

1. Hold the problem drug, not the hormones

 Card 1 of 11

Holding a drug for a clinical reason isn't stopping hormones. Don't stop oestradiol or testosterone by reflex: hold the drug that is the problem, and reassess as the situation changes ♦.

Find the card	Card
Which drug to hold: high potassium or AKI, abnormal LFTs, meningioma, clot, pregnancy	1 (this card)
Clot, chest pain, MI, stroke or TIA	2
Surgery, anaesthesia, airway after facial or voice surgery	3
A blood result, a lab flag, eGFR and drug dosing, PSA, troponin, oestradiol level	4
High haematocrit on testosterone	5
Ran out of hormones; own, self-sourced or non-formulary supply; warfarin or lamotrigine	6
Pregnancy tests, screening, breast lump, scrotal pain, transfusion, neovagina and catheters, sexual assault	7
Abdominal or pelvic pain, or vaginal bleeding, with a uterus or ovaries	8
Urinary retention, bleeding or dilator problems after genital surgery; chest haematoma	9
Headache, visual change or seizure	10
Contraception and emergency contraception	11

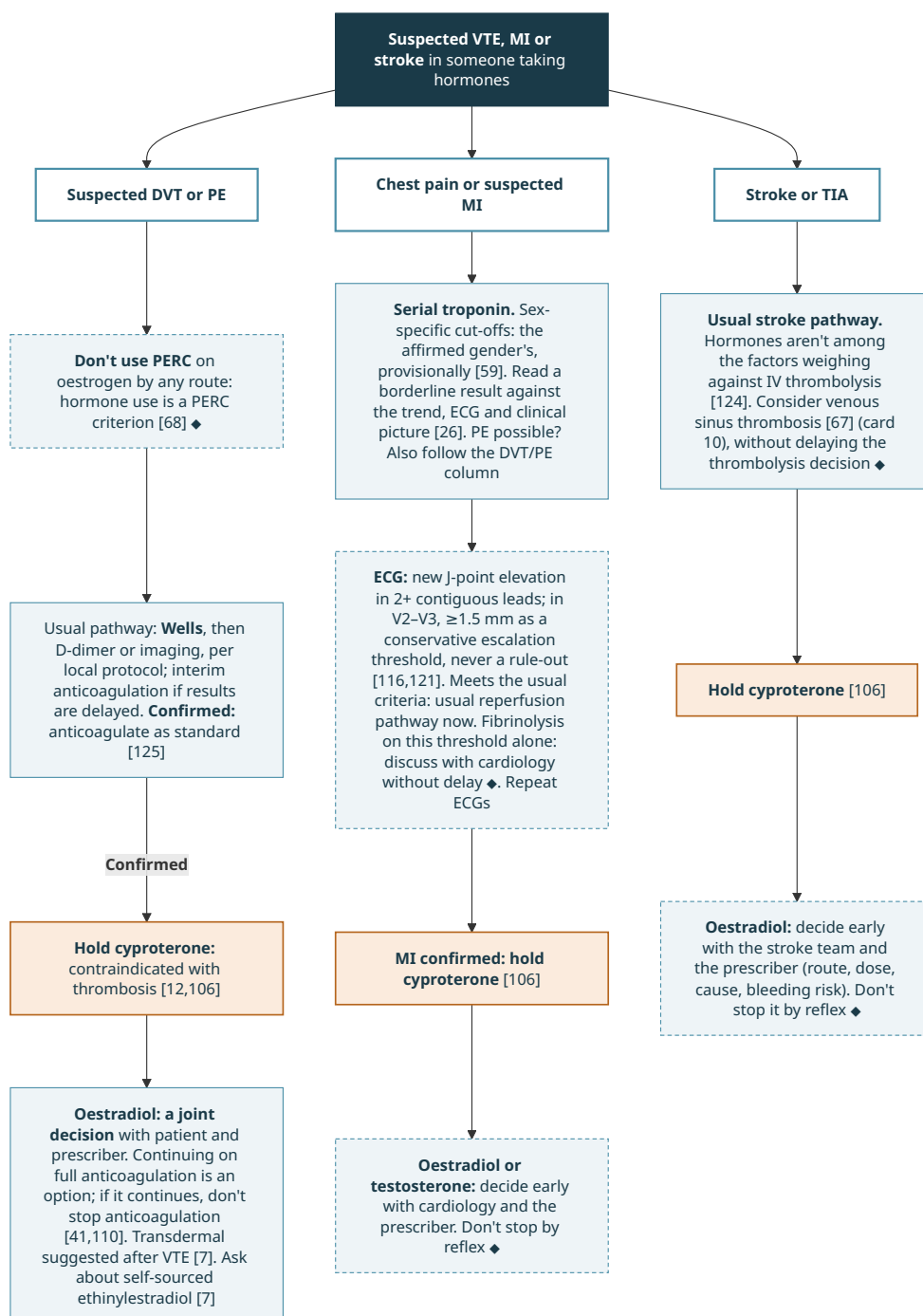
Situation	Hold	Keep, or decide
High potassium, AKI, dehydration or low blood pressure	Treat by the usual protocol first ♦. Spironolactone [19]; sick-day rules pause diuretics in dehydrating illness [74]. Decide about any ACE inhibitor or ARB too ♦ ✖	Oestradiol. Alone it may not fully suppress testosterone: tell the prescriber [3,75]
Meningioma found	Cyproterone, permanently [9,12]	Oestradiol: discuss with neurosurgery and the prescriber ♦ (card 10)
Liver injury confirmed, no other cause	Cyproterone [12] ✖	Oestradiol; tell the prescriber (suppression may be lost) and recheck LFTs ♦
Confirmed DVT or PE	Cyproterone : contraindicated with thrombosis [12,106]	Oestradiol on full anticoagulation is an option, agreed with the patient and prescriber [41] (card 2)
MI, stroke or TIA	Cyproterone : its warnings name MI and stroke [106]	Decide about oestradiol or testosterone early with the specialist team and the prescriber. Don't start anticoagulation just to continue hormones ♦ (card 2)
Haematocrit above about 54%, confirmed or with symptoms	Testosterone until it falls; restart at a lower dose [86]	Dose and formulation with the prescriber [25,86] (card 5)
Pregnancy	Testosterone [7,51]	Refer [7]
Surgery	Usually nothing [58]	Testosterone: continue [58]. Oestradiol: case by case [40,58] (card 3)

