SPECIALTY

Transgender Medicine

CHIEF COMPLAINT

Hormone Consultation

COMMENTS TO SPECIALIST

I would like your opinion on Hormone Replacement Therapy (HRT) moving forward for this patient who had a Pulmonary Embolism (PE) 6 months ago.

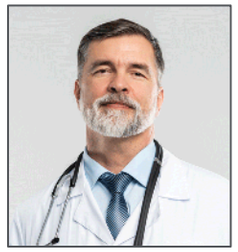
I am awaiting results of hypercoagulable workup done by hematology, but I suspect the results will be negative per the hematologist. She recommends Eliquis while the patient is on HRT.

MAIN QUESTION

The guidelines suggest patches to reduce the risk of recurrent clots.

What is your recommendation regarding estradiol/progesterone/spiro moving forward?

Arista|MD



Response from eConsult Specialist

PAUL HUGHES, MD, TRANSGENDER MEDICINE

NPI: 1000000048

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Thanks for asking this important question. The issue of PEs is a tricky one, as you've determined. There is not perfect evidence about the true rate of HRT-related PEs, nor do we have perfect guidance. It sounds like this PE was unprovoked, which is why hematology is obtaining a hypercoag workup.

- If that workup does determine an etiology, then treating the underlying cause to prevent a second PE is of course, the natural next step.
- If no primary cause is determined, then there is nothing to do but review general venous thromboembolism (VTE) reduction strategies:
  - STOP SMOKING (which could be a primary contributor here)
  - Avoid being sedentary on long flights
  - Take only the hormones prescribed.

In both cases, anticoagulation would be appropriate since it is difficult to say with certainty that smoking caused the PE. HRT can be continued while on anticoagulation, and using patches is the best rec we have at this time. Shared decision-making with the patient is important here; there would still be a risk they have another VTE while on anticoag, so adherence is key, as is an understanding of signs and symptoms of Deep Vein Thrombosis (DVT)and PE. Progesterone could be an alternative or adjunct, as the literature we have does not suggest a significant association with VTE. Progesterone alone will not induce significant feminizing effects, however. Spironolactone could be used safely as well, although alone also will not contribute significantly.

To summarize, lifelong HRT in any combination should be safe in this patient as long as they maintain anticoagulation. Use shared decision-making and strongly advise smoking cessation, which could be a contributing or the causal factor. Please reach out with any additional questions.

Paul Hughes

Paul Hughes, MD, Transgender Medicine

03/17/23 07:31 p.m. PST

Response Date Stamp

EARLY REQUESTS FOR INFORMATION

Thank you so much. I am still learning pieces of gender-affirming care, and you have been a great help to me! one last question because I do not have many patients on patches. What dose of patch you would start given that patient is currently taking 6mg orally?

Primary Care Provider

03/18/23 08:31 a.m. PST

EARLY REQUESTS FOR INFORMATION (Continued)

Great question! But a not-so-great answer. It turns out that coming up with a standardized conversion across formulations has been challenging because so many bodies process the estradiol more or less rapidly in an unpredictable way; a high dose of oral, for example, does not mean they'll need a high dose of transdermal or intermuscular estradiol.
You basically have to start over each time when you change formulations, but I tend to start a strength or so above starting dose since they are not estradiol naïve.

In this case, I would start with 200mg TD and then evaluate in 3 months, as noted previously. Emphasize good patch care to ensure optimal absorption. Please let me know if you have any other questions. Always happy to help!

Paul Hughes

03/18/23 09:47 a.m. PST

Paul Hughes, MD, Transgender Medicine

Response Date Stamp