	PEDIATRIC AND ADOLESCENT MEDICAL CARE OF	
	GENDER DIVERSE PATIENTS	-
	JEN DEMMA, CNM	
	DEB THORP, MD	
	,	
	APRIL 13, 2024	
	4/6/2028 Partner for good 🔹	
	Partier to good	
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	DISCLOSURES	
	We have no financial disclosures	
	All gender affirming medications are considered "off label"	
	by the FDA but they are all FDA approved medications with research to support effectiveness and safety and guidelines	
	for their use.	
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•		
	ACTIVITY OBJECTIVES	
•	Apply strategies to utilize gender exploration, mental health therapy and	
	family therapy to support patients, parents/guardians, and families as they pursue gender-affirming care.	
•	Describe the options for gender-affirming medical and surgical care and key	
	counseling components for consenting adolescents and parents/guardians for treatment.	
•	Discuss the requirements for informed consent for gender-affirming care and	
	learn how to navigate situations when agreement to care is not present.	
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Gender-Affirming C	are	F	People choose which, if any, option(s) will help bring them closer to a sense of gender congruence, based on their unique goals and needs.
Formal or Informat, Supporters and alforning Intends, family, thereplets, until vulnam aparton can discore, discorer and explain their gender dentity invited granter dentity orientation orientation	Social		ine w/GI, th others in the
Options include legally changing one's name, gender marker and other documentation: birth certificate, passport, social security card, etc.	ra l	ender ression	Options include binding/pucking, abinstyles/stowing, clothing, changing pitch of socio/speech
Hormone Medical	Surgical		patterns (voice therapy), etc. ming surgery,

#### WPATH SOC 8 Recommendations:

Relevant WPATH SOC 8 recommendations: Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

- to 6.12.F. Adolescent has reached Tanner Stage 2 of puberty for pubertal suppression to be initiated.

  6.6- Health education on chest binding and genital tucking is provided, including a review of the benefits and risks.
- risks.

  6.7- Providers consider menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for treakthrough bleeding.

  6.8- HCP's maintain an ongoing relationship with the gender diverse and transgender adolescent and section of the control of the con

  - 5.0. The patient is make aware of the reproductive effects including potential loss of fertility and options to preserve fertility within the context of the you'ldr slage of publicatel development.
    7.2. Information about gender affirming medical interventions, effects of treatment on future fertility, and options for fertility preservation are provided to gender devisers official and failmiseld-caregivers when they approach public productions.



10

#### Puberty

- Puberty may be a time when an acute dysphoric crisis develops as a child/teen recognizes body changes in a direction not desired, or that feel incongruent to their developing gender identity. Can lead child/teen and parents/family to sekc area and support.
- Can increase their distress and lead to risk of suicide and self-harming behaviors.
   Suicide is the leading cause of death among LGBTQ youth
   41% suicide attempt rate and much higher incidence of self-harming behaviors than in non-LGBTQ population
- "Pronouns matter, to the point of life or death: Transgender and nonbinary youth who reported having their pronouns respected by all or most of the people in their lives attempted suicide at half the rate of those whose pronouns were disregarded."
   The Trevor Project National Survey on LGBTQ Youth Mental Health 2020

