



Dear Colleague

Gender Reassignment Protocol

Summary

This letter is to provide Boards with the Gender Reassignment Protocol for Scotland. The protocol incorporates recommendations from the 7th edition of The World Professional Association for Transgender Health (WPATH) Standards of Care, September 2011. The protocol sets out those procedures which may be provided on the NHS; procedures exclusive to gender reassignment should be accessed via this protocol. All other procedures not exclusive to gender reassignment should be accessed via The Adult Exceptional Aesthetic Referral protocol, and are provided on the basis that there is clear evidence of benefit to the patient.

Background

Following an assessment of guidance and provision of services pertaining to Gender Reassignment, it was agreed to develop and implement a specific 'Gender Reassignment Protocol.'

1. The Gender Reassignment Working Group held its first meeting in February 2011 and membership consisted of clinicians, members of the transgender community, representatives from the Scottish Government, National Services Division and a lay person with an interest in transgender issues. The working group was co-ordinated by NHS Health Scotland.
2. In order to ensure collaborative working and patient focused holistic care, community engagement groups were held across Scotland and feedback from the participants helped inform the detail of the protocol. Throughout the duration of the working group, engagement was maintained with senior NHS managers and a specialist clinical psychologist attached to one of the plastic surgery centres.
3. For procedures not exclusive to gender reassignment, the working group agreed that a specialist panel, including gender specialists and surgeons should evaluate each case collaboratively to reach agreement on the most effective treatment. To ensure equity, these procedures should be accessed via The Adult Exceptional Aesthetic Referral protocol. Patients could be represented by their gender specialist. The evaluation should take place without undue delay and in a place and manner supportive to the patient.

Addresses

For action

Chief Executives (NHS Boards)
Medical Directors (NHS Boards)
Chief Executives (Operating Divisions)
Medical Directors (Operating Divisions)
Director (Information Services Division)

For information

Chief Executive (Golden Jubilee National Hospital)
Regional Directors of Planning
Chief Executive (NHS National Services Scotland)
Chief Executive (Healthcare Improvement Scotland)
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4. For procedures exclusive to gender reassignment, arrangements for delivering agreed procedures are under review with the objective of ensuring that an effective, equitable and sustainable service is implemented.
5. The protocol is intended to be flexible for each transgender patient. Each patient's request for assessment and treatment will be considered, in conjunction with their clinician(s), to meet their individual needs.

Actions to Promote Success

NHS Boards should now work to ensure that services are provided in keeping with the protocol. Multi-disciplinary collaboration should help to ensure equity of access and clinical effectiveness for all patients accessing Gender Reassignment and the Adult Exceptional Aesthetic Referral procedures. The protocol should be fully communicated throughout each Board area to relevant staff and patient groups. An implementation plan will be agreed with each NHS Board.

Services should be provided in an equitable, effective, patient focussed and timely manner. A formal audit of the protocol will be established within 3 months of the date of this CEL and will run for 12 months, with a report produced on the effectiveness of the protocol. The audit will include patient experience feed-back. The effective, equitable and timely working of the Adult Exceptional Aesthetic Referral Protocol within the Gender Reassignment Protocol will be reviewed as part of this audit.

