Reproductive and Sexual Health Considerations for Transgender and Nonbinary People Webinar Transcript December 16, 2022

Nicole Nguyen:

Yes. Hi, everyone. Good afternoon. Thank you for joining us today for our webinar titled Sexual Reproductive and Sexual Health Considerations for Transgender and Non-Binary People. We hope you are all doing well and staying safe. My name is Nicole Nguyen, I'm the program manager of the family planning program here at the California Prevention Training Center. The CAPTC, under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event and I'm really excited to have you all because I know we're close to the holidays, so I know a lot of you are out of town. I'm glad that you can make the time to join us FAR webinar today.

Nicole Nguyen:

Before we go ahead and get started, I just want to go over some quick housekeeping slides. First, please make sure you're able to check your audio and select your desire settings to join in through your computer audio or to call in through your phone. If your internet connection is a bit shaky, I highly recommend that you call in through your phone for the best possible sound. And then second, please check that you're able to see the viewer screen with the slides on your left and the go-to webinar control panel on your right. And then this little orange box with the white arrow, this is how you can minimize the dashboard if you don't want to see it or if you accidentally clicked it, this is how you can make it appear again. And right under the audio tab is where you can change your audio preference at any time. And third, please submit all your comments and questions via the question box.

Nicole Nguyen:

Today's webinar will take about 90 minutes and we'll definitely include time at the end for the presenter to answer all of your questions, so please send them in throughout the webinar and our speaker will address as many of them as possible at the end. The webinar will be recorded and our any questions that our presenter aren't able to answer will get sent out to the participants later, along with the recording and the slide deck. There is an evaluation at the end, so please fill it out because your feedback is extremely important to us, and it really guides us in developing our future content.

Nicole Nguyen:

And then before I go ahead and introduce our presenters, I also want to acknowledge that we're excited to be working with University of Nevada's Reno School of Medicine to provide

CMEs for this event. This webinar will qualify for a 1.5 CME credits and only available to those who watch the webinar live today. Those who watch the recording afterwards unfortunately will not be eligible for the CME credits. The link to access your CME certificate will be included in the follow-up email that we'll send out today along with the recording, slides, and evaluations.

Nicole Nguyen:

And then of course also for transparency's sake, we also want to state that our presenters, planners, anyone in a position to control the medical content of this activity, neither they nor their spouses or legally recognize domestic partners have any financial or commercial interests related to the content of this activity.

Nicole Nguyen:

Okay, so now I would like to introduce our presenter. We are really, really thrilled to have Gayge Maggio join us today. Gayge is a nurse practitioner working at the Callen-Lorde Community Health Center in New York City. It is an LGBTQ+ focused [inaudible 00:02:57] qualified health center. There she works as a primary care provider, providing primary care including sexual and reproductive health services, gender affirming hormone therapy, treatment of HIV and substance use disorder treatment.

Nicole Nguyen:

She also works in the flex care program providing walk-in primary care to patients who are unable to keep scheduled appointments. And prior to Callen-Lorde, she has also worked in homeless services at another FQHC. I came to meet Gayge as she delivered a fantastic webinar for our clinical team last year at the CAPTC on sexual reproductive health for transgender patients that I thought was really fitting and answered a lot of the questions about this topic that our own family pack providers have been asking for, so we're really happy she's able to be here and present on a similar topic.

Nicole Nguyen:

And then right before I hand off this mic to Gayge, I also just want to note that this webinar, while it is sponsored by Office of Family Planning and the Family Pack Program, the information Gayge will be discussing is more focused on the clinical considerations for clients who identified as trans or non-binary and won't delve into deep policy or benefits specific to these patients. If you have questions regarding administrative policies or benefits or wondering if your clients will qualify for family pack services, please continue to send those questions into the question box and we will get them answered. It'll be in the written Q&A that we'll send out after the webinar ends.

Nicole Nguyen:

Unfortunately, we won't be able to answer those questions live today, but rest assured we will collect them and get those answers out to you. And so, with that, thank you for joining us today and Gayge, the floor is yours.

Gayge Maggio:

Great. It's great to get to talk to everyone and I will... Let me just set up to show my PowerPoint and let me see here. Oh, here we go. We're going to talk about transgender reproductive and sexual health and I'm going to give you kind of an overview of several topics and leave a plenty of time for questions just because this is a huge field and I want to make sure that you get to ask questions specific to your own clinical practice. And so, I have no conflicts of interest to disclose, and I will mention off-label use of medication, but all off-label uses that are mentioned follow accepted clinical guidelines. None of those are things we're going to focus on. But gender affirming hormone therapy is not on label but follows accepted clinical guidelines, and that does get mentioned.

