UNIVERSITY OF CENTRAL FLORIDA

Caring for Lesbian, Gay, Bisexual, and Transgender (LGBT) Clients

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Personal Disclosure

The author of this presentation has no identified conflicts of interest of any kind whatsoever with any of the entities discussed within this presentation.

Presentation Objectives

- At the end of this presentation, the participant will be able to:

1. Identify at least one unique health disparity that affects lesbians, gay men, bisexual, and transgender (LGBT) persons;
2. Recognize three components of the health history that are unique to LGBT individuals;
3. Provide at least one strategy to eliminate health disparities in LGBT individuals;
4. Identify the pharmacologic agents used in HIV PrEP and PEP prophylactic regimens and outline their associated prescribing principles;
5. Articulate the role nurse practitioners can play in community outreach in LGBT and queer communities;
6. Prioritize suggested future research directives in LGBT health.

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What do Clinicians Know?

- **Research tell us: <u>VERY LITTLE</u>**

  - Critical inquiries have shown that health providers are unaware of the many health disparities of GLBT persons
  - Scant studies focus on attitudinal perceptions and homophobia levels; but not many specifically assess knowledge level
  - Little or no national-level health data exist
    - Probably because many data collection tools do not ascertain sexual orientation

What do Clinicians Know?

- **Research tell us: <u>VERY LITTLE</u>**

- NPs report low self-efficacy in the treatment of transgender persons (Levesque, 2013).
- Data assessing nurses' knowledge indicate these nurses do not have the knowledge or skills needed to identify and address the needs of GLBT youth
  - LGBTQ students report they are 40% more likely to skip school out of fear for their safety.
  - Additionally, problems facing LGBTQ youth are **increased drug and alcohol use, sexually transmitted infections and pregnancy risks, depression and suicide, and increased likelihood of being a victim of harassment or assault**

What Disparities Exist?

- **GLMA: Perhaps the most authoritative organization advocating for GLBT health**
- **GLMA's document *Healthy People 2010 Companion Document for LGBT Health* is an amazing resource as is *Guidelines for Caring for LGBT Patients* (2006, updated 2014)**
- **GLMA identifies disparities related to:**
  - Access to quality health services
  - Cancers
  - HIV/AIDS
  - Immunization and infectious diseases
  - Mental health and mental disorders
  - Nutrition and weight
  - Sexually transmitted infections
  - Substance abuse: ETOH/tobacco/illicit drugs
  - Violence

GLMA
GAY & LESBIAN MEDICAL ASSOCIATION

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What Disparities Exist?

- *Healthy People 2020*:

- *https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health*

- *https://www.healthypeople.gov/2020/data-search/Search-the-Data#topic-area=3494;*

First Thing's First: Health History

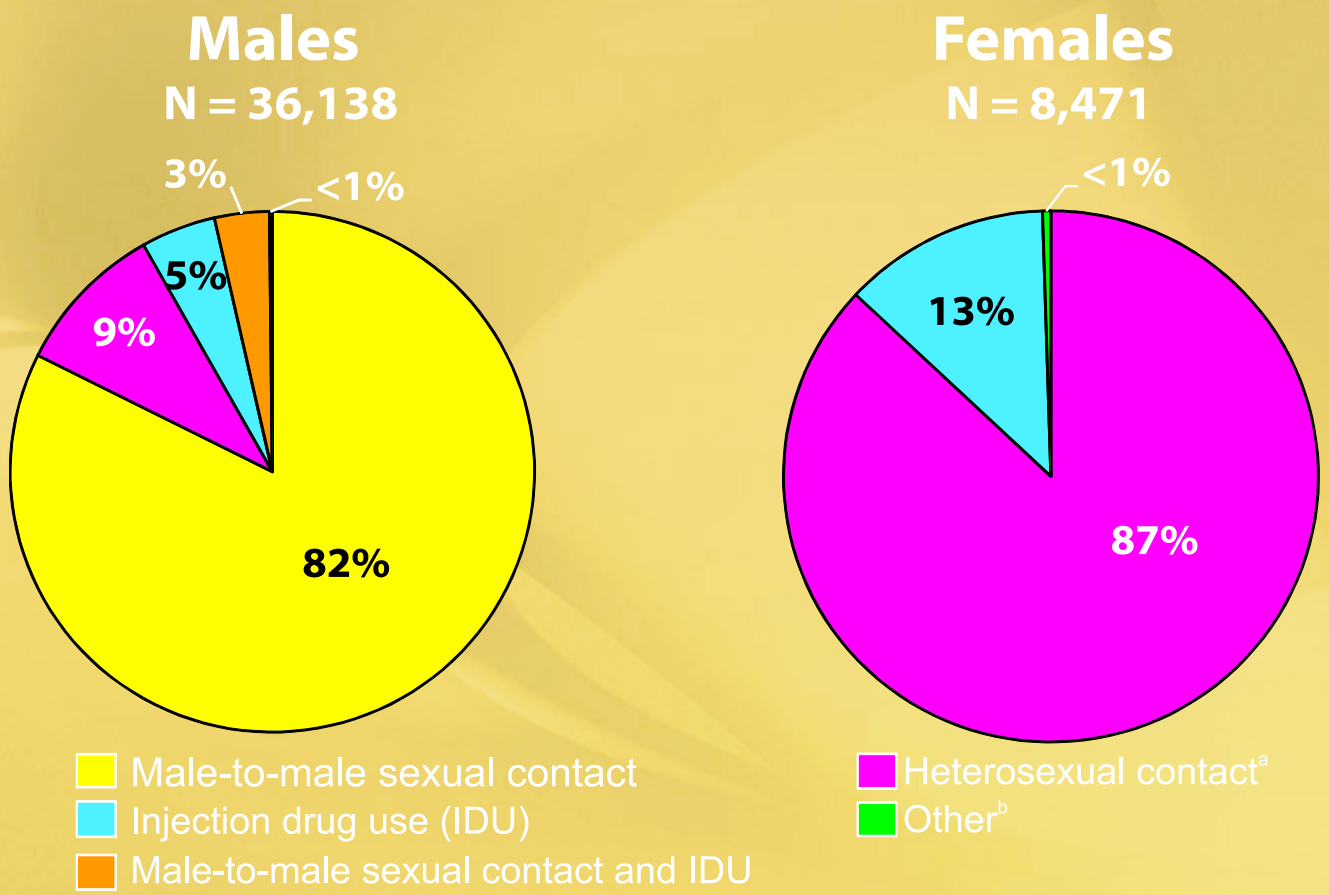
- **It is essential that clinicians ascertain the sexual orientation of *every* client**
  - Estimates indicate that up to 10% of the American population have a sexual orientation other than heterosexual; the clinician must not assume a client's sexual orientation, either heterosexual, homosexual, or bisexual
- **Most researchers suggest that practitioners approach the questioning of a client's sexual orientation in a direct manner:**
  - "Do you have sexual relationships with men, women, or both?"
- **Using the term "sexual preference" is not recommended, as this implies the individual made a choice regarding his or her sexual orientation**
- **Statements which imply judgment or which are leading are inappropriate; for example, questions such as:**
  - "You aren't gay, are you?" or "Do you have a wife?"

