

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Elliot J. Vandermeer-Hoskins

DOB

05/19/2002

AGE / SEX

24 yrs / Male (transgender man)

MRN / PATIENT ID

GAC-3096718

DATE OF SERVICE

08/13/2026

PROVIDER

Anouk T. Bergström, MD

CREDENTIALS

MD, MSc, ABIM — Endocrinology

PRIMARY CARE PROVIDER

R. Nakashima, FNP-BC — Eastside Community Health

VISIT TYPE

Hormone Therapy Follow-Up — month 14, lab monitoring and dose review

CARE SETTING

Outpatient gender-affirming care clinic

REFERRING PROVIDER

Continuity within this clinic since initiation 06/2025

INTERPRETER USED

No

CC CHIEF COMPLAINT

2 PRIMARY REASON FOR VISIT

"The changes have been what I hoped for and I do not want the dose lowered. But I have had headaches and my face flushes red for no reason, and the nurse said my blood count came back high again. I also need to talk about whether I can still have children, because my partner and I have started thinking about it and nobody has raised it since my very first appointment."

S SUBJECTIVE

3 SYMPTOMS, GOALS, TREATMENT HISTORY & RISK REVIEW

3a GOALS & HORMONE-RELATED SYMPTOMS

Reason for hormone therapy evaluation

Month-14 gender-affirming hormone therapy monitoring visit, brought forward from month 18 because of a second consecutive elevated hematocrit. Purpose is review of erythrocytosis, evaluation of new headaches and facial flushing,

assessment of therapeutic effect against his stated goals, fertility counselling that has not been revisited since initiation, and preventive screening review.

Patient goals and priorities

His own order: (1) continue masculinising effects, specifically further voice deepening and facial hair — he is explicit that dose reduction is his least preferred option and asks that alternatives be considered first; (2) resolve the headaches and flushing; (3) understand fertility options now that he and his partner are considering children in the next 3–5 years; (4) know what routine screening he still needs. He is well informed and has read the clinic's own patient materials.

Hormone-related symptoms

Desired effects, largely achieved: voice deepened over months 3–9 and now stable; facial and body hair increased with a full jawline beard; fat redistribution to the abdomen; increased muscle mass; clitoral growth; menses ceased at month 5 and no bleeding since; libido markedly increased. **Unwanted or concerning:** new intermittent frontal headaches 2–3 times weekly for 6 weeks, dull and non-throbbing, without aura, photophobia or vomiting; facial flushing and plethora, most noticeable after his gym sessions and after his injections; mild scalp hair recession at both temples; acne on the upper back which peaked at months 4–8 and has improved; occasional lower-limb cramping. Denies vaginal dryness or pelvic pain.

3b REPRODUCTIVE, ENDOCRINE & THERAPY-SPECIFIC HISTORY

Menstrual / reproductive history

Menarche age 12. Cycles regular until testosterone initiation. **Amenorrhoeic since month 5 (11/2025), no breakthrough bleeding since** — reassuring for endometrial quiescence. Uterus and both ovaries in situ; no hysterectomy or oophorectomy, and none currently planned. Never pregnant. **Not using contraception; partner is a cisgender man and they are sexually active.** Counselling at initiation that testosterone is not a contraceptive, but this had not been revisited — a gap he raises himself. Pregnancy would be unintended at present.

Gender-affirming hormone therapy context

Identifies as a transgender man, socially transitioned since 2021, legal name and gender marker changed 2024. Treatment goals at initiation were voice deepening, facial hair, cessation of menses and body recontouring — all substantially met. Chest masculinisation surgery scheduled for 02/2027 with plastic surgery; no genital surgery planned at present. **Fertility preservation was discussed once at initiation in 06/2025 and declined at the time, and has not been revisited in 14 months** — his circumstances have since changed. Strong social support: partner of 3 years, both parents affirming, employed. Established with a gender-affirming therapist, seen every 6–8 weeks.

Current hormone therapy regimen

Testosterone cypionate 100 mg intramuscularly every 2 weeks, self-administered into the thigh, since 06/2025 — started at 50 mg and titrated to 100 mg at month 4. Fully adherent, no missed doses, and he keeps a written injection log. **Notably, he injects on a Saturday and the clinic has drawn every trough level on a Monday — 2 days post-injection rather than at true trough**, which he identified himself after reading the clinic handout. No estrogen, progestin or antiandrogen. No GnRH analogue. No DHEA.

