How does hormone transition in transgender women change body composition, muscle strength and haemoglobin? Systematic review with a focus on the implications for sport participation

Joanna Harper, Emma O’Donnell, Behzad Sorouri Khorashad, Hilary McDermott, Gemma L Witcomb

ABSTRACT

Objectives We systematically reviewed the literature to assess how long-term testosterone suppressing gender-affirming hormone therapy influenced lean body mass (LBM), muscular area, muscular strength and haemoglobin (Hgb)/haematocrit (HCT).

Design Systematic review.

Data sources Four databases (BioMed Central, PubMed, Scopus and Web of Science) were searched in April 2020 for papers from 1999 to 2020.

Eligibility criteria for selecting studies Eligible studies were those that measured at least one of the variables of interest, included transwomen and were written in English.

Results Twenty-four studies were identified and reviewed. Transwomen experienced significant decreases in all parameters measured, with different time courses noted. After 4 months of hormone therapy, transwomen have Hgb/HCT levels equivalent to those of cisgender women. After 12 months of hormone therapy, significant decreases in measures of strength, LBM and muscle area are observed. The effects of longer duration therapy (36 months) in eliciting further decrements in these measures are unclear due to paucity of data. Notwithstanding, values for strength, LBM and muscle area in transwomen remain above those of cisgender women, even after 36 months of hormone therapy.

Conclusion In transwomen, hormone therapy rapidly reduces Hgb to levels seen in cisgender women. In contrast, hormone therapy decreases strength, LBM and muscle area, yet values remain above that observed in cisgender women, even after 36 months. These findings suggest that strength may be well preserved in transwomen during the first 3 years of hormone therapy.

INTRODUCTION

Currently the world of sport, from grassroots level to elite, is facing the challenge of how to include transgender people in sporting competitions. Regulations governing the participation of athletes from outside the sex/gender binary have existed since the 1940s.1–4 Presently, World Athletics requires that transgender athletes5 and athletes with differences of sexual development6 have testosterone levels ≤5 nmol/L in order to be eligible for the female category. There has been heavy criticism of this, and previous, testosterone-based regulations.7–9 Although no openly transgender athlete has competed in the Olympics to date, the increasing visibility of gender-diverse people in society10 means that the sports administrators and legislators must create rules to accommodate athletes from outside the sex/gender binary.11

There are many quantifiable performance-related differences between male and female athletes. In contrast, the performance-related differences between transwomen who have received gender affirming hormone treatment (GAHT) and cisgender women are less clear. GAHT for transwomen consists of an antiandrogen agent plus the introduction of exogenous oestrogen,12 with the goal of altering the hormonal milieu and, as a result, feminisation of the body.13 To date, there have been no prospective studies investigating the changes in athletic performance in transgender athletes after hormonal transition. In non-athletic transwomen populations, studies are commonly focused on clinical outcomes, such as bone health.14 However, studies in non-athletic transwomen undergoing GAHT also report changes in lean body mass (LBM),15 muscle cross-sectional area (CSA),16 muscular strength17 and haemoglobin (Hgb)18 and/or haematocrit (HCT).19 These parameters are of relevance to athletic performance.

In endurance sports, Hgb is of importance. Hgb is a protein carried by the red blood cells that is responsible for transporting oxygen from the lungs to peripheral tissues.20 Low Hgb, or low HCT, the volume of red blood cells compared with total blood volume, can lead to a diminished supply of oxygen to the tissues, and therefore have a direct effect on endurance performance. Typical values for Hgb differ between males and females, with ‘normal’ values ranging between 131–179 g/L for men and 117–155 g/L for women.21 HCT values are also higher in males (42%–52%) than females (37%–47%).22 Testosterone exerts erythropoietic effects that results in increases in both HCT and Hgb.23 Since GAHT significantly lowers testosterone levels in transgender women,24 it is possible that they may experience reductions in HCT and Hgb, which would be anticipated to negatively affect endurance performance.

In sports demanding speed and power, muscular strength and the ability to generate high rates of force are recognised as key determinant in athletic success.25 In cisgender men, increases in testosterone due to puberty promote muscular strength...
in association with increased muscle CSA, and increased lean muscle mass. It has been hypothesised that muscle retains a long-term memory allowing it to perform tasks that it has undertaken many times previously and myonuclei retention is thought to play an important role in such muscle memory. Myonuclei number is increased with training and with use of anabolic steroids. However, detraining does not diminish the myonuclei number, and it has been hypothesised that cessation of steroids may also not lead to reductions in myonuclei number. Hence, it is possible that strength advantages gained when training in a high-testosterone environment may not be fully reversed by testosterone suppression.

