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Transgender Health: Sensitivity in Care, Treatment, and Life Care Considerations for Female to Male Transgender Individuals

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Abstract

People who identify as transgender are not a new global population. They have lived and worked among the general population, but remained hidden due to fear of social and vocational discrimination and harassment. Time, and changing views, brought by changing generational philosophy, has allowed more people who identify as transgender into the forefront. This improved visibility has highlighted similar health care access issues and disparities already realized within many marginalized populations. The problem is compounded as legislation is inconsistent and dynamic with regard to provision of health care and basic rights to this specialized and complex population. Services are warranted; transgender people have a high need for a variety of health care services. Studies support this need with correlations of mental illness and high suicide rates for those who are under-served. Life care planners are in a unique position to provide support and services to this increasingly visible and deserving population.

Key words: gender dysphoria, Transman, transsexual, gender affirming surgery

Literature Review and Background: Lack of Transgender Oriented Health Care Access

The lesbian, gay, bisexual and transgender (LBGT) community in general has realized recent social and legal progress, yet transgender people still face discrimination in many key areas of life, including work, school, housing, public accommodation, and in basic access to medical care (Schwartz, 2016). Individual state laws continue to limit legal protections for the LBGT community as a whole. Of interest, numerous states have introduced bills in an attempt to reduce LGBT people's basic rights, with the transgender population most frequently targeted (Turner, 2018). A 2017 Human Rights Campaign (HRC) legislative preview report found that many state legislators were expected to focus regulations specifically in regard to transgender people -- particularly in the critical areas of health care and access to appropriate restrooms (Turner, 2018).

Yet, accountability for ensuring reproductive and sexual rights is now receiving attention at a global level. Publications focus on accountability strategies to include: legal, social, and performance accountability. Successful approaches toward this end are lacking however (Van Belle, Boydell, George, Brinkerhof, & Khosla, 2018). Life care planners are in an exceptional position to obtain a nuanced understanding of the varied underpinnings for provision of a successful approach at national and sub-national levels through provision of essential care to this deserving and uniquely complex population. Statistics have shown that people who are transgender, and who do not receive proper health services, are at risk for increased mental health issues and high suicide rates (Schreiber & Hausenblas, 2016citation?).

Medical Necessity and Discrimination in Health Care Equates to Tragic Outcomes: Suicide and Mental Health Issues

A recent 2013-2015 *California Healthy Kids Survey* of middle and high school youth (n=31,896) found that adolescents who identify as transgender feel the school environment is not safe and perceived being victims of bias-based bullying. The sample was racially and ethnically diverse with 1.0% self-reporting as being transgender (Day, Perez-Brumer, & Russell, 2018). Kaiser Permanente also recently reported that transgender and gender-nonconforming youth are 3 to 13 times more likely than their cisgender (gender on birth certificate at birth); (Urban Dictionary, 2015), counterparts to suffer from mental health conditions. The most commonly reported diagnoses were attention deficit disorder in 3 to 9 year old's and depressive conditions in adolescents. The study authors postulated that the higher prevalence rates were likely a consequence of gender dysphoria (Becerra-Culqui et al., 2018).

It is speculated that these higher rates of mental illness are a result of the stigma, rejection, bias, discrimination, and physical abuse faced by the transgender population. Schreiber and Hausenblas (2016) report that these effects are variables which lead to higher levels of risk-taking behaviors and stress levels. Stigmatization often leads to avoidance of social interactions, and healthcare postponement (Schrieber & Hausenblas, 2016). Research has indicated that up to 24% of transgender people have reported discrimination in a health care setting in Massachusetts (Reisner et al., 2017). The National Center for Transgender Equality Survey also reports that 50% of all transgender individuals end up informing or teaching their medical providers about transgender care; 19% reported refusal of care due to their transgender or gender non-conforming status (Grant et al., 2011).