Yours sincerely

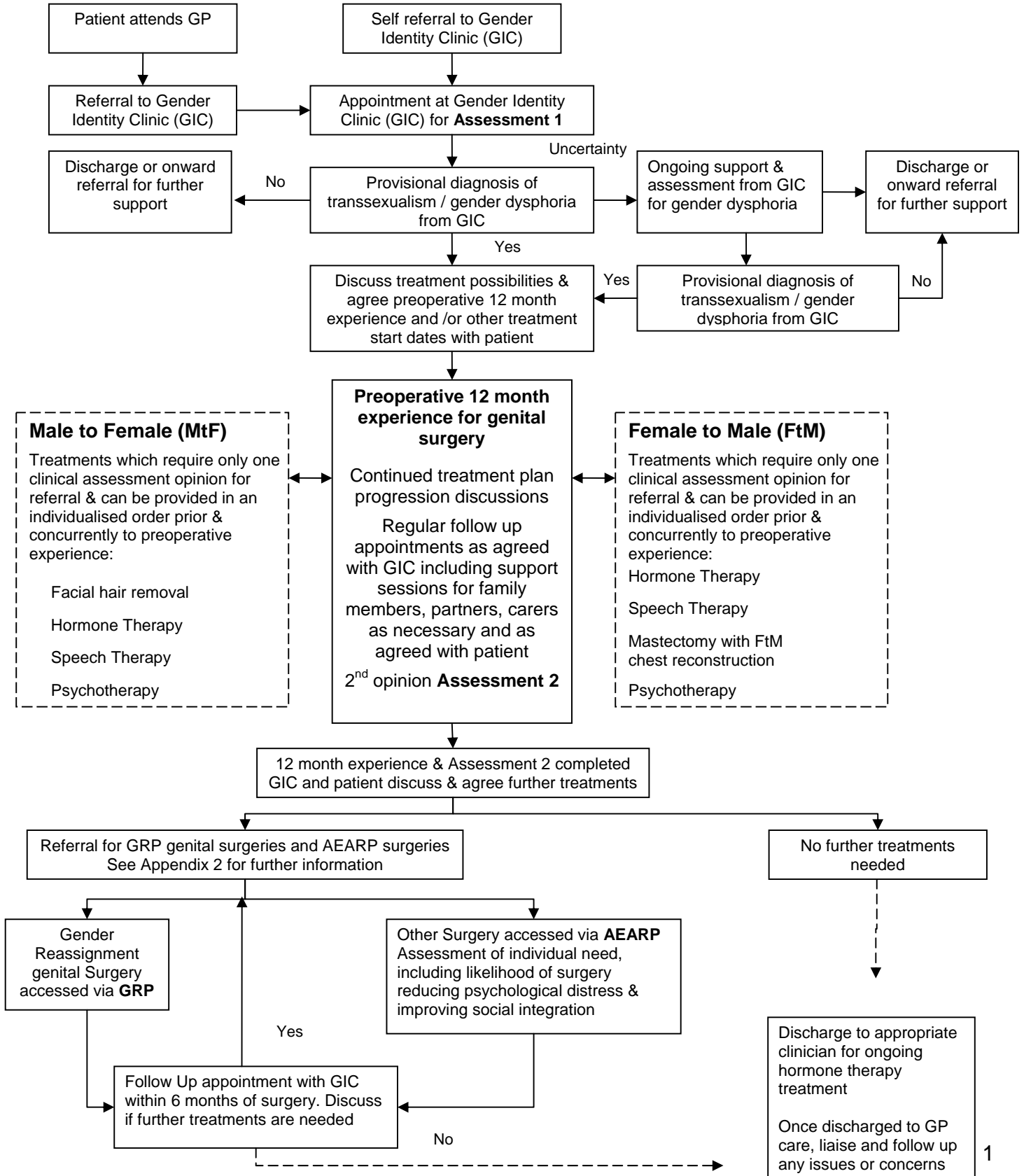


Mike Lyon

Deputy Director, Health and Social Care Directorate

Gender Reassignment Protocol

When implementing the protocol, the patient should be a full participant in decisions about their healthcare and wellbeing and be given any information or support that they need in order to do so.



The Treatment Time Guarantee (TTG) set out in the Patient Rights' (Scotland) Act 2011 will apply to in-patient / day-case treatments where the treatment has been agreed between the patient and the Health Board clinician. The TTG does not apply to those procedures provided outside NHSScotland.