Why not stop everything? Stopping oestrogen can bring back low mood and anxiety within days [39]. After the ovaries or testes have been removed, stopping will cause bone loss [7]. SOC8 asks that any interruption be "as brief as possible" [7].

Self-sourced ethinylestradiol or contraceptive pills carry the highest clot risk: ask, and never substitute them [7].

2. Clot, heart attack or stroke on hormones Card 2 of 11

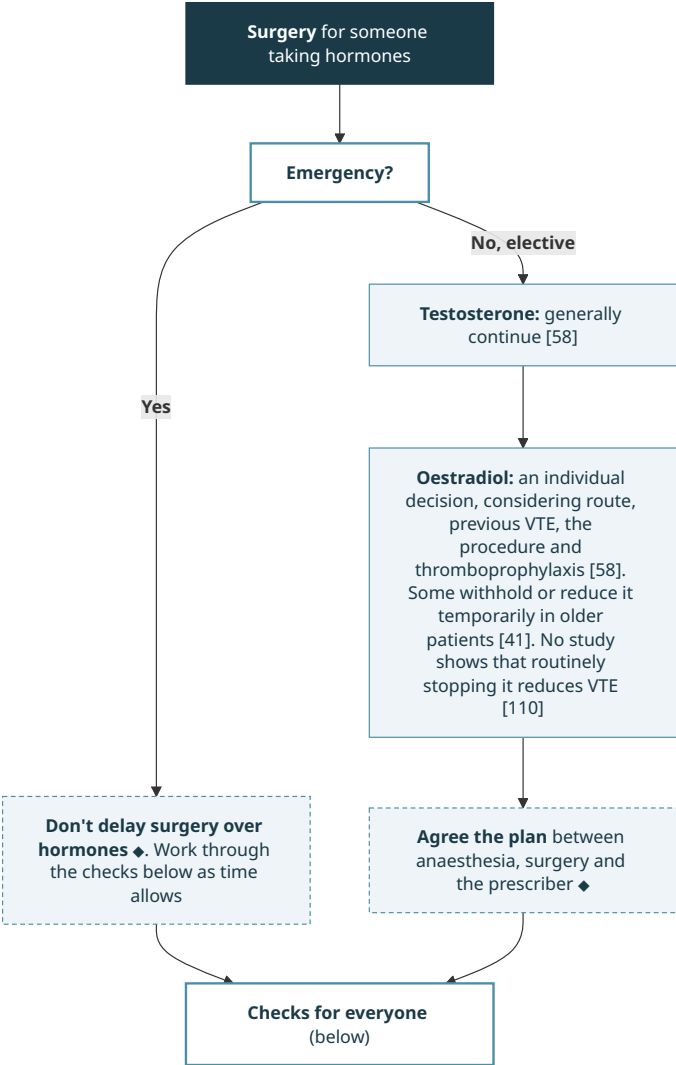
Follow every branch that fits: PE and MI can look alike ♦. Treat the event by its usual protocol. Hold cyproterone. Decide about oestradiol or testosterone early, with the specialist team and the prescriber: don't stop them by reflex.



Question Action (cited) Mainly Eden Openly advice (♦ marks which part) Hold or never

Never start anticoagulation just so that hormones can continue ♦. Treat the event by its own protocol.

Hormones are usually continued. Oestradiol is an individual decision, not an automatic stop.