Prior hormone therapy / treatment history

No hormone therapy before 06/2025. No compounded preparations. No non-prescribed or internet-sourced testosterone at any point — asked directly and answered clearly. No prior gel or patch trial; injections were his preference from the outset. Prior contraceptive use: combined oral contraceptive ages 17–20 for dysmenorrhoea, stopped without complication.

Medication and supplement history

Testosterone cypionate as above. Levocetirizine 5 mg seasonally. **Creatine monohydrate 5 g daily and a pre-workout containing caffeine and beta-alanine, both started 3 months ago** — volunteered on direct questioning; relevant to both his creatinine and his flushing. Whey protein. No anticoagulants, no steroids, no NSAID use beyond occasional ibuprofen. No affordability barrier; insurance covers testosterone with a \$15 copay.

3c RISK FACTORS, SCREENING & BACKGROUND

Risk factor review

No personal history of breast, endometrial, ovarian or any cancer. **No prior thromboembolism, stroke or myocardial infarction.** No migraine with or without aura before this year. No liver disease; transaminases have been normal throughout. Blood pressure previously normal, mildly elevated today. **Non-smoker — never smoked, and no vaping,** which materially lowers his erythrocytosis and thrombotic risk. No known clotting disorder. No sleep apnea diagnosis but new snoring reported by his partner. No osteoporosis risk factors; on testosterone with normal bone turnover expected.

Family history

Father — hypertension, alive at 56. Mother — hypothyroidism, alive at 52. **Maternal grandfather — deep vein thrombosis at 60 after surgery, provoked, no known thrombophilia.** No breast, ovarian, endometrial or prostate cancer in any relative. No premature cardiovascular disease, no sudden death. No hereditary cancer syndrome. No polycythaemia in the family.

Bone health

No fracture history. No DEXA performed — not indicated at 24 on adequate testosterone with no risk factors. Calcium intake adequate through dairy. Vitamin D not previously measured. Weight-bearing and resistance exercise 4 times weekly — protective. No steroid exposure.

Cardiometabolic health

Blood pressure historically 118–124 systolic; **138/86 today, the highest recorded.** Lipids at 12 months showed the expected testosterone effect — HDL fell from 58 to 44, LDL rose from 88 to 112. No diabetes, HbA1c 5.2%. Weight up 16 lb since initiation, predominantly lean mass with waist unchanged. Exercises 4 times weekly. Diet adequate in protein, moderate in processed food. New snoring raises sleep apnea as a testosterone-associated consideration.

Cancer screening / preventive care

Cervical screening: cervix in situ, never screened — now 24 and due. He has declined twice, citing dysphoria around pelvic examination. Chest tissue present until 02/2027 surgery; no mammography indicated at 24 with no family history. No prostate tissue — prostate screening not applicable. Colorectal screening not due. Vaccinations: HPV series completed at 14, influenza 10/2025, COVID-19 11/2025, hepatitis B immune. STI screening 02/2026 — HIV, syphilis, gonorrhoea and chlamydia all negative.

Recent testing / specialist care

Laboratory monitoring at months 3, 6 and 12, plus a repeat hematocrit at month 13. Therapist every 6–8 weeks. Plastic surgery consultation 06/2026 with surgery booked for 02/2027. No endocrinology involvement other than this clinic. No emergency visits, hospitalizations or surgeries.

Pertinent negatives

Denies chest pain, shortness of breath, unilateral leg swelling or calf pain, visual disturbance, aura, focal weakness, numbness, speech disturbance, and vision loss. Denies thunderclap or positional headache. Denies any vaginal bleeding since month 5. Denies breast or chest mass. Denies severe mood instability and suicidal ideation. No symptoms of hormone excess beyond those documented.

