

Updated Australian Standards of Care for Informed Consent Gender Affirming Hormone Therapy

23 May 2026

PATHA is pleased to welcome the [Australian Standards of Care for Informed Consent Gender Affirming Hormone Therapy](#), released in November 2025. They reflect an ongoing commitment to advancing best practices aligned with the latest research. We would like to highlight several areas for consideration when prescribing and monitoring gender affirming hormone therapy.

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The first area of interest is around concerns with bone density and a lower reference range for oestrogen levels. While the minimal oestradiol concentration required to maintain bone health remains uncertain, the Australian guidelines recommend a lower reference range of 250 pmol/L, with evidence of bone density loss being likely below 182 pmol/L. This is an area for consideration where people are on lower doses of oestrogen, or have oestrogen levels consistently below 250pmol/L. It also notes that responses to gender affirming hormone therapy (GAHT) are highly individual, and blood hormone levels do not reliably correlate with clinical outcomes.

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There is a comment on lab reference ranges, highlighting the importance of considering how long someone has been on GAHT when interpreting lab results, which have binary gendered reference ranges.

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There is mention of the potential for penile pain and erectile dysfunction. Guidance is given for ways to mitigate or reduce penile pain in people on oestrogen-based GAHT. These are regular use by masturbation or sexual intercourse, penile vacuum pumps, and low-dose testosterone cream such as AndroFemme applied to the genitals.

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Whilst progesterone is not included in the standard hormone prescribing tables, the guidelines include commentary about prescribing progesterone. PATHA recognises that progesterone is an increasingly requested medication in oestrogen-based GAHT. While there are no well-designed studies on progesterone use in oestrogen-based GAHT, individuals and the community often cite anecdotal benefits. The guidelines state that when it is used, doses are commonly 100-200mg of micronised

progesterone nightly, and that given the lack of strong evidence for benefits, this should be reviewed in 3-6 months to assess effectiveness and determine ongoing use.

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Information is provided on Pulmonary Oil Micro-Embolicism (POME). This is an important factor to consider, particularly when injecting Reandron. For this reason, Reandron should be injected by a health professional. It may be useful to advise health consumers of this risk when they start Reandron, given the potential for self-administration attempts. Many people who have been using Reandron for a long time are used to self-injecting due to historical access issues, and this may be of interest for ongoing informed consent around the risk of self-injection.

Hot tip

From page 41 onward, in a section named “Beyond hormones: clinical scenarios and key considerations”, the guidelines contain useful information which goes beyond the basics of hormone prescribing and gets into some commonly encountered clinical questions and scenarios. This includes areas such as androgenic alopecia, cardiovascular risk, and gynaecological and pelvic health. These are great for continual professional development and extra learning.

Application in an Aotearoa Context

These areas represent emerging research in GAHT that may be applicable in an Aotearoa context, given the similarities between Australian and Aotearoa environments, and are food for thought when tailoring individual care for health consumers. Informed consent should be used throughout the prescribing process, and health consumers should be aware of the limitations of evidence on potential treatment options and their risks.