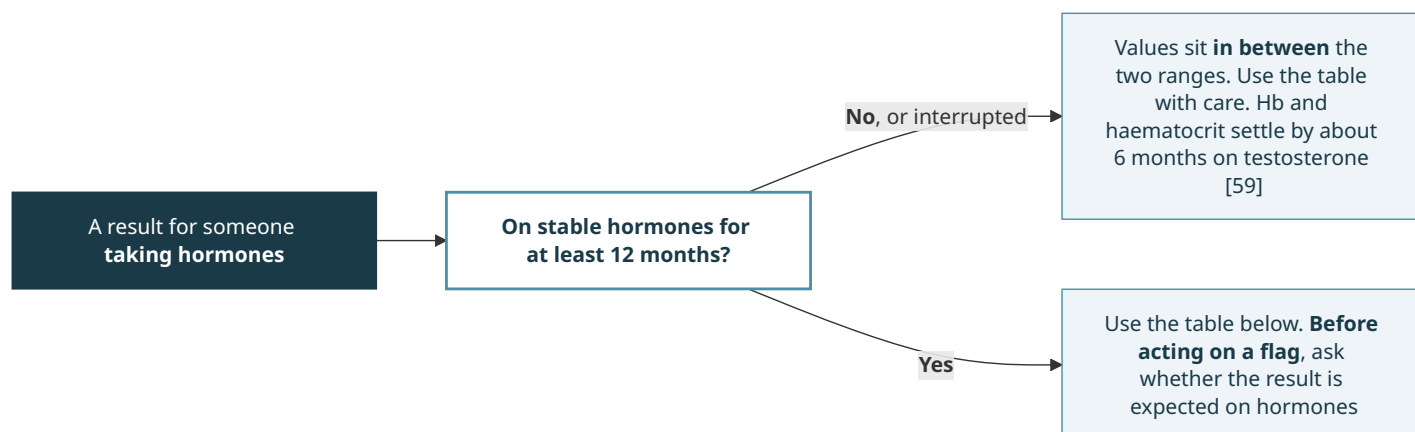


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VTE	Assess VTE and bleeding risk with the usual tool, counting oestrogen as a risk factor [50]. Oestrogen isn't a reason to withhold prophylaxis [97].
Pregnancy	(Transfusion: card 7.) Offer a test to anyone with a uterus and ovaries aged 12–55, whatever their contraception (UK anaesthesia guidance; follow local policy) [58].
Chest binder	Remove before anaesthesia, with consent, and agree when it goes back on [58].
Spironolactone	Watch for hyperkalaemia and AKI [19,58].
Testosterone	Use a recent full blood count (haematocrit) where your preoperative-testing policy calls for one ♦.
Facial or voice surgery	Tell the operating surgeon and the anaesthetist about previous voice, laryngeal or facial surgery, and get the operation note ♦. Airway assessment is unreliable: jaw reduction, chin implants and a tracheal shave alter the usual landmarks. After cricothyroid approximation there may be no cricothyroid membrane: plan front-of-neck access in advance. Within 8–12 weeks of voice surgery, avoid instrumenting the airway unless essential; if intubation is unavoidable, use a microlaryngeal tube (ID 5–6 mm). After glottoplasty the glottis may stay smaller (narrowed by up to a third): use the smallest suitable tube [58].
Sugammadex	Counts as one missed pill for oral contraceptives: follow missed-pill advice. Non-oral hormonal methods: extra contraception for 7 days [95,104]. Testosterone isn't contraception.
Other drugs	Usual perioperative rules, which differ by country (for example SGLT-2 inhibitors) [94,120,122].
Ward	Ask where the patient would feel safe, follow local policy, and offer a side room where possible [58].

4. Reading a blood result Card 4 of 11

The lab flags results against the sex on file, so the flag can be wrong in either direction. Read the number yourself.



Haemoglobin, haematocrit	Affirmed-gender range [23]; US laboratory-medicine guidance (ADLM) says by about 6 months on testosterone [59]. Haematocrit above 54% is the level guidelines treat as needing action [86,129]: repeat an isolated high value in a well patient ♦; same-day assessment if symptomatic (card 5). Rising towards it: review smoking, lung disease, sleep apnoea, and the dose or formulation with the prescriber [25,86].
Creatinine, eGFR	Not simply the affirmed range [24]. Calculate eGFR with both the male and female setting and use the range. Below 60: cystatin C or a measured GFR where dosing depends on it [59,62]. In AKI, eGFR is unreliable: use the change from baseline [61].
Drug dosing	Don't reduce an indicated loading dose just because renal function is uncertain; follow the drug's protocol ♦. For maintenance: eGFR and Cockcroft–Gault aren't interchangeable, so use the one the label specifies; dosing weights are sex-based too. Involve a pharmacist and use drug levels [59,62,63] ⚠.
PSA on oestrogen	Very low. The 4 ng/mL cut-off is far too high, and no validated cut-off exists [21,22]. Look for a confirmed rise from the lowest value; discuss a rise with urology [108] ♦.
Troponin	Serial values. Affirmed-gender cut-off provisionally recommended [59].
Liver enzymes	Generally shift towards the affirmed gender [24].
HbA1c, electrolytes, urea, hsCRP	Little change: standard ranges [24].
Oestradiol	Guideline convention 100–200 pg/mL (about 367–734 pmol/L), with testosterone below 50 ng/dL (1.7 nmol/L) [3,7]; a guide, not a validated target [28]. Assays don't measure ethinylestradiol or conjugated oestrogens: a low result on these doesn't mean low exposure. Never raise a dose because of a low result in someone taking these [34]. On injections , note the ester and days since the last dose: levels peak about 2 days after valerate; most studies compare troughs [126]. Discuss a high trough with the prescriber ♦.
LH, FSH	Cisgender ranges don't apply; interpretation is specialist [32,33].

Test blocked by the sex marker? Ask the lab to override; don't drop the test [59,71].