ROS HORMONE THERAPY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Hot flashes, night sweats, temperature intolerance, sleep disturbance, fatigue	Positive — facial flushing and plethora; new snoring. No hot flashes. Sleep otherwise adequate.
Mood changes, anxiety, depression, irritability, brain fog, concentration	Negative — mood notably improved since initiation. PHQ-9 2, GAD-7 3.
Libido, sexual dysfunction, vaginal dryness, dyspareunia, genital symptoms	Positive — libido markedly increased (desired). No dryness, no dyspareunia, no pain.
Menstrual changes, abnormal bleeding, pelvic pain	Amenorrhoeic since month 5 — desired and reassuring. No

breast tenderness, mass	breakthrough bleeding. No mass.
Weight change, appetite, acne, hair loss, hirsutism, skin changes	Positive — +16 lb mostly lean; back acne improving; temporal scalp recession; facial and body hair increased (desired).
Palpitations, chest pain, dyspnea, edema, unilateral leg swelling, dizziness	Negative for all — specifically no calf swelling or pain, no dyspnea, no chest pain. Lower-limb cramping only.
Headache, migraine with aura, vision changes, weakness, numbness, neurologic	Positive — new frontal headaches 2–3× weekly for 6 weeks. No aura, no visual change, no focal deficit.
Medication side effects, adherence, injection site reactions, patch irritation	Adherence complete with a written log. No injection site reaction. Creatine and caffeinated pre-workout newly disclosed.

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OBJECTIVE

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OBSERVED FINDINGS

V

VITALS

TEMPERATURE

98.1 °F

HEART RATE

68 bpm

OXYGEN SATURATION

98% RA

WEIGHT

168 lb (152 lb at initiation)

WAIST CIRCUMFERENCE

32 in — unchanged from initiation

BLOOD PRESSURE

138/86 mmHg (repeat 136/84; prior 120/76)

RESPIRATORY RATE

14 /min

HEIGHT

5 ft 6 in

BMI

27.1

PAIN SCORE

2/10 — headache present today

General appearance

Well-appearing young man, muscular build, no distress. Masculine presentation consistent with gender identity; correct name and pronouns used throughout and recorded in the chart. Engaged, well informed, arrived with his own written injection and symptom log.

Head / eyes / ears / nose / throat

Facial plethora and malar flushing evident at rest. Conjunctiva injected without discharge. Sclera anicteric. Pupils equal and reactive. **Full jawline and chin beard, terminal hair, patient-reported satisfaction high.** Mild bitemporal scalp recession, Norwood II, without vertex thinning. Oral mucosa moist. Voice deep and stable, no strain.

Neck / thyroid

Supple. Thyroid impalpable, no nodule or tenderness. No lymphadenopathy. No neck mass. **Neck circumference 15.5 in.** No signs of thyroid dysfunction.

Cardiovascular

Regular rate and rhythm at 68. Normal S1 and S2, no murmur, rub or gallop. Peripheral pulses 2+ and symmetric. Capillary refill under 2 seconds. **No peripheral edema. Calves soft, non-tender, symmetric, no cords, no asymmetric swelling**

— specifically examined given the erythrocytosis.

Pulmonary

Normal effort. Clear to auscultation bilaterally. No wheeze, no crackles. No accessory muscle use.

Breast / chest

Examined with consent and a chaperone present, with the exam framed and paced at his direction given documented dysphoria. Chest tissue present, symmetric, **no mass, no skin change, no nipple discharge, no axillary lymphadenopathy**. Planned masculinisation surgery 02/2027 noted. Exam well tolerated.

Abdomen

Soft, non-tender. Central fat redistribution consistent with androgen effect. Bowel sounds normal. **No hepatomegaly or splenomegaly** — specifically assessed given the raised hematocrit. No mass, no bruit.

Genitourinary / pelvic

Not examined today — declined by the patient, and no clinical indication in the absence of bleeding, discharge or pain. Documented that cervical screening is due and that a self-collected HPV sample was offered as an alternative and accepted. No prostate tissue; prostate examination not applicable.

Skin / hair

Facial and truncal plethora. Resolving comedonal and mild inflammatory acne over the upper back, improved from month 6. Terminal hair on the face, chest, abdomen and thighs. Bitemporal recession as above. **Injection sites in both thighs clean, no induration, erythema, nodule or lipoatrophy** — good technique. No bruising, no striae, no acanthosis nigricans.

Musculoskeletal

Increased muscle bulk in the upper limbs, chest and thighs. Strength 5/5 throughout, grip 46 kg bilaterally. Full range of motion. Normal gait. No joint tenderness. No fracture tenderness.

Neurologic

Alert and fully oriented. **Cranial nerves II–XII intact; visual fields full to confrontation and fundoscopy shows sharp disc margins with no papilloedema** — examined because of the new headaches. Power 5/5. Sensation intact. Reflexes 2+ symmetric, plantars downgoing. No tremor. Coordination and gait normal. No focal deficit.

Psychiatric

Mood euthymic, affect full and bright. Speech normal. Thought process linear. **Insight excellent — he identified the trough-timing error in his own lab draws.** Judgment intact. No suicidal ideation. Reports substantial improvement in mood and self-image since starting therapy, and describes the treatment as the single most helpful intervention of his life.

RA HORMONE THERAPY SAFETY / RISK ASSESSMENT

6 INDIVIDUALIZED TREATMENT SAFETY REVIEW

INDICATION FOR HORMONE THERAPY

Gender incongruence (F64.0) — masculinising hormone therapy, established 06/2025 with documented informed consent and sustained benefit

CONTRAINDICATIONS REVIEWED

None absolute. No hormone-sensitive cancer, no prior thromboembolism, no uncontrolled polycythaemia at this level, no unstable cardiac or hepatic disease

PERSONAL CANCER HISTORY

None

FAMILY CANCER HISTORY

None relevant — no breast, ovarian, endometrial or

CARDIOVASCULAR RISK FACTORS

Emerging — new systolic elevation 138/86, HDL fall

prostate cancer

THROMBOEMBOLIC RISK FACTORS

Hematocrit 55.2% is the principal risk. No prior VTE, no thrombophilia, non-smoker, no immobility. One provoked VTE in a grandparent. Chest surgery in 02/2027 makes correction before then essential

LIVER DISEASE RISK

None — transaminases normal throughout; no oral 17-alpha-alkylated androgen exposure

SMOKING / NICOTINE STATUS

Never smoked, no vaping — a significant protective factor here

FERTILITY / PREGNANCY CONSIDERATIONS

Uterus and ovaries in situ. Sexually active with a cisgender male partner and using no contraception. Amenorrhoea is not contraception. Fertility preservation declined at initiation but circumstances have changed

MEDICATION INTERACTIONS

No prescription interactions. Creatine confounds creatinine interpretation; caffeinated pre-workout plausibly contributes to flushing and blood pressure

ROUTE-SPECIFIC RISKS AND BENEFITS

Intramuscular cypionate every 2 weeks produces supraphysiologic peaks and troughs; peak-driven erythrocytosis is a recognised consequence of this interval. Weekly or twice-weekly subcutaneous dosing delivers the same total exposure with a flatter curve — the key therapeutic lever available here

SHARED DECISION-MAKING / INFORMED CONSENT

Full discussion documented. His stated priority not to lose masculinising effect was taken as a constraint on the plan, and the regimen change was chosen specifically to preserve total exposure. Re-consent documented for the route change and for the fertility discussion

58→44, LDL rise 88→112, 16 lb gain. Non-smoker. 10-year risk remains low at 24, but the trajectory matters

MIGRAINE WITH AURA / NEUROLOGIC RISK

No aura, no focal features, no papilloedema. Headaches temporally match the hematocrit rise and the caffeinated pre-workout

BLOOD PRESSURE STATUS

Newly elevated — 138/86 today, 136/84 on repeat, against a prior baseline of 118–124 systolic

SLEEP APNEA RISK

New snoring reported by partner; STOP-Bang 3. Testosterone can unmask or worsen OSA, which itself drives erythrocytosis — a plausible second contributor

BONE HEALTH

Low risk — adequate androgen, resistance training, no fracture history. DEXA not indicated

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THERAPY-SPECIFIC MONITORING

7 TESTOSTERONE THERAPY & GENDER-AFFIRMING CARE

Testosterone therapy

Route and dose: testosterone cypionate 100 mg IM every 2 weeks, self-administered, 14 months. **Symptom response:** excellent — all primary goals met (voice, facial hair, amenorrhoea, recontouring). **Acne:** peaked months 4–8, now improving without treatment. **Hair:** bitemporal recession, Norwood II — discussed as androgen-mediated and expected, and he does not wish to treat it. **Mood:** substantially improved, no lability. **Sleep apnea:** new snoring — screening initiated. **Erythrocytosis:** hematocrit 51.8% at month 12, **55.2% at month 14** — above the 54% threshold at which intervention is indicated, and rising. **Fertility:** revisited today after 14 months. **Cardiovascular:** new blood pressure elevation and adverse lipid shift, both expected androgen effects requiring monitoring rather than cessation.

