Preventive Care Checklist for Estrogen-based GAHT Patients

For annual health assessments of patients on estrogen-based GAHT, applying to patients who were assigned male at birth and have a gender identity that is female or on the feminine spectrum, who may or may not have accessed hormonal and/or surgical treatments for gender dysphoria/gender incongruence.

Prepared by: Dr. A. Bourns · Adapted from the Preventive Care Checklist Form © 2016 - Terminology updated by 2SQTP-NB/P2SQT-NB 2022.

(see Ridley, J, Ischayek, A., Dubey, V., Iglar, K., *Adult health Checkup: Update on the Preventive Care Checklist Form*© Canadian Family Physician, 2016 Apr; 62:307-313).

IDENTIFYING DATA:

Name: _____

Tel: _____

DOB: _____

Age: _____

Date of Examination: _____

MEDICAL TRANSITION HISTORY:

Androgen Blocker:

- ☐ Spironolactone
- ☐ Cyproterone
- ☐ N/A

Estrogen:

- ☐ Yes, If Yes, Start Date: _____
- ☐ No

Orchiectomy:

- ☐ Yes
- ☐ No

Vaginoplasty:

- ☐ Yes
- ☐ No

Breast Aug:

- ☐ Yes
- ☐ No

LIFESTYLE/HABITS/PSYCHOSOCIAL:

Diet: _____

Fat/Cholesterol: _____

Fiber: _____

Calcium: _____

Sodium: _____

Exercise: _____

Work/Education:_____

Economic Status:_____

Social supports:_____

Family (including chosen family):_____

Relationships: _____

Sexual History: _____

Family Planning/Contraception: _____

Name change/identification: _____

Sleep: _____

Smoking: _____

Alcohol: _____

Safe Guidelines ≤10/week, ≤2/day

Drugs: _____

CURRENT CONCERNS

MENTAL HEALTH Screen for:

Depression

- ☐ Positive
- ☐ Negative

Suicidal Ideation Self-harm

- ☐ Positive
- ☐ Negative

Anxiety

- ☐ Positive
- ☐ Negative

Persistent Gender Dysphoria

- ☐ Positive
- ☐ Negative

Experiences/Impacts of transphobia

- ☐ Positive
- ☐ Negative

EDUCATION/COUNSELLING

Behavioural

- ☐ adverse nutritional habits
- ☐ dietary advice on fat/cholesterol
- ☐ adequate calcium intake (1200 mg daily diet + supp)
- ☐ adequate vitamin D (1000 IU daily)
- ☐ hormone adherence
- ☐ regular, moderate physical activity
- ☐ avoid sun exposure, use protective clothing
- ☐ safe sex practices/STI counselling/PrEP indications

Overweight (BMI 25-29) or Obese (BMI 30-39)

- ☐ Overweight (BMI 25-29)
- ☐ Obese (BMI 30-39)
  - ☐ structured behavioural interventions for weight loss
  - ☐ screen for mental health contributors
  - ☐ multidisciplinary approach

Underweight

- ☐ Underweight (BMI<18)
  - ☐ screen for eating disorders

Smoking

- ☐ smoking cessation
- ☐ nicotine replacement therapy/other medications
- ☐ dietary advice on fruits and green leafy vegetables
- ☐ referral to validated smoking cessation program

Alcohol & other substances

- ☐ case finding for problematic substance use
- ☐ counselling for problematic substance use
- ☐ referral for substance abuse treatment
- ☐ provide naloxone kit if indicated

Elderly

- ☐ cognitive assessment (if concerns)
- ☐ fall assessment (if history of falls)

advanced care planning

Oral hygiene

- ☐ **brushing/flossing teeth**
- ☐ **fluoride (toothpaste/supplement)**
- ☐ **tooth scaling and prophylaxis**
- ☐ **smoking cessation**

Personal safety

- ☐ hearing protection
- ☐ noise control programs seat belts
- ☐ injection safety
- ☐ bathroom safety

Parents with children

- ☐ **poison control prevention**
- ☐ **smoke detectors**
- ☐ **non-flammable sleepwear**
- ☐ **hot water thermostat settings (<54°C)**

