The aim of this paper is to provide a review of gender dysphoria and current treatment modalities followed by a discussion of ethical concerns for the Catholic physician. Gender dysphoria is an incongruence between experienced and assigned gender. It is classified as a psychiatric illness with biological etiology likely stemming from in utero hormones and genetics. Gender dysphoria in children almost always resolves by puberty. Past puberty, the disease tends to persist and can be treated with psychotherapy with or without GnRH agonists. Side effects of GnRH agonists include bone mineral density loss and stunted growth. If the patient is eligible and ready, cross-sex hormones are typically started after age 16. Short term side effects of cross-sex hormones include 20% increase in blood clots for male-to-females and liver dysfunction in female-to-males. Long term effects, including risk of coronary artery disease and cancer are unknown. In adulthood, surgical sexual reassignment can be pursued. Surgical risks include three times increased risk of all cause mortality at 10 years when matched to non gender dysphoric controls. Due to its natural history of in utero hormone and genetic abnormalities, gender dysphoria may be a CNS variant of intersex which limits traditional ethical concerns. However, due to the lack of an evidence base, gender reassignment should be considered experimental and if possible, patients should be treated in a clinical trial. It is reasonable for Catholic physicians to utilize hormonal and surgical treatments for gender dysphoria if the benefits outweigh the risks. Further, if possible, patients should be placed in a clinical trial in order to better define the risk/benefit ratio for future patients.

### Medical Data

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
<th>Type</th>
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<tr>
<td>#1</td>
<td>N/A</td>
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### Natural History/ Treatment

#### In Utero

- **GnRH agonist:** Begin oral Bmpa at 8-12 months of gestation or at birth. Begin 100 mg every 6 months.

#### Adolescence

- **Transgender treatment paid for by:** VA Medicine, Some Medicaid, Blue Shield of California

### Fully Reversible Intervention

- **GnRH agonist:** Begin oral Bmpa at 8-12 months of gestation or at birth. Begin 100 mg every 6 months.

### Partially Reversible Intervention

- **GnRH agonist:** Begin oral Bmpa at 8-12 months of gestation or at birth.

### Non-reversible Intervention

- **Orchidectomy:** Transvesical total occlusion of vas deferens

### Lifelong Maintenance

- **Estrogen therapy:** May be lifelong for post-transsexual patients. Therapy may be increased in dosage as tolerated or decreased once secondary sex characteristics are essentially fully developed.

### Ethical Issues

1. Natural law says that gender is binary.
2. Some SRS require sterilization.
3. There is a lack of clinical evidence for treatment.

### Discussion

Because there is a reasonable medical possibility that the patient is indeed the stated gender, the ethical concern of natural law is resolved. Because sterilization is an incidental event rather than a goal, that ethical concern is resolved.

However, there have been no randomized controlled trials on any therapy, drug, or surgery for gender dysphoria. This poses an ethical issue for a health care provider as it is impossible to offer informed consent to the patient or to ensure that no harm is being done to them. This concern is resolved if patients are referred to providers actively researching these treatment.

### References

For a complete list of references please see the presenter.

### Gender Dysphoria Beyond the Televised Case Studies

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Portsmouth, NH

### ABSTRACT

The aim of this paper is to provide a review of gender dysphoria and current treatment modalities followed by a discussion of ethical concerns for the Catholic physician. Gender dysphoria is an incongruence between experienced and assigned gender. It is classified as a psychiatric illness with biological etiology likely stemming from in utero hormones and genetics. Gender dysphoria in children almost always resolves by puberty. Past puberty, the disease tends to persist and can be treated with psychotherapy with or without GnRH agonists. Side effects of GnRH agonists include bone mineral density loss and stunted growth. If the patient is eligible and ready, cross-sex hormones are typically started after age 16. Short term side effects of cross-sex hormones include 20% increase in blood clots for male-to-females and liver dysfunction in female-to-males. Long term effects, including risk of coronary artery disease and cancer are unknown. In adulthood, surgical sexual reassignment can be pursued. Surgical risks include three times increased risk of all cause mortality at 10 years when matched to non gender dysphoric controls. Due to its natural history of in utero hormone and genetic abnormalities, gender dysphoria may be a CNS variant of intersex which limits traditional ethical concerns. However, due to the lack of an evidence base, gender reassignment should be considered experimental and if possible, patients should be treated in a clinical trial. It is reasonable for Catholic physicians to utilize hormonal and surgical treatments for gender dysphoria if the benefits outweigh the risks. Further, if possible, patients should be placed in a clinical trial in order to better define the risk/benefit ratio for future patients.