GI Cancer Screening & Providing Inclusive Care to LGBTQIA2S+ Patients

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LEARNING OBJECTIVES

1. Define important terms and concepts related to the LGBTQIA2S+ population, understand that these terms change frequently, and articulate how to figure out what terms to use with your patients.
2. Articulate how the medical management recommendations for GI cancers change between the cisgender and gender diverse population, as well as what areas still need more research.
3. Feel comfortable implementing strategies for providing inclusive care to the LGBTQIA2S+ population in your practice.
4. Find resources for further provider and patient education.

I have no financial disclosures to make.

DEFINITIONS

LGBTQIA2S+ = An acronym for different gender identities and sexual orientations; lesbian, gay, bisexual, transgender, questioning or queer, intersex, asexual, and Two-Spirit; the + indicates other identities that aren't explicitly included

- **There are many variations of this acronym!

Sex = A category often assigned at birth based on biological attributes (e.g., the appearance of genitalia or secondary sex characteristics)

- Female, male, intersex / variations of sexual characteristics (VSC)

Gender identity = A person's sense of self and how they fit into the world from the perspective of gender, which may or may not align with sex assigned at birth

- Female, male, transgender, cisgender, non-binary

Gender expression = How someone expresses their gender identity (clothes, hair, name, **pronouns**, etc.)

Sexual orientation = An individual's attraction and identity related to romantic and sexual desire

- Lesbian, gay, bisexual, asexual, pansexual, aromantic, polyromantic, etc. …

Bennett, R. L., French, K. S., Resta, R. G., & Austin, J. (2022). Practice resource-focused revision: Standardized pedigree nomenclature update centered on sex and gender inclusivity: A practice resource of the National Society of Genetic Counselors. Journal of Genetic Counseling, 31(6), 1239. https://doi.org/10.1002/jgc4.1621

DEFINITIONS



Cisgender / Cis = An individual whose gender identity **aligns** with the sex they were assigned at birth

- Someone assigned male at birth who identifies as male (he/him)
- Someone assigned female at birth who identifies as female (she/her)

Gender diverse (GD) = An umbrella term used to describe gender identities beyond the binary framework

- **Transgender / Trans =** An individual whose gender identity **differs** from the sex assigned to them at birth
  - **Transfeminine** = Someone assigned male at birth who identifies as female (she/her)
  - **Transmasculine** = Someone assigned female at birth who identifies as male (he/him)
- **Non-binary / Gender-nonconforming** = Someone who identifies as neither male nor female but somewhere in between
  - They/them, she/they, he/they

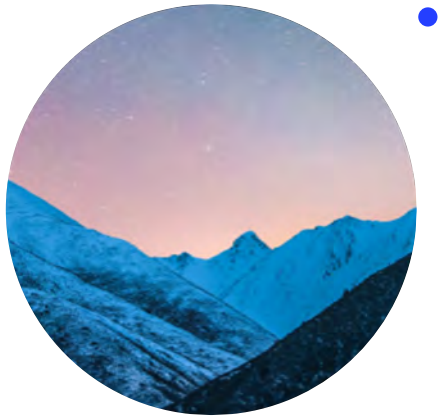
Bennett, R. L., French, K. S., Resta, R. G., & Austin, J. (2022). Practice resource-focused revision: Standardized pedigree nomenclature update centered on sex and gender inclusivity: A practice resource of the National Society of Genetic Counselors. Journal of Genetic Counseling, 31(6), 1239. https://doi.org/10.1002/jgc4.1621

DEFINITIONS

These definitions are constantly changing!

The best you can do is ask a patient how they would like to be addressed, if it’s not already listed in their chart.

INTRODUCTION



WHY IS THIS IMPORTANT?

- There aren’t many clinical guidelines for GD individuals with GI cancers, particularly guidelines for Lynch syndrome (LS) or other syndromes with increased risks for GI cancers
  - Most GD hereditary cancer syndrome info is focused around *BRCA1/2*

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2025
Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic

NCCN Guidelines Index
Table of Contents
Discussion

Find an NCCN Member Institution: https://www.nccn.org/home/member-institutions.

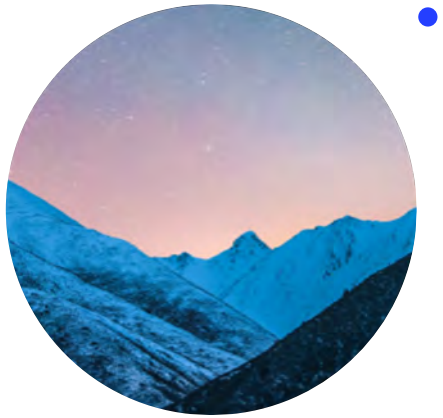
NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See NCCN Categories of Evidence and Consensus.

Daly, M., Pal, T., et. al (2024, September 11). *NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic Cancers, Version 1.2025*. NCCN; NCCN. https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1503

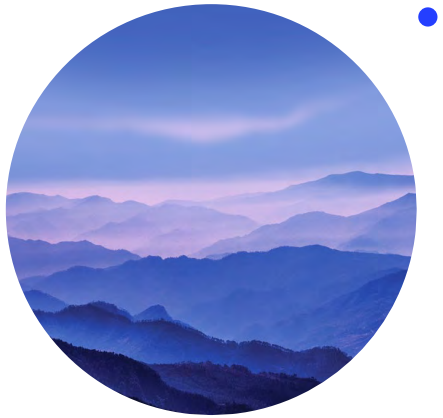
- Breast, Ovary, Uterine, and Prostate Cancer Risk Reduction Strategies for Transgender, Non-Binary and Gender Diverse People with Hereditary Cancer Syndromes (TNBGD-1)
- Summary of Genes and/or Syndromes Included/ Mentioned in Other NCCN Guidelines (SUMM-1)
- Abbreviations (ABBR-1)
- For chemoprevention options, see NCCN Guidelines for Breast Cancer Risk Reduction.