Gender-affirming hormone therapy

Desired effects achieved: voice deepening (stable since month 9), facial and body hair, fat redistribution, increased muscle mass, cessation of menses, clitoral growth, increased libido. **Achieved effects he wishes to continue — explicitly stated and honoured in the plan.** **Side effects:** erythrocytosis, blood pressure rise, lipid shift, temporal recession, resolving acne, possible OSA. **Lab monitoring:** per Endocrine Society guidance — testosterone, hematocrit, lipids and liver function, now with corrected draw timing. **Fertility:** full discussion today, oocyte cryopreservation referral accepted. **Preventive screening:** cervical screening due and addressed by self-collection; chest surgery 02/2027. **Mental health:** established therapist, PHQ-9 2, GAD-7 3, strong social support.

Estrogen, progestin, antiandrogen and thyroid therapy

Not applicable — none prescribed and none indicated. No progestin required for endometrial protection: amenorrhoea is androgen-induced with no unopposed estrogen exposure, and there has been no breakthrough bleeding in 9 months.

Compounded / non-standard hormone use

None. All testosterone is pharmacy-dispensed FDA-approved cypionate. No compounded creams, pellets or internet-sourced product at any point — asked directly and confirmed. Counselling to continue avoiding non-pharmacy sources.

ST SCREENING / ASSESSMENT TOOLS

8 SCORES, INTERPRETATION & COMPARISON

GENDER AFFIRMATION GOALS ASSESSMENT

All five initiation goals met; two ongoing (further facial hair density, chest surgery 02/2027). Satisfaction 9/10

GAD-7

3 — negative (was 11 at initiation)

STOP-BANG

3 — snoring, male sex, BMI >27; new since initiation

ASCVD 10-YEAR RISK

<2% at age 24 — not yet actionable, but lipid and blood pressure trajectory is

MEDICATION ADHERENCE

Complete — 14 months, zero missed doses, written self-maintained log

INTERPRETATION

This is a highly successful course of therapy with one manageable dose-related complication. Mood scores fell from 14 to 2 and 11 to 3, every stated goal was met, and adherence is perfect. The erythrocytosis is a predictable consequence of a 2-weekly intramuscular interval producing supraphysiologic peaks — a schedule problem, not a reason to reduce total exposure.

PHQ-9

2 — negative (was 14 at initiation in 06/2025)

HEADACHE SCREEN

No aura, no red flags, no papilloedema; temporally concordant with hematocrit rise and pre-workout use

EPWORTH SLEEPINESS SCALE

7 — normal

FRAX SCORE

Not applicable at 24 with no risk factors

INJECTION TECHNIQUE ASSESSMENT

Excellent — sites rotated, no complications observed

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED OR ORDERED

Sex hormone testing

Total testosterone 1,180 ng/dL drawn 2 days post-injection (month 14) — supraphysiologic for a mid-interval sample. Month 12: 1,040 ng/dL, also drawn 2 days post-injection. **No true trough has ever been measured**; the 350–700 ng/dL target range applies to trough sampling, so prior results were uninterpretable against it. Free testosterone 24 ng/dL. Estradiol 38 pg/mL. SHBG 21 nmol/L. LH <0.3 and FSH 1.1 IU/L — appropriately suppressed. Prolactin 9 ng/mL, normal.

Thyroid testing

TSH 1.4 mIU/L, free T4 1.1 ng/dL — euthyroid. No antibodies indicated. No thyroid imaging.

Safety monitoring labs

Hematocrit 55.2% and hemoglobin 18.4 g/dL (month 14), against 51.8% and 17.2 g/dL at month 12 and 44.1% and 14.6 g/dL at baseline — a rising trend now above the 54% intervention threshold. White cells 6.8 k, platelets 244 k. Ferritin 68 ng/mL, iron studies normal — no iron deficiency to confound. Erythropoietin not measured; not required in a clear androgen-related picture. CMP normal: ALT 26, AST 22, bilirubin 0.6, albumin 4.4. **Creatinine 1.16 mg/dL, up from 0.88 — attributable to increased muscle mass plus creatine supplementation rather than renal impairment; eGFR by cystatin C requested to confirm.** Potassium 4.3. HbA1c 5.2%. **Lipids: total cholesterol 186, LDL 112 (was 88), HDL 44 (was 58), triglycerides 148** — the expected androgen pattern. Pregnancy test negative today.

Cancer / preventive screening

Cervical screening never performed — self-collected HPV sample obtained today, accepted after clinician-collected examination was declined. No mammography indicated at 24. Pelvic ultrasound not indicated: no bleeding, no pain, no mass. Prostate screening not applicable. STI panel 02/2026 all negative; repeat panel sent today given a non-monogamous history disclosure period and no barrier use.

