

Sheet 1 · In clinic Side 1 of 2

GPs, practice nurses, pharmacists, gynaecologists

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The first two minutes

A bad first visit keeps people away: 23% of US trans adults avoided needed care for fear of mistreatment, and 43% of Korean trans adults delayed or avoided hospital visits in a year.

- ♦ **Ask** what name and pronouns they use, and use them. Ask which words they prefer for their body.
- ♦ **Ask only what today's problem needs.** If a question is relevant, say why you're asking. ♦
- ♦ **Records:** keep the legal name and sex (for identity checks) separate from the name used. Keep a list of the organs present, so that screening follows anatomy, not the sex marker.
- ♦ **Confidentiality:** ask what may be shared, and with whom. Being next of kin doesn't authorise disclosure.
- ♦ **What you write travels.** Record the clinical fact (the hormone and dose, the organs present) rather than the identity. This never limits clinically essential records, injury documentation, safeguarding or legally required reports. ♦
- ♦ **Examination:** examine only what's relevant. Explain first, and remind the patient they can stop at any time. Offer a chaperone, and let the patient choose the chaperone's gender where possible. If no suitable chaperone is available, offer to delay, if delay won't harm their health. Use the smallest speculum, or offer self-collected swabs.
- ♦ **If you misgender someone,** apologise briefly, correct yourself and carry on. ♦

What they may be taking (overview, not a conversion chart)

	Usual adult range
Oestradiol, oral · patch	2–6 mg/day · 25–200 µg/day
Oestradiol valerate or cypionate (IM or SC)	5–30 mg every 2 weeks, or 2–10 mg weekly (often above target: ≤5 mg weekly suggested). Other esters (e.g. benzoate): ask which
Cyproterone	10 mg/day is current practice. Flag 25 mg/day or more (meningioma risk)
Spironolactone	100–300 mg/day
GnRH analogue	Product-specific (e.g. 3.75 mg monthly or 11.25 mg every 3 months)
Testosterone enanthate or cypionate (IM or SC)	50–100 mg weekly, or 100–200 mg every 2 weeks
Injectable testosterone undecanoate (IM, never SC)	Nebido: 1000 mg; 2nd dose at 6 weeks, then every 10–14 weeks · Aveed (US): 750 mg; 2nd dose at 4 weeks, then every 10 weeks
Testosterone gel	Depends on the product: e.g. Testogel 16.2 mg/g, 20.25–81 mg/day (usual start 40.5 mg)

- ♦ **Never ethinylestradiol** (including contraceptive pills used as hormones): it carries the highest clot risk.
- ♦ **Self-sourced hormones are common.** Ask without judgement, check bloods and blood pressure, and help the patient move to prescribed treatment.
- ♦ **Don't stop hormones yourself.** Stopping oestrogen can bring back low mood and anxiety within days. Stopping hormones

may cause bone loss, and after gonadectomy it will.

- ♦ **Running out:** bridge, don't stop (Sheet 2).
- ♦ **Some testosterone effects are permanent:** voice, facial hair, hair loss and genital growth.
- ♦ **Non-binary patients** may want lower-dose or partial regimens; discuss what's achievable.

Hold the problem drug, not the hormones

Situation	Hold	Keep or decide
High K ⁺ , AKI, dehydration, low BP	Spironolactone (decide on any ACE inhibitor or ARB too)	Oestradiol (tell the prescriber)
Meningioma, or liver injury confirmed with no other cause	Stop cyproterone	Oestradiol
Confirmed DVT or PE	Cyproterone (restarting is a specialist decision)	Oestradiol on full anticoagulation is an option: a joint decision. While oestrogen continues, don't stop anticoagulation
MI, stroke or TIA	Cyproterone (restarting is a specialist decision)	Decide early with the specialist team. Don't start anticoagulation just to continue hormones ♦
Haematocrit >54%, confirmed on repeat or with symptoms	Testosterone, until it falls	Restart at a lower dose
Pregnancy	Testosterone	

Red flags

On oestrogen

- ♦ **Clot** (leg swelling, chest pain, breathlessness): the risk is roughly doubled but low in absolute terms. Prefer transdermal oestradiol over age 45 or after a VTE. Advise stopping smoking.
- ♦ **Cyproterone:** new headache, visual change, seizure or weakness → urgent assessment and imaging ♦. Check LFTs before starting and periodically.
- ♦ **Spironolactone:** hyperkalaemia risk is higher over 45, with renal impairment, and with ACE inhibitors, ARBs, NSAIDs or trimethoprim.

