED REGIMENS AND MONITORING

MASCULINIZING HORMONE THERAPY

TESTOSTERONE OPTIONS

ROUTE	FORMULATION	POSSIBLE RISKS
Intramuscular (IM) or subcutaneous (SQ)	Testosterone enanthate or cypionate: 50–100 mg IM or SQ weekly or 100–200 mg IM or SQ every 2 weeks	Erythrocytosis, acne (Consider dose decrease for severe acne)
	Testosterone undecanoate: 1000 mg every 12 weeks	
Transdermal or transbuccal	Testosterone gel: 50–100 mg daily	
	Testosterone patch: 2–8 mg daily	
	Transbuccal patch: 30 mg to gums every 12 hours	

MONITORING RECOMMENDATIONS FOR PERSONS USING TESTOSTERONE

1. Monitor every 3 months initially (i.e., when dose is changed), then every 6-12 months when stable
2. Check serum testosterone levels. Target testosterone: 300-1000 ng/dL.
   Note: Peak levels measured 24-48 hours after injection. Trough levels measured before injection.
3. Check hematocrit/hemoglobin
4. Other labs may be included by provider as confirmatory tests (e.g., estrogen and LH/FSH) or relating to general primary care (e.g., HgbA1c, lipids).

FEMINIZING HORMONE THERAPY

ESTROGEN OPTIONS

ROUTE	FORMULATION	POSSIBLE RISKS
Oral	First-line: Estradiol: initial 1–2 mg daily; maintenance: 2–6 mg daily	Increased rates of venous thromboembolism
	Alternative: Conjugated estrogens: initial 1.25–2.5 mg daily; maintenance 5–7.5 mg daily	
Transdermal	Estradiol patch: 0.025–0.2 mg daily (new patch placed every 3–5 days)	
Intramuscular	Estradiol valerate: 2–10 mg IM weekly or 5–30 mg IM every 2 weeks	

ANTI-ANDROGEN OPTIONS

ROUTE	FORMULATION	POSSIBLE RISKS
Oral (first-line)	Spironolactone: initial: 50 mg/daily; maintenance: 100–300 mg daily	Hyperkalemia risk
Intramuscular (Second line for adults)	Leuprolide: 3.75–7.5 mg IM or SQ monthly or 11.25–22.5 mg IM or SQ depot every 3 months	

MONITORING RECOMMENDATIONS FOR PERSONS USING ESTROGEN AND ANTI-ANDROGENS

1. Measure total testosterone and estradiol levels approximately every 3 months (i.e., with dose changes) initially and approximately annually when stable
   (a) Target serum testosterone: <55 ng/dl | **(b)** Target estrogen: 100-200 pg/ml
2. Spironolactone only: Verify safety of potassium level after each dose increase
3. Other labs may be included by provider as confirmatory tests (like estrogen and LH/FSH) or relating to general primary care (e.g., HgbA1c, lipids).

For more information regarding transgender care, go to:
https://www.mountsinai.org/locations/center-transgender-medicine-surgery

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Center for Transgender Medicine and Surgery

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