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Medical Advisory Bulletin

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Polycystic Ovary Syndrome in FTM Transsexual Persons

The Problem

Polycystic Ovary Syndrome (PCOS) is a medical condition that may affect as many as 25% of Female-to-Male (FTM) transsexual persons. The symptoms of PCOS may include hirsutism (in the absence of androgen treatment), irregular or absent menses, dysmenorreah (painful menses), obesity, and, rarely, true virilization. However, many people show no obvious symptoms. Persons with PCOS are at increased risk for endometrial hyperplasia (overgrowth of the lining of the uterus), endometrial cancer, and breast cancer. Polycystic ovaries and uterine fibroids, which may or may not be related to PCOS, are common in FTM people and may be aggravated by testosterone therapy.

Advisory

Persons with symptoms of PCOS should consult their physicians concerning possible diagnostic tests. The usual treatment for PCOS is administration of progesterone, with or without estrogen – therapy which some FTM transsexual persons might find undesirable. Combined with exogenously administered testosterone, the effects of the hormonal imbalances inherent in PCOS could lead to serious lipid metabolism alterations and consequent heart disease. In some cases, the diagnosis of PCOS might constitute a justification for hysterectomy and salpingo-oophorectomy (surgical removal of the uterus, tubes and ovaries). All FTM persons, prior to starting testosterone, should consider having pelvic and/or transvaginal ultrasound to look for cystic ovaries and fibroids, and a blood test to determine any elevation of adrenal androgens. Patients with PCOS or problematic tissue should discuss treatment options and side effects with their physicians.

Discussion

PCOS affects from 1 to 5% of the natal female-bodied population; yet it is estimated that 25% of FTM people are afflicted with the syndrome. In 70% of PCOS cases, the condition is accompanied by elevated levels of dehydroepiandrosterone. In more than 50% of cases another adrenal androgen, 11beta hydroxy androstenedione, is elevated. These substances increase the risk of heart disease and hypertension. In FTMs, surgery to remove the uterus and polycystic ovaries may be advisable. However, it is not always easy for an FTM person to obtain such surgery. If an FTM is transitioned or cross-living and insured as a man, his insurance company is likely to balk at the revelation of his female body parts that need attention. Ironically, if the FTM individual is known as a female, doctors may be reluctant to remove reproductive organs and preclude childbirth. If the person has also revealed his FTM identity, doctors may be reluctant to perform a salpingo-oophorectomy because they see the procedure as assisting in the masculinization process, and they may not wish to be involved in providing medical treatment for what they view as a psychiatric condition. Insurance companies also may deny payment for the procedure if they deem it associated with sex reassignment, which is almost always excluded from coverage in the U.S. Trans-positive healthcare reform must include the acknowledgement that human bodies deserve medical care regardless of the gender identity they present or contain. PCOS is not a psychiatric condition, and if an FTM person has the disease, he should be treated for it with every consideration given to relieving both the physical distress caused by the disease, and the emotional distress caused by being male-identified and living in a female body. Until such reforms are in place, every FTM person must negotiate his own solution to the PCOS problem.

See Balen, A.H., et al. (1993) Polycystic ovaries are a common finding in untreated female-to-male transsexuals. *Clinical Endocrinology*, 38(3), 325-329.

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