On testosterone

- ♦ **Haematocrit >54%:** if the patient is well, repeat the test at trough, well hydrated ♦; if confirmed, hold and review the dose. With symptoms, assess the same day.
- ♦ **Pelvic pain or new bleeding: pregnancy test first.** Testosterone is not contraception. Consider ectopic pregnancy and torsion.
- ♦ **Bleeding:** pregnancy test first. After missed or late doses, restore dosing and discuss contraception. Otherwise check levels; bleeding that persists or is unexplained → pelvic imaging and gynaecology (endometrial hyperplasia or cancer). Also consider cervicitis, STIs and atrophy (a short course of vaginal oestrogen may help).
- ♦ Rising BP or sleep apnoea: check at reviews.

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Screen the organs present

- **Cervix:** screen as for cisgender women; people registered male may need a manual invitation. Use a small speculum and lubricant; self-sampling may suit. No cervix after vaginoplasty.
- **Breast:** trans women, as for cisgender women once on oestrogen for at least 5 years (UCSF: not before 50); trans men without chest surgery, as for cisgender women. After mastectomy there's no validated screening, but **investigate any lump**.
- **Prostate:** always retained; after vaginoplasty, examine through the anterior wall of the neovagina. **PSA is very low on oestrogen**, so "normal" doesn't reassure, and there's no single-value trigger. Discuss a confirmed rise above their own baseline with urology. ♦
- **Bone:** consider DXA after gonadectomy or long gaps in hormones.
- **Cardiovascular:** usual risk factors. No calculator is validated; consider running both sexes.

Reading the bloods

- **After 12 months or more on stable hormones, read results against the affirmed gender** for Hb, haematocrit and liver enzymes. Before that, or after a gap, values sit in between. The lab flags against the sex on file, so the flag can be wrong.
- **Creatinine and eGFR: calculate both ways** and use the range. If stable and below 60 → cystatin C or measured GFR. In acute illness or AKI, see Sheet 2.
- **Oestradiol assays miss ethinylestradiol:** never raise a dose on a low result in someone taking it. **On injections**, note the ester and days since the last dose: levels peak about 2 days after valerate; compare troughs.
- **Prolactin:** mild rises are common, especially with cyproterone; antipsychotics raise it too. Very high, or with visual symptoms → MRI, visual fields and endocrinology.
- **Monitoring:** every 3 months in the first year, then once or twice a year. Undecanoate: sample just before the next injection (trough). Oral oestrogen can raise levothyroxine needs: recheck TFTs.
- **Take blood away from gel sites.**
- **Request forms:** give the lab what it needs for a safe result, and agree the minimum with the patient ♦. If a system blocks a test by sex marker, ask the lab to override; don't drop the test.

Mental health

- **Ask directly** about suicide. Being trans is not a mental illness. Conversion practices are harmful.
- **Identity-based abuse** includes threats to out someone and controlling their hormones ♦. Ask the patient alone, and refer to specialist services.

Pharmacists: interactions

- **Enzyme inducers** (carbamazepine, phenytoin, rifampicin, efavirenz...) lower oestradiol and hormonal contraception.

- **HIV drugs:** check every regimen at [hiv-druginteractions.org](https://www.hiv-druginteractions.org). Ritonavir boosting, efavirenz, etravirine and nevirapine are predicted to **lower oestradiol**; cobicistat boosting raises it. All boosters raise cyproterone and testosterone; efavirenz, etravirine and nevirapine lower them. **Never raise an established low cyproterone dose to match the chart.** ♦
- **Lamotrigine:** oestrogen can lower its levels and stopping oestrogen can raise them, so check levels. Starting lamotrigine on oestrogen: normal escalation, never faster.
- **Warfarin:** testosterone **raises** the INR. Monitor closely when it starts or stops.
- **Gel:** wash hands and cover the site, because it transfers to others.
- **Injectable undecanoate:** IM, never SC. Follow the product's protocol (Aveed: 30 minutes' observation).