Understanding both the physiological effects of GAHT on athletic performance, and the time course of these effects, is of importance to decision-makers and those undertaking policy reviews. While it is known that testosterone levels are markedly reduced in transgender women taking testosterone suppressing GAHT, the effects of this hormonal change on physiology, and the time course in which these changes occur, are less clear. Individual studies provide crucial, primary research on the topic, but a systematic review is warranted to provide a robust summary of the available evidence. Because bone mineral density studies have already been subject to systematic review, this review focuses on physiological changes induced by GAHT in transwomen that affect athletic performance; specifically, LBM, CSA, strength and Hgb/HCT.

**Aim**
The aim of this systematic review was to: (1) summarise the current state of knowledge as it relates to the changes, and the time course of these changes, in physiological parameters associated with athletic performance in non-athletic transwomen resulting from GAHT (suppression of testosterone and supplementation with oestrogen), and (2) consider the potential implications for the participation of transwomen in elite sport.

**MATERIALS AND METHODS**

**Search strategy and selection criteria**
This systematic review was conducted in line with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Two electronic searches of four online databases (BioMed Central, PubMed, Scopus and Web of Science) were completed 15 months apart. The first was performed by BSK in January 2019 and the second by JH in April 2020. The two sets of search results were compared by GLW. The second search identified novel data from three additional studies using the same cohorts as three studies identified in the first search. The more recent search also identified three additional recent papers. Reference lists were also searched for additional citations pertinent to the review. The searches combined terms related to transwomen, GAHT, muscle and blood parameters (online supplemental table 1).

**Study selection, quality assessment, and data extraction**
Each study was initially categorised based on its design (eg, cohort, case–control) and examined for quality in line with the Effective Public Health Practise Project (EPHPP) tool. This is a generic tool used to evaluate a variety of intervention study designs and is suitable for use in systematic reviews, having content and construct validity. Based on the EPHPP, six domains are evaluated: (1) selection bias; (2) study design; (3) confounders; (4) blinding; (5) data collection method; and (6) withdrawals/dropouts. Each domain is rated as strong (3 points), moderate (2 points) or weak (1 point), and domain scores are averaged to provide the overall mean rating. Based on the overall mean rating, studies are rated as weak (1.00–1.50), moderate (1.51–2.50) or strong (2.51–3.00).

For longitudinal studies, data were extracted to examine changes in LBM, CSA, strength and Hgb/HCT in transwomen taking GAHT. In cross-sectional studies, data in transwomen were compared with data from both cisgender men and cisgender women. The study authors were contacted if there were any questions regarding the presented data. In this regard, authors of the nine studies carried out by the European Network for the Investigation of Gender Incongruence (ENIGI) were contacted regarding potential overlapping participants and another author was contacted to clarify graphical data content.

**RESULTS**

**Search results**
Figure 1 shows the search strategy following PRISMA guidelines. From an initial yield of 795 articles, 24 studies were included in this review. The following information was extracted from each study: name of the first author, country, year of publication, number of transfemale participants, number of cisgender male and female participants (where applicable), duration of any follow-up, type of medical treatment, method of measurement, evaluation time, and results.

**Quality assessment**
Based on the mean EPHPP scores, all studies were categorised as moderate in quality. The individual scores are listed in the online supplemental table 2.

**Study characteristics**
A summary of the study characteristics is reported in table 1. The sample sizes of the studies varied from 12 to 249. Three large studies from the ENIGI group published in 2018 and 2019 contained much novel data, but also included many participants from previous studies making it impossible to accurately state the number of unique participants.

**Study designs**

Figure 1 PRISMA flow chart illustrating search strategy. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.
### Table 1 Characteristics of reviewed studies