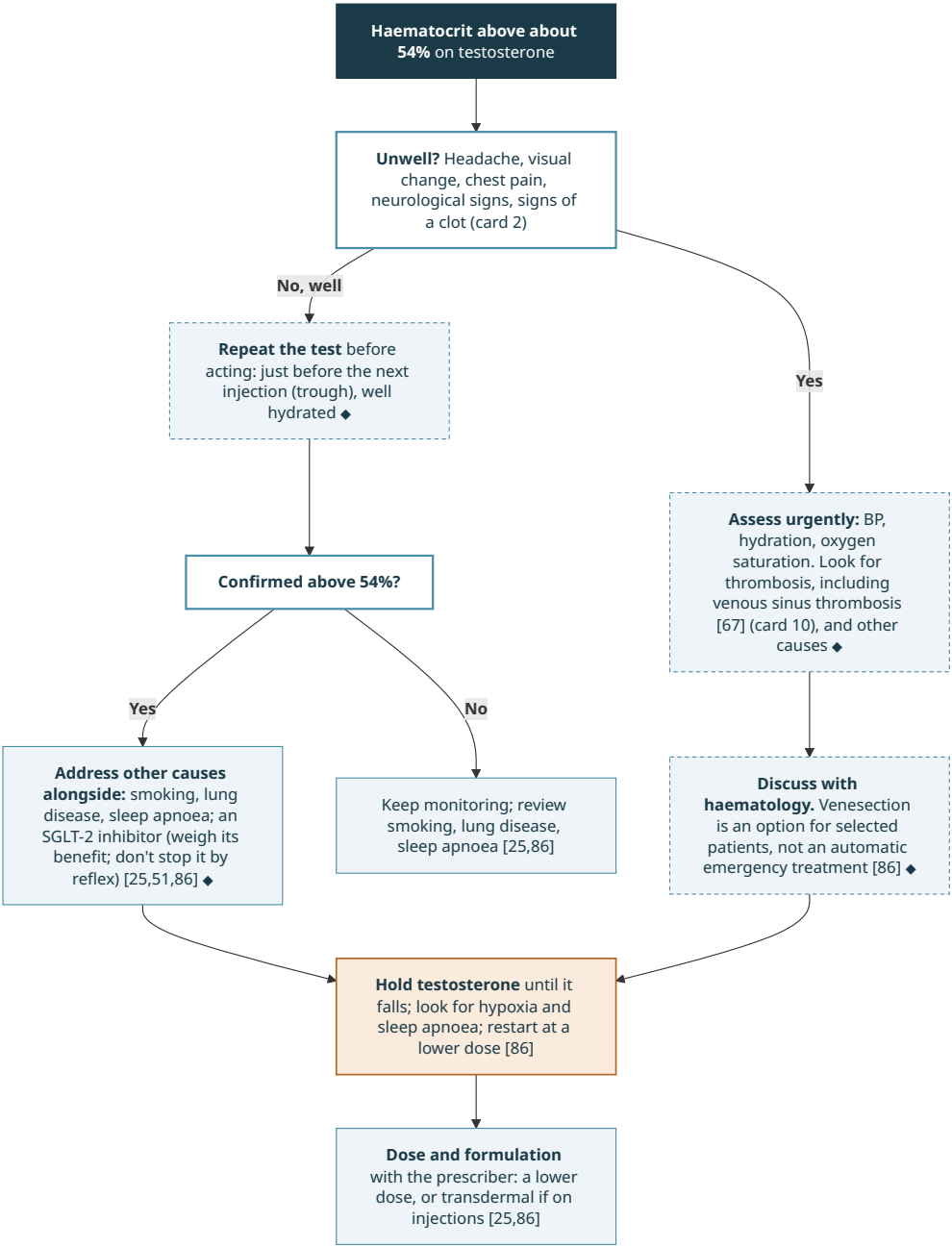
Implausibly high testosterone or oestradiol? Gel on the skin can cause it: take blood away from gel sites and check LH and FSH [59].

Request form: give the clinical fact, not the identity, for example "on oestradiol 4 mg/day since 2023" ♦.

5. Haematocrit above about 54% on testosterone Card 5 of 11

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On testosterone, read haemoglobin and haematocrit against the male range [23]. Above 54% is the level guidelines treat as needing action [86,129], but it was set in other populations ♦.



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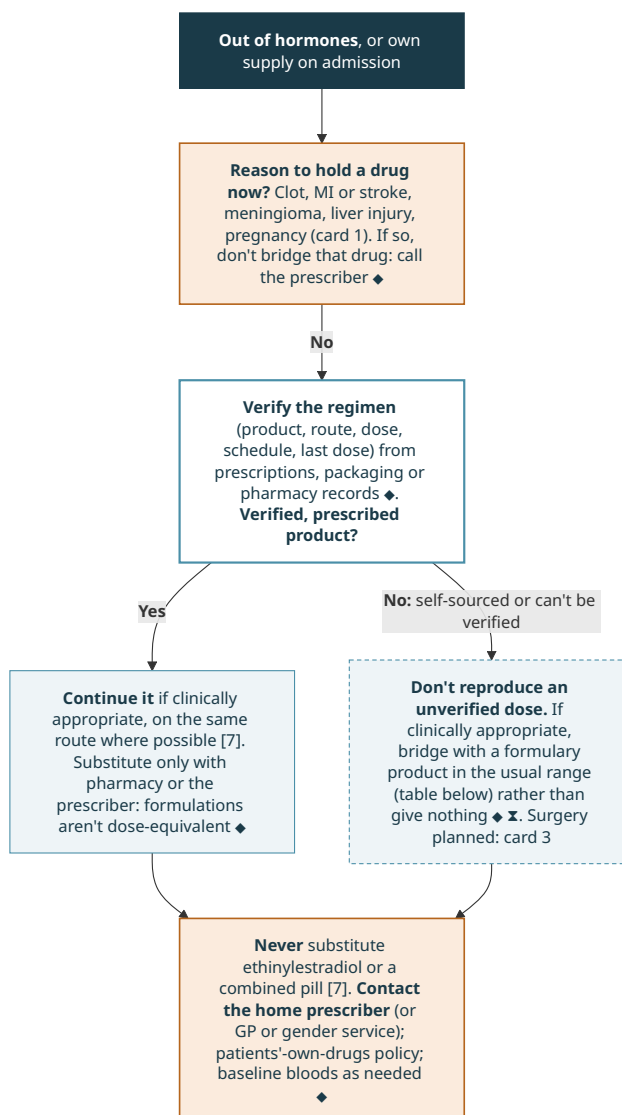
Undecanoate (Nebido, Aveed)	"Hold" means deferring the next injection. Levels fall slowly: check the trough before the next dose [51,86] ♦.
Other causes	Smoking, lung disease and higher BMI [25]; sleep apnoea [86]; SGLT-2 inhibitors [51]: weigh the drug's benefit and don't stop it by reflex ♦. Unexplained rise: consider a primary cause and discuss with haematology ♦.
What to expect	Haematocrit typically rises about 3–7 percentage points in the first year, most in the first 3 months [128]. In 1,073 trans men, 0.5% were above 54% on two measurements (2.2% once) [25].
What the number is	No trials have tested the outcomes of acting on these thresholds in trans men [129]. An unvalidated threshold isn't a wrong one: act on it, and explain it honestly ♦.

