Common Clinical Pitfalls in Masculinising FTM Gender-Affirming Hormone Therapy

Dr. Paul Tervit

Pitfall	Why it Matters	Clinical Approach
Assuming testosterone is contraception	Ovulation may still occur despite amenorrhoea; pregnancy is possible.	Discuss fertility goals and offer contraception if pregnancy is possible. Perform pregnancy testing when clinically indicated before starting testosterone.
Targeting supraphysiological testosterone levels	Increases risk of erythrocytosis, acne, mood changes and adverse cardiovascular effects without improving masculinisation.	Aim for physiological adult male testosterone concentrations (~10–30 nmol/L). Adjust dose based on symptoms and serum levels.
Checking testosterone at the wrong time	Results may be misleading, leading to inappropriate dose changes.	Measure at the appropriate point for the formulation (e.g. midpoint for cypionate/Sustanon, trough before Reandron, steady state for gels).
Escalating dose because changes are "too slow"	Many masculinising effects occur gradually over 2–5 years.	Counsel regarding expected timelines before increasing doses solely for lack of early physical changes.
Ignoring erythrocytosis	Elevated haematocrit increases thrombotic risk.	Monitor FBC regularly. Reduce dose, lengthen interval, investigate other causes (e.g. smoking, sleep apnoea) if haematocrit becomes elevated.
Not assessing persistent uterine bleeding	Persistent bleeding may indicate inadequate testosterone levels or unrelated gynaecological pathology.	Confirm testosterone level, exclude pregnancy, consider additional menstrual suppression, and investigate persistent or new bleeding appropriately.
Stopping cervical screening	Retained cervix remains at risk of cervical cancer.	Continue cervical screening according to NZ guidelines while a cervix is present.
Assuming testosterone eliminates breast cancer risk	Residual breast tissue remains after chest surgery.	Continue risk-based breast/chest surveillance according to residual tissue and individual risk factors.
Ignoring fertility discussions	Testosterone may reduce fertility but is not reliable contraception, and fertility may recover after cessation.	Discuss fertility preservation before therapy and revisit reproductive goals periodically.
Using gender-affirming surgery as a prerequisite for hormones	Creates unnecessary barriers to care.	Hormone therapy and surgery are independent treatment options based on informed consent and patient goals.
Failing to individualise goals	Not every transmasculine person desires complete masculinisation or binary outcomes.	Establish individual goals and tailor dose and formulation accordingly.
Misinterpreting laboratory reference ranges	Female reference ranges may incorrectly flag expected testosterone or haemoglobin values as abnormal.	Interpret results using affirmed gender where appropriate and consider duration of testosterone therapy.
Neglecting cardiovascular risk factors	Testosterone may unmask or worsen hypertension, dyslipidaemia and other cardiovascular risks.	Optimise BP, diabetes, smoking cessation, weight and lipid management alongside hormone therapy.
Overlooking sleep apnoea	Testosterone may worsen untreated OSA, contributing to erythrocytosis and cardiovascular risk.	Screen symptomatic patients and investigate when indicated.
Stopping testosterone before routine surgery unnecessarily	Evidence does not support routine cessation for most operations.	Continue therapy unless the surgical or anaesthetic team advises otherwise for specific circumstances.

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Not educating about gel transfer	Secondary exposure may affect partners or children.	Apply to covered skin, allow to dry completely, wash hands and avoid skin contact until dry.
Missing injection technique issues	Incorrect IM or SC technique can cause pain, poor absorption or injury.	Review injection technique periodically and rotate sites.
Assuming mood changes are always testosterone-related	Depression, anxiety and gender dysphoria may have other causes.	Assess mental health comprehensively rather than automatically reducing testosterone.
Using testosterone despite pregnancy	Testosterone is teratogenic and can virilise a female fetus.	Stop testosterone if pregnancy occurs and arrange appropriate obstetric care.
Failing to review medications and comorbidities	Polycythaemia, liver disease and cardiovascular disease may require dose modification or closer monitoring.	Perform regular medication reconciliation and risk assessment.
Not recognising formulation-specific issues	Sustanon contains peanut (arachis) oil; Reandron requires deep IM administration by trained personnel.	Select formulations based on allergies, patient preference, ability to self-inject and access to healthcare.

High-Yield Clinical Pearls

Pearl	Clinical Significance
Treat the patient, not just the testosterone level.	Clinical goals and adverse effects are as important as laboratory values.
Amenorrhoea is not contraception.	Always discuss pregnancy risk if relevant.
Most dose changes should occur no more frequently than every 3 months.	Allows adequate time to assess steady-state effects.
Persistent bleeding is never “normal” after prolonged testosterone therapy.	Investigate rather than repeatedly increasing testosterone.
Erythrocytosis is the most important laboratory adverse effect.	Regular FBC monitoring is essential.
Routine preventive healthcare continues.	Cervical, breast/chest, STI and cardiovascular screening should follow organ inventory and individual risk, not gender identity alone.
Masculinisation is gradual.	Setting realistic expectations improves adherence and satisfaction.