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Study type</th>
<th>Country</th>
<th>Study quality rating</th>
<th>Participants (N)</th>
<th>Age (years)</th>
<th>Timing (months post GAHT)</th>
<th>T (nmol/L)</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbers et al (1999)</td>
<td>Follow-up</td>
<td>Netherlands</td>
<td>Mod</td>
<td>20</td>
<td>–</td>
<td>–</td>
<td>26±6</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Gooren and Bunck (2004)</td>
<td>Follow-up</td>
<td>Netherlands</td>
<td>Mod</td>
<td>19</td>
<td>–</td>
<td>–</td>
<td>NR</td>
<td>Baseline 12 36</td>
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<tr>
<td>Mueller et al (2011)</td>
<td>Prospective</td>
<td>Germany</td>
<td>Mod</td>
<td>84</td>
<td>–</td>
<td>–</td>
<td>36±11.3</td>
<td>Baseline 12 24</td>
</tr>
<tr>
<td>Wierdix et al (2014)</td>
<td>Follow-up</td>
<td>Norway and Belgium</td>
<td>Mod</td>
<td>53</td>
<td>–</td>
<td>–</td>
<td>31.7±14.8 19.3±2.4</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Gava et al (2016)</td>
<td>Follow-up</td>
<td>Italy</td>
<td>Mod</td>
<td>40</td>
<td>–</td>
<td>–</td>
<td>32.9±9.4 29.4±10.2</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Auer et al (2016)</td>
<td>Follow-up</td>
<td>Belgium</td>
<td>Mod</td>
<td>20</td>
<td>–</td>
<td>–</td>
<td>NR</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Auer et al (2018)</td>
<td>Follow-up</td>
<td>Belgium</td>
<td>Mod</td>
<td>45</td>
<td>–</td>
<td>–</td>
<td>34±1.4</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Jarin et al (2017)</td>
<td>Follow-up</td>
<td>USA</td>
<td>Mod</td>
<td>13</td>
<td>–</td>
<td>–</td>
<td>18 (14–25)</td>
<td>Baseline 6</td>
</tr>
<tr>
<td>Defreyne et al (2018)</td>
<td>Follow-up</td>
<td>Netherlands and Belgium</td>
<td>Mod</td>
<td>239</td>
<td>–</td>
<td>–</td>
<td>28.5 (16–65)</td>
<td>Baseline 3 6 24</td>
</tr>
<tr>
<td>Vita et al (2018)</td>
<td>Follow-up</td>
<td>Italy</td>
<td>Mod</td>
<td>21</td>
<td>–</td>
<td>–</td>
<td>25.2±7.0</td>
<td>Baseline 30</td>
</tr>
<tr>
<td>Klaver et al (2018)</td>
<td>Follow-up</td>
<td>Netherlands and Belgium</td>
<td>Mod</td>
<td>179</td>
<td>–</td>
<td>–</td>
<td>29.0 (18–66)</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Olson-Kennedy et al (2018)</td>
<td>Prospective</td>
<td>USA</td>
<td>Mod</td>
<td>23</td>
<td>–</td>
<td>–</td>
<td>18 (12–23)</td>
<td>Baseline 24</td>
</tr>
<tr>
<td>Tack et al (2018)</td>
<td>Follow-up</td>
<td>Belgium</td>
<td>Mod</td>
<td>21</td>
<td>–</td>
<td>–</td>
<td>16.3±1.2</td>
<td>Baseline 5–31</td>
</tr>
<tr>
<td>Tack et al (2017)</td>
<td>Follow-up</td>
<td>Belgium</td>
<td>Mod</td>
<td>21</td>
<td>–</td>
<td>–</td>
<td>16.3±1.2</td>
<td>Baseline 12–31</td>
</tr>
<tr>
<td>Schaff et al (2019)</td>
<td>Follow-up</td>
<td>Netherlands and Belgium</td>
<td>Mod</td>
<td>249</td>
<td>–</td>
<td>–</td>
<td>28 (23–40)</td>
<td>Baseline 12</td>
</tr>
<tr>
<td>Wilk (2020)</td>
<td>Prospective</td>
<td>Sweden</td>
<td>Mod</td>
<td>11</td>
<td>–</td>
<td>–</td>
<td>27±4</td>
<td>Baseline 4 12</td>
</tr>
<tr>
<td>Van Caenegem et al (2014)</td>
<td>Follow-up and cross-sectional</td>
<td>Belgium</td>
<td>Mod</td>
<td>49</td>
<td>49</td>
<td>–</td>
<td>33±12 30 (17–67) 33±12</td>
<td>Baseline 12 24</td>
</tr>
<tr>
<td>Haraldsen et al (2007)</td>
<td>Follow-up and cross-sectional</td>
<td>Norway</td>
<td>Mod</td>
<td>12</td>
<td>77</td>
<td>–</td>
<td>29.3±7.8 33.9±9.3</td>
<td>Baseline 12 24</td>
</tr>
</tbody>
</table>

Continued
used an exclusively cross-sectional design; three comparing transwomen on GAHT with cisgender controls,\textsuperscript{18, 33, 34} and three comparing transwomen on GAHT with hormone-naive transwomen.\textsuperscript{45, 50, 52} Three studies\textsuperscript{16, 44, 49} used a prospective method gathering data over 12–24 months. Aside from these three studies, data were extracted from medical charts (nine of which were from the same research group,\textsuperscript{15, 17, 19, 36–43}) posing a risk of selective data reporting and publication bias.

### Medical treatments

Medical treatments for endocrine transition were varied, in line with the individualised approach advised by the WPATH Standards of Care.\textsuperscript{23} Fourteen studies\textsuperscript{17, 19, 36–43, 46, 48, 54} used cyproterone acetate (50–100 mg daily) as an antiandrogen. In six studies,\textsuperscript{16, 38, 40, 44, 46, 49} a form of gonadotropin-releasing hormone agonist was administered either to suppress puberty or androgens. In four studies\textsuperscript{18, 49, 50, 52} spironolactone was used as an antiandrogen. Seventeen studies\textsuperscript{15, 17–19, 36–39, 41, 44, 47–50, 52} used 2–4 mg/day of oral oestradiol valerate. Eleven studies\textsuperscript{15–17, 19, 39, 42, 43, 45, 47–50} used transdermal 17-beta-oestradiol releasing 100 mcg/day. Four studies\textsuperscript{16, 38, 47, 49} used an injection of oestradiol valerate (10 mg/ampoule, every 1–4 months). Two studies\textsuperscript{45, 54} used 0.625–2.5 mg/day of conjugated equine oestradiol. Ethinyl oestradiol was not used in any study after 2010, primarily due to increased risk of thrombogenesis.\textsuperscript{36}

