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Case Series

Gender identity disorder: role of the gynecologist

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ABSTRACT

Gender dysphoria refers to distress that is caused by a sense of incongruity between an individual's self-identified gender and natal sex. Over 1.4 million adults are identified as transgender. Transpatients face many barriers when it comes to basic health needs including education, housing, and health care. Because of these barriers, many patients do not receive proper health care that they need. Additionally, because of certain high-risk behaviours as well as long-term hormonal therapy, transpatients have different routine health care needs that should be addressed in the primary care setting. Diagnosis is made in accordance with the diagnostic and statistical manual of mental disorders and treatment first involves psychiatric therapy, which can help determine a patient's true goals in regards to achieving gender identity. Patients who wish to undergo transition to the opposite sex must undergo a supervised real-life test and often are treated with hormonal therapy to develop physical characteristics consistent with their gender identity. Many of these individuals have undergone, or plan to undergo, gender-affirming surgery. While not all gender-affirming surgeries are provided by obstetricians and gynecologists (OBGYNs). It is a multi-disciplinary team which involves psychiatrist, endocrinologist, gynecologist and plastic surgeon. OBGYNs are uniquely skilled to perform certain gender-affirming surgeries such as hysterectomies, bilateral oophorectomies. In this case report we discuss the medical and surgical options available for the transgender population. In addition, it also highlights the role of gynecologists in having care for this population, and should be knowledgeable about the general principles of transgender health.

Keywords: Gender dysphoria, Gender identity disorder, Sex reassignment, Transgender, Transsexual, Hysterectomy, Bilateral oopherectomies

INTRODUCTION

Gender dysphoria (GD) is defined as the presence of clinically important discomfort or distress due to incongruence between a person's birth-assigned sex and gender identity.[1] An individual experiencing feelings of GD has the right to receive standard, free-of-stigma medical services, adjusted to their needs. GD may present at any point of the individual's life.[1] In childhood, GD can manifest at a very young age, sometimes even before the age of 7.[2] It first becomes apparent as gender-diverse behaviour. In children, GD will be expressed through their clothing preferences, leisure activities, and choice of playmates.[3]

Birth-assigned female children experiencing GD may express their dissatisfaction toward stereotypically feminine clothing, such as dresses, ribbons.[3] They may prefer short haircuts, state that they wish "they were boys," or ask their parents to call them by a male nickname. It is worth noting that the occurrence of gender-diverse behaviour in a child is most likely to subside when the child enters adolescence.[4]

Late-onset gender dysphoric feelings may also first appear in adolescence. At this age, adolescents usually verbalize their discomfort, mainly focusing on the development of secondary sexual characteristics. A birth-assigned female adolescent may exhibit discomfort toward the development of breasts by covering them using oversized clothes.[5]

Finally, in adulthood, individuals with GD will either clearly state their discomfort regarding their birth-assigned gender or will adopt a lifestyle that is more aligned with their gender identity.

CASE SERIES

Three patients who had gender dysphoria were counseled by a psychiatrist and were diagnosed to be having gender identity disorder. The patients were given injection testosterone based on their body requirements and were asked to follow up by an endocrinologist. After the desired levels of testosterone is obtained, according to the patient's request hysterectomy with bilateral salpingo-oopherectomy was done by a trained gynecologist. If the patient desired, bilateral mastectomy was done simultaneously by trained surgical personnel. Post-op was uneventful and patients were asked to follow-up.

Case 1

Mr. X, aged 24 years, unmarried, had gender dysphoria since the age of 6 years and has not undergone any prior surgery. Patient has taken psychiatric counselling. There was no family support. Patient was started on injection testosterone 250 mg I.M, monthly once. There were changes in the secondary sexual characteristics like growth of facial hair, hoarseness of voice and clitoromegaly after 4 months of inj. testosterone. Pt was advised to stop inj. testosterone one month prior to the surgery. Total abdominal hysterectomy with bilateral salpingoopherectomy followed by B/L liposuction with mastectomy was done. Intra-op- uterus- normal in size, B/L- ovaries- normal, B/L adnexa- normal. Bleeding was minimal. Post-operatively patient was stable and was shifted to ward. Patient was asked to follow-up after 2 weeks for general check-up.

Case 2

Mr. A, aged 24 years, married since-1 year, had gender dysphoria since the age of 10 years and has undergone B/L mastectomy with liposuction one year back. Patient has taken psychiatric counselling, and had family support, was started on inj. testosterone 250 mg I.M, monthly once. There were changes in the secondary sexual characteristics like growth of facial hair, hoarseness of voice and clitoromegaly after two doses inj. testosterone. Pt was advised to stop inj. testosterone three weeks prior to the surgery. Pt was posted for total abdominal hysterectomy with bilateral salpingoopherectomy was done. Intra-op- uterus- normal in size, B/L- ovaries- normal, B/L adnexa- normal. Bleeding was minimal. Post-op patient was stable and shifted to ward. Patient was asked to follow up after 2 weeks for general check-up.