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Consultation with patient and parent(s)/guardian(s)	
Discuss gender history	
Discuss goals and expectations	
Discuss family/social support system	
Assess pubertal stage	
Review medical, surgical, family, social, and mental health history     Discuss gender-affirming care options:	
Social transition	
○ Legal transition	
Puberty suppression therapy (if appropriate)  Userson therapy (if appropriate)	
o Hormone therapy (if appropriate)	
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L <sup>+</sup>	
Gender history	
Diagnosis of gender incongruence and/or dysphoria  Marked incongruence between one's experienced gender and one's natal gender of	
at least 6 months duration as experienced by at least 2 of the following:	
Marked inconguence between one's experienced gender and one's primary  and/anagened-between one's experienced gender and one's primary  and/anagened-between one's experienced gender and one's primary	
and/or secondary sex characteristics (or what is expected to develop)  • A marked desire to be rid of one's primary and/or secondary sex	
characteristics due to the incongruence	
A strong desire for the primary and/or secondary sex characteristics of another	
gender  • A strong desire to be another gender	
A strong desire to be treated as another gender	
<ul> <li>A strong conviction that one has the typical feelings and reactions of another</li> </ul>	
gender  4/9/2024 Partner for good ♦♦♦	
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Mental health support and letter of support	
When is active mental health support and/or a LOS needed/should be requested to prescribe puberty	
suppression or hormone therapy?  • If gender history is unclear or unsure if experiencing gender dysphoria	
<ul> <li>If therapeutic interventions and gender exploration are needed</li> </ul>	
<ul> <li>If mental health concerns are present/co-occurring (to continue therapy and/or confirm stability)</li> </ul>	
<ul> <li>If parent/family support isn't present or needs more support with/for parents and family</li> </ul>	
<ul> <li>If goals include future gender-affirming surgery</li> </ul>	
<ul> <li>If prescribing clinician is unable to do complete biopsychosocial assessment/diagnostic assessment needed for insurance or surgeries (may be beyond scope of practice)</li> </ul>	
If prescribing clinician concerned that prescribing may be clinically unsafe, a LOS may be	
indicated (listen to your gut) but not "gate keeping"	
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Discussion of goals & expectations	
<ul> <li>Short-term goals</li> <li>What physical changes in the short run are most important to them?</li> <li>Do goals line up with what is feasible for puberty suppression, menstrual suppression and/or gender affirming hormone administration?</li> </ul>	
Long-term goals	
<ul> <li>What physical changes to they want to have accomplished in 3-5 years? 10 years?</li> </ul>	
Are those goals feasible medically?	
<ul> <li>Expectations of what puberty suppression therapy, hormone therapy, or surgery will do for them.</li> </ul>	
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Discuss family/assist support system	
Discuss family/social support system	
<ul> <li>Family support throughout the process is the biggest predictor of mental health and wellbeing and can reduce the risk of suicide, depression, illegal drug use</li> </ul>	-
and other risky behaviors.	
<ul> <li>Partner with mental health clinician to support patient and family.</li> <li>Provide community resources and support groups to help patient and families</li> </ul>	
find support.	-
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Resources for Support	
• •	
transforming families RECLASM	
ONESD.	
gender @UEER SPACE collective	
collective	
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## Review patient history

Surgical	Medical	Mental health	Family	Social
<ul> <li>Previous penile or scrotal surgery</li> <li>Previous breast surgery</li> <li>Previous gynecological surgery</li> </ul>	total bone density  Vit D deficiency or calcium abnormality  Vit Sidney disease  Endocrine	Co-occurring mental health concerns	Early onset cardiovascular disease     Mental health concerns     Clotting disorders-specifically parents     Diabetes     Thyroid disease	Nicotine use Cannabis use Alcohol use Drugs use Sexual activity: Pregnancy test STIS PrEP

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24

### Assessing pubertal stages

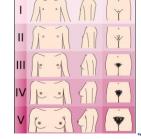
- 6.12.f- Adolescent has reached Tanner Stage 2 of puberty for pubertal suppression to be initiated.
- Discuss any concerns/dysphoria with anatomy and developing (anticipate developing) secondary sex characteristics.

25

## Tanner staging of puberty

- Assess for:
   Chest tissue/breast growth
   Public hair growth
   Menstruation





#### Tanner staging of puberty

- Assess for:
  Growth of penis, scrotum, testes
  Public hair growth



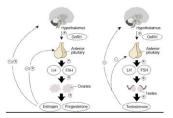
Additional details of "Validity of Self-Assessment of Puberal Maturation" available through American Academy of Pudiatric Pediatrics. 2015;136(1):88-93. doi:10.1542/peds.2014-0793 Validity of Self-Assessment of Puberal Maturation. | Pediatric American Academy of Maturation | Puberal American Academy of Puberal Pu

27

#### **Puberty Suppression Therapy**

- Gonadotropin-releasing hormone agonist (GnRH agonist) medication is used for puberty suppression (puberty blockers), which reduces sex hormone levels and temporarily stops the development of the secondary sex characteristics with puberty.
- · Used for a long time in children with precocious puberty. Used for 20+ years to treat healthy adolescents with gender dysphoria.
- · Using therapy gives time to explore gender identity and doesn't mean one must use hormone replacement therapy or have gender-affirming surgery in the future.
- Can't reverse secondary sex characteristics that have already developed.