Gay Men

- For this presentation, “Gay Men” includes all men who have sex with men (MSM)
- These individuals have higher rates of HIV/AIDS, substance abuse (ETOH/illicit drugs, tobacco), depression and anxiety, hepatitis, STIs, eating disorders, and anorectal carcinoma

Gay Men: HIV/AIDS

- **Perhaps the biggest health concern of MSM**



Incidence of HIV Infection & AIDS: 2010-2015 Take Away Points

- From 2010 through 2015, among male adults and adolescents, the annual number of diagnosed HIV infections attributed to male-to-male sexual contact **increased** from 60% to 66%.
- **Among the 750,921 male adults and adolescents living with diagnosed HIV infection at the** end of 2015, 71% of infections were attributed to male-to-male sexual contact.
  - Approximately 11% of infections were attributed to injection drug use
  - 11% to heterosexual contact
  - 7% to male-to-male sexual contact *and* injection
  - 1% of males had infection attributed to perinatal exposure.
  - 36% in AA men; White men not far behind at 35%

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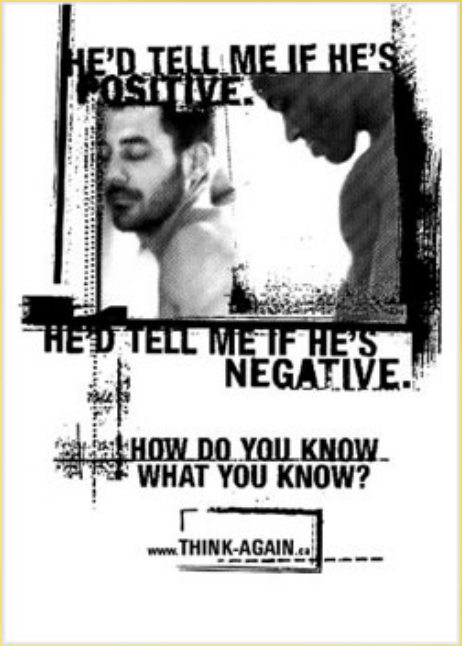
Incidence of HIV Infection & AIDS: 2010-2015 Take Away Points

- **Among the 238,034 female adults and adolescents living with diagnosed HIV infection at the end of** 2015, 75% of infections were attributed to heterosexual contact
  - 22% to injection drug use
  - 2% of females had infection attributed to perinatal exposure.
  - Females MUCH higher heterosexual transmission (75%).
  - African Americans HIGHEST rates in males (36%) and females (58%)
  - Progression to AIDS and related deaths decreased.

Gay Men: HIV/AIDS

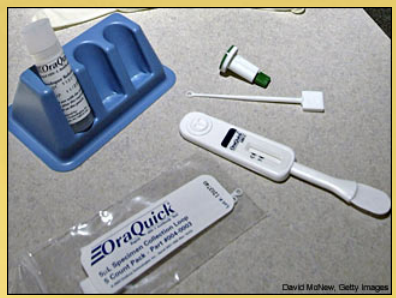
- **Perhaps the biggest health concern of MSM**

- When HIV first began to impact the gay community, prevention efforts reversed the trend of ↑ infections
- But recently, a younger generation of gay men have returned to unsafe sex due to:
  - improvements in HIV treatment
  - more complex sexual decision making
  - the Internet
  - substance use
  - safer sex fatigue
  - changes in HIV prevention programs



Gay Men: HIV/AIDS

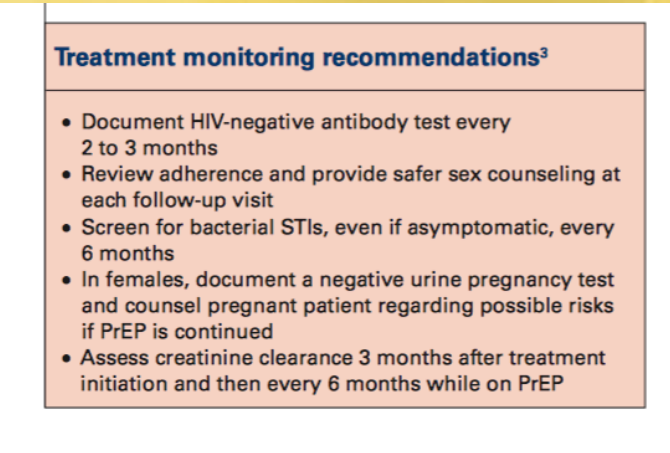
- **Clinicians should vigorously screen clients for HIV:**
  - New CDC (2006) guidelines recommend *at least* annual screening for gay men
  - Heterosexuals should be screened routinely
  - Testing is available for free in most cities
    - In Orlando, testing is 100% free at the CFGLBTCC
    - GLBTCC now offers OraSure® testing



  - Clinicians must also strive to educate, NOT DICTATE!!!
    - Encourage clients to live healthy lifestyles, make smart choices, and spread the word that "condoms are cool"
    - Prevention counseling is no longer recommended—so don't be afraid to refer to community resources

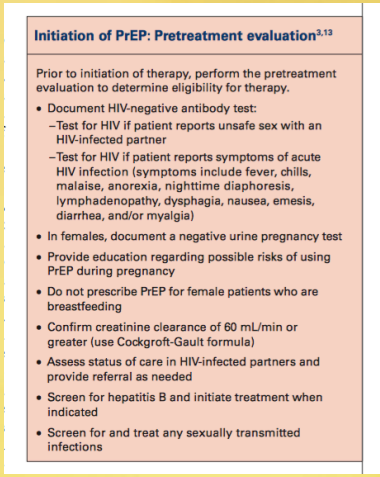
Gay Men: HIV/AIDS

- **Clinicians MUST be familiar with PrEP and PEP:**
  - The PrEP dosage is one Truvada tablet (emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg).
  - The drug is taken orally with or without food and should be prescribed with a frequency of once daily.
  - In addition to the medication, which should be prescribed in no more than a 90-day supply, the patient should be educated about risk reduction strategies, particularly consistent use of condoms during every sexual encounter.



Treatment monitoring recommendations[3]

- Document HIV-negative antibody test every 2 to 3 months
- Review adherence and provide safer sex counseling at each follow-up visit
- Screen for bacterial STIs, even if asymptomatic, every 6 months
- In females, document a negative urine pregnancy test and counsel pregnant patient regarding possible risks if PrEP is continued
- Assess creatinine clearance 3 months after treatment initiation and then every 6 months while on PrEP



Initiation of PrEP: Pretreatment evaluation[3,13]

Prior to initiation of therapy, perform the pretreatment evaluation to determine eligibility for therapy.

