


SPECIAL CONTRIBUTION

Diversity, Equity and Inclusion

A guide to caring for patients who identify as transgender and gender diverse in the emergency department

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Abstract

Through a review of current research, standards of care, and best practices, this paper serves as a resource for emergency physicians (EPs) caring for persons who identify as transgender and gender diverse (T/GD) in the emergency department (ED). Both patient- and physician-based research have identified existent potential knowledge gaps for EPs caring for T/GD in the ED. T/GD have negative experiences related to their gender identity when seeking emergency medical care and may even delay emergency care for fear of discrimination. Through the lens of cultural humility, this paper aims to address potential knowledge gaps for EPs, identify and reduce barriers to care, highlight gender-affirming hospital policies and protocols, and improve the care and experience of T/GD in the ED.

KEYWORDS

delivery of healthcare, emergency medicine, gender-affirming care, health inequities, medical education, social determinants of health, transgender persons

1 | BACKGROUND

Gender identity refers to one's inherent sense and experience of gender as a set of socially constructed roles, behaviors, activities,

and attributes.¹⁻³ Persons who identify as transgender and gender diverse (T/GD) have a gender identity different from the sex they were assigned at birth.⁴ There are an estimated 1.6 million T/GD in the United States.⁵ T/GD often avoid emergency medical care, and when they do seek care, they have negative experiences in the emergency department (ED) related to their gender identity.⁶⁻⁸ T/GD

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experience compounding social, institutional, and structural barriers that affect their health and impact their ability to access affirming and knowledgeable healthcare.⁶⁻⁹

Despite a reported increase in LGBTQIA+ educational content in emergency medicine residency programs, clinician-based research suggests an existent knowledge gap for clinicians caring for T/GD in the ED.¹⁰⁻¹² An emergency physician (EP)-based study found that 88% of physicians reported caring for T/GD, yet 82.5% had no formal training on caring for T/GD and lacked medical knowledge about common medications and surgeries related to their care.¹¹ Much of the available training literature centers on LGBTQIA+ without distinguishing the specific needs of gender minority subgroups, highlighting the importance of T/GD-specific educational resources for EPs.¹¹

1.1 | Methods

Review topics were selected from the World Professional Association for Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People, the University of California San Francisco Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, and known LGBTQIA+ ED care guides.¹³⁻¹⁶ Topics include terminology, health disparities and conditions, barriers to healthcare, ED environment, care in the ED that affirms T/GD, social gender affirmation, gender-affirming hormone therapy (GAHT), gender-affirming surgeries and complications, and pediatric T/GD in the ED. Resources used to research each topic included PubMed literature searches and online resources and publications by well-established LGBTQIA+ organizations and government agencies.

2 | TERMINOLOGY

Terminology evolves and varies, as it often describes personal experience and intersects with cultural reference. There are innumerable ways individuals use language to describe their identity. The best practice is to ask people what words they use to describe themselves and how they would like you to refer to them.¹ Common terminology is found in Table 1 but is not comprehensive.

3 | HEALTH DISPARITIES AND CONDITIONS

3.1 | Social determinants

T/GD experienced higher rates of poverty, unemployment, homelessness, and gender-related housing discrimination and have greater health disparities than their cisgender counterparts.^{6,18,19} T/GD are four times more likely to experience violent victimization than people who were cisgender.²⁰ Transgender women of color are disproportionately targeted by hate-related homicide (HRH), with a 2017 U.S. study