Daly, M., Pal, T., et. al (2024, September 11). *NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic Cancers, Version 1.2025*. NCCN; NCCN. https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1503



WHY IS THIS IMPORTANT?

- There aren't many clinical guidelines for GD individuals with GI cancers, particularly guidelines for Lynch syndrome (LS) or other syndromes with increased risks for GI cancers
  - Most GD hereditary cancer syndrome info is focused around *BRCA1/2*
- This is a problem because…
  - LS is the most common inherited cause of CRC and endometrial cancer
  - Medical providers know less about GD topics and may feel unprepared to see these patients
  - GD patients are often unaware of and less likely to complete preventative screenings like colonoscopies and pap smears
  - GD people have higher rates of advanced cancer and poorer survival, in addition to facing various health disparities
  - ***We don't know how gender-affirming care and other factors in the GD community may affect cancer risk and risk management***



LYNCH SYNDROME

- Caused by a pathogenic variant in one of the DNA mismatch repair genes (*MLH1, MSH2, MSH6, PMS2*) or a deletion of part of the *EPCAM* gene (next to *MSH2*)
- Up to 56% chance to develop CRC depending on the gene
- Increased risks for other cancers as well:
    - Gastric
    - Small bowel
    - Pancreas
    - Ovarian
    - Endometrial
    - Urothelial
    - Prostate
    - Brain

OTHER HEREDITARY CANCER SYNDROMES / GENES WITH INCREASED GI CANCER RISKS

- Li-Fraumeni syndrome (*TP53*): CRC, pancreatic, and gastric cancers
- Polyposis syndromes
  - Familial Adenomatous Polyposis (*APC*): CRC
  - *MUTYH*-Associated Polyposis (*MUTYH*): CRC
  - Peutz-Jeghers syndrome (*STK11*): CRC, pancreatic cancer
  - Juvenile Polyposis syndrome (*BMPR1A, SMAD4*): CRC, gastric cancer
  - Serrated Polyposis syndrome (*RNF43*): CRC
- Cowden syndrome (*PTEM*): CRC
- Hereditary Diffuse Gastric Cancer (*CDH1*)
- *ATM, BRCA1/2, CDKN2A, PALB2*: Pancreatic cancer
- *NF1:* Gastrointestinal stromal tumors (GIST)
- *BLM, NTHL1, POLD1, POLE*: CRC

HOW MANY PEOPLE ARE LGBTQIA2S+?

Inc, G. (2024, March 13). *LGBTQ+ Identification in U. S. Now at 7.6%*. Gallup.com. https://news.gallup.com/poll/611864/lgbtq-identification.aspx

HOW MANY PEOPLE ARE LGBTQIA2S+?

LGBTQ+ Identity, by Generation, 2023

Which of the following do you consider yourself to be? You can select as many as apply. Straight or heterosexual; Lesbian; Gay; Bisexual; Transgender

	Generation Z	Millennials	Generation X	Baby Boomers	Silent Generation
All adult members of the generation	%	%	%	%	%
Total LGBTQ+	**22.3**	**9.8**	**4.5**	**2.3**	**1.1**
Lesbian	3.0	1.3	0.7	0.7	0.2
Gay	2.6	1.6	1.3	0.9	0.4
Bisexual	15.3	5.9	1.9	0.6	0.1
Transgender	2.8	1.1	0.5	0.2	0.4
Other LGBTQ+	1.0	0.4	0.2	0.0	0.0

Sum of categories may exceed the total because respondents can choose multiple identities.
Birth years for each generation: Generation Z (1997-2005), millennials (1981-1996), Generation X (1965-1980), baby boomers (1946-1964), Silent Generation (1945 and earlier).
Based on aggregated data from 2023 Gallup telephone polls.

Get the data • Download image

GALLUP

Inc, G. (2024, March 13). *LGBTQ+ Identification in U. S. Now at 7.6%*. Gallup.com. https://news.gallup.com/poll/611864/lgbtq-identification.aspx

GENDER-AFFIRMING CARE

- Can include psychological support, hormonal treatments, surgery, and/or voice therapy, **or some or none** of the above
- Is highly individualized

- Gender-affirming surgery = GAS
- Gender-affirming hormone therapy = GAHT

GENDER-AFFIRMING CARE

Transmasculine patients:

- Usual goals:
  - Voice deepening
  - Amenorrhea
  - Increased facial and body hair
  - Redistribution of fat and muscle for more masculine body shape
- Usually achieved through testosterone and/or surgery

Transfeminine patients:

- Usual goals:
  - Breast growth
  - Reduced muscle mass and body hair
  - Skin softening
  - Body fat redistribution
  - Decreased libido and erections
- Usually achieved through androgen blockers, estrogen, progesterone, and/or surgery

- *Some changes are irreversible, some are not*
- *Hormone therapy can be lifelong*
- *Non-binary people might choose lower doses or shorter treatments, ending once desired irreversible results are achieved*

CANCER RISK, SURVEILLANCE, AND GAHT FOR GD INDIVIDUALS

ISSUES TO CONSIDER

- Genetic testing is recommended when the results will impact medical decision-making
- Many people with LS will have testing in early adulthood long before colonoscopies begin, BUT…
- *GD people often start gender-affirming care long before they consider their future cancer risks*
- You might be the first provider who has brought up cancer risk reduction to them; allow for this discussion and/or refer to genetics
  - Having LS affects their own care, family members' care, and future family planning considerations