Hypothalamic pituitary gonadal axes



28

### Puberty Suppression- benefits & risks

Tuberty Suppression- benefits & risks						
Benefits	Risks					
Pauses the pubertal changes, and fear of ongoing future changes, that can be a source of dysphoria and pressure.	Long-term side effects on overall health and brain development are unknown.					
Gives time to work with behavioral health/sexual health to explore gender identity and pros/cons of natal puberty vs hormone replacement therapy.	Side effects of the medications.  Potential effects on mood (mood changes, mood swings)					
Pause changes before permanent body changes/characteristics occur. May lead to fewer and less complex medical/surgical interventions in future to align the body with gender identity.	For assigned male at birth, less tissue may develop on penis and scrotum and may make future bottom surgery (i.e. penile inversion vaginoplasty) more difficult to complete (less tissue available to use for surgery).					
Can stop puberty suppression at any time and body will continue through natal puberty.	Affects how body absorbs calcium and can reduce bone density. Unknown if increases risk of osteoporosis when older. (Calcium and vitamin D intake/supplement and weight-bearing exercises is important)					
	Infertility if using puberty suppression then gender-affirming hormone therapy and didn't go through natal puberty.					

29

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Puberty Suppression- options	
Gonadotropin-releasing hormone (GnRH) agonists  Injectables: Lupron Depot (IM) and Eligard (SQ) (typical dosage 22.5 mg every 3	
months)  Shorter duration, so easy to stop if wanting to discontinue treatment.  If not given at regularly prescribed intervals, pubertal changes may still	
O if not given at regularly prescribed intervals, publicated changes may sum occur.      Usually given in clinic every 3 months (depending on prescribed dose and	
adjustments during course of treatment).  Implants (in-clinic insertion procedure): Histrelin Supprelin LA (dosage 50 mg)	
<ul> <li>Histrelin Vantas implants no longer available.</li> <li>Longer duration, so pt is not reminded as regularly of need for suppression,</li> </ul>	
which can decrease dysphoria for some patients.  In-clinic insertion procedure placed under skin on inner side of upper arm and can stay in place for 1 year (unless removed earlier to discontinue	
treatment).	
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31	
31	
Puberty Suppression- considerations  Medication considerations:	
o Very expensive (Supprelin LA \$50,000+ per implant, Lupron/Eligard 22.5mg	
approximately \$1400 per injection, Lupron 11.25mg approximately \$11,700 per injection).	
<ul> <li>Prior authorization needed through insurance.</li> <li>General recommendation is to use suppression for no longer than 2-5 years, but</li> </ul>	-
it may be possible to use them longer depending on clinician's recommendation.  Histrelin could stay in to be used for its androgen suppression effects, while also	
prescribing estrogen hormone therapy to achieve feminizing secondary sex changes.  Once suppression therapy ends, either natal puberty	
or hormone therapy begins (estrogen or testosterone therapy). The body can't avoid	
puberty entirely or not have any hormones in it Will not develop pubertal changes at the same time as same age peers (though the range for the	
rate/timing of pubertal development is notoriously wide)  **Partner for good  ***	
32	
Puberty Suppression- considerations	
■ Monitor growth (height, weight) and puberty changes every 3-6 months	
<ul> <li>If taken during growth spurt, may have slightly shorter final adult height than would have otherwise</li> </ul>	
■ Monitor labs every 6-12 months	
<ul> <li>CBC, CMP, LH, FSH, Estradiol, Testosterone, Vit D</li> <li>Monitor bone density with Dexa scan every 1-2 years</li> </ul>	
, , ,	
<ul> <li>This medication isn't contraception and doesn't protect from sexually transmitted diseases.</li> </ul>	
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34	

