INTRODUCTION
Recent nationwide surveys have highlighted significant disparities in healthcare for transgender persons, who are currently considered a "priority population." The gaps in quality healthcare for transgender individuals include delayed diagnosis of HIV, C. difficile, and other conditions, lack of training in addressing transgender-specific health needs in medical school/residency programs, and other unmet needs.

Although best practice guidelines exist for providers in the fields of primary care and obstetrics, studies have shown that healthcare providers often feel unprepared and unsure of how to address transgender health needs. Given the variability in patient presentation, lack of current best practice guidelines, and varying comfort levels of healthcare providers, there are areas of significant improvement in the medical care of transgender patients. This case study describes an adolescent transgender patient receiving services at a comprehensive care center (CCC) for MS. The patient initially presented as a biological female and later identified as transgender male (female-to-male; FTM). The following includes a comprehensive medical and psychosocial history along with best practice guidelines for serving a transgendered population with a multidisciplinary approach in a CCC for MS.

CASE STUDY
Patient is a 19-year-old transgender male and identifies as gender neutral and prefers use of gender neutral pronouns. Thus, patient will be referred to as “he” or “their” throughout the case description.

Psychological History
Patient reported onset of gender confusion and later preference of gender neutral pronouns. Thus, patient will be referred to as “he” or “their” throughout the case description.

Patient is biological female, identifies as transgender male and occasionally as gender fluid. The patient’s personal gender identity has fluctuated over time, and he has experienced periods of gender identity uncertainty. The patient has identified as transgender over a period of approximately 10 years as of Fall 2017. Patient’s medical record in 2012 described gender nonconformity, chronic absence, and gender-ambiguous speech.

Patient described non-gender conforming attitudes beginning during middle childhood and began experimenting with outward expressions of male and female presentation in dress as an early adolescence. The patient reported feeling表意感 and sometimes criticized by school-aged peers and extended family members for decision to live as a male. Patient also recalled dating male and female partners during adolescence and has identified as a bisexual since the age of 13.

This has been non-consensually involved with male partners for approximately three years, and currently cohabitates with partner. The patient’s partner is active in coordinating the patient’s medical care and attending appointments, often acting in parental role and currently cohabitates with partner.

Patient reported feeling isolated and often lonely. He had difficulty socializing and felt left out at school and at work. Patient’s early life experiences included racial harassment and verbal criticism by school staff.

Patient has been employed in retail and manufacturing positions. Patient is the only child of biological parents. Parents divorced when the patient was four years old. Patient was raised by maternal grandmother in rural Maine until the age of 16. Attempts to complete coursework via online programming were unsuccessful due to personal and family stresses. Currently attending community college. Support is limited to romantic partner, immediate family members, and online gay, lesbian, and transgender community.

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