TABLE 1 Commonly accepted terminology.^{1-3,15,17}

Terminology	Description
Sex (noun)	Refers to sex assigned at birth based on assessment of external genitalia, chromosomes, and gonads.
AFAB, AMAB	Assigned female at birth, assigned male at birth.
Gender identity (noun)	One's inherent sense and experience of gender as a set of socially constructed roles, behaviors, activities, and attributes.
Sexual orientation (noun)	An individual's emotional, romantic, and/or sexual attraction to others, often based on sex and/or gender. For example, lesbian, gay, bisexual, etc.
LGBTQIA+	Acronym stands for "lesbian, gay, bisexual, transgender, queer, intersex, and asexual" the "+" sign stands for the limitless sexual orientations and gender identities.
Transgender (adj.)	Individuals whose gender identity and/or expression is incongruent with the societal norms of their sex assigned at birth.
Non-binary (adj.)	Individuals whose gender identity and/or expression exists between or beyond the binary classifications of male or female.
Gender diverse (adj.)	Umbrella term sometimes used to describe people who expand notions of gender expression and identity beyond perceived or expected societal gender norms.
Cisgender (adj.)	Individual whose gender identity aligns with the sex assigned at birth.
Transition (noun)	The various social, legal, and/or medical processes undertaken to affirm and express one's gender identity. The process is specific to individuals and varies based on what an individual deems necessary and what is accessible to them.
Gender-affirming surgery (noun)	Various surgical procedures that assist individuals to adjust their bodies to be more congruent with their innate gender identity.

finding that 40% of HRH victims were transgender women of color.²¹ Examples of T/GD-specific interpersonal abuse are found in Table 2.

3.2 | HIV and other infections

Although the overall prevalence of HIV infection is relatively low among T/GD nationally, the prevalence may be much higher in certain subgroups, with studies reporting the highest infection rates among people who are black and transgender.²³⁻²⁵ Coinfection with HIV and at least one viral hepatitis or sexually transmitted infection (STI) is more common among T/GD as compared to people who are identified as cisgender.²⁶ T/GD may also be at risk for HIV and hepatitis C viral transmission due to sharing of needles for hormones and liquid silicone.²⁵

TABLE 2 Examples of transgender and gender diverse-specific abuse.²²

Being forced to conform to an undesired gender presentation or to stop pursuing gender transition
Being pressured to remain in a relationship by being told no one would date a transgender person
Blackmailing with non-consensual “outing”
Hiding or destroying transition-related hormones, prosthetics, or clothing

3.3 | Substance use

Studies examining substance use disorders (SUD) among T/GD are limited by accurate gender identity data collection. Research suggests that T/GD are subject to “minority” stress from social discrimination, heightened vigilance, and internalized stigma.²⁷ Psychological stress from gender identity-related mistreatment and gender-denying experiences is believed to contribute to substance use risk and severity.^{28,29} While it is known that T/GD are at an increased risk for developing SUD, less is understood about the differences in addiction that exist between individual T/GD subgroups.³⁰

3.4 | Mental health

According to the 2015 U.S. Transgender Survey, 39% of respondents experienced serious psychological distress in the preceding month, compared to 5% of the general adult U.S. population.⁶ The survey revealed a 40% lifetime prevalence of suicide attempts among T/GD as compared to 4.6% among the general adult U.S. population.⁶ Fourteen percent of adult T/GD respondents reported exposure to gender identity conversion efforts, which was associated with higher rates of serious psychological distress and suicide attempts than those who were not exposed.^{6,31} The prevalence of clinically significant depression was similar between T/GD women (51%) and men (48%).³²

3.5 | COVID-19 pandemic

Although the full impact is still unknown, the COVID-19 pandemic exacerbated known disparities among T/GD, especially those with intersecting marginalized identities.^{33,34} T/GD people of color experienced higher rates of unemployment (26%) and economic hardship (67%) due to the pandemic than their white counterparts (19% and 59%) and the general population (12% and 15%).³⁴ Pandemic-related delays in gender-affirming health services and procedures, reduced access to care, and limited social connectedness impacted mental health indicators, with greater rates of depression, anxiety, and suicidality among T/GD.^{33,35}