Cardiometabolic testing

Blood pressure trend reviewed: 120/76 at initiation, 124/78 at month 6, 122/74 at month 12, **138/86 today**. Lipid trend as above. EKG performed today — normal sinus rhythm at 68, normal axis and intervals, no chamber enlargement, no ischemic change. **Home sleep apnea test ordered** given new snoring with a STOP-Bang of 3 and erythrocytosis, since untreated OSA is itself a cause of secondary polycythaemia.

Imaging

None indicated today. No pelvic imaging, no thyroid imaging, no DEXA. Brain imaging not indicated for the headaches — no red flags, normal neurologic examination, no papilloedema, and a clear alternative explanation.

Prior records reviewed

Full clinic record from initiation 06/2025 including the informed consent document and the initial fertility discussion note; laboratory series at months 3, 6, 12 and 13; therapist correspondence 07/2026; plastic surgery consultation of 06/2026 with the 02/2027 surgical date; primary care record; and his own 14-month injection log, which corroborated the draw-timing problem.

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ASSESSMENT

10 HORMONE THERAPY CLINICAL INTERPRETATION

- **Gender incongruence (F64.0) on masculinising hormone therapy, month 14 — therapy is working and should continue.** Every goal set at initiation has been met, PHQ-9 fell from 14 to 2 and GAD-7 from 11 to 3, adherence is complete, and the patient describes it as the most beneficial treatment of his life. That context frames everything below: the aim is to fix a complication without sacrificing effect.
- **Testosterone-induced erythrocytosis (D75.1), hematocrit 55.2%, rising and above the 54% intervention threshold.** Progression from 44.1% to 51.8% to 55.2% across 14 months. This carries a real thrombotic risk and matters more than usual because chest masculinisation surgery is booked for 02/2027 — it must be corrected well before then.

- **The mechanism is the dosing interval, not the dose.** One hundred milligrams intramuscularly every 2 weeks produces high supraphysiologic peaks; erythrocytosis in this setting is peak-driven. **Switching to weekly or twice-weekly subcutaneous dosing at the same total exposure flattens the curve and typically lowers hematocrit without reducing masculinising effect** — which directly answers his stated priority. Reducing total dose is the fallback, not the first move.
- **All prior testosterone levels were drawn at the wrong point in the cycle.** Every sample was taken 2 days post-injection rather than at trough, so the 1,040 and 1,180 ng/dL results cannot be judged against the 350–700 ng/dL trough target — they are mid-interval peaks and were never interpretable. **The patient identified this himself.** This is a monitoring process error, and it means his true exposure is currently unknown.
- **Possible obstructive sleep apnea (G47.33, provisional) as a second contributor.** New partner-reported snoring, STOP-Bang 3, and BMI 27.1. Testosterone can unmask or worsen OSA, and untreated OSA independently causes secondary polycythaemia. Testing this may explain part of the hematocrit rise and is a modifiable target in its own right.
- **New headaches and facial plethora — most plausibly hyperviscosity from the erythrocytosis, compounded by a caffeinated pre-workout supplement.** No aura, no focal deficit, no papilloedema, no red-flag features, and no positional or thunderclap character. No imaging indicated; the correct test is to correct the hematocrit and stop the pre-workout, then reassess.
- **Newly elevated blood pressure (R03.0) and adverse lipid shift (E78.5)** — 138/86 against a 118–124 baseline; HDL 58→44 and LDL 88→112. Both are recognised androgen effects, not reasons to stop therapy, but they define his long-term cardiovascular surveillance and are worth establishing habits around now rather than at 40.
- **Elevated creatinine (1.16 from 0.88) that is not renal disease.** Increased lean mass plus 5 g daily creatine both raise serum creatinine without affecting glomerular filtration. Cystatin C-based eGFR requested to confirm. Misreading this as chronic kidney disease is a recognised pitfall in this population.
- **Unaddressed pregnancy risk — a significant gap.** Uterus and both ovaries in situ, sexually active with a cisgender male partner, using no contraception, on no method other than androgen-induced amenorrhoea. **Amenorrhoea on testosterone is not contraception and pregnancy is possible.** Pregnancy would also be unintended and teratogenic risk applies. This was covered once at initiation and never revisited.
- **Fertility preservation warrants re-discussion after 14 months.** Declined at initiation and reasonably so at the time, but he and his partner are now actively considering children within 3–5 years. Oocyte cryopreservation remains feasible; it requires temporary testosterone interruption, which he needs to weigh knowingly rather than discover later.
- **Cervical screening overdue at 24 with a cervix in situ (Z12.4).** Declined twice because of dysphoria around pelvic examination — an access barrier, not refusal of care. Self-collected HPV sampling resolves it and was accepted immediately when offered.
- **Androgenetic alopecia, Norwood II (L64.0)** — expected, mild, and he does not wish to treat it. Documented as an informed choice.
- **Red flags assessed and absent:** no VTE signs, no calf swelling or asymmetry, no dyspnea or chest pain, no papilloedema, no focal neurologic deficit, no breast or chest mass, no vaginal bleeding, no hepatosplenomegaly, no visual disturbance.

