

at birth. Testosterone gender affirming care started at age 14 to age 18 but discontinued secondary to irritability and rage. Progesterone and etonogestrel implant were used without success of suppression of menses, requiring hysterectomy with retention of ovaries, to relieve gender dysphoria (GD), in addition to gender affirming bilateral mastectomy. Physical exam is notable for normal vital signs, weight 111 Kg, BMI 33, +male pattern alopecia, terminal facial hair, full beard, acne, supraclavicular fat deposition, and pink thin abdominal stria. Total testosterone and DHEA were elevated at 58.7 ng/dl (13.84-53.35 ng/dL) and 501 ug/dl (18-391 ug/dL) respectively; random estradiol 63 pg/ml; SHBG, LH, FSH, TSH, free T4, T3, IGF1, prolactin, 24-hour urine cortisol and 5-HIAA were normal. Repeat labs were similar, and free testosterone was 26 pg/ml (1-18 pg/mL). Pelvic US showed multi follicular ovaries.

A trial of low dose oral estradiol resulted in total resolution of symptomatology.

**Discussion:** PCOS was diagnosed based on hirsutism and PCO. He was not bothered by virilization; testosterone was declined as his GD was relieved by gender affirming surgical interventions. We hypothesize that mood disturbances may have been secondary to high endogenous and exogenous androgen levels, as symptomatology resolved upon testosterone withdrawal. We postulate that climacteric symptoms relieved by low dose estradiol may have been the result of an alteration in hormonal feedback. Decreased feedback of testosterone to the hypothalamus has been described during antiandrogen therapy for prostate cancer, as the cause of hot flashes and nausea. Our patient did not have low androgen levels; however, it is possible that drastic fluctuations in androgens, caused "relative hypogonadal" status resulting in his symptomatology. There are no clear guidelines on evaluation and treatment of PCOS in transmen; as virilization is usually not bothersome, however more research is needed on the metabolic effects and CV risk in this population. Our case emphasizes the importance of obtaining baseline hormonal levels before initiation of hormonal affirming care. Transmen are to be screened for PCOS and work up of unexplained hirsutism pursued to treat metabolic and CV risk factors aggressively.

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## Reproductive Endocrinology

PMON281

### **PERSISTENT VIRILIZATION AND VASOMOTOR SYMPTOMS IN A TRANSMAN 5-YEARS POST TESTOSTERONE WITHDRAWAL**

Maryam Nemati, MD and Lorena Wright, MD, FACE

**Introduction:** Polycystic ovarian syndrome (PCOS) is one of the most common reproductive abnormalities, characterized by irregular menses, hirsutism, and polycystic ovaries (PCO). In cisgender females is associated with insulin resistance and increased risk of metabolic and CV disease. Management of PCOS in transmen has not been established.

**Case Presentation:** Twenty-three-year-old transman referred for evaluation of heat intolerance, upper body flushing, sweating, and nausea. Symptoms were severe, non-responsive to lifestyle modifications. He denied change in size of hats, rings or shoes, no easy bruising, no muscular weakness but increased facial hair even after 5-year testosterone withdrawal. He had a normal puberty, menses, breast growth and distribution of fat for assigned female