UPDATE CUMULATIVE PATIENT PROFILE

- ☐ **Family History**
- ☐ **Medications**
- ☐ **Hospitalizations/Surgeries**
- ☐ **Allergies**

PHYSICAL EXAMINATION:
Physical examination, as required, taking into consideration pre-existing conditions and presenting complaints
BP _____
HT _____
WT _____
BMI_____

- ☐ **Or See EMR Vitals**

May include:
Breasts _____
Tanner stage _____
Breast circumference
_____
Areolar diametre
_____

Genitourinary
_____

Ano-rectum
_____

FUNCTIONAL INQUIRY

HEENT: _____
CVS: _____
Resp: _____
Breasts: _____
GI: _____
GU: _____
Sexual Function: _____
MSK: _____
Neuro: _____
Derm: _____
Constitutional Sx:_____

Labs/Investigations	≤64 YEARS	≥65 YEARS
	Mammogram (estrogen ≥5 years total and avg risk: age 50-64 q2 yrs)	Mammogram (estrogen ≥5 years total and avg risk age: 65-74 q2 yrs
	Fecal immunochemical test (FIT) (age 50-64 q2 yrs) OR Sigmoidoscopy OR Colonoscopy	Fecal immunochemical test (FIT) (up to 74 yrs q2 yrs) OR Sigmoidoscopy OR Colonoscopy
	GC/CT/Syphilis/HIV/HBV/HCV screen (high risk)	GC/CT/Syphilis/HIV/HBV/HCV screen (high risk)
	Bone Mineral Density if at risk	Bone Mineral Density
		Audioscope (or inquire/whispered voice test)
	Consider Anal Pap if history of receptive anal sex, q2-3 yrs or yearly if HIV+ (age range not defined)	

ANNUAL BLOOD WORK (ALL AGES, ASSUMING 1 YEAR ON HORMONE THERAPY)

Lab Test	Indication
CBC*	on cypro or first year on hormone therapy
Cr, lytes**	on spiro or first year on cypro
ALT+/-AST	on estrogen or cypro
Lipid Profile	at 12 mos, then per routine guidelines
Hba1c or FPG	at 12 mos, then per routine guidelines
Estradiol	on estrogen
Prolactin	on cypro
Total testosterone	on antiandrogen
*Hb/Hct - use female reference for LLN and male reference for ULN **Cr - use male reference range for ULN	

IMMUNIZATIONS	≤64 YEARS	≥65 YEARS
	Tetanus vaccine q10 yrs	Tetanus vaccine q10 yrs
	Influenza vaccine q1 yr	Influenza vaccine q1 yr
	Acellular pertussis vaccine	Pneumococcal vaccine
	Varicella vaccine (2 doses)	Acellular pertussis vaccine
	Human papillomavirus vaccine (consider up to age 45 yrs, publicly covered ≤26 yrs if sexually active with MSM)	Varicella vaccine (2 doses)
	Measles/mumps/rubella vaccine	Herpes zoster vaccine (publicly covered 65-70yrs)
	Meningococcal vaccine	
	Herpes zoster vaccine (consider ≥60 yrs)	
	Hepatitis A/Hepatitis B	

ASSESSMENT AND PLANS

EXPLANATIONS FOR TRANS- SPECIFIC RECOMMENDATIONS

Note: This form has been adapted with permission from Dr. V. Dubey from the CFPC-endorsed Preventive Care Checklist Form©. The use of these trans-specific forms assumes familiarity with the original forms and their explanations. The original form contains graded evidence- based recommendations, which may or may not be applicable to 2STIGD**patients. Unbolded recommendations should be followed as per the original forms. The specific recommendations herein represent an effort to incorporate expert opinion and limited trans-specific evidence with standard National and Provincial primary care practices in a practical format that can be accessed at the point-of-care.**

MEDICAL TRANSITION HISTORY

Establishment of a patient's status regarding gender-related treatments and timing of these treatments at the outset of a preventive care assessment allows for patient-centred tailoring of counselling, education, physical examination, and screening recommendations.