Gayge Maggio:

We're going to be able to discuss and perform a culturally sensitive sexual health inventory with transgender patients. You should be able to describe how to provide culturally sensitive trauma-informed cervical cancer screening and the impact of testosterone on testing. And you're going to discuss options or be able to discuss options for contraception in assigned female at birth, transgender, and gender nonconforming patients.

Gayge Maggio:

I wanted to start by talking about the importance of increasing competence around transgender reproductive and sexual health. We do know that transgender people are discriminated against in healthcare, employment, housing, and wider society, and are at a higher risk of violence. And that's unfortunately, that's something that continues to be true in our society. I'm going to give some data on the next four slides from the 2015 US Transgender survey report, which I believe was the most recent report completed. It was a fairly in-depth report. You can access it at the link on this slide put together by the National Center for Transgender Equality.

Gayge Maggio:

One third of trans people have experienced negative experiences with healthcare providers due to being transgender specifically. Rates are higher for people of color and people with disabilities and negative experiences range from refusal to treat verbal harassment, having to educate providers and physical or sexual assault. In the past year, 23% just didn't see a doctor when they needed to due to a fear of mistreatment and 32% due to inability to pay. This is where we also see economic considerations also come into play. And also, they reported issues with insurance, which can be another barrier to sexual and reproductive health services. 25%

was any problem related to being transgender. 55% denial of coverage for transition related surgeries, 25% denial of coverage for hormones.

Gayge Maggio:

Of course, this isn't limited to stuff that is very narrowly transgender specific. Things can happen where someone who's female assigned at birth has changed their gender marker to male and you send out cervical cancer screening and insurance doesn't like that because, "We have a male gender marker on file. Why are you doing cervical cancer screening?" Can also lead to issues with insurance even though that is care that non-transgender people, cisgender people, also get.

Gayge Maggio:

And so, what does this mean for you? It means that your patients may be initially slow to trust you due to past negative experiences. They're coming into the room oftentimes expecting a negative experience, kind of afraid of one and their guard is going to be up because they have been harmed before. We all go through our lives with expectations for future events based on our past experiences and oftentimes their past experiences are going to be negative. They may also have healthcare related trauma. If you're in a very gendered healthcare environment, it's going to compound those difficulties. If you're in maybe an OB GYN practice, that can be a field that's very heavily gendered. That can be very, very hard for female assigned to birth trans and non-binary people to access. They may feel like they don't belong there.

Gayge Maggio:

And they may have delayed care. They maybe have gone quite some time without testing or treatment or having received routine care services because of how they be treated or because of the cost. They may be getting insurance rejections and bills due to that perceived mismatch between a requested test or specialist and the gender marker on their insurance. It's not just going to be them being discriminated for being trans in a direct way, but also, they could be contacting your billing department of, "Hey, they're trying to bill. My insurance won't pay for the cervical cancer screening."

Gayge Maggio:

And we also see much higher rates of HIV in transgender people versus cisgender, the overall US population. It's about almost five times as of 2015. 1.4% versus 0.3%. It was higher among transgender women at 3.4%. Transgender women of color experience even higher rates of HIV. 19% of black transgender women reported living with HIV, as did 4.6% of American Indian and 4.4% of Latina trans women. And so, HIV prevention treatment, it remains an urgent issue in transgender communities. Higher rates of HIV plus poorer access to care are a bad combination.

Gayge Maggio:

Transgender people engage in sex work at a higher rate than the rest of the population as a whole. 12% had done sex work in exchange for income at any point, with 9% having done so in the past year. And more than 77% of those who had done sex work had experienced intimate partner violence and 72% had been sexually assaulted. To provide sensitive, competent, sexual healthcare to transgender people, you must be comfortable providing care to sex workers and provide that care in a non-judgmental, trauma-informed way. Anyone who does sex work, there are a variety of reasons that people do sex work. They may or may not want to continue doing it. That's their decision to make. I think we should often try to find ways to make their lives safer and we need to recognize that transgender people who are sex workers are often at the highest risks of violence because of how they're multiply marginalized.

Gayge Maggio:

And so, some language I'm going to use in this presentation. Transgender I'm using as the umbrella term of anyone who does not feel that the sex/gender they were assigned at birth does not describe them or does not fully describe them. That covers a wide variety of people and identities, so I want you to think of transgender as this broad umbrella term that can mean a lot of things. If someone says they're transgender, it doesn't tell you everything about their relationship to their sex assigned at birth and their gender and their body. It doesn't give you an easy answer.

