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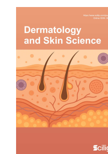

Review

Management of Acne in Transgender Men

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Abstract: Acne is the most common dermatologic complication encountered by transgender men during the transition phase. It affects approximately 1 in 3 individuals, and they consider it severe in about 1 in 3 cases as well, mainly transgender men receiving testosterone. There are no specific recommendations for the management of acne in transgender patients but care generally follows the same approach as for cisgender patients. Prescribing isotretinoin is particular in transgender men because clinicians must inquire about their genital anatomy and sexual practices. Testosterone therapy and amenorrhea in a transgender man with native female reproductive organs do not eliminate the risk of pregnancy. Contraception with regular pregnancy testing may therefore be necessary.

Keywords: acne; isotretinoin; testosterone; transgender; treatment

1. Prevalence of transgender individuals

It is estimated that 0.4 to 1.3% of the global population is trans or gender diverse [1]. Approximately 2.8 million people aged 13 and older (1.0% of the U.S. population in that age group) including 2.1 million adults aged 18 and older (0.8% of adults) identify as transgender, according to new estimates from the Williams Institute at UCLA School of Law [2].

2. Definitions of Transgender Identity and Transgender People

The following simple definitions related to transgender identity should be recalled [3]:

- Transgender people are individuals whose gender identity or expression, to varying degrees, differs from the sex assigned at birth.
- A transgender man (TgM; female-to-male transgender, formerly transsexual man) is a person assigned female at birth who identifies as a man.
- A transgender woman (TgW; male-to-female transgender individual, formerly transsexual woman) is a person assigned male at birth who identifies as a woman.
- Transition (or gender affirmation) is the process of recognizing, accepting, and expressing one's gender identity.
- Gender dysphoria is the psychological distress a person may experience due to incongruence between biological sex and gender identity. This discomfort or dissatisfaction may be intense enough to lead to depression and anxiety and negatively affect daily life.

It is also important to remember that transition or transgender identity is independent of surgical or medical treatments. Thus, a transgender man may retain female genital organs, which, as will be discussed, has implications for initiating isotretinoin.

Transgender patients have unique and often unmet dermatologic needs during gender transition related to hormone therapy and gender-affirming surgery. The goals of hormone therapy, testosterone for TgM or estrogen for TgW, are similar but opposite: modification of facial and body hair, redistribution of body fat, changes in perspiration and body odor, voice change, cessation of menstruation, breast reduction or development, clitoral enlargement, and reduction of gender dysphoria [4].

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TgM and TgW are exposed to various dermatologic complications; however, this review focuses solely on acne and the particularities of its management in transgender men.

3. Testosterone-Associated Acne

Testosterone is converted to dihydrotestosterone (DHT) by 5α-reductase in sebaceous glands, which binds androgen receptors and upregulates sebum production. Excess sebum, combined with follicular hyperkeratinization and *Cutibacterium acnes* proliferation, triggers an inflammatory cascade via Toll-like receptors (TLR-2), leading to comedone and inflammatory lesion formation [5]. The development of acne in patients taking high dose of testosterone for medical purpose such as excessive tall stature [6] or anabolic steroids by body builders is well known. It is does not come as a surprise that transgender individuals taking testosterone develop similar symptoms as well.

3.1. Prevalence of Acne in Transgender Men

Acne may affect TgM and TgW before the initiation of any treatment. After hormone therapy begins, acne particularly affects TgM receiving testosterone, whereas its prevalence is significantly reduced in TgW receiving estrogen compared with cisgender women, cisgender men, and transgender individuals who have not begun hormone therapy [7,8]. Acne accounts for nearly 80% of dermatologic problems in TgM, and in 70% of cases they are receiving testosterone [9]. Severity and onset timing vary among individuals. The average time to acne onset is 11.5 months [9], but acne can develop as early as the first month of therapy [10]. Acne prevalence is highly variable according to studies and methodology [10]. A very recent study from the U.S. that included 11,234 TgM and 9486 TgW showed a cumulative incidence of acne at 5 years of 15.8% in TgM and 6.0% in TgW [8]. In a U.S. retrospective electronic medical record study including 1576 TgM, acne prevalence was 26.3% [9]. In another U.S. study of 55 TgM, acne prevalence increased progressively after testosterone initiation: 9% at 3 months, 18% at 6 months, 25% at 12 months, and 38% at 24 months [11]. Acne was significantly associated with higher testosterone levels (>640 ng/dL) and higher body mass index (BMI). To a lesser extent, active smoking was also associated with acne [11]. Thoreson et al. found an overall prevalence of 26.5% under treatment, with progressive increase over time (19% incidence at 1 year and 25.1% at 2 years), and a relationship with younger age at hormone therapy initiation, but not with BMI [12].

