



- Health Issues
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TRANSGENDER HEALTH

The term *transgender* describes people whose gender identities differ from their anatomic sex. Transpeople may seek to alter their bodies in a variety of ways, or decide against any medical intervention. Transmen and transwomen (see box, "Terminology 101") may express their gender identity through a myriad of presentations and behaviors, hoping to "pass" and be accepted in their preferred gender.^{1,2} Transpeople come from every walk of life, every sexual orientation, and every region of the country. Some may identify not as transgender but simply as male or female, or they may choose not to identify with any gender labels at all. There are many cultures and subcultures represented within transgender communities, each with rich and varied expressions of gender identity.

Transpeople as a group experience health disparities including difficulty accessing care and a lack of medical providers able—or willing—to address their needs. Compounding these challenges, some transgender subgroups, such as recent immigrants, youth, the homeless, and those with unstable or no employment, often find themselves in transient circumstances, making engagement, enrollment, and retention in health care, and social services all the more difficult.³

The size of the transgender population is largely unknown, primarily because surveillance data often excludes or miscounts transpeople (e.g. transwomen being placed in the category of men who have sex with men [MSM]). Lack of national data on the transgender population affects funding for prevention, outreach, testing, and health care focusing on transpeople. It also hinders public health professionals from better understanding and addressing transgender needs. Additionally, transgender health is traditionally taught under the umbrella of psychiatry and psychology and is not a standard part of the core primary health curriculum in most medical schools.⁵

DID YOU KNOW?

- ▶ Estimated HIV rates are higher among transwomen than any other subpopulation;⁴ Ryan White grantees have an important role in addressing this and treating the trans community.
- ▶ Steps like posting trans-friendly materials in provider waiting rooms and having single-occupancy bathrooms go a long way in making transpeople feel welcomed and comfortable in your clinic space.



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Transgender women are more disproportionately affected by HIV disease than any other subpopulation. According to a U.S. Centers for Disease Control and Prevention meta-analysis, more than one-half of HIV-positive transwomen were unaware of their status, underscoring the need to increase attention, testing, and treatment of this population.

Though HIV rates are much lower among transmen, they have unique health care needs and may still be at risk for infection. As such, we must continue to do more to become clinically and culturally competent in addressing transgender health needs.

There are many subcultures that exist within the transgender population but despite its diversity, one thing is clear: Ryan White HIV/AIDS Program providers have a big role to play in increasing access to and efficacy of HIV primary care to this population. The Ryan White HIV/AIDS Program has always prided itself—in fact it built itself—on patient-centered, comprehensive care to those most in need and that is why we're devoting this issue to *HRSA CAREAction*, so together we can do more for our trans patients and curtail the epidemic within this community.

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Cover: A patient and provider at the Ursuline Sisters HIV/AIDS ministry in Youngstown, Ohio. Photograph by: Ben Fraser

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HIV/AIDS

Prevalence

The percentage of U.S. transpeople who are HIV positive is unknown, but estimates place HIV prevalence among this population as the highest in the Nation.⁴ The California Department of Health Services found that self-identified transgender clients—specifically, transwomen—had the highest proportion of HIV diagnoses, greater than high-risk populations such as MSM and partners of people living with HIV/AIDS.⁴

Furthermore, findings suggest that a significant proportion of HIV-positive transwomen are unaware of their status. Data-based assessments point to high HIV risk among transpeople, self-perception of risk is often low,² signaling a need for increased prevention education and awareness. A U.S. Centers for Disease Control and Prevention (CDC) meta-analysis of 29 studies on transwomen found the average HIV prevalence was 28 percent when results were lab confirmed, but that prevalence was 12 percent by self-report.⁴ In addition, the CDC analysis found African-American transwomen to have the highest prevalence regardless of test assessment with 56 percent testing HIV positive, and 31 percent self-reporting a positive status.⁴

In contrast, HIV prevalence among transmen is low. A study in the *American Journal of Public Health* reported 2-percent prevalence of HIV infection in this population. Other studies have estimated prevalence ranging from less than 1 percent to 3 percent. More studies are necessary to better understand this population and its specific risks.⁶

