Cancer Care in Transgender Youth Patients: Things to Consider

Oncologists should take gender identity into account in making decisions about cancer treatment.

April 12, 2021 By Dana-Farber Cancer Institute

Increasingly, transgender youth and adults are undergoing (or planning) gender-affirming surgery and taking masculinizing or feminizing hormones. If they have cancer, these treatments can have implications for their care, and cancer treatments in turn can have implications for their gender-affirming care.

Oncologists should take gender identity into account in making decisions about cancer treatment. This starts with a respectful and open discussion.

“If they’re not asked, patients may not disclose their gender identity to a clinician — especially teens or young adults who find it hard to advocate for themselves,” says Carly Guss, MD, MPH, an adolescent/young adult medicine physician at Boston Children’s who is part of the hospital’s Gender Multispecialty Service (GeMS) and Division of Endocrinology. “In other cases, minors may disclose to their clinician but not to their family.”

Care decisions can be complex, especially when cancer develops in a reproductive organ the patient has chosen to keep, such as ovarian or breast cancer in transmasculine patients or prostate cancer in transfeminine patients.

“There are very few guidelines on cancer care in transgender patients,” notes Kevin Liu, MD, DPhil, a radiation oncology resident at Boston Children’s Hospital, Dana-Farber Cancer Institute, and Brigham and Women’s Hospital. “And there are almost no data.”

Transgender patients with cancer: A case series

In a recent study in JAMA Oncology, Liu, Guss, and other colleagues reviewed the records of 37 transgender patients diagnosed with a variety of cancers, eight of them at age 18 or younger. Daphne Haas-Kogan, MD, chair of Radiation Oncology at Dana-Farber Cancer Institute, Brigham and Women’s Hospital, and Boston Children’s Hospital, was a coauthor on the study.

Of the 37 patients, 28 had received gender-affirming hormone therapy, 16 had undergone at least one gender-affirming operation, and 16 initiated gender-affirming hormones or surgery after being

diagnosed with cancer.

Notably, only five had documented conversations with their oncologist about potential interactions between their gender-affirming and cancer treatments. These included:

- the decision to have gender-affirming mastectomy in the unaffected breast in a transgender man with breast cancer
- the potential effect of radiation therapy on a transgender woman's breast implant
- the impact of elective orchiectomy on prostate cancer treatment in a transgender woman
- the potential impact of gender-affirming estrogen therapy on levothyroxine dosing for hypothyroidism (secondary to a hematopoietic stem cell transplant)

These are just a few care scenarios that can come up. Many will raise issues that are sensitive for patients, and all decisions are highly individual.

Starting a dialogue

It's important to put patients at ease when you meet. Many transgender patients are reluctant to come to medical appointments, having experienced discrimination or made to feel "other" in health care settings. Cancer screenings like mammograms, cervical exams, and even colonoscopies often cause stress. Patients may put off care and present with later-stage disease, and then be reluctant to come for treatments.

Liu and Guss offer this advice:

- First, respectfully ask about patients' gender identity and pronouns. Record these details — including patients' chosen name — in their medical records, with their permission. Some patients may be non-binary. Consider updating your EMR systems if needed to incorporate this information.
- Ask transgender patients about their transition goals. If they have started gender-affirming treatment, ask for a list of their medications. "It is important to understand where they are in that process and what they are comfortable discussing," says Liu.
- Broach a discussion of how cancer treatments may affect the patient's outward gender expression. Be frank and detailed, including specific effects on the anatomy. For example, radiation covering the chest may affect the cosmetic outcomes of top surgery (double mastectomy) in a transmasculine patient or breast augmentation in a transfeminine patient.

- Balance concerns about possible medical risks from gender-affirming hormones (see below) against patients' overall needs. "Gender-affirming hormones are associated with reduced depression and reduced suicidal thoughts — and so can be lifesaving," notes Guss.
- Continue revisiting potential long-term effects of cancer treatment that may impact gender-affirming care.
- For patients who transition after starting or completing cancer care, continue discussions about gender-affirming treatments during follow-up cancer survivorship care.

Guidelines for oncology practices in caring for transgender patients

Care for transgender patients should ideally involve not just oncologists, but other specialists such as adolescent medicine physicians, endocrinologists, psychosocial providers, and in some cases gynecologists or urologists. In a 2019 commentary in The Lancet Oncology, Liu, Haas-Kogan, and other colleagues offer several practice recommendations, including:

- Seek formal training for all staff on transgender patients' health needs. Courses are available through organizations such as the World Professional Association for Transgender Health (WPATH).
- Review clinic procedures and layout. For example, it is important to have gender-neutral single-occupancy bathrooms changing and waiting rooms. Providing a supportive clinic environment will further help patients navigate their often difficult treatment courses.
- Document transgender patients' experiences and outcomes, and incorporate them in publications. Even case reports and small qualitative studies soliciting patients' stories are helpful in defining best practices, and will add to a literature that is still very sparse.

Are there risks from gender-affirming hormones?

Gender-affirming hormones can pose a risk for patients with hormone-sensitive cancers; however, data specifically from transgender individuals are limited. It's unclear whether gender-affirming hormones increase the risk for developing cancer or for recurrence in cancer survivors, as no prospective cohort studies have addressed this question.

Secondary questions can also arise. For example, should a transmasculine patient who develops premature ovarian failure due to cancer chemotherapy receive estrogen supplementation for bone health? Many transmasculine patients would prefer testosterone, and it is important for endocrinologists to be part of such discussions.

A recent case report discussed a 17-year-old transmasculine patient who developed a serous borderline ovarian tumor while receiving testosterone and underwent a right salpingo-oophorectomy. His care team, including Kate Millington, MD, (endocrinology), Sarah Pilcher, MSN, RN, CPNP (endocrinology), and Allison O'Neill, MD (Solid Tumor Center, Dana-Farber/Boston Children's Cancer and Blood Disorders Center), eventually restarted his testosterone and is following him with abdominal rather than transvaginal ultrasound per his preference. The team proposes establishing a registry for reproductive-tract tumors in transgender patients.

This article was originally published on March 30, 2021, by Dana-Farber Cancer Institute. It is republished with permission.

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