TRANSGENDER CARE: SUGGESTED HORMONE REGIMENS

Male-to-Female:

Estrogens:

Estradiol (Estrace®), 6 - 8 mg PO or sublingual qD (divided doses); *or*
Conjugated estrogens (Premarin®), 5 mg PO qD (divided doses); *or*
Estradiol (e.g., Climara®,) two 0.1 mg patches, changed weekly; *or*
Estradiol valerate, 20 mg IM q two weeks.

Anti-androgen:

Spironolactone (Aldactone®), 100 - 300 mg PO qD (divided doses).

Progestogens: (usually optional)

Micronized Progesterone (Prometrium®), 100 mg PO BID; *or*
Medroxyprogesterone (Provera®), 5 - 10 mg PO qD

One possible regimen: start with a moderate estrogen dose (e.g., estradiol, 2 mg BID); one month later, advance to a higher dose (e.g., estradiol, 6-8 mg qD, divided doses); one month later, add spironolactone, 100 mg BID or TID. Subsequently add more estrogen or a progestogen as needed to achieve desired feminization, to eliminate spontaneous erections (an index of free testosterone), and to achieve serum testosterone levels in the female range and serum estradiol levels approximately one-third to one-half of the female mid-cycle peak.

Consider transdermal estradiol for patients over age 40, and for those who have risk factors such as smoking, a personal or family history of DVT or cardiovascular disease, etc.

After orchiectomy, estrogen can be decreased to one-quarter to one-half of the pre-op dosage, and anti-androgens can be discontinued.

Female-to-Male:

Testosterone enanthate (Delatestryl®) or cypionate (Depo-Testosterone®), 150 - 250 mg IM q two weeks; *or*
Transdermal testosterone patch (Androderm®), 5 – 7.5 mg, changed daily; *or*
Transdermal testosterone gel (Androgel®), 5 – 10 mg, applied daily.

Transdermal testosterone provides slower masculinization and cessation of menses, but more uniform blood levels, and perhaps fewer side effects and problems with excessive dosage.

After oophorectomy**,** androgen can be decreased to one-half or less of the pre-op dosage.

SUGGESTED LABORATORY STUDIES

Male-to-Female:

Free testosterone, fasting glucose, liver function tests, and complete blood count – pre-treatment, at 6 and 12 months, and yearly thereafter. An estradiol level may be helpful if feminization appears to be inadequate. Prolactin – pre-treatment and at 1, 2, and 3 years. If hyperprolactinemia does not occur during this time, no further measurements are necessary.

Female-to-Male:

Free testosterone, lipid profile, liver function tests, and complete blood count – pre-treatment, at 6 and 12 months, and yearly thereafter. Perform Pap smears in patients who have not had hysterectomy.

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