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Opinion

A Transgender Guy on Testosterone Treatment Developed Endometrial Intraepithelial Neoplasia on Male Reproductive System

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ABOUT THE STUDY

To induce masculinization in transmasculine persons, testosterone is widely utilized as gender-affirming treatment. While some people develop endometrial shrinkage while on testosterone, others do not. Reports of gynecologic malignancies, particularly endometrial carcinoma, in transmasculine individuals on testosterone are relatively rare. Changes in social gender expression, psychotherapy to explore and improve understanding of one's own gender identity, hormone therapy to achieve masculinization or feminization, and surgical removal or reconstruction of sex-related tissues such as the genitalia and reproductive organs are all interventions aimed at gender affirmation in transgender patients. To live in their gender identity, many transgender patients employ a combination of these techniques. Transgender patients experience severe health inequalities across all socioeconomic levels across the world, and prejudice and a lack of understanding from physicians are important barriers to care for this group. A 32-year-old transgender male with gender dysphoria arrived for gender-affirming hysterectomy consultation. He'd been on testosterone for four years and had had a bilateral mastectomy and masculine chest reconstruction. After 6 weeks of testosterone treatment, he became amenorrheic. He afterwards revealed substantial distress over vaginal bleeding that he had experienced before changing his testosterone level. He did not report any vaginal bleeding or discharge, pelvic discomfort, hematuria, dysuria, or any symptoms at his initial session. Only the childhood congenital cataract removal and his gender-affirming bilateral mastectomy and chest reconstruction were remarkable in his surgical history.

Data on the risk of gynecologic malignancy in transmasculine people is limited, owing to the low frequency of these tumours and a lack of large-scale investigations in this community. The connection between sex hormone treatment and carcinogenesis in reproductive tissues is still being studied. Androgens such as testosterone are used to produce masculinization in transmasculine people taking hormone treatment for gender affirmation. The endometrium's response to androgen treatment is unknown. The significant frequency of amenorrhea among transmasculine testosterone users has led to the conclusion that testosterone, particularly its very powerful metabolite Dihydrotestosterone (DHT, generated by testosterone reduction by 5-reductase), cause endometrial atrophy. Transgender males who use testosterone treatment are at increased risk of developing endometrial cancer and EIN. A workup that includes neoplasia in the differential should be performed if there is abnormal vaginal bleeding. The risk of malignant endometrial pathology is poorly characterised, and further research is needed to enhance oncologic treatment delivery in this group.

CONCLUSION

However, the evidence currently available is inadequate to demonstrate a definite relationship between testosterone therapy and endometrial cancer development. The exceedingly low rate of gynecologic malignancies in testosterone recipients implies that testosterone is safe for gender affirming treatment. Furthermore, even if testosterone does cause endometrial cancer, the length of testosterone exposure prior to hysterectomy may be too brief in most cases to be clinically meaningful. More research is needed to determine the risk of gynecologic cancer in transgender males, and individuals undergoing hormone treatment should not be denied cancer screening and monitoring. Vaginal bleeding is normal for the first 1-6 months after starting testosterone treatment. If bleeding persists after 6 months, more testing should be performed to determine the cause.

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