LIFESTYLE/HABITS/PSYCHOSOCIAL

An effort should be made to assess the impact of transition/trans identity, experiences of transphobia and impact on employment, housing, family, relationships, and economic well-being.

Social Supports – specific attention should be given to assessing the extent of a patient's social support, creating an opportunity to suggest additional resources if needed.

Sexual History – delineating the types of sex that a patient is having and with whom will direct the indicated type and frequency of STI screening.

Family Planning/Contraception – transfeminine patients planning to undergo hormonal treatment and/or gonadectomy should be counselled regarding the option for fertility preservation, those who have not undergone gonadectomy and are on hormonal therapy should be counselled regarding the variable effect on fertility and **the need for contraception if sexually active with a partner who may become pregnant.**

Name change/identification – assess patient need/desire to change name and/or sex marker on identification and offer support for this process.

Alcohol – estrogen affects the metabolism of alcohol by the liver and has been associated with elevation in liver enzymes, thus we suggest using the same safe-drinking guidelines for transfeminine individuals as for cis women (i.e. max 10 drinks a week with no more than 2 drinks a day most days, see Canada's Low-risk Alcohol Drinking Guidelines).

FUNCTIONAL INQUIRY

An effort should be made to use language consistent with a patient's gender identity; if unsure - consider asking the patient how they refer to their gendered body parts.

Mental Health – inquire re: experiences/ impacts of transphobia; screen for depressive symptoms, anxiety (particularly social anxiety), and self-harm; suicidal ideation and attempts are particularly high in the trans population and should be specifically inquired about; inquire re: current level of gender dysphoria and body image, (re-)assess patient interest in transition-related surgeries if not undergone.

Breasts – inquire re: breast pain (can be normal in early phases of feminization), and nipple discharge (bilateral/non-bloody discharge can be considered normal in early phases, otherwise may be indicative of hyperprolactinemia or local breast disease); if implants present consider inquiry re: symptoms of capsular contracture or rupture (pain, loss of contour, deflation).

GU – inquiry re: urinary symptoms is relevant regardless of genital operative status: spironolactone can cause urinary frequency; the prostate remains post-vaginoplasty; vaginoplasty may lead to urinary complications including increased frequency of UTIs, stricture, fistula; if post-op vaginoplasty; inquire re: vaginal discharge, pruritus, pelvic pain. Odour/discharge is most frequently due to sebum, dead skin, or keratin debris (skin graft) – routine douching with soapy water is usually adequate to maintain hygiene. Imbalances in neovaginal flora may also occur – cleansing/douching with a solution of 25% povidine iodine in water for 2-3 days may be helpful and if symptoms persist; a 5-day course of vaginal metronidazole is reasonable; STIs, granulation tissue, and other neovaginal lesions should also be considered in the differential.

Sexual Function – if patient has not undergone vaginoplasty, inquire re: erectile dysfunction and if present, whether this is of concern for the patient (PDE-5 inhibitors may be considered in patients wishing to maintain erectile function); if the patient has undergone vaginoplasty, inquire re: problems with dilation, dyspareunia, post-coital bleeding, and ability to achieve orgasm.

Constitutional Symptoms – fatigue in the absence of other associated symptoms suggesting another cause may be due to testosterone levels below the physiologic female range.

EDUCATION/COUNSELLING

Review S/Sx DVT/PE/Stroke – consider periodic review of the signs and symptoms of DVT, PE, and stroke for transfeminine patients on hormone therapy who have additional risk factors.

Adequate Calcium Intake – all transfeminine patients on hormone therapy should ensure a minimum intake of 1200 mg of Calcium daily (total: diet + supplements).

Adequate Vitamin D – all transfeminine patients on feminizing hormone therapy should take 1000 IU of vitamin D daily.

Hormone Adherence – poor hormone adherence may impact bone health if post-orchiectomy, while extra doses may lead to risks associated with high serum levels of estrogen.

Regular, moderate physical activity – some transfeminine individuals may tend to avoid exercise for fear of unwanted muscle development; encourage aerobic exercise as well as high-repetition weight-bearing exercise for osteoporosis prevention.