Factors Contributing to HIV Risk and Health Disparities

Stigma

Transpeople face an enormous amount of stigma, which often leads to lower self-esteem; depression; and increased likelihood of survival sex work, substance abuse, and risk-taking behaviors.² Social marginalization can result in denial of employment, housing, and even educational opportunities.² Stigma can manifest in multiple ways; it can appear as overt or covert discriminatory practices against members of a stigmatized group, and it is often internalized among members of that group. It arises in part from a lack of the public's understanding of a population and its needs.⁷

Many transpeople face other sources of stigma, including HIV status, sexual orientation, sex work, and race/ethnicity, further compounding the challenges they face and the need for appropriate messaging and education. In addition, many transpeople have had negative past experiences with the health care system due to the insensitivity, ignorance, or discomfort of medical providers, creating further barriers to engagement and retention in care.⁸ Some do not

want to access HIV services at clinics frequented by other transpeople because they fear losing anonymity. Those fears may be alleviated if the clinic isn't known as an HIV clinic but, instead, as a primary health care clinic offering hormone therapy.³

Sex Work and Survival Sex

In a Los Angeles study, more than one-half of transwomen reported a history of sex work. For some transwomen, sex work provides affirmation of their gender identity, and it may help fund sexual reassignment, silicone injection, or cosmetic surgery. Transpeople, particularly transwomen, experience high rates of housing discrimination as well as employment discrimination, which often leads to homelessness—both cited as contributing factors to survival sex.^{4,6,9,10} While many transpeople engage in sex work for a variety of reasons, it places this population at increased risk for HIV and is one contributing factor to high rates of incarceration.^{11,12}

Unprotected Sex

Risk factors such as multiple sexual partners and irregular condom use are common in the transgender community.² Examples of sexual risk factors include:

- ▶ Eighty-five percent of transwomen in a San Francisco Department of Public Health project reported receptive anal intercourse without a condom on a lifetime basis.^{8,13}
- ▶ Furthermore, transwomen who perform commercial sex work have reported that they are often paid more for services if they do not wear a condom, increasing their risk for HIV.^{8,14}
- ▶ Although HIV prevalence among transmen is much less than among transwomen, an important study on transmen who have sex with nontrans men (also commonly referred to as gay transmen) consistently reported not using condoms during receptive anal or vaginal sex.¹⁵

High rates of HIV among transwomen place their sexual partners at increased risk for acquiring HIV. Conversely, trans MSM have reportedly low incidence, but their sexual partners (nontrans MSM) have high rates of HIV, placing trans MSM at increased risk.¹⁵ Little HIV prevention messaging targets transgender populations or their partners. Improved prevention messaging that takes partners into account and relates to the everyday reality of transmen and transwomen is required to adequately increase awareness and reduce rates of HIV transmission.¹⁵

Silicone Use

Many transwomen inject silicone as a fast, cheap alternative to hormone therapy or cosmetic surgery. It assists in giving them a more feminine body shape (curves) which helps them “pass” in public. (Passing also provides a measure of safety from discrimination and hate crimes.¹⁶) Silicone use also preserves male sexual drive, which is usually suppressed by hormonal therapy, offers quicker results than hormone therapy, and is

cheaper than cosmetic surgery. Silicone injection, however, is not legal and carries numerous health risks. Medical silicone is hard to obtain, so other fluids are often injected as substitutes including lubricants, sealants, grease oil, and other toxic materials not meant for bodily injection.

Transwomen may attend “pump parties” where they take turns injecting silicone, often in unsanitary conditions. The sharing of injection needles carries the risk for HIV and hepatitis. Silicone often hardens and migrates over time, leading to systemic illness (i.e., medical complications of tissues and organs), disfigurement, or even death.¹⁷ Some transwomen may be reluctant to give up silicone use, and providers should therefore consider harm reduction strategies to educate them about needle sharing.¹⁸

As Earline Budd, founder of Transgender Health Empowerment cautions, “At the end of the day, all the counseling in the world just does not seem to heal the wounded heart of a transgender woman who says she wants breasts overnight.” Budd adds, “This is where we hope word of mouth can help, that if we educate our clients about the risks of silicone that they’ll let others know, too.”

To counter silicone use, Madeleine Deutsch, physician at the Los Angeles Gay & Lesbian Center’s Transgender Health Program, displays a picture of a patient who is deformed because of silicone. “The woman’s chest wall is a rock-hard mass,” says Deutsch. “The patient gave me permission to use her picture to educate others. The sad thing is, she’ll likely die from this.”

