Reproductive Care and Obstetrics for LGBTQIA+ Individuals

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Disclosures

- I have no financial disclosures
Objective

Incorporate reproductive counseling into routine care

Understand the potential effects of Gender Affirming Hormone Therapy on fertility

Counsel on reproductive choices for family building
“We’re going to start with the birds and the bees and then work our way up to the new reproductive technologies.”
Clinical Case #1

- 35 y.o. lesbian desiring pregnancy
- **PMH**: Anxiety, BMI 26
- **PGynH**: No abnormal pap or STI; monogamous with cis female
- **FH**: No birth defects or intellectual disabilities
- **SH**: No alcohol, tobacco, drugs. No recent travel; employed; married
Pregnancy

- Reciprocal IVF
- partner’s egg + anonymous donor sperm
- Aneuploidy testing of embryo
- Pan ethnic testing for both patient and partner
Antepartum

- Immunizations up to date
- EPDS=5
- Low risk aneuploidy testing
- Normal fetal survey
- Normal testing for gestational diabetes
- Working with doula
- Attended childbirth classes
- Created birthing preference plan
Delivery

- Gestational hypertension at 40 wks
- Intrapartum severe hypertension
- Cesarean delivery for 2\textsuperscript{nd} stage arrest
- Female bodied baby, 8\# 2 oz, Apgars 8,9
- Clear drapes
- Partner, Skin to skin in OR
- Postpartum breastfeeding

**LGBTQ FAMILY BUILDING SURVEY**

**KEY FINDINGS**

- The number of LGBTQ-headed families in the United States is set to grow dramatically in coming years.
  - Among LGBTQ Millennials (aged 18-35):
    - 77% are already parents, or are considering having children, a 44% increase over older generations.
    - 63% are considering expanding their families, as first-time parents or by having more children.
    - 48% are actively planning to grow their families or intending to do so in the future.

- 3.8 million LGBTQ Millennials are considering expanding their families in the coming years, and 2.9 million are actively planning to do so.

- Gaps both in parenthood rates and plans to become parents between LGBTQ and non-LGBTQ people are narrowing.

- 48% of LGBTQ Millennials are planning to grow their families, compared to 55% of non-LGBTQ Millennials — a gap of only 7%.

- In future, more LGBTQ families will be formed through assisted reproductive technology, adoption, and foster care.

- 63% of LGBTQ people planning families are looking to foster care, adoption, and assisted reproductive technology.
  
  This is a dramatic shift from existing LGBTQ families, in which 73% have children conceived from intercourse.
Reproductive Wish

- Survey of 50 transmen after GRS
- 22% participants already had children
  - 8 had partners conceived with donor sperm
  - 3 conceived prior to GRS
- 54% were interested in having children at time of study
- 37.5% would have considered fertility preservation if available

The Gynecologic visit

- Avoid making assumptions about sexual orientation, sexual practices, surgeries

- Document organ inventory and continue natal sex surveillance

- *Listen* and *incorporate* how persons describe their own identities, partners and body parts

ADVANCING EXCELLENCE IN SEXUAL AND GENDER MINORITY HEALTH
Fertility Counseling

▪ **WPATH**: “...it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs...”

▪ **UCSF Center of Excellence**: “It is recommended that prior to transition all transgender persons be counseled on the effects of transition on their fertility as well as regarding options for fertility preservation and reproduction.”
CONTRACEPTION

“Because infertility is not absolute or universal in transgender people undergoing hormone therapy, all transgender people who have gonads and engage in sexual activity that could result in pregnancy should be counseled on the need for contraception. *Gender affirming hormone therapy alone is not a reliable form of contraception, and testosterone is a teratogen that is contraindicated in pregnancy.*“

- UCSF Center of Excellence for Transgender Health
Preconception considerations

▪ Who?

▪ When?

▪ How?
Building a family

▪ “In order to make a baby, you need *sperm*, an *egg*, and a *uterus* for the embryo to grow in.

▪ Any one of those can be *your own*, *your partner's*, or a *donor's*. All that matters is that the sperm meets the egg, and the fertilized embryo implants and then grows inside the uterus. How and where the magic happens is ultimately a matter of logistics and planning”

Preconception Counseling

- Healthy diet
- Prenatal vitamin with folic acid
- Natal sex organ screening
- Medication review
- Travel precautions
- Immunizations
- Genetic testing
Feminizing Hormone Therapy

- Estrogen therapy decreases testosterone production
  - ↓ sperm count and motility

- Stopping estrogen therapy *may/may not* reverse effects

- Fertility Preservation
  - Sperm cryopreservation
  - Testicular sperm extraction
  - Testicular tissue preservation
Semen Parameters Among Transgender Women with a History of Hormonal Treatment