Contraception and fertility

- **Testosterone and feminising hormones are not contraception.**
- On testosterone: progestogen-only methods or an IUD are often preferred. Emergency contraception: levonorgestrel, ulipristal or a copper IUD (the most effective).
- **On an enzyme inducer** (e.g. efavirenz, nevirapine, rifampicin, carbamazepine): use a copper IUD, LNG-IUS or injectable. Emergency contraception: refer for a copper IUD (up to 5 days) and give oral EC now in case it can't be fitted: levonorgestrel 3 mg within 96 hours (off-licence after 72); with an inducer, ulipristal isn't recommended. (Testosterone isn't an inducer.) Other HIV drugs, including boosted regimens: check [hiv-druginteractions.org](https://www.hiv-druginteractions.org) before choosing contraception. An inducer affects only the person taking it ♦.
- Discuss fertility and gamete storage **before** starting hormones.

PrEP and HIV testing

- Confirm HIV-negative status before starting. Repeat tests on PrEP.
- **Daily, not event-driven**, PrEP for anyone on oestradiol.
- **Receptive vaginal or front-hole sex: daily TDF/FTC only. TAF/FTC isn't recommended for this exposure.** Alternative: injectable cabotegravir.
- Tell patients PrEP doesn't affect their hormones.
- **Renal check (Cockcroft-Gault, not eGFR):** ≥60 mL/min for TDF/FTC; ≥30 for TAF/FTC where TAF is suitable ✕ (US cut-offs; local rules may differ). Screen for hepatitis B without delaying the start.
- **Injectable lenacapavir:** day 1, the first injection plus oral tablets; day 2, oral tablets. With an enzyme inducer: specialist advice ✕ (dosing depends on which started first).

Breast lump · fracture

- Lump → suspected-cancer pathway, whatever the sex marker.
- Low-trauma fracture after gonadectomy or a long hormone gap → fragility work-up and DXA. FRAX: state which sex you entered. Ask why hormones stopped, then refer back to the prescriber to restart them.

Sheet 2 · In the ED / on the ward Side 1 of 2

Emergency doctors, ward nurses, anaesthetists, hospital pharmacists

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Find the presentation and act on the first line. Interactions and contraception: Sheet 1.

Before anything else

1. **Name and pronouns.** Link the wristband's legal name to the name used. Follow local patient-ID rules.
2. **Ask which organs and surgeries are present.**
3. **Pregnancy test whenever pregnancy is possible** (uterus and ovaries), whatever the sex on file, and even on testosterone. Never delay resuscitation for it. If the system blocks the order, use a bedside test. ♦
4. **Don't stop hormones by reflex: hold the problem drug, and reassess as things change** ♦. Spironolactone: high K⁺, AKI, low BP. Cyproterone: confirmed VTE, MI, stroke, meningioma, confirmed liver injury. Testosterone: haematocrit >54% (confirmed or symptomatic), pregnancy.
5. **VTE:** assess every admission. Oestrogen counts as a risk factor, not a reason to withhold prophylaxis.
6. **Transfusion:** compatibility as for anyone. **Never delay an emergency transfusion.** Tell the blood bank, on a need-to-know basis, if the patient could become pregnant ✕: an RhD-negative patient with a uterus gets RhD-negative red cells; trans women can receive RhD-positive blood. K-negative cells and anti-D: local policy ✕.
7. **Ward:** ask where they would feel safe; offer a side room where possible.
8. **What you write travels:** record the clinical fact, not the identity. Never at the expense of essential records, injuries or safeguarding. ♦

Chest pain · stroke · clot

- **Troponin:** serial values. If your lab uses sex-specific cut-offs, the affirmed-gender cut-off is provisionally recommended; read a borderline result against the trend.
- **ECG:** usual ST-elevation criteria, except in V2–V3, where ≥1.5 mm counts as positive for everyone (cautious, not validated) ♦. Before fibrinolysis, confirm with cardiology ♦. Below threshold **doesn't rule out** an occlusion: repeat ECGs and troponin.
- **PERC can't rule out PE on oestrogen**, by any route ♦ (hormone use is a PERC criterion). Use Wells, then D-dimer or imaging.
- **Suspected DVT or PE:** usual pathway, with interim anticoagulation if results will be delayed.
- **Confirmed VTE:** anticoagulate; hold cyproterone. Oestradiol is a joint decision: if it continues, **don't stop anticoagulation**, and prefer transdermal. Ask about self-sourced ethinylestradiol or pills.
- **Stroke:** usual pathway. Hormone therapy isn't a listed reason against thrombolysis.
- **MI or stroke:** hold cyproterone. Decide about oestradiol or testosterone early with the specialist team; don't stop or continue by reflex.