6. Ran out of hormones, or own supply on admission

Card 6 of 11

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Bridge, don't stop. Stopping is itself an intervention: low mood and anxiety can return within days [39].



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Usual ranges	Oestradiol oral 2–6 mg/day; patch 25–200 µg/day; valerate or cypionate injection (IM or SC) 2–10 mg weekly [3,7,126]. Testosterone enanthate or cypionate 50–100 mg weekly; undecanoate (Nebido) 1000 mg every 10–14 weeks [51]; Testogel 16.2 mg/g 20.25–81 mg/day [73]. An overview for checking, not a conversion chart [3,7].
Injections	A verified injection schedule continues: give the due dose rather than skip it ♦. Ask which ester: benzoate and others aren't covered by the main guidelines [126].
Can't take oral medicines	Oestradiol can be given as a patch, gel or injection [3,7].
No blocker available	Oestradiol alone short-term is reasonable, though testosterone suppression may be lost: tell the prescriber [3,75].
Testosterone	A controlled drug in many countries (UK Schedule 4 Part II; US Schedule III). Check local rules [83,84].
Lamotrigine	If oestrogen stops, levels may rise: watch for toxicity and consider a level [72].
Warfarin	Monitor INR closely when testosterone starts or stops [51,73]. Anticoagulated: consider SC rather than IM injection, for testosterone or oestradiol ♦ ⚡.
Long gap	Ask why hormones stopped (a clot, a hormone-sensitive cancer, a meningioma, access or choice), then refer back to the prescriber ♦. After gonadectomy, replacement is needed [3].

7. Test the organs present, not the sex on file Card 7 of 11

Ask which organs and surgeries are present [7]. Pregnancy testing, screening, transfusion and reference ranges all depend on it.

If present	Do	Remember
Uterus and ovaries	Pregnancy test whenever pregnancy is possible , whatever the sex on file, even on testosterone or without periods [7,16,58]. Never delay resuscitation for it ♦. Pelvic pain: pregnancy test first; consider ectopic and torsion [16]. Transfusion: tell the transfusion service the patient could become pregnant, because RhD selection depends on it and systems may follow the sex marker [59]. RhD-negative: RhD-negative red cells, including in emergencies [59]; K-negative red cells per local policy ♦. Never delay emergency transfusion: follow the local protocol ♦.	Testosterone isn't contraception [7,52,53]. Ovaries kept after hysterectomy can still develop disease [7]. Positive test: stop testosterone and refer [7,51].
Cervix (trans men, nonbinary people; never trans women)	Cervical screening as for cisgender women [7]. People registered as male may need to opt in [20]. Use a small speculum and water-based lubricant [16,20]; HPV self-sampling may suit some [7].	Unsatisfactory samples are more common on testosterone [16]. Never make screening a condition of testosterone [16]. After vaginoplasty there is no cervix [89].
Breast tissue	Trans women: screen as for cisgender women, taking duration and age into account; UCSF guidance: not before 5 years of hormones nor before 50 [7,34]. Registered as male? The GP refers [20]. Trans men without chest surgery, or after reduction only: as for cisgender women [7,34].	A new lump goes on the urgent pathway whatever the sex marker [71]; don't route it as gynaecomastia ♦. After mastectomy no screening is validated, but a lump still needs ultrasound or MRI [34].
Prostate	Always retained after vaginoplasty; it can be examined via the neovagina (anterior wall) [7]. Screen by individual risk [3].	PSA is very low on oestrogen: a "normal" result doesn't reassure [21,22]. A UTI after vaginoplasty counts as complicated [57].
Testes	Acute scrotal pain: suspect torsion. Emergency urology; don't wait for imaging; repair ideally within 6 hours [34,100].	Torsion can still happen on feminising hormones ♦.
Neovagina	Keep the dilation schedule during any admission unless the surgical team says otherwise; never advise stopping dilation [57]. STI testing at every site used for sex [89]: it can still be infected; after penile-inversion vaginoplasty, urine may be better than a swab for gonorrhoea and chlamydia [127]. Agree specimen labelling with the lab ♦. Examination: smallest speculum or an anoscope, with lubricant [82].	Can't insert the dilator: operating team the same day ♦ ✕ (card 9). Never force it [43]. Catheter: the urethral opening can sit anywhere from below the clitoris to inside the canal; an experienced clinician catheterises [57]. Confirm urine flows before inflating the balloon; never inflate it in the neovagina ♦. No repeated or blind attempts: urology [44,57].

Sexual assault: the usual pathway, now. PEP is time-critical: start as soon as possible, ideally within 24 hours and no later than 72, without waiting for results [111]. Emergency contraception and a pregnancy test if pregnancy is possible; STI prophylaxis and hepatitis B vaccination per local protocol [80]. Offer forensic examination with consent, by a trained team, before routine swabs ♦. Trauma-informed: say what you'll do before each step and ask consent for each part [127]. After vaginoplasty: smallest speculum or an anoscope; the tissue tears easily [82].

