



Commentary

Considerations for Providing Pediatric Gender-Affirmative Care During the COVID-19 Pandemic


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As interdisciplinary professionals working with gender diverse youth, it is crucial that we continue to provide access to gender-affirming care (GAC) during the COVID-19 pandemic. Before the pandemic, telemedicine was an effective delivery method of mental health services and consultation in GAC, particularly for those living in more rural areas, and has been successfully used for gender diverse adolescents [1–4]. While professionals may find that the guidelines and laws of their respective state licensing and regulatory boards (e.g., practicing telemedicine across state lines) vary, it is imperative to overcome these challenges to provide continuity in care to support transgender and nonconforming youth during this time. Here we review considerations for optimizing GAC care of gender diverse youth during the COVID-19 pandemic.

Psychosocial Considerations

Gender diverse youth face unique adversities during the COVID-19 pandemic. It has been well established that gender diverse youth face disproportionate mental health disparities, such as higher rates of depression and suicidality yet also demonstrate remarkable resiliency [5]. Many professionals who work with this community have a growing concern that there will be an increase in these health disparities as the COVID-19 pandemic continues. Some gender diverse youth face the additional challenge of being at home with family members who are unsupportive and nonaffirming of their gender identities and may experience daily microaggressions and overt aggressions. Providers can guide family members who are struggling with acceptance of their gender diverse youth to become more

supportive and affirming such as encouraging families to use a youth's chosen name and pronouns as consistently as possible [6]. Parental support has been demonstrated to reduce rates of negative health outcomes and prevent against suicidality [6]. Additionally, mental health providers have the opportunity to create new services, such as telemedicine group psychotherapy experiences, to provide supportive experiences to gender diverse youth.

Medical Considerations

Chest binding

The use of chest binders in transmasculine and nonbinary youth has been documented to improve gender dysphoria and may also continue to help affirm gender diverse youth who may have delayed top surgeries [7]. However, providers should consider a harm reduction approach to minimize or discontinue chest binder use, especially during suspected or confirmed COVID-19 infection, which could result in worsened respiratory symptoms.

Pubertal blockade

The ability to perform clinical and/or biochemical assessments of pubertal onset may be affected by the safe ability to perform in-person visits and/or laboratory testing and, thus, is individualized based on local disease prevalence, federal and state mandates, and local hospital policies. An estimated growth velocity, especially for assigned females, may be supportive of pubertal onset as well as early morning luteinizing hormone level and sex steroid levels [8,9].

A baseline bone age x-ray and/or bone density (e.g., DXA scan), as recommended by current clinical practice guidelines, may be deferred and could still be obtained likely up to six months after treatment initiation and still be considered a baseline [8,9]. While current clinical practice guidelines recommend long-acting GnRH agonists, in clinical settings, where surgical procedures for Histrelin implants have been suspended,

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injectable forms of GnRH agonist such as use of Leuprolide Acetate (monthly or every 3, 4, or 6 months), or Triptorelin (every 6 months) can be considered [8,9]. In some cases, alternatively, use of progestin (e.g., medroxyprogesterone) to lead to pubertal suppression could be considered although are less effective than GnRH agonists [8,10].

Gender-affirming hormones

Similar to pubertal suppression, implementation of gender-affirming hormones will be individualized to local policies. For patients desiring injectable hormones, consideration should be made for a virtual visit to supervise the patient through their first injection and/or use of publicly available injection administration videos. In some cases, the use of topical testosterone could be considered for transmasculine patients; however, caution should be exercised in some clinical scenarios due to the potential to unintentionally masculinize cisgender females who may have close contact [11]. Adjunctive therapies, as recommended by current clinical practice guidelines, such as progestins for menstrual suppression or spironolactone for facial hair growth, can be offered if gender-affirming hormones are not being actively prescribed by programs [8,9,12].

Fertility preservation

While international reproductive medicine organizations originally recommended limiting fertility services, such as to oncologic cases, due to the pandemic, their recommendations continue to evolve [13]. The majority of fertility preservation counseling, as these services have low rates of utilization by transgender youth, is easily rendered in virtual visits including discussion of processes involved to undergo fertility preservation (e.g., ovulation induction for oocyte cryopreservation or sperm banking) [14–16]. Additionally, gender diverse youth and their guardians should be reminded that fertility preservation does not have to occur before gender-affirming hormone therapy and studies have documented both successful pregnancy and oocyte retrieval after discontinuation of testosterone, and sperm retrieval after discontinuation of estrogen [17–19]. Even during the pandemic, fertility preservation is an important part of counseling before medical transition.

Considerations for Surgical Transition

There are various factors that may influence when gender-affirmative surgery is able to be performed as surgical centers return to higher capacity. First, surgeries require resources (e.g., personal protective equipment) which are needed for the care of COVID-19 patients. Furthermore, surgeries will have different requirements regarding postoperative inpatient care which may impact reinitiating certain procedures (e.g., outpatient surgeries may be prioritized, thus allowing for mastectomies and hysterectomies, but not phalloplasty). Finally, a person's COVID-19 status, such as active or past infection, is a new surgical consideration.