Headache, visual change, seizure

- **ABC and red flags first.** Fundoscopy must not delay imaging. ♦
- **Venous sinus thrombosis:** hormones are a risk factor. On testosterone, check haematocrit.
- **Red flags → urgent imaging by the usual pathway:** thunderclap headache → non-contrast CT now; add venography if sinus thrombosis is possible; MRI for suspected meningioma ♦.
- **Cyproterone:** meningioma → MRI. If confirmed, stop cyproterone permanently.
- **Pituitary:** check prolactin; with visual symptoms, MRI and fields.

Abdominal or pelvic pain (uterus or ovaries present)

- **Unstable:** resuscitate and call gynaecology or surgery now. Treat as ectopic if pregnancy is possible. Don't wait for a test. ♦
- **Stable: pregnancy test first.** Positive with pain or bleeding: ectopic until proven otherwise, same-day gynaecology ♦. Then ectopic, torsion and the usual causes. Ovaries kept after hysterectomy can still cause disease, including torsion. A negative urine test with high suspicion → serum hCG.
- **Vaginal bleeding on testosterone:** check observations and Hb (male range once on stable testosterone). Pregnancy test; ask about missed or late doses and anticoagulants; check levels; pelvic imaging and gynaecology.

Scrotal pain (testes present, including on feminising hormones)

- Suspect torsion → emergency urology. Don't wait for imaging.

Sepsis, AKI, drug dosing

- **In AKI every eGFR is unreliable.** Use the change from baseline. Don't automatically reduce an indicated antibiotic loading dose because renal function is uncertain. ♦
- **Maintenance:** calculate both sex settings (eGFR, Cockcroft–Gault and ideal or adjusted body weight), then use a pharmacist and drug levels ✕. eGFR and Cockcroft–Gault aren't interchangeable.
- **Contrast:** don't withhold contrast needed for diagnosis because of a sex-dependent eGFR. ♦
- **High K⁺:** treat as standard. **Hold spironolactone;** decide on any ACE inhibitor or ARB ✕. Keep oestradiol.

Haematocrit >54% on testosterone

- Unwell → assess urgently for clot (including venous sinus thrombosis) or hypoxia. Venesection only in selected cases, with haematology.
- Confirmed or symptomatic: hold testosterone. For undecanoate, defer the next injection (levels fall slowly).

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After genital or chest surgery

Vaginoplasty

- **Retention:** bladder scan and decompress urgently; involve the operating team or urology early. **An experienced clinician catheterises.** The meatus can sit anywhere from below the clitoris to inside the canal. Never inflate the balloon in the neovagina. No repeated blind attempts: urology places a urethral or suprapubic catheter.
- **Bleeding:** resuscitate if unstable; check Hb, clotting and any anticoagulant. Bleeding often comes from the urethral edge: apply direct pressure there. Packing and cautery are surgeon-led. Late heavy bleeding → surgical examination. Spotting while still able to dilate: often granulation tissue, non-urgent.
- **Can't insert the dilator: never force it.** Contact the operating team the same day ♦✕. The patient may try a thinner dilator. Packing only under surgical direction.
- Stool or gas per vagina → urgent referral (fistula). Urine per vagina → urology.
- **Surgery abroad or team unreachable:** a local reconstructive urologist.
- **Keep dilating during any admission,** unless the surgeon says otherwise.