Safe sex practices/STI counselling - transfeminine patients may be at high risk of STIs depending on behavioural factors; inquire re: sexual practices and risks including sex work; safer sex counselling, frequent screening (i.e. every 3 months) and an assessment of indications for HIV PrEP are indicated for those at high risk. For patient-centred handout materials, see ***Brazen 2.0: Trans women's Safer Sex Guide***.

Overweight/Obese – obesity may increase the thromboembolic and metabolic risks associated with estrogen therapy, weight loss counselling should be emphasized; screen for eating disorders (more prevalent in LGBT2SQ populations, particularly amongst youth).

Underweight - screen for disordered eating – persistent gender dysphoria/incongruence may be associated with a desire to maintain a thinner body habitus in order to hide indicators of natal sex, which may have negative health impacts; strategizing around other ways to address persistent gender dysphoria/incongruence may be helpful.

Smoking – smoking greatly increases the thromboembolic risks associated with estrogen therapy, smoking cessation should be emphasized.

Alcohol and other substances – substance use is more prevalent in members of the LGBT2SQ community; inquire re: problematic use of substances including hormones without a prescription; if referral to a substance abuse program is indicated, consider an LGBT2SQ-specific or LGBT2SQ-positive program such as Rainbow Services at CAMH. Offer safer smoking and injection kits when indicated for harm reduction. A naloxone kit and instructions on use should be offered to all patients who are at risk of opioid overdose, as well as friends and family of those at risk.

Advanced care planning – A discussion regarding advanced care planning is recommended at least once for patients ≥65. Trans and gender diverse patients may have particular needs in ensuring that their gender identity and expression are respected and a respectful decision-maker is chosen.

Injection safety – for patients who self-inject estrogen: confirm dose, review aseptic injection technique, inquire re: rotating injections sites, injection site reactions, and pre-injection anxiety; consider review of route options (IM vs. SC injectable, oral, transdermal), ensure safe sharps disposal; counsel re: risks of injecting non-medical silicone (i.e. 'pumping' to enhance body shape) including chronic inflammation, disfigurement, pulmonary complications, sepsis, and death.

Bathroom safety - finding a bathroom that feels comfortable and safe can frequently be a source of stress for trans individuals. Resources such as ***Refuge Restrooms*** can assist 2STIGD people in locating gender neutral bathrooms. For those who may be experiencing urinary frequency due to spironolactone, timing of administration can be adjusted if safe bathroom access is a concern.

PHYSICAL EXAMINATION

Breasts – Evidence to date suggests that the risk of breast cancer in transfeminine individuals is not higher than in cis women and may potentially be lower than in cis women, however both benign and malignant breast disease can occur in transfeminine patients on hormone therapy; annual routine clinical breast exams in transfeminine patients with or without implants are of questionable utility but may be useful to assess the degree of breast development or to detect implant complications

respectively. Transfeminine patients should receive counselling around breast self-awareness as is recommended for cis women.

Genitourinary – In patients who have not undergone orchiectomy, testicular examination may reveal testicular atrophy in the setting of feminizing therapy but is not routinely needed.

For those who have undergone vaginoplasty, we do suggest annual (starting 1 year post-op) neovaginal speculum examination to detect any abnormalities such as granulation tissue (which may be treated with silver nitrate), active hair follicles (which may be tweezed or if extensive, cauterized under local anesthetic), warts, abnormal discharge, or malignancy; vault smears are not generally recommended as their utility in detecting dysplasia or metaplasia in keratinized epithelium is not established; neovaginal tissue created from colon can be screened for malignancy by direct visual inspection; in the extremely rare case that a neo- cervix has been surgically created, Pap guidelines may be followed as for cis women; if examination of the prostate is indicated, the prostate may be palpated along the anterior wall of the neovagina by digital examination in the lithotomy position.

