Gender Incongruence in Adolescents: Experience of a Tertiary Care Center in Portugal

Incongruência de Género em Adolescentes: Experiência de um Centro Terciário em Portugal

Keywords: Adolescent; Gender Dysphoria; Gender Identity
Palavras-chave: Adolescente; Disforia de Género; Identidade de Género

Dear Editors,

We have read with great interest the article "Coping with Gender Dysphoria in a Rural Environment during Adolescence" published in May 2024.[1] In this article, the authors reported a case of an adolescent with gender dysphoria, emphasizing the importance of a multidisciplinary, patient-centered approach to improve outcomes in this population.

Gender incongruence (GI) is defined as a discrepancy between an individual's gender identity and their assigned sex at birth and it is classified as gender dysphoria when it is associated with clinically significant distress.[2]

We would like to contribute with findings from our recent study of 68 adolescents with gender incongruence followed in an endocrinology pediatric outpatient clinic of a tertiary hospital in Portugal. Given the retrospective nature of the work, in which data were collected anonymously, exclusively by consulting clinical files, without conducting face-to-face interviews, this study did not meet the criteria for submission to our institution's Ethics Committee. Our study demonstrated an almost eight-fold increase in referrals for gender incongruence over recent years (eight referrals between 2017 and 2020; 60 referrals between 2021 and 2024), underscoring heightened social awareness and healthcare engagement. We observed that the median age at the first consultation in pediatric endocrinology was 16 years, although the majority of these individuals reported symptoms in childhood and 73.5% of the patients had been referred to us by the outpatient child psychiatry consultation, having already established a diagnosis of gender incongruence. A key finding was the high prevalence of psychiatric comorbidities, with 47.1% of adolescents requiring pharmacological treatment. This aligns with the literature indicating that stigma, social pressures, and lack of family acceptance significantly contribute to poor mental health outcomes.[3] Integrating mental health support with gender-affirming care is critical, particularly given the potential for improved psychological well-being with timely interventions.[4] Earlier recognition, particularly in primary care and community settings, is crucial to mitigate the psychological distress associated with delayed interventions.[1]

Our study also provided insights into the management trajectory. Nearly 78% of patients initiated medical treatment, including puberty blockers and gender-affirming

Table 1 – Characterization of pediatric patients with gender incongruence

	Total n = 68	Male transgender n = 43	Female transgender n = 25	*p*
Age at first appointment – median (IQR) in years	16 (14 - 16)	16 (14 - 16)	15 (12.5 - 15)	0.324
Childhood onset of gender incongruence – n (%)	47 (69.1%)	27 (62.8%)	20 (80.0%)	0.139
Adolescence onset of gender incongruence – n (%)	21 (30.9%)	16 (37.2%)	5 (20.0%)	0.139
Psychopathology requiring pharmacotherapy – n (%)	32 (47.1%)	19 (44.2%)	17 (68.0%)	0,058
Medical treatment – n (%)	53 (77.9%)	37 (86.0%)	16 (64.0%)	0.035
Time to medical treatment following first consultation – median (IQR) in months	4 (3 - 12)	6 (3 - 12)	4 (3 - 6.75)	0.266
Age at medical treatment onset – median (IQR); min/max in years	16 (14 - 16.5); min 12/max 18	16 (14 - 16.5); min 12/max 18	16 (13.5 - 16.8); min 12/max 18	0.805
Oral progestagens – n (%)	-	30 (81.0%)	-	-
Puberty blocker isolated – n (%)	10 (18.9%)	3 (8.1%)	7 (43.8%)	0.005
Gender-affirming hormone therapy – n (%)	11 (20.8%)	10 (27%)	1 (6.3%)	0.141
Puberty blocker plus gender-affirming hormone therapy – n (%)	18 (34.0%)	10 (27%)	8 (50.0%)	0.105
Surgical procedures – n (%)	6 (11.3%)	5 (13.5%) (mastectomy)	1 (6.3%) (chondrolaryngoplasty)	0.402
Fertility preservation – n (%)	9 (13.2%)	3 (6.9%)	6 (24.0%)	0.066
Duration of follow-up – median (IQR) in months	11 (3.3 - 21)	12 (3 - 21)	9 (4 - 22.5)	0.682

hormonal therapy. These interventions were well-tolerated, with only one reported case of transient hyperprolactinemia.

Fertility preservation was discussed with all patients but only 13.2% (n = 9) decided to undergo the procedure, probably due to the emotional and logistical complexities involved during a critical period of self-discovery. Furthermore, our clinic reported no cases of detransition (i.e., reverting to the sex assigned at birth or stopping transition-related care), consistent with literature suggesting that regret rates are low when interventions follow thorough multidisciplinary assessments.[5]

Our findings echo Ribeiro *et al* call to action: comprehensive training for healthcare providers, enhanced access to specialized care, and culturally sensitive approaches are essential to improve outcomes for transgender youth. Expanding research to include multi-center and longitudinal studies will further refine care strategies, ensuring holistic support for this vulnerable population.

AUTHOR CONTRIBUTIONS

JG, JVM: Data collection, analysis, and interpretation, draft and critical review of the manuscript.

ARH, CP, MLS: Data analysis and interpretation, draft and critical review of the manuscript.

All authors approved the final version to be published.

PROTECTION OF HUMANS AND ANIMALS

The authors declare that the procedures were followed according to the regulations established by the Clinical Research and Ethics Committee and to the Helsinki Declaration of the World Medical Association updated in October 2024.

DATA CONFIDENTIALITY

The authors declare having followed the protocols in use at their working center regarding patients' data publication.

COMPETING INTERESTS

The authors have declared that no competing interests exist.

FUNDING SOURCES

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Recebido/*Received*: 16/12/2024 - **Aceite/*Accepted*:** 06/02/2025 - **Publicado *Online*/*Published Online*:** 12/06/2025 - **Publicado/*Published*:** 01/08/2025

https://doi.org/10.20344/amp.22705