COMITATO PER LE PARI OPPORTUNITÀ

ORDINE AVVOCATI TORINO

In occasione della giornata internazionale contro l'omolesbobitransfobia che si celebra il 17 maggio di ogni anno il CPO e il COA organizzeranno l'evento

I DIRITTI TRA(N)SVERSALI

I percorsi di transizione di genere dal riconoscimento all'effettività del diritto, quali tutele?

16 MAGGIO 2025 h. 14:30/17:30

In presenza

Biblioteca del Consiglio dell'Ordine degli Avvocati presso Curia Maxima, Via Corte d'Appello 16 - Torino

Saluti Istituzionali
Avv.ta Simona GRABBI, Presidente Coa di Torino
Avv.ta Cesarina MANASSERO, Presidente CPO di Torino

INTERVERRANNO:
Dott.ssa Daniela GIANNONE, già Giudice presso il Tribunale di Torino, sezione famiglia
Il percorso di affermazione di genere in sede giudiziaria

Dott.ssa Giorgia FENOCCHIO e **Dott.ssa Chiara CRESPI**, psicologhe
Aspetti psicologici nei disturbi della differenziazione sessuale
La presa in carico psicologica delle persone transgender

Dott.ssa Giovanna MOTTA, specializzata in endocrinologia e malattie del ricambio
Il percorso di affermazione di genere dal punto di vista medico-sanitario

Avv. Marco RAPICAVOLI, Foro di Torino
Corsa ad ostacoli nel percorso di affermazione di genere

Avv.ta Daniela DI ROSA, Foro di Torino, componente della Commissione Relazioni Internazionali e Diritti Umani del Coa di Torino
Soggettività queer e diritto alla protezione internazionale

Moderano l'evento:
Avv. Wisam ZREG, Foro di Torino, Componente Commissione Relazioni Internazionali e Diritti Umani del Coa di Torino e Componente CPO
Avv.ta Monica DELLA GATTA, Foro di Torino, Componente CPO

Il percorso di affermazione di genere dal punto di vista medico-sanitario

Giovanna Motta

SC Endocrinologia, Diabetologia e Metabolismo U

CIDIGEM (Centro Interdipartimentale Disforia di Genere Molinette)

AOU Città della Salute e della Scienza di Torino

Torino, 16/05/2025

AZIENDA OSPEDALIERO - UNIVERSITARIA
Città della Salute e della Scienza di Torino

Il punto di vista dell'endocrinologo

Complessità e multidisciplinarietà…

SIGIS Società Italiana Genere Identità Salute

https://www.sigis.info/

Terapia medica di affermazione di genere

Prima di partire…

1) informare e discutere in modo critico*: rischi e benefici del trattamento ormonale- compreso tema fertilità e genitorialità*

→ consenso informato

→ Farmaci off label

2) A comprehensive medical history and laboratory/instrumental evaluations are necessary to assess risks/contraindications for hormone therapy

	Baseline
AMAB trans people	Clinical evaluation (including BP and BMI) LH, FSH, total testosterone, estradiol, prolactin levels, blood counts, renal and liver function, lipid and glucose profile Thrombophilia screening panel* BMD in older than 60 years or in those who are not compliant with hormone therapy
AFAB trans people	Clinical evaluation (including BP and BMI) LH, FSH, total testosterone, estradiol, prolactin levels, blood counts, renal and liver function, lipid and glucose profile BMD in older than 6 0 years or in those who are not compliant with hormone therapy

HCP should explore e *nderlying reasons.*

→ It is essential to ex transgender people in order to offer a **pers**

2) necessaria

- anamnesi familiare e personale accurata
- esami ematochimici e strumentali

per valutare i potenziali rischi e/o controindicazioni alla terapia ormonale

	Baseline
AMAB trans people	Clinical evaluation (including BP and BMI) LH, FSH, total testosterone, estradiol, prolactin levels, blood counts, renal and liver function, lipid and glucose profile Thrombophilia screening panel* BMD in older than 60 years or in those who are not compliant with hormone therapy
AFAB trans people	Clinical evaluation (including BP and BMI) LH, FSH, total testosterone, estradiol, prolactin levels, blood counts, renal and liver function, lipid and glucose profile BMD in older than 6 0 years or in those who are not compliant with hormone therapy

Fisher et al, JEI 2022 Oct 22

3) *HCP are advised to provide a safe and non-judgmental environment* *to allow transgender people to freely express themselves*

Fisher et al. SIGIS-SIAMS-SIE position statement of gender affirming hormonal treatment in transgender and non-binary people. J Endocrinol Invest. 2022 Mar;45(3):657-673

Terapia di affermazione di genere: scopo

The main purpose of GAHT is to improve the quality of life, primarily through alignment of the physical features with the GI.