It is not surprising that depression and suicide are a tragic variable within our society, yet people who identify as

transgender have higher percent rates than average (Schreiber & Hausenblas, 2016). Transgender people appear to experience a higher ratio of mental health issues as compared to the general population. Rates of depression and anxiety are experienced by almost 50% of all people who identify as transgender. Within the general population of the United States, 6.7% reportedly experience depression, and 18% experience some form of anxiety. According to a transgender discrimination survey published in 2011, an estimated 41% of people who identify as transgender have attempted suicide (Schreiber & Hausenblas, 2016); this is in comparison to 1.6% of the general population (Grant et al., 2011). High rates of homelessness and unemployment among the transgender population (Schreiber & Hausenblas, 2016), and a Human Rights Campaign report from 2017, document a continuation of enhanced deadly violence against transgender people (HRC, 2018; McBride, 2017) serve only to compound and exacerbate mental health problems.

Rates of substance abuse, inclusive of alcohol and nicotine products, and illicit street drugs, are used at higher rates by transgender people compared to non-transgender. This elevated drug abuse rate leads to higher rates of Sexually Transmitted Diseases (STDs), HIV infection, and other serious negative health risks – such as heart disease and stroke (Vanderbilt Medical Center, 2018).

In conclusion, the life care planners must be aware and understand the unique and unfortunate challenges that a transgender evaluee may face and be on guard to avoid personal bias against the very person they seek to assist. Gender dysphoria is a well-established entity and well defined by the DSM-5. The American Psychiatric Association (2013) provides an excellent primer on gender dysphoria (www.psychiatry.org); evaluee empowerment through self-education often goes a long way in eliminating internal bias. Transgender people seem to suffer disproportionally compared to the general population (Schrieber & Hausenblas, 2016); well-informed life care planners could serve as a bridge to assist this population in attaining much deserved and needed care, while serving to help eliminate misinformation and bias.

Regret

The frequency of gender dysphoria is difficult to gage; follow-up studies of transgender people are limited in number and often small study size. A 2014 German study of post-operative male to female transgender individuals concluded that there was a high rate of subjective satisfaction following surgery (Hess, Neto, Panic, Rübben, & Senf, 2014). The popular press is now reporting with increasing frequency, issues related to transgenderism. A Newsweek article (Borreli, 2017), reports that gender confirmation surgeries have increased by 20% from 2015 to 2016 with more than 3,000 such operations performed in 2016. As might be expected, the topic of post-operative regret is starting to surface. The same Newsweek article mentions a Serbian urologist who reports that a number of transgender women are now seeking reversal procedures in hopes of regaining their male genital structures. He mentions suicide and depression as driving factors in the decision to re-transition (Borreli, 2017). As defined by MacMillian (n.d.), detransitioning is the term given to the process of going back to ones gender assigned at birth following an attempt at transition to the opposite gender.

The advent of the internet has also propagated a format for many individuals to voice their dissatisfaction and regrets about transitioning from one gender to another. The popular web site, YouTube, catalogs a host of postings about this topic of detransitioning. The conservative media and web sites like, Sexchangeregret.com, will also support high rates of dissatisfaction with gender change; Sex Change Regret purports that up to 20% of transgender individuals regret transitioning from their natal gender (Heyer, 2016). Current medical literature on actual regret rates is limited, but it is safe to surmise that there are, and will be, individuals who self-identify as transgender who will express regret and seek to detransition (Heyer, 2016). The life care planner must be aware of the potential for regret and make certain that transgender evaluees have gone through appropriate counseling, both before and after surgery, to avoid the situation where an individual has taken cross gender hormones and undergone surgical procedures, only to realize that they did not truly have gender dysphoria.

Literature regarding Gender Affirmative (GA) treatment or gender reaffirming surgery (GRS) is limited. There are challenges in diagnosis and treatment (Meijer, Eeckhout, van Vlerken, & de Vries, 2018). The stakes are very high, yet GA treatment should not be ignored. It is possible to have positive outcomes for those who truly do have gender dysphoria (Meijer et al., 2018). Early involvement of an astute, knowledgeable, and caring life care planner could serve as a check and balance for gender change process.

Life Care Planning Considerations

With the passage of time comes changes in population demographics and generational shifts in attitude and behavior. It is not difficult to assert that laws and prevailing sentiments regarding societal norms will change. According to *Neilsen's New Total Audience Report,* millennials and Gen-Z now comprise 48% of the total media audience. Gen-Z is now the single largest audience segment at 26% (Sterling, 2017). According to Sterling (2017), the Baby Boom generation makes up 24% of this segment. It is therefore important to understand more about this generation which is soon projected to dominant and control all segments of society.

Individuals belonging to Gen-Z (iGen) generation were born between the years of 1995 and 2012. Some defining characteristics of this group include the following attributes: more tolerant of others -- different cultures, sexual orientation, and race; less likely to go to church; more likely

to think for themselves and not believe in authority figures such as career planners. Recent data from a *2016 Minnesota Student Survey* (consisting of 9th and 11th grade students) found that 2.7% of the survey population of nearly 81K students identified as transgender and

gender non-conforming (Rider, McMorris, Gower, Coleman, & Eisenberg, 2018). A report by forecasting agency, J. Walter Thompson Group, found that 48% of a Gen-Z sample population identified exclusively as heterosexual, as compared to 65% of sample individuals from those aged 21 to 34 (Millennials); (Laughlin, 2016).

The statistical data for the population of young adults and adolescents, soon to gain political and social dominance, would portend a greater likelihood of public acceptance and support for the transgender population. Life care planners should seek to become knowledgeable about the unique needs of transgender people, and be poised and capable to offer meaningful assistance for this growing segment of our population.

A Word of Caution

Life care planners need to be careful that evaluees are properly vetted. In the past, people had gatekeepers and needed to live as the sex they wished to embrace for a period of time before transitioning (Cascio, 2003). These practices are no longer an expectation for taking the permanent step of transition (Levine, 2009). "While the WPATH Standards of Care require two mental health assessments prior to hysterectomy, this has been challenged academically and in practice given that non-transgender women may undergo a hysterectomy for equally or less compelling complaints without similar restrictions" (Obedin-Maliver, para,5, 2018). It is imperative that life care planners and ancillary health professionals understand the importance of medical management and correct hormonal dosage to safeguard against potential side-effects. Improper or accidental dosage can result in profound complications not only on transgender, but non-transgender women alike (Barros-Bailey & Saunders, 2008).

Sensitivity with Communication and Terminology

The use of pronouns and proper public recognition of chosen gender is vital for establishing open and respectful rapport with the transgender evaluee. "There are a few key things to keep in mind when a transgender evaluee comes into your office. Most importantly, use the evaluee's chosen name and pronoun. This gives evaluees the dignity they don't always enjoy elsewhere" (Schwartz, para. 23, 2016). An understanding of terminology can assist with navigating this important course of good communication and provider/evaluee relationship building. Terms and language are dynamic. Self-education is recommended. Below is a short list of terminology. Part II of this series, Transgender Health: Sensitivity in Care, Treatment, and *"Life Care Considerations for Male to Female Transgender Individuals*" (Van Duyne & Stuart, 2019), has a more inclusive list.

-*Transgender*: A person whose gender identity differs from the sex that was assigned at birth. May be abbreviated to **trans**. A **transgender man** is someone with a male gender identity and a female birth assigned sex; a **transgender woman** is someone with a female gender identity and a male birth assigned sex. A **non-transgender** person may be referred to as **cisgender** (cis=same side in Latin); (Deutsch, 2016).

-*Transsexual*: A person who transitions from one sex to another through the use of hormones and/or surgical procedures (Scutti, 2014).

Treatment: Hormones and Lab Protocol (Male)

Masculinizing hormone regimen would include testosterone which can be administered by transdermal (patches or gel), implantable pellets, or intra-muscular (IM) means. Pre and post-hysterectomy effects dosage levels, with less required post-hysterectomy. Depo-Provera may be used prior to introducing testosterone, in some cases, to provide cessation of menses. Finasteride may be used to treat male pattern baldness that develops on testosterone treatment (Fenway Health, 2015). Table 1 contains an example of a standard timeline for lab tests used during a female to male transition.