Based on the variability in drug regimens used, there is substantial heterogeneity in the hormone levels achieved. Although the transwomen in most of the studies achieved testosterone levels within the reference range for cisgender women, there were five studies\textsuperscript{18, 40, 47, 49, 51} in which the transfemales had post-GAHT testosterone values greater than 5 nmol/L. Four of the five studies\textsuperscript{18, 40, 47, 49} were carried out on adolescent transfemales; two of the five studies\textsuperscript{38, 51} did not involve the use of an antiandrogen agent; one study\textsuperscript{40} did not involve the use of any form of oestrogen. The high post-GAHT testosterone is a possible confounder, and potential physiological differences between adolescent and adult participants may also confound results.

### Muscle mass and body fat changes

Table 2 summarises the studies reporting muscle mass and body fat. Eight studies\textsuperscript{15, 36, 39–41, 44, 46, 53} used a follow-up design to assess changes in LBM; seven studies assessed after 12 months,\textsuperscript{15, 36, 39–41, 44, 46, 51} and one\textsuperscript{40} study reviewed patients who had been under treatment for 5–31 months. Seven of these studies,\textsuperscript{15, 36–39, 41, 44, 51} including the large (n=179) ENIGI study,\textsuperscript{55} and two studies\textsuperscript{40, 51} with high post-GAHT testosterone (≥8 nmol/L), showed that total LBM was decreased by 3.0%–5.4% following hormone transition (p<0.05). The one study that failed to demonstrate significant changes in LBM\textsuperscript{40} was not an outlier in any obvious way. The large ENIGI study\textsuperscript{55} was the only study in which the limits of agreement would indicate a change in LBM at the 95% CI. All studies reported an increase in total body fat mass in transwomen after hormone transition. Three cross-sectional studies\textsuperscript{31, 33, 54} compared transwomen with cisgender men. Two studies included hormone-naive transwomen.\textsuperscript{41, 51} These studies reported 6.4% and 8.0% lower LBM than in cisgender men and reductions of 4% in LBM in the transwomen with 12 months of GAHT. The third cross-sectional study compared transwomen who had undergone at least 48 months of GAHT with cisgender men\textsuperscript{44} and reported 17% lower LBM in transwomen than in cisgender men.
CSA changes

Four follow-up studies\textsuperscript{16 40–42} investigated the CSA either in the quadriceps, forearm or calf regions using MRI\textsuperscript{16 42} or peripheral quantitative computed tomography (pQCT).\textsuperscript{40 41} Of note, two of the studies measured the total CSA of the individual MRI\textsuperscript{12} or pQCT\textsuperscript{41} image while two studies measured the isolated muscle.\textsuperscript{16 40} A decrease in CSA of 1.5%–11.7% was reported quantitatively computed tomography (pQCT).\textsuperscript{40 41} Of note, two longitudinal studies\textsuperscript{16 17 37 40} investigated the muscular strength changes of transwomen with cisgender men. One study reported 9% decrease in quadriceps CSA compared with baseline after 12 months.\textsuperscript{16} Two studies\textsuperscript{41 42} found no significant strength differences, although one of these studies\textsuperscript{40} was carried out on adolescents who failed to reach typical female testosterone levels (8.8 nmol/L after GAHT). The large ENIGI study\textsuperscript{17} was the only study in which the limits of agreement would indicate a change in strength at the 95% CI. The fifth longitudinal study to assess strength measured upper leg strength using knee flexion and extension and found no significant difference after 12 months.\textsuperscript{16} Two studies\textsuperscript{41 54} used a cross-sectional design to compare the strength of transwomen to cisgender men. One study found 14% lower hand grip strength in hormone-naive transwomen than in cisgender men (p<0.001)\textsuperscript{41} and a further 7% reduction in hand grip strength of the transwomen after 12 months of GAHT. The other study\textsuperscript{54} found 24% lower hand grip and quadriceps strength in transwomen than in cisgender men after 48 months or more on GAHT (p<0.001).

