Like A Horse With Blinders: Care of A Transgender Person

Sir,

Mr. S is a Female (F) to Male (M) transgender. Mr. S will be addressed as “He” as he prefers the same. He is 24-year-old and consulted for cross-sex hormone treatment. He is from a small village in Tamil Nadu and given his gender identity, he moved out of his family. Mr. S has researched well and understood the process of cross-sex hormone therapy. He is a teetotaler, has no sexual partner and opted out of fertility preservation. He consulted a psychiatrist and is diagnosed with gender incongruence and had no other psychiatric conditions. After baseline hormone investigation, which was all-normal, he was started on testosterone 100 mg intramuscular (IM) every two weeks. During his regular follow up after two years on cross-sex hormone treatment he developed grade 2 pitting pedal oedema. He reported tiredness and easy fatigability. Mr. S was managing a terrace garden and he attributed his tiredness to his job. His lab work repeatedly showed triglycerides (TGL) 600 mg/dl (normal <150), normal liver function test, fasting blood glucose of 94 mg/dl (normal <100 mg/dl), TSH 2.4 (0.5-5.4 µIU/ml) and Testosterone 480 ng/dl (65-800). This unusual change in his clinical profile and lipid was attributed to testosterone therapy even though his testosterone level was in the normal male range. He was not taking any other forms of over the counter cross-sex hormones. He was started on statin and gemfibrozil in addition due to his lifestyle changes for hypertriglyceridemia. He was asked not to take testosterone therapy until his next follow up.

In the next few months, his leg swelling worsened. He reported exertional shortness of breath, extreme fatigability, daytime sleepiness, and had not resumed his menstrual cycle. He was evaluated by a cardiologist for his worsening symptoms. His electrocardiogram showed a resting heart rate of 44 bpm and the echocardiogram (ECHO) did show mild pericardial effusion. Cardiologist ordered a full thyroid profile which showed a very low free T3 0.5 pg/ml (1.4-4.4 pg/ml), free T4 0.2 ng/dl (0.8-1.8) and a normal TSH 1.2 µIU/ml (0.5-5.3). He was advised to review with an endocrinologist for an abnormal thyroid function test.

Pituitary hormone evaluation showed secondary adrenal insufficiency, hypogonadism, and hypothyroidism. Magnetic resonance imaging (MRI) done showed an empty Sella syndrome. He was started on hormone replacement therapy and within one month all his symptoms resolved completely. His abnormal lipid profile normalized during follow up. He was restarted on testosterone treatment.

There are substantial barriers to care in the management of transgender individuals. Nearly 25% of the transgender individuals responded that they have been denied medical service and 30% reported that they have avoided medical care due to discrimination according to a web-based survey that included 6000 transgender individuals.[1] In this patient of mine, I did not think about the possibility of other medical conditions and attributed all his problems to cross-sex hormone treatment. It took nearly 8 months to diagnose pituitary hormone deficiency and start him on pituitary hormone replacement.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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There are no conflicts of interest.

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Sir,

Herein, we are describing a 52-year-old lady presented with blurring of vision for past 3 weeks presented to an ophthalmologist. Her evaluation showed optic atrophy in the left eye and hemianopia on the right side. MRI brain was ordered and it showed a pituitary macroadenoma along with suprasellar extension with a cystic area in the upper portion of macroadenoma [Figure 1]. She was referred to a neurosurgeon and he further referred her for endocrinology consultation. She was advised transsphenoidal surgery. However, due to financial constraints, she did not undergo surgery.

She was referred for review endocrine opinion. On enquiring further, she reported having a recurrent headache but no vomiting. She was postmenopausal and her prolactin level was 4549 ng/mL. Her thyroid function test was T3 83 ng/mL, T4 6.4 mcg/Dl and TSH 1.41, cortisol 10.8 mcg/dL, FSH 1.57 mIU/mL, and LH 0.1 mIU/mL.

MRI showed a sellar mass of 3.5 × 2.5 × 2.9 cm, superiorly compressing optic chiasma and bilateral cavernous sinus invasion. In addition, the superior aspect of the tumor had a non-contrast enhancing area, probably cystic area [Figures 1 and 2].

After cautioning her about the success rates with medical therapy and carefully keeping her under observation for further worsening of eye symptoms, cabergoline 0.5 mg daily for 4 days was started. After 4 days, her visual symptoms were slightly better and her serum prolactin was 58 ng/mL; hence, the same dose of cabergoline was continued for 10 more days. After 2 weeks of the start of treatment, her diplopia completely subsided and vision improved. Ophthalmology review revealed better vision in the right eye; however, the field of vision could not be mapped. Her prolactin levels were 3.1 ng/mL and cabergoline dose was reduced to 1 mg thrice a week.

After one month, her prolactin level was 14 ng/mL and ophthalmology review showed visual acuity of 6/6 and significant improvement in the field of vision. After 2 months her prolactin level was 0.97 ng/mL and cabergoline was reduced to 0.5 mg weekly twice and MRI was repeated. It showed sellar lesion reduced in size to 2 × 2.2 × 2.2 cm and cystic lesion completely disappeared [Figures 3 and 4].

Now after 6 months her eye symptoms and headache completely recovered and presently she is on cabergoline 0.5 mg weekly once.

Most of the prolactinomas are microadenomas which are more common in females; males, on the contrary, harbour more macroadenomas. Cystic prolactinomas are prolactinomas that harbor cystic regions, usually occupying ≥50% of the tumor volume. According to the pituitary society guidelines, surgery should be considered as a treatment for cystic macroadenomas causing neurological symptoms.

REFERENCE

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