4 | BARRIERS TO HEALTHCARE

Structural, institutional, stigma, and bias-related barriers affect T/GD ability to access healthcare. According to the 2015 U.S. Transgender Survey, 33% of T/GD reported at least one negative experience with a healthcare practitioner related to their gender, 23% did not seek healthcare they needed due to fear of being mistreated, and 33% did not seek medical care because they could not afford it.⁶ Twenty-four percent reported needing to educate practitioners about T/GD-specific health issues to receive appropriate care.⁶ Thirty-two percent of T/GD reported verbal harassment, denial of benefits or services, being asked to leave, or being assaulted when they showed ID with a name or gender that did not match their gender presentation while accessing healthcare.⁶ Discrimination of T/GD in healthcare includes gender insensitivity, displays of discomfort and contempt, lower quality care, as well as denial of services, gatekeeping, verbal abuse, and forced or unwanted care.³⁶ Historical gatekeeping of gender-affirming care and the pathologizing of T/GD have contributed to social stigma and to mistrust of the medical community by T/GD.^{37,38}

Structural stigma in healthcare, where policies or laws harm or fail to protect T/GD, is a barrier that contributes to health inequities.³⁹ Despite federal anti-discrimination laws and statutes, many states lack laws and policies that protect T/GD from gender-affirming healthcare insurance coverage exclusions.^{40–42} The passage of “anti-transgender” bills and policies that specifically limit or prevent T/GD from accessing gender-affirming medical care create detrimental barriers that especially impact pediatric T/GD.^{43,44}

5 | EMERGENCY DEPARTMENT ENVIRONMENT

The Joint Commission and the Patient Protection and Affordable Care Act (Section 1577) prohibits discrimination in healthcare settings based on sex, sexual orientation, and gender identity or expression.^{40,45} Institutions should reinforce non-discrimination in their policies and through the patient’s bill of rights.⁴⁶ Staff training may be required to address implicit bias and meet cultural competency needs. Hospital policies should include clear mechanisms for reporting incidents of discrimination, establishing accountability, and prioritizing unbiased care.^{47,48}

A welcoming ED environment could be achieved through visuals of T/GD patients and families, non-offensive content on television screens, and T/GD-supporting magazines or newspapers.¹⁵ Legal identification and insurance information may not align with the patient’s gender or name, yet accurate demographic information collection during registration is essential to affirm the patient’s identity. Patient-centered protocols should accurately collect and document sexual orientation and gender identity (SOGI) data, along with pronouns and chosen name, while maintaining patient confidentiality and privacy.^{47,49} Using only surnames in waiting rooms and avoiding gender identification, unless it is relevant to the provision of care, is recommended by T/GD.⁸

Electronic medical records (EMRs) may allow for SOGI data and chosen names and pronouns, to be documented by staff as well as by patients themselves through integrated patient portals.⁴⁹ EMRs can be tailored to include organ inventory information as part of a patient's health history.⁵⁰ EDs can enlist informaticists to identify options within EMR settings and advocate for changes to address chosen name/pronouns, gender-specific laboratories, laboratory reference ranges, and best practice advisories for T/GD.¹⁵

"Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies," a report published by the Human Rights Campaign and Lambda Legal in conjunction with the New York State Bar Association, provides recommendations on gender-affirming hospital policies.⁴⁶ All patients need safe and equal access to restrooms in accordance with their gender, and single stall bathrooms should be labeled as "all gender."⁴⁶ During the hospital admission process, staff should coordinate with the patient to determine the room assignment with which the patient is most comfortable.⁴⁶ Private rooms should be offered for T/GD if available, and reasonable accommodations should be honored, such as blocking a double-bed room, rearranging other patient room assignments, and allowing T/GD to remain in the ED until a private room is available.⁴⁶