Familial Cancer (2023) 22:437–448
https://doi.org/10.1007/s10689-023-00341-4

REVIEW

Cancer surveillance for transgender and gender diverse patients with Lynch syndrome: a practice resource of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer

Rachel Hodan[1] · Linda Rodgers-Fouche[2] · Anu Chittenden[3] · Mev Dominguez-Valentin[4] · James Ferriss[5] · Lauren Gima[6] · Ole-Petter R. Hamnvik[7] · Gregory E. Idos[8] · Kevin Kline[9] · Diane R. Koeller[3] · Jessica M. Long[10] · Danielle McKenna[10] · Charles Muller[11] · Maxton Thoman[12] · Anton Wintner[12] · Bronwyn S. Bedrick[13] · On behalf of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer

Received: 10 April 2023 / Accepted: 31 May 2023 / Published online: 21 June 2023

Abstract

Transgender and gender diverse (TGD) populations with hereditary cancer syndromes face unique obstacles to identifying and obtaining appropriate cancer surveillance and risk-reducing procedures. There is a lack of care provider knowledge about TGD health management. Lynch syndrome (LS) is one of the most common hereditary cancer syndromes, affecting an estimated 1 in 279 individuals. There are no clinical guidelines specific for TGD individuals with LS, highlighting a need to improve the quality of care for this population. There is an urgent need for cancer surveillance recommendations for TGD patients. This commentary provides recommendations for cancer surveillance, risk-reducing strategies, and genetic counseling considerations for TGD patients with LS.

Keywords Transgender and gender diverse · Cancer · Lynch syndrome · Surveillance · Management

Table 1 Surveillance and management recommendations for TGD individuals with Lynch Syndrome

	LS management for CG patients[a]		Additional considerations for TGD patients	
General	Elicit organ inventory before making recommendations			
	Apply principles of trauma-informed care [127]			
Site/Organ	*MLH1/MSH2/EPCAM*	*MSH6/PMS2*	Transfeminine	Transmasculine
CRC	Colonoscopy at age 20-25y or 2-5y prior to earliest CRC and repeat every 1-2y Consider chemoprevention	Colonoscopy at age 30-35y or 2-5y prior to earliest CRC and repeat every 1-3y Consider chemoprevention	Use of sigmoid colon for neovagina creation is contraindicated. For those who are diagnosed with LS after GAS with use of sigmoid colon, pelvic exam and colposcopy recommended at interval paralleling colorectal surveillance	Gynecologic screening can be offered at the time of colonoscopy sedation to minimize pelvic exam anxiety
Endometrial	Consider EMB at age 30-35y and repeat every 1-2y Consider post-menopausal transvaginal ultrasound Consider TAH Education on symptoms[b]		N/A	EMB for bleeding after GAHT induced amenorrhea Consider short-term vaginal estradiol to reduce vaginal atrophy and discomfort
Ovarian	Consider BSO[c]		N/A	If undergoing gender-affirming hysterectomy, consider BSO concurrently
Urothelial	Annual urinalysis beginning age 30-35y			
Gastric/small bowel	EGD at age 30–40 and repeat every 2-4y			

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Site/Organ	*MLH1/MSH2/EPCAM*	*MSH6/PMS2*	Transfeminine	Transmasculine
Pancreas	Alternate annual MRI/MRCP and/or EUS beginning at age 50y if there is a family history of pancreatic cancer in a 1st or 2nd degree relative (or 10y young than the youngest age of pancreatic cancer diagnosis in the family)			
Prostate	Consider annual PSA and DRE beginning at age 40		Awareness of vaginoplasty, intestinal interposition, or perineal flap which may affect palpation during DRE Consider MRI for elevated PSA or abnormal prostate exam or finding raising concern for prostate malignancy PSA > 1 ng/mL is considered abnormal with testosterone suppression	N/A
Breast	Not enough evidence to support increased screening		Follow local breast cancer screening guidelines[d] developed for CG women for those who have taken estradiol for ≥ 5 years	No imaging indicated after bilateral mastectomies. Otherwise, follow local breast cancer screening guidelines[d] and/or based on family history

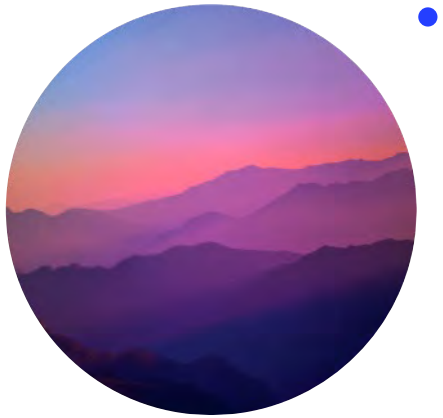
BSO bilateral salpingo-oophorectomy, *CG* cisgender, *CRC* colorectal cancer, *DRE* digital rectal exam, *EGD* Esophagogastroduodenoscopy, *EMB* endometrial biopsy, *EUS* endoscopic ultrasound, *GAHT* gender affirming hormone therapy, *GAS* gender affirming surgery, *LS* Lynch syndrome, *mpMRI* multiparametric magnetic resonance imaging, *MRCP* Magnetic resonance cholangiopancreatography, *MRI* Magnetic resonance imaging, *N/A* not applicable, *PSA* prostate specific antigen, *TAH* total abdominal hysterectomy, *y* year(s)

[a]Adapted from NCCN Genetic/Familial High-Risk Assessment: Colorectal Version 2.2022[21]

