Shared Care for Transgender and Gender Diverse Patients (TGD)*

*TDG includes all gender identities outside the binary cisgender experience where sex assigned at birth matches the person's identity over their lifetime.

This document aims to provide basic advice for GPs providing care to TGD patients and referral pathways for shared care or hand over.

Referral options:

Medical / hormonal management	
Services with multidisciplinary capacity	GP clinics with LGBTIQA+ focus
Gender Health Australia QCGP+, General Practice Royal Brisbane and Women's Hospital Gender Service Queensland Children's Gender Service	Holdsworth House Stonewall Medical Centre Gladstone Road Medical Centre
Psychosocial support	
Organisations above and those listed below	Private practise
QC Mental Health Services Open Doors Youth Service Q-Life Brisbane Youth service The LGBTI Legal Service Caxton Street Legal Service	The Courageous Space Reframe Psychology We are all human Reravel

Professional Support

AusPATH, Gender Health Australia, Gender Affirming Health Network Qld., RACGP Interest group, Equinox (Thorne Harbour health)

Common Medications

Gonadotropin-releasing hormone agonist GnRH also known as luteinizing hormone-releasing hormone (LnRH) agonists. : Leuprolide (Lupron, Eligard) To delay onset of puberty most often initiated by a specialised Multidisciplinary team.

Oestrogen (only PBS listed)[1]	Androgens[1]	Anti-Androgens[1]
Progynova Climara 25 Estradot 25, 37.5, Estraderm 25 MX 50 MX 100MX Sandrena	Testogel Androforte Primoteston Reandron	Spironolactone Cyproterone acetate
Aim for target oestradiol trough level of 300-600 pmol/L, monitor levels 6-8 weeks after changing therapy Aim for clinical response as judged by patient	Use target trough level of 10-15 nmol/L total testosterone Aim for clinical response as judged by patient	Use target trough level of <2nmol/L (normal female range) Aim for clinical response as judged by patient

[1] Change of hormone state in early medical transition may be associated with significant mood changes.

AusPATH prescribing resource

Equinox- Thorne Harbour Health prescribing resource

PBS prescriptions for testosterone must be initiated by a specialist in sexual health or endocrinology. All of the prescribing noted in this guide is covered by medical indemnity insurance because it is current best practice.

Common Clinical Considerations:

For Under 18s best practice requires referral to or share care with a multidisciplinary team

Clinical Issues	Practice Points
Fertility	Gender transition is highly likely to produce infertility. Fertility preservation needs to be explored and documented.
Contraception	Testosterone is not adequate contraception, consider Implanon / IUD / Depo-Provera
Period Suppression	Norethisterone (Primolut N) continuously Progestin (Amethyst) continuously IUD plus progestin (Mirena)
Vaginal irritation (FtM)	Atrophy clients can use Vagifem low, twice weekly
Polycythaemia	If HCT>0.50, occurs reduce dose / frequency of testosterone , haematology referral may be required
Dyslipidaemia	Testosterone may increase heart disease risk and cause dyslipidaemia. Encourage that clients quit smoking, optimise their BMI and reduce other risk factors.
Rare Oestrogen Side Effects	DVT, PE, liver impairment, caution for patients who experience migraine with aura.
Sexual Function	Some MtF will want preservation of (some) Testosterone to maintain erectile function.
Hair Loss	Finasteride can be useful in FtM toavoid pattern baldness
Monitoring	E/lft, hormone levels (trough) lipids bone density FBC 3 monthly at first then 6monthly
HPV	All persons with a cervix require HPV screening per national guidelines
STI guidelines	Detailed advice here, https://sti.guidelines.org.au/populations-and-situations/