6 | CARE IN THE ED THAT AFFIRMS T/GD

6.1 | Names and pronouns

Using correct names, pronouns, and appropriate non-offensive terminology are essential when caring for T/GD. Resist assumptions about gender identity based on voice, physical appearance, medical procedures, and GAHT use, and avoid gendered language or gendered identifiers to address patients until the name and pronoun the patient uses has been established.^{2,15,47} Maintain privacy standards and communicate the name and pronoun that the patient uses to relevant staff involved in the patient's care.⁴⁸ Reference the EMR for the patient's chosen name and pronouns before addressing the patient.⁵¹ Promptly correct and apologize for accidental usage of the wrong name or pronoun.⁴⁷ Create an environment of accountability by constructively correcting staff and colleagues that are observed using the wrong name or pronoun for the patient.⁴⁷ Scripted suggestions for addressing names and pronouns are listed in Table 3. EPs can wear pins or identification tags that include their pronouns⁵² and use their pronouns in communication insignia to show support for pronoun disclosure.

6.2 | History

Questions about gender-affirming surgery (GAS), hormone use, or other gender identity-related questions should be focused and relevant.⁵³ Use non-gendered language to refer to body parts (eg, genitals, external pelvic area, genital opening, front canal, internal organs, chest, monthly bleeding) and ask patients how they refer to their body parts and use those terms.^{54,55} Sexual history taking should include

TABLE 3 Names and pronouns in the emergency department (ED): scripted suggestions.^{15,47,48}

Context	Use	Avoid
When asking for name and pronouns	"Hi, my name is [your name] and I'm going to be your (title). My pronouns are [your pronouns]. How would you like me to address you? What are your pronouns?"	"Preferred name" or "preferred pronoun" implies that the pronoun or name is optional
When calling for a patient in the waiting room	"Patient [last name]"	Avoid "Mr./Mrs." [last name] Avoid "Sir/Ma'am"
When requesting other names, charts, legal names, that is, for billing, registration purposes, or chart review purposes as indicated	"Could your chart be listed under another name?" "What is the name listed on your insurance card or ID?"	"What is your real name?"
When confirming two patient identifiers for labs, medication, and diagnostic safety purposes	"Please tell me the name listed on your record or wristband and your date of birth, it is hospital policy that I confirm this information before I [draw labs/administer medication/etc]."	Asking a patient to state their birth name/"dead name" without explaining the context and reason

sexuality, gender identity and anatomy of sexual partners, activities engaged in, STI protection and STI history.⁵⁶ An organ survey is important if relevant for the chief complaint and presentation in order to identify the appropriate workup.⁵⁷ Screening should be done in accordance with best practices in the ED for STI, SUD, alcohol use disorder, mental health, and food and housing insecurity with linkage to resources and services, as appropriate.⁵⁸

6.3 | Physical examination

To avoid traumatization, take the time to explain the reason for the examination and what the examination entails and invite questions.^{59,60} In addition to genital, rectal, and chest examinations, checking for pelvic stability, auscultating the heart and lung, and performing point of care ultrasound may be upsetting for T/GD. Social gender affirmation practices can impede certain examinations and procedures and may require a patient-centered discussion about removing their compression garments or prostheses.^{57,61} Following the principles of trauma-informed care (TIC) can help prevent traumatization and minimize re-traumatization of T/GD.^{59,60} Reinforcing concepts of patient self-autonomy and providing appropriate alternative options for patients for whom certain examinations may cause significant harm.^{59,60} Principles and applications of TIC are found in Table 4.

TABLE 4 Principles and applications of trauma-informed care (TIC).^{55,59,60}

TIC key concepts	Application/examples
Safety	<ul style="list-style-type: none"> • Avoid potentially triggering language • Stay within the patient’s line of sight • Maintain an appropriate physical distance
Trustworthiness/transparency	<ul style="list-style-type: none"> • Explain the reason for the examination, what the examination entails, and be open to questions
Peer support	<ul style="list-style-type: none"> • Use a chaperone of the gender of the patient’s choice, and allow a support person to be present, if requested
Collaboration and mutuality	<ul style="list-style-type: none"> • Reinforce concepts of patient self-autonomy • Review options to optimize patient comfort during the examination
Empowerment, voice, and choice	<ul style="list-style-type: none"> • Ask before touching, obtain permission before proceeding • Provide appropriate alternative options for patients for whom certain aspects of an examination may cause significant harm • For anoscope or speculum examinations, offer the patient the option to self-insert • Offer for patients to self-swab for STIs
Cultural, historical, gender issues	<ul style="list-style-type: none"> • Ask about and use chosen name/pronouns and preferred body part terminology • Consider how past trauma, historical mistreatment, and mistrust may inform your interaction

Abbreviation: STI, sexually transmitted infection.

Consider using a small-sized speculum for pelvic examinations, especially for T/GD who may have vaginal atrophy from testosterone use.^{55,60} An anoscope may be more anatomically appropriate for a visual examination of a neovagina.⁵⁷ Lidocaine gel may be helpful when used as an anesthetic before insertion of a speculum or anoscope.⁵⁵ For routine STI testing, unless a genital/pelvic examination is indicated, consider self-swabbing. Self-collected vaginal, rectal, and urine specimens for nucleic acid amplification gonorrhea, chlamydia, and trichomonas have equivalent sensitivity and specificity to samples collected by medical staff.⁶² Patients born with a prostate will likely still have a prostate regardless of having undergone GAS and may need a prostate examination, as indicated by the chief complaint.⁶³ T/GD who have undergone vaginoplasty have a prostate anterior to the vaginal wall; a digital examination of the prostate from the neovagina may be more effective.^{64,65}

6.4 | Laboratory tests

Many common laboratory tests such as hemoglobin, hematocrit, iron studies, high-sensitivity cardiac troponin, creatinine, and glomerular filtration rate are affected by sex steroids or body/organ size.^{66,67} Gender-specific laboratory reference values that correlate with the binary sex assigned at birth may not account for the effects of GAHT.⁶⁷

TABLE 5 Social affirmation practices and complications.^{16,61,71,72}

Name	Description	Complications
Tucking	Manually displacing the testes upward into the inguinal canal and positioning the penis and scrotal skin between the legs and rearward. Tight underwear, tape, or a gaff is used to maintain positioning	Pain, urinary reflux, epididymo-orchitis, prostatitis, cystitis
Binding	Use of tight-fitting sports bras, shirts, ace bandages, or a specially made binder to provide a flat chest contour	Pain, local skin irritation, fungal infections, rib fractures, atelectasis, pneumonia, shortness breath, binders may interfere with respiratory mechanics of ventilation
Use of prostheses	Use of a prosthesis to produce the desired outward appearance	Local skin irritation
<ul style="list-style-type: none"> • Packing • Breast • Padding 		

There is little research and no consensus on the appropriate laboratory reference ranges for T/GD.⁶⁷ T/GD with ovaries and a uterus who are sexually active with someone with sperm-producing genitalia may need pregnancy testing regardless of GAHT.⁶⁸

6.5 | Other considerations

As with all patients, privacy is an important consideration. T/GD may not have disclosed their gender identity or related information to accompanying hospital visitors. Establish with the patient alone what they feel comfortable discussing in front of their visitor. T/GD often rely on “chosen families” rather than “traditional” bio-legal bonds for advocacy, support, care, and surrogate decision making.⁶⁹

7 | SOCIAL GENDER AFFIRMATION

Social gender affirmation may include living in one’s identified gender, changing one’s pronouns or name, dressing in ways that align with one’s gender identity, and disclosing one’s gender or transgender experience with others.^{70,71} Tucking, binding, and the use of prostheses are practices commonly used to align physical appearance with gender identity.⁷¹ Table 5 outlines common social gender affirmation practices and complications.