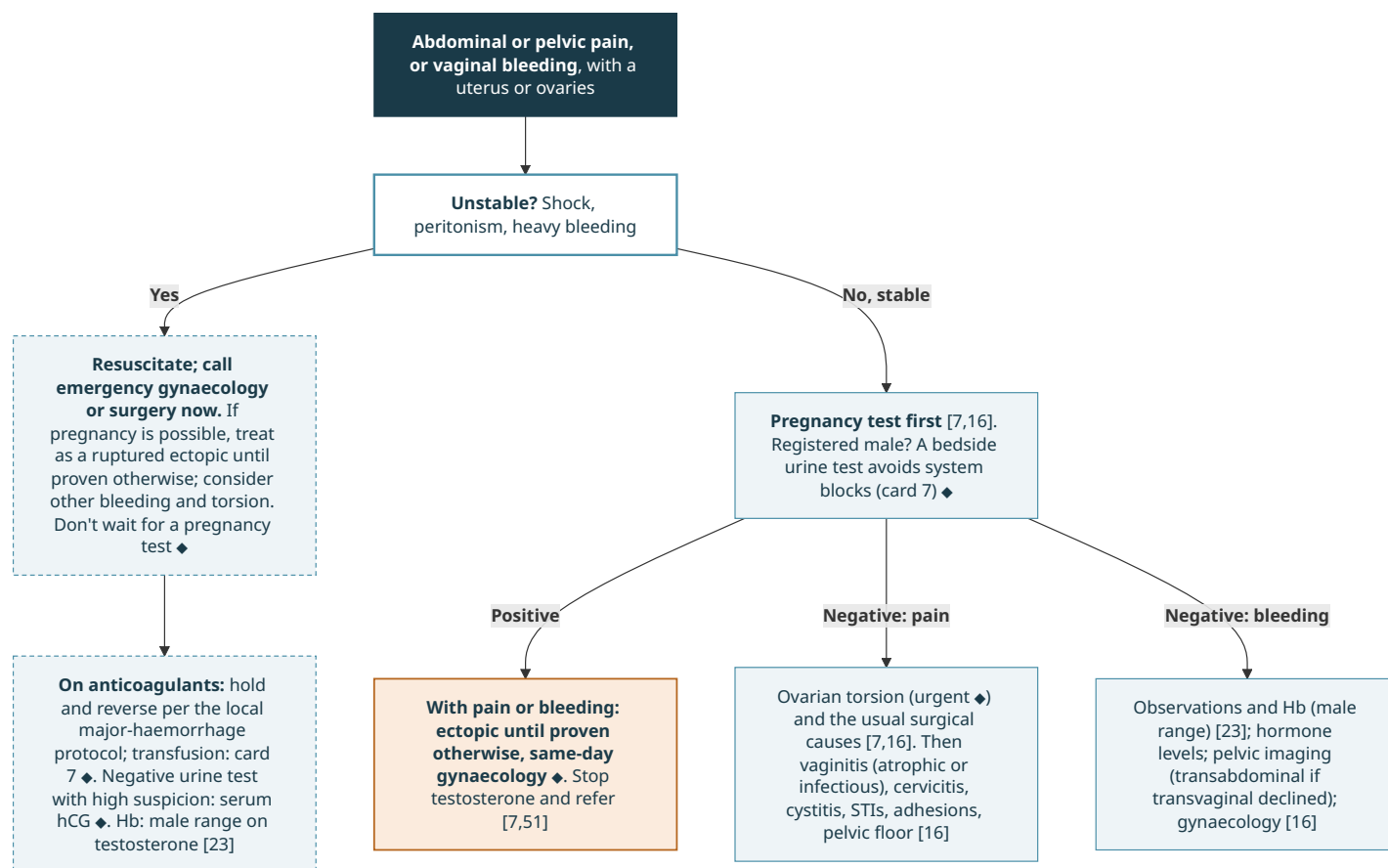
System blocks a pregnancy test, screening or referral because of the sex marker? Ask the lab to override, or escalate. Don't drop the test [59,71]. A bedside urine pregnancy test avoids system blocks ♦.

8. Pelvic pain or bleeding: uterus or ovaries present

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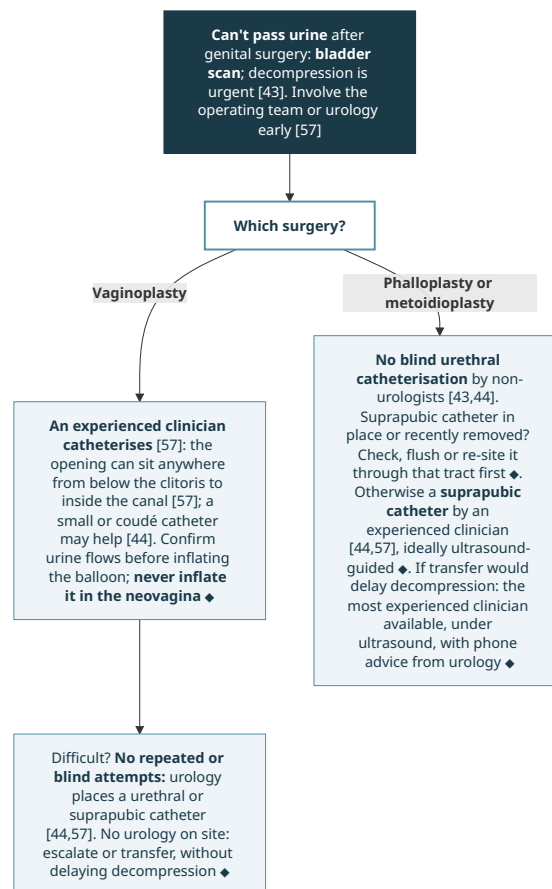
Testosterone doesn't reliably prevent pregnancy, and ovulation can happen without periods [7,16]. Ask which organs are present, whatever the sex on file.



