Preanesthetic Assessment of the Transgender Patient:
What the Anesthesiologist Should Know

PREANESTHETIC ASSESSMENT
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PROFESSIONAL GAPS
Despite recommendations by the Joint Commission that hospitals in the United States promote an inclusive atmosphere to improve the health care of lesbian, gay, bisexual, and transgender patients, many anesthesiologists have not been trained to treat, and lack the basic knowledge of how to approach, these patients as well as the anesthetic challenges they can present and the particular vulnerabilities of this group of the population.

TARGET AUDIENCE
Anesthesiologists

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LEARNING OBJECTIVES
After completion of this activity, the reader should be able to:

1. Delineate the professional terminology related to the perioperative care of a transgender patient
2. Navigate the terminology applicable to sexual identities
3. Describe the health and health care disparities faced by transgender people
4. Understand the meaning of “gender reassignment surgery” and the types of surgical interventions associated with it
5. Predict the possible difficulties in management of the transgender patient’s airway
6. Foresee the possible perioperative complications related to use of feminizing or masculinizing hormonal therapy
7. Procure the medical history of transgender patients pertinent to anesthetic care in a sensitive and respectful manner
8. Explain the implications for patient safety of a lack of understanding of transgender issues among members of the operating room (OR) team
9. Predict the major implications for perioperative care of completed transgender surgery
10. Formulate a sensitive and informed communication approach to a transgender patient in the perioperative setting
CASE

Late at night, a 27-year-old patient presented to a small community hospital for an emergency appendectomy. The patient’s name was listed as Mr. G. According to the notes of the emergency room (ER) physician, the patient had no significant medical history. The surgical history consisted of breast augmentation. Concerned that the identification was indeed correct, the anesthesiologist returned to the ER to interview the patient whose appearance seemed to be female. On further review of the medical files, the record number and name on the wristband matched the one from his/her electronic medical record.

With a masculine voice, the patient stated: “My name is Ellen.” She confirmed no significant medical history and reported that she had received breast implants under general anesthesia approximately 6 months ago with no complications. She also reported that she is currently on medication “to help her body look more feminine.” She complained only of nausea and right lower quadrant abdominal pain. Her lab work was significant for an elevated white blood cell count. The abdominal computed tomographic results were consistent with the diagnosis of acute appendicitis. In the presence of the ER physician, a physical examination was undertaken.

The patient was transferred to the OR. The anesthesiologist was uncertain as to how much information he/she should share with the OR and post-anesthesia care unit personnel, and the best manner in which to carry out that task. In addition, a family member of the patient asked about the patient’s condition, and again the anesthesiologist was unsure how much information should be divulged.

Introduction

Since 1965, when Columbia University psychiatrist John F. Oliven, MD, coined the term “transgender,” there has been much misunderstanding about its meaning. By the mid-1980s, a “transgender community” had developed significantly in the United States. The term transgender is still mostly an “umbrella term” that is widely confused with other terms: transsexualism, gay, transvestism, androgynous, panenderism, homosexuality, etc.

Transgenderism is usually not directly related to sexual orientation. It can be described as a mismatch of a person’s own gender identity and his/her assigned sex at birth. Transgender people traditionally experience a mismatch of their self-perception with expectations of the surrounding society. Such a dichotomy can create significant stress with a predisposition to psychological and social problems, which affect health and quality of life. Transgender people often choose a number of medical capabilities to align the appearance of their bodies with their own self-gender awareness. Many choose to undergo hormone replacement therapy, feminizing or masculinizing plastic surgery, Adam’s apple reconstruction, and gender reassignment surgery, commonly referred to as a “sex change.” Some transgender people choose only 1 or 2 procedures, but some may choose to undergo a complete change of their phenotype. People who pursue gender reassignment surgery are transsexuals.

The American Medical Association considers denial of gender reassignment surgery for gender dysphoria treatment to be discrimination. A large number of US commercial and public health insurance plans contain benefits covering gender confirmation surgery. The American Medical Association, National Association of Social Workers, and American Psychological Association encourage health insurance coverage of gender reassignment surgery. Transgender people, depending on personal needs, should always choose the amount of surgical intervention they desire.

Transgender people are frequent victims of rejection, humiliation, and stigmatization. Violations of transgender people’s rights are still widespread. Clinical training in medical schools and curricula still lacks sufficient information to adequately provide health care to transgender patients. Many health care providers know very little about transgenderism and transgender people. The lack of information is not limited to primary care. Anesthesiologists, as perioperative care physicians, need to be aware of these issues and prepared to give adequate and sensitive perioperative care to this population.

What Is “Transgender”?

Understanding proper terminology is an important part of the perioperative care of transgender people. A continuing misconception of appropriate definitions remains. Sexual orientation is a pattern of romantic or sexual attraction to persons of the opposite sex, same sex, or both sexes. Regarding this disposition, one may be gay or lesbian, straight, or bisexual.