Violence and Victimization

Distrust of police and the criminal justice system, along with fears of further victimization, often result in underreporting of violence against transpeople. Violence against this group, particularly against transwomen of color, is believed to be rampant, however. Several urban needs assessments and behavioral risk studies, along with data from *Remembering Our Dead* (an online memorial for deceased transpeople), support findings of victimization, domestic violence, and hate crimes.¹⁹

Sexual violence against transwomen is extraordinarily high. In San Francisco, the health department found that 59 percent of transwomen have been raped.^{8,13} Another study of 402 transpersons revealed that more than 50 percent reported experiencing some form of harassment (e.g., bullying) in their lives and 25 percent reported experiencing a violent incident.^{20,21} Even in shelters, transpersons experience discrimination as a result of gender segregation policies—which can place transpersons at risk for shelter violence, as they may be housed with persons uncomfortable by their presence and subsequently assault them.¹²

Harassment in school and employer discrimination prevent many transpersons from completing their education, keeping jobs, or feeling safe and accepted—conditions associated with high risk behaviors that can cause HIV infection.²² Some studies have found that approximately 1 in 4 transwomen have not received a high school diploma. Among transgender Latinas, this number may be as high as 1 in 2.²¹

A needs assessment for the Boston Health Care for the Homeless Program found high rates of verbal and emotional harassment among their transwomen patients (both at the clinic and on their way to the clinic). In response, the program instituted evening hours so these patients could feel safe and welcomed. As Pam Klein, a nurse at the program, explains, “All of the issues of a vulnerable, marginalized group are present among this population. The issues themselves aren’t necessarily different, but they are worse.”

Incarceration

High rates of sex work and drug use can lead to incarceration and overrepresentation of transwomen in prisons and jails. An estimated 37 to 65 percent of transwomen have been incarcerated at some point in their lives.¹² Incarceration can be particularly stressful for transpeople because they are often housed according to whether they have undergone genital surgery; are often without hormone therapy; and are at increased risk for discrimination, violence, and unprotected sex.²³

DEPRESSION

Rates of depression are higher among transpeople than among the general public. Suicidal ideation among transwomen is in epidemic proportion. The CDC meta-analysis found that across studies, an average of 54 percent of transwomen reported suicidal thoughts and an average of 31 percent reported lifetime suicide attempts.⁴ Like transwomen, many transmen suffer from low-self esteem, high rates of depression, suicidality, substance use, and risk taking.²⁴

Transpersons may also suffer social isolation that ranges from discomfort in public settings to fear of partner rejection to limited family and friend support.^{25,26,27,28} Transpeople who identify as gay, lesbian, or bisexual sometimes feel that they are not truly welcomed within those communities, further contributing to social disconnectedness.²⁸ Several interviewees stated that the sentiment “two is a crowd” is common within the transgender community—that is, the fear of being outed in public and the concomitant threat to personal safety means transpeople can even feel concerned about being seen with their peers in public. Feelings of isolation are compounded for transpersons who don’t “pass.”²⁹

SYSTEMIC BARRIERS

Insurance

Even transpeople with health insurance face significant barriers because hormone therapy and sex reassignment surgery are commonly excluded by U.S. health insurers. In fact, transpeople are the only population required to have some sort of psychiatric evaluation before cosmetic surgery, a requirement often seen as stigmatizing.⁵ A formal diagnosis of gender identity disorder, however, is sometimes a “necessary evil” to ensure that patients have access to appropriate and necessary mental health services³⁰ and health insurance coverage.³¹

Insurance companies may deem necessary procedures (e.g., a transman needing a hysterectomy) as sexual reassignment surgery and may deny claims.¹⁶ When challenges arise

from billing requirements and gender identification, providers should explain the situation to the patient and discuss options for how to proceed.¹⁸ This may include physicians and support staff members interacting with insurance claims processors on behalf of their transpatients. Providers may also use non-specific diagnostic and procedural codes to work around the issue.³²

Substance Abuse Treatment

Substance abuse treatment (both inpatient and outpatient rehab) can present barriers to transpeople including provider insensitivity, strict gender segregation, and requirements to refrain from hormone use.^{12,19,33} Providers should refer patients to trans-friendly treatment facilities where hormone use is not considered substance use.