8 | GENDER-AFFIRMING HORMONE THERAPY

Some T/GD may use GAHT to align their body with their gender identity and desired physical appearance. GAHT medications require a

TABLE 6 Gender-affirming hormone therapy.^{13,74–78}

Hormone category	Name	Effects	Complications
Feminizing hormones	Estrogen	Breast growth (variable), decreased muscle mass, body fat redistribution, slowed body hair growth, decreased testicular volume sperm production and libido	VTE, hypertriglyceridemia, cholelithiasis
	Anti-androgens (spironolactone, GnRH agonist, 5 alpha reductase inhibitors)	Reduce exogenous testosterone levels and activity	Hyperkalemia (spironolactone)
	Progestogens	Reported to improve breast development, mood, libido, but controversial with little data to support use	Depression, weight gain, lipid changes, increased VTE risk when used with estrogen
Masculinizing hormones	Testosterone	Deepened voice, clitoral enlargement, growth in facial and body hair, cessation of menses, atrophy of breast tissue, vaginal atrophy, decreased percentage of body fat, increased muscle mass	Polycythemia vera, hyperlipidemia
Puberty blockers	GnRH agonist	Reversibly blocks the secretion of sex hormones, suspends puberty	Diminished bone mineral density acquisition, weight gain, abscesses at the site of injection (if injectable used), irregular vaginal bleeding, and emotional lability
Other	Continuous combined contraceptives, oral progestins, depot medroxyprogesterone acetate, etonogestrel implant, progestin intrauterine device	Used to achieve amenorrhea or reduced amount and days of bleeding	Irregular bleeding, estrogen- containing increased risk of VTE, progestins can cause weight gain, adverse effects on bone density, hyperlipidemia

Abbreviations: GnRH, gonadotropin-releasing hormone. VTE, venous thromboembolism.

prescription and longitudinal monitoring. Because of availability, cost, lack of medical insurance, or obstructive medical access legislation, it may be difficult for some patients to access a prescriber.⁷³ Patients may obtain hormonal medications without a prescription from alternate sources.^{13,73} Effects of hormone use occur gradually over months to years; some effects of hormonal medications are reversible, and some effects are more permanent.^{13,74} Table 6 summarizes gender-affirming hormone therapies, effects, and complications.

9 | GENDER-AFFIRMING SURGERIES AND COMPLICATIONS

T/GD may have GAS to align their body with their gender identity and desired physical appearance. T/GD may present to the ED with post-operative complications after GAS, including bleeding, infection, and pain. Table 7 outlines common GAS procedures and complications. Due to cost, access, surgical expertise, reputation, or other factors, T/GD living in the United States may travel to other states or abroad for GAS.^{79,80} EPs may have difficulty obtaining medical records, contacting the patient's surgeon, or scheduling specialty follow-up locally for T/GD who need GAS-related emergency care in a geographic location different from where they had surgery.

T/GD may engage in medically unsanctioned procedures, such as large volume injectable fillers, where the composition of the injected material is often unknown.⁸¹ T/GD may seek out injectable fillers due to a desire for immediate results, lack of awareness of risks, peer

pressure, lack of access to healthcare, to support survival sex work, or to achieve desired sex characteristics without the side effects of hormones.^{81–83} Filler injections carry significant risk and can lead to infection, erosion, necrosis, silicone embolism, acute respiratory distress syndrome, and other serious complications.⁸¹

10 | PEDIATRIC T/GD IN THE ED

There are specific considerations when treating pediatric T/GD. One important intervention is for EPs to normalize gender diversity by changing their language around introductions to include soliciting the pronouns of the patient. It is particularly important to do this twice in the adolescent population if needed, once while the parents/caregivers are in the room, and again when engaging the adolescent alone. As with adult T/GD, it is imperative to take a gender-inclusive sexual history. If patients divulge information about their gender identity or sexual orientation, clinicians should ask what they are comfortable sharing with parents, guardians, or visitors, and take caution to never “out” their patients, given the potential for harm.⁹² Ten percent of respondents to the National Transgender Survey reported violence from family after coming out, 8% were kicked out of their homes, and 10% ran away.⁶