[b]Warning signs of endometrial cancer include abnormal vaginal bleeding, especially postmenopausal bleeding, bloating, changes to bowel or bladder habits, weight loss, abdominal or pelvic pain, increased satiety, increased abdominal girth

[c]There is not enough evidence to recommend BSO for individuals with *MSH6/PMS2* mutations

[d][102]



COLORECTAL CANCER

- **Transfeminine / intersex** patients with LS or increased CRC risk:
  - Don’t use the sigmoid colon for neovaginal creation
  - If this surgery has already been done, pelvic exam and colposcopy at time of colonoscopy may be necessary
  - Intestinal mucosa tissue may be more susceptible to STIs
  - Persistent HPV infection has been reported in pts with a neovagina
- It’s important to know what surgeries / vaccinations have been done prior to the patient establishing care with you
- **Transmasculine** patients:
  - Gynecologic screening can be offered at time of colonoscopy sedation to decrease pelvic exam discomfort / anxiety
- No current data suggest that hormone therapy increases or decreases risk for CRC

Brown, B., Poteat, T., Marg, L., & Galea, J. T. (2017). Human papillomavirus-related cancer surveillance, prevention, and screening among transgender men and women: Neglected populations at high risk. LGBT Health, 4(5), 315–319. https://doi.org/10.1089/lgbt.2016.0142

Hodan, R., Rodgers-Fouche, L., Chittenden, A., Dominguez-Valentin, M., Ferriss, J., Gima, L., Hamnvik, O.-P. R., Idos, G. E., Kline, K., Koeller, D. R., Long, J. M., McKenna, D., Muller, C., Thoman, M., Wintner, A., Bedrick, B. S., & on behalf of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer. (2023). Cancer surveillance for transgender and gender diverse patients with Lynch syndrome: A practice resource of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer. Familial Cancer, 22(4), 437–448. https://doi.org/10.1007/s10689-023-00341-4

ESOPHAGEAL CANCER

- HPV is a possible mechanism for esophageal squamous cell carcinoma
- Since HPV infection is more prevalent in the LGBTQIA2S+ population, they could be eligible for an esophageal screening program

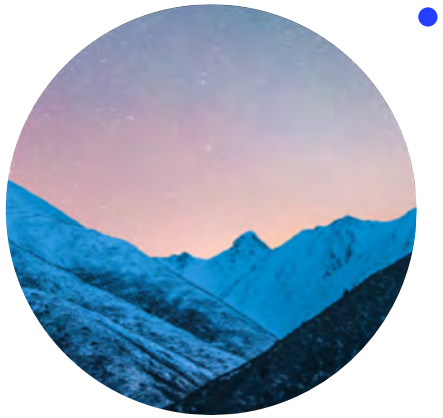
Coelho, R., Gonçalves, R., Mendes, F., & Macedo, G. (2024). Gastroenterology healthcare in LGBTQ+ individuals. European Journal of Gastroenterology & Hepatology, 36(9), 1059–1067. https://doi.org/10.1097/MEG.0000000000002808

ANAL CANCER

- Usually caused by HPV / HIV, which is present at higher rates in the LGBTQIA2S+ population
  - Men who have sex with men, especially if they are HIV+, are at highest risk
  - Also at risk: those with HPV+, higher # sexual partners, genital warts
- No standard guidelines for anal cancer screening, but…
- HPV vaccination is recommended for people through age 26; ask if patient has had it
- All adults with HIV should have a digital anorectal exam (DARE) once per year
  - People <35 who are symptomatic or show signs of anal cancer during DARE should undergo standard anoscopy
  - Older people should undergo high resolution anoscopy (HRA) if they are…
    - Men who have sex with men
    - Transfeminine people ages 35+
    - All other people with HIV 45+
- Can perform surveillance annually for HIV+ males and every 3-6 months for people with low- or high-grade squamous intraepithelial lesions

Coelho, R., Gonçalves, R., Mendes, F., & Macedo, G. (2024). Gastroenterology healthcare in LGBTQ+ individuals. European Journal of Gastroenterology & Hepatology, 36(9), 1059–1067. https://doi.org/10.1097/MEG.0000000000002808

HIV clinical guidelines now recommend high resolution anoscopy as part of anal cancer screening program for people with HIV. (n.d.). National Institutes of Health. Retrieved October 10, 2024, from https://oar.nih.gov/update-clinical-guidelines-high-resolution-anoscopy-anal-cancer-screening



OTHER RISK FACTORS

Other risk factors for GI cancer can be higher in LGBTQIA2S+ populations:

- HPV or HIV infections
- Smoking
  - 16% of LGB adults, 4% of LGB youth, and 5% of trans youth smoke compared to 12% heterosexual adults and 1% heterosexual / cisgender youth
- Excessive alcohol use
  - 14% bi women consume >7 drinks/wk vs. 6% heterosexual women
- Higher BMI
  - 68% of LB women vs 61% of heterosexual women

Kratzer, T. B., Star, J., Minihan, A. K., Bandi, P., Scout, N. F. N., Gary, M., Riddle-Jones, L., Giaquinto, A. N., Islami, F., Jemal, A., & Siegel, R. L. (2024). Cancer in people who identify as lesbian, gay, bisexual, transgender, queer, or gender-nonconforming. *Cancer*, *130*(17), 2948–2967. https://doi.org/10.1002/cncr.35355

MORE RESEARCH IS NEEDED

- That is all the info we currently have about how to change screenings for GD patients with an increased risk for GI cancers.

- More equitable research is needed, particularly around hormone therapy!