Notes

1. Transsexualism is the desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment (ICD-10 code F64.0).
2. Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristic).¹
3. Patients not diagnosed with transsexualism / gender dysphoria will be supported on to a treatment pathway appropriate to their need by the Gender Identity Clinic (GIC).
4. Some patients may require formal psychiatric intervention to assist with psychiatric comorbidities and in such cases shared care may be appropriate.
5. Assessment, diagnosis and confirmation of transsexualism / gender dysphoria (for both the 1st and 2nd opinion) must be by a mental health professional who specialises in transsexualism / gender dysphoria and has general clinical competence in diagnosis and treatment of mental or emotional disorders for example psychiatrist and psychologist. (Refer to page 22 of WPATH Standards of Care, V7 for further information)²
6. At the beginning of the preoperative 12 month experience the GIC and patient should discuss the practicalities and requirements of the experience and details of patient and family support mechanisms as well as the possible treatments available.
7. The 12 month experience can be extended if the GIC and / or patient feel that further time is needed or if attendance at the clinic is inconsistent.
8. Throughout the process of gender reassignment all treatments, procedures, access criteria, associated risks and expectations should be clarified with the patient. An individualised programme of information provision, services, treatment, and surgery as appropriate to the person's individual needs and situation should be discussed and agreed as the patient progresses through the preoperative 12 month experience. Treatment can be reviewed and modified by agreement of those involved.
9. Patients who elect not to have surgery can continue on hormone therapy. This may be supervised by specialist endocrinologists or gynaecologists if this supervision is available. The appropriate clinician should assume responsibility for continued prescribing of hormone therapy (with support as required from the GIC). GICs should ensure that GPs are aware of the hormone management guidelines as detailed in the protocol. In cases where there is uncertainty about the stability of the patient's gender role, gender specialists should consider offering regular (e.g. annual) review appointments.

¹ The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, September 2011 (page 5), <http://www.wpath.org/>

² Ibid, (page 22)

10. Surgical providers should inform primary care medical and nursing staff of the nature of the procedure, anticipated post-operative care needs, common complications and contact details of the surgical team and associated nursing staff (who provide post-operative care to local patients) 3 weeks prior to the procedure. Surgical providers should also confirm with gender identity clinics that this information has been passed on to the relevant staff. This advanced information will supplement multidisciplinary discharge planning procedures common to all patient groups.
11. All patients who have surgery should have an appointment with the GIC within 6 months of surgery to discuss any issues and be provided with a post-op plan. Information regarding the procedures and post-op plan should be made available to primary care staff, including district and practising nursing staff. This should also be provided for the patients GP.

Appendix 1 – Preoperative 12 month experience³

The rationale for a preoperative, 12-month experience of living in an identity-congruent gender role is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

The social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from the Gender Identity Clinic and from peers can be invaluable in ensuring a successful gender role adaptation.

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

The GIC should clearly document a patient's experience in the gender role in their medical records, including the start date of living in their chosen gender role. Patients will be required to provide the GIC with verification that this criterion has been fulfilled e.g. collateral interviews, official documentation from employers, educational institutions or other formal organisations. The 12 month experience can be extended if the GIC and /or patient feel that further time is needed or if attendance at the GIC is inconsistent.

On completion of the preoperative 12 month experience, the patient and GIC will review and agree their treatment plan and revisit the discussion on treatments, procedures, access criteria, associated risks and expectations (refer to appendix 2 for information for treatment plan discussion).

Patients who elect not to have surgery can continue on hormone therapy. This may be supervised by specialist endocrinologists or gynaecologists if this supervision is available. The appropriate clinician should be asked to assume responsibility for continued prescribing of hormone therapy (with support as required from the GIC). GICs should ensure that GPs are aware of the hormone management guidelines as detailed in the protocol. In cases where there is uncertainty about the stability of the patient's gender role, gender specialists should consider offering regular (e.g. annual) review appointments.

³ Adapted from The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, September 2011 (page 61), <http://www.wpath.org/>

Appendix 2 – Treatment information to help inform Treatment Plan discussions

Once a provisional diagnosis has been made the patient can begin treatment. The treatments listed in the table below are those which are available via the Gender Reassignment Protocol. The list is not intended to be prescriptive. Treatment should be flexible in response to individual needs and circumstances.

