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STI Screening and Counseling Strategies for Transgender Patients

Narrator:

Welcome to Clinician's Roundtable on ReachMD. The following activity, titled "STI Screening and Counseling Strategies for Transgender Patients" was recorded at Prova Education's Guideline to Practice: Managing Challenging Cases in Primary Care.

Your host is Dr. Matt T. Rosenberg.

Dr. Rosenberg:

The 2015 CDC Treatment Guidelines include transgender men and women as special populations, and recommend risk assessment based on current anatomy and sexual behaviors, awareness of symptoms consistent with common sexually-transmitted infections and screening for asymptomatic STIs based on behavior history and sexual practices.

I am Dr. Matt T. Rosenberg, and joining me is Aiden Harrington, advance practice nurse and certified nurse midwife at Howard Brown Health in Chicago, Illinois. Today, we'll be discussing STI screening, prophylaxis and treatment recommendations for transgender patients. Aiden, welcome to the program.

Ms. Harrington:

Thank you.

Dr. Rosenberg:

To start, let's review why it is so important for physicians to become sensitive to the needs of LGBTQ patients.

Ms. Harrington:

So, it is important for us to acknowledge that most of us get less than 5 hours of any kind of education related to LGBTQ community, and with about 10 million Americans identifying within the community, or 4.6% of the population in 2016, it bears importance that we start to really address it. And there has been a dramatic increase in the number of folks identifying as LGBTQ and I think it is largely because of the millennials. One of the limitation, though, in research, is that it bases on who someone identifies as, and unfortunately, because of stigma, and that often times our identity and behavior aren't always met, we are really not capturing everyone that truly is LGBT. And with 1 million people in the United States identifying as transgender, it is important that we start to really do more for those folks.

LGBT folks are less likely to come out to healthcare providers due to fear of discrimination, mistreatment, refusal of care. And so, what that really translates to is that many of our patients will never tell us unless they feel that it is safe to do so. So, we really need to ask.

Dr. Rosenberg:

What do we know about the avoidance of care among the transgender population?

Ms. Harrington:

Many trans-folk avoid care for routine screenings, urgent medical care. It leads to a higher rate of mortality and morbidity. In fact, 19% of trans-folks surveyed in the United States reported experiencing some type of refusal of care due to being transgender, including denial of lifesaving cancer treatments and emergency care services. To bring it a little bit closer to home for those of us locally, if you live in Illinois, 11% of trans-folk reported refusal of care due to a gender identity or expression, 3.9% were living with HIV versus 0.6% of the United States population. Twenty-two percent postponed care when they were sick or injured due to fear of discrimination, 48 versus 59% of general population had employer-based insurance, and 45%, 45% reported having attempted suicide at some point in their life, which is 28 times the general population of 1.6.

Dr. Rosenberg:

Those are some staggering numbers. Given this experience of refusal of care and the high numbers that you are just mentioning, what added health risks, do transgender patients face?

Ms. Harrington:

Well, LGBTQ folk, in general, face a lot of risk factors that are unique to them, but also common. We are definitely a very diverse community where we may have more in common with those in our local communities than in general, however, LGBT persons experience greater instances of depression and anxiety, substance abuse, cardiovascular disease, sexual and physical assault, violence, HIV and other STIs, more so than any other group. And chronic stress of being marginalized, especially when we are also part of other marginalized groups, whether we are a person of color, we are an immigrant, documented or not, and even being a woman can further create barriers to affect our health outcomes and access to care. And not surprising, transgender and bisexual individuals face the highest depression and suicide rates of any group.

Dr. Rosenberg:

So, given these staggering numbers, obviously, there are a lot of things that we, as healthcare providers, can do. So, let's say the providers here listening today might want to expand their practices to serve more of the transgender and sexual minority patients, how would you suggest they do that?