Legal Issues

Identification documents (ex. birth certificates and drivers licenses) often do not match the gender or name of the transperson, thus causing barriers to employment or to qualify for social services.¹² For legal purposes, only sex (either assigned at surgery, or if changed through surgery) is used on most documents. Even if intersex persons (those with chromosomal abnormalities, mixed sex characteristics and, rarely, ambiguous genitalia) are assigned a sex at birth.⁷ As of June 10, 2010, however, sexual reassignment surgery is no longer a prerequisite for passport issuance in a transperson’s preferred gender; now applicants need only present a certificate from their physician indicating treatment for gender transition (but not surgery).³⁴ Still, name and sex changes continue to pose barriers to appropriate identification, which itself becomes a barrier when accessing services.

Electronic Medical Records

Electronic medical records (EMRs) sometimes do not have transgender-specific options. Such systems make it more difficult for transpeople to change their sex designation. Some EMR systems may permit a change but retain a record of the change that can be seen without the need for the physician or patient to provide permission. Such systems leave transpatients vulnerable to exposure and discrimination.³² Carole Hohl, director of HIV services at the Boston Health Care for the Homeless Program, explains, “We include preferred name in a chart alongside legal name, which is a trigger to other providers so they know what name to call the patient and helps avoid creating billing issues.” Clinics are encouraged to adopt flexible EMR systems or develop workarounds like the one Hohl describes.

CULTURAL COMPETENCY

According to the *Transgender HIV/AIDS Health Services Best Practices Guidelines*, providers should be able to talk about a range of health care and social issues that affect transpersons, such as safe and unsafe ways to modify their bodies and appearances, sexual risk behaviors, mental health and substance use issues, intimate partner violence, housing,

Gender

A system of classification used to describe characteristics and behaviors ascribed to bodies. Sex and gender are believed to be independent of each other.

Gender expression

The way in which a person communicates their gender to others.

Gender identity

A person's sense of their own gender

Gender identity disorder

Diagnosis used by psychologists to describe persons who suffer from severe gender dysphoria (discontent with biological sex and/or gender assigned at birth).

Intersex (formerly called hermaphrodites)

Persons born with chromosomal or physiological anomalies and/or ambiguous genitalia.

Outing

Revealing a transgender person's status without his or her permission.

Passing

Refers to trans persons who are successful at presenting in public in their chosen gender.

Sex

Refers to anatomy and biology.

Transgender

People whose gender identities are different than their anatomic sex.

Transitioning

The process of moving from one sex or gender to another.

immigration issues (if applicable), hormone therapy, and surgery.¹⁸ Providers are encouraged to create patient satisfaction surveys that address patient comfort with clinic providers.¹⁸ Providers have the most success when their approaches take race and ethnicity into account and incorporate involvement from the community.³⁵

Training and Addressing Misconceptions

Trainings should be implemented for all provider staff, including receptionists, and provide information on local transgender-specific resources, sexual orientation and gender identity issues, transgender culture and its diversity, sexual and other forms of harassment as well as domestic violence and anti-discrimination laws.¹⁸ In addition, it should provide communication skills training to ensure use of culturally appropriate language.¹⁸

Training should address misinformation. As Deutsch explains, "There are a lot of misconceptions about transpeople. There's a sense they all fit the same demographic profile [and that they] are transitioning to realize their sexual identity, but sexual identity and gender identity are completely different."

Providers shouldn't assume all transpersons are seeking or have had gender reassignment surgery; there is no one way—or right way—to gender transition.³⁶ Transitioning can be a difficult time, and peer mentors who are open about their transgender status can be important resources and sources of support, especially for young transpeople.²²

Transman (also known as female-to-male, or FTM)

A man classified as female at birth but who identifies as a man and expresses a male gender identity.

Transsexual

A person who has undergone steps (e.g., hormones, surgery) to attain the physical characteristics concurrent with their gender identity.

Transwoman (also known as male-to-female, or MTF)

A woman classified as male at birth but who identifies as a woman and expresses a female gender identity.

Sources: De Vries ALC, Cohen-Kettenis PT, Delemarre-Van de Waal, H. *Caring for transgender adolescents in BC: suggested guidelines: clinical management of gender dysphoria in adolescents*. January 2006. Available at: <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-adolescent.pdf>. Accessed July 18, 2011.