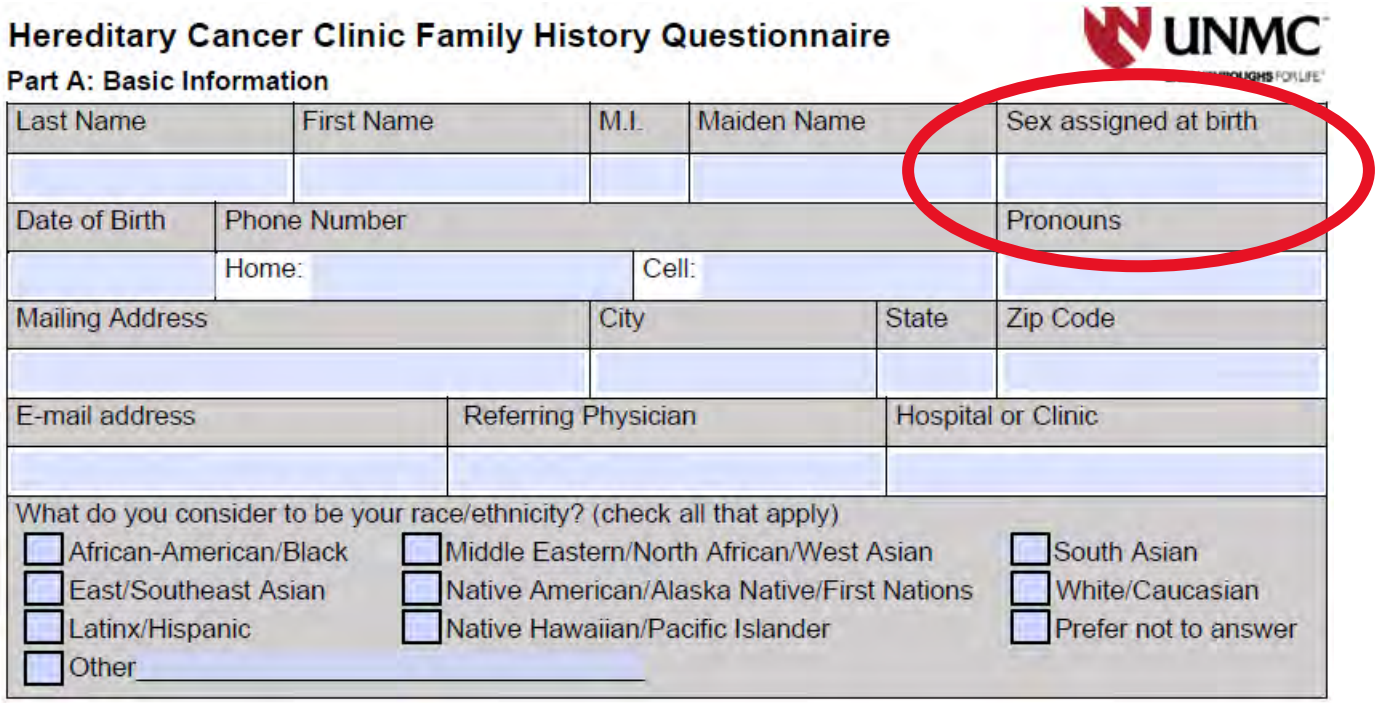
WE SEE THESE PATIENTS LESS

- The GD patient population has a lot of general medical mistrust and anxiety, as well as discomfort around organs associated with gender identity
  - *" 19% [of transgender patients] have reported refusal of care, 28% reported harassment, and 50% were turned off of the healthcare system due to a lack of gender nonconforming providers"* (Sterling & Garcia, 2020, p. 2)
- Many patients may only seek gender-affirming care and not primary care
- Many don't regularly see a doctor due to lack of insurance coverage, discrimination, living in a rural area, and/or other socioeconomic factors

INCREASING SAFETY AND COMFORT

BEFORE THE APPOINTMENT

- Intake forms should include *"chosen name, pronouns, gender identity, sex assigned at birth, sexual orientation as well as marital, partnership, and family status*" (Hodan et. al, p. 442)



Hereditary Cancer Clinic Family History Questionnaire

UNMC

Part A: Basic Information

Last Name	First Name	M.I.	Maiden Name	Sex assigned at birth

Date of Birth	Phone Number		Pronouns
	Home:	Cell:	

Mailing Address	City	State	Zip Code

E-mail address	Referring Physician	Hospital or Clinic

What do you consider to be your race/ethnicity? (check all that apply)

- ☐ African-American/Black
- ☐ East/Southeast Asian
- ☐ Latinx/Hispanic
- ☐ Middle Eastern/North African/West Asian
- ☐ Native American/Alaska Native/First Nations
- ☐ Native Hawaiian/Pacific Islander
- ☐ South Asian
- ☐ White/Caucasian
- ☐ Prefer not to answer
- ☐ Other_____