Adeleya AJ, Reid G, Kao CN, Mok-Lin E, Smith JF

Urology. 2019 Feb;124:136-141
Transgender women

- Retrospective cohort
- 28 transwomen for semen cryopreservation
  - No GAH (n=18)
  - Prior GAH (n=3)
  - Current GAH (n=7)
- Semen analysis
RESULTS:
Semen Parameters Among Transgender Women with a History of Hormonal Treatment

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<th>Parameter</th>
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<th>Previous Use</th>
<th>Current Use</th>
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<td>Vials Stored</td>
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<td>% Motility</td>
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<td>Concentration M/mL</td>
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<td>Volume mL</td>
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<tr>
<td>Total Motile Count (millions)</td>
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</tbody>
</table>
RESULTS

- Current use of GAH
- Lower semen concentration
- Lower %motility
- Lower total motile count
- Less vials stored
- 3/7 were azoospermic with low volume
Author SUMMARY

- Use of GAH at the time of semen specimen collection is NEUTRALLY associated with parameters of semen quality
- Unable to determine optimal time of discontinuation of GAHT prior to fertility preservation
- Study patient population does not reflect general transfeminine population
Masculinizing Hormone Therapy

- Testosterone therapy *usually* leads to anovulation and amenorrhea

- Stopping Testosterone therapy *may/may not* reverse effects
Egg/Embryo preservation

- Oocyte Cryopreservation
- Hormone-induced ovulation
- Ultrasound guided retrieval under anesthesia

- Embryo Banking
- Egg retrieval with immediate fertilization with chosen donor sperm
Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine

Angela Leung MD, Denny Sakkas PhD, Samuel Pang MD, Kim Thornton MD, Nina Resetkova MD, MBA
Transgender Reproductive Medicine

- Matched retrospective cohort study
- Cycle outcomes in 26 transmen from 2010-2018
- Ages 14-39
- 61% already on Testosterone
- All stopped Testosterone prior to cycles
- Nearly all had return of menses
RESULTS

More oocytes retrieved in transgender cycles than cisgender cycles (P=.04)
• 19.9 vs 15.9

Higher doses of gonadotropins were used in the transgender stimulation cycles (P= <.001)
• 3891 vs 2599
What does this mean?

- Transgender men can have similar ovarian stimulation outcomes to cisgender women.
- Prior use of testosterone does not seem to have negative effect on ovarian stimulation.
LIMITATIONS

- Age
- Appropriate matching cohort
- Small numbers
- Pregnancy outcomes
Family forming options

Conception through intercourse

Adoption and Foster care

Assisted Reproductive Treatment (ART)

Home insemination

Artificial/Intrauterine insemination

In Vitro Fertilization

Reciprocal In Vitro Fertilization

Surrogacy

Fertility preservation
Alternative Insemination

- Frozen (cryopreserved) sperm
  - Current guidelines prohibit insemination of fresh sperm
- Natural vs medicated cycle
- Fertility center vs office
- Limited insurance coverage
  - Infertility coverage/diagnosis
Health Insurance

- Only pays if patient has diagnosis of infertility (except BCBS of MA)
  - Does not pay for sperm specimens
- Definition of infertility varies according to insurance company
  - 6 to 12 cycle attempts
- Home insemination not considered valid attempt
- Clients self pay for all AI services
- Infertility coverage mandated in Massachusetts
Adoption & Foster care

- International or domestic
- Private or state
- Marriage equality restrictions
- LGBTQ friendly adoption agencies
- DCF (MA)
- Cost $2000-$40,000
Assisted Reproductive Technology

- Fertility/reproductive specialist
- Comprehensive fertility and genetic testing and reproductive imaging
- IUI with medicated ovulation + frozen sperm
- In vitro Fertilization (IVF): embryo formed in lab, transferred to uterus
  - Donor or partner sperm, Donor or partner egg, Surrogate or partner uterus
Surrogacy

- Managed by attorneys and medical providers
- Assisted Reproductive Technology
- Traditional or Gestational Surrogacy
  - Traditional: Own egg; higher legal risk
  - Gestational: Egg donor
Legal Considerations

- Laws based on genetic connections
- Contracts when using donor/surrogate
- Co-parent or 2\textsuperscript{nd} parent adoption
- Varying state laws/policies
COST

- Donor sperm: $500 - $1000 per vial, 1 vial/cycle
- Sperm banking and FDA testing: $1000
- Intrauterine insemination: $250 - $500
- Fenway cost: <$300 to enroll, $250/IUI/cycle
- In vitro fertilization: $15,000 per cycle
- In vitro fertilization, egg donation: $15,000 - $25,000 per cycle
- Oocyte/embryo cryopreservation: $6,000 - $10,000
- Gestational surrogacy: $50,000 - $100,000
Pregnancy in Transmen