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To demonstrate that a clinic is transgender friendly, it is important to have materials in the waiting room that are specific to this population. Clinics should also post antidiscrimination policies and provide written hiring policies indicating the organization's desire to employ qualified, diverse candidates.¹⁸

Flexibility

When possible, clinics should consider flexible hours. Flexible hours are particularly helpful for transpersons engaged in sex work.³ Others may simply feel more comfortable attending clinic during off-peak hours. Additionally, availability of single-occupancy bathrooms rather than gender-specific bathrooms will help ensure that patients are neither outed nor uncomfortable, and it relieves staff from having to choose a bathroom to which to direct a transperson.

Referrals

Providers should also make contact with trans-serving community organizations; have comprehensive referral lists for trans-friendly resources and health services; be actively involved in making referrals and following up; and refer transpersons to a specific contact person so they know whom to ask for and feel more comfortable inquiring about services. Providers should also discuss with patients whether it is important to disclose their gender to the new agency so the transperson's needs can be adequately addressed.¹⁸

Use of Pronouns

Clinics should respect what gender a client says he or she is. If providers are in doubt, they should ask the patient politely and discreetly what his or her preference is. Use of gender-neutral language ensures inclusion of all transpersons and avoids inadvertently “outing” someone in public. It’s also important to understand that

Patients may wish to be labeled male or female according to their gender identity and expression, their legal status, or according to the way they are registered with their insurance carrier. They may wish to be referred to as female in one situation (e.g., in their record with the physician’s office and in personal interactions with the physician and staff), but male in other situations (e.g., on forms related to their insurance coverage, lab work, etc.). This application of terminology could change at any time as individuals come to understand or evaluate their gender.³²

CLINICAL COMPETENCY

“Regardless of their socioeconomic status, all transgender people are medically underserved.”³⁷

As Jessica Xavier, project officer at HAB, explains, “When seeing a new provider for the first time, the very act of disrobing can make a transgender patient feel unsafe. Many patients have had negative experiences with health providers and can find the notion of a physical exam terrifying.” It is recommended that providers delay sensitive exams, if possible, until patients become more comfortable.³⁸

Providers should ask only questions directly pertinent to the patient’s health, and not out of curiosity.³⁹ If sensitive questions are required (e.g., during an HIV or STD assessment), the following approach is recommended by HRSA’s AIDS Education and Training Center:

I will be discussing some sensitive topics with you today. I will be asking you questions about your sexual behavior and will ask you what body parts you use for sexual activity. I am asking you these questions in order to help you best assess your HIV and STD risks so that we can keep you and your partners healthy. I do not want to assume anything, and most of all I want you to feel comfortable speaking with me today. If you prefer I use other language or words to describe a body part or activity, just let me know. Please feel free to ask me questions any time.⁷

Physical exams should be conducted on the basis of the organs present rather than the perceived gender of the patient. Measures such as smoking cessation, exercise, and family history, remain important to include in general health maintenance discussions.¹⁸ JoAnne Keatley, director of the Center of Excellence for Transgender Health explains that a lot of primary care doctors already have the skills required to address transgender primary care needs and thus, shouldn’t be deterred from treating trans patients.

Remember that the presence of a transgender patient is not a training opportunity for other providers. “I really

advocate that physicians be willing to learn from their patients but not make the patients teach them,” says Keatley. “Putting trans patients in the role of the educator is unfair. They don’t have the medical background and, in fact, may have low health literacy.”

Mitigate patient worries around the confidentiality of client-level data and assure patients that any patient-specific information disclosed among medical staff is restricted to appropriately addressing their health needs. Providers should also create a nonjudgmental environment where patients feel comfortable discussing any risk-taking behaviors.¹⁸

Hormones

Hormone therapy plays an important role in the anatomical and psychological gender transition for transpeople and may be necessary for successful living in the person’s preferred gender (Figure 1).¹⁸ In addition, hormones are considered to improve quality of life and decrease psychiatric issues, because patients feel like members of their preferred gender.³¹ “Transwomen are typically given estrogen and testosterone blockers,” says Deutsch. “Progesterone may be tried if they’re having mood issues or their libido is too low, but this certainly isn’t used for everyone. For transmen, we just give testosterone.”