Like adults, adolescents may utilize social gender-affirming methods to align their bodies with their gender identity (Table 5). Many of the complications associated with these practices resolve with cessation; however, advocating for cessation can often create more harm, as

TABLE 7 Common gender-affirming surgery procedures and complications.^{13,15,16,61,84-91}

Feminizing procedure	Description	Complications
"Bottom surgery" • Penectomy • Orchiectomy • Clitoroplasty • Labiaplasty • Vaginoplasty	The creation of a neovaginal vault between the rectum and urethra and lined with penile skin, intestinal, peritoneal, or buccal mucosa. Labia (labiaplasty) are created using scrotal skin, and testes are removed (orchiectomy). A clitoris (clitoroplasty) is created from the glans. Packing remains in the neovagina 5–7 days post-op. After removal of packing, the patient will start using dilators. Penectomy, orchiectomy, clitoroplasty, labiaplasty may be performed without vaginoplasty	More immediate complications: bleeding, hematoma, infection, partial necrosis of the vagina, clitoris or labia, bladder or bowel fistula, urethral stenosis, urinary tract infection, urinary retention, wound dehiscence Other neovaginal conditions: bacterial or candidal neovaginal infections, neovaginal granulation tissue formation, vaginal stenosis
Body contouring • Liposuction • Gluteal augmentation • Abdomino-plasty	Removal or translocation of body fat or the use of implants to create the desired body contour	Infection, bleeding, bruising
Breast augmentation	Saline or silicone implants to create larger breasts	Infection, bleeding, implant rupture
Facial feminization • Brow contouring • Scalp advancement • Chin augmentation, contouring, mandible reduction • Rhinoplasty • Cheek lift w/wo implants • Facelift • Blepharoplasty	Multiple gender-affirming procedures tailored to the individual	Soft tissue swelling, infection, chin augmentation may reduce the reliability of the perceived thyro-mental distance during airway assessment, mandible reduction may lead to overcrowding of oropharynx and difficult intubation
"Silicone injections" "Pumping"	Refers to any number of medically unsanctioned/unsupervised soft tissue fillers injected freely to enhance areas of the body such as hips or breasts, actual composition of substance is often unknown, often large volume injections	Silicone embolization possibly leading to acute respiratory distress syndrome, hypersensitivity pneumonitis, immune reconstitution inflammatory syndrome, hypercalcemia, infection, bleeding, pain, erosions and necrosis, migration of silicone, abscess, fistula formation
Cricothyroid approximation	Increase vocal cord tension by anterior–inferior movement of thyroid cartilage, posterior–superior movement of cricoid cartilage	Infection, local swelling, loss of cricothyroid membrane making cricothyroidotomy impossible
Glottoplasty	The anterior portion of the vocal cords are sutured in order to reduce the glottic aperture to that of a cis-female	Infection, local edema with airway compromise, difficult intubation (may require smaller endotracheal tube size selection due to reduced glottic aperture)
Tracheal shave	Reduction in the size of the thyroid cartilage	Local swelling, infection
Masculinizing procedure	Description	Complications
Erectile device placement	Penile implant to allow rigidity for penetration	Infection, erosion
Hysterectomy	Removal of the uterus typically with bilateral salpingectomy, oophorectomy is variable, increasingly common that unilateral or bilateral ovaries are retained for bone health protection	Infection, bleeding
Body contouring "mansculpting"	Liposuction of hips, thighs, or other areas to change the contour of the body	Bruising, pain, bleeding, infection
Mastectomy	Subcutaneous mastectomy with repositioning/resizing/reshaping of nipple–areola complex	Hematoma/seroma, wound drain blockage, infection, nipple graft necrosis, dehiscence
Metoidioplasty	Testosterone enlarged clitoris is freed from ligamentous attachments and local tissue is used to create a 1–3 inch phallus, urethral lengthening may be performed to allow urination through the phallus, may be accompanied by vaginectomy or scrotoplasty	Wound breakdown, infection, urethral strictures, and fistula formation