Table 1

Laboratory Tests Timeline	
Baseline	Fasting lipid panel, hemoglobin (CBC), fasting glucose, AST/ALT
3 months after beginning/modifying testosterone dosage	Testosterone (total), AST/ALT, hemoglobin (CBC)
6 months after beginning/modifying testosterone dosage	Testosterone (total), AST/ALT, hemoglobin (CBC), lipids
12 months after beginning/modifying testosterone dosage	Testosterone (total), AST/ALT, hemoglobin (CBC), lipids, fasting glucose

(Imborek, 2015, p.6)

Diagnosis: ICDM 10 Codes

As the ICD system was produced separately from the DSM system, the DSM-5 tries to classify the closest calculation of *ICD-CM* codes for diagnoses. This is in an attempt to make it easier for both insurance companies and the public health sectors. Because of this, the American Psychiatric Association (2013) recommends that *ICD-10-CM* list this disorder as gender dysphoria (adolescence and adulthood), and uses the *ICD-10* code that relates to transsexualism or (F64.0); (American Psychiatric Association, 2013; Moran, 2013). If one looks at the changes and progressions over the recent years, these separate systems can be expected to continue to develop and transform (Dickey, Karasic, & Sharon, 2017); (Van Duyne & Stuart, in press).

Vocational Considerations

Life care planners ought to remain current in law to best serve such specialized populations as people who are transgender. This population has reported a high degree of discrimination and hardship within the work place. Seventy-eight percent report some form of mistreatment and/or harassment attributed to gender identity (Schwartz, 2016). "Multiple federal circuits have held that discrimination against transgender people is sex discrimination and is therefore a clear violation of the Fourteenth Amendment's Equal Protection Clause" (Schwartz, para. 23, 2016). A sound understanding of Title VII of the Civil Rights Act is prudent (Schwartz, 2016).

The Varied State of LGBTQ Legislation

According to HRC president Chad Griffin,

> If an LGBTQ couple drove from Maine to California today, their legal rights and civil rights protections could change more than 20 times at state borders and city lines. The vast majority of Americans today understand that this crazy quilt of protections – and lack thereof – is wrong, impractical, and unacceptable (Turner, 2018, para 3).

Fifteen states currently offer no specific legal protections for the LGBT population, and another 21 states only offer partial protections (MAP, 2018).

Life care planners are in a distinctive position to provide their specialized services to a formally under-recognized and under-supported population. What was normally considered a small population has now come forward as more Millennials report identifying as Lesbian, Gay, Bisexual, Transgender or Queer (LGBTQ). A 2017 study revealed that 20% of millennials identify as LGBTQ (GLAAD, 2017). People who identify as transgender are predicted to grow as those who identify begin to come forward (Rider et al., 2018; Schwartz, 2018).

Future Research

The authors propose that future research ought to target improved surgical outcomes through specific formulation of provider guidelines, as well as accountability on both sides with re-instating gatekeepers. People transitioning female-to-male do not need counseling before having a hysterectomy (Obedin-Maliver, 2018). Transition with GRS is a permanent life decision and ought not to be taken lightly. Re-transitioning, though possible, is fraught with its own issues especially once GRS is performed; for one, the use of bathrooms can be problematic after transitioning and certainly should be a consideration if re-transitioning as an option going in. Also, urinary incontinence following bottom surgery (see page 18), for both gender reassignment populations appears to be an area warranting of future research and subsequent establishment of guidelines (Dreher et al., 2017; Melloni, 2017; Neto, Hintz, Kreege, Rübben, & vom Dorp, 2012). A *2013-2015 California Student Survey* found implications for improvement in school policies to improve school environments and decrease truancy in transgender adolescents (this survey was a subsample of the California Healthy Kids Survey; it is recognized as having the leading known sample of transgender youth). Perceptions of this population were that of victimization and bias-based bullying (Day et al., 2018). It was proposed that future research target gender identity related disparities in school-based outcomes. Supporting people who identify as transgender early on may help mitigate the depression and the high suicide rates associated with this population (Schrieber & Hausenblas, 2016).

