Seattle Children's Gender Clinic

Case Study: 14-Year-Old Nonbinary Person Desiring Menstrual Suppression

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Summary

14-year-old nonbinary person desiring menstrual suppression.

Patient History

J is a 14-year, 6-month-old child assigned female at birth who identifies as nonbinary and uses they/them pronouns. They have been exploring their gender for one year, initially talking with friends about gender and more recently coming out to parents and family as nonbinary about six months ago. Since then, they have been using they/them pronouns and a new chosen name and have changed their hairstyle and clothing to a more androgynous style. This has helped them feel more comfortable and confident. Parents initially struggled with using they/them pronouns, but they have been trying more and have been supportive of J.

J began having chest development around age 10 years old and had menarche at age 12 years old. Bleeding cycles occur regularly once a month. J was initially distressed by their chest and currently wears a binder, which has been helpful. They are very distressed by bleeding cycles and have noticed more depression and anxiety during these cycles. J does not want any effects of testosterone such as a deeper voice or facial hair.

J is pansexual and emotionally and physically attracted to people of all gender identities and body types. They have never been sexually active and are not currently in any relationships or planning on being sexually active in the near future.
Patient Diagnosis

The patient has gender dysphoria, as their gender identity is incongruent with their sex assigned at birth. The patient identifies as nonbinary, often described as a person whose gender identity falls outside of the traditional gender binary structure of male or female.

Labs/Imaging

None. If patient were sexually active with a partner with a penis in a way that could result in pregnancy, would recommend urine pregnancy test and STI screening.

Treatment and Discussion

Patients who are gender diverse have higher rates of suicide, self-harm, depression, anxiety, eating disorders, violence and bullying, family rejection and homelessness and risky sexual behaviors. Gender-affirming care (oriented towards understanding a patient’s gender experience), parental and family support of affirmed gender identity and medical interventions can help improve many of these mental health comorbidities and health disparities.

Patients with nonbinary gender identities may not desire to have a “masculine” or “feminine” gender expression. It is important to treat every patient as an individual and to discuss their gender goals and what aspects of their bodies are causing distress. For many patients who are assigned female at birth, menstrual bleeding can be very distressing. Menstrual suppression can be beneficial to stop bleeding and decrease distress. When discussing menstrual suppression options with gender diverse patients, it is important to use less gendered, more inclusive terms such as uterine bleeding instead of menses or periods. See references for further resources on inclusive language in reproductive and sexual health care.

Options for menstrual suppression include a number of hormonal contraceptive options that contain progesterone only or progesterone and estrogen. One of the medications we recommend frequently is the progesterone-only pill (POP) norethindrone acetate (Aygestin) 5 mg once a day. POPs are easy to take and have few side effects. They must be taken regularly at the same time each day to prevent irregular bleeding. If menstrual suppression is not sufficient, the dose can be increased to two pills (10 mg) once a day. Aygestin has not been approved as a contraceptive so would not be recommended for a patient who is having penile-vaginal sexual intercourse. The other POP (Micronor, or norethindrone 0.35 mg tablet) has been studied as a contraceptive, though in our practice, is often not as effective as other contraceptive methods at achieving menstrual suppression. Combined oral pills (with estrogen and progesterone) are more effective than POPs for contraception and are often more effective at suppressing bleeding when taken continuously (skipping the last week of placebo pills). Some patients feel that taking a pill containing estrogen does not align with their gender identity and so choose progesterone-only options over combined pills. Estrogen-containing pills may also cause some chest tenderness, which can make chest binding more difficult. There is also an increased risk of blood clots from the ethinyl estradiol in combined oral pills.
Other progesterone-only options for menstrual suppression that also provide contraception include medroxyprogesterone injections (Depo-Provera), etonogestrel implant (Nexplanon), and levonorgestrel intrauterine device (IUD). These options may be preferable in patients who cannot take daily medications consistently or who desire more effective contraception. Medroxyprogesterone injections and etonogestrel implants may have higher rates of irregular bleeding and spotting. Long-term use of medroxyprogesterone may also decrease bone density. Levonorgestrel IUD is effective for menstrual suppression as well as contraception, but gender diverse youth may be uncomfortable with the insertion procedure.

In Washington state, minors over the age of 14 years old can consent to reproductive health care on their own, including contraception and menstrual suppression. Laboratory evaluation is typically not required prior to starting menstrual suppression, but it is important to take a thorough medical and sexual history. If the patient has had penile-vaginal sexual intercourse, pregnancy should be ruled out before starting menstrual suppression. Testing for sexually transmitted infections should also be considered for patients who are sexually active.

Depending on what stage the patient is in puberty, puberty blockers (GnRH agonists) may be an option to pause further pubertal development and prevent or stop menses from occurring. However, puberty blockers alone cannot be used long-term due to concerns of low bone density with prolonged use. If the patient does not want effects of testosterone in the future, puberty blockers may still be beneficial to use for a short period to provide more time for gender exploration. Puberty blockers are not typically started more than two years post-menarche, as chest development is complete by this time. After this time, menstrual suppression is often a better option due to lower cost and options for administration.

If a patient decides to pursue gender-affirming hormones such as testosterone later on, menstrual suppression medications may be continued while the patient is beginning testosterone and then discontinued once testosterone is at a therapeutic level to suppress menses, or they can be continued long-term for contraceptive purposes, as testosterone alone does not provide adequate contraception.

**Outcome**

J started the progesterone-only pill norethindrone acetate (common brand name Aygestin) 5 mg once a day for menstrual suppression. Bleeding decreased but after 2 weeks they continued to have intermittent spotting, despite taking their Aygestin regularly at the same time every day. The dose of Aygestin was increased to 10 mg once a day, and bleeding has been fully suppressed since that time. J has noticed an improvement in mood and a decrease in anxiety now that menses are suppressed. They are thinking about pursuing top surgery in the future.

**References**

**Seattle Children’s Gender Clinic Website:**
https://www.seattlechildrens.org/clinics/gender-clinic/education-resources-healthcare-professionals/
Menstrual suppression algorithm:

Gender affirming hormone protocols (page 11 menstrual suppression):

Menstrual Suppression Review Article:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5684657/

Terminology Resources:


UCSF Center of Excellence for Transgender Health:
Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at www.transhealth.ucsf.edu/guidelines

AAP Policy Statement: