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Letter to: Endocrinological Approach to Adolescents with Gender Dysphoria: Experience of a Pediatric Endocrinology Department in a Tertiary Center in Turkey

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Dear Editor,

There are some contradictions, ambiguities, and even ethical and legal violations in this study published in your journal, which performed pubertal suppression (PS) in 22 adolescents and gender reassignment surgeries (bilateral mastectomy, voice and facial feminization, and breast augmentation) in 7 adolescents under the age of 18. This is against the law in Turkey.

In the conclusion/abstract, it is stated that "no significant side effects were observed". However, there is no evidence to support this conclusion in the results (moreover, a decrease in BMD-z scores was detected). Also in the results, the findings are not presented, only some limited information describing the sample is presented. Similarly, the methods are not explained in the method.

"All physical examinations were performed by the same physician at each visit (ECO)". So who did the psychiatric evaluation? This was not explicitly stated, instead using the general phrase "made by a gender identity expert". This situation raises the suspicion that the psychiatric evaluation is not performed by the appropriate person(s).

Although genital examination was not performed in most of the adolescents, the authors state, *"No signs of a difference/disorder of sex development were detected, and all subjects had appropriate sex characteristics of the sex assigned at birth".* How was this result obtained without genital examination? How were possible genital pathologies/intersex ruled out? (cannot be done). Also, how can gonadotropin-releasing hormone (GnRHa)/CSH be used without genital examination?

The authors report that gender dysphoria (GD) begins in adolescence (>10 years) in 28.3% of cases. There is no indication for PS in these adolescents according to the original criteria of the Dutch model (1,2). Also, in how many adolescents did GD flare up with puberty? What were the psychiatric comorbidities in these adolescents? Was adequate psychological and social support provided during PS? These criteria were not taken into account in the study, meaning that a significant portion of these adolescents did not meet the eligibility criteria of the Dutch model.

The guidelines cited in the study were also not followed (in terms of principles such as adequate psychiatric follow-up, detection of permanent GD, detection/treatment of psychiatric comorbidities, eligibility criteria for GnRHa/CSH, confirmation of mental competence for detailed consent, and psychosocial support) (3).

The authors not only ignore the side effects they detected, but also do not mention the side effects and dilemmas of PS known in the literature (4). They ignore the current literature. PS has many physical and mental side effects, and its long-term consequences are also unknown (4,5). In addition, the expected benefit cannot be achieved with PS. A team from

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the Tavistock clinic in the UK detected in 2021 showing no detectable improvement in mental health among young people who were administered puberty-blocking drugs and were followed for up to three years (5).

In conclusion, the study contains methodological and presentational problems and ethical and legal violations. The authors even ignore the side effects they detected and state in the main message that "no significant side effects were observed". This shows that the authors focused on their intended results and were biased.

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