

# Gender-affirming care during lactation

## Case report of a transmasculine parent

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According to the 2021 census from Statistics Canada, approximately 59,460 Canadians identify as transgender, and 41,355 as nonbinary.<sup>1</sup> Transgender men (ie, individuals who identify as men as opposed to their assigned sex at birth) may desire gestation and parenthood. However, pregnancy, labour, and lactation can trigger or exacerbate gender dysphoria in nonbinary and transgender individuals.<sup>2</sup> While testosterone therapy can alleviate dysphoria in transgender men, limited safety data regarding use of testosterone during lactation restricts evidence-based patient counselling.<sup>3</sup> This may force parents to forgo lactation initiation, wean infants early, or delay gender-affirming care.

Family physicians play a unique role in the human life cycle as they are involved in pregnancy, childbirth, and postpartum patient care. Thus, being informed about reproductive care options for all patients, including transgender individuals, is important for family physicians.

### Case

A 34-year-old transmasculine patient who was the gestating parent for his infant was referred to our clinic shortly after the child's birth to discuss options for testosterone therapy while chestfeeding. The infant (assigned female at birth) was born via cesarean delivery at 41 weeks' gestation. There were no medical complications during pregnancy or delivery. The patient wanted to weigh the risks of testosterone therapy against the known benefits of lactation, as direct latching had been less dysphoric than expected, and he wanted to continue chestfeeding.

We discussed that research on testosterone therapy during lactation is limited. According to the LactMed database, infants do not appear to be adversely affected by parental testosterone therapy.<sup>4</sup> One study of a cisgender woman receiving testosterone therapy via subcutaneous pellet implant showed no measurable

testosterone excretion into breast milk, and no adverse clinical effects on the breastfed infant after 7 months of continuous testosterone therapy to the mother by subcutaneous pellet implant.<sup>5</sup> High levels of testosterone can result in decreased milk supply by inhibiting prolactin, a hormone necessary for milk production.<sup>4</sup>

After reviewing the available literature that suggested there is minimal transfer of testosterone to an infant via human milk,<sup>3</sup> the patient elected to initiate testosterone therapy. To date, the patient had had a normal milk supply, and the infant had maintained appropriate growth. The patient felt safest initiating testosterone therapy after the infant was 6 months old and had started eating complementary solid foods, reducing the potential impact that a reduced milk supply might have on the child's feeding.

Possible modes of testosterone delivery, including transdermal and subcutaneous preparations, were discussed with a pediatric endocrinologist and the patient's adult endocrinologist. Due to the possible risk of transmission to the infant by topical medication, we concluded injectable testosterone would be a safer delivery method at the minimal injectable dose of 5 mg twice weekly. For reference, typical doses for initiating testosterone therapy range between 20 mg and 50 mg of injectable testosterone weekly.<sup>6</sup> The patient and his endocrinologist established a desired temporary testosterone target level in the high range of normal for a cisgender woman. Following consultation with a pediatric endocrinologist, we developed a plan to monitor patient and infant serum testosterone levels and assess the infant for virilization, such as development of unexpected acne or androgenized hair. We measured baseline levels prior to initiating testosterone, and measured again at 3 to 4 weeks, and 7 to 8 weeks after testosterone initiation (**Table 1**).<sup>7-9</sup> Throughout these assessments, all infant testosterone

### Editor's key points

- ▶ Gender-diverse individuals' experiences and needs during gestation and lactation are critically underexplored.
- ▶ Shared decision making with families is key to providing gender-affirming care during lactation.
- ▶ Family physician education on gender-affirming care and lactation contributes to inclusive medical care for gender-divergent individuals who may desire lactation.
- ▶ Concurrent lactation and gender-affirming testosterone therapy in a transmasculine parent is possible with no adverse effects to either the parent or infant.

**Table 1. Patient and infant laboratory test values before and after initiating testosterone**

INDIVIDUAL	BEFORE INITIATING TESTOSTERONE*	3 WEEKS AFTER INITIATING TESTOSTERONE	7 WEEKS AFTER INITIATING TESTOSTERONE
<b>Parent</b>			
Free testosterone (0.002-0.03 nmol/L)	0.006	0.016	0.012
Total testosterone (<2 nmol/L)	0.5	1.6	1.1
SHBG (18-130 nmol/L)	63	67	66
<b>Infant</b>			
Free testosterone (0.0021-0.0087 nmol/L)	Too low to measure	Too low to measure	Too low to measure
Total testosterone (<2 nmol/L)	<0.2	<0.3	<0.4
SHBG (60-252 nmol/L)	199	282	155

SHBG—sex hormone-binding globulin.  
 \*All values measured in nmol/L.  
 Data from Forest et al<sup>7</sup> and Alberta Precision Laboratories.<sup>8,9</sup>

levels remained undetectable with no clinical evidence of virilization (Table 1).<sup>7-9</sup> The parent successfully maintained chestfeeding while receiving testosterone therapy without complications.

## Discussion

As clinicians strive to improve gender-affirming care, they increasingly encounter patients whose reproductive goals and transition pathways intersect. Our case demonstrates the complex balance between affirming gender identity and supporting lactation. Transgender and lactation medicine are rapidly evolving, yet literature on lactation in transgender men is limited.<sup>3</sup> We were able to identify only 2 case reports on this topic. One described the case of a lactating transgender man who initiated testosterone therapy at 13 months postpartum and continued to provide milk to his infant for an additional 5 months<sup>3</sup>; the other described a lactating transgender man who restarted testosterone therapy when his child was approximately 21 months old and continued to chestfeed the child for approximately 15 more months.<sup>10</sup> Continued chestfeeding beyond 12 months remains beneficial to the parent and child but typically contributes less to infant nutrition.<sup>11</sup>

To our knowledge, this case report is the first to examine the effects of testosterone therapy by a chestfeeding transmasculine parent during an infant's first year of life. There was no evidence in laboratory testing or on physical examination of testosterone being passed to the infant through the patient's milk. The infant's undetectable serum testosterone level was likely due, in part, to testosterone's limited oral bioavailability. We were unable to obtain detailed analysis of the milk components to confirm testosterone levels in the milk due to this type of testing not being commercially available in our laboratory.

Further research is needed to explore a range of clinical scenarios, including earlier testosterone therapy initiation, varied testosterone dosing, and long-term monitoring of infant outcomes. These additional studies are needed to support informed decision making about the use of testosterone during lactation for patients and clinicians.

## Conclusion

Comprehensive patient counselling on transgender lactation should include guidance on hormone therapy tailored to individual goals, as well as access to lactation consultants and breastfeeding and lactation medicine physicians who are trained in gender-affirming care. 🌱

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### Competing interests

**Debby Oladimeji** received funding for this work from the Northern Alberta Academic Family Medicine Fund.

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This article has been peer reviewed.

*Can Fam Physician*. 2026 Mar;72(3):e66-7.

doi: [10.46747/cfp.7203e66](https://doi.org/10.46747/cfp.7203e66)