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Bleeding: ask about	Missed or late doses, a change of interval or formulation, new medicines ♦; coagulopathy and anticoagulants [34,73]. Bleeding after missed doses: pregnancy test (ovulation may resume) and discuss contraception [52,53].
Persistent bleeding	Bleeding 6–12 months after testosterone reaches male-range levels: treat as abnormal uterine bleeding; it can come from hyperplasia or malignancy, evaluated with imaging and endometrial biopsy [16].
After hysterectomy	Ovaries kept after hysterectomy can still develop disease, including torsion [7].
Atrophy	A short course of vaginal oestrogen may help; absorption is minimal and shouldn't interfere with testosterone [34].
Ward	Offer a choice of ward or a side room ♦.

Refer back to the operating surgeon, or to a local reconstructive urologist if surgery was abroad [57]. Ask which operation, which stage, and where the patient passes urine from ♦.



After vaginoplasty	Action
Bleeding	Resuscitate if unstable; Hb, clotting, anticoagulants ♦. Often from the urethral edge: direct pressure. Packing, cautery or suture are surgeon-led. Late heavy bleeding → surgical examination [57].
Can't insert the dilator	Operating team the same day ♦ ⚡. Never force it : injury can cause a rectovaginal fistula [43]. Try a thinner dilator with analgesia and lubricant; never advise stopping dilation [57].
Stool or gas from the vagina	Rectovaginal fistula: urgent referral to the surgeon or colorectal surgery; assess for sepsis ♦. Imaging and management are specialist-led [57].
Urine into the vagina, new incontinence	Possible urethrovaginal fistula: urology for cystoscopy [57].
Fever, pain, swelling	Antibiotics; consider drainage. A UTI counts as complicated: the prostate remains [57].
Discharge or spotting, still dilating	Often hypergranulation (silver nitrate): non-urgent surgical referral [57].
Prolapse	Make sure the urethral opening isn't obstructed; contact the surgical team [57].
After phalloplasty or metoidioplasty, and chest surgery	
Weak stream, straining, UTIs, leak from a new opening	Stricture or fistula: refer before retention develops; strictures usually form at a join, 6–36 months after surgery [44,57].
Erectile implant red, hot or exposed	Urology the same day ♦; treatment is usually removal [57].
Chest surgery: one-sided tense swelling	Haematoma until proven otherwise; most need evacuation: urgent surgical review [34].

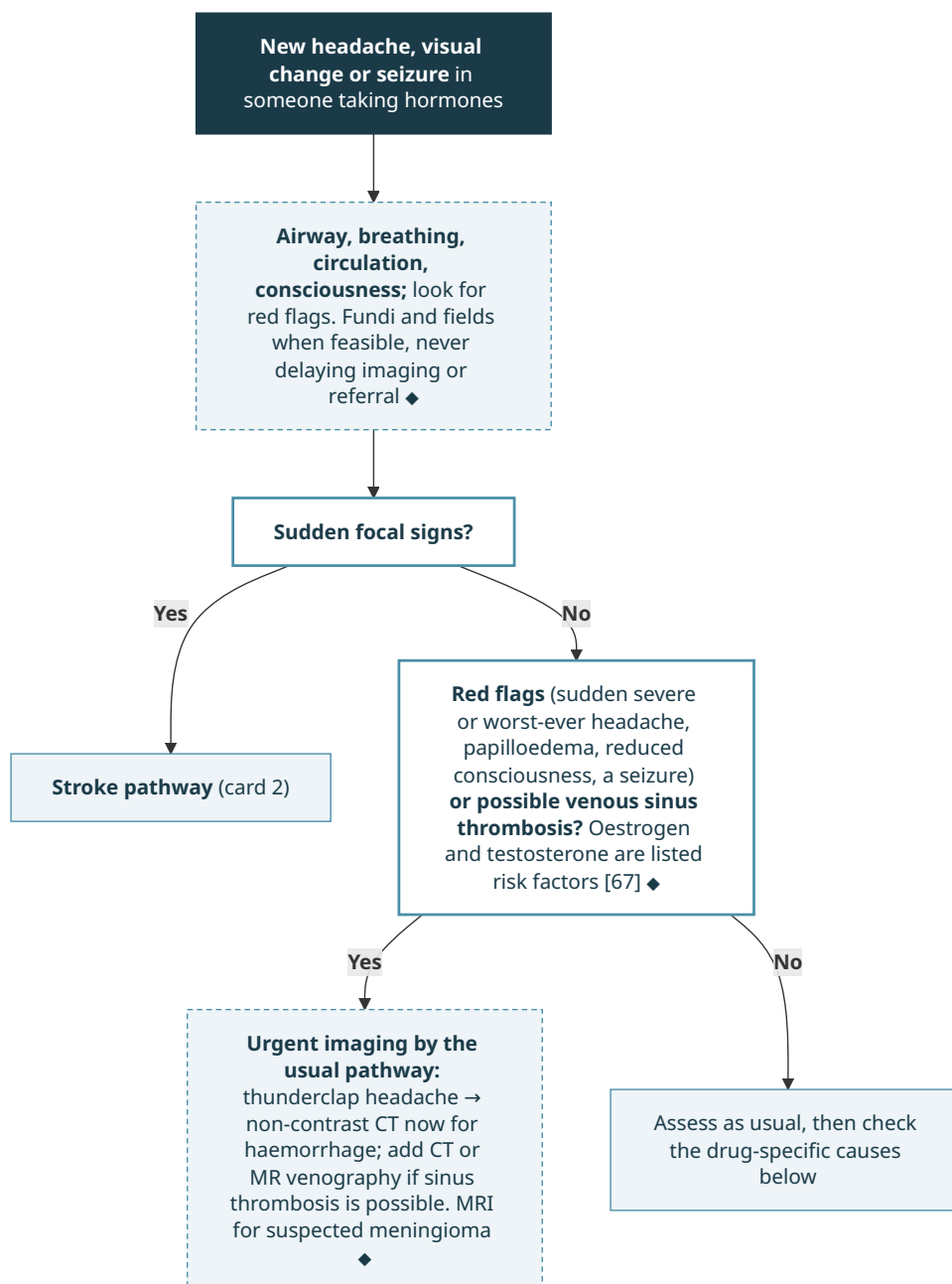
On the ward: keep the dilation schedule unless the surgical team says otherwise [57].