Treatments governed by the Gender Reassignment Protocol	
Ongoing psychotherapy and counselling	Regular psychotherapy and counselling should be available throughout the process. Patients require counselling from those with specialist knowledge of gender issues. GPs and Gender Clinicians should also signpost patients to external support networks. Sessions should be made available to help the patient, their families, partners and carers.
Hormone Therapy	The appropriate clinician is required to prescribe and monitor hormone treatment via blood tests (with support from the GIC). This includes the referral to endocrinologists and gynaecologists. This should be monitored at least 6 monthly in the first 3 years by the GP / gynaecologist / endocrinologist depending on local availability and yearly thereafter dependant on clinical need.
Facial hair removal	This is an essential treatment for MtF patients. Removal of facial hair relates directly to confidence and safety whilst undertaking the preoperative 12 month experience. Electrolysis, laser and Intense Pulse Light (IPL) treatment may be used. See appendix 4.
Speech therapy	Speech and language therapy enables patients to work towards a voice which is more appropriate for their chosen gender.
Hair removal donor site (electrolysis)	Successful hair removal from the donor site used for genital reconstructive surgery is key to avoiding further post surgical complications. Electrolysis prior to surgery is recommended for this. See appendix 4.
Surgical treatments	
Male to Female (MtF)	<p>Not all patients will undergo genital surgery. Patients will be referred for surgeries as agreed in their treatment plan.</p> <p>Procedures offered may include some or all of the following: Penectomy (Removal of the penis) Orchiectomy (Removal of the testes) Vaginoplasty (Creation of the vagina) Clitoroplasty & Labiaplasty (Creation of clitoris and labia)</p>
Female to Male (FtM)	<p>Not all patients will undergo genital surgery. Patients will be referred for surgeries as agreed in their treatment plan.</p> <p>Bi-lateral mastectomy (removal of breasts) and chest reconstruction FtM patients may require this life-changing surgery early in their pathway so as not to perpetuate respiratory and other problems caused by wearing binders and also to “pass” in male gender. See appendix 3, page 13.</p> <p>Hysterectomy (Removal of uterus) Vaginectomy (Removal of vagina) Salpingo-oophorectomy (Removal of ovaries and Fallopian tubes) Metoidoplasty (Creation of micropenis) Phalloplasty (Creation of penis from using skin and muscle tissue from another site, e.g. forearm or thigh) Urethoplasty (Creation of urethra) Scrotoplasty (Creation of scrotum) Placement of testicular prostheses</p>

Procedures not exclusive to gender reassignment

Some patients may require other medical procedures as part of the process of transforming their body to be more congruent with their gender. Other procedures that are not considered within the Gender Reassignment Protocol will only be considered on an exceptional basis in line with plastic surgical policy, for example the Adult Exceptional Aesthetic Referral Protocol⁴. Some examples of such procedures are given in the table below.

Aesthetic surgery is not routinely offered by the NHS and can only be provided on an exceptional case basis. Patients will only be referred for this surgery following a clinical assessment by their GIC and where there is a symptomatic or functional requirement for surgery. All cases will be referred to a panel for consideration and assessment against agreed criteria on an individual basis. Access criteria will consider age, body mass index (BMI), impairment of function, and psychological distress. Referral for consideration does not necessarily mean that surgery will be offered. **This must be communicated to the patient.**

Referrals made under the AEARP should be clear and contain all relevant clinical information if the referral panel is to be able to make a proper assessment of the justification for performing such procedures. Practitioners from a patient’s Gender Identity Clinic are able to attend referral panel meetings to contribute to discussions.

Please note the list of treatments in the table below is not exhaustive:

Treatments governed by the Adult Exceptional Aesthetic Referral Protocol (AEARP)	
Breast augmentation	This should only be considered where there is a clear failure of breast growth with hormone treatment. Breast development should be reviewed after 18-24 months of hormone treatment and this should be made clear during treatment plan discussions. Suitable patient cases should then be discussed by the exceptional referral panel in partnership with the GIC for approval.
Facial Feminisation Surgery (FFS)	Treatments may include: Thyroid chondroplasty / Tracheal shave (reducing size of larynx) Rhinoplasty (nasal surgery) Facial bone reduction Blepharoplasty / Facelift
Lipoplasty / Body contouring	Liposuction and / or body sculpture

⁴ The AEARP is reviewed annually. Any aesthetic treatments currently not listed within the AEARP may be considered for inclusion in future versions as part of the review process.