Hgb and HCT changes

Nine studies\textsuperscript{16 19 36–38 43 47–49} reported the levels of Hgb or HCT in transwomen before and after GAHT, from a minimum of three to a maximum of 36 months post hormone therapy. Eight of these studies,\textsuperscript{16 19 36–38 43 48 49} including the large (n=239) ENIGI study,\textsuperscript{19} found that hormone therapy led to a significant (4.6%–14.0%) decrease in Hgb/HCT (p<0.01), while one study found no significant difference after 6 months.\textsuperscript{47} The mean age of participants in the latter study was 18 years and the range was 14–25 years. The participants also failed to reach typical female testosterone levels (after 6 months mean testosterone=6.9 nmol/L), while in six\textsuperscript{16 19 36–38 43 48} of the eight studies mean testosterone levels after GAHT was less than 2.0 nmol/L. The large ENIGI study\textsuperscript{19} was the only study in which the limits of agreement would indicate a change in Hgb/HCT at the 95% confidence interval.

Muscular strength changes

Table 4 summarises the studies reporting muscular strength. Five longitudinal studies\textsuperscript{16 17 37 40 41} investigated the muscular strength of transwomen. Four of the studies\textsuperscript{17 37 40 41} measured hand grip strength in participants on the ENIGI study. The largest of the three (n=249) ENIGI studies\textsuperscript{19} and one other study\textsuperscript{41} found significant (p<0.001) reductions (4.3% and 7.1%, respectively) after 12 months on GAHT. Two ENIGI studies\textsuperscript{17 40} found no significant strength differences, although one of these studies\textsuperscript{40} was carried out on adolescents who failed to reach typical female testosterone levels (8.8 nmol/L after GAHT). The large ENIGI study\textsuperscript{17} was the only study in which the limits of agreement would indicate a change in strength at the 95% CI. The fifth longitudinal study to assess strength measured upper leg strength using knee flexion and extension and found no significant difference after 12 months.\textsuperscript{16} Two studies\textsuperscript{41 54} used a cross-sectional design to compare the strength of transwomen to cisgender men. One study found 14% lower hand grip strength in hormone-naive transwomen than in cisgender men (p<0.001)\textsuperscript{41} and a further 7% reduction in hand grip strength of the transwomen after 12 months of GAHT. The other study\textsuperscript{54} found 24% lower hand grip and quadriceps strength in transwomen than in cisgender men after 48 months or more on GAHT (p<0.001).

Table 2  Changes in total LBM in kilograms

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Baseline mean±SD (95% CI)</th>
<th>12 Months mean±SD (95% CI)</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mueller et al (2011)\textsuperscript{11}</td>
<td>84</td>
<td>59.6 (54.6–64.6)</td>
<td>57.2 (54.0–64.1)</td>
<td>−4.0</td>
<td>&lt;0.005</td>
<td>13.6–0.6</td>
</tr>
<tr>
<td>Wiercks et al (2014)\textsuperscript{46}</td>
<td>40 (oral oestrogen)</td>
<td>56.0±7.5</td>
<td>53±8</td>
<td>−5.4</td>
<td>&lt;0.001</td>
<td>18.0–0.4</td>
</tr>
<tr>
<td>Johnny et al (2016)\textsuperscript{18}</td>
<td>12 (transdermal oestrogen)</td>
<td>62.6±9.3</td>
<td>59.7±8.1</td>
<td>−4.6</td>
<td>0.05</td>
<td>19.7–0.5</td>
</tr>
<tr>
<td>Gava et al (2016)\textsuperscript{41}</td>
<td>20 (cyproterone acetate)</td>
<td>51.7±8.3</td>
<td>49.9±7.8</td>
<td>−3.5</td>
<td>0.05</td>
<td>16.3–0.7</td>
</tr>
<tr>
<td>Johnny et al (2016)\textsuperscript{40}</td>
<td>20 (leuprolide acetate)</td>
<td>50.2±7.0</td>
<td>49.8±6.7</td>
<td>−0.8</td>
<td>0.05</td>
<td>22.2–0.7</td>
</tr>
<tr>
<td>Auer et al (2018)\textsuperscript{40}</td>
<td>45</td>
<td>59.5±8.7 (96.9±9.2)</td>
<td>57.5±12 (53.9–60.2)</td>
<td>−3.4</td>
<td>&lt;0.001</td>
<td>17.5–1.9</td>
</tr>
<tr>
<td>Klaver et al (2018)\textsuperscript{49}</td>
<td>179</td>
<td>57.2±8.3</td>
<td>55.5</td>
<td>−3.0</td>
<td>&lt;0.001</td>
<td>15.9–8.8</td>
</tr>
<tr>
<td>Tack et al (2018)\textsuperscript{16}</td>
<td>21</td>
<td>47.0±6.4</td>
<td>44.8±6.3</td>
<td>−4.7</td>
<td>&lt;0.01</td>
<td>16.8–8.6</td>
</tr>
<tr>
<td>Haraldsen et al (2007)\textsuperscript{51}</td>
<td>12</td>
<td>54.4±6.2</td>
<td>52.2</td>
<td>−4.0</td>
<td>&lt;0.001</td>
<td>16.8–8.6</td>
</tr>
<tr>
<td>Van Caenegem el al (2015)\textsuperscript{54}</td>
<td>49</td>
<td>57.4±8.7</td>
<td>55.1±8.7</td>
<td>−4.0</td>
<td>&lt;0.001</td>
<td>19.0–0.5</td>
</tr>
</tbody>
</table>

Data are from dual energy X-ray absorptiometry scans. CM, cismen; LBM, lean body mass; TW, transwomen.