Gender-affirming hormonal treatment

Recommendation: We recommend HCP exploring together with transgender people wishing GAHT their individual needs and to offer a personalized clinical approach (1⊕⊕OO).

We recommend counseling transgender people against GATH self-prescriptions and use of unauthorized drugs available on the market (mainly on internet).

The GAHT aims to reduce the action and the levels of the endogenous hormones and replace them with the sexual steroids of experienced gender, following the principles of hormone replacement therapy in hypogonadal biological male and men.

Fisher et al. SIGIS-SIAMS-SIE position statement of gender affirming hormonal treatment in transgender and non-binary people. J Endocrinol Invest. 2022 Mar;45(3):657-673

CONSENSUS STATEMENT

SIGIS–SIAMS–SIE position statement of gender affirming hormonal treatment in transgender and non-binary people

A. D. Fisher[1] · G. Senofonte[2] · C. Cocchetti[1] · G. Guercio[3] · V. Lingiardi[4] · M. C. Meriggiola[5] · M. Mosconi[6] · G. Motta[7] · J. Ristori[1] · A. M. Speranza[4] · M. Pierdominici[8] · M. Maggi[9] · G. Corona[10] · F. Lombardo[2]

Table 1 Hormonal treatment for binary trans people available in Italy

Desired effect	Hormonal compounds	Mode of administration and recommended dose
Masculinization	Mixed T esters preparations	Intramuscularly, 250 mg every 3 weeks
	T enanthate	Intramuscularly, 250 mg every 2–4 weeks
	T undecanoate[a]	Intramuscularly, 1000 mg every 12 weeks
	T gel 1–2%	Transdermal, 50 mg/day (available in dispenser pump or as single dose sachets)
De-masculinization	Cyproterone acetate	Oral, 10–50 mg/day
	Spironolactone	Oral, 100–200 mg/day
	GnRHa (leuprolide, triptorelin)	Intramuscularly or subcutaneously, 3.75 mg monthly or 11.25 mg every 3 months
Feminization	Estradiol valerate	Oral, 2–6 mg/day
	Estradiol	Transdermal, patch 25–100 mcg/24 h twice or once weekly
	Estradiol hemihydrate	Transdermal, gel 1.5–3 mg/day (available in dispenser pump or as single-dose sachets)

[a]One thousand milligrams initially followed by an injection at 6 weeks then at 12 weeks

T testosterone, *GnRHa* gonadotropin-releasing hormone analogs

Fisher et al. SIGIS-SIAMS-SIE position statement of gender affirming hormonal treatment in transgender and non-binary people. J Endocrinol Invest. 2022 Mar;45(3):657-673

TERAPIA ORMONALE GENDER AFFIRMING

Transgender men (transgender assigned female at birth- AFAB)

