

CORRIGENDUM

CORRIGENDUM FOR “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline”

In the above-named article by Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, and T’Sjoen GG (*J Clin Endocrinol Metab.* 2017;102(11):3869–3903; doi: 10.1210/jc.2017-01658), the following errors occurred.

In the Summary of Recommendations, 1.0 Evaluation of youth and adults, Recommendation 1.1 on page 3870 and in Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence on page 3877, the Recommendation was originally:

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

The Recommendation should read:

1.1. We advise that only trained mental health professionals (MHPs) AND/OR TRAINED PHYSICIANS who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing RELATED psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

In Section 4.0 Adverse Outcome Prevention and Long-Term Care, Subsections Evidence and Transgender females, on pp. 3891–3892 a citation was omitted from the text.

The paragraph and citation were originally:

“There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent

normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).”

The paragraph and citations should read:

“There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154, 267).”

267. Radix A and Deutsch MB. Bone health and osteoporosis. In: Deutsch MB, ed. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*; second edition. Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco; June 2016. Available at www.transhealth.ucsf.edu/guidelines.

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