Homosexuality is often confused with transgenderism. Homosexuality implies emotional, romantic, erotic, or sexual attraction exclusively to persons of the same sex. Gay is another commonly confused term that primarily refers to homosexual persons of either sex. Lesbianism refers exclusively to female homosexuality. Bisexuality refers to a romantic, erotic, or sexual attraction to both sexes. Sexual orientation differs from sexual behavior. An individual may choose to exercise sexual orientation in sexual behavior, or people may prefer to maintain behavior that does not match their sexual orientation. Sexual orientation is not the same as sexual identity.

Transgender people can have any of these orientations. Traditionally, gender describes a phenotype. It is based on the type of gonads and genital appearance. In a wider definition, gender is self-identification and is usually congruent with a specific phenotype. Transgender means that one’s gender identification is inconsistent with the phenotype. The transgender term is often interchanged with the term transsexual. A transsexual person possesses a physical phenotype that is completely inconsistent with his/her gender identity. A transsexual seeks to modify his/her phenotype, to make it more congruent with his/her gender identity. Therefore, a transsexual is always a transgender person, but not every transgender person is transsexual. Transvestism refers to
dressing up in clothes that social conventions prescribe to the opposite sex. Although it can be a sign of gender dysphoria and transgenderism, it is generally not considered a necessary attribute. Cross-dressing is usually regarded as a form of sexual behavior and may be characterized by the fact that sexual gratification is achieved by wearing clothes of the opposite sex. Androgyny is a condition in which people prefer not to meet qualities of either sex. This term describes a psychosocial state of mind rather than psychological or anatomic characteristics. A recently adopted term is “men who have sex with men.” This expression is primarily social and epidemiological and refers to men who either continuously or occasionally engage in sex acts with other men without taking their sexual orientation or behavior into account.

What Are the Important Issues of Transgender Health?

Lesbian, gay, bisexual, and transgender (LGBT) people traditionally experience barriers related to their sexual orientation, sexual behavior, and expression. The LGBT community experiences higher rates of sexually transmitted diseases, alcoholism, tobacco use, HIV, hepatitis C, and mental health issues. Transgender people experience health care disparities and have distinct health care needs. These differences are not only apparent in affluent, urban centers; a recent study demonstrated the role of stigma in shaping access to primary health care among rural LGBT people and points to the need for interventions focused on decreasing this outward expression and increasing patients’ disclosure of sexual orientation and gender identity. Only with these interventions can there be an increased utilization of primary and preventive health care services by LGBT people.

LGBT patients have a high prevalence of anxiety, personality disorders, eating disorders, substance dependency and abuse, tobacco use, domestic violence, and incarceration. Suicide risk is high both before and after gender reassignment surgery. LGBT patients are unwilling and hesitant to seek medical care. Transgender people often are unaware of their HIV status.

A final ruling issued by the Centers for Medicare & Medicaid Services and the office of the National Coordinator for Health Information Technology, in October 2015, requires electronic health record software certified for Meaningful Use to include sexual orientation and gender identity fields. This critical step should make sexual orientation and gender identity data collection a standard practice in clinical settings. Notwithstanding, sexuality is still not incorporated as a factor into the majority of medical data collection.

Transgender people are underinsured compared with the general population. Health care providers who lack knowledge and appropriate education in transgender health occasionally reject these people. There is a national need for transgender-sensitive medical training. According to the National Transgender Survey conducted in 2011, 9% of the 6,000 respondents reported difficulties in finding a primary care physician as a result of their transgender status. Twenty-eight percent of the respondents postponed necessary care when they were ill; 33% postponed preventive care. In a 2007 survey of 736 California physicians (13% response rate), 18.3% of the respondents were sometimes unsure as to how to provide care to a transgender person.

The Association of American Medical Colleges (AAMC) recommends including “comprehensive content addressing the specific healthcare
needs of [LGBT] patients” and “training in communication skills with patients and colleagues regarding issues of sexual orientation and gender identity” in medical school curricula.7 The AAMC recognizes these problems and advocates that “medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for [LGBT] patients.” The AAMC recommends medical schools incorporate “comprehensive content addressing the specific health care needs of [LGBT] patients” and “training in communication skills with patients and colleagues regarding issues of sexual orientation and gender identity” into the curricula. The Joint Commission also advises US hospitals to promote an inclusive atmosphere to improve health care for LGBT patients. In 2010, the Joint Commission published hospital guidelines titled Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.8 As of 2012, the Joint Commission enforced a patient–provider communication standard as part of the accreditation process.