Appendix 3 – Treatment criteria

Within this section you will find information on criteria for the referral and prescription of hormone therapy (including hormone management) and surgical procedures. Further more detailed information and evidence-based clinical guidance can also be found in *The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version* (September 2011), <http://www.wpath.org/>

Referral for feminising / masculinising hormone therapy

The Gender Identity Clinic should provide documentation in the referral letter of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter to the patient's clinician for feminising/masculinising hormone therapy is as follows⁵:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Hormone Therapy

Criteria for the prescription of hormone therapy

The GIC must first ensure patients meet the following eligibility and readiness criteria as adapted from the WPATH Standards of Care⁶ before taking the decision to refer the appropriate clinician prescription of hormones.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 16 (see Appendix 5 for protocol details for children and adolescents aged under 16)
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

⁵ Ibid (page 26)

⁶ The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version, September 2011 (P 34-50), <http://www.wpath.org>

The presence of co-existing mental health concerns does not necessarily preclude access to feminising/masculinising hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria.

Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. Hormones can be given to patients who do not want surgery following diagnosis with a qualified mental health professional following minimal standards listed above. In some patients hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

Risks

It should be noted that there is limited data on the long term health risks of hormone treatment and patients should be made aware of the risks and the importance of long term monitoring. Some risks are identified in the following hormone management guides.

Further information on the medical risks of hormone therapy can also be found in the Standards of Care, 7th Version (page 97).

Hormone management for Trans Woman

The following guidelines are a suggested treatment for patients undergoing gender transition. The guidelines have been developed as part of the National (UK) Standards of Care document by an interdisciplinary committee which has met and is currently finalising the documents following public consultation.⁷

Monitoring Tests

Patients should be encouraged to stop smoking, take regular exercise, have a sensible diet and consume no more than 14 units of alcohol per week.

Baseline:

Blood pressure, full blood count, urea and electrolytes, liver function tests, fasting blood glucose, lipid profile, serum free T4, TSH, testosterone, estradiol (should be less than 100pmol/l), prolactin (50 – 400mU/L)

Monitoring:

On a six monthly basis for three years and then yearly depending on clinical assessment and results. Provision of prescription is contingent on satisfactory tests, namely;

- Blood pressure, full blood count, urea and electrolytes, liver function test, fasting glucose, lipid profile, testosterone, serum estradiol 24 hours after a tablet or 48 hours after application of a patch (levels should be in the upper half of the normal follicular range, 300-400 pmol/L), prolactin (less than 400mU/L).

Medication

The specialist clinician will provide the prescription or if the GP is in agreement with shared care prescribing, this will be supervised by the gender specialist who has obtained valid consent. Typical prescriptions would be for:

1. **Estrogen** – Dosage of estrogen depends on results of circulating oestradiol levels (see above):

Estradiol (1-6mg oral daily) *increase clotting factors; antiepileptic and antifungal medication decrease E2 levels;*

Or

Estradiol patches (50mcg – 150mcg, 2-3 times per week) particularly for patients over 40 years (lower risk of thrombosis) note e.g. Estraderm 50 = 50mcg over 24 hours.

Or

Estragel. 2 squirts applied daily = 1.5mg oestradiol

2. **GnRH analogue** – inhibits secretion of pituitary gonadotrophin and testosterone secretion:

Goserelin 3.6mg implant subcutaneously four weekly or 10.8mg implant twelve weekly.

Or

⁷ Hormone Management for Trans Women, NHS Sheffield, Prof K Wylie, Clinical Director, regional Gender Identity Clinic.

Leuprorelin 3.75mg s.c./i.m. four weekly or 11.25mg s.c. twelve weekly

Or

an alternative GnRH agonist

Additional therapies, which may be helpful include:

- Cyproterone Acetate – (50mg – 100mg orally daily) – less satisfactory than a GnRH analogue (side effect profile)
- Spironolactone (100mg – 200mg orally daily) may be required for additional androgen receptor blockade – long term use associated with liver dysfunction and possibly hepatoma risk (animal data)

N.B. Cypoterone and spironolactone are not recommended for long term therapy unless there are no good alternatives as chronic side effects may ensue. CT head scan to check for meningioma if long term cypoterone.