#### Puberty Suppression- body effects/changes Stops growth of testes, scrotum, and penis. Decreases fertility/ability to get someone pregnant while using medication. Fertility returns if progresses through natal puberty after stopping medication. Stops menses (or won't start). Decreases fertility/ability to get pregnant while using medication. Fertility returns if progresses through natal puberty after stopping suppression. Stops chest tissue/breast growth (or won't start). Decreases or stops nocturnal emissions (or won't start) Growth/height slower than if going through puberty. Growth/height slower than if going through puberty May experience vaginal dryness and reduced sex drive. Causes erectile dysfunction, fewer spontaneous Won't develop softer skin, wider hips, and/or more fat on hips. Stops further increase of facial and body hair growth (or won't start) Stops further development of facial structures (increased brow ridge, Adam's apple, angular appearance) and body structure (broader shoulders, more muscle development)

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35

#### **Puberty Suppression-side effects**

- Puberty changes/symptoms can continue in the first 4 weeks after starting treatment (i.e. irregular bleeding).
- · Mood changes and mood swings
- Headaches, hot flashes (sweating, warmth or redness in face, neck, arms, upper chest) and night sweats, figure, muscle pain and weakness, dizziness
- GI upset- nausea, vomiting, diarrhea
- Risk of allergic reaction; pain, soreness, bruising at injection/implant site; risk of infection with any injection or implant. Risk of implant migrating from insertion site.
- Uncommon risks:
  - o Increased risk seizures
  - Cardiovascular effects (risk in cisgender males using medication for prostate cancer. Risk in healthy adolescents is unknown.)
  - o Pseudotumor Cerebri (idiopathic intracranial hypertension)

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36

## Menstrual suppression

Multiple options which can be used together or separately

- Depo Provera potential for weight gain, mood issues
- High dose oral progestins Medroxyprogesterone 20-30 mg daily or Norethindrone 5-10 mg daily same side effects
  Nexplanon can work enough for some patients but usually not amenorrheic
- Mirena IUD can work but lead in of several months spotting and can be associated with cramping. Disadvantage of needing to insert either in the office or the operating room, and not a good choice if uterus is too small.

  Continuous OCPs/NuvaRing but may be dysphoric and/or induce more feminizing changes if early in puberty
- Leuprolide Acetate (DepoLupron)
- Elagolix GnRH antagonist, no data in young patients
- General Approaches to Medical Management of Menstrual Suppression | ACOG

Partner for good (6)

Increasingly, there are people who express the desire to avoid having either masculinizing or feminizing hormones in their bodies.

### Counseling points:

- · Puberty cannot be avoided entirely
- · Hormones affect more than secondary sex characteristics: bone health, growth, brain development, cardiovascular health
- Patients can use time while on suppression therapy to consider which hormones will be the least dysphoric for them.

39

### **HORMONE THERAPY BENEFITS AND RISKS**

Benefits	Risks	
Individualized therapy based on patient's goals for gender alignment. Better align body with gender identity.	Long-term risk are not fully known.  Potential effects on mood (mood changes, mood swings) and worsen mental health conditions (anxiety, depression bipolar disorder, schizophrenia, ADHD).	
Increased positive mental health outcomes and quality of life.		
Decreased risk of anti-LGBTQ violence, by helping to "pass" as individual's identified gender.	Affects how body absorbs calcium and can reduce bone density. Unknown if increases risk of osteoporosis when older.	
Close to zero regret: lower than for knee replacement.	Decreased fertility during treatment. Infertility if using puberty suppression then gender- affirming hormone therapy and didn't go through natal puberty.	

41

### **HORMONE THERAPY - GOALS AND EXPECTATIONS**

Gender-affirming hormone therapy is used to develop the secondary sex characteristics that are in line with the patients' gender identity.

- $_{\odot}\,\text{Changes}$  take time and happen at different rates.
- o The rate of change depends on an individual's body, and the medication's route and dose, though higher doses do not necessarily correlate with faster changes.
- o Some changes are reversible, some are semi-permanent, and others are
- o The affects achieved through hormones are dependent on an individual's genes. Ex: some people grow lots of facial hair in a day, for others it can take months; some people develop large breasts, others' breasts are smaller.