BEFORE THE APPOINTMENT

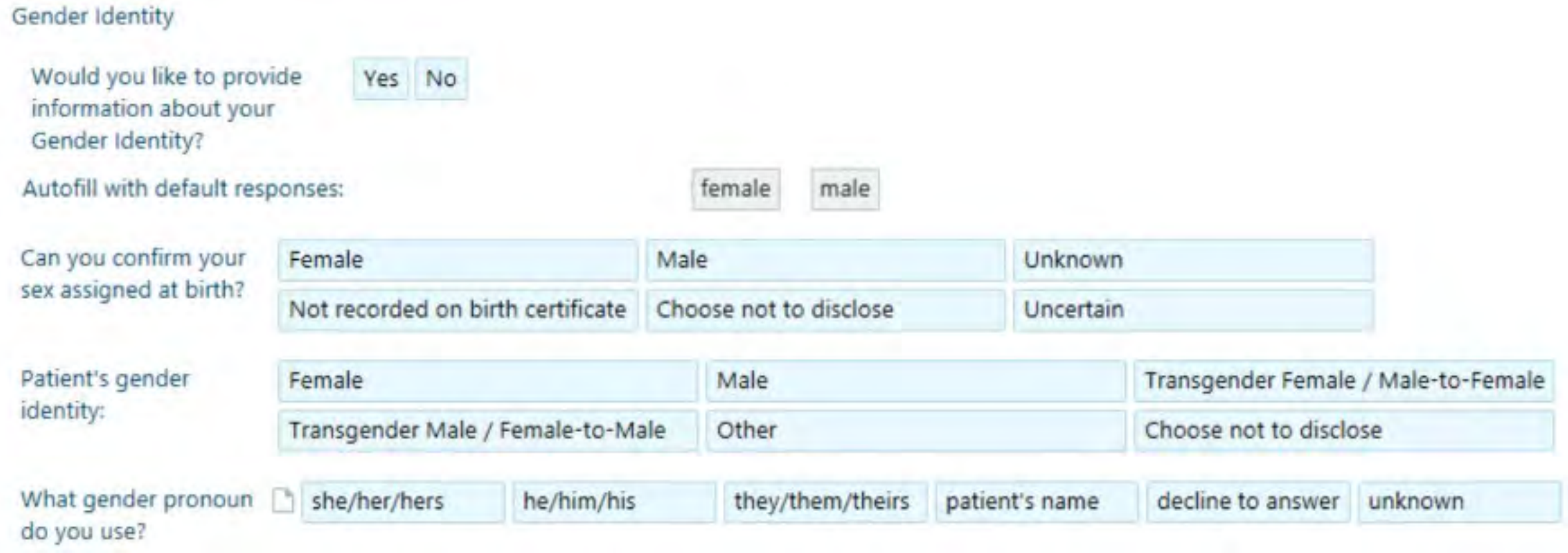
Part E: Family History Information

What is your **mother's** ancestry/country of origin? (German, Dominican Republic, Nigerian, Russian, etc.)	What is your **father's** ancestry/country of origin? (German, Dominican Republic, Nigerian, Russian, etc.)
Are any of your relatives of Ashkenazi Jewish decent? ☐ Yes ☐ No	
How many biological children do you have? _____	Number of sons _____ Number of daughters _____ Number of non-binary children _____
Please list the first name, age, and any health concerns/diagnoses for your children:	
How many biological siblings do you have? _____ Number of brothers_____ Number of sisters_____ Number of non-binary siblings_____	**If any siblings have a <u>different mother or father</u>:** How many have the same mother as you? _____ _____ _____ (brothers) (sisters) (non-binary) How many have the same father as you? _____ _____ _____ (brothers) (sisters) (non-binary)
How many biological siblings does your **mother** have? _____	Number of brothers _____ Number of sisters _____ Number of non-binary siblings _____
How many biological siblings does your **father** have? _____	Number of brothers _____ Number of sisters _____ Number of non-binary siblings _____

Part D: For Female Patients an Patients assigned Female at birth

BEFORE THE APPOINTMENT

- Use EHRs that allow inclusive documentation of GD patients



McKenna, D. (2024, September 5). *Gender Inclusive Counseling for Hereditary Cancer Risk*. https://www.ambrygen.com/providers/webinar/252/gender-inclusive-counseling-for-hereditary-cancer-risk-with-danielle-mckenna-ms-lcgc

Sexual Orientation and Gender Identity SmartForm

Inform the patient that anything entered here will be visible to anyone with access to this legal medical record.

Sexuality

Patient's sexual orientation: Straight | Bisexual | Something else | Don't know | Choose not to disclose | Gay | Lesbian

Legal Information

Legal first name: [redacted]

Legal last name: [redacted]

Legal sex: **Female** | Male | Unknown

Gender Identity

Autofill with default responses for: Cisgender female | Cisgender male

Patient's gender identity: Female | Male | Transgender Female | Transgender Male | Other | Choose not to disclose | Non-Binary

Patient's sex assigned at birth: Female | Male | Unknown | Not recorded on birth certificate | Choose not to disclose | Uncertain

Patient pronouns: she/her/hers | he/him/his | they/them/theirs | patient's name | decline to answer | unknown | not listed

Affirmation steps patient has taken, if any: presentation aligned with gender identity | preferred name aligned with gender identity | legal name aligned with gender identity | legal sex aligned with gender identity | medical or surgical interventions

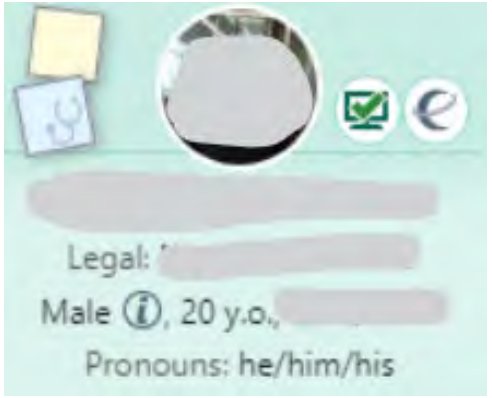
Patient's future affirmation plans, if any: Insert SmartText 100%

BEFORE THE APPOINTMENT

Gender identity: Male
Legal sex: Male
Sex assigned at birth: Female
It may be possible for this patient to become pregnant

Legal Sex	Gender Identity	Sex Assigned at Birth
Male	Non-Binary	Male
Sexual Orientation		
Bisexual		