- Document HIV-negative antibody test:
  - Test for HIV if patient reports unsafe sex with an HIV-infected partner
  - Test for HIV if patient reports symptoms of acute HIV infection (symptoms include fever, chills, malaise, anorexia, nighttime diaphoresis, lymphadenopathy, dysphagia, nausea, emesis, diarrhea, and/or myalgia)
- In females, document a negative urine pregnancy test
- Provide education regarding possible risks of using PrEP during pregnancy
- Do not prescribe PrEP for female patients who are breastfeeding
- Confirm creatinine clearance of 60 mL/min or greater (use Cockgroft-Gault formula)
- Assess status of care in HIV-infected partners and provide referral as needed
- Screen for hepatitis B and initiate treatment when indicated
- Screen for and treat any sexually transmitted infections

- Image Source from Presenter: Blackwell, C.W. (2014). Preexposure prophylaxis: An emerging clinical approach to preventing HIV in high-risk adults. *The Nurse Practitioner: The American Journal of Primary Healthcare 39*(9), 50-53. doi: 10.1097/01.NPR.0000452976..92052.fa.

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Gay Men: HIV/AIDS

- **Clinicians MUST be familiar with PrEP and PEP:**
- **Although large-scale studies about PEP are lacking, PEP is clinically effective (80%) and recommended (Landovitz & Currier, 2009) when:**
  - The source is known to be HIV+
  - The source is of unknown serostatus (test source in occupational exposure)
  - The source has an increased likelihood of being HIV+:
    - MSM, MSM/W, commercial sex workers, history of incarceration, residence in a county with a seroprevalence rate $\geq$ 1%
  - The behavior has an increased ($\geq$ 1%) likelihood of transmitting HIV:
    - Receptive Anal Intercourse = 1%-30% chance of infection
    - Insertive Anal Intercourse = .1-10% chance of infection
    - Receptive Vaginal Intercourse = .1-10% chance of infection
    - Insertive Vaginal Intercourse = .1-1% chance of infection
    - Oral Intercourse: Few documented cases
    - Needle Sharing: .67% per needle-sharing event
- **Ideally, begin PEP within 36 hours but no more than 72 hours after exposure**
- **Treat with zidovudine-lamivudine (Combivir®) PO BID or tenofovir-emtricitabine (Truvada ®) PO QD for 28 days**

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Gay Men: Substance Abuse

- Gay and transgender people smoke tobacco up to 200% more than their heterosexual and non-transgender peers
- 25% of gay men and transgender people abuse ETOH, compared to 5%-10% of the general population
- MSM are 3.5 times more likely to use marijuana that men who do not have sex with men
- MSM 12.5 times more likely to use amphetamines than men who do not have sex with men
- MSM are 9.5 times more likely to use heroin than men who do not have sex with men

Gay Men: Substance Abuse
(Green & Feinstein, 2012)

Table 1
Summary of Recent Research on Substance Use Patterns in LGB Populations

Study	Sample	Definition of sexual orientation	Alcohol use		Drug use	
			Male	Female	Male	Female
Cochran et al. (2000)	N = 9,908 2% LGB men and women	Past year sexual behavior	No differences	LB > H for use, diagnosis, and treatment seeking	—	—
Cochran et al. (2004)	N = 9,908 2% LGB men and women	Past year sexual behavior	—	—	GB > H for use and symptoms	LB > H for use, symptoms, and diagnosis
Gruskin et al. (2001)	N = 8,113 1.5% LB women	Self-reported identity	—	LB > H for use (only for those aged 20–34)	—	—
Burgard et al. (2005)	N = 11,204 3% LB women	Lifetime and past year sexual behavior	—	LB > H for use	—	—
Drabble et al. (2005)	N = 7,248 1% L/G 1% B 2% H with same-sex behavior	Sexual behavior and self-reported identity	G > H for use	LB > H for use, problems, and treatment seeking	—	—
McCabe et al. (2005)	N = 8,337 1% only homosexual 1% mostly homosexual 1.5% bisexual 7.5% mostly heterosexual	Sexual identity, attraction, and behavior	H > G for use	—	G > H for marijuana use; B > H for drug use	—
Parsons, Kelly, & Wells (2006)	N = 1,104 46% LB	Self-reported identity	—	—	—	LB > H for club drug use
Parsons, Halkitis, & Bimbi (2006)	N = 5,665 1% LGB	Self-reported identity	—	—	H > GB for LSD use	LB > H for cocaine use H > LB for LSD use
Ford & Jasinski (2006)	N = 9,389 2% LG 4% B	Lifetime sexual behavior	—	—	B > GH for other illicit drug use	B > LH for marijuana use
Jasinski & Ford (2007)	N = 7,659 4% LG 4% B	Lifetime sexual behavior	H > GB for use	No differences	—	—
Cochran et al. (2007)	N = 4,498 5% LGB	Self-reported identity and past year sexual behavior	No differences	No differences	No differences	LB > H for drug use disorders
Wilsnack et al. (2008)	N = 953 42% L	Self-reported identity	—	LB > H for use, problems, and diagnosis	—	—
McCabe et al. (2009)	N = 34,653 2% LGB 6% same-sex attraction 4% same-sex behavior	Sexual identity, attraction, and behavior	GB > H for use and diagnosis	LB > H for use and diagnosis	G > H for marijuana use and other drug use and dependence; B > H for other drug use and dependence	L > H for marijuana and other drug use and dependence; B > H for marijuana dependence and other drug use

Note. H = heterosexuals; G = gay men; L = lesbians; B = bisexuals; Use = substance use frequency or intensity; Symptoms = symptoms of alcohol/drug abuse or dependence; Problems = alcohol or drug-related problems; Diagnosis = alcohol or drug use disorder diagnosis; Treatment Seeking = likelihood of seeking treatment for alcohol or drug use problems.

From "Substance Use in Lesbian, Gay, and Bisexual Populations: An Update on Empirical Research and Implications for Treatment," by K. E. Green, & B. A. Feinstein, 2012, *Psychology of Addictive Behaviors, 26(2),* p. 279.

