Hormone Replacement Therapy

Enhancing the Response to Trans Survivors of Sexual Assault

Hormone Replacement Therapy (HRT) is an important medical intervention in the healthcare of many trans clients. Trans persons may use HRT not only for physical changes, but to reduce distress often associated with gender dysphoria. HRT is often a life-long treatment and is used to masculinize or feminize trans persons depending on their gender identity. Trans persons may take testosterone (a masculinizing hormone) or may take estrogen, sometimes in conjunction with progesterone (feminizing hormones), and/or an anti-androgen such as cyproterone or spironolactone. Anti-androgens inhibit the effect of masculinizing hormones and can therefore be taken in combination with estrogens to lower testosterone levels. Testosterone stimulates the masculinization of sex organs and triggers the development of secondary sex characteristics, such as facial hair and a deep voice. Estrogen, on the other hand, feminizes sex organs and stimulates the development of secondary sex characteristics such as breasts as well as redistributes fat to the hips, thighs, and buttocks (Vázquez, 2008).

Every person, regardless of the sex assigned at birth, is born with some level of both testosterone and estrogen hormones in their body. Therefore, regimens of hormone therapy prescribed for trans clients are often highly individualized (Vázquez, 2008). There are common changes associated with the use of HRT that should be taken into consideration when providing medical care to trans clients. While it is important to become familiar with these changes as you may encounter them during an examination, it is also important to note that not all trans clients using HRT will experience the same changes.

Testosterone

Permanent changes associated with the use of testosterone may include sterility (Vázquez, 2008). However, this is a long-term side effect and, therefore, transmasculine clients within childbearing years who still have ovaries and a uterus may become pregnant from a sexual assault even if they are currently on testosterone and/or have not been menstruating (FORGE, 2014; U.S. Department of Justice, Office on Violence Against Women, 2013).

The use of testosterone can also impact vaginal tissues, leading to vaginal atrophy, decreased elasticity, and increased fragility. Therefore, clients using testosterone who are vaginally assaulted may be at increased risk of injury, tearing, and infection after a sexual assault (Leach, 2017)

Other permanent changes associated with testosterone include hair loss (androgenic alopecia), facial hair growth, deepening of the voice, enlargement of the clitoris (clitoromegaly), and increased growth of body hair. Temporary changes associated with the use of testosterone include behavioural changes such as aggression and increased libido.

Estrogen

Permanent changes associated with the use of estrogen may include breast development, enlargement of nipples, and sterility. Temporary changes include a decrease in acne, decrease in body hair, decrease in muscle mass and strength, softening of skin, slowing of balding patterns, decrease in libido, suppression of testosterone production, and redistribution of fat from the abdominal area to hips and buttocks (Vázquez, 2008). Estrogen does not physically alter the voice or help reduce facial hair.

It is important to note that use of estrogen may have important implications for those who are also HIV positive; although the data on reported drug interactions is very limited (Bourns, 2018). Therefore, while trans clients who are using estrogen can safely use HIV PEP, they often need more tailored long-term treatment should they contract HIV post-sexual assault.

It may be critical that trans clients who require long-term HIV treatment follow up with a primary care provider so that HIV can be managed safely alongside their estrogen use. Some clients who are at higher risk for HIV, such as sex workers, may not have easy access to a primary care provider due to social, structural, and economic barriers and should be referred to one if possible.

References:

Bourns, A. (2018 update). G*uidelines and protocols for hormone therapy and primary health care for trans clients.* Toronto, ON: Sherbourne Health Centre. Retrieved from http://sherbourne.on.ca/wp-content/uploads/2014/02/Guidelines-and-Protocols-for-Comprehensive-Primary-Care-for-Trans-Clients-2015.pdf

FORGE. (2014). *SAFE protocol: Trans-specific annotation*. Milwaukee, WI: Author. Retrieved from http://forge-forward.org/wp-content/docs/SANE-protocol-trans-inclusive-handout2.pdf

Leach, T. (2017). The medical forensic evaluation: Ano-genital exam. *Sexual Assault Nurse Examiner training*. Toronto, ON: Ontario Network of Sexual Assault/Domestic Violence Treatment Centres.

U.S. Department of Justice, Office on Violence Against Women. (2013) *A national protocol for sexual assault medical forensic examinations: Adults/adolescents*. (2nd ed.). Washington, DC: Author. Retrieved from http://www.ncjrs.gov/pdffiles1/ovw/241903.pdf

Vázquez, E. (2008). A trans therapy primer. Basic information for hormonal treatment and drug interactions. *Positively Aware: The Monthly Journal of the Test Positive Aware Network*, *19*(4), 46-48.

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