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MASCULINIZING I	ORMONE TH	ERAPY O	PTIONS		
Testosterone options:					
Transdermal: Gels of v	arying strengths				
<ul> <li>Injection (IM or subQ)</li> </ul>	, usually weekly				
Testosterone cypic					
Testosterone enan					
Xyosted SQ injection					
Long acting:					
Aveed testosteron	e undecannate iniec	tion (at PN MI	PLS Gender Servi	-es)	
Testopel testostero				2037	
• Oral	,		,		
Jatenzo, Tlando an	d Kuzatrov aro all tos	stosterone uno	decannate with a	hsorntion via	
	ng the liver. Not inte		accarioate with a	bsorption via	
.,					
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MASCULINIZING I	HORMONE IH	ERAPY O	PHONS		
Typically, visits are even	ry 8-12 weeks for	r the first ve	ar than vicits	ra lass oftan	
				ire iess orten	
<ul> <li>Each visit clinical and l</li> </ul>	aboratory respon	ise is assesse	ed		
<ul> <li>Assessment of impact</li> </ul>	of medication an	d other adiu	ınctive measur	es on gender	
dysphoria is done as p				es on genaer	
dysprioria is doric as p	art or assessing c	iii iicai respo	1136.		
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TESTOSTERONE T	HERAPY PHY	SICAL EF	FECIS		
Timeline is typically 1-12 months	Timeline for Effects of Masculi	inizing Hormone Ther	ару		
and can take up to 1-5 years for maximal changes to occur.	Effect Acne, oily skin	Onset of changes 1 to 6 months	Maximum effect reached a 1 to 2 years	t: Reversibility	
Potentially permanent body	Fat redistribution	1 to 6 months	2 to 5 years	Moderate	
changes:	Menstrual suppression, cessation of menses	1 to 6 months, most often closer to 6 months		High*	
· growth of facial hair and body	of menses Citoral enlargement	I to 6 months	1 to 2 years	Low	
hair,	Vaginal atrophy	1 to 6 months	1 to 2 years	Low	
<ul> <li>decreased scalp hair (including</li> </ul>		2 to 6 months	1 to 2 years	Considered permanent	
male pattern baldness),	Increase in muscle mass and strength	6 to 12 months	2 to 5 years	Moderate	
<ul> <li>deepening of voice,</li> </ul>	Facial/body hair growth  Scalp hair loss**	6 to 12 months 6 to 12 months	4 to 5 years Dependent on genetic	Low	
clitoromegaly (clitoral enlargement)			Dependent on genetic predisposition		

clitoromegaly (clitoral enlargement),
 menstrual suppression/cessation of menses,
 infertility.

TESTOSTERONE T	HERAPY POTENTIAL RISKS AND SIDE-E	FFECTS	
Decreased estrogen	Testosterone		
Hot flashes, headaches,	Acne		
mood swings	<ul> <li>Polycythemia and blood clots</li> </ul>		
Vaginal dryness (can last years)	<ul> <li>Mood swings, quicker to anger</li> <li>Increased depression, increased anxiety</li> </ul>		
Urinary frequency	Mental health instability (especially with bipolar, schi and other mood disorders)	zophrenia,	
	<ul> <li>Worsening ADHD symptoms (including difficult to focus</li> </ul>	us, concentrate)	
	<ul> <li>Increased sex drive (evens out over time)</li> </ul>		
	Elevated blood pressure, elevated cholesterol, diaber	tes.	
	<ul> <li>Irregular vaginal bleeding</li> <li>Too high testosterone, metabolizes to estrogen</li> </ul>		
	Too low testosterone, may NOT suppress ovulation	n	
	o loo low testesterone, may not supplies ovaluate		
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48			
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ESTROGEN AND A	NDROGEN BLOCKERS - OPTIONS		
LOTTOOLITAIDA	NDROGEN BEGONERO OF HORO		
Estrogen options:	Brogostorono	is not typically	
• Pills		scents, since it	
<ul> <li>Patches</li> </ul>	is not used un	ntil 1-2 years after	-
<ul> <li>Injections (IM or su</li> </ul>	ıbQ), usually weekly starting estroc	gen to promote	
<ul> <li>Estradiol valera</li> </ul>			
<ul> <li>Estradiol cypion</li> </ul>	nate Lise of Ricalut	amide pills for	
<ul> <li>Androgen blockers opt</li> </ul>	cions: androgen bloo		
<ul> <li>Spironolactone</li> </ul>	recommended		
<ul> <li>Finasteride</li> </ul>			
<ul> <li>Dutasteride</li> </ul>			
<ul> <li>Clinician visits and lab 2 times per year once</li> </ul>	monitoring typically every 3 months for first year of in levels are stable.	itiation then 1 to	
	ontraception and doesn't protect from sexually transm	nitted diseases.	
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#### ESTROGEN AND ANTI-ANDROGEN PHYSICAL EFFECTS