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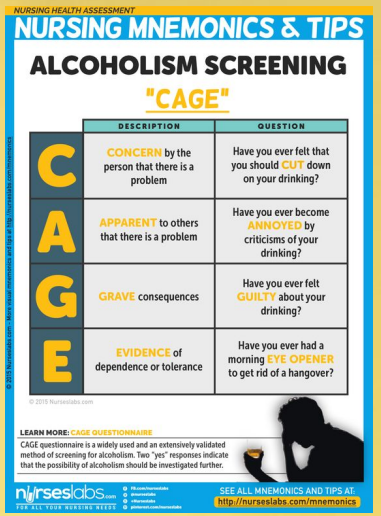
Gay Men: Substance Abuse

- **Clinicians must vigorously screen for substance abuse in clients:**
  - DON'T JUDGE, offer help and move-on
  - Use screening methods like CAGE:
    - Cutting down on ETOH?
    - Annoyed by criticisms of your drinking?
    - Guilty for drinking?
    - Eye-openers?
  - Ask the client's perceptions of his use and desire to quit
  - If the client isn't interested, it doesn't do any good to preach or dwell, move-on
  - Discuss the relationships between some drug use and unsafe sexual behaviors, example: crystal meth



Gay Men: STIs/ Hepatitis

- **Gay men are at increased risk for all subtypes of hepatitis:**
  - 2013 USPTF update recommends screening for HCV in those w/ higher risk and one time screening for those born between 1945-1965.
  - However, clinicians should encourage vaccination: HAV and HBV are available
  - Educate regarding virulence and communication
- **Gay men are at increased risk for syphilis, gonorrhea, herpes, Chlamydia, and peduculosis pubis**
  - Current recommendations do not recommend routine screening of Chlamydia, serologic herpes, or gonorrhea in asymptomatic **men** (USPTF, 2013)
  - Educate about spread and screen in symptomatic clients
  - Emphasize the use of condoms in decreasing the spread of these infections

Gay Men: Anorectal Carcinoma

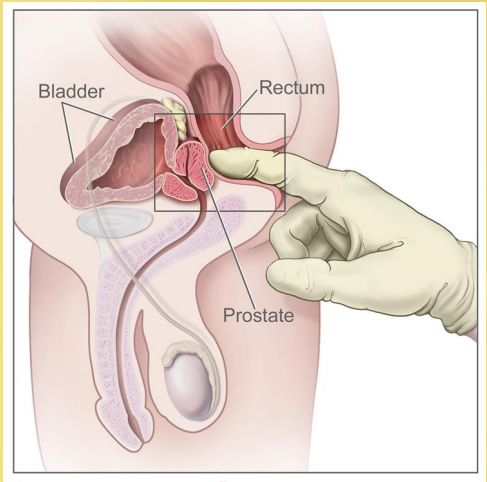
- The prevalence rate of anal carcinoma is relatively low in the general population, estimated at 0.9 cases per 100,000 persons
- Among men who have sex with men, the prevalence this rate may be as high as 35 per 100,000 persons
  - This prevalence rate mirrors that of carcinoma of the uterine cervix before the widespread implementation of cervical Pap screening
- Although the precise etiologic mechanism for the increased development of anal carcinoma in gay men is unknown, current research supports a link between ongoing sexual exposure to the human papillomavirus (HPV) and the consequent development of anal cancer.

Gay Men: Anorectal Carcinoma

- Data indicate that gay men have an increased number of lifetime sexual partners and episodes of receptive anal intercourse.
- Also, more and more gay men have been participating in a greater number of sexual risk-taking behaviors, perhaps because of HIV/AIDS "burnout," (a return to unsafe sexual practices resulting from over-proliferation of prevention messages), low self-esteem, lack of peer support, and lack of access to preventative services

Gay Men: Anorectal Carcinoma

- Sexual risk-taking behaviors can increase opportunities for sexually-transmitted infections (STIs), including HIV and HPV infections, both of which have higher prevalence in gay men compared to heterosexual men
- Current data indicate that between 60%-75% of men who have sex with men are infected with HPV



Gay Men: Anorectal Carcinoma

- Condoms should be encouraged but may not stop the spread of HPV
- Physical exam may reveal gross lesions visible on the exterior surface of the anus
- Other manifestations of the disease include a polypoid mass, or more commonly, a firm, nodular, rolled edge of an ulcerated malignancy
- Diffuse peritoneal metastases from any source may develop in the area of the peritoneal reflection, just anterior to the rectum
- A firm to hard nodular rectal shelf may be just palpable with the tip of the examining finger
  - However, visible findings are not always present in patients with anorectal carcinoma, highlighting the significance of the annual anal Pap

Gay Men: Anorectal Carcinoma

- **Anal Pap Cytology Screening: Advanced Practice Considerations:**
  - The technical procedure for obtaining an anal Pap smear is fairly similar to that of obtaining a cervical smear
  - NPs should use a Dacron cotton swab; wooden sticks are to be avoided because of their increased tendency to splinter and break
  - Male patients are placed in the lateral recumbent position
  - Without direct visualization, the swab should be inserted approximately 5-6 cm into the anal canal.
  - NPs should apply direct, firm, lateral pressure on the swab handle while rotating and slowly removing it
  - By inserting the swab 5-6 cm into the anal canal, they ensure that the transition zone, where columnar epithelial cells of the rectum separate from the keratinized cells of the anal mucosa, is sampled-- data suggest that most anal intraepithelial neoplasms arise from this zone

Gay Men: Mental Health Issues

- Depression and anxiety appear to affect gay men at a higher rate than in the general population
- The likelihood of depression or anxiety may be greater, and the problem may be more severe for those men who remain in the closet or who do not have adequate social supports

Gay Men: Mental Health Issues

- Screen clients carefully for depression using diagnostic screening tools such as *Brief Symptom Inventory-18* (*BSI-18)*
- Use gay-affirming language and remain non-judgmental
- Remember that research strongly suggests that "reparative" therapies or "conversion therapies" are psychologically damaging, unethical, and non-efficacious
  - See:
- Blackwell, C.W. (2008). Nursing implications in the application of conversion therapies on gay, lesbian, bisexual, and transgender clients. *Issues in Mental Health Nursing 29* (6), 651-656. DOI: 10.1080/01612840802048915.

Gay Men: Mental Health Issues

- Adolescents and young adults may be at particularly high risk of suicide because of these concerns
- Culturally sensitive mental health services targeted specifically at gay men may be more effective in the prevention, early detection, and treatment of these conditions

Gay Men: Mental Health Issues

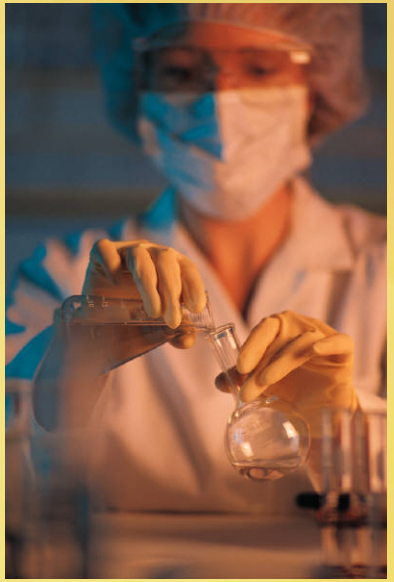
- **Lee, Oliffe, Kelly, & Ferlatte (2017):**
  - The prevalence of depression among gay men is three times higher than the general adult population.
  - Because depression is a known risk factor for suicide, gay men are also at high risk for suicidality.

Gay Men: Mental Health Issues

- **Michaels, Parent, & Torrey, (2015) found:**
  - Depressive symptoms partially mediated the relationship between (less) outness predicting suicidal ideation.
  - These findings imply that therapeutic approaches targeting the coming out process may be more effective than approaches targeting internalized homophobia when suicidal ideation is indicated in the clinical presentation of gay and bisexual men.

