Reproductive and Sexual Health Considerations for Transgender and Non-binary People Webinar Q&A 12/16/2022

Disclaimer: The following responses are provided by Gayge Maggio FNP-BC, AAHIVS, who practices in the state of New York, and may not apply to the Family PACT Program. Refer to the Policies, Procedures, and Billing Instructions (PPBI) manual for information about the services covered under Family PACT.

HPV Screening/Testing

1. **Is there any progress on self-collection of HPV for cervical cancer screening?**
2. **Are the patients using a swab for the self HPV test? Or the usual brush/broom for pap?**
3. **May I know what laboratory your center uses for the HPV self-test?**
4. **Can I have more details of self-swab for HPV?**

   For all the above, HPV self-swab is an option. A swab and not a brush/broom would be used, and the patient would self-swab the vaginal canal and then mix the swab in the medium and seal the container (the same medium as used for the PAP).

Cervical Cancer Screenings/PAP Tests

5. **What do you do with the abnormal rectal pap?**
   An abnormal rectal pap would be referred for high resolution Anoscopy. If you don't have someone in house, who does it, you would generally refer to a colorectal surgeon for follow up.

6. **If pap result state "unable to provide interpretation due to unsatisfactory specimen adequacy" for a transman, do you suggest they use vaginal estrogen and re-pap? Should this patient have HPV only testing to check? My concern is the unsatisfactory pap is missing HPV and possible cervical cancer risk undetected.**
7. **Do you recommend vaginal estrogen prior to a pap for patients on T to reduce risk of inadequate pap?**
   In response to questions 6 and 7, I do not recommend vaginal estrogen prior to pap solely for that purpose.

8. **Which guidelines are you referencing regarding the age change for first pap?**
   For all cervical cancer screening in HIV negative patients, we have been using the American Cancer Society guidelines. In summary, for all patients with a cervix, screening starts at age 25. The primary testing is HPV; for a positive HPV test, a pap is then done (preferably done as a reflex).
   In the new guidelines, positive HPV (of unknown genotype) and unsatisfactory pap can be repeated in 2-4 months or referred to colposcopy; HPV 16 or 18 positive would be colposcopy as the only follow up option.

9. **Any good resources for anal PAP guidelines?**
10. **Similarly, which professional organization provides the anal pap guidelines?**
    In response to questions 9 and 10, NY State's anal dysplasia and cancer screening guidelines for adults with HIV can be found here, for those interested: https://www.hivguidelines.org/hiv-care/anal-cancer/

11. **How can I increase rates of cervical cancer screening for trans male patients? I provide counseling and encourage it, but I perceive a significant gap in this screening among my trans male patient population and want to improve access and adherence to preventative healthcare.**
    I have found that the option of an HPV self-swab has definitely made people more open, even if they end up doing a pelvic exam. One thing I'll do is I try to get on the intake visit or anytime I'm kind of doing updates and general health, kind of try to check in if I don't have in our system a past test result, check in when was the last time it happened. Sometimes people go somewhere else for it. Sometimes people have only been seeing us for a year and had one two years ago, so it'll be a few years before it's current. I try to note that every time I do a physical, what they're due for.

12. **What organizational guidelines are utilized for cervical cancer screening in trans patients?**
    Full article on the new ACS guidelines here:
    https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21628
    Summaries here: https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/cervical-cancer-screening-guidelines.html

Contraception

13. **So, any hormonal contraceptive method is ok for a trans male patient, and should contraception always be part of the conversation?**

    Yes, any form of hormonal contraception can be okay. I like to know if my patients are engaging in activities that could possibly cause pregnancy and keep the conversation open in case that status changes. For anyone whose current life involves the possibility of pregnancy, it is always good to know how they feel about that and what they want/what their goals are. I make sure that when my patients start testosterone that they know it is not an effective means of contraception and it is contraindicated in pregnancy so they know why the conversation can be important.

14. **Does uterine atrophy affect IUD placement?**

    Uterine atrophy is pretty rare and not a huge concern with IUD placement.

15. **Could you share more about combining T w/ estrogen-containing contraceptives? Cumulative/compounded VTE risk?**

The hematologic risks from testosterone are possible elevations in red blood cell count, hemoglobin, and hematocrit and not directly related to hypercoagulability.

