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SUPPORTING TRANSGENDER MALE PATIENTS THROUGH FERTILITY TREATMENT: AIDING CREATION OF THE MODERN FAMILY THROUGH ASSISTED REPRODUCTIVE TECHNOLOGY

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OBJECTIVE:

Recent advances in reproductive rights have granted increased access to assisted reproductive technology (ART) treatment for transgender patients. Several articles have described fertility considerations in transgender people including the desire to have children, effects of hormonal and surgical therapies on future fertility, and current fertility preservation options.¹⁻³ However, data is still limited regarding the overall FTM experience with fertility treatment. This study aims to describe our center's experience supporting FTM transgender patients in their journey through fertility treatment.

MATERIALS AND METHODS:

This retrospective cohort study identified all FTM transgender patients presenting to care at a single academic center between 2013 and 2021. Information collected included baseline demographics, number of patients who progressed to treatment, treatment pathways, and challenges faced.

RESULTS:

A total of 16 patients who identified as transgender male were identified, of whom 9 progressed to treatment. The average age was 29 ± 4.9 years old and mean BMI was 23.7 ± 4.3 . Two patients had partners who also identified as transgender. Mean AMH was 5.3 ± 3.2 and mean basal antral follicle count (BAFC) was 21.3 ± 7.4 . Planned cycle types included IVF (n=2), reciprocal IVF (Co-IVF) (n=3), IUI (n=4), oocyte freezing (n=6), and embryo freezing (n=1). Of the five planned IVF & Co-IVF cycles, one patient underwent a fresh embryo transfer and achieved a live birth. One patient froze embryos and three have yet to start treatment. Of the four patients who underwent an IUI, all patients were discharged with ongoing pregnancies and two have achieved a live birth. Of the six planned egg freezing cycles, three patients completed retrieval and cryopreserved eggs while the remaining three patients have yet to start treatment. Of these, two desired cryopreservation before proceeding with gender affirming total abdominal hysterectomy and bilateral salpingo-oophorectomy. One patient desired cryopreservation before gender affirming total abdominal hysterectomy. Two wanted to freeze their eggs prior to starting testosterone therapy, and one patient did not have plans for hormonal therapy or gender affirming surgery. The patient who planned embryo cryopreservation has also not yet started treatment. Patient care was optimized through proper attention to preferred pronouns, aided by the use of cycle reminders.

CONCLUSIONS:

This study enhances our understanding of the transgender patient journey through fertility treatment.

IMPACT STATEMENT:

Transgender individuals continue to face adversity, stigma, and inequality, especially in the healthcare setting. With advances in access to care and modern medicine, ART has helped empower transgender patients to balance their goals of transitioning to the gender they identify with



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while also building a modern family structure. As we further understand challenges that the transgender community faces in reproductive health care, we will be able to make progress in targeting and tailoring healthcare to support their family building journeys.

REFERENCES:

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