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## Anesthesia Inclusive Practices Amidst Adversity: Caring for the Transgender Patient

There is a considerable need among CRNAs and clinical practitioners to be proficient and competent in the perioperative care of transgender patients. Part of one of the many initiatives of the AANA Diversity and Inclusion Committee, this article is the second of a two-part overview for CRNAs and student registered nurse anesthetists (SRNAs) on how to better care for transgender patients through cultural competency.

Part one of this review, published on pages 14-15 of the March 2019 issue of the *NewsBulletin*, provided an overview of preoperative care of the transgender patient, stressing the importance of communicating with understanding and sensitivity from the first encounter. In part two, I will delve further into the CRNA's role in perioperative care, including mental health assessment, contour shaping, medications and coexisting diseases, intraoperative considerations, and postoperative care.

### Mental Health Assessment

Throughout the perioperative assessment process, one of the CRNA's responsibilities is to inquire if the patient has sought consultation with a mental health professional. Mental health professionals such as psychiatric mental health nurse practitioners, psychologists, licensed mental health counselors, and licensed clinical social workers are critical in the care of transgender patients. They assess and treat mental health issues, provide options for social and/or peer support with or without family therapy, and evaluate the level of gender expression and the patients' readiness for fully reversible interventions (e.g., dress with estrogen and androgen analogues), partially reversible interventions (e.g., feminizing or masculinizing HRT), and irreversible interventions (e.g., sex reassignment procedures).<sup>1</sup> For patients scheduled for gender reassignment surgery, referral/s from a mental health professional are required. Per the WPATH<sup>1</sup> for above-the-waist procedures (e.g., mastectomy, chest surgery, etc.), one referral is required. Two referrals are required for below the waist procedures (e.g., orchiectomy, hysterectomy, metoidioplasty, vaginectomy, etc.). Referral documentations must be available preoperatively.

### Contour Shaping

Transgender patients can present with varying levels of contour shaping<sup>1(p10)</sup> such as breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks, which can present multiple issues to the CRNA and the entire surgical team. The team must be aware of and evaluate external body contouring gender expression, paraphernalia, or equipment in the preoperative area to avoid surprises intraoperatively.

Furthermore, consent with accurate documentation in the health record must be established prior to the removal or alteration of these external expressions, paraphernalia, or equipment.<sup>1</sup>

### Medications and Coexisting Diseases

Transgender patients may be taking anti-depressants, anti-anxiety, anti-psychotics, and other psychotropic medications. Pre-exposure prophylactic drugs and Human Immuno-Deficiency Virus (HIV) drugs may also be included in the mixture aside from the usual medications associated with diabetes mellitus (DM), hypertension, and other conditions.<sup>1</sup> Homelessness, sexually transmitted diseases, tobacco use, and substance abuse may also be present and must be adequately addressed in the preoperative arena<sup>2</sup>

Male to female (MtF) hormone replacement therapy (HRT) medications such as estrogens, progestins, anti-androgens, etc., and female to male (FtM) HRT medications such as testosterone cypionate, androGel, androderm, etc., may come with cardiovascular (e.g., venous thromboembolism [VTE] and hypertension) and endocrine (e.g., DM) risks. A detailed history and physical, including laboratory-blood work (e.g., hematocrit, hemoglobin, HDL, LDL, ALT, AST, lipid panel, and kidney function tests)<sup>2</sup> must be completed for transgender patients on HRT. Most importantly, if the patient has no documented HRT medications listed, then the CRNA must always ask the question about self-medicating with hormones.<sup>3</sup> With most individuals, the physical manifestations could be apparent, but being accurate could change the anesthetic plan of care.

Pregnancy testing might pose as a challenge with female to male (FtM) transgender

patients. With utmost respect and professionalism, the CRNA can complete these tests with preservation of patient privacy and dignity.<sup>2</sup> All of these preoperative workup data can then be used to design the anesthesia plan of care.