Timeline for body changes is typically 3-6 months after starting therapy and can take up to 2-3 years for maximal changes to occur.

- Potentially permanent body changes:
   breast growth
   decrease testicular volume
   decreased sperm production
   infertility

Decreased spontaneous erections	1 to 3 months	3 to 6 months	High
Erectile dysfunction	Variable	Variable	High
Decreased libido	1 to 3 months	3 to 6 months	High
Decrease in muscle mass and strength	3 to 6 months	1 to 2 years	High
Redistribution of body fat	3 to 6 months	2 to 3 years	High
Softening of skin/decreased oiliness	3 to 6 months	Unknown	High
Decreased testicular volume	3 to 6 months	2 to 3 years	Unknown
Decreased sperm production	Unknown	> 3 years	Unknown**
Breast growth	3 to 6 months	2 to 3 years	Considered permanent
Decreased terminal hair growth	6 to 12 months	> 3 years*	High, except for electrolysis or laser treatment
Scalp hair	Variable	Variable; familial scalp hair loss pattern may occur	Low
Voice changes	Only achieved through voice training by speech pathologists		High

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ESTROGEN AND ANTI-ANDROGEN POTENTIAL RISKS AND SIDE-EFFECTS	
• Estrogen	•
<ul> <li>Hot flashes, headaches, mood swings (usually in the first few weeks of use)</li> </ul>	
Weight Gain     Elevated blood pressure	
Elevated triglycerides, cholesterol	
Blood clots – worst with oral administration     Gallbladder disease with oral administration	
Unknown about decreased bone density, breast cancer	
<ul> <li>Prolactinoma</li> <li>Mental health instability, worsening mood issues, increased</li> </ul>	
anxiety, depression  • Infertility	
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54	
34	
ESTROGEN AND ANTI-ANDROGEN POTENTIAL RISKS AND SIDE-EFFECTS	
Anti-Androgens	
Spironolactone	
Lower blood pressure     Dizziness	
<ul> <li>Frequent urination</li> <li>Elevated potassium and/or elevated creatinine</li> </ul>	
Infertility     Finasteride, Dutasteride	
Depression	
Infertility     Rarely, liver disease	
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FERTILITY PRESERVATION DISCUSSION	
- Tools available to facilitate a family discussion. Trans Voyth	
<ul> <li>Tools available to facilitate a family discussion – Trans Youth and Family/Parent Questionaires that can be a starting point for</li> </ul>	
discussion at home and then brought in for more in depth conversation with mental health and/or medical clinicians	
More than one visit discussion	
Storing actual testicular or ovarian tissue via cryopreservation is	
possible at Mayo Children's Program as part of a study	
<ul> <li>Storing sperm or ova may be very dysphoric for the patient</li> </ul>	
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59	

FERTILITY PRESERVATION DISCUSSIO	Ν
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Assigned male at birth

- Best to store sperm before starting gender affirming medication. Sperm is not mature enough for storage in pre-pubertal males.
- Fertility may return off estrogen and anti-androgens

Assigned female at birth

- Freezing ova technology is improving, is possible before starting gender affirming testosterone if menarche has occurred
- Fertility usually returns off testosterone

DECREASED FERTILITY DOES NOT IMPLY THAT CROSS GENDER HORMONES ARE CONTRACEPTION!