Table 4  Summary of studies reporting muscular strength

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Baseline mean±SD</th>
<th>12 Months mean±SD</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
</table>


Review
CI. Three cross-sectional studies compared HCT in transwomen post GAHT with cisgender controls (table 5). Two studies found that transwomen on GAHT for 6 or 48 months had lower (10%) HCT than cisgender men (p<0.005), while two studies found no difference between transwomen after 6 and 12 months of GAHT and cisgender women.18 53 Three cross-sectional studies found significant differences (p<0.05) or large effect sizes (Cohen’s d=1.0) in HCT between transwomen on GAHT for 6 or 48 months and hormone-naive transwomen, and HCT decreases of 7.4%–10.9%. See table 5.

### DISCUSSION

We summarise changes induced by GAHT in non-athletic transwomen in four characteristics strongly associated with athletic performance: LBM, muscle CSA, muscular strength, and Hgb/HCT levels. Overall, the findings demonstrate a reduction in these parameters over time. However, the time course of these reductions was not consistent across the parameters assessed.

In keeping with the muscular anabolic effects of testosterone and the mixed effects of oestrogens, studies using dual energy X-ray absorptiometry report decreased LBM (0.8%–5.4%) in association with testosterone treatment.57 58

### Table 3 Changes in muscle CSA

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>CSA region (units)</th>
<th>Baseline CSA means±SD (95% CI)</th>
<th>Follow-up CSA means±SD (95% CI)</th>
<th>Number of months of GAHT</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbers et al (1999)</td>
<td>20</td>
<td>Thigh (cm²)</td>
<td>307±47</td>
<td>278±37</td>
<td>269–287</td>
<td>271±39</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td>Wiik (2020)</td>
<td>11</td>
<td>Quadriceps (mm²)</td>
<td>6193±679</td>
<td>5931±671</td>
<td>5680–6190</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tack et al (2015)</td>
<td>21</td>
<td>Forearm (mm²)</td>
<td>3275±541</td>
<td>3142±574</td>
<td>3282±478</td>
<td>12–31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van Caenegem et al (2015)</td>
<td>49</td>
<td>Forearm (mm²)</td>
<td>3999±746</td>
<td>3664±783</td>
<td>3825±867</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM, cismen; TW, transwomen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Data are from MRI or pQCT. CM, cismen; CSA, cross-sectional area; TW, transwomen.

### Table 4 Changes in strength measures

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Strength measure (units)</th>
<th>Baseline means±SD (95% CI)</th>
<th>12 months means±SD (95% CI)</th>
<th>21–31 monthsMeans±SD</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Caenegem et al (2015)</td>
<td>49</td>
<td>Hand grip (kg)</td>
<td>42±9</td>
<td>39±9</td>
<td></td>
<td>−7.1</td>
<td>&lt;0.001</td>
<td>19.0–0.5</td>
</tr>
<tr>
<td>Auer et al (2016)</td>
<td>20</td>
<td>Hand grip (kg)</td>
<td>41.7±7.8</td>
<td>41.9±7</td>
<td></td>
<td>0.5</td>
<td>&lt;0.05</td>
<td>17.5–1.9</td>
</tr>
<tr>
<td>Tack et al (2015)</td>
<td>21</td>
<td>Hand grip (kg)</td>
<td>33.8±8.1</td>
<td>34.3±5.6</td>
<td>39.2–40.8</td>
<td>4.3</td>
<td>&lt;0.001</td>
<td>18.3–0.8</td>
</tr>
<tr>
<td>Scharff (2019)</td>
<td>249</td>
<td>Hand grip (kg)</td>
<td>41.8±8.9</td>
<td>40.0±8.9</td>
<td>39.2–40.8</td>
<td>1.2</td>
<td>&lt;0.05</td>
<td>18.0–0.5</td>
</tr>
<tr>
<td>Wiik (2020)</td>
<td>11</td>
<td>Knee extension (N-m)</td>
<td>239.7±44.0</td>
<td>242.6±41.5</td>
<td>230–252</td>
<td>101.5±15.5</td>
<td>1.5</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Strength measure (units)</th>
<th>TW baseline means±SD</th>
<th>TW 48 months means±SD</th>
<th>CM means±SD</th>
<th>% Difference</th>
<th>P</th>
<th>T (nmol/L) TW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Caenegem et al (2015)</td>
<td>49</td>
<td>Hand grip (kg)</td>
<td>42±9</td>
<td>49±6</td>
<td></td>
<td>−14.3</td>
<td>&lt;0.001</td>
<td>19.0</td>
</tr>
<tr>
<td>Lapauw et al (2008)</td>
<td>23</td>
<td>Hand grip (kg)</td>
<td>41±8</td>
<td>53±8</td>
<td></td>
<td>−22.6</td>
<td>&lt;0.001</td>
<td>1.1</td>
</tr>
</tbody>
</table>