Gayge Maggio:

Gender nonconforming is anyone whose gender expression does not match the gender they were assigned at birth. They may or may not be transgender, and this always depends on the cultural context. I like to say that 200 years ago, a female assigned at birth person wearing pants would be gender nonconforming. Now they're not. It's very much something that is about how someone's perceived versus the cultural context they're in, so it varies with time and place. This includes an even broader range of people than people who identify as transgender.

Gayge Maggio:

Non-binary is someone who is not a man or woman or feels that neither of those terms fully describe their gender. Gender queer is an older term that has significant overlap with non-binary. It's sometimes also a political identity. It's very generational, both based on age and when someone came out, which term you'll tend to see people prefer. Two spirit is a term used by Native American First Nations people that may also identify with an LGBTQ+ identity. It's cultural misappropriation when used by non-Native American First Nations people. Not your place to question the terms that anyone uses but be aware that this is a term that means something, a very specific cultural context among people who are oppressed and so it has a lot of cultural meaning that outside of that context is lost.

Gayge Maggio:

You'll also see me using the term A(F) AB or A(M) AB a lot. That's assigned female or assigned male at birth. It's a useful term, but if you can use language that uses the patient's affirmed gender, use that instead. It's more useful when we talk about a larger group that may have a wide variety of identities rather than a specific person or identity. You wouldn't say a trans woman is an assigned male at birth person, you'd say she's a trans woman because that gives you the necessary specificity. But you might, if you wanted to talk about prostate health, you would kind of recognize that assigned male at birth people are the people who have prostates. You might also see it written as the sex first and then assigned at birth. You may also see it written that way.

Gayge Maggio:

Gender is made up of identity, social roles, social expectations, and gender presentation. Transitioning is the social and/or medical process of aligning documentation, role expression and or body with one's identity. And if you see me use the term GAHT, that's gender affirming hormone therapy. That's when a trans person, as part of their transition, is taking hormonal therapy, we refer to as gender affirming hormone therapy. You'll see Affirmed Gender, that's the gender stated by them. It's not necessarily the one they were assigned at birth. Sex, of course, is another label we use, and it lumps together a variety of physical traits. We're trying to put people's primary and secondary sexual characteristics, their chromosomes or hormone levels, all into one or two boxes.

Gayge Maggio:

Some of those traits are mutable and for trans and intersex people, they're often not all going to match male or female because obviously we can change primary and secondary sexual characteristics in hormone levels, so sex is not as fixed or as binary as the very surface level reading would give you. And we talked about sex assigned at birth when we talked about the abbreviations for it. And it was generally determined by a doctor or midwife and was based generally on genitals. And legal sex is the sex that's currently on identification documents, insurance cards. Obviously, sex assigned at birth and legal sex don't always line up.

Gayge Maggio:

Okay, so for our first question, "You are seeing a patient who is a trans man for the first time in your clinic. This patient is new to your practice. In the process of taking the patient's social history, how should you obtain information about sexual history and sexual and reproductive health needs?"

Gayge Maggio:

A, you should skip over this as it is more awkward to talk about these matters with trans patients and your patient will bring it up if he needs anything. B, assume the patient is only active with cisgender women because he is a man and does not need to worry about

contraception. C don't assume anything about his sexuality and start with open-ended questions that center the identities of him and any possible partners, and then sensitively ask about specific acts to assess STI risks the need for contraception. D, have a standardized detailed sexual history form for your clinic, so that you can look over that before you see your patients. And if we can open up the poll.

Nicole Nguyen:

The poll just opened. I'm going to give everyone about 60 seconds to answer. Another [inaudible 00:17:01] can abbreviate a little bit, so I hope you are able to still understand the question in the answer. Okay, about 10 to 15 more seconds. We have about 80% answered so far. Okay, so I'm going to go ahead and close the poll and share the answers. Okay, go ahead.

Gayge Maggio:

Okay. It looks like most of you did get that it was C. Open-ended questions done in a sensitive way will elicit the best information, create the most comfortable environment. You should discuss sexual health with your patients, and you should not make assumptions about a patient's sexuality based on gender identity or expression. Getting certain information before your appointment in the sense of form does make sense. I think a detailed sexual history a little much, you might want to ask kind of your basic SOGI questions. What's someone's sexual orientation? What's their gender identity? What's their sex assigned at birth? Could be on your intake form, but a long detailed sexual health history is going to be A, intimidating and B, really hard to do in a structured piece of paperwork and probably not something most of your patients are going to want to fill out.