3.2. Clinical Manifestations of Acne in Transgender Men

Testosterone-induced acne is identical to other forms of androgen-dependent acne. It affects the lower third of the face, chest, upper arms, and back [13]. It is considered moderate to severe in 20.8% of transgender individuals overall and particularly in 28% of transgender men [14]. In another study by the same group, among 283 transgender men, 16.3% reported active moderate-to-severe acne and 17.3% reported a history of moderate-to-severe acne [15]. These data were subjective and not based on clinical examination.

Testosterone may be a risk factor for acne fulminans, as observed in adolescents treated with testosterone for tall stature. Lee et al. recently reported a case of acne fulminans in a 16-year-old transgender male after 6 months of testosterone therapy [16].

A specific form of truncal acne has been described in transgender men due to chest binding, creating a flatter chest appearance using sports bras, elastic bandages, or compression garments. It affects nearly 1 in 3 TgM [17].

4. Management of Acne

There are currently no specific guidelines or evidence-based data for managing testosterone-induced hormonal acne in transgender patients. The same treatments used for cisgender individuals not receiving testosterone are recommended [11,18,19]. Thus, standard topical therapies, antibiotics, and isotretinoin may be used depending on acne severity [11,18,19] (Figure 1).

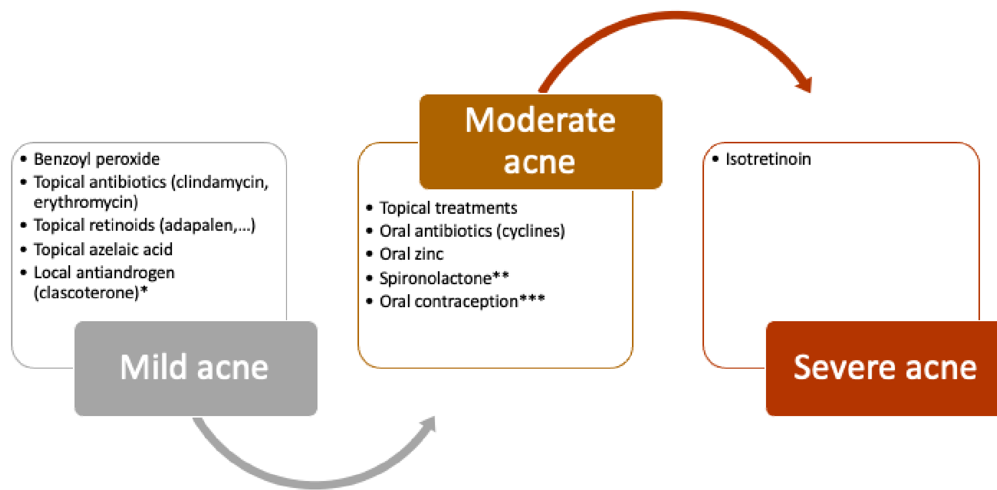

Figure 1. Management of acne according to severity in a transgender patient inspired from [13,18,19]. * Clascoterone 1% is a topical antiandrogen that is approved in the United States for acne in children older than 12 years. Position in transmasculine patients still remains to be evaluated. ** Spironolactone can be given primarily to transfeminine patients (male-to-female). *** Oral contraception can be given primarily to transmasculine patients (female-to-male).

Some authors recommend monitoring liver function during tetracycline or isotretinoin therapy due to a theoretically increased hepatotoxic risk with testosterone [20].

Among management considerations specific to transgender patients, clascoterone (cortexolone 17α-propionate) is the first topical androgen receptor antagonist FDA-approved for acne. It binds androgen receptors in sebaceous glands and hair follicles, inhibiting DHT binding, with good efficacy, safety, and tolerability. It shows minimal systemic absorption when applied to skin which is a key advantage in TgM on masculinizing hormone therapy [21]. However, to our knowledge, there are no published clinical data specifically for clascoterone in transgender patient. Furthermore, the impact of a local androgen antagonist on facial hairs and beard growth is unclear, as TgM may find desirable to have facial hairs. More data are needed to position clascosterone in the management of acne in TgM. Oral spironolactone may improve acne in TgW and has feminizing effects that may be desired. Conversely, it should be avoided in TgM because of its testosterone-antagonizing effects [13]. Testosterone is not a contraindication to contraception, whether hormonal or non-hormonal. Contraceptive options for TgM include implant, hormonal or copper intrauterine device, hormonal patch, oral contraception, hormonal injection, vaginal ring, and tubal sterilization. Induced amenorrhea is often a desired effect in transgender men who still experience bleeding. Although little change is seen in masculinization when these methods are used, many TgM prefer to avoid estrogen-containing methods [22]. Hormonal treatments that may cause bleeding, spotting, or abdominal pain should be avoided because they are unpleasant and may trigger gender dysphoria Consultation with a clinician specialized in transgender health is helpful to tailor contraceptive methods to patient needs.