Gender identity: Male
Legal sex: Female
Sex assigned at birth: Female
It may be possible for this patient to become pregnant



- GD patients may have **lower insurance coverage** and/or **higher rates of insurance denials** for services (why would a guy need a pap smear? etc.)
  - Additional documentation may be necessary

BEFORE THE APPOINTMENT

- Educate patients about:
  - The importance of sharing their SOGI
  - Institutional privacy policies
- Ask if patient has medical records under a different name rather than asking what their name was prior to transitioning (“deadname”)
- Avoid gendered terms like “women’s health” or “men’s health”

DURING THE APPOINTMENT

- Train ALL STAFF who will interact with the patient (schedulers, admin, billing, doctors, nurses, etc.) to use inclusive language
- Call a patient from the waiting room using their last name
- Physical things:
  - Have pronouns on your badge
  - Have a pride flag / safe space sticker / some other indication that you're LGBTQIA2S+ friendly
  - Have diverse posters on the walls of the waiting room / exam room

DURING THE APPOINTMENT

- Pronouns: Give them the option to tell you their pronouns but don't force it
  - "My name is _ and my pronouns are _"
- Ask what name they go by
- Don't assume a patient has a partner, or that their partner is of the opposite sex
- If someone else is with them, ask, "and who do you have with you today?" – don't assume it's their partner
- Mirror a patient's language when possible; use the organ terminology they prefer
- Acknowledge that you have limited experience working with this population (cultural humility)
- If you do end up misgendering someone in person, correct it and move on; **don't dwell on it**

DURING THE APPOINTMENT

- Collect an organ inventory, surgical history, and vaccination history
  - Explain that it's important to discuss these organs to understand and reduce their cancer risk…
  - …BUT, stick to what's relevant

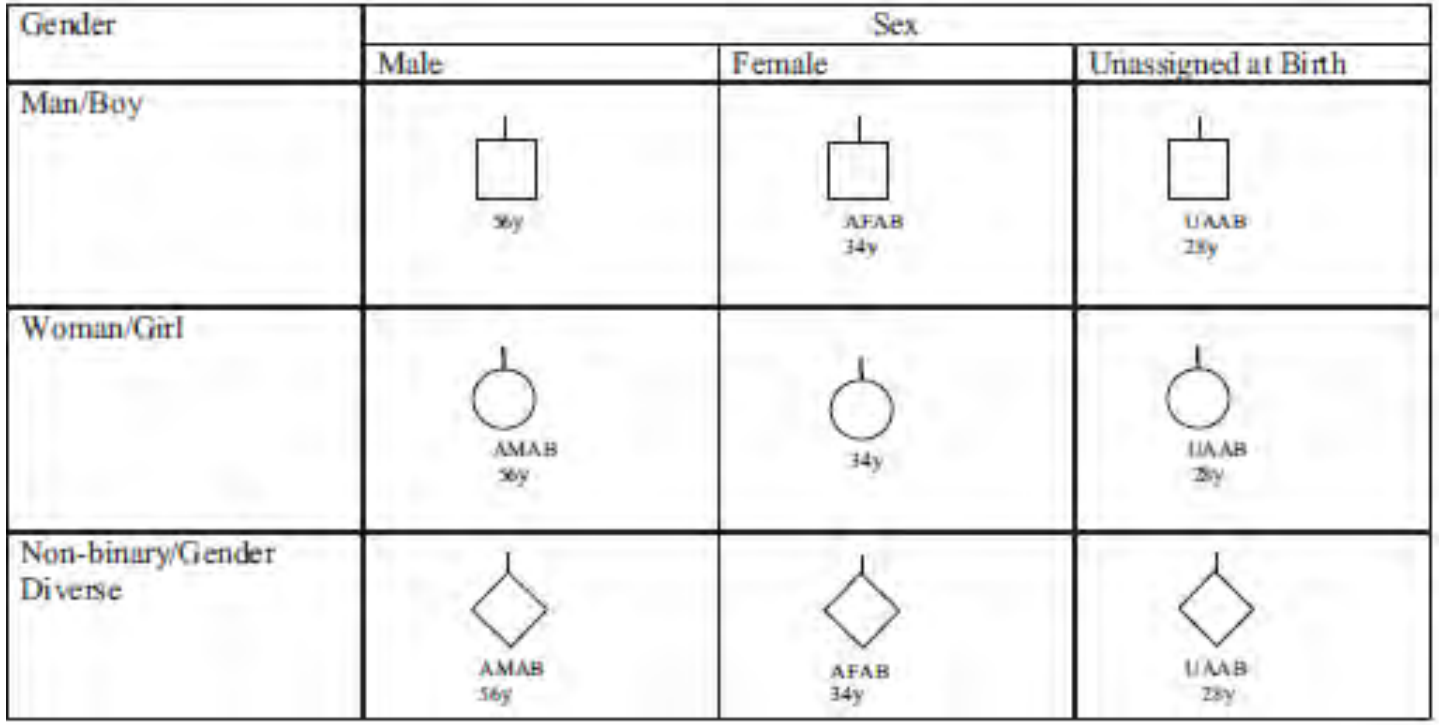
Transfeminine patients:			**Transmasculine patients:**	
HPV vaccination?	Y/N		HPV vaccination?	Y/N
HPV+?	Y/N		HPV+?	Y/N
HIV+?	Y/N		HIV+?	Y/N
Neovaginal surgery?	Y/N		Would pt want gyn care during colonoscopies?	Y/N
Tissue used?				
Surgery date?				