Case Study and Life Care Plan: Routine Future Medical Care-Physician Only, Projected Therapeutic Modalities, Medication Needs, and Supplies

Your evaluee is a 23 year old landscape specialist who is transgender and wishes to be called by his, he, him pronouns. He was assigned female at birth. His partner is female and supportive of his wish to both surgically and legally transition from female to male. They plan to marry within 2 years. She works as a hotel receptionist; she has medical insurance and he does not. Your evaluee has a primary care physician and a gynecologist. They are both supportive of your evaluee's future wishes to transition, however he is having difficulty finding an endocrinologist who will assume care and monitor hormone levels. Regular counseling has been helpful. He plans to continue with the same counselor through the transition. A goal is assisting with problem-solving the best approach when speaking with his employer, parents, siblings, and specific friends, who are important to him, but who have been less than supportive with this future course. He came-out to his parents as a lesbian at age 14, and was met with acceptance, however the recent announcement of a transition has been met with family and friend's judgment, concern, and some confusion, according to your evaluee.

Life care planning will need to include the intricacies of his life to make reasonable accommodations from current to future needs. Current and future medical providers will bring various viewpoints to individual areas of need. Gender dysphoria has pervasive effects on all levels of function to include social, vocational, personal, and avocational. Each area should to be recognized and appropriately taken into consideration.

Masculinization is achieved primarily through the use of testosterone in doses that are usual male physiological doses. It is common for a female-to-male transgender person to utilize one form of a masculinizing hormone (implantable tablets, IM injection, patch or gel transdermal forms); (Fenway Health, 2015).

> Most healthy adults can be started on the usual adult dosage of testosterone; many providers will start at a half dose and then quickly increase to a full dosage at the first follow-up visit or later depending on the evaluee's response and goals for treatment (Fenway Health, 2015, p. 11).

The following includes the initial medication and lab related entries from his life care plan, plus Routine Future Medical Care (physician only), Projected Therapeutic Modalities, and Future Medical Care/Surgical Interventions.

Table 2

Routine Future Medical Care-Physician Only			
Recommendation	**Frequency and Duration**	**Purpose**	**Expected Cost** (Varies according to where in transition)
Endocrinologist Blood hormone lab work	Monthly to quarterly to annually for lifetime	Monitor hormone levels due to medication treatment	Co-pay or out-of-pocket according to individual insurance guidelines
Primary Care Physician	Annul visit and prn for lifetime	Monitor general health and prescribing of consultants prn	Co-pay or out-of-pocket according to individual insurance guidelines
Gynecologist	prn for lifetime	Until hysterectomy and oophorectomy; need for services for those who have female reproductive organs and breast tissue (HPV, CA prevention)	Co-pay or out-of-pocket according to individual insurance guidelines
Hormones Transdermal -Patches	Androderm patch 2 or 4 mg. Starting dosage 2 mg and increase after 2-4 weeks to 6mg daily. Usual dose 4 mg. applied daily to upper arm, thigh or back (Fenway Health, 2015).	Masculinizing	$594.97 CVS Pharmacy 30/ 4 mg patches (GoodRX.com., 2018)
-Gel	Androgel 5 gram packet (50 mg testosterone). Usual		Average retail price $447.78 30 packets (50

Table 2 cont.