Gayge Maggio:

This is definitely a skill that you learn via practice with your patients of just like when you're going through your training, takes a little while to get comfortable asking cisgender patients about their sexual history. You just need to be asking transgender patients about their sexual history over and over. And as you talk to more transgender patients about it, you'll get comfortable, and you'll become kind of part of your standard practice of how you ask all your patients.

Gayge Maggio:

Trans people may have any sexual orientation. Unless the trans person specifies otherwise, their sexual orientation is in terms of their affirmed gender. Not every trans person will specify their sexual orientation this way, but it's kind of the way to default. But you can also ask clarifying questions. Do not assume anatomies of partners or assume that all partners are cisgender or transgender. Obviously, just like cisgender people, trans people can have cis and trans partners. And don't assume that sexual orientation of partner choice is necessarily a perfect match. Identity and action don’t always line up for a variety of reasons. And don't

assume that everyone with the same sexual orientation, gender identity or embodiment engages in the same type of sexual activities in the same ways.

Gayge Maggio:

Risk assessment and recommendations are going to vary from person to person. Even though we talked about how HIV rates are higher, you shouldn't assume that everyone's at high risk. You also shouldn't assume no one's at high risk. You kind of have to go based on what person, somebody's actual day-to-day risk factors are. You want to mirror language unless it's a slur. And it's okay to ask what language is appropriate to use. I will generally ask before doing a sensitive exam or talking about sensitive body parts, I'll often ask, "Is it okay to use medical terminology," and kind of use that as the starting point.

Gayge Maggio:

In a clinical setting, a lot of trans people are fine with that. If they're not, work out ways to be very clear what both of you are talking about. I do open-ended questions as part of a social history. I try to make it feel routine. You go through, we all have our EMRs that set up our history intake in certain ways, and if you make it routine and kind of a structured thing and have a rhythm with how you ask everything, it makes it seem like it's something to do with all patients rather than you're getting really inquisitive and different because someone is trans. I like to ask open-ended questions. That gives people room for complexity and allow them to define themselves. Sometimes yes, no, or A or B is not going to be easy for someone to answer. I often say, "How would you describe your sexual orientation?"

Gayge Maggio:

I like to ask, "Are you currently sexually active? Have you been in the past? Tell me about the gender or genders of your partner or partners. What safer sex methods do you use?" I do like to ask some closed questions as I get down to specifics. "Are the partners cis or trans? Can any of them cause pregnancy or become pregnant? And do they engage in any activities that can potentially cause pregnancy?" If you have a trans man, just because he has cis male partners doesn't mean he's necessarily engaging in activities that could potentially cause pregnancy. And then we always, of course, if pregnancy is a possibility, ask what sorts of methods, contraception is being used, what people's thoughts about pregnancy are. That kind of gives you what you need for further information or kind of to present options to help people live the lives they want to live.

Gayge Maggio:

You have to let patients give as much or little information they want. Some people don't want to talk about it. Sometimes somebody will ask for STI testing but doesn't want to give you any details. Go ahead and offer the testing and explain what each test you're going to do looks for and where. Don't force people to maybe have conversations they don't want to have to get the

tests they need. And this can take a lot of time, and it's okay if it doesn't all happen in the first visit. You just want to make sure it happens.

Gayge Maggio:

You're building relationships with your patients and a lot of the clinical environments we're in, if you're a primary care provider, if you're in a sexual or reproductive health practice where you see people repeatedly. Other good times for questions are yearly physicals, routine follow-ups, when patients request STI testing. I tend to offer STI testing every time we talk about what labs we're going to do. It's a good way for me to remember, to offer, so it's not something that-

Gayge Maggio:

... To do. It's a good way for me to remember to offer, so it's not something that falls by the wayside. It kind of makes it opt out. Patients don't have to ask. Sometimes patients feel a little uncomfortable if they feel like they're at high risk asking every time they're in, even if they want testing. By giving that option of every time they come, they ask if we're going to do labs, we offer, "Hey, do you want to do your STI testing as part of this?" It gives them the... Make it less awkward for some patients. And so, patients get more comfortable over time. Sometimes you'll get something from them on the second or 10th visit they didn't tell you at the first visit. And you have to know when to stop. If a patient wants to change the subject, you let them and move on.