DURING THE APPOINTMENT

- Don’t forget to discuss non-genetic factors like tobacco and alcohol use
- Ask permission before touching the patient, describe the exam in detail, and make sure they are comfortable with every step of what’s happening as it happens
- If performing pap smears, pelvic exams, endometrial biopsies, etc. during colonoscopies / endoscopies…
  - Can offer topical vaginal estradiol 2 weeks prior to soften area (won’t affect their hormone therapy)
  - Can administer an anxiolytic prior to exam
  - Offer patients use of a mirror and/or to have a support person in the room

AFTER THE APPOINTMENT

- Avoid misgendering, blaming, or stigmatizing patients in notes
  - This erodes trust and contributes to minority stress and adverse health outcomes
- Use standard inclusive pedigree nomenclature



Bennett, R. L., French, K. S., Resta, R. G., & Austin, J. (2022). Practice resource-focused revision: Standardized pedigree nomenclature update centered on sex and gender inclusivity: A practice resource of the National Society of Genetic Counselors. Journal of Genetic Counseling, 31(6), 1239. https://doi.org/10.1002/jgc4.1621

RESOURCES

RESOURCES FOR GD PEOPLE WITH LS

Table 2 Additional resources for TGD individuals with Lynch Syndrome

Organization	Resource
The Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project, a collaborative, community-based program funded by the Massachusetts Department of Public Health (MDPH)	*Community standards of practice for provision of quality health care services for Gay, Lesbian, Bisexual and Transgendered Clients* http://www.glbthealth.org/documents/SOP.pdf
National LGBTQIA +Education Center, a program of the Fenway Institute	*10 strategies for creating inclusive health care environments* https://www.lgbtqiahealtheducation.org/wp-content/uploads/2021/05/Ten-Strategies-for-Creating-Inclusive-Health-Care-Environments-for-LGBTQIA-People-Brief.pdf
The World Professional Association for Transgender Health (WPATH), formerly known as the (Harry Benjamin International Gender Dysphoria Association (HBIGDA)	*Standard of care version 8* https://www.wpath.org/soc8

Hodan, R., Rodgers-Fouche, L., Chittenden, A., Dominguez-Valentin, M., Ferriss, J., Gima, L., Hamnvik, O.-P. R., Idos, G. E., Kline, K., Koeller, D. R., Long, J. M., McKenna, D., Muller, C., Thoman, M., Wintner, A., Bedrick, B. S., & on behalf of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer. (2023). Cancer surveillance for transgender and gender diverse patients with Lynch syndrome: A practice resource of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer. Familial Cancer, 22(4), 437–448. https://doi.org/10.1007/s10689-023-00341-4

RESOURCES FOR LGBTQIA2S+ PATIENTS

- UNMC Gender Care Clinic: https://www.nebraskamed.com/transgender-care
- National LGBT Cancer Network: https://colorectalcancer.cancer-network.org/risk-reduction/
- Find an LGBTQIA2S+ welcoming provider: https://cancer-network.org/providerdatabases/
- TGD CanScreen Project http://tgd.dfci.harvard.edu/main
- GLAAD Transgender Resources: https://glaad.org/transgender/resources/
- Fenway Health: https://fenwayhealth.org/
- InterACT: https://interactadvocates.org/resources/

RESOURCES FOR PROVIDERS

- (Add yourself) Find an LGBTQIA2S+ welcoming provider: https://cancer-network.org/providerdatabases/
- UNMC Gender Care Clinic: https://www.nebraskamed.com/transgender-care
- Increasing CRC Screening Among LGBTQ+ Communities Brief: https://nccrt.org/resource/80-in-every-community-lgbt/
- Provider Cultural Competency Training: https://cancer-network.org/cultural-competency-training/
- LGBTQ+ Cancer Fact Sheet for Providers: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/lgbtq-people-with-cancer-fact-sheet.pdf
- Collecting SOGI Data: https://www.whitehouse.gov/wp-content/uploads/2023/01/SOGI-Best-Practices.pdf
- Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People: https://transcare.ucsf.edu/guidelines
- Fenway Health: https://fenwayhealth.org/
- InterACT: https://interactadvocates.org/resources/

CONCLUSIONS

- The LGBTQIA2S+ population in the US is growing and you are likely to see these patients in your practice.
- These patients face health disparities, higher rates of advanced cancer, and lower rates of survival than cis individuals.
- We need GI cancer guidelines for this population to provide better care!
- Further studies are needed to determine the impact of hormones and other cancer risks in this population.
- There are many resources and ways you can make this patient population feel welcome and safe.

THANK YOU

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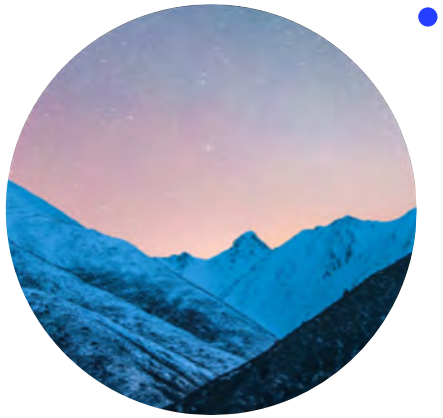

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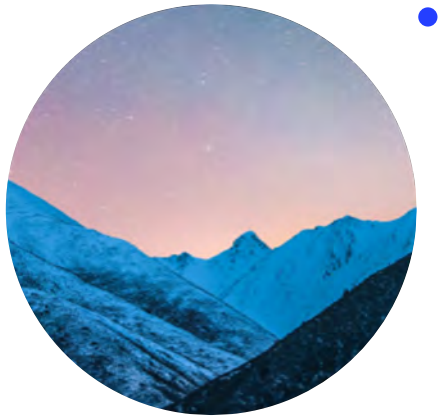

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