There are also considerations unique to gender-affirming surgeries. Surgical delays can be additional stressors for gender diverse youth who have often waited a number of years for these procedures. Some youth and young adults have overcome geographic, legal, financial, or insurance barriers to be able to access surgery, as well as being placed on long surgical waitlists. Those who are experiencing greater stress and/or dysphoria, or

who may have higher risk of resurgence of those barriers, might benefit from greater surgical prioritization.

Regardless of how surgeries are phased in, there are many ways in which clinicians can help support patients experiencing surgical delays. Surgeons can support their patients by maintaining open and honest communication regarding the status of surgeries and validating the experiences of their patients, such as by acknowledging the distress that surgical delay may cause. It is important to avoid the use of terms such as “elective,” “cosmetic” or “non-essential.” Both surgeons and nonsurgical clinicians can remind patients that gender-affirming surgeries are medically necessary and that they will advocate for their prioritization.[9].

Conclusion

It is of the utmost importance that all providers, across disciplines, stress that GAC is “essential,” even during a pandemic. Unfortunately, many gender diverse youth have experienced delays in medically necessary treatment (e.g., pubertal suppression, hormone therapy, surgeries, etc.) and potentially have received the unintended, yet damaging message, that GAC is not a priority; therefore, it is important that multidisciplinary professionals working with gender diverse youth and their families counter this narrative. Facilitating open and appropriate communication about the efforts being taken to provide GAC is critical so that gender diverse patients and their families know that their health care is valued and medically necessary.

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References

- [1] Shipherd JC, Kauth MR, Matza A. Nationwide interdisciplinary E-consultation on transgender care in the Veterans health administration. *Telemed J EHealth* 2016;22:1008–12.
- [2] Magnus M, Edwards E, Dright A, et al. A Feasibility study of a Telehealth Intervention on health care service utilization among transgender Women of Color in Washington, DC. *ACI Open* 2018;02:e1–9.
- [3] Sequeira GM, Kidd K, Coulter RW, et al. 59. Transgender youth's Perspectives on Telehealth for delivery of gender-Related care. *J Adolesc Health* 2020;66:S31–2.
- [4] Wood SM, White K, Peebles R, et al. Outcomes of a Rapid adolescent Telehealth Scale-up during the COVID-19 pandemic. *J Adolesc Health* 2020;67:172–8.
- [5] James SE, Herman JL, Rankin S, et al. The report of the 2015 U.S. Transgender Survey. 2016. Available at: <https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>. Accessed May 28, 2020.
- [6] Russell ST, Pollitt AM, Li G, Grossman AH. Chosen name Use is Linked to reduced depressive symptoms, suicidal Ideation, and suicidal Behavior among transgender youth. *J Adolesc Health* 2018;63:503–5.
- [7] Peitzmeier S, Gardner I, Weinand J, et al. Health impact of chest binding among transgender adults: A community-engaged, cross-sectional study. *Cult Health Sex* 2016;19:64–75.
- [8] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-Dysphoric/gender-Incongruent persons: An Endocrine Society clinical practice guideline. *Endocr Pract* 2017;23:1437.
- [9] Coleman E, Bockting W, Boltzer M, et al. Standards of care for the health of Transsexual, transgender, and gender-Nonconforming People, Version 7. *Int J Transgend Health* 2012;13:165–232.
- [10] Lynch MM, Khandheria MM, Meyer WJ. Retrospective study of the Management of Childhood and adolescent gender identity Disorder using medroxyprogesterone Acetate. *J Transgend Health* 2015;16:201–8.
- [11] Ronde WD. Hyperandrogenism after transfer of topical testosterone gel: Case report and review of published and unpublished studies. *Hum Reprod* 2009;24:425–8.
- [12] Carswell JM, Roberts SA. Induction and Maintenance of Amenorrhea in transmasculine and Nonbinary adolescents. *Transgender Health* 2017;2:195–201.
- [13] American Society for Reproductive Medicine (ASRM). Patient Management and clinical recommendations during the Coronavirus (COVID-19) pandemic. 2020. Available at: <https://www.asrm.org/globalassets/asrm/>

- asrm-content/news-and-publications/covid-19/covidtaskforceupdate3.pdf. Accessed May 28, 2020.
- [14] Chen D, Simons L, Johnson EK, et al. Fertility preservation for transgender adolescents. *J Adolesc Health* 2017;61:120–3.
- [15] Nahata L, Chen D, Moravek MB, et al. Understudied and Under-Reported: Fertility Issues in transgender youth—a Narrative review. *J Pediatr* 2019; 205:265–71.
- [16] Grimstad F, Boskey E. Empowering transmasculine youth by Enhancing reproductive health counseling in the Primary care setting. *J Adolesc Health* 2020;66:653–5.
- [17] Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol* 2014;124:1120–7.
- [18] Barnard EP, Dhar CP, Rothenberg SS, et al. Fertility preservation outcomes in adolescent and young adult Feminizing transgender patients. *Pediatrics* 2019;144.
- [19] Leung A, Sakkas D, Pang S, et al. Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: A new frontier in reproductive medicine. *Fertil Steril* 2019;112: 858–65.