Gayge Maggio:

The visits about them and let them talk about what they're ready to talk about and what they want to talk about. And for patients who are sex workers, doing this in a sensitive and non-judgmental way. If you give off the attitude that this is non-judgmental, we're asking things in a value neutral way, this will give patients space to talk about sex work. And also sometimes, I often ask my patients, do a social history, "What do you currently do for work?" Sometimes patients who are engaged in sex work will say that then. Sometimes they won't. We talked about the higher prevalence rates of trans people due to socioeconomic stressors and exclusion oftentimes from other employment or losing jobs because of being trans, the higher prevalence of having engaged in sex work. But also remember, do not assume just because someone's trans, particularly a trans woman or particularly a trans woman of color, that they are sex workers because they... Oftentimes, that is an assumption that's made and often has led to harassment by law enforcement or others.

Gayge Maggio:

So be understanding of this. This may have people, have those patients be more hesitant to discuss sex work with you if they are engaged in sex work or have been in the past. Legal implications are another barrier to open communication. Work with the patient to find ways they're comfortable with to put information in the chart. Remember that medical record can be subpoenaed. Obviously, you have to put truthful information in there. But oftentimes before a

patient gives me specific information, so at that point I legitimately don't know, they'll bring up in conversation, "How is this going to be recorded?"

Gayge Maggio:

Discuss what types of work the patient does to help determine risks, not only of HIV and other STIs but also violence and legal consequences. And also, I've had a lot of conversations with patients who do sex work on how they can reduce their COVID-19 risk. Sometimes that's making sure patients have access to rapid tests and maybe they can arrange for them and their client to do rapid testing prior to any activity. I had those conversations more I feel like in 2021 than I have had in 2022. But definitely something we don't normally think of, but also close physical contact with other people is obviously going to be very high risk for COVID transmission. And always before you assume someone wants to stop doing sex work or if they want to be doing sex work, ask how they feel about it. If you have case... Don't just refer someone to a case manager assuming that they're going to want resources for employment or housing so they cannot do sex work without knowing that that's something they want. Let the patient decide what they want and what they need and help them access those things.

Gayge Maggio:

Okay, so moving on to our second question. One of your patients is a 26-year-old trans man with no surgical history who's on testosterone cypionate 50 milligrams intramuscular weekly, which is a pretty typical dose, and he states that he has never had a cervical cancer screening. He is HIV negative. He would be comfortable having a pelvic exam and a Pap smear done. What is the best way to proceed? A, tell him that as he is on testosterone, accurate cervical cancer screening is not possible. Tell him that testosterone increases his risk, so he should have HPV/Pap co-testing. C, run HPV with reflex to Pap as normal, or D, run HPV with reflex to Pap but note on the sample that the patient is taking testosterone. So, if we can open up the poll.

Nicole Nguyen:

The poll is launched. So again, I'll give everyone 60 seconds to get your choice in. Okay. About 10 more seconds. All right. I'm going to stop and close the poll.

Gayge Maggio:

Okay, I see that most people did know that to screen via current guidelines, but that testosterone could increase the likelihood of an inadequate Pap. This is due to some atrophic changes. What we do is we always let the lab know that the patient's currently taking a testosterone, so they know to expect that. This has become much less of an issue with the change in the guidelines from HPV/Pap co-testing at 30 or Pap alone below 30 to just doing HPV with reflex to Pap. Because now obviously everyone whose HPV testing comes back negative, the Pap isn't run so you don't find out if the Pap is inadequate.

Gayge Maggio:

So that's really the only big difference to the current guidelines is it would be good to let the lab know that the patient's on testosterone. And also, I kind of do counsel my patients on testosterone that if we do end up needing to run a Pap, there is this chance that there's a higher chance of it being inadequate and that we'll just go from there. And obviously we need to provide care for the anatomy currently present. All HIV negative patients with a cervix of the age 25 or greater should have cervical cancer screening every five years. That's the new standard.

Gayge Maggio:

We're not starting at 21 anymore. It's not every three years under 30. Self-swabs for HPV are now an option but they do have the disadvantage that a Pap smear cannot be done from the sample. And I discussed this option with all my patients with cervices. I don't assume that my trans-masculine spectrum patients can't tolerate a pelvic exam, and I don't assume that if someone's a cis woman that she can tolerate a pelvic exam. So, we talk about the risks and benefits. Obviously if someone's self-swabbed for HPV comes back negative, we're done, we're good for five years, no pelvic exam needed. However, there is that possibility that if it comes back positive, they now are going to need a Pap or for very high strains, possibly a colposcopy.