- Transgender Men Who Experienced Pregnancy After Female-to-Male Gender Transitioning

- Alexis D. Light, MD, MPH, Juno Obedin-Maliver, MD, MPH, Jae M. Sevelius, PhD, and Jennifer L. Kerns, MD, MPH

- Obstetrics & Gynecology Vol. 124, NO. 6 , Dec 2014
Cross sectional survey

- March –Dec 2013
- Online survey
- >18 y.o.
- Self identified as male BEFORE pregnancy
- Delivered within 10 years
- Testosterone therapy or gender affirming surgery not required
RESULTS: 41 Participants

- 25 used pre-pregnancy T
- 20 return of menses within 6 months of stopping T
- 28 planned pregnancy (19T/9)
- 13 unplanned (6T/7)
- 20 conceived within 6 months (14T/6)
- 29 Vaginal delivery (16T/13)
- 12 Cesarean delivery (9T/3)
- 21 breast/chest-fed (10T/11)

PREGNANCY OUTCOMES

No difference in pregnancy, delivery or birth outcomes in those with prior T use

- 30% Cesarean delivery (9T/3)
- 12% Hypertensive disorders (4T/1)
- 10% Preterm Labor (3T/1)
- 10% Placental Abruption (2T/2)
- 5% Gestational Diabetes (2T/0)
- 5% Postpartum infection (1T/1)
Pregnancy experience

Feeling of isolation common

Lack of resources available to pregnant transgender men

Varying degrees of gender dysphoria

“It was relieving to feel comfortable in the body I’d been born with”

“Heavy time, having a baby, not passing as male, all the changes and a society telling me to just be happy”
Pregnancy experience

- **Positive** experience associated with proper use of gender-related language by health care team
- **Negative** experience due to improper pronouns and denial of services
  - “Treat us as if we are normal human beings with normal bodies”
Chestfeeding

- Transmasculine individuals’ experiences with lactation, chestfeeding, and gender identity: a qualitative study

- Trevor MacDonald, Joy Noel-Weiss, Diana West, Michelle Walks, MaryLynne Biener, Alanna Kibbe and Elizabeth Myler

- *BMC Pregnancy and Childbirth*, May 2016
Results: 22 Responders

- 9 with prior chest surgery
  - No discussion with surgeon regarding future infant feeding choices
- 16 chose to chest feed
  - 7 had gender dysphoria
  - 11 chest fed for more than 1 year
  - 7 received donor milk
  - 1 resumed testosterone therapy
Chestfeeding after Top Surgery

- 9 with prior chest surgery
  - 6 experienced some growth in chest tissue
  - 2 reported chest tissue grew back to original size
  - 2 experienced engorgement and mastitis post-partum
Chestfeeding Support

- Use non-gendered language
- Avoid touching without permission
- Privacy is important
- Support all decisions around feeding
Clinical Case #2

- 29 y.o. G1 transgender man with positive pregnancy test
- Partner present
- Assigned female at birth, identifies as transgender, uses they/them pronouns
- Conceived with home inseminations using known genetically related donor sperm.
Past Medical History

- Hormone disorder, asthma, anxiety, migraines, ADHD, IBS
- Stopped Ritalin
- Continued Wellbutrin, followed by psychiatrist
- Stopped testosterone x 1 year
Antepartum

- Low risk aneuploidy testing
- Normal fetal survey
- Normal testing for gestational diabetes
- Uneventful prenatal course except GERD
- 1st trimester EPDS=9 ; 2nd trimester EPDS=11
Antepartum

- Attended FH Transparenting group
- Desired vaginal birth
- Planned breastfeeding x 1 year and then restarting Testosterone
- Birth parent to be called "Dad", partner will be "Baba"
- "They" pronouns for baby
DELIVERY & POSTPARTUM

- IOL for post dates, pushed x 4 hours
- VAVD due to "maternal" exhaustion
- Breastfeeding
- Home on postpartum day #1

- EPDS=3
- Breastfeeding well; baby healthy
- Active involvement in parenting group
TAKE HOME POINTS

- LGBTQ-headed families are increasing
- **Plan Ahead.** Routinely discuss reproductive options and fertility preservation
- **Optimize health.** Same health issues that impact cisgender fertility impact transgender fertility
- **Be financially/legally prepared.** Assisted reproductive options are expensive, potentially complex
- Pregnancy and chestfeeding in transmasculine persons is possible
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for images:
Here is What a Standard Slide Looks Like

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Includes Fenway Health Colors Built In