CASE REPORT

Shades of Gray

The sex factor is not always black and white

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CASE PRESENTATION

Patients with complex healthcare needs are the mainstay of medicine today. In order to simplify management, physicians classify their patients' symptoms, risk factors and medical histories into categories. A category commonly used by healthcare practitioners and researchers alike is "sex", since in many diseases, sex can play an important role in attributing level of risk. ML, 64 years old and SL, 66 years old, are two patients who do not fit neatly into such categories. They are a transgendered, surgically reconstructed married couple, who are both female. I had the pleasure of meeting them on a rural family medicine rotation where they presented together, as they always do, on a follow up appointment regarding their many complicated medical issues.

One was tall with cascading platinum blonde ringlets (a wig on closer inspection), the other wore her hair in a low-slung ponytail and wide-brimmed sun hat – both found exquisitely individual ways to hide their male-patterned baldness in their current female life. Right away, their openness and matter-of-fact manner made it easy to honestly question them about their past, present and future. ML and SL both had their gender reassignment surgeries conducted in Montreal in 1989. Opting for the same type of surgery, each had their penis and scrotum removed and a vaginal vault constructed but retained their prostate. Their surgeries went well and they now live a happy life together, spending half the year in Canada and the other half in the southern United States golfing. They are highly aware of their medical issues and actively involved in each other's health. Each one suffers from major conditions with a few notable examples which are placed in sharp focus when discussing risk factors related to "sex" in this unique couple.

USING 'SEX' AS A DEFINING FEATURE IN RESEARCH

Some of their health needs are easily taken care of because they strictly involve screenings for men or women – in this case, both are applicable. For instance, despite being female, since ML and SL still have their prostates and are over the age of 50, as recommended by Canadian guidelines, they receive their prostate cancer screenings via DRE testing.¹ Furthermore, SL has a positive immediate family history of prostate cancer which would usually require more vigilant monitoring, but with taking estrogen and removing her testicles, her risk becomes much lower. To add to their repertoire of annual screening, they also take part in the Ontario Breast Screening program for women over 50. Just because they now live their lives as females does not mean that they can erase the risks they were born into as males.

Other health needs, such as ML's impaired glucose tolerance and SL's full blown diabetes, are more difficult to keep track of. Physicians use "sex" as a useful marker to improve their estimates of risks that

apply to their patients, but what happens when the research is telling you two different things? The MONICA Augsburg Cohort Study examines sex difference in risk factors for type 2 diabetes and finds some interesting patterns.² Systolic blood pressure, smoking and high daily alcohol intake predict diabetes development only in men whereas uric acid and physical inactivity are factors associated with women. It is a difficult decision for the family physician as to which of these factors apply to patients like ML who need to be monitored closely for the possible development of diabetes. There is a similar dilemma present regarding cardiac health risk factors: ML and SL suffer from hypertension, dyslipidemia, hypercholesterolemia and a certain love for red meat and bacon. Some of these conditions have been shown to be greater risks for women in the development of coronary heart disease, while others are more dangerous in men.³ In such cases, even meticulously conducted research has its limitations in application to unique patients like ML and SL

DISCUSSION

The role of the family physician is paramount in the care of patients like ML and SL who have extra risk factors and screening needs. As discussed, research performed with males and females in mind can only provide so much information in the case of certain patients. The scenario is further convoluted when patients present with uncommon medical backgrounds with which the average physician may be unfamiliar. Information about less common procedures such as gender reassignment surgeries should be made available especially early on in the training of medical professionals.⁴ These patients must be cared for with great sensitivity for their unique needs and be understood in the context of each person as an individual. Patients should be treated as wholes regardless of the complexity of their medical needs – male, female or both.

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