Phalloplasty or metoidioplasty

- **Retention:** bladder scan, then urology. **No blind urethral catheterisation.** Existing suprapubic catheter or tract: check, flush or re-site it first ♦. Otherwise a suprapubic catheter by an experienced clinician, ideally ultrasound-guided ♦. No urology on site → escalate or transfer, without delaying decompression ♦.
- Weak stream, straining, recurrent UTI or a new leak → refer before retention (stricture, typically 6–36 months after surgery).
- **Erectile implant red, hot or exposed → urology the same day ♦.**

Chest surgery: tense, one-sided swelling = haematoma → urgent surgical review.

After voice surgery: avoid the airway for 8–12 weeks if possible. Use the smallest tube; the glottis may stay narrower afterwards (glottoplasty). After cricothyroid approximation, front-of-neck access may be impossible: plan ahead.

Surgery

- **Don't delay emergency surgery over hormones.** Testosterone usually continues; oestradiol case by case, with thromboprophylaxis.
- **Sugammadex** = one missed pill (combined or progestogen-only): follow missed-pill rules. Non-oral hormonal contraception: condoms for 7 days. Testosterone isn't contraception.
- SGLT-2 inhibitors: local rules (UK: the day before and the day of surgery; US: at least 3 days).
- Remove a chest binder before anaesthesia, with consent.

HIV, PEP, STIs

- **PEP: start as soon as possible, ideally within 24 hours and no later than 72, for 28 days.** Don't wait for results. Retest at 4–6 and 12 weeks. Not needed if the source has HIV with sustained viral suppression; source status unknown: case by

case. Preferred: bictegravir/FTC/TAF, or dolutegravir + tenofovir + FTC or 3TC.

- Interactions: [hiv-druginteractions.org](https://www.edenopenly.com/publications/clinical-guides/caring-for-trans-and-gender-diverse-patients) (Sheet 1).
- Test every site used for sex. After vaginoplasty there's a prostate, but no cervix; the neovagina can still be infected (urine may be better than a swab for gonorrhoea and chlamydia). Agree swab labelling with the lab ♦.

Assault

- Ask in private. The patient decides about police involvement, subject to legal duties. Refer to LGBT+ abuse services.
- **Sexual assault:** PEP is time-critical. Emergency contraception and a pregnancy test if pregnancy is possible (uterus and ovaries present). Offer forensic examination with consent, by a trained team per local protocol ♦. Offer a choice of examiner gender ♦. Trauma-informed: say what you'll do before each step and ask consent for each part ♦. After vaginoplasty, use the smallest speculum or an anoscope: the tissue tears easily.
- **Document every injury fully.** "Minimum necessary" applies to gender history, not to injuries or what was said. ♦

Mental health crisis

- Standard risk assessment, and ask directly about suicide. Don't attribute the crisis to being trans.
- Continue hormones on admission. Searches and intimate care: staff of the gender the patient prefers, where safe ♦.
- **Binders and dilators:** make an individual plan, not removal by default ✕. Binders restrict breathing: plan ahead of restraint or rapid tranquillisation, removing with consent where possible ✕.
- Antipsychotics raise prolactin. Spironolactone raises lithium levels. Lamotrigine shifts with oestrogen.

Self-sourced injections and silicone

- **Breathless, hypoxic or confused soon after a silicone injection: suspect silicone embolism.** Give oxygen and call critical care.
- Lump or abscess where silicone or filler was injected: ask what was injected. It may be a sterile abscess or granuloma: image first (ultrasound, CT or MRI); surgical team before incising ♦. Septic, or at a hormone injection site: usual management; imaging mustn't delay drainage ♦. Send cultures including AFB, and check tetanus. Offer HIV and hepatitis B and C testing.
- Check calcium with symptoms or extensive granulomas.

Ran out of hormones

- **Reason to hold a drug now** (Sheet 1 table)? Don't bridge that drug; call the prescriber ♦.
- **Bridge, don't stop.** Verify the product and dose; substitute only with pharmacy. Unverified self-sourced dose: a formulary product in the usual range (Sheet 1) ✕. Never substitute ethinylestradiol or the combined pill. If nil by mouth, use a patch, gel or injection. A verified injection schedule continues: give the due dose ♦. No blocker available: oestradiol alone short-term.
- Anticoagulated patient on injected testosterone or oestradiol: consider SC rather than IM ✕. **Never subcutaneous undecanoate.** Monitor INR.