	dose 50 mg testosterone applied daily to upper arms or thighs (Fenway, Health, 2015).		mg 1% testosterone) (GoodRX.com., 2018)
Implantable Pellets	Testopel 75 mg. Usual dose 6-10 pellets implanted every 3-6 months (requires minor surgical procedure to implant pellets into subcutaneous tissue) (Fenway Health, 2015).		$102.00 or more for one box (10 pellets of Testolpel 75 mg). RX cannot be filled at regular pharmacy but at provider's clinic or office; excludes procedure fee (GoodRX.com., 2018)
Intra-muscular Injections (IM)	Testosterone Cypionate usual dose 100 mg IM weekly or 200 mg IM every 2 weeks (Fenway Health, 2015).		Average retail price $26.62 for 1 vial (1 ml) of Testosterone Cypionate 200 mg/ml (or 2 vials/month); (GoodRX.com, 2018).
-Depo-Provera	Medroxyprogesterone 1 syringe (1ml) 150mg/ml. Usual dose 150 mg IM every 3 months. May be used prior to starting testosterone; long term use unlikely (Fenway Health, 2015).		Average retail $105.79 for 1 syringe (1ml); (GoodRX.com., 2018)
Tablets -Finasteride	Usual dose 1 mg-5 mg by mouth daily (Fenway Health, 2015).	Treats male pattern baldness	Average retail $83.54 for 30 /5mg tablets (GoodRX.com., 2018)

Table 3

Projected Therapeutic Modalities			
Recommendation	**Frequency and Duration**	**Purpose**	**Expected Cost**
Counseling; Individual/Family	6-12 sessions/year then prn	Adjustment, education, coping, marital/sexual relations etc.	Initial visit: $175-200 Follow-up: $150-200 per session
Peer Support Group for Individuals who are Transgender	1x/week if available prn for lifetime	Support and societal adjustment	Typically no cost for support group if offered through a local network
Lawyer	1x/ then prn	Name change and birth certificate, gender change, and possible divorce*	Individual hourly rate Range: $75-$400/hour
Personal Trainer *Costs vary per region and notoriety of provider.*	1x/week then prn	Body building for a more natural male physique	Individual hourly rate Range $20-$100/hour Average $50/hour

*Divorce rates for those going through transition are 45% (Leventis Lourgos, 2015).

Transmen will often undergo surgical procedures to better align their body with their internalized gender. Potential surgical options available may include: mastectomy, chest reconstruction, hysterectomy/salpingo-oophorectomy, metoidioplasty, urethroplasty, clitoral free-up, phalloplasty, vaginectomy/colpocleisis, scrotoplasty, implants (testicular, penile), body contouring (liposuction and fillers), and facial masculinization surgery (Fenway Health, 2015). Although many transmen may undergo at least one or more procedures in their lifetime, many will not, due to the cost, personal, and/or health reasons (*Hudson's FtM Resource Guide,* 2018).

Table 4

Future Medical Care/Surgical Interventions/Aggressive (*Costs vary by region, provider, and country. Below costs are from the United States)			
	Recommendation	**Frequency & Duration**	**Expected Cost**
Top Surgery	-Mastectomy	1x	$3,500-$9,000. Does not include consultation. May require down payment of up to 50% of cost to secure surgery date (Top Surgery, 2018).
	-Chest reconstruction/masculinizing surgery	1x	$8,000 (Crane, 2018b)
	-Top Surgery	1x	$11,500 (Meltzer, 2018)
Bottom Surgery	-Hysterectomy & Oophorectomy	1x	$7,000-$20,000 (Hudson's FtM Resource Guide, 2018)
	-Clitoral release (free up)	1x	$6,000 (Crane, 2018b)
	-Phalloplasty	1x	$50,000-$150,000 (Hudson's FtM Resource Guide, 2018)
	-Metoidioplasty/Vaginectomy/(colpocleisis)	1x	$27,000 (Crane, 2018b)
	-Scrotoplasty & Urethra lengthening	1x	
	-Above without Urethra lengthening	1x	$17,000 (Crane, 2018b)
General Surgery	-Body contouring (Fenway Health, 2015)	1x	Prices vary per procedure and body type/BMI (Willett, 2014)
	-Fillers (Fenway Health, 2015)	See Above	

Top Surgery

Surgery for transmen is often subdivided into top and bottom surgery. According to Fenway Health (2015) most transmen will desire chest reconstruction. The World Professional Association for Transgender Health (WPATH) *Standards of Care* does not require hormonal therapy as a criterion for chest surgery (Fenway Health, 2015). The most common techniques applied for masculinizing chest surgery include subcutaneous mastectomy via a peri-areolar incision and inframammary mastectomy with free nipple grafting. There is no consensus approach to surgical planning. Surgical technique is dependent not only on the plastic surgeon's individual experience and evaluee-specific preferences, but also on evaluation of the evaluee's preoperative body habitus, breast size and shape, and skin quality according to Wang & Kim (2018). The procedure will usually take 2 to 4 hours and evaluees may require a short hospital stay; drains and compressive dressings are generally required for 1 to 2 weeks (Wang & Kim, 2018).