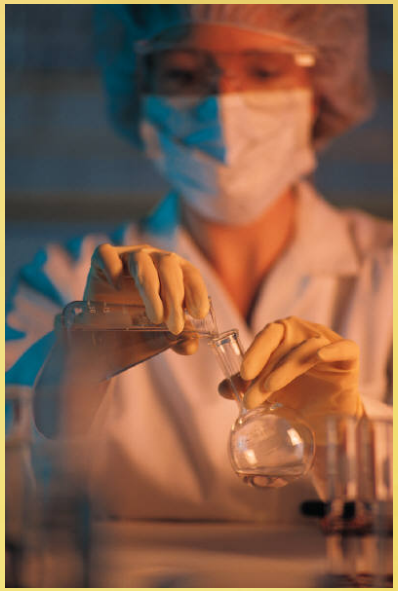
Gay Men: MRSA

- A study appearing in an issue of the *Annals of Internal Medicine*, Diep et al (2008) looked at isolates of MRSA - USA300 strains containing a particular plasmid associated with additional drug resistance
- The paper shows that multidrug-resistant USA300 has emerged as an important source of disease among men with have sex with men in 2 geographically distinct communities (SF/ Boston)



Gay Men: MRSA

- The strains of MRSA described have mostly been identified in certain groups of men who have sex with men (MSM), but have also been found in some persons who are not MSM
- It is important to note that the groups of MSM in which these isolates have been described are not representative of all MSM, so conclusions can not be drawn about the prevalence of these strains among all MSM

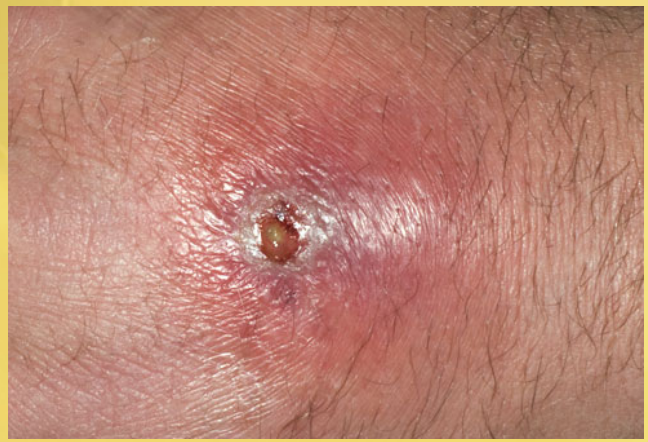


Gay Men: MRSA

- The groups studied in this report may share other characteristics or behaviors that facilitate spread of MRSA, such as frequent skin-to-skin contact
- CDC's extensive and continuing study of invasive MRSA in 9 US states indicates that these strains are rare.
- It remains important to do what we can to prevent transmission of these strains and of MRSA in general

Gay Men: MRSA

- MRSA is typically transmitted through skin-to-skin contact, which occurs during a variety of activities, including sex
- There is no evidence at this time to suggest that it MRSA is a sexually-transmitted infection in the classical sense.
- Therefore, CDC believes that our recommended prevention measures for CA-MRSA in general are also the most appropriate response to the strains described among MSM

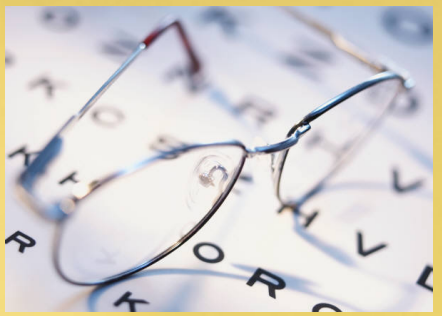


Lesbians: Breast Cancer

- For this presentation, the term “Lesbian” refers to WSW
- Lesbians have the richest concentration of risk factors for breast cancer than any subset of women in the world
- Combine this with the fact that many lesbians over 40 do not get routine mammograms, do breast self-exams, or have a clinical breast exam, and this cancer may elude early diagnosis, when it is most curable

Lesbians: Breast Cancer

- VERY limited data are available (National LGBT Cancer Network, 2016)
  - Study findings are contradictory
- Meads and Moore (2013):
  - 198 references
  - No incidence rates were found.
  - Nine studies gave prevalence estimates - two showed higher, four showed no differences, one showed mixed results depending on definitions, one had no comparison group and one gave no sample size.
  - All studies were small with poor methodological and/or reporting quality.



Lesbians: Breast Cancer

- VERY limited data are available (National LGBT Cancer Network, 2016)
  - Study findings are contradictory
- Meads and Moore (2013):
  - One incidence modeling study suggested a higher rate.
  - Four risk modeling studies were found, one Rosner-Colditz and three Gail models.
  - Three suggested higher and one lower rate in LB compared to heterosexual women. Six risk-factor estimates suggested higher risk and one no difference between LB and heterosexual women.
  - Conclusions
    - The only realistic way to establish rates in LB women would be to collect sexual orientation within routine statistics, including cancer registry data, or from large cohort studies.

Lesbians: Breast Cancer

- Annual mammograms for those ≥ 40 no longer recommended:
  - 40-44: Screening + Mamo if pt wants it
  - 45-54: Annual Mammo
  - ≥ 55: Mammo q 2 yrs
    - Annual Mammo + MRI:
      - Lifetime risk > 20%-25%
      - Known BRCA 1 or 2 mutation
      - Hx Radiation to chest between 10-30 years of age
      - Hx of Li-Fraumeni Syndrome, Cowden Syndrome, or Bannayan-Riley-Ruvalcaba Syndrome or have 1st-degree relatives with this Hx

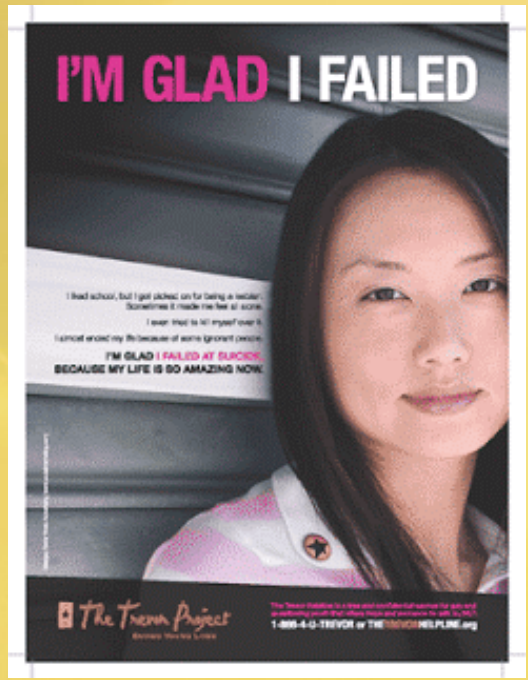
- Clinical Breast Exam (CBE) & SBE no longer recommended

Lesbians: Mental Health Issues

- Lesbians have been shown to experience chronic stress from homophobic discrimination
- This stress is compounded by the need that some still have to hide their orientation from family and colleagues at work, and by the fact that many lesbians have lost the important emotional support most others get from their families due to alienation stemming from their sexual orientation