Ano-rectum – for those who engage in receptive anal sex, visual examination of the perianal region for any evidence of anal warts or other anorectal problems such as hemorrhoids should be considered–particularly those who are HIV+. Additionally, consider DRE for detection of internal lesions. HIV+ patients with physical findings consistent with warts or other HPV-related changes should also be referred for HRA.

LABS/INVESTIGATIONS

Mammography – consider mammography in transfeminine patients on hormone therapy every 2 years if aged 50-74 AND on estrogen for ≥5 years total (i.e. years do not need to be consecutive), consider initiating screening at a younger age if additional risk factors are present (i.e. estrogen + progestin for > 5 yrs, family history), consider obtaining expert opinion regarding the need for annual mammography with MRI for those aged 30-69 with family history suggestive of hereditary breast cancer; the presence of breast implants necessitates diagnostic mammography rather than routine screening mammography; additional imaging modalities (ultrasound, MRI) may be recommended by implant manufacturers or a patient's surgeon at regular intervals to detect silent rupture

of silicone implants. GRS Montreal currently recommends annual ultrasounds from the 5th year onward to screen for silent rupture in silicone implants, while suggesting clinical exam only (without imaging) for monitoring of saline implants given that rupture causes visible deflation.

GC/CT/Syphilis/HIV/HBV/HCV screen – consider STI detection from the following sites as indicated: throat, urethra, neovagina, anorectum, and serum.

Yearly trans bloodwork – bloodwork should be tailored to the patient's hormone regimen, risk factors and pre-existing conditions; screening for DMII and dyslipidemia should be performed at baseline and 1 year following hormone therapy initiation, and otherwise according to routine guidelines for cis patients; Framingham calculation will be less reliable with exogenous hormone use - depending on the age of hormone initiation and duration of hormone exposure providers may choose to use the risk calculator for sex assigned at birth, affirmed gender, or an average of both.

Note: For patients on anti- androgen +/- estrogen:

- **Hb/Hct - use the female reference for lower limit of normal and male reference for upper limit of normal**
- **Cr - use male reference range for upper limit of normal**

BMD screening – exogenous estrogens appear to effectively maintain bone mass in transfeminine patients although they may have lower BMD than age-matched cis-men at baseline. In accordance with national recommendations, perform bone mineral density testing in all transfeminine patients over age 65. BMD should be considered earlier in those at high risk, such as those who, for a significant period of time (i.e. >2 yrs):

- have been on low-dose or no hormones and are agonadal
- have been on anti-androgens without the co-administration of exogenous estrogen
- have been on a GnRH analogue without exogenous estrogen

Note: frequency of follow-up BMD screening will depend on the results of the initial scan.

Anal Pap screening – for those who have a history of receptive anal sex, consider anal pap every 2-3 years or yearly in those who are HIV+ (if local HRA for the follow up of abnormal results is available).

IMMUNIZATIONS

Hepatitis A/Hepatitis B – transfeminine patients may be at higher risk of Hepatitis A/B depending on behavioural risks, if behavioural risk factors are present, the patient may qualify for publicly funded vaccination similarly to MSM.

HPV – consider HPV vaccination x 3 doses in patients up to the age of 45, tailor to risk.

CFPC – College of Family Physicians of Canada, STI - sexually transmitted infection,
RHO – Rainbow Health Ontario,
GU - genitourinary,
UTI – urinary tract infection,
PDE-5 – phosphodiesterase-5,
DVT – deep vein thrombosis, PE – pulmonary embolus,
IU – international units,
HIV - human immunodeficiency virus,
LGBT2SQ - lesbian, gay, bisexual, trans, queer, and 2 spirit, CAMH – Centre for Addiction and Mental Health,
IM - intramuscular,
SC - subcutaneous,
MRI- magnetic resonance imaging,
DRE - digital rectal exam,
HRA - high resolution anoscopy,
GC – gonococcus,
CT – chlamydia trachomatis,
HBV – hepatitis B virus,
HCV - Hepatitis C virus,
DMII - Diabetes mellitus type II,
Hb - hemoglobin,
Hct - hematocrit,
Cr - creatinine,
BMD – bone mineral density,
HPV – human papillomavirus,
MSM - men who have sex with men