TESTOSTERONE

The principles of hormone replacement therapy in hypogonadism are followed

Table. 2. Hormone treatment in AFAB people

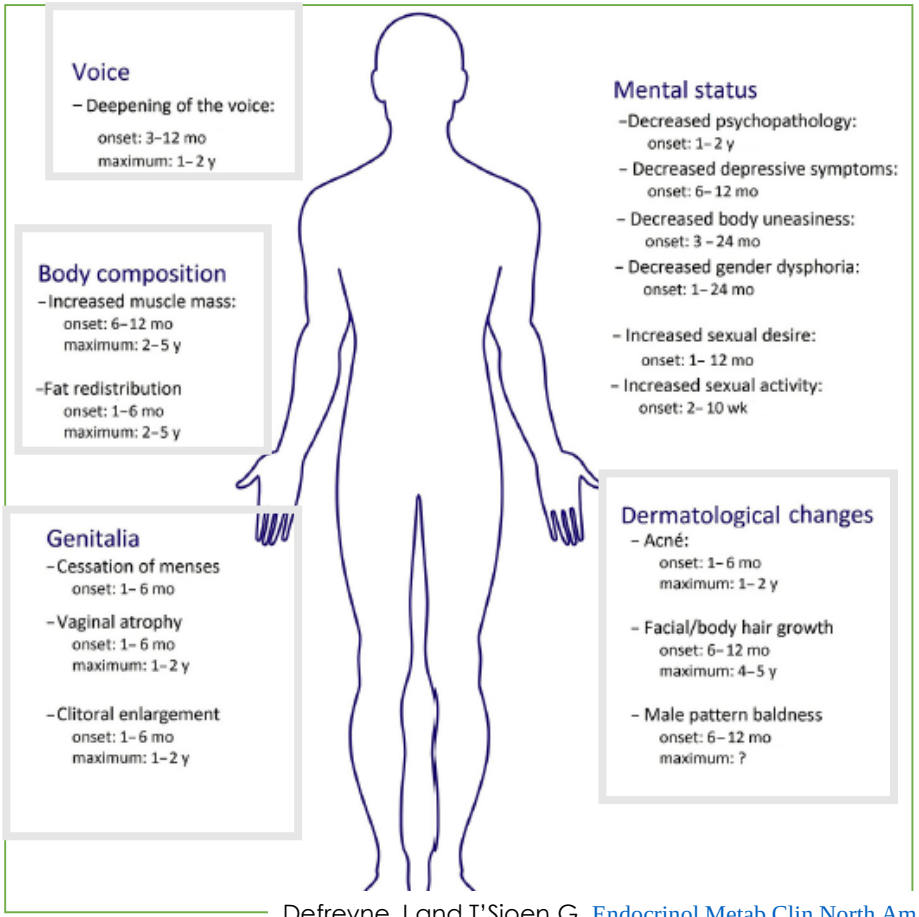
	Mode of administration		Type	Dosage	Frequency
Testosterone	Parenteral	Intramuscular	Testosterone esters	200–250 mg	Every 2–3 weeks
			Testosterone undecanoate	1,000 mg	Every 10–12 weeks
		Subcutaneous	Testosterone esters	75–125 mg	Every week
	Transdermal		Androgen gel	25–100 mg	Once daily
	Oral		Testosterone undecanoate	160 mg	Once or twice daily
Progestational agents	Oral		Lynesterol	5–10 mg	Once daily
			Medroxyprogesterone	5–10 mg	Once daily
	Parenteral		Medroxyprogesterone	150 mg	Once every 3 months

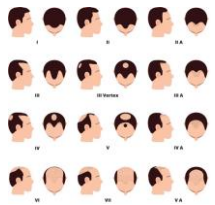
AFAB = assigned female at birth.

serum T levels within the adult **cisgender men range**

T'Sjoen et al.,J Sex Med. 2020 Apr;17(4):570-584

Efficacy





Defreyne J and T'Sjoen G. Endocrinol Metab Clin North Am. 2019;48(2):357-375

Timing

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a] Prevention and treatment as recommended for biological men.

[b] Menorrhagia requires diagnosis and treatment by a gynecologist.

Hembree et al., J Clin Endocrinol Metab, November 2017, 102(11):1–35

Safety

Erythrocytosis

Very high risk of adverse outcomes:

- Erythrocytosis (hematocrit > 50%)

Moderate risk of adverse outcomes:

- Severe liver dysfunction (transaminases > threefold upper limit of normal)
- Coronary artery disease
- Cerebrovascular disease
- Hypertension
- Breast or uterine cancer

ENDOCRINE SOCIETY

Lipid profile

Hembree et al., J Clin Endocrinol Metab, November 2017, 102(11):1–35

TERAPIA ORMONALE GENDER AFFIRMING

Transgender women (transgender assigned male at birth-AMAB)

Transgender women

Full feminization and de-masculinization in AMAB trans people

Recommendations:

We recommend using estradiol in association with anti-androgen therapies to induce desired phenotypical effects in AMAB trans people wishing a full feminization and a full de-masculinization (1⊕⊕⊕O).