Lesbians: Mental Health Issues

- Suicidal ideations and attempts much higher in LBG individuals
- Screen using same approach as previously discussed



Lesbians: Heart Disease

- Lesbians tend to have higher BMIs than their heterosexual counterparts
- Denial of being overweight or obese is also significant for lesbians
- Comparison studies indicate civil-partnered or married couples are more stable, which can decrease incidence of cardiovascular disease

Lesbians: Heart Disease

- Smoking and obesity are the most prevalent risk factors for heart disease among lesbians; both are higher in lesbians
  - Perform an annual clinical exam assessing blood pressure, cholesterol, and diabetes risk
  - Discuss the importance of exercise and review diet and nutrition
  - Encourage smoking abstinence and discuss cessation:
    - Nicotine replacement + group therapy = best outcome
  - Preventing heart disease, which kills 45 percent of women, should be paramount to every clinical visit

Lesbians: Gynecological Cancers

- Lesbians have higher risks for many of the gynecologic cancers
- What they may not know is that having a yearly exam by a gynecologist can significantly facilitate early diagnosis and a better chance of cure:
  - No penis doesn't = no Pap
  - Matthews, et. al, 2003; Robinson, Galloway, Bewley, & Meads (2016):
    - More lesbians than heterosexuals initiated sexual relationships $\leq$ 18:
      - This includes heterosexual intercourse, higher in lesbians and bisexuals
    - Lesbians had more sexual partners than heterosexuals
    - 86% of lesbians reported "never" using a safe sex device
    - Lesbians were less likely to report having an STI
    - Lesbians have higher rates of smoking and ETOH use
    - Heterosexuals much more likely to report an annual Pap
    - Lesbians 10 times less likely to get cervical screening (Fenway Health, 2013)

Lesbians: Gynecological Cancers

Cervical Cancer Screening Guidelines for Average-Risk Women[a]

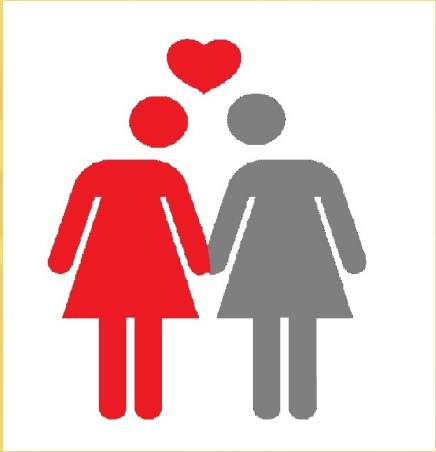
	American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP), and American Society for Clinical Pathology (ASCP)[1] 2012	U.S. Preventive Services Task Force (USPSTF)[2] 2012	American College of Obstetricians and Gynecologists (ACOG)[3] 2012	Society of Gynecologic Oncology (SGO) and the American Society for Colposcopy and Cervical Pathology (ASCCP): Interim clinical guidance for primary hrHPV testing[4] 2015
When to start screening[b]	Age 21. Women aged <21 years should not be screened regardless of the age of sexual initiation or other risk factors.	Age 21. *(A recommendation)* Recommend against screening women aged <21 years *(D recommendation).*	Age 21 regardless of the age of onset of sexual activity. Women aged <21 years should not be screened regardless of age at sexual initiation and other behavior-related risk factors *(Level A evidence).*	Refer to major guidelines.
Statement about annual screening	Women of any age should not be screened annually by any screening method.	Individuals and clinicians can use the annual Pap test screening visit as an opportunity to discuss other health problems and preventive measures. Individuals, clinicians, and health systems should seek effective ways to facilitate the receipt of recommended preventive services at intervals that are beneficial to the patient. Efforts also should be made to ensure that individuals are able to seek care for additional health concerns as they present.	In women aged 30–65 years, annual cervical cancer screening should not be performed. *(Level A evidence)* Patients should be counseled that annual well-woman visits are recommended even if cervical cancer screening is not performed at each visit.	Not addressed.
Screening method and intervals				
Cytology (conventional or liquid based)[c] 21–29 years of age	Every 3 years.[d]	Every 3 years *(A recommendation).*	Every 3 years *(Level A evidence).*	Not addressed.
Cytology (conventional or liquid based)[c] 30–65 years of age	Every 3 years.[d]	Every 3 years *(A recommendation).*	Every 3 years *(Level A evidence).*	Not addressed.
HPV co-test (cytology + HPV test administered together) 21–29 years of age	HPV co-testing should not be used for women aged <30 years.	Recommend against HPV co-testing in women aged <30 years *(D recommendation).*	HPV co-testing[e] should not be performed in women aged <30 years. *(Level A evidence)*	Not addressed.
HPV co-test (cytology + HPV test administered together) 30–65 years of age	Every 5 years; this is the preferred method.	For women who want to extend their screening interval, HPV co-testing every 5 years is an option *(A recommendation).*	Every 5 years; this is the preferred method *(Level A evidence).*	Not addressed.
Primary hrHPV testing[f] (as an alternative to cotesting or cytology alone)[g]	For women aged 30–65 years, screening by HPV testing alone is not recommended in most clinical settings.[h]	Recommend against screening for cervical cancer with HPV testing (alone or in combination with cytology) in women aged <30 years *(D recommendation).*	Not addressed.	Every 3 years. Recommend against primary hrHPV screening in women aged <25 years of age.[i]
When to stop screening	Aged >65 years with adequate negative prior screening* and no history of CIN2 or higher within the last 20 years.[j] **Adequate negative prior screening results are defined as 3 consecutive negative cytology results or 2 consecutive negative co-test results within the previous 10 years, with the most recent test performed within the past 5 years.*	Aged >65 years with adequate screening history* and are not otherwise at high risk for cervical cancer[j] *(D recommendation).*	Aged >65 years with adequate negative prior screening* results and no history of CIN 2 or higher[j] *(Level A evidence).*	Not addressed.

Lesbians: Gynecological Cancers

- Educate lesbians about safe sexual practices
- Current guidelines recommend that screening start for all women at age 21, regardless of HPV vaccination or age of sexual debut, and continue every three years until age 29; the screening interval may be lengthened to every five years for women ages 30-65 if HPV co-testing is done in addition to the Pap test

Lesbians: Gynecological Cancers

- Women with a history of a prior abnormal Pap test or who are immune compromised (e.g. by HIV) should be screened yearly
- Educate lesbians about their increased risk for developing gynecological cancers
- Don’t assume that lesbians have not had heterosexual intercourse



Lesbians: Substance Abuse

- Similar to gay men, research suggests higher rates of smoking, illicit drug use, and alcohol abuse
- Smokeless tobacco less prevalent
- Apply some of the same strategies discussed already
- Remember, try to refer GLBT clients to treatment groups designed for them
  - Data indicate these programs have much more efficacious outcomes for GLBT clients than non-GLBT oriented ones

Lesbians: Domestic Violence

- The National Violence Against Women survey found that 21.5 percent of men and 35.4 percent of women living with a same-sex partner experienced intimate-partner physical violence in their lifetimes
- This is compared with 7.1 percent and 20.4 percent for men and women, respectively, with a history of only opposite-sex cohabitation.