- Finasteride (5mg orally daily) – blocks conversion of testosterone (which may derive from adrenal androgens in the absence of secreting testes) to the more active dihydrotestosterone (DHT). This agent can discourage male pattern hair loss and testosterone dependent body hair growth. **N.B. Drug Safety update 2009, 3, 5 re breast cancer**

Surgery

- Stop hormones 4 weeks before surgery and cover with a single dose of subcutaneous goserelin 3.6mg or equivalent. Hair regrowth can occur when the effects of GnRH agonist wear off after four weeks.
- Perioperative prophylaxis with Low Molecular Weight Heparin (LMWH) is mandatory to prevent thrombo-embolic events.
- Hormones should be resumed four weeks post op if there are no complications namely estradiol tablets or patches for over 40 year olds (as above).
- Anti-androgen usually not required but androgens may still be significantly derived from adrenals – Finasteride as above can be prescribed if androgen effects are still evident.
- Monitoring for osteoporosis (DEXA scan), breast and prostate carcinoma required.
- Medication and tests needed for life as described above on 6 monthly basis for 3 years, then yearly if well.

Risks – estrogen⁸

Very high risk of serious adverse outcomes

- Thrombo-embolic disease

Moderate to high risk of adverse outcomes

- Macroprolactinoma
- Sever liver dysfunction (transaminases > 3x upper limit of normal)
- Breast cancer
- Coronary artery disease
- Cerebrovascular disease

⁸ Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, The Endocrine Society, 2009

Hormone Management for Trans Man

The following guidelines are a suggested treatment for patients undergoing gender transition. The guidelines have been developed as part of the National (UK) Standards of Care document by an interdisciplinary committee which has met and is currently finalising the documents following public consultation.⁹

Monitoring Tests

Patients should be encouraged to stop smoking, take regular exercise, have a sensible diet and consume no more than 14 units of alcohol per week.

Baseline:

Blood pressure, full blood count, urea and electrolytes, liver function tests, fasting glucose, lipid profile, serum free T4, TSH, prolactin (should be less than 400mU/l), serum estradiol and testosterone.

Monitoring

On a six monthly basis for three years and then yearly if well depending on clinical assessment and results. Provision of prescription is contingent on satisfactory tests, namely:

- Blood pressure, full blood count (Hb & Hct), urea and electrolytes, liver function tests, fasting glucose, lipid profile, serum oestradiol (for adequacy of suppression less than 70pmol/l), prolactin (less than 400mu/l).
- Serum testosterone should be at or below lower end of normal range (<10nmol/L) just before next dose is due to avoid accumulation or inadequate dosage. If on oral testosterone, measure DHT levels 3-4 hours after a dose.

Medication

The specialist clinician will provide prescription or if the GP is in agreement with collaborative care prescribing, this will be supervised by the gender specialist who has obtained valid consent.

Typical prescriptions would be for:

1. Androgens:

Testosterone enanthate 250mg-500mg intramuscularly 2-6 weekly depending on serum testosterone levels (see above)

Or

Testogel (50 mg/5g) gel once daily – occasionally two doses are required) rubbed onto skin of shoulders, arms or abdomen after shower. Or Testim (same dose) onto skin of shoulders or upper arm. Or Tostran (2% gel) rubbed onto skin of abdomen or both inner thighs.

Or

Testosterone undecanoate 120-160mg/day orally 1g intramuscularly (Nebido) every three months.

⁹ Hormone Management for Trans Women, NHS Sheffield, Prof K Wylie, Clinical Director, regional Gender Identity Clinic.

2. **GnRH analogue** – inhibits secretion of pituitary gonadotrophin and testosterone secretion

Goserelin 3.6mg implant subcutaneously four weekly or 10.8mg implant twelve weekly.

Or

Leuprorelin 3.75mg s.c./i.m. four weekly or 10.8mg implant twelve weekly

Or

An alternative GnRH agonist

Surgery

- Hormones do not need to be stopped preoperatively
- Androgen (testosterone) should be continued for life if there are no contraindications.
- Monitoring for osteoporosis (DEXA scan), breast lumps (especially if family history (FH) of breast cancer); ovaries and endometrium (if appropriate – especially if FH of carcinoma or patient anxious – annual abdominal ultrasound of the structures and measurement of CA125) and cervical carcinoma (if appropriate) are required.

Medication and blood tests needed for life as described above on 6 monthly basis for 3 years, then yearly if well.

Risks – testosterone¹⁰

Very high risk of serious adverse outcomes

- Breast or uterine cancer
- Erythrocytosis (hematocrit > 50%)

Moderate to high risk of adverse outcomes

- Severe liver dysfunction
(transaminases > 3x upper limit of normal)

¹⁰ Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, The Endocrine Society, 2009

Surgical treatment

Criteria for surgical procedures

To undergo such major irreversible procedures patients must be sufficiently physically fit and meet the criteria listed below as adapted from the WPATH Standard of Care, 7th version.