4.1 Isotretinoin Considerations in Transgender Men

TgM with native female internal reproductive organs remain at risk of pregnancy, even with testosterone-induced amenorrhea, although the magnitude of this risk is difficult to quantify [23]. In a 2014 online survey, among 25 TgM who reported using testosterone before pregnancy, 5 (20%) conceived while amenorrheic due to testosterone use [24]. Between 2009 and 2019, Australian health insurance recorded 228 pregnancies in TgM [25].

Therefore, an honest, open, and respectful discussion about current anatomy and sexual practices is essential. If pregnancy risk exists, it should be addressed with acceptable contraception and regular pregnancy testing [25]. A TgM who has exclusively female sexual partners, a single vasectomized male partner, or who has undergone tubal ligation, hysterectomy, and/or bilateral oophorectomy as part of gender-affirming surgery will not receive the same counseling regarding pregnancy risk [23]. Unless TgM with native female reproductive organs state they are completely abstinent with male partners, they should be considered potentially at risk of pregnancy and undergo baseline and monthly pregnancy testing. In the US, the FDA—pregnancy prevention programme iPLEDGE currently uses gender-neutral, reproductive capacity-based categories rather than sexual orientation or gender identity to determine pregnancy monitoring requirements. Patients are categorized as either “patients who can become pregnant” or “patients who cannot become pregnant” based on reproductive anatomy and surgical history,

not on sexual orientation or gender identity. Patients who can become pregnant (including lesbian women and transgender men with intact uterus/ovaries) must comply with full iPLEDGE pregnancy prevention requirements regardless of sexual orientation or gender identity [26]. Of note, the UK has made partial implicit progress through biology-based language (patients of childbearing potentials), but the EU, Canada, and Australia still use female-centric frameworks.

There are no data guiding isotretinoin dose-escalation protocols; however, given the risk of acne fulminans with concurrent testosterone and isotretinoin therapy, gradual dose increases seem prudent.

Rates of depression, anxiety, and suicidality are higher among transgender individuals [13]. Braun et al. reported that 71% and 50% of individuals with current or past moderate-to-severe acne, respectively, had clinically significant depressive symptoms [15]. Additionally, isolated cases of depression, anxiety, or self-harm have been reported during isotretinoin therapy [27].

A recent meta-analysis that found no epidemiological evidence to suggest an increased relative risk of suicide or psychiatric conditions among isotretinoin users at a population level is reassuring [28]. However, acknowledging that those results may not be fully translatable to the transgender populations, clinicians should still screen for these symptoms before treatment, if necessary with the use of specific questionnaires (BDI, PHQ-2, PHQ-9 etc.), and inform patients about possible risks.

Wound healing may be prolonged during isotretinoin therapy. Dermatologists should ask about plans for gender-affirming surgery (mastectomy, phalloplasty, corrective tattoo procedures, etc.) and warn patients of potential delayed healing if surgery occurs during treatment.

Finally, the duration of isotretinoin therapy—standard course versus long-term low-dose regimens—should be considered in the context of ongoing hormone therapy.

5. Conclusions

Acne is common and significantly impacts the social life and quality of life of transgender men receiving testosterone. Transgender patients deserve the same quality of care as cisgender patients. Therapeutic escalation mirrors that used in cisgender individuals. Inclusive history-taking, systematic collection of sexual orientation and gender identity data, and physical examination are essential to assess isotretinoin-related risks. Honest and compassionate discussion is particularly crucial when contraception initiation is necessary in a TgM patient.

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Conflicts of Interest

The author declares no conflict of interest.

Use of AI and AI-Assisted Technologies

During the preparation of this work, the author used Claude by anthropic to edit and refine the language. After using this tool, the author reviewed and edited the content as needed and takes full responsibility for the content of the published article.

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