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BRIEF COMMUNICATION

The Brexit in adolescent gender dysphoria care?

On 10 April 2024, the independent review of gender identity services for children and young people in the United Kingdom was published, the so-called 'Cass review'.[1] The review aimed to advise the English National Health System on how to improve gender identity services. The review strongly recommends a new model of care where puberty blockers 'should only be offered under a research protocol', because 'we have no good evidence on the long-term outcomes of interventions to manage gender-related distress'.[1] This decision came after a systematic review by the University of York that concluded that 'no high-quality studies were identified that used an appropriate study design to assess the outcomes of puberty suppression in adolescents experiencing gender dysphoria/incongruence'.[2]

While being 388 pages long, the review did not consider at the end that clinical decisions, especially in paediatrics, are not solely reliant on evidence from randomised clinical trials. For example, a study showed that among recent Cochrane Reviews, more than 9 in 10 studied health-care interventions are not supported by high-quality evidence.[3] Perhaps we should not use any more non-pharmacological strategies to reduce procedural pain in children (such as non-nutritive sucking, facilitated tucking, and swaddling) because most analyses in this topic were based on very low- or low-certainty grades of evidence and none were based on high-certainty evidence.[4]

The same puberty blockers have been utilised since 1981 for treating central precocious puberty, and their use is now considered safe and effective, with no known severe long-term adverse effects. They have been licensed for central precocious puberty based on relatively short open-label studies with small groups of patients because it was impossible and unethical to perform more robust studies (i.e., randomised controlled trials).[5] Limited evidence exists, for example, on their psychological outcomes in children with central precocious puberty. If we aspire to the same scientific rigour as Cass review then, by the transitive property, we may well consider ceasing the prescription of puberty blockers also in children with precocious puberty.

The suggestion to increase the available evidence by using a research protocol is obviously spot-on. However, a question should be asked. On the grounds of the available evidence, including non-randomised trials, would it be ethical to force children to adhere to research protocols or to wait for >10-year follow-up study results to start using puberty blockers in clinical practice? What are the risks at stake? Children with untreated gender dysphoria are at higher risk of psychological suffering and suicide when compared to peers.[6] Moreover, available controlled evidence suggests that puberty blockers decrease the percentage of adolescents switching to affirming therapy.[7]

Puberty blockers have been the standard of care for many years in different countries when applied in well-staffed certified centres with high-quality multi-professional teams, and it is very unusual in the history of medicine that a time-honoured treatment, with a good safety record, even if based on non-randomised trials and experts' opinion, is simply banned, while waiting for better evidence.

The extent of the impact of the Cass review will not be known any time soon, but what is likely to be the case is the fact that it will significantly affect gender care in England already undermined by very long waiting lists. It is also going to be particularly interesting to see how these recommendations are going to be put in place. Predicting the global impact of this review is challenging, but one logical consequence is its potential to further polarise the debate.

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