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Comments on the «Clinical practice guidelines for the assessment and treatment of transsexuality» issued by the sexual identity and differentiation group of the SEEN (GIDSEEN)[☆]



Comentarios sobre las «Guías de práctica clínica para la valoración y tratamiento de la transexualidad», emitidas por el Grupo de identidad y diferenciación sexual de la SEEN (GIDSEEN)

Sir,

Moreno-Pérez and Esteva de Antonio have recently claimed, on behalf of the Sexual Identity and Differentiation Group of the Spanish Society of Endocrinology and Nutrition (GIDSEEN),¹ that we need a coordinated action protocol to provide integral health care to transsexual people in the framework of the benefits of the National Health System (SNS), i.e. throughout Spain. It is true that such national care to transsexual people does not exist (yet), and it is indeed desirable, particularly in order to harmonize and provide equal health care in all the regions.²

The new 2012 version of the «Clinical practice guidelines for the assessment and treatment of transsexuality»¹ was published in full awareness of the Standards of Care (SOC)-7,³ quoted by Moreno-Pérez and Esteva de Antonio.¹ In the scientific opinion of the author, however, this new version of the Spanish guidelines¹ lacks clarity and topicality in several aspects and demands unnecessary care systems and environments, not to mention some conditions some-

times counterproductive which are mentioned and discussed below:

- 1) The authors state that adequate care to transsexual people may only be provided at the so-called “functional units”. i.e. that the three PES components (clinical psychiatry and/or psychology, endocrinology and surgery) should be concentrated at a single gender identity disorder unit (GIDU) of the same hospital, preferably a teaching hospital. This option may be challenged by arguing that new technologies allow for excellent and fast communications between the different members of the multidisciplinary PES team. If this team does not work at the same clinic, which is very common in other European countries and the United States, transfer of the required information between the psychologist and the endocrinologist, or between these and the plastic surgeon, should suffice. Only a confirmation phone call, which would hardly impair the efficacy of care to transsexual patients, would be required. The same considerations apply to useless patient referrals (e.g. from Asturias to the Malaga GIDU, a trip of 2000 km, just for blood sampling and testing). Instead of this, mutual recognition of clinical test results may be used, because laboratories from all hospitals, not only teaching hospitals, are integrated in a quality control system.
- 2) Moreno-Pérez and Esteva de Antonio¹ emphasize that diagnosis of GID or transsexualism should be a «prolonged and complex process under rigorous, extensive control». Exactly the same definition is found in the Madrid GIDU guidelines, which, unlike those of the Malaga GIDU, do not consider transsexualism to be a mental disease,⁴ while the Barcelona GIDU applies international standards more flexibly, particularly as regards individualized diagnostic times (E. Gomez-Gil, personal information). In the related literature, many authors from other countries have stated that transsexualism, which does not require psychotherapy in most cases, may be diagnosed after only 4–5 appointments of 40–45 min.⁵ SOCs require an accurate, but not necessarily long, evaluation. By contrast, comprehensive evaluation is needed for diagnosis in minors and adolescents, or in patients with some psychopathology.

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- 3) Moreno-Pérez and Esteva de Antonio¹ state that the so-called real life test (RLT) or real life experience (RLE) are still part of SOC-7,³ which is not true. Moreover, this new edition includes many updates aimed at promoting the health, dignity, autonomy, well-being, and gender diversity of patients. The terms RLT or RLE only appear in the section of references of this seventh edition, where they are included in the titles of some previous publications. The relevant point is that eligibility for hormone prescription or minor surgery does not require patients to live for a given time in their desired gender. Only informed consent is required. Only for sex reassignment surgery (SRS), are the patients required, in addition to diagnosis and feminizing or masculinizing hormone therapy for 12 months, to have lived in a gender role consistent with their gender identity. That is, eligibility does not depend on the existence of a stereotypical female or male role in its traditional and binary understanding. Patients are given the freedom to define their own sex/gender identity.
- 4) As regards the etiology of transsexualism, Moreno-Pérez and Esteva de Antonio¹ believe in speculative genetic and hereditary disorders which have not yet been demonstrated: the human genome was fully sequenced in 2001, and no gene encoding for a factor clearly related to transsexualism is known yet. Moreover, some of the studies mentioned (refs. 12 to 16, especially those relating to the birth order ratio of twins, obsolete references) have been questioned by the scientific community.⁶ Moreno-Pérez and Esteva de Antonio also deny the impact of sex steroids on brain development and function, despite the fact that many scientific studies have clearly demonstrated such an influence.⁷
- 5) As regards the prevalence of transsexualism, the figures should be updated, and a comment is in order: a Belgian study published in 2007 is missed in Table 1 of the Moreno-Pérez and Esteva de Antonio article.¹ This study reported rates of 1:12,900 (m > f) and 1:33,800 (f > m), with huge differences between data from large cities and villages, on the one hand, and from Flanders (with a predominantly Protestant population) and the Walloon region (Catholic), on the other.⁸ In general, the worldwide prevalence (epidemiology) of transsexuals is significantly underestimated in the references cited, and the two authors indeed speculate about the underestimation of such figures (which they give as 1 in every 4000 people), incorrectly citing reference 6 (GIRES, England). That is to say, the prevalence rate in this 2009 study has itself been inadequately interpreted; it is approximately 1 per 500 of the population.⁹ But even these data are

now obsolete: the most recent studies reported in 2011 and 2012 (GIRES and a Dutch study) show that approximately 1% of the population in these countries feels or experiences some degree of gender dysphoria.^{10,11} These figures are probably applicable to the Spanish population, also.

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