### Intraoperative Considerations

Based on collected preoperative data, clinicians must personalize intraoperative considerations for each transgender patient. Always address the patient in the preferred name and pronoun disclosed in the preoperative setting. Transgender patients who have had gender reassignment procedures or have external body contouring gender expressions, paraphernalia, or equipment may present a challenge with transfers from stretcher to the operating room table and vice versa and positioning. Move and position the patient with extreme care; standard precautions apply with every patient contact.<sup>2</sup>

Vigilant hemodynamic monitoring must be done in order to avoid HRT medication-related cardiovascular sequelae.<sup>2</sup> VTE or pulmonary embolism is a major perioperative concern due to the use of HRT medications.<sup>3</sup> These hypercoagulable states, seen with both MtF and FtM HRT medications, can lead to cerebrovascular accidents and/or can potentiate preexisting coronary disease. The establishment of prophylactic anti-coagulation and the use of sequential stockings/compression devices intraoperatively are musts.<sup>2</sup>

Side effects from HRT include mood swings, elevated liver enzymes, and decreased insulin sensitivity.<sup>3</sup> Should transgender patients take HRT medications right up to the night before surgery? Tollinche and colleagues<sup>3</sup> found that there have been no published interactions with anesthesia medications. This does not mean that there are none. I have heard from CRNAs who provide anesthesia for gender reassignment surgeries for FtM patients that anecdotal evidence of interactions exists. These CRNAs mentioned that testosterone therapy must be discontinued with FtM transgender patients for at least two weeks prior to the procedure, or the patient may exhibit postoperative delirium during emergence similar to that exhibited by adolescent and young adult cisgender males. This is an area of research that should be investigated further.

### Postoperative Care

In the recovery unit, validation of the preferred disclosed name and pronoun is one of the major parts of the handoff procedure.<sup>2</sup> At this point, the patient could still be partially sedated but semi-awake. Postoperative caregivers must be sensitive to the needs of the transgender patient, who could be waking up anxious, depressed, or exhibit mistrust due to an unfamiliar environment and sedated state. Promoting an environment of respect, non-judgment, and non-

discrimination is tantamount to the care spectrum with all patients.<sup>2</sup> Conversations between postoperative caregivers and other healthcare providers must always remain professional. Furthermore, if a patient is to be admitted after the procedure, care must be coordinated to continue consultation with a mental health professional.

Routine postoperative hemodynamic monitoring (e.g., bleeding, hematoma formation, hypoxia, etc.) remains. Depending on the kind and length of surgery, it is imperative to discern if anti-coagulation therapy for VTE prevention should be continued.<sup>3</sup> Laboratory testing could guide this decision as necessary.

### Standards and Best Practices

Transgender people are underrepresented and are often misunderstood and disrespected in our society. While strides are being made in the areas of workplace sensitivity training and academic curriculum integration, there is still unwillingness<sup>4</sup> or hesitation to provide care for transgender patients in certain sectors in our society.

Most healthcare facilities do not have policies on best practices about the care of transgender patients. On a national scale, the protected rights of all patients are mentioned in the *Affordable Care Act*, Centers for Medicare & Medicaid Services, and the Health Insurance Portability and Accountability Act.<sup>3</sup> The Joint Commission has rules that ban discrimination founded on gender orientation.<sup>3</sup> There are variable levels of policies, standards, guidelines, and rules implemented among the 50 states and their respective counties and cities (e.g., gender neutral bathrooms, discrimination, and bullying), but little to no clear-cut policies on practices on the healthcare facility level (e.g., hospital, medical offices, skilled nursing facilities, etc.). CRNAs can be at the forefront, be a voice, and initiate the conversation in bridging the gap in the perioperative care of transgender patients.

### Conclusion

During the Transgender Health Care for Advanced Practice Nurses meeting in November 2017, one participant raised the question of whether we are going to cater to every sector of the population. I believe that the answer is yes. First and foremost, we are nurses. We use our skills and knowledge to care for patients of any sexual orientation, race, creed, ethnic background, status and stage in life, and disability.<sup>3</sup>

Canner and colleagues<sup>5</sup> report an increased need for care for transgender patients, raising the importance of formal training for CRNAs on best practices to promote a safe, respectful, and holistic approach to anesthesia delivery. Fostering trust and

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diminishing ambiguity in the surgical arena have a tremendous potential to produce better outcomes for transgender patients. There is still a long road ahead of us, but we should embrace these challenges. CRNAs should strive for inclusion amidst adversity to deliver clinical and culturally competent care based on existing policies, standards, and best practice guidelines.

### References

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