We recommend against the use of esterified estrogens (ethinyl-estradiol, EE) and nonhuman derived estrogens (conjugated equine estrogens, CEE) (1⊕⊕⊕O).

We suggest using cyproterone acetate (CPA), spirono-lactone or gonadotropin-releasing hormone analogs (GnRHa) as antiandrogens (2⊕⊕OO).

We suggest against the routine use of progestins as part of feminizing hormonal treatment (2⊕OOO).

We recommend informing binary trans AMAB people on the expected effects of hormonal treatment (1⊕⊕OO).

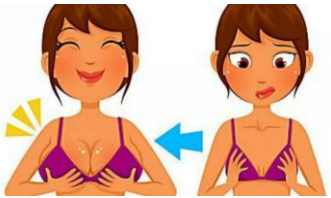
Table 1. *Gender-affirming hormone treatment in trans women [23]*

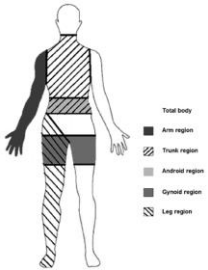
	Mode of administration	Type	Total dose	Frequency
Estrogen	Oral	Estradiol (17beta-estradiol valerate)	2–6 mg	Once or twice daily
	Parenteral (intramuscular)	Estradiol valerate	5–30 mg	Every 1–2 weeks
		Estradiol cypionate	2–10 mg	Every week
	Transdermal	Estradiol patch	25–100 g/24 h	New patch every 3 days
		Estradiol gel	1.5 mg	Once or twice daily
Antiandrogens	Oral	Spironolactone	100 mg	Once or twice daily
		Cyproterone acetate	10–(50) mg	
Gonadotropin-releasing hormone agonists	Intramuscular Intramuscular or subcutaneous	Triptorelin	11.23 mg 3.75 mg	3 monthly Monthly

D'hoore L, T'Sjoen G. J Intern Med. 2022 May;291(5):574-592.

serum E2 levels within the adult **cisgender women range**
(premenopausal phase 100–200 pg/mL)

Feminine effects in trasngender women





Breast development
Onset: 3–6 mo
Maximum effect: 2–3 y

Voice
No change

Body composition
Weight gain, fat redistribution, ↓Lean muscle mass and strength
↑Visceral fat, ↑fat mass
Onset: 3–6 mo
Maximum effect: 1–3 y

Reproductive system
Testicular atrophy (onset: 3–6 mo), ↓prostate size, ↓sperm count and quality
Maximum effect: >3 y

Hair
↓Male pattern baldness
Onset: 1–3 mo
↓Softer facial and body hair, ↓terminal hair growth
Onset: 6–12 mo
Maximum effect: 4–5 y

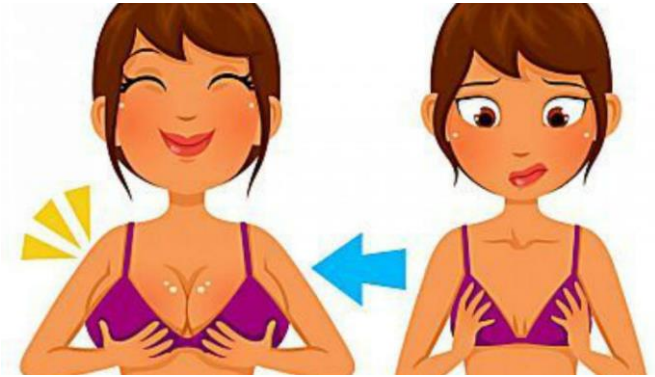
Skin
Skin softening, ↓sebum and acne
Onset: 3–6 mo

Sexual health
↓Libido and spontaneous erections
Onset: 1–3 mo
Maximum effect: 3–6 mo

Hamidi and Davidge-Pitts, Endocrinol Metab Clin N Am 48 (2019) 341–355

Transwomen

Breast development



It is an important outcome for transwomen.

N° 229 transgender women (median age 28 years)→ ENIGI
GAHT consisted of CPA or spironolactone together with estrogens (oral or transdermal).
Most breast development occurs in the first 6 months, with mean breast-chest difference increasing from 4.1 cm ± 2.9 cm at baseline to 7.9 cm ± 3.1 cm after 1 year of FHT (de Block et al., JCEM 2018).