Lesbians: Domestic Violence

- But the question is where do lesbians go when they are battered?
  - Lesbians report a sense of isolation when abused
  - Transgender and lesbian victims report fear of homo/transphobia as reasons for avoiding assistance
  - LBT victims rely heavily on their social networks and the importance of friends; they also report that batterers should be held accountable
  - Clinicians need to screen clients for domestic violence—use an open-ended approach and don't jump to conclusions—allow the client to speak
  - Use standardized assessment tools
  - Shelters need to welcome and include battered lesbians, and offer counseling to the offending partners

Lesbians: Domestic Violence

- **RADAR Screening Tool**

R	Routinely ask about abuse or violence related to a spouse or partner.
A	Ask specific questions related to types of violence (in private).
D	Document her answers and your observations.
A	Assess her safety.
R	Review her options.

Lesbians: Osteoporosis

- The rates and risks of osteoporosis among lesbians have not been well characterized yet
- Calcium and weight-bearing exercise as well as the avoidance of tobacco and alcohol are the mainstays of prevention
- It is also important to get bone density tests every few years to see if medication is needed to prevent fracture
- DXA scan annually for those > 65

Variable	Score
Age, yr	
≥ 75	15
65–74	9
55–64	5
45–54	0
Weight, kg	
< 60	9
60–69	3
≥ 70	0
Current estrogen use	
No	2
Yes	0

*Women with a total score of 9 or greater would be selected for bone densitometry.

Transgenders: Access to Healthcare

- Transgender persons are often reluctant to seek medical care through a traditional provider-patient relationship
- Some are even turned away by providers
- A clinician who refuses to treat a trans person may be acting out of fear and transphobia, or may have a religious bias against LGBT patients

Transgenders: Access to Healthcare

- It's also possible that the clinician simply doesn't have the knowledge or experience needed to treat the client
- Furthermore, health care related to transgender issues is usually not covered by insurance, so it is more expensive
- Whatever the reasons, transgender people have sometimes become very ill because they were afraid to visit their providers
  - Be aware of available resources: GLMA has a physician referral service on their Web Site

Transgenders: Health History

- Trans persons may hide important details of their health history from their providers
- Perhaps they fear being denied care if their history is known
- Even many years after surgery, they may omit the history of their transition when seeing a new provider
- Patients should see their provider as an equal partner in their health care, not as a gatekeeper or an obstacle to be overcome

Transgenders: Health History

- This makes a trusting relationship so essential
  - Reassure the client that you're relationship is a helping, professional one, not based in judgment
  - Remember the ANA *Code of Ethics*:
  - **The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.**

Transgenders: Hormones

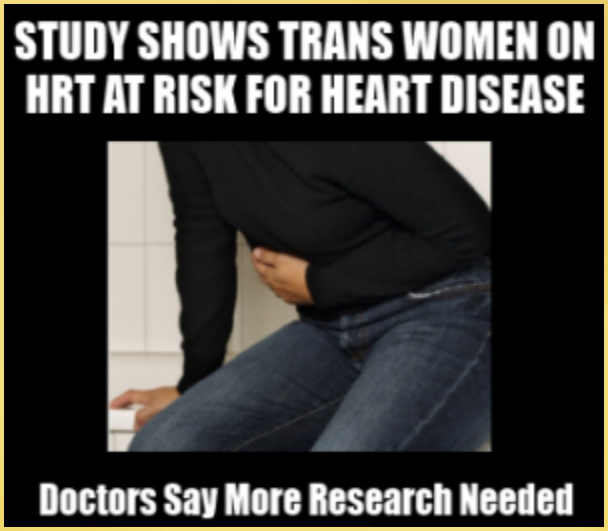
- Cross-gender hormone therapy gives desirable feminizing (or masculinizing) effects, but carries its own unique risks
- Estrogen has the potential to increase the risk of blood clotting, high blood pressure, elevated blood sugar and water retention
- Anti-androgens such as spironolactone can produce dehydration, low blood pressure, and electrolyte disturbances
- Testosterone, especially when given orally or in high doses, carries the risk of liver damage

Transgenders: Hormones

- Hormone use should be appropriately monitored by the patient and provider
- Some trans people tend to obtain hormones and other treatment through indirect means, bypassing the health care system
- Taking hormones without supervision can result in doses too high or too low, with undesired results
  - Educate the client about the dangers of acquiring medications from non-FDA-approved sources
  - Don't be afraid to refer the client out if endocrine Tx is outside of your realm of practice; GLMA's Site can be helpful for this

Transgenders: Cardiovascular Health

- Trans persons may be at increased risk for heart attack or stroke, not only from hormone use but from cigarette smoking, obesity, hypertension, and failure to monitor cardiovascular risks

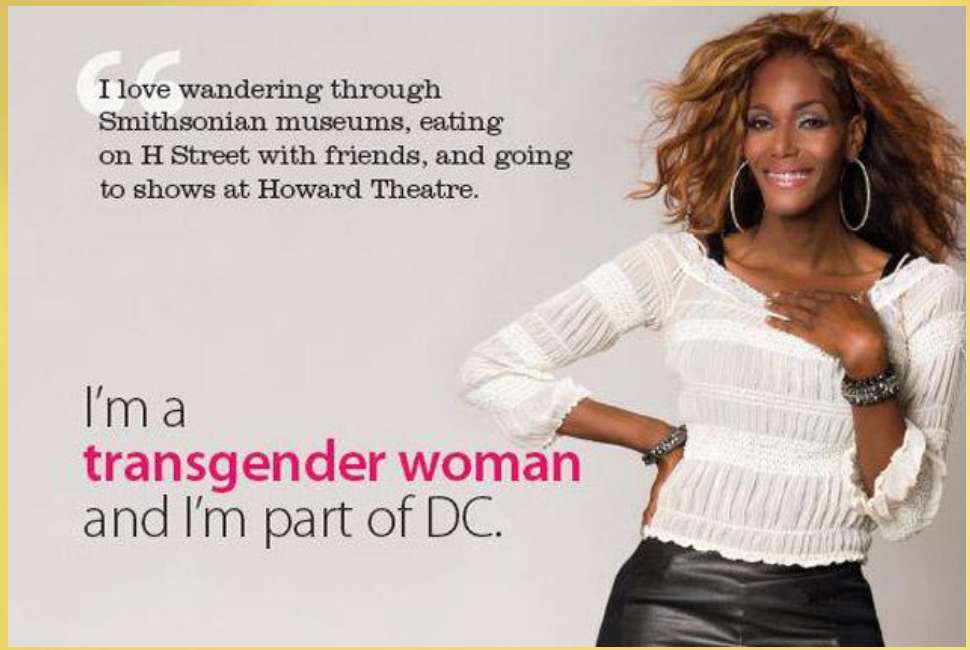


Transgenders: Cardiovascular Health

- Trans women may fear that a provider who finds them at risk for cardiovascular disease will instruct them to stop their hormones, and so they do not seek medical attention even when they have early warning signs of heart disease or stroke
  - This highlights the significance of vigilant screening, evaluation, EDUCATION, and referral if necessary

