

Preventative Care for Gender Diverse Patients

General Principles for Cancer Screening

- Approach cancer screening as you would for cisgender patients. If they have it, screen it!
- Hormone therapy does not eliminate the potential for malignancy of the patient’s natal sex organs.
- Current evidence suggests no increased risk of cancer with hormone therapy.
- Maintain a gender-affirming approach, including using chosen terms (names, pronouns, body parts). If you are uncertain, consider using gender neutral language. Some example language is included in the table below.

| Non-Gendered Language | |
|--|---------------------------------|
| Use This: | Instead of This: |
| Genitals | Vulva, vagina, penis, testicles |
| External area, external pelvic area, outside | Vulva, penis, testicles |
| Frontal canal, internal canal, inside | Vagina |
| Internal organs, organs you retain | Uterus, ovaries, cervix |
| Chest | Breasts |
| Bleeding | Period, menstruation |

Can be helpful to take an “organ inventory” approach. Take into account what surgeries the patient has or has not had and then use the table below to decide what screening is indicated. When talking with gender diverse patients about routine cancer screening, remember that this topic can be sensitive and can trigger feelings of dysphoria for some. Ask permission before starting the conversation. “A part of my job as your primary care doctor is to screen for common cancers. That was on my agenda to talk about today. However, for some patients, this is hard and can trigger feelings of gender dysphoria, which I take very seriously. Therefore, I want to check in with you before I talk about this. Is it alright if we address this topic today.” If the patient is okay with talking about this, ask them if there is terminology they prefer that you to use.

Cancer Screening






“If you have it, screen it”

| Screening Test | Transfeminine patients and AMAB (Assigned Male at Birth) | Transmasculine patients and AFAB (Assigned Female at Birth) |
|----------------------------|--|---|
| Chest / Breast Cancer | If 5+ years of estradiol, follow guidelines for cisgender women. Screen with mammogram. Discuss that there is a higher likelihood for a false positive screen. | No top surgery: follow guidelines for cisgender women, regardless of testosterone use Top surgery: no reliable evidence. Risk significantly reduced by not zero. Can offer physical exam and chest ultrasound. |
| Pelvic / Cervical Cancer | | If cervix intact, follow ASCCP guidelines for cisgender women. Testosterone therapy may cause an unsatisfactory pap. Always make a note in your order that the patient is on testosterone so that the pathologist is aware. |
| Ovarian/endometrial cancer | | Screening not recommended. |
| Prostate | Use guidelines for cisgender men. Consider reducing the upper limit of PSA to 1.0 | |

OTHER PREVENTITIVE CARE

| Screening Test | Transfeminine patients and AMAB (Assigned Male at Birth) | Transmasculine patients and AFAB (Assigned Female at Birth) |
|------------------------|--|--|
| Osteoporosis | Begin at age 65 If s/p gonadectomy & 5 years without GAHT, consider testing regardless of age | Begin at age 65 |
| CV disease | ASCVD risk estimator using female designation or take average of male/female | ASCVD risk estimator using male designation or take average of male/female |
| Colon cancer | Same as for general population | Same as for general population |
| Immunizations | | |
| DM | | |
| STI and HIV screenings | Same as for general population AND good sexual history | Same as for general population AND good sexual history |

CORE IM PEARLS FOR TRANS AFFIRMING CARE

| ? | INSTEAD OF | TRY... | THE RATIONALE |
|---|---|--|---|
|  | Letting your discomfort get in the way of asking about pronouns ... | Stating your own pronouns, then asking your patients'. | This method signals your LGBTQ+ allyship early on – plus, it provides an organic way to ask your patients how they themselves identify. |
|  | Documenting your trans patients as MtF, FtM in your EMR... | Using the acronyms " AFAB " or " AMAB " instead. | These terms – along with current gender identity – are more sensitive and reliable ways of capturing the trans experience. |
|  | Using the billing code for " gender dysphoria " in the charts of your trans patients... | Considering other billing codes such as "hormone imbalance" or "hypogonadism". | Not all trans folks experience dysphoria; moreover, others may not want this diagnosis attached to their chart. Consider alternative billing options specific to individual patients. |
|  | Dwelling on mistakes you might make while providing care to your trans patients... | Acknowledging your error, apologizing , and moving on with the encounter. | Mistakes happen. Admitting them is key. But a lengthy apology may only alienate your patients more. Best course is to apologize and get back to providing affirming care. |
|  | Letting your actions/words during patient encounters serve as your primary form of trans allyship... | Using the physical clinic environment to reinforce your trans affirming care. | Your clinic's physical atmosphere is an extension of your practice. Adding trans flags to the walls or LGBTQ+ representation to your pamphlets can signal inclusivity and allyship. |