P

PLAN

11 HORMONE THERAPY MANAGEMENT BY PROBLEM

- **Hormone therapy — route and schedule change, total exposure preserved:** switch from testosterone cypionate 100 mg IM every 2 weeks to **50 mg subcutaneously weekly**. Identical total monthly exposure, flatter pharmacokinetics, and the intervention most likely to lower hematocrit without any loss of masculinising effect.

Subcutaneous technique, needle change and site rotation taught in clinic today with a successful supervised self-injection. He was told plainly that this is not a dose reduction — the concern he arrived with.

- **Erythrocytosis management:** hematocrit in 6 weeks after the schedule change. If still above 54%, reduce to 40 mg weekly. If above 56% at any point, or if any thrombotic symptom occurs, therapeutic phlebotomy and haematology referral. **Correction to below 52% is required before the 02/2027 chest surgery** — surgeon informed today with consent. Adjuncts: hydration, ensure no smoking (already the case), and treat OSA if confirmed. Iron studies normal, so no confounder to address.
- **Stop the caffeinated pre-workout supplement** — a plausible contributor to both the flushing and the blood pressure rise. Creatine may continue, but its effect on serum creatinine is now documented so that no future clinician misreads it as renal disease. Cystatin C-based eGFR to confirm normal function.
- **Headaches:** no imaging — no red flags, normal examination, no papilloedema, and two correctable explanations being addressed. Paracetamol as needed. Reassess at 6 weeks alongside the hematocrit. If headaches persist after the hematocrit normalises and the pre-workout is stopped, escalate to imaging and neurology.
- **Sleep apnea:** home sleep apnea test ordered, to be completed within 3 weeks. Sleep medicine referral if positive. Treating OSA would benefit the hematocrit, the blood pressure and the headaches together.
- **Blood pressure and lipids:** home blood pressure monitoring with a log, target below 130/80. Repeat lipids in 12 weeks after the schedule change and pre-workout cessation. No antihypertensive or statin today — three variables are changing at once and both are expected androgen effects. Continue aerobic exercise alongside resistance training. Handed to primary care for long-term cardiovascular surveillance with a letter, since this will be a 40-year issue.
- **Contraception — addressed today:** explained clearly that androgen-induced amenorrhoea is *not* contraception and that pregnancy is possible with ovaries and a uterus in situ. Options discussed in full: a copper or levonorgestrel intrauterine device (no estrogen, no interference with masculinisation, and the LNG-IUS may add endometrial benefit), progestin implant, or condoms. **He chose a levonorgestrel intrauterine system**, insertion booked for 09/03/2026 with the offer of anxiolysis and a trauma- and dysphoria-informed approach documented. Condoms provided in the interim.
- **Fertility preservation — re-opened after 14 months:** 16-minute discussion. Oocyte cryopreservation remains feasible; it requires stopping testosterone for approximately 2–3 months with the return of menses, which he found difficult but wanted to hear stated honestly. **Referral to reproductive endocrinology accepted** for counselling and a cost and timeline discussion, with no commitment implied. His partner invited to attend. Documented that the decision is his and can be revisited again at any point.
- **Preventive screening:** self-collected HPV sample obtained today — the access barrier removed rather than argued with. Repeat STI panel sent. Chest examination completed and documented as normal, with masculinisation surgery on track for 02/2027. Influenza vaccine in October. Vitamin D checked with today's panel. No DEXA, no mammography, no prostate screening indicated.
- **Monitoring schedule corrected:** all future testosterone levels to be drawn **immediately before the weekly injection**, with the timing written into the lab order and the patient's own log. This single fix makes his levels interpretable for the first time. Hematocrit, testosterone, lipids and liver function at 6 weeks, then 3-monthly until stable, then twice yearly.
- **Alopecia:** no treatment at his informed request. Topical minoxidil and the reasons finasteride is generally inappropriate here (it opposes the masculinisation he is seeking) both explained and declined. Documented as a knowing choice.
- **Mental health:** continue his established gender-affirming therapist. PHQ-9 2 and GAD-7 3 need no intervention. Noted for the record that his mood improvement is a treatment outcome, and that it is a reason to protect the therapy rather than curtail it.
- **Safety counselling and red flags:** written and verbal instruction to seek emergency care for calf pain or swelling, chest pain, breathlessness, sudden severe headache, visual loss, weakness, numbness or speech disturbance. Counselling on hyperviscosity symptoms, hydration, and never sourcing testosterone outside a pharmacy. Written summary of every change given, with copies to primary care, his therapist and the surgical team with consent.