CM, cismen; TW, transwomen.
with GAHT. Twelve months of GAHT also decreased muscle CSA (1.5%–9.7%). However, a further 12 or 24 months of GAHT did not always elicit further decreases in muscle CSA. Strength loss with 12 months of GAHT also decreased muscle CSA. This postulate is consistent with findings reported in one study conducted in athletic transwomen. In this study, the race times of eight transmale distance runners were compared at baseline and after one or more years of GAHT. After adjusting performance for age, the eight runners were not more competitive in the female category (after GAHT) than they had been in the male category (before GAHT). Given this, and that the changes in Hgb/HCT follow a different time course than strength changes, sport-specific regulations for transwomen in endurance versus strength sports may be needed.

Of interest, compared with cisgender men, hormone-naive transwomen demonstrate 6.4%–8.0% lower LBM, 36%–39% lower hand-grip strength and 35%–61% lower knee extension strength compared with cisgender men, the small decrease in strength in transwomen after 12–36 months of GAHT suggests that transwomen likely retain a strength advantage over cisgender women. Whether longer duration of GAHT would yield further decrements in strength in transgender women is unknown.

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Measure (units)</th>
<th>Baseline meansSD (95% CI)</th>
<th>Follow-up meansSD (95% CI)</th>
<th>Number of months</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TW</td>
<td>CM, cismen; CW, ciswomen; HCT, haematocrit; Hgb, haemoglobin; HNTW, hormone-naive transwomen; TW, transwomen.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Longitudinal studies

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Measure (units)</th>
<th>Baseline meansSD (95% CI)</th>
<th>Follow-up meansSD (95% CI)</th>
<th>Number of months</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wierckx (2014)</td>
<td>40 (oral oestrogen) 12 (transdermal oestrogen)</td>
<td>HCT (%) 45±1.5 45±1.7</td>
<td>42±5.7 42±2.3</td>
<td>12</td>
<td>−7.0</td>
<td>&lt;0.01</td>
<td>18.0–0.4</td>
<td></td>
</tr>
<tr>
<td>Auer et al (2016)</td>
<td>20</td>
<td>HCT (%) 42±2 2.7</td>
<td>42±1.8</td>
<td>12</td>
<td>−5.5</td>
<td>&lt;0.01</td>
<td>17.5–1.9</td>
<td></td>
</tr>
<tr>
<td>Jain et al (2017)</td>
<td>13</td>
<td>HCT (%) 43.8</td>
<td>42.3</td>
<td>6</td>
<td>−3.4</td>
<td>&gt;0.05</td>
<td>13.6–6.9</td>
<td></td>
</tr>
<tr>
<td>Vita et al (2018)</td>
<td>21</td>
<td>HCT (%) 44.8±2.9</td>
<td>40±2.6</td>
<td>6–30</td>
<td>−10.5</td>
<td>&lt;0.001</td>
<td>20.5–1.1</td>
<td></td>
</tr>
<tr>
<td>Defreyne et al (2018)</td>
<td>239</td>
<td>HCT (%) 45.0±2.5 (44.9–45.5)</td>
<td>41.0±3.1 (40.9–41.7) 41.1±3.2 (40.5–41.2) 40.7±3.2 (40.0–40.8)</td>
<td>3</td>
<td>−8.9</td>
<td>&lt;0.001</td>
<td>17.4–0.7</td>
<td></td>
</tr>
<tr>
<td>Tack et al (2017)</td>
<td>21</td>
<td>HCT (%) 43.8±1.9</td>
<td>39.9±2.2</td>
<td>12–31</td>
<td>−8.9</td>
<td>&lt;0.001</td>
<td>15.2–8.8</td>
<td></td>
</tr>
<tr>
<td>Gooren and Bunck (2004)</td>
<td>19</td>
<td>Hgb (mmol/L) 9.3±0.7</td>
<td>8.0±0.7</td>
<td>12</td>
<td>−14.0</td>
<td>&lt;0.001</td>
<td>21.5–1.0</td>
<td></td>
</tr>
<tr>
<td>Olson-Kennedy et al (2018)</td>
<td>23</td>
<td>Hgb (g/dL) 153±11</td>
<td>140±12</td>
<td>12</td>
<td>−8.3</td>
<td>&lt;0.001</td>
<td>14.8–5.9</td>
<td></td>
</tr>
<tr>
<td>Wilk (2020)</td>
<td>9 10</td>
<td>Hgb (g/L) 148.3±10.1 150.3±9.1</td>
<td>132.7±9.1 133.3±9.0</td>
<td>4</td>
<td>−10.5</td>
<td>&lt;0.001</td>
<td>18.0–0.5</td>
<td></td>
</tr>
</tbody>
</table>