Ms. Harrington:

Well, I mean, first off we need to just learn more. We need to put together, amass more information about how we can serve the community, what risk factors they have, include more expansive trends and options on our intake forms, options that include domestic partner, partnered, non-monogamist, various genders and, perhaps, even a fill-in option. Allow folks to designate their sex versus their gender, allow for information about what their insurance paperwork says, versus how they identify, using preferred name and pronouns in our EMRs. We need to ask more questions than do you have sex with men or women? And no, I don't just mean both, I mean asking about gender and sexual identity, our behaviors and actually ask what sex looks like for people. What parts of their body they are using. We can't make any assumptions, because we won't be able to accurately assess their risk, and provide effective interactions, if we don't know what people are actually doing with their bodies. And we really need to train everyone from the front desk to the folks in the clinic on LGBT cultural or competency. Organizations like Howard Brown will come to agencies to do education, but also Fenway Health has online modules to do training.

Dr. Rosenberg:

Okay, so let me hone down on something. You just mentioned the appropriate way of asking something. And so, let's say that I am in my clinic and I am seeing a patient who is new to me and I am doing a physical, and one of the things we ask about is your sex life. And we try to be very careful with that, so we will say are you sexually active?

Ms. Harrington:

Mm-hmm, because we don't want to make assumptions that someone actually is sexually active.

Dr. Rosenberg:

So, we start sexually active. "Yes, I am." Now, I want to assess risk so I am trying to figure out if it is heterosexual or homosexual sex.

Ms. Harrington:

Well, and it's more than just that. So, I mean, I say, so, how do you identify as far as your gender? What label feels good for you on that? Okay, great. and then what label do you use as far as your sexual orientation, and I allow the person to tell me. They may say, heterosexual, they may say homosexual, they may say lesbian, they may say queer, they may say demi-sexual. Let them tell you the term. And then I ask them, so, how would you describe the people that you are sexually and romantically attracted to? What genders do they have? What parts of your body are you using for sex? I think that is more important than finding out what types of people they are having sex with. It's are you using your mouth for sex, and if so, how? Are you using your genitals, if so, how? You know, we can ask the question are you having sex? You know we can ask a person during a well woman visit, are you having sex with men, and she may say, yes. Okay, even just to assist gender context.

Ms. Harrington:

She may be having strap on sex with her partner, where her genitals aren't even being penetrated. But if you don't ask her how sex looks, you won't know that. So, I mean, that's even just in somebody in non-LGBT.

Dr. Rosenberg:

This is fantastic information, and I can tell you as a provider, it's not necessarily the most comfortable conversation either way, because if you insinuate to somebody either way, somebody might get upset. So, I like that. So, starting with, how do you identify, and then, maybe, branch into more questions if appropriate.

Ms. Harrington:

I find that most patients are completely okay with having these conversations. They pick up on our reticence to talk about it. We are nervous about it, because we didn't get enough training on how to do these conversations. We don't feel comfortable with sex but we need to get more comfortable because sex is so important. People that aren't haven't having sex live shorter lives, and then, as we get older, we need to worry about HIV, because our older populations after menopause, we're not worried about preventing pregnancy, they haven't been told about using condoms for safer sex, and so they are at greater risk for HIV.

Dr. Rosenberg:

So, let's turn to the subject of HIV risk and focus on men who have sex with men and transgender women who are disproportionately affected by HIV. What role does the primary care provider play in reducing this risk?

Ms. Harrington:

Well, we need to be screening people. We really need to do a better job about encouraging everyone to get screened consistently. You know, just because we are in a monogamous relationship doesn't mean that we shouldn't be doing screening. So everyone should get site specific screening for gonorrhea, chlamydia, syphilis. We should test for HIV, hepatitis.

We are seeing more STIs, in general, among our men who have sex with men, and transgender individuals, so those folks need to be targeted and we need to offer them PEP and PREP, when we can. We need to really identify those folks at risk. Are they using condoms consistently? Are they not? I have about 350 patients on my panel that are on PREP and it's been enormous getting to see them take charge of their sexuality, and I have seen a decline in inconsistent condom use among those folks even though they were already at risk. I am seeing them really be more empowered to take care of their health and avoid HIV. And they are reducing their risk for sexually transmitted infections as well.

Dr. Rosenberg:

So, you just mentioned something that I think is really important and I want to emphasize. But, can you once again explain PEP and PREP?