12 REASSESSMENT PLAN

Follow-up

Six-week review (09/24/2026): hematocrit, hemoglobin, trough testosterone drawn immediately pre-injection, and blood pressure log review — the decision point for whether a dose reduction to 40 mg weekly is needed. Home sleep apnea test within 3 weeks with same-week result review. Levonorgestrel IUS insertion 09/03/2026. Reproductive endocrinology within 4 weeks. HPV self-collection and STI results reviewed within 10 days. Repeat lipids and cystatin C eGFR at 12 weeks. Three-monthly monitoring until hematocrit is stable below 52%, then twice yearly. **Pre-operative review in 12/2026 to confirm hematocrit correction ahead of the 02/2027 chest surgery.** Immediate emergency presentation for calf pain or swelling, chest pain, breathlessness, sudden severe headache, visual loss, or focal neurologic symptoms.

TOTAL TIME SPENT

64 minutes

RISK-BENEFIT COUNSELING TIME

14 minutes — erythrocytosis, thrombotic and surgical risk

CARE COORDINATION TIME

9 minutes — surgery, primary care, therapist, reproductive endocrinology

LAB REVIEW TIME

7 minutes

E/M LEVEL

99215 — established patient, high complexity MDM; total time 64 minutes also documented

PREVENTIVE COUNSELING CODE(S)

96127 × 2 (PHQ-9, GAD-7) · 99401 preventive counselling — contraception and fertility

PROCEDURE CODE(S)

93000 EKG with interpretation and report · Q0091 screening cytology specimen collection (self-collected HPV)

GENDER-AFFIRMING CARE / ENDOCRINE CARE CODE(S)

Z79.890 hormone replacement therapy monitoring; 58300 IUD insertion scheduled 09/03/2026

BASIS FOR BILLING

High-complexity medical decision making — drug therapy requiring intensive monitoring for toxicity, a new complication with thrombotic and peri-operative implications, and independent interpretation of a 14-month laboratory series identifying a monitoring error

PRIMARY ICD-10

F64.0 — Transsexualism (gender incongruence)

SECONDARY ICD-10

D75.1 secondary polycythemia · Z79.890 hormone replacement therapy · R51.9 headache, unspecified · R03.0 elevated blood pressure reading without diagnosis of hypertension · E78.5 hyperlipidemia, unspecified · G47.33 obstructive sleep apnea (provisional) · L64.0 drug-induced androgenic alopecia · Z30.014 encounter for initial prescription of IUD · Z31.62 encounter for fertility preservation counseling · Z12.4 encounter for screening for malignant neoplasm of cervix · R79.89 other abnormal findings of blood chemistry

MEDICATION MANAGEMENT TIME

17 minutes — route and schedule change with injection teaching

SHARED DECISION-MAKING TIME

16 minutes — fertility preservation and contraception

RECORDS REVIEW TIME

8 minutes — 14-month lab series and patient injection log

MEDICATION MANAGEMENT CODE(S)

Included in the E/M level; drug therapy requiring intensive monitoring for toxicity

SO**PROVIDER SIGN-OFF****PROVIDER NAME****Anouk T. Bergström****CREDENTIALS****MD, MSc —
Endocrinology****SPECIALTY****Gender-Affirming Care /
Hormone Therapy****DATE****08/13/2026****TIME****2:41 PM**

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