There were **no predictive factors of total breast development**, including age, weight change, smoking, BMI, serum estradiol levels, and route of estrogen administration.

From a retrospective Amsterdam study of 773 trans women (median age = 50), 80% had chosen or considered breast augmentation as part of their gender-affirming treatment [de Block et at., JCEM 2020].

Timing

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Hembree et al., J Clin Endocrinol Metab, November 2017, 102(11):1–35

Safety

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen

Very high risk of adverse outcomes:

- Thromboembolic disease

Moderate risk of adverse outcomes:

- Macroprolactinoma
- Breast cancer
- Coronary artery disease
- Cerebrovascular disease
- Cholelithiasis
- Hypertriglyceridemia

ENDOCRINE SOCIETY

Hembree et al., J Clin Endocrinol Metab, November 2017, 102(11):1–35

Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy

Results From a Large Cohort Study

The mean and median follow-up durations were 9.07 for TW and 5.95 years for TM

n=2,517 transgender women with GAHT; median age 30 years
n=1358 transmen with GAHT; median age 23 years.

Incidence ratios for VTE and stroke were significantly higher for transgender women than for reference people

Table. Standardized Incidence Ratios for Acute Cardiovascular Events in Transwomen and Transmen Receiving Hormone Therapy

Acute Cardiovascular Events	OCs (IR)*	Using Women as Reference		Using Men as Reference	
		ECs	SIR (95% CI)	ECs	SIR (95% CI)
Transwomen					
Stroke	29 (127)	12.01	2.42 (1.65–3.42)†	16.08	1.80 (1.23–2.56)†
Myocardial infarction	30 (131)	11.38	2.64 (1.81–3.72)†	38.03	0.79 (0.54–1.11)
Venous thromboembolism	73 (320)	13.22	5.52 (4.36–6.90)†	16.04	4.55 (3.59–5.69)†
Transmen					
Stroke	6 (55)	3.49	1.72 (0.70–3.58)	4.10	1.46 (0.59–3.04)
Myocardial infarction	11 (100)	2.98	3.69 (1.94–6.42)†	10.99	1.00 (0.53–1.74)
Venous thromboembolism	2 (18)	4.84	0.41 (0.07–1.37)	5.56	0.36 (0.06–1.19)

ECs indicates expected cases; IR, incidence rate; OCs, observed cases; and SIR, standardized incidence ratio.
*Per 100 000 person-years.
†Significant finding.

Nota et al. Circulation 2019; 139(11):1461-1462.

Follow up

Transgender women

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

"If You Have It, Check It"