Bi-lateral mastectomy and FtM chest reconstruction

For transsexual men this procedure is usually the first surgery performed and for some patients it is the only surgery undertaken. The procedure can take place during the preoperative 12 month experience provided it has been agreed in their treatment plan with their GIC and referral is accompanied by one assessment from an appropriately qualified professional.

Testosterone can make the binding of breasts more uncomfortable, whereby some patients experience breast growth and increased sensitivity, thereby raising the issue of having this treatment prior to hormone treatment. This is an irreversible procedure and timescales for when the surgery should take place should be agreed by the GIC in discussion with the patient.

Criteria for mastectomy and creation of a male chest in FtM patients¹¹:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 16 (see Appendix 5 for protocol details for children and adolescents aged under 16)
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Genital Surgery

Patients should only be referred for genital surgery once they have completed the preoperative 12 month experience as agreed in their treatment plan with their GIC and two separate assessments and diagnoses of transsexualism have been provided from appropriately qualified professionals.

Criteria for genital surgery in FtM patients and MtF patients¹²:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Aged at least 16 (see Appendix 5 for protocol details for children and adolescents aged under 16);
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);
6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Breast augmentation and other surgeries governed by the AEARP

Breast augmentation is not routinely offered as part of the gender reassignment protocol but will be considered on exceptional basis in line with the Adult Exceptional Aesthetic Referral Protocol (AEARP) for breast augmentation : <http://www.18weeks.scot.nhs.uk/task-and-finish-groups/plastic-surgery/>

¹¹ Adapted from the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version, September 2011, (page 59), <http://www.wpath.org>

¹² Adapted from Ibid (page 60),

In line with AEARP practice a patient's case will be referred to the exceptional referral panel for review in partnership with the GIC.

Surgeries governed by the AEARP

The protocol recognises that some patients may require other medical procedures as part of the process of transforming their body to be more congruent with their gender. Aesthetic surgery and other procedures that are not considered part of gender reassignment surgery will only be considered on an exceptional basis in line with plastic surgical policy for example the AEARP. The GIC should discuss possible treatments with the patient and explain the process for accessing these procedures.

Although most of these procedures are generally labelled “purely aesthetic,” these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.¹³

¹³ the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, 7th Version, September 2011, (page 64), <http://www.wpath.org>

Appendix 4 – Hair Removal

Facial hair removal

The removal of facial hair is seen as an essential part of gender reassignment for a transsexual woman to facilitate the preoperative 12 month experience. The absence of facial hair is of psychological benefit and will produce a greater well-being for the patient as there should be little or no need to remove hair on a constant basis.

It is recommended that facial hair removal should commence prior to the preoperative 12 month experience as the beard must grow to visible lengths to be removed.

Electrolysis is the most safe, effective way of removing facial hair. Hair removal should be funded by the patients Health Board and should only be carried out by a skilled operator. Electrolysis may require between 200 – 400 hours of treatment¹⁴.

Laser and Intense Pulse Light (IPL) treatment for facial hair removal may require up to 15 sessions¹⁵. It is most effective on those with dark hair and fair skin and is unsuitable for treating non-pigmented hairs such as grey, white, blonde and red. Some modern lasers are able to effectively treat racially pigmented skin¹⁶.

Hair removal from donor site

If hair is not adequately removed from areas directly involved in reconstructive genital surgery prior to surgery it can become a post-operative complication causing risk to the patient and necessitating further surgery to rectify the complication.

FtM patients require hair removal prior to radial artery phalloplasty or radial artery urethroplasty; otherwise the patient would have hair-bearing skin on the inside of the neourethra. MtF patients require hair removal prior to vaginoplasty and labiaplasty.

Electrolysis may require 32 sessions over a period of 6 months (ensuring no re-growth)¹⁷. An alternative and more cost effective approach is for hair follicles to be removed during surgery, this would have to be discussed and agreed with the surgeon performing the procedure.