Complications

Complications are reported in approximately 12% of evaluees, and include hematoma, seroma, infection, nipple complications, and aesthetic (scar and contour) deformities following top surgery (Wang & Kim, 2018). Overall operative revision rate for aesthetic improvement was reported as high as 32% in a large published series of masculinizing chest surgery. Transgender men should be counseled that androgenic hormone therapy and chest wall reconstruction procedures do not eliminate the risk of breast cancer development. Ongoing screening for breast cancer would remain necessary (Wang, 2018).

Bottom Surgery

Bottom surgery comprises a varied subset of operations that many transmen will seek as part of gender affirmation. Principle surgical procedures range from hysterectomy to genital reconstruction/phalloplasty which potentially includes an array of complex techniques that serve to create a realistic and functional penis. The type of bottom surgery which are pursued is highly dependent on the needs of the individual. The WPATH considers hysterectomy with or without salpingo-oophorectomy to be medically necessary as a component of gender affirming surgical therapy for those transmen who choose to seek this procedure. In the National Transgender Discrimination Survey from 2011 (Obedin-Maliver, 2018), it was reported that only 21% of transmen surveyed had actually undergone hysterectomy. Hysterectomy may be performed abdominally, laparoscopically, or vaginally. Vaginal hysterectomy generally has the fewest complications and allows for the quickest recovery. Hysterectomy has been successfully combined with other gender affirming surgeries on the same day. Concurrent surgeries may include vaginectomy, colpocleisis (closure of the vaginal canal), salpingo-oophorectomy, mastectomy, and genital reconstruction. The surgical needs and considerations of individual transmen are variable and play the dominant role in planning for surgery. The WPATH Standards of Care require two mental health assessments prior to hysterectomy (Obedin-Maliver, 2018).

Phalloplasty in transmen involves the creation of a penis using any one of a number of procedures. In brief, phalloplasty is complex and involves the use of a free lap or pedicled flap of skin taken from the radial forearm or anterior lateral thigh. The procedure typically involves multiple staged procedures and can be combined with scrotoplasty. Urethroplasty/urethral hookup may be performed using vaginal or buccal mucosa; testicular implants and erectile implants can be added at later dates. Potential risks to surgery include infection, bleeding, fistula formation, damage to surrounding tissues, and pain. Metoidioplasty is a less complex procedure and involves freeing up the clitoris, which has generally enlarged under the influence of testosterone, into a phallus. The urethra may or may be transposed into the phallus. A scrotum can be created from the labia majora. Metoidioplasty (enlarged clitoris following a period of testosterone); (The Free Medical Dictionary, 2018), generally result in a phallus that can measure up to 3 inches with a girth approximating a thumb; the tissue is naturally erectile (Crane, 2018a).

Testosterone usually masculinizes facial features to an acceptable level for most transgender males and facial plastic surgery is usually not pursued. Some transmen will seek this procedure in an effort to achieve improved self-esteem and self-image. Facial masculinization may include forehead lengthening/augmentation, cheek augmentation, rhinoplasty, chin and jaw re-contouring, and thyroid cartilage enhancement (International Center for Transgender Care: Plano, Texas n.d.).

Conclusion

In summary, people who identify as transgender are not a new facet of society; they were simply hidden. As more people who embrace this way of living come to the forefront, they will bring with them a new variety and cache of medical needs and necessities. Studies show that this population's needs are not currently being adequately met. Life Care Planners are in a unique position to provide cutting edge services to this emerging population who have very unique health care requirements. Studies support the need for improved guidelines, standards, and policies to provide the opportunity for this population to finally realize best health outcomes and long-term positive care.

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