Administration of hormones is not to be taken lightly and it is recommended that patients who take them be at least 18 years old (unless with parental consent); demonstrate knowledge about what hormones can and cannot do; and be able to document real-life experience of either at least 3 months living in their preferred gender, or, receipt of psychotherapy and have a mental health professional’s recommendation.³¹ “I use the informed consent model. I do a half-hour intake with the patient, make assessment of patient ability to make informed decision, similar to how you would assess someone who comes in for plastic surgery. They need to demonstrate capacity to understand risks and provide necessary self-care as well as comply with a regimen,” explains Deutsch. Says Hohl, “We try to use administration of hormones as a chance to do education. . . . If someone’s labs come back and it’s clear they’re using other hormones, then we’ll do individualized education with them and we’ll adjust how much hormone we’re giving.”

Although many changes due to hormone therapy are reversible, some are not. To maintain these changes, hormone therapy must continue throughout one’s life. Thus initiation of hormonal therapy is a serious commitment and it should be administered by a physician after adequate assessment.³¹ Hormone use should also precede any sexual reassignment surgery interventions.³¹

Adolescents may be eligible for puberty-delaying luteinizing-hormone releasing hormone (LHRH) agonists (i.e., testosterone blockers, estrogen blockers) as soon as puberty has set in, although parents need to make informed decisions and provide consent. Delaying puberty affords more time to explore gender identity and other developmental issues, and the therapies may make passing easier which can aid in this exploration. Another factor is that this intervention is fully reversible.

Whenever possible and medically appropriate, providers should make onsite hormone therapy available to transgender clients. This single component of care for trans patients is an important and reliable draw that can counteract other barriers to HIV care. Offering onsite hormone therapy allows providers to better monitor HIV-positive patients' antiretroviral adherence, reduce risk of unsafe street drugs, and link patients to support services. Although there are some risks associated with hormonal therapy (outlined in Figure 1) according to Deutsch, today's newer therapies carry substantially less risk than they used to. She encourages HIV care providers not to be dissuaded from considering incorporating hormone therapy. Rather, they should do research and talk to others already offering such services in their practices.

CONCLUSION

As one transsexual woman explained, "It's not like my real body; it's like a mask I want to shed, and it's really hard because people just don't seem to understand." This sentiment is shared by many transpeople and demonstrates the need for an array of services to make them feel welcome; address their individual needs; and deliver the kind of comprehensive, culturally sensitive services the Ryan White HIV/AIDS Program was founded on.

Transmen and transwomen face significant health disparities and barriers in access, and Ryan White providers can ensure that patients receive the care and services they need. No one model of care delivery works for all transgender sub-populations, so doing research, enlisting the assistance of local trans-friendly agencies, and talking to members of this population will go far in helping craft an approach that best serves the needs—and wants—of a provider's transgender community.

Forthcoming changes to the CDC's HIV surveillance methodology are expected to include using the two-step model to collect data on sex assigned at birth, as well as current gender identity. These changes should ensure that transpeople who identify as male or female but not transgender are classified as transgender.^{38,40} In addition, Section 4302 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) seeks to create specificity, uniformity, and increased quality in data collection. These improvements, together with the U.S. Department of Health and Human Services national data progression plan (in development), will create a more comprehensive picture of trans health care needs and inform our health efforts in years to come.

 **FIGURE 1. BODILY CHANGES WITH HORMONE THERAPY**

FOR MALE-TO-FEMALES

Increase in: breast size and body fat (which is redistributed, particularly to the hips)
Also, softening of skin

Decrease in: upper body strength, body hair, fertility, testicle size, and sexual arousal

Risks: blood clotting, infertility, liver disease, hypertension, gallstone formation, diabetes mellitus, increased blood pressure, shift in lipid profiles, potential vitamin deficiency (including vitamin D and calcium), and potential to develop benign and malignant liver tumors and hepatic dysfunction.

FOR FEMALE-TO-MALES

Increase in: clitoris size, facial and body hair, sexual arousal, and upper body strength
Also, deepening of voice

Decrease in: hip fat, breast size, scalp hair (potential pattern baldness)

Risks: ovarian cancer, infertility, and cardiac risk.

Risk of hormonal therapy not under a doctor's care include bacterial and viral infections from non-sterile injections; liver damage; blood clotting problems; deep vein thrombosis; and potential drug interactions.

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