A survey by the Gay and Lesbian Alliance Against Defamation and The Harris Poll revealed that up to 12% of the US population identifies as lesbian, gay, bisexual, transgender, and/or queer/questioning (LGBTQ), with approximately 1.4 million US adults identifying specifically as transgender. Unlike a cisgender person, who identifies with their birth sex, those identifying as transgender have a sense of personal identity and gender that does not match their sex assigned at birth. In comparison, identifying as gender nonconforming (GNC) means a person’s behavior or appearance does not conform to traditional cultural and social norms about what is appropriate for their gender.

Addressing knowledge gaps, discrimination, and attitudes

Medical providers report knowledge gaps about cancer risk factors affecting transgender and gender nonconforming patients. Students and trainees preparing for health care roles report receiving little formal education about transgender health issues. Decreasing these knowledge gaps, changing attitudes, and increasing experience among medical providers can transform health care experiences of LGBTQ individuals from those of fear and discrimination into positive encounters where they feel safe and welcome.

Many LGBTQ patients experience discrimination based on their sexuality and/or gender identities, even in medical settings. According to the Fenway Institute, 25% of transgender people report having been harassed in a doctor’s office, and 19% report being denied medical care. This can be related to both provider bias and lack of experience in caring for the LGBTQ population. A study among medical students revealed that 46% expressed explicit bias and over 80% expressed implicit bias toward LGBTQ people.

Providing safe care and recommending cancer screenings for transgender and GNC people

Awareness of social barriers in the transgender and GNC population may lead to providers ensuring that comprehensive prevention and screening are possible for certain cancers and conditions that can predispose individuals to them, such as HIV, HPV, tobacco use, and obesity. Supplementing preventive healthcare with mental health resources is important, since concomitant mood disorders are more common among LGBTQ patients and can contribute to cancer risk.

- Addressing gender identity, sexual history, and organ-based screening:
  - The best way to assess gender identity and sexual activity is to ask.
  - Inclusive intake forms allow people to self-report gender identity and sexual activity information in a non-threatening way.
  - An “organ inventory” is a list of organs that someone possesses, and can also include history of non-anatomical treatments like hormone therapies. It enables providers to follow organ-based cancer screening guidelines and to assess sexual risks.
  - Sexual risks are related to sexual behavior and cannot be inferred alone from an organ inventory or gender identity.
  - Once an organ inventory and relevant sexual behaviors have been discussed, offer appropriate assessment and relevant screening recommendations as discussed in the table on the next page.
  - When using anatomical terminology, avoid categorizing organs into “male” or “female.” The use of anatomical terminology may be triggering for some people, including those known to have gender dysphoria, and they should be asked what terms they prefer when referring to their own anatomy.
Creating a safe health care environment:
- Update intake forms and clinic spaces to be inclusive (e.g., including more than two options for gender identification, providing all-gender restrooms).
- Create patient information (and review existing patient information documents) to ensure LGBTQ inclusivity.
- Align processes and policies to maintain an awareness that LGBTQ identities are multilayered and often affected by discrimination.
- Improve knowledge and skills of all staff through gender-inclusive training to promote a culture of inclusivity.
- Ensure that all staff use the patient’s correct name, pronouns, and preferred anatomical terms.
- Help improve care for LGBTQ patients by engaging in advocacy outside of the individual patient encounter.
- Form collaborations with local LGBTQ community groups.
- Advocate for including LGBTQ patients and providers on hospital or clinic advisory boards.
- Add LGBTQ-inclusive language and images on boards and posters.

Cancer screening and prevention research in transgender and GNC people

Rigorous studies specifically examining cancer screening and prevention in transgender and GNC populations are lacking. More research is needed to better understand whether the incidence of various cancers differs between GNC and cisgender populations. Additionally, further investigation into cancer prevention for transgender and GNC individuals can help develop interventions aimed at reducing cancer among these groups. Lastly, specific studies are needed to elucidate the need for tailored treatment guidelines in transgender and GNC people who have a cancer diagnosis.

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Assessment Considerations</th>
<th>Interventions or Relevant Screening Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal cancer</td>
<td>- People with HIV having receptive anal sex</td>
<td>- Consider anal Pap (no guidelines exist currently)</td>
</tr>
<tr>
<td></td>
<td>- People who take chronic immunosuppressants with or a history of solid organ transplantation</td>
<td>- Human papillomavirus (HPV) vaccination per ACS guidelines</td>
</tr>
<tr>
<td></td>
<td>- People with a history of anal warts</td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td>- People with mature or developed lobular breast tissue (e.g., transgender men who have not had top surgery to remove breast tissue)</td>
<td>- Chemoprevention to reduce risk</td>
</tr>
<tr>
<td></td>
<td>- People who developed lobular breast tissue from hormonal therapy (e.g., transgender women, or those who have taken estrogen)</td>
<td>- Mammogram per ACS guidelines</td>
</tr>
<tr>
<td></td>
<td>- People with a family history of breast cancer or cancer syndromes (e.g., BRCA)</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>- People with a cervix</td>
<td>- Primary HPV test or co-testing with Pap and HPV test based on ACS guidelines</td>
</tr>
<tr>
<td>Endometrial cancer</td>
<td>- People with a uterus and risk factors for unopposed estrogen exposure*</td>
<td>- HPV vaccination per ACS guidelines</td>
</tr>
<tr>
<td></td>
<td>- People with a uterus and abnormal uterine bleeding</td>
<td></td>
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<tr>
<td></td>
<td>- People with a uterus and uterine bleeding after bilateral oophorectomy or onset of menopause</td>
<td></td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>- People with a prostate</td>
<td>- Discussion about PSA and screening per ACS guidelines</td>
</tr>
</tbody>
</table>

*Data are insufficient to establish whether testosterone should be considered as a substitute for progesterone with regard to endometrial cancer risk.

References