10. Headache, visual change or seizure on hormones

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Treat as for anyone first. Then think of the drug-specific causes: venous sinus thrombosis, meningioma on cyproterone, and the pituitary.



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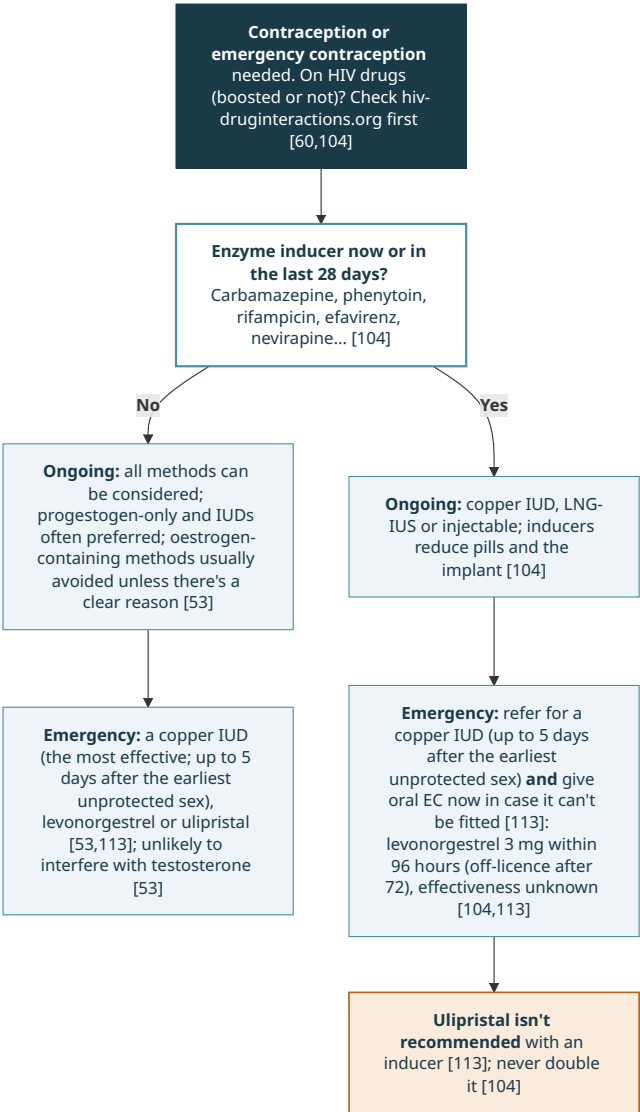
Cyproterone: meningioma	Risk rises with cumulative dose, highest at 25 mg/day or more [9,10]. New focal neurology, seizures or visual disturbance: urgent standard assessment and imaging, usually MRI. No screening MRI without symptoms ♦. If found: stop cyproterone permanently [9,12]; discuss oestradiol with neurosurgery and the prescriber ♦. Some regress after stopping [11].
Pituitary	Check prolactin; prolactinoma is rare [15]. Visual symptoms or markedly raised prolactin: MRI and formal visual fields [14,99], and endocrinology ♦. Antipsychotics raise prolactin too [99].
Testosterone	Check haematocrit (card 5).
Lamotrigine	Oestradiol is expected to lower levels, and limited data support this [50,117]. Seizure on lamotrigine: check a level and discuss the dose with neurology [72].

11. Contraception and emergency contraception

Card 11 of 11

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Testosterone is not contraception: pregnancy can happen on it, even without periods [7,52,53]. Feminising hormones are not contraception either [7].



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Other HIV drugs	Including boosted regimens: check hiv-druginteractions.org before choosing contraception [60,104]. An inducer affects only the person taking it ♦.
Levonorgestrel	Use after 72 hours is off-licence [113].
Partner could become pregnant	The flowchart then applies to the partner's contraception ♦.
Pregnancy on testosterone	Stop testosterone: it may harm a developing fetus [7,52].
Feminising hormones	Reduce sperm production but don't reliably stop it: use condoms or another method if pregnancy is possible [7].
Sugammadex	Counts as one missed pill for oral methods; non-oral hormonal methods need extra contraception for 7 days [95,104].
Fertility	Discuss before starting hormones and refer for egg or sperm storage if wanted; return after stopping can't be guaranteed [3,7].