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Letter to the Editor

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Letter to the Editor from William J. Malone et al: "Proper Care of Transgender and Gender-diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective"

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We agree with Walch et al that medical treatments should be based on scientific evidence rather than becoming political matters (1). However, Walch et al endorse a position statement by the Endocrine Society (ES) that is unsupported by the available evidence.

Walch et al endorse the ES position that puberty suppression (PS), cross-sex hormones (CSH), and surgeries are "effective," "relatively safe," and have been "established as the standard of care" (2). However, the ES clearly states that its practice guidelines "cannot guarantee any specific outcome, nor do they establish a standard of care" (3). The World Professional Organization for Transgender Health (WPATH) also acknowledges that despite the misleading name, WPATH Standards of Care 7 are also *practice guidelines*, not standards of care (4). Unlike standards of care, which should be authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased. In addition, the ES claim of effectiveness of these interventions is at odds with several systematic reviews, including a recent Cochrane review of evidence (5), and a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being (6). Lastly, the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret.

Walch et al also endorse the ES position, claiming there is an established "durable biological underpinning" to gender identity (GI) (2). However, the first citation supplied by the ES for this position highlights contradictory studies and describes the biological origin of gender dysphoria (GD) as simply a "current hypothesis" (7). The other citation describes GI as a "complex interplay of biological, environmental, and cultural factors" (8). Further, the concept of "durability" is challenged by the fact that most cases of GD in children naturally resolve by adulthood. It is precisely this lack of durability that should give pause to administering potentially harmful and often irreversible medical interventions to young patients with GD.

The ES position statement also overlooks a key fact that the existing body of evidence regarding treatment outcomes for GD was not only graded as "low quality," but has been derived from a vastly different population than the one presenting with GD today. Currently, GD predominantly

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presents in adolescent females with no childhood history, in contrast to the prior predominantly male and childhood-onset GD presentation. It is not yet known whether this novel patient segment, which remains poorly understood and largely unstudied, will benefit or be harmed by hormonal and surgical interventions.

We concur with the 3rd ES position calling for more research. However, we are concerned that bias and politicization are preventing an honest scientific debate about interventions that carry lifelong implications for young people. There is a need for increased funding not only to better understand the natural history of this condition and its sharp increase in adolescent females, but also to help determine the optimal care of youth with GD.

Additional Information

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