Hair removal from the donor site can be performed with a surgeon's recommendation prior to completion of the preoperative 12 month experience in order to reduce delays in surgery.

^{14, 15, 16} Commissioning of Core and Non-Core Surgical Procedures, Gender Dysphoria Consortium, London, 2009.

¹⁷ Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria (Draft), RCPsych Intercollegiate SoC Committee, 2006.

Appendix 5 – Services for Children and Young People under 16

Children and young people experiencing gender dysphoria will access treatment and support via the gender reassignment protocol. Each patient will be considered on an individual basis by their gender identity clinic.

Teenagers who are 16 and 17 years of age are entitled to consent to their own treatment and follow the standard adult protocol, and this consent cannot be overruled by their parents. Children who are under 16 years old can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment¹⁸.

At present specialist gender identity development services for children and young people under 16 are not available in Scotland. Children and young people should contact their GP or a GIC in the first instance and thereafter may be referred to the Gender Identity Development Service at The Tavistock and Portman NHS Foundation Trust, London.

Other professionals in Health, Social Services and Education departments as well as young people and their families can contact the Service directly to discuss a possible referral¹⁹. Further information can be found at <http://www.tavistockandportman.nhs.uk/genderidentityissues>.

Additional contact details:

Gender Identity Development Service
The Tavistock and Portman NHS Foundation Trust
Tavistock Centre
120 Belsize Lane
London
NW3 5BA
Tel: 020 8938 2030
Fax: 020 7431 8320
Web: www.tavi-port.org

The Gender Identity Development Service at The Tavistock and Portman NHS Foundation Trust is part of the NHS Camden Child and Adolescent Mental Health Service (CAMHS) which offers help to children and adolescents from birth until their 19th birthday, their families and carers as well as offering advice and consultation to other professionals working with children, adolescents and their families.

Further information on assessment and treatment of children and young people under 16 with gender dysphoria can also be found in the WPATH Standards of Care, 7th version (page 10, <http://www.wpath.org>).

¹⁸ NHS Inform, 2010, <http://www.nhsinform.co.uk/Health-Library/Articles/C/consent-to-treatment/how-does-it-work.aspx>

¹⁹ The Tavistock and Portman NHS Foundation Trust Gender Identity Development Service Booklet, 2009, <http://www.tavistockandportman.nhs.uk/sites/default/files/Gender%20Identity%20Development%20Service%20leaflet%202009.pdf>

Appendix 6 – Supporting information for GPs

There are 4 gender specialist clinics in NHS Scotland and referrals can be made to these clinics to explore with the patient the options available to them.

- The main NHS Scotland Gender Identity Clinic is based at the Sandyford in Glasgow and accepts referrals from across Scotland. It is also possible to self-refer to the Sandyford clinic www.sandyford.org or 0141 211 8130.
- The Sexual Problems Clinic within the Royal Infirmary of Edinburgh accepts patients from NHS Lothian Health Board area and also NHS Fife, NHS Borders, NHS Forth Valley, NHS Tayside and the North of England. The clinic can be contacted on 0131 242 2515.
- NHS Grampian. Referrals are accepted from general practitioners of patients residing in Grampian, Orkney and Shetland. All referrals should be made to Dr John Callender, Royal Cornhill Hospital, Aberdeen AB25 7ZH.
- NHS Highland Sexual Health Clinic based at Raigmore Hospital, Inverness accepts self-referrals. The clinic can be contacted on 01463 704202. The clinic does not accept out of area referrals.

Further guidance, good practice resources & support organisations:

- NHS Inform website: Gender Dysphoria Introduction – <http://www.nhsinform.co.uk/health-library/articles/g/gender-dysphoria/introduction.aspx>
- Sandyford Gender Identity Services Information booklet – [http://www.sandyford.org/media/88274/genderidentityservice_sf\[1\].pdf](http://www.sandyford.org/media/88274/genderidentityservice_sf[1].pdf)
- Fair for All – The Wider Challenge: Good LGBT Practice in the NHS (section 10) – http://www.healthscotland.com/uploads/documents/6307-Fair%20For%20All%20-%20Good_LGBT_Practice_NHS.pdf
- Transgender support organisations – http://www.scottishtrans.org/Page/Transgender_Intersex_Organisations.aspx