(Continues)

TABLE 7 (Continued)

Masculinizing procedure	Description	Complications
Phalloplasty <ul style="list-style-type: none"> • Pedicle groin flap • Radial forearm free flap • Latissimus dorsi free flap • Other 	A pedicle flap is never severed from its blood supply. Free flap is removed from the donor site along with blood and nerve supply and anastomosed at the transfer site. Phallus is created from donor skin and grafted to pubic area. Often performed after hysterectomy and vaginectomy. Scrotoplasty may also be performed. Urethral lengthening can be performed using cheek or vaginal mucosa. Erectile implant may be placed. Involves multiple staged surgeries	Infection, bleeding, pain, wound breakdown, urinary catheter issues (clogged catheter, bladder spasms, urinary tract infection), flap loss (usually presents within 72 h, early recognition can be salvaged in operating room), pelvic or groin hematoma, rectal injury, fistula formation, urethral strictures (6–12 months post-op)
Scrotoplasty	Scrotum created from skin flaps from the labia majora. Tissue expanders are used before placement of permanent testicular implant	Infection, extrusion of testicular implant
Vaginectomy	Colpectomy with colpocleisis—removal of vaginal mucosa, suturing, and closure of the vagina	Hemorrhage, bladder injury, rectal injury

it ignores the positive effects these practices have on both mental and psychological wellbeing and safety. Strategic breaks from these practices while in locations or situations they consider safe may be preferable.⁹³

Gender-affirming medical care for pediatric T/GD includes pubertal suppression, feminizing or masculinizing hormones, contraception, and fertility preservation.¹³ Pubertal suppression in pediatric T/GD is associated with improvements in global functioning, depression, overall behavioral and emotional problems, and significantly lower lifelong odds of suicidality.^{94,95} The physiological effects of pubertal suppression are largely reversible and carry little risk with minimal side effects.⁹⁵ Older adolescents may choose to start feminizing or masculinizing hormones, and while GAS for minors is uncommon, some may undergo surgical intervention.

Pediatric T/GD have higher documented rates of psychological comorbidities than their cisgender peers secondary to stigma, rejection, and societal bias.⁹⁶ Pediatric T/GD have increased rates of psychiatric morbidity, disordered eating, and suicidal ideation and attempts as compared to their cisgender peers, which should be considered when assessing overall risk.^{44,97–100} Pediatric T/GD have higher rates of SUDs compared to their cisgender peers, and ED screening and counseling are recommended.¹⁰¹ EPs should provide gender-inclusive resources and T/GD-focused pediatric clinic referrals to parents and pediatric T/GD who need them.¹⁰²

11 | CONCLUSION

T/GD experience compounding social, institutional, and structural barriers that affect their health and access to care.⁶ Research has found that T/GD often avoid emergency medical care and have negative experiences in the ED related to their gender identity.^{6–8} Patient-based and clinician-based research indicates a knowledge gap around caring for T/GD.^{6,11,12} Institutions should take steps to reduce barriers and create environments that are welcoming for T/GD through staff

education and training, expansion of gender and name designation capabilities in registration and EMRs, and adoption of gender-affirming hospital policies.^{15,46,47} As with any medication or surgical procedure, transition-related social affirmation practices, hormonal medications, and GAS have associated risks and complications. Pediatric T/GD have unique healthcare and social support needs.⁹³ The best practices for providing evidence-based gender-affirming care for T/GD in the ED should continue to be developed and implemented. Health-related research and policies that impact T/GD are rapidly evolving, and communities change over time, highlighting the importance of continued self-education through a lens of cultural humility.

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CONFLICT OF INTEREST STATEMENT

Courtney Edwards serves as the Chair of the DEI Committee for the Texas Emergency Nurse Association and receives support from the Texas Emergency Nurses Association to attend state meetings serving in this role. The remaining authors declare they have no conflicts of interest.

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