Transgender men

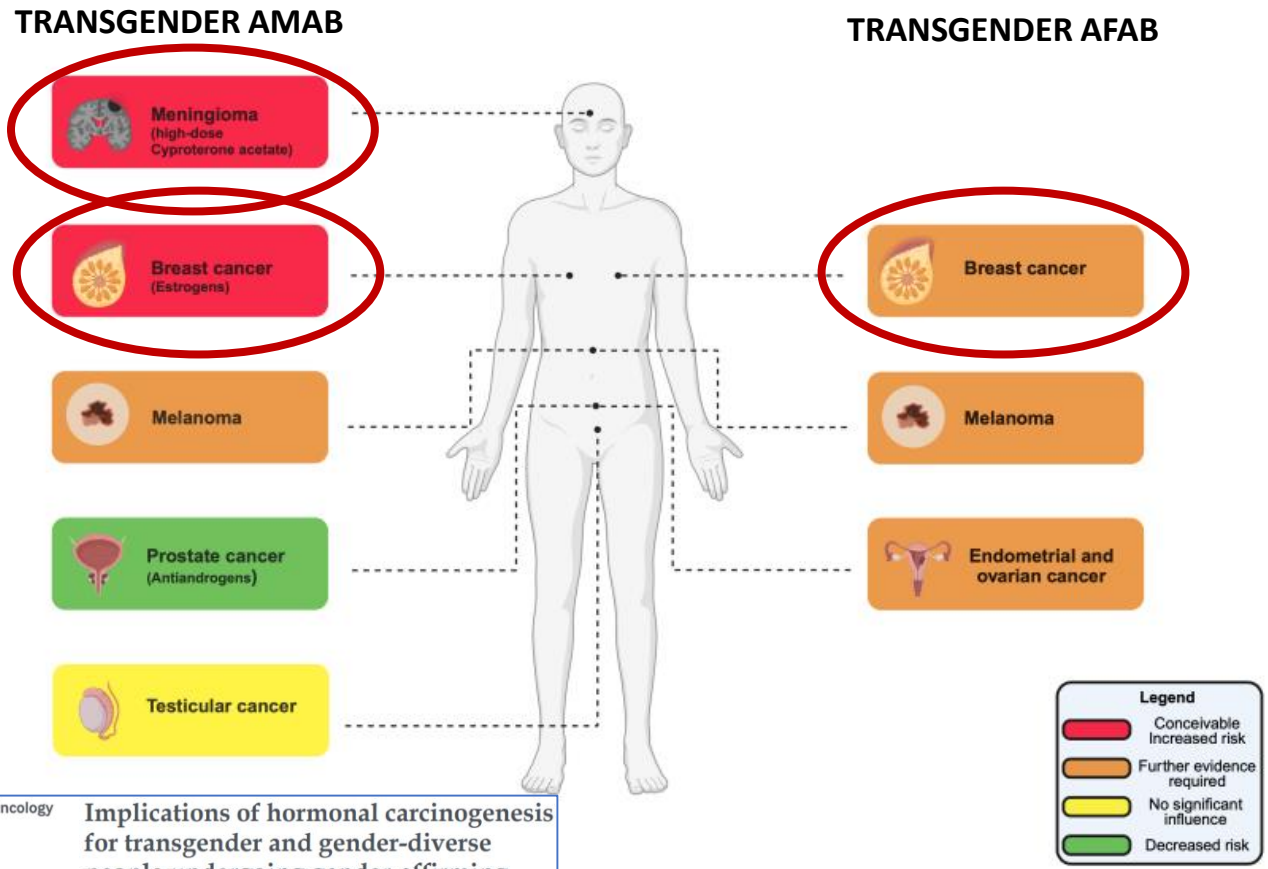
Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

"If You Have It, Check It"

Hembree et al., J Clin Endocrinol Metab, November 2017, 102(11):1–35

Routine cancer screening



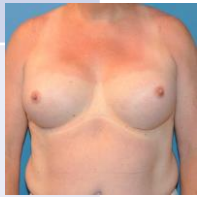
BMJ Oncology

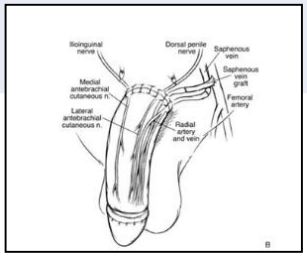
Implications of hormonal carcinogenesis for transgender and gender-diverse people undergoing gender-affirming hormone therapy: an up-to-date review

Leone AG, et al. BMJ Oncology 2024;3:e000330

Gli **interventi chirurgici di affermazione di genere** possono prevedere:

	T-AFAB	T-AMAB
Asportazione degli organi genitali presenti alla nascita	Utero e Ovaie	Testicoli e/o Pene
Affermazione di genere chirurgica	Mascolinizzazione del torace Falloplastica Clitoridoplastica …	Mastoplastica additiva Vaginoplastica Vulvoplastica Femminilizzazione volto …





È importante inoltre che la persona abbia consapevolezza di quelli che saranno gli esiti realistici della chirurgia

Take home messages

Prima di partire:
Clinico deve informare in modo critico→ consenso informato

Far conoscere rischi e benefici
Sartorializzare la terapia

Benessere della persona

Equipe multidisciplinare: endocrinologia et al.

SC Endocrinologia, Diabetologia e Metabolismo U

Prof. Ghigo

CIDIGEM (Centro Interdipartimentale Disforia di Genere Molinette)

Dott.ssa Crespi
Dott.ssa Bichiri
Dott. Castella
Dott.ssa Ledda

SIGIS Società Italiana Genere Identità Salute

Grazie per l'ascolto…