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60

## **TYFAQ Youth Questions**

	Natur	Teday's Eate		
	Please answer the following quartiers. Please note: "Skringical children" means children			
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	Familiary quantities     Familiary years projet year age;     Other Str in the bland.     I did not be one bid in bornease it watered used it make it difficult to bear way one beingland oblighteen prior to this questionaries.	0 Agent 0 Stragent 0 Strangly disagram 0 1-der/1 hours	Mis fissings about wonting the own biological child might change whea Fin state.     Homeon against     April     Congress	Family be anyon title doctor after hird one that however treatment and other any after on how my one to height distinct.      Family again     Alive     Family again
	Their I have prouped to task to take on the original or through deback which can be desired to take the property of their states of the states	Towards have bith semistry. (This could be either you be a disposed bith).     Towards (All Services)	Sometimes     It is a facilities     It is a manufact from any against that would allow one to have any own bibliograph delicement of the on homosom.     I through again     Again	Sweet's Street     1 Annie Street     1 Annie Street
r.	#These skill, it would be important to ten that they are my biological bids.  O Serveyle asses.  O Agene  O Transport  O Strongly Eastern	I would consider adoption someday.     Simmely agent     Signer     Signer     Signer     Signer     Signer     Signer	Engine     Engine     Engine     Engine     I Annhalis  I Annhalis  III. Teach has the Fire Engineering by Earlin Frontal set been my one Standard Mill.	Compare     Compare     Compare     Compare     Compare     Compare     Compare
	0 MorNinose	4 identifican	Descriptionalities     Agree     Description     Description     Description     Description     Description     Description     Description	G Strongth agains  G Age  G Stranger  G Stranger  G I dec't Strong
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61

## TYFAQ Parent Questions

	TYTAQ Parent/Guardian Questions			
	Nane	Tettay's Bate:		
	Please arrange the following specialry. Please note: "Biological children" means, children	han all hand life annual a comm		
	to inserting to have about how he waste trademan wide after my chiefs			
	t is important to learn about how hormose treatment might affect my child's shifty to have bridges of children.	<ol> <li>Lem aware chert humanous yearmost could co ability to have their man biological dilibrar.</li> </ol>	acter brown with my (MAC)	
	2 Strongs seem	o Stock was		
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_	g Identition		23. I would be disappointed if my child could not have their own biological child.	14. I want my child to consider medical procedures that would allow them to
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	4/9/2024		@ 1800access*	puberly thickers, bostonics or other mortistrypagement.
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ΤŸ	TYFAQ Comparison Chart								
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# FERTILITY EFFECTS OF PUBERTY SUPPRESSION AND/OR GENDER AFFIRMING HORMONE THERAPY

Assigned female at birth	Assigned male at birth
Suppresses menses	Stops growth of testes, scrotum, penis Decreases/stops nocturnal emissions Causes erectile dysfunction, decreases spontaneous erections Decreases libido
Menses resume and reproductive organs fully develop	Sperm production resumes and reproductive organs fully develop
Infertility, because reproductive organs didn't fully develop	Infertility, because reproductive organs didn't fully develop
Suppresses menses Suppresses ovulation (not always, so pregnancy still possible. Testosterone is category X teratogenic medication so can cause birth defects) Increases libido (may level out over time)	Decreases sperm production (though could still get someone pregnant) Decreases testicular volume Causes erectile dysfunction, decreases spontaneous erections Decreases libido
	Suppresses menses  Menses resume and reproductive organs fully develop  Infertility, because reproductive organs didn't fully develop  Suppresses menses  Suppresses ovulation (not always, so pregnancy still possible. Testosterone is category X teratogenic medication so can cause birth defects)

64

## NAVIGATING DISCUSSIONS WHEN PARENTS/GUARDIANS DON'T AGREE TO CARE

- Clinicians can and should:
  - Educate all parties on what puberty suppression and/or gender affirming hormones will and will not do for and to the patient, and options available to address concerns
  - Listen to goals and expectations of each party
  - Is there anyplace where agreement can be found to build consensus?
  - Offer family therapy, individual therapy resources
  - Offer resources for support groups to help with family education around gender diversity

Partner for good	44

### **HealthPartners and Park Nicollet Gender Services**

If you work in the system, there is a referral you can place to Gender Services and we will get the patient in with the appropriate clinician(s)

If you don't want to place a referral or don't work in the system, call 952-993-8052 and we will get the patient in with the appropriate clinician(s)

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68