16. **Thank you for mentioning Emergency Contraception, what resources/recommendations are available for abortion for transgender and non-binary folks?**

    A good DIY/doula self-care zine can be found here: https://static1.squarespace.com/static/57f7026fb3db2bbcce92abb3/t/5811796029687f04802e8180/1477540212493/DIYDoulaZine.pdf

17. **The trans affirming endocrinologist we consulted about contraception said progestin only is all he uses and does not Rx combined progestin/estrogens for this purpose. Could you post the studies that address this please?**

    This would be the relevant reference: Contraception across the transmasculine spectrum. Chance Krempasky, Miles Harris, Lauren Abern, Frances Grimstad
    DOI: 10.1016/j.ajog.2019.07.043

PrEP/Pep

18. **Did you say that TDF/TAF should be avoided for PrEP in transwomen, as well as those patients with vaginas?**

    Everyone (without medical contraindication) can use FTC/TDF. FTC/TAF should be avoided in all patients with vaginas due to concerns around inadequate tenofovir levels in the vagina.

19. **What's the difference between Pep and nPEP?**

    PEP was originally used for occupational post exposure prophylaxis; nPEP specifically refers to non-occupational post exposure prophylaxis. The treatment protocol is the same, the terminology just refers to the circumstances of exposure.

20. **Any thoughts on 2-1-1 PrEP and also STI PEP w/ doxycycline?**

    I use 2-1-1 PrEP with a few of my AMAB patients who are not on GAHT. For a certain subset of patients, itis great – for patients who are at risk infrequently and know when they will be at risk. I have seen, however, some patients do poorly with it (not knowing when they will be sexually active), and I have had other patients go back to daily because they realized that they were not avoiding all that many doses of FTC/TDF by doing 2-1-1.

    The research on STI PEP with doxycycline looks promising; I have not done it for any patients yet, however.

STI Testing/Screening

21. **If you test negative for an STI genitally, do you recommend always testing someone for STIs orally as well?**

I offer three site testing as a default and explain to patients why – itis more common for patients to opt out of the anal swab than the oral swab. I quite often see patients who are GC/CT negative for the urine sample but positive in the oral and/or anal sample, so important to have that conversation in the patient and then test appropriately.

22. **Do you offer 4-site testing for people with neovagina? I know data isn't clear for a recommendation on this, but data does demonstrate similar vaginal flora for neovagina.**

    Not generally – though for symptomatic vaginitis I will swab and send out testing for BV/candidiasis.

Language/Documentation

23. **Is it important for physicians to ask AFAB people if they have a uterus/can get pregnant? Many of us have had hysterectomies and don't need to go through those questions with our physicians but they assume we do since we're AFAB.**

    Important to ask – really important to get that bit of surgical history in there. Hopefully, with the right EMR set up, itis possible to get rid of all the possibility of pregnancy alerts there as well as unnecessarily asking this question over and over.

24. **What is the best way to document transgender in a medical chart?**

    The best way to document is with an EMR that lets you record sex assigned at birth, gender identity, legal sex, etc. all separately. That way the gender identity field can make it clear.

25. **Is there an appropriate way to ask patients what body parts they have?**

    I start by asking if itis okay to do a body part inventory, often in the context of a medical/surgical history. For instance, if a trans patient comes into my care and has been on GAHT and had past surgeries, I ask if we can go through and discuss what parts are present.

26. **What EMR do you use now because organ inventory is awesome!**

    We just switched to Epic – it – or at least our particular build – handles this well.

27. **Do you have suggestions or tips for navigating an organ inventory conversation?**

    See above

28. **If a patient is fearful attending clinical visits due to immigration status, what steps would you recommend for this patient to access care?**

    Clarity on what gets reported to the state or local health department, making it clear that security at the clinic is not law enforcement; staff from impacted communities can also be helpful.

Other

29. **How are those referral departments receiving the feedback from patients? Do they conduct follow-up calls post-service appointment?**

For referrals that were placed as urgent, they do call to follow up. We have a patient experience department where patients who voice concerns are directed to – if a patient calls with a negative experience with a referral, patient experience will talk to them and the referrals department.

30. **Do NPs in New York have full scope of practice without Standardized Procedures to provide Family Planning?**

    Yes, we have full independent practice once we have 3600 hours of experience.

31. **Are you aware of any readily available resource list of trans-friendly healthcare providers? 1) so, I could enroll and 2) so I can help my patients locate a trans-friendly PCP, therapist, etc.**

    TLDEF's Trans Health Project has a list of resources here: https://transhealthproject.org/resources/trans-health-care-providers/

32. **Where can we access training resources for law enforcement interactions with transgender communities?**

    I am unaware of any trainings like this.