Ms. Harrington:

Absolutely. So, PEP is post exposure prophylaxis. It is basically a regimen of HIV medication that we take within 72 hours of a possible exposure. It should be offered to anyone who has had a possible exposure whether it is through a needle stick, an unprotected sexual encounter, you know, anyone. We should be offering it like we offer contraceptives, Plan B rather. And so, it's within the first 3 days after an unprotected sex encounter. We do baseline labs, we check a 4th generation HIV test. We are assessing for whether or not they are having any acute HIV symptoms. They may have been exposed previous to that encounter and so we want to make sure that they are not having those symptoms. And so, we are screening, we are doing all baseline labs. We get them started. I typically will do Truvada and Tivicay because most patients that are at an indication for PEP, especially for sexual exposure or IV drug use, they are going to be indicated for PREP, which is preexposure prophylaxis. PREP is 99% effective when taken every single day. I encourage all of my patients to really make a routine of it. The research currently shows that it becomes effective after 7 days in the rectum and then it needs about 21 days to reach effective levels in vaginal tissue. But when we are talking about PREP, we are doing

routine labs, the first month we have them come back and we check a CMP to make sure that their kidneys are tolerating it. We can see an increase in creatinine with Truvada, but after that we do every 3 months, we are just doing routine checks making sure no HIV, their kidneys are tolerating it well, and we are checking for routine STIs, because again, if we are at risk for engaging in risky behavior, we are wanting to treat when we are having those.

Dr. Rosenberg:

My guess is that a lot of primary care providers nationally are not as comfortable with this.

Ms. Harrington:

Mm-hmm.

Dr. Rosenberg:

But it sounds like the important thing for us to understand, and myself as a primary care provider as well, is to know there are options post-exposure, preexposure, and if I am not comfortable with it, at least I can help the patient and possibly align them with an infectious disease specialist that can work on this with me and that way we really cover the gamut.

Ms. Harrington:

I would encourage primary care providers to really become comfortable and not make our patients have more barriers to care. I am seeing a lot of patients who their primary care provider has them come see us, but really it is not hard. And we are making more hurdles and it could be potentially increasing their risk for HIV in that interim period between when they leave your office and they come to mine.

Dr. Rosenberg:

Right, on the other hand, as a provider, if I am look this might be relatively new to me, if I were to call your clinic, or my local clinic, and say, "You know what, I've got a patient who is at risk, can you help me get this started? Let's work on this together." Now I am paying attention to their symptoms and I am validating what's going on, so I am not putting them off, but I am trying to give them the best care possible.

Ms. Harrington:

Absolutely.

Dr. Rosenberg:

Let's, you know, this has been some great information. I want to get a couple of things, you had mentioned, well we talked about PEP and PREP, and obviously PREP doesn't protect against other STIs, and are we seeing more infection rates among other STIs for patients on PREP and does that reflect any communication errors around promiscuity or poor condom use?

Ms. Harrington:

So, we have seen people nervous about whether or not it increases risk taking, and as I said, I am seeing a decrease overall. These folks were already engaging in risky behavior, and so by protecting them against HIV you really are doing an enormous good.

Ms. Harrington:

And we do routine screening for, as I said, gonorrhea, chlamydia, site specific, so if you are using your mouth, using our rectum, using our vagina, checking for syphilis, hepatitis, we are also doing routine screening. We are seeing an increase in LGB, which is a new, I call it, chlamydia on steroids. It started from overseas and came to New York about 2009, I think, and now we've got it here in the Chicago area and it just causes more severe symptoms. We can see enlarged lymph nodes, spasms of the anus, we see more discharge, rectal bleeding. It can be more painful and it requires 3 weeks of doxycycline 100 mg twice a day. It's definitely a longer course of antibiotics to clear it, but because chlamydia is better treated with doxycycline, we typically like to do that treatment even in routine chlamydia.

Dr. Rosenberg:

That's great. Well, this has been some fantastic information and it's a lot to digest, but I think as we are starting this process and opening the doors, we are going to be doing our patients a tremendous service. So, I want to thank you for joining me today and kind of enlightening the audience as well as myself.

Ms. Harrington:

Thank you for having me.

Narrator:

This has been Clinician's Roundtable on ReachMD, provided in partnership with Prova Education. Thank you for joining us.