Transgenders: Cancer

- Hormone-related cancer (breast in trans women, liver in women or men) is very rare but should be included in health screenings
- A greater worry is cancer of the reproductive organs
- Trans men who have not had removal of the uterus, ovaries, or breasts are still at risk to develop cancer of these organs



Transgenders: Cancer

- Trans women remain at risk, although low, for cancer of the prostate:
  - Early castration has been assumed to protect against prostate cancer because androgens regulate prostate cancer cell growth
  - Two case series of eunuchs with an average age of 57.5 years and an average duration of castration of 44 years demonstrated small or nonpalpable prostate glands on examination (n = 36) and an atrophic prostate on autopsy (n = 1)
  - Although male-to-female gender reassignment surgery generally does not include prostatectomy, a small cross-sectional study suggested that prostate disease may not be common

Transgenders: Cancer

- Trans women remain at risk, although low, for cancer of the prostate:
  - Prostate ultrasonography and biopsy demonstrated atrophy in 9 transgender women aged 51 to 71 years a mean of 15.8 years after estrogen initiation and 13.4 years after orchiectomy
  - Three cases of prostate cancer in transgender women have been reported
- Furthermore, some providers are uncomfortable with treating such cancers in trans people
- Some cases have been reported in which persons delay seeking treatment, or are refused treatment, until the cancer has metastasized

Transgenders: STIs and Safe Sex

- Trans people, especially youth, may be rejected by their families and find themselves homeless
- They may be forced into sex work to make a living, and therefore at high risk for STDs including HIV
- Other trans people may practice unsafe sex when they are beginning to experience sexuality in their desired gender
- Safe sex is still possible even in transgender relationships

Transgenders: STIs and Safe Sex

- Giami & Le Bail (2011) found:
  - Difficulties related to establishing a consistent and consensual definition of the transgender population and its different subgroups and also to identifying its sociodemographic characteristics.
  - The diversity of risk factors and the risk for HIV infection and STIs, which endanger the different subgroups of this population to different degrees.
  - Belonging to an ethnic minority, international migration, social instability, and participation in sex work are the major risk factors for this population.

Education of health professionals about transgender identity and sexuality and support groups for transgender people with HIV/AIDS are urgently needed.

Transgenders: ETOH & Tobacco

- Alcohol abuse is common in transgender people who experience family and social rejection, and the depression which accompanies such rejection
- Alcohol combined with sex hormone administration increases the risk of liver disease
- Tobacco use is high among all trans persons, especially those who use tobacco to maintain weight loss
- Risks of heart attack and stroke are increased in persons who smoke tobacco and take estrogen or testosterone

Transgenders: ETOH & Tobacco

- *The National Association of Lesbian, Gay, Bisexual and Transgender Community Centers* (www.lgbtcenters.org) Web site has an interactive directory of LGBT community centers across the United States
- The directory is organized by state and includes a link to each center's Web site, if there is one
- Based on my completely unscientific survey of a small proportion of these links, most LGBT community centers host some form of 12-step group and include these meetings on their program calendars
- This could be a valuable resource for referring traveling or relocating clients who need 12-step meetings or just increased connection with a local LGBT community

Transgenders: Mental Health Issues

- For many reasons, trans people are particularly prone to depression and anxiety
- In addition to loss of family and friends, they face job stress and the risk of unemployment
- Trans people who have not transitioned and remain in their birth gender are very prone to depression and anxiety
- Suicide is a risk, both prior to transition and afterward
- One of the most important aspects of the transgender therapy relationship is management of depression and/or anxiety

Transgenders: Injectable Silicone

- Some trans women want physical feminization without having to wait for the effects of estrogen
- They expect injectable silicone to give them "instant curves"
- The silicone, often administered at "pumping parties" by non-medical persons, may migrate in the tissues and cause disfigurement years later
- Also may increase risk for lymphoma and other cancers
- It is usually not medical grade, may contain many contaminants, and is often injected using a shared needle

Transgenders: Injectable Silicone

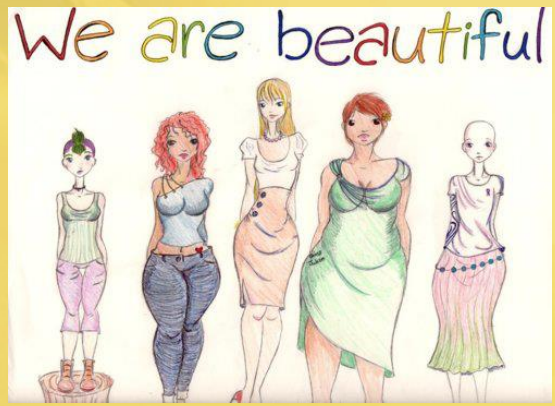
- Oneal Morris

Transgenders: Fitness & Exercise

- Many trans people are sedentary and overweight
- Exercise is not always priority, and they may be working long hours to support their transitions
- A healthy diet and a frequent exercise routine are just as important for trans persons as for the public
- Exercise prior to sex reassignment surgery will reduce a person's operative risk and promote faster recovery

Transgenders: Body Image

- McGuire, Doty, Catalpa, & Ola (2016).
  - Evidence of self-criticism and social distress related to body image dissatisfaction and self-acceptance and social acceptance related to body image satisfaction.
  - Data demonstrated how gender, body size, and the intersection of gender and body size influenced personal perceptions of body dissatisfaction and satisfaction.
  - Developmental processes were evident: participants further along in consolidating a gender identity described gaining a sense of social awareness, self-acceptance, and body satisfaction reflecting a sense of resilience.



Conclusion

- Remember, we all have the ethical responsibility to meet the healthcare needs of *all* clients, regardless of sexual orientation and/or our own personal beliefs regarding sexual orientation
- Our profession is built on helping and healing, not judging and discrimination
- Become more familiar with GLBT health disparities and make a commitment to help address them
- It's okay to not know everything, but become familiar with community resources that can help your GLBT clients

Conclusion

- Want more info?
  - Check out Dr. Blackwell's Web Site:
    - http://drchristopherblackwell.com/research
- Consider working in LGBT health
- Consider contributing to LGBT health and nursing scholarship:
  - HIM
  - Graduate Studies
  - Researcher

References and Acknowledgement

- There is a separate resource document available to you as a conference handout that includes a list of incredibly helpful resources on the topic.
- This reference/bibliography list was prepared by:

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Caring for Lesbian, Gay, Bisexual, and Transgender (LGBT) Clients

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