What's Love, Sex, and Gender Got to Do with It?:

Cancer Care Considerations for Sexual and Gender Minorities

Did you know that lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people have unique cancer prevention, screening, treatment, and survivorship needs? You may be surprised by this – why does it matter who you love or what a person's gender identity is when it comes to cancer? The answer to this question is complex. Social determinants of health, sex-based genes and relational differences from mainstream society all play a part.

First, LGBTQI people are more likely to face routine microaggressions. What does this mean? Microaggressions are comments or behaviors that are hostile or negative toward a marginalized group. The person performing the microaggression most often does not realize they are coming across as insulting, biased, or unwelcoming. The perception of heterosexuality as "normal" is an example. Of course, the point is not that heterosexuality is not normal! The point is that there is a healthy range of human sexuality and dismissing same sex behavior as abnormal is hostile toward LGBQ people. For transgender individuals, assuming that people who are not transgender are "normal" and transgender people are "abnormal" is similarly insulting and unwelcoming.

In addition, system-level factors often perpetuate bias. The Movement Advance Project tracks social policies that influence LGBTQI peoples' ability to be parents, access nondiscriminatory health care, and change their gender identity documents in the U.S. Globally, 76 countries continue to criminalize same sex practices. The penalty for same sex behavior in these countries varies from discrimination to the death penalty. Notably, the host country of the 2020 World Cancer Congress—Oman—retains a punishment of up to three years imprisonment

for same sex behavior, disallows same sex marriage, disallows adoption by same sex couples, disallows legal gender identity change, and allows for housing discrimination. Some LGBTQI people develop maladaptive coping strategies to deal with latent and explicit aggression: LGBTQI people are more likely to smoke, drink alcohol, and abuse substances—leading to greater risk for many cancers.

Cancer screening and treatment differences mostly affect transgender and intersex individuals. These individuals may be taking exogenous hormones that modify risks for cancer. Estrogen is a known risk factor for breast cancer, so transgender women over the age of 50 who have more than five years of estrogen exposure should start getting mammograms. Transgender men over the age of 21 who retain a cervix still need cervical exams and/or HPV testing--but testosterone may alter histology, making pap smears difficult to read for pathologists who are inexperienced in reading transmasculine smears. (For more cancer screening considerations, see the Table below). Additionally, hormone status and sex chromosomes may alter the effects of certain pharmacotherapies, so knowing a patient's sex assigned at birth as well as any exogenous hormones is critical to provide quality cancer treatment. Intersex patients need care to be tailored to their individual anatomy, chromosome status, and gender identity. Despite knowing that transgender and intersex patients require careful clinical management, we have almost no research to guide evidence based practices in these populations. All patients need to have their social support network and caregivers acknowledged and included in their care regardless of sexual orientation.

Finally, post-treatment challenges for LGBTQI patients also differ from the mainstream. On the one hand, some groups experience greater resilience post-treatment as a result of learning to adapt to adversity early in life. On the other hand, assuming that all cancer patients want and

can benefit from the same things can lead to disaffirming care. For example, not all LBTQ people who have had surgery for breast cancer wish for female breast reconstruction and existing drugs are inadequate to support same sex intercourse for prostate cancer patients.

Our research and clinical enterprises continue to fail LGBTQI people. For a more in-depth look at Cancer Care Considerations for Sexual and Gender Minorities, check out my full article in *Oncology Issues*.

Cancer Screening Considerations for Transgender and Intersex People

Cancer Screening	Transfeminine	Transmasculine	Intersex
Breast	• Screen per USPSTF guidelines for women if estrogen exposure is ≥ 5 years and age is 50+	• If top surgery has been performed, individualize screening based on amount of breast tissue and risk profile • If top surgery has not been performed, screen using USPSTF guidelines for women	• Individualize screening based on amount of breast tissue and risk profile
Cervical	• Not indicated	• Screen per USPSTF guidelines for women if cervix is retained • Gender dysphoria is strong and gender-affirming precautions should be taken • Histological changes for people on testosterone may result in false positive screening	• Screen per USPSTF guidelines for women if cervix is present
Endometrial and Ovarian	• Not indicated	• If bottom surgery, not indicated • If no bottom surgery, inform of risks and symptoms; encourage patient to report unexpected bleeding	• Inform patients with a uterus of risks and symptoms • Encourage patient to report unexpected bleeding
Prostate	• Individualize based on risk factors, (e.g., ≥ 50 years old, African-American) and benefits • PSA 1ng/ML is upper limit of normal if patient is on estrogen therapy	• Not indicated	• Research is insufficient to provide recommendation • Individualize based on risk and benefits if patient has a prostate