Cross-sectional studies

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Measure (units)</th>
<th>Control meansSD or (range)</th>
<th>% Difference</th>
<th>Number of months</th>
<th>P</th>
<th>T (nmol/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TW</td>
<td>CM, cismen; CW, ciswomen; HCT, haematocrit; Hgb, haemoglobin; HNTW, hormone-naive transwomen; TW, transwomen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Longitudinal studies

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Participants (N)</th>
<th>Measure (units)</th>
<th>Baseline meansSD (95% CI)</th>
<th>Follow-up meansSD (95% CI)</th>
<th>Number of months</th>
<th>% Change</th>
<th>P</th>
<th>T (nmol/L) Base-post GAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lippou et al (2008)</td>
<td>24</td>
<td>HCT (%) 41±2.3</td>
<td>45±2.3</td>
<td>&gt;48</td>
<td>−9.1</td>
<td>&lt;0.001</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Soffele et al (2019)</td>
<td>105</td>
<td>HCT (%) (35–48.7)</td>
<td>(39.0–50.6)</td>
<td>&gt;6</td>
<td>–</td>
<td>=0.1</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Greene et al (2019)</td>
<td>93</td>
<td>HCT (%) (35–46)</td>
<td>(38.4–45.7)</td>
<td>&gt;12</td>
<td>–</td>
<td>=0.05</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Roberts et al (2014)</td>
<td>65</td>
<td>HCT (%) (34–43.7)</td>
<td>(34.4–41.9)</td>
<td>&gt;6</td>
<td>–</td>
<td>&lt;0.01</td>
<td>CM</td>
<td></td>
</tr>
<tr>
<td>Jain (2019)</td>
<td>182 (oestrogen) 95 (oestrogen + progesterone) 92</td>
<td>HCT (%) 42.5 40.9</td>
<td>45.9±2.0</td>
<td>&gt;3</td>
<td>−7.4</td>
<td>&lt;0.05</td>
<td>21.5–0.9</td>
<td></td>
</tr>
<tr>
<td>Sharula (2012)</td>
<td>129</td>
<td>HCT (%) 40±2.3 44±2.4</td>
<td>&gt;3</td>
<td>−9.5</td>
<td>&lt;0.001</td>
<td>2.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and the research being conducted in Western countries, contrib-
uting to geographical bias. Furthermore, as with much research with
transgender individuals, there is a sparse data risk because of small
sample sizes and short study durations, indicative of the relatively
small population, difficulties with recruitment and high drop-out
rates over time. Indeed, the overlap of participants in the ENIGI
studies and the heterogenous methodology in the other studies
precluded the possibility of meaningful meta-analysis. However,
only, some findings in the current study are consistent with the findings of the current
and muscle C
bodies wish to be inclusive to all athletes, and there is a critical desire
data for valuable and rigorous research going forward. Sporting
help to shape future studies with transgender athletes and provide
after 3–4 months, of GAHT in transwomen. These findings may
1.5
in 1
mile fitness test than ciswomen. These observations in trained
transgender individuals are consistent with the findings of the current
review in untrained transgender individuals, whereby 30 months of GAHT
may be sufficient to attenuate some, but not all, influencing
factors associated with muscular endurance and performance.

Overall, this review reports decreases in muscle strength, LBM and
muscle CSA in response to 12–36 months, and decreases in Hbg
after 3–4 months, of GAHT in transwomen. These findings may
help to shape future studies with transgender athletes and provide
data for valuable and rigorous research going forward. Sporting
women are important to all athletes, and there is a critical desire
and need for more research to be able to develop evidence-based
policies around this topic. Given that the range of physical param-
eters important for success varies considerably between sports,
and that the physiological effects of GAHT vary in their time course (eg, muscle vs blood),
future research should be sport specific as well as

There is much debate on whether (and when) transwomen
should be permitted to compete in the female category in
sport.

What is already known

- Longitudinal and cross-sectional studies identify that
  hormone therapy in transwomen decreases muscle cross-
  sectional area, lean body mass, strength and haemoglobin
  levels, with noted differences in the time course of change.
- Haemoglobin levels decrease to those seen in cisgender
  women after 4 months of hormone therapy. In contrast,
  despite significant decreases in muscle cross-sectional area,
  lean body mass and strength after 12–36 months of hormone
  therapy, values remain higher than that in cisgender women.
- It is possible that transwomen competing in sports may retain
  strength advantages over cisgender women, even after 3
  years of hormone therapy.

What are the new findings

Competition interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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