In 2015, the American Psychological Association adopted “Guidelines for Psychological Practice With Transgender and Gender Nonconforming Clients” (TGNC).9 Sixteen guidelines to aid TGNC-affirmative psychological practice across the life span are organized into 5 clusters: foundational knowledge and awareness; stigma and barriers to care; life span development; assessment therapy and intervention; and research, education, and training.

How To Approach and Greet a Transgender Patient

It is estimated that 1 of 100,000 people in the United States is a transgender woman and 1 of 400,000 is a transgender man, although these estimates are probably low.10 Thus, although rare, it is likely that anesthesiologists will encounter TGNC in the course of practice. Perioperative care personnel always must respect a patient’s gender identity. A transgender patient’s body may still be in transition and possess features, components, or attributes of the opposite sex. In other words, his/her body might still not uphold to the transgender patient’s gender identity.

Transgender people may require procedures that are mostly provided for people of the opposite sex. In such cases, physicians need to remember that the anatomy of the transgender person does not describe him/her, and those patients must be approached in the most sensitive way. Transgender patients should be treated as their bodies simply belong to them rather than defining them as people. For some transgender people, seeing health care professionals is stressful. For many transgender people, a physical exam involves a certain degree of “ outing” themselves as transgender and potentially can cause some degree of privacy violation. There is no need for questions such as, “What is your real name?” and “When or why did you decide to be trans?” The correct name is the only one that the transgender person offers. If in doubt, the physician should ask how the patient wishes to be addressed.
Transgender identity should be validated at all times. If pronouns are mistakenly used, then a simple apology should be made. Nobody should ever assume that the transgender person would like to discuss transgender community issues or educate the health care worker about them. The patient’s preferred gender identity, correct pronouns, and terminology should always be honored without exception.11

Transgender people may exhibit a variety of health problems. As noted above, frequently their health has been neglected and they may have multiple comorbidities.11,12 To achieve better feminization, transgender people may choose to use silicon injections, which are sometimes performed by nonlicensed amateurs. Considerable medical complications, including disfigurement and infection, can result.

Understanding Gender Reassignment Surgery

Besides the usual surgical history inquiries, transgender patients need to be asked specifically about gender reassignment surgery. Sometimes complete sex transition is desired, termed gender reassignment or gender confirmation surgery. The term “sex change” should not be used because it may be considered offensive. Male-to-female gender reassignment surgery may require gonadectomy, external genitalia remodelling, breast implantation, rhinoplasty, and vaginoplasty. Furthermore, transgender people may choose to have nongenital feminizing surgeries, including chondroaryngoplasty, to lessen the size of the Adam’s apple by contouring down the thyroid cartilage. Chondroaryngoplasty may be done with vocal cord surgery to change the pitch of the voice. These surgeries can compromise the tracheal lumen and cause some degree of tracheal stenosis. Vocal cord damage and postoperative dysphagia also can occur. Adam’s apple augmentation with an implant is carried out when masculinization is desired. Sometimes rhinoplasty and facial feminization surgery with facial implants are added. These procedures also require special attention regarding assessment of the airway.13

Medications

Hormonal therapy suppresses sex attributes associated with the person’s birth sex and induces attributes of the desired sex. Many transgender patients choose to be on masculinizing or feminizing hormonal therapy in order to make their physical presentation more congruent with their gender identity. Physicians should ensure that transgender patients do not have any comorbidity that could be worsened by hormonal therapy. Due to a lack of resources, transgender people occasionally may choose to use unprescribed hormones obtained from abroad or on the black market via the Internet. Such medications can potentially carry a risk for overdose or infection if injected.

Hormones increase the risks for blood clots, hypertension, hyperglycemia, liver damage, and electrolyte imbalance, among other problems. Hormones also increase the risk for heart attack and stroke. Estrogen therapy in male-to-female patients is associated with a risk for prolactinoma, breast cancer, liver disease, and coronary artery disease. Female-to-male patients on testosterone therapy may have an increased risk for developing liver disease and breast and endometrial cancers.14

The patient’s biological sex should be known in order to perform measurements such as creatinine clearance and to prevent teratogenic agents from being given to a transgender or transsexual man who could be or is capable of becoming pregnant.9

Physical Examination

Care should be provided regardless of a patient’s self-description, presenting gender, legal status, and identification. It should be done in a most sensitive and affirming way since transgender patients may experience extreme discomfort with their body appearance. Physical examination for them may be a traumatic experience and must be done with sensitivity. A male- or female-identified patient should always be addressed with the name he or she prefers. Usually it is wise to perform a physical examination with a chaperone present, but situational judgment must be used. The patient should be allowed to choose the gender of the chaperone.15

Sharing Information With Perioperative Staff and Family Members

Operating room (OR) and post-anesthesia care unit staff should be encouraged to respect and accept the manner in which transgender people present themselves. The nursing staff should be fully alerted
and allow these patients to feel safe disclosing their gender identity. A neutral approach is preferable. Only questions pertinent to the patient’s medical care should be asked. Any questions and comments should not bring excessive attention to a patient’s transgender status. It also is important to keep in mind that patients may bring recording devices, including phones, into the OR that can either be disclosed or tucked in clothing under a stretcher, especially during outpatient procedures. Unwarranted comments can thus be captured at a time when OR staff believe the patient to be anesthetized and thus unable to hear.

