Pregnancy During Transition

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This is a fictional case study meant to represent the medical need of an underserved and often slighted population of patients.

Case Overview

H.G. is a transgender man wishing to have a child after 36 months on masculinizing hormone treatment.

Patient Profile

- Initials: H.G.
- Age: 28
- Sex/Gender: Transgender man
- Gravida: 0
- Occupation: Starbucks barista
- Living situation/marital status: unmarried committed relationship
- Substance use (e.g. smoking, alcohol, street drugs): smokes one pack of cigarettes per week and drinks 5- 7 drinks per week, typically beer

Medical History

H.G. is a transitioning transgender man. In affirming his gender identity, he has undergone the following procedures: masculinizing hormone treatment, subcutaneous mastectomy and pectoral implants (“topsurgery”), rhinoplasty, and genitoplasty.

In addition to these, H.G. has suffered from migraines since age 12. He was in a car accident at age 22 during which he broke several ribs and his tibia. He has suffered from depression for most of his life and has taken 25mg of Paroxetine (Paxil) for the past 4 years without any major side effects.

Presenting Complaint

H.G. began medical treatments to guide in his transition approximately 36 months ago. He has remained on testosterone treatment and has undergone masculinizing facial surgery and “top-surgery”.

H.G. has a sperm producing partner and they would like to now have a child together. They would strongly prefer for H.G. to carry this child rather than using a surrogate or pursuing adoption.

Evaluation and Diagnosis

Movement off of masculinizing hormones can be associated with painful return of menses as well as considerable mental and social morbidity. We therefore first offered and provided a gynecological evaluation to assess if there are any major structural anomalies or pathophysiological entities that would be expected to complicate the pregnancy.

All evidence indicated good gynecological health suggesting reasonable chance of fertilization, implantation, and fetal growth.

Treatment

Cessation of hormone treatment was recommended. It was important to remind H.G. that return of menses can take six months or longer following cessation of hormones but that he can get pregnant prior to its return.[1]

The primary concern of H.G. and his partner surrounded risk of congenital defects in their child as a result of his testosterone use. Past work has shown high (endogenous) androgen levels to be associated with lower birth weight[2,3] and lower infant weight gain[3], though work to date has not examined risk specifically in transgender men (who receive exogenous androgens). Some work indicates hyperandrogenism may lead to epigenetic changes in the oocyte leading to increased incidence of glucose metabolism disorder in offspring[4], though more work is needed. In light of the lack of work to support negative consequences from H.G.'s testosterone treatment, we supported their decision to conceive but advised that they wait to try to have children until H.G.'s testosterone levels return to normal female physiological range to minimize risk of reduced birth weight.

Discussion

Some transgender men still want to have children after having begun transitioning. Masculinizing hormone treatments can complicate this process (as they do in this case) and surgeries can complicate or preclude it. In light of these complications, providers should discuss with patients whether they have any future interest in having offspring and provide options such as cryofreezing eggs prior to providing such care. Cryofreezing could enable the patient to avoid cessation of hormones if they wished to use assisted reproductive technologies at a future time.[5] Additionally, the strong gender associations present in our society linking pregnancy and femininity can complicate the self-image of a trans man as the carrier of their own child.

This violation of typical gender roles surrounding pregnancy can make pregnant parents feel isolated, and interviewed parents have reported the "lack of clear role models of what a positive, well integrated, gender-variant parental role might look like," to be especially difficult.[6] The importance of the physician to provide a supporting and accepting environment is stressed. This can begin with asking the patient for their preferred name and pronouns.[7]

The entire medical team should also be familiarized with what it means to be transgender and similarly play an integral role in providing a supportive environment for the parent-to-be.

Particular attention has been paid toward the importance of knowledgeable nursing staff around transgender men's identities and their post-partum needs, particularly surrounding lactation.[8] Obstetric care and delivery do not appear to differ in pregnancies of non-gender conforming and transgender patients and cisgender patients' pregnancies. In light of the increased incidence of depression and suicidal ideation amongst transgender individuals,[9,10] care focusing on prevention, detection, and treatment of post-partum depression may be warranted.

While transitioned and transitioning parents do present some clinical challenges, they are more like to other obstetric patients than different: they require a careful history with care adjusting accordingly, an accepting medical environment, and standard obstetric monitoring. By providing these patients with the care they need, we can help to ensure both their safety and the safety of their future children.

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