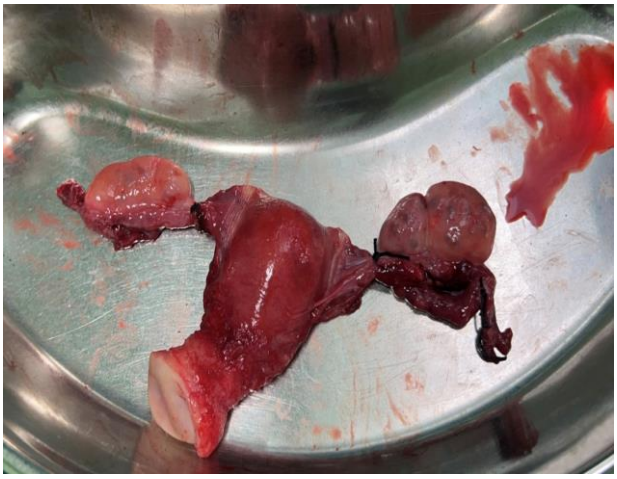

Figure 1: Uterus with cervix and bilateral fallopian tubes and ovaries.

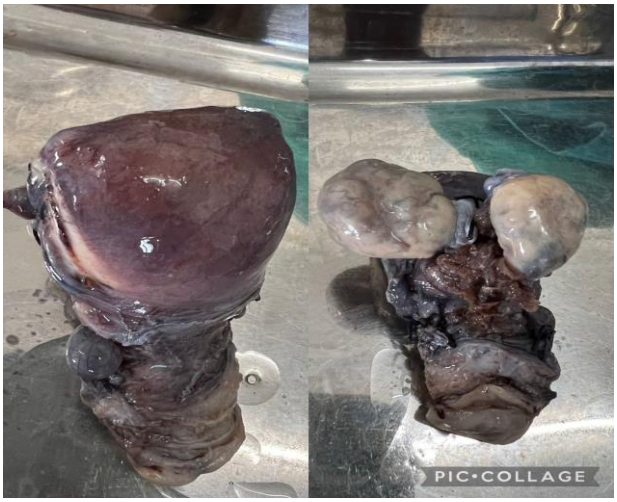

Figure 2: Uterus with bilateral ovaries.

Case 3

Mr. A, aged 24 years, married since-1 year, had gender dysphoria since the age of 10 years and has undergone B/L mastectomy with liposuction one year back. Patient has taken Psychiatric counselling, and had family support, was started on inj. testosterone 250 mg I.M, monthly once. There were changes in the secondary sexual characteristics like growth of facial hair, hoarseness of voice and clitoromegaly after two doses inj. testosterone. Pt was advised to stop inj. testosterone three weeks prior to the surgery. Pt was posted for total abdominal hysterectomy with bilateral salpingoopherectomy was done. Intra-op- uterus- normal in size, B/L- ovaries- normal, B/L adnexa- normal. Bleeding was minimal. Post-op patient was stable and shifted to ward. Patient was asked to follow-up after 2 weeks for general check-up.

Table 1: Summary of treatment before and procedures performed.

Case	Age	Married/ unmarried	Inj. testosterone			Surgery undergone
			Started	Stopped before surgery	Re-started after surgery	
1	24	Unmarried	2019	1 month	after 2 weeks	TAH+ B/L mastectomy
2	24	Married	2020	2 months	after 2 weeks	TAH+B/L mastectomy
3	24	Married	2019	3 weeks	After 1 month	TAH

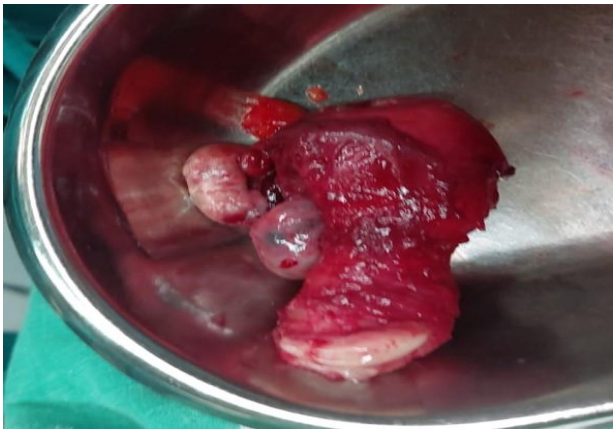

Figure 3: Uterus cervix and bilateral ovaries.

DISCUSSION

In our study, comparing to other similar studies, seeking and receiving health care can be challenging for many individuals and the specific health care maybe unique to that individual or applicable to an entire group.[6] Regardless of their future plans for genital reassignment surgery, trans men frequently pursue hysterectomy as part of their gender re-affirmation. After the surgery, access to vagina was frequently challenging due to absence of prior vaginal intercourse and marked vaginal atrophy due to high dose testosterone.[7] Proper follow-up of the post-op cases would help in neglecting the chance of infection.

CONCLUSION

According to many healthcare guidelines, a major governmental health care goal is to improve the health, safety, and wellbeing of the lesbian, gay, bisexual, and transgender population. Transgender men sometimes seek gynecologic care as many of these patients do not fully transition with sex reassignment and do not have their pelvic organs removed and need routine screening such as Pap smears and bimanual pelvic examinations. In addition, some patients may receive their hormonal treatments and surveillance through reproductive endocrinology specialists who may prefer to refer patients to gynecologists in their practice for routine health management to facilitate good continuity of care. For all the reasons above, gynecologists need to be familiar with the health care needs of these patients. Lastly, gynecologists should be aware of the barriers that transpatients face with regards to accessing care as well as feeling comfortable once they have found a provider.

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