Transgender people may have extraordinary family backgrounds and exceptional vulnerabilities in the context of law. They differ significantly in their choice as to how much information they wish to disclose to their families, friends, and significant others. It is important that the staff and transgender patient agree who he/she wishes to receive health care information. Anesthesiologists should only disclose the minimum information necessary. It is paramount not to breach confidentiality, and consent must be obtained before any discussion with family members. Even with consent, conversations should be limited to current conditions and status. If questions arise as to what can or cannot be disclosed, the risk management office and/or administration should be immediately contacted.

Management of the Case

Preoperative assessment was completed in the emergency room. The airway was assessed as within normal limits, and the patient denied any vocal cord surgery. General anesthesia was planned. The OR staff directly involved in the patient’s surgical care was made aware of the patient’s preferred name and pronoun. Anesthetic management was uneventful. Appendectomy was successfully completed. The post-anesthesia care unit staff also was made aware of the patient’s preferred name and pronoun. The patient was later followed into the post-anesthesia care unit. A male visitor was noted at her bedside, who introduced himself as the patient’s partner. Only questions related to the current anesthetic and postoperative condition were answered. The postoperative course was uneventful, and no anesthetic-related complications were noted. The patient was referred to her surgeon for follow-up care.

Conclusion

Transgender people have distinctive health risks, specific health care needs, and health care disparities. Chronic disease risks, mental health problems, depression, sexually transmitted diseases, and domestic violence are not uncommon. Training in medical schools today often fails to address the issues of this group of society. Further recognition and education are essential.

References


Post-Test:

1. **What is a preferred definition of transgender?**
   a. Transgender is an “umbrella” term that describes those who experience a mismatch between their gender identity and their assigned sex at birth.
   b. Transgender means emotional, romantic, erotic, or sexual attraction exclusively to persons of the same sex.
   c. Transgender primarily refers to a homosexual person who prefers to dress as a woman.
   d. Transgender primarily refers to people whose sexual orientation is different from their sexual behavior.

2. **Transvestism is a term describing:**
   a. dressing up in clothes that social conventions prescribe to the opposite sex
   b. a gender identification that is inconsistent with the phenotype
   c. a form of sexual behavior that is characterized by the fact that sexual gratification is achieved by wearing clothes of the opposite sex
   d. a type of sexual orientation

3. **All are types of sexual orientation, except:**
   a. homosexual
   b. heterosexual
   c. bisexual
   d. transgender

4. **Which are known issues of transgender health?**
   a. Transgender people experience health and health care disparities.
   b. Transgender people are at risk for depression, anxiety, substance abuse, and eating and personality disorders.
   c. Transgender people delay their medical care.
   d. All of the above.

5. **When conversing with a transgender patient, all are appropriate, except:**
   a. to use only the name the transgender patient gives you
   b. to inquire what name he/she was given at birth
   c. to use only the pronoun preferred by the transgender patient
   d. to ask politely by what name he/she prefers to be called

6. **What is gender reassignment surgery?**
   a. A type of plastic surgery to feminize the face
   b. Gonadectomy
   c. An option for those transgender people who desire a complete transition
   d. A surgery resulting in feminization

7. **What special attention is needed for a transgender patient’s airway?**
   a. Additional nongenital feminizing procedures include chondrolaryngoplasty, which potentially can compromise a transgender patient’s airway.
   b. Transgender patients may have an anatomically difficult airway as a result of hormonal therapy.
   c. Transgender individuals are prone to upper airway malignancy.
   d. Transgenderism is associated with a difficult airway anatomy.

8. **The implications of feminizing or masculinizing hormonal therapy include:**
   a. increased risk for heart attack and stroke
   b. increased risk for thromboembolic events
   c. increased risk for liver disease
   d. all of the above

9. **When conducting a transgender patient’s physical exam:**
   a. a chaperone must be always present
   b. a male-identified transgender patient should always be addressed with masculine pronouns and his preferred name
   c. a chaperone’s gender should always be the same as the transgender patient’s affirmed gender
   d. a transgender person who underwent gender reassignment surgery should always be addressed with a pronoun matching his/her phenotype

10. **What information can be shared with a transgender patient’s family?**
    a. Only the information that the transgender patient agrees to and wishes his/her family to receive
    b. All information can be shared with a transgender patient’s spouse
    c. All information can be disclosed, unless it is related to gender reassignment surgery
    d. No information can be shared, as transgender people may regard that as “outing”