Gayge Maggio:

And I am not the expert. Once you get to that stage, I'm not the one doing the colposcopies. But there is that thing of now you need to do the pelvic exam knowing that you have HPV. Is that going to be more stressful? And of course, my practice is for anyone who needs a pelvic exam knows they're going to need it and doesn't have another contraindication for this and is going to have a lot of anxiety, I am not hesitant to prescribe a low dose of a benzodiazepine for that situational anxiety for that one-time thing. Definitely also when you do have to do those, refer to that next step of screening.

Gayge Maggio:

Do know that you're going to refer to someone trans-friendly, that the patient's going to be comfortable with that environment and also know that testosterone can cause atrophic vaginitis. That's because of the drop in estrogens that accompany testosterone being elevated because that causes ovarian estradiol production to shut down. So much like in menopause, that tissue becomes more fragile. So, they may need a smaller speculum to be comfortable. So definitely something that you should be aware of. And so, like I said, discuss those risks of the self-swab. Do not do HPV screening on trans women post vaginoplasty. There's no guidance on what to do with any positive result. There is no cervix present.

Gayge Maggio:

If there's any symptoms that make you think you want to take a look, do a pelvic exam. Do refer appropriately if you're not... In those few months after surgery, if they can't get to the surgeon,

do know someone you can refer to as experienced with postoperative complications because obviously that's its own kind of specialized thing, but don't do HPV screening. I have had trans women ask me post vaginoplasty for HPV screening. I do have to explain, "Well, we don't know what to do if your result's positive. There isn't a next step, and there isn't a cervix present, so it's just not done." And so, in New York State we have guidelines that all HIV positive MSM, transgender women and transgender men 35 and over should have a yearly anal Pap. There is no national guideline for this as of yet. We don't currently recommend anal cancer screening in HIV negative people.

Gayge Maggio:

So, if you're not an HIV specialist, you really don't need to worry about this as much other than knowing that your HIV positive patients should be in care of an HIV specialist. And obviously if somebody who has... A person living with HIV has a cervix, it's not HPV testing alone, and testing starts a little earlier and there is annual testing. So, this gets a little complicated. The HIV specialist will either be doing this or giving the recommendations for it. And once again if someone's HIV negative, there is not routine anal cancer screening currently recommended by any organization. There have been studies on that so that may change at some point in the future, but I'm sure that there'll be some good education around that when and if that does happen. So, screenings for all patients, frequency risk screenings are all going to be dependent on patient risk.

Gayge Maggio:

So, for those at a higher risk of HIV and STIs, quarterly screenings are a good idea, plus known or expected exposures or possible symptoms. Like I said earlier, I offer at the initial patient visit, the yearly physical, and any time labs are done, it's my "Would you like fries with that" of testing. Kind of literally just like you might get asked, "Would you like fries with that?" I'm like, "Would you like STI testing with that?" It really normalizes it. For the vast majority of patients, it makes it not awkward for them to ask and also not awkward for them to decline because they know that if labs come up, I'm going to ask if they want STI testing. So, it's not like me suspecting whether they need it or not. It's me just putting that option on the table, so kind of normalizes it. It's kind of part of the same sort of thing that when you check someone's blood pressure, when you do labs, you offer STI testing. And don't ever stigmatize someone for asking. Don't make them feel like you're judging them because they ask for STI testing. It can obviously be awkward. Oftentimes when you ask for STI testing, you are kind of conveying to a provider that you are worried about this.

Gayge Maggio:

And if they know that everyone gets offered, it makes it easier to say both yes and no. And it also gives an opening for them to bring up their concerns. Also know your gonorrhea and chlamydia testing needs to be done site by site. You can use urine or swab for genital and use pharyngeal and rectal swabs for oral and anal infection. Our patients do oral and anal self-swabs. We kind of have instructions in the patient bathroom for that. They're quite easy to do.

Most patients can do them fine. I definitely have conversations with patients on that, "We need to test the site there. So, if you're having different kinds of sex, you need to check those sites because just because you don't have a genital infection doesn't mean you don't have an oral gonorrhea or chlamydia infection." We do HIV and syphilis testing. Do not, do not, do not do asymptomatic HSV testing.

Gayge Maggio:

It doesn't tell you where a potential infection is. It doesn't tell you if someone's never had a herpes outbreak. It doesn't tell you whether they will. It just opens up this whole can of worms of stress and worry and, "What do I tell partners," That you do not need. I only ever really test for HSV by swabbing lesions that I suspect are herpetic lesions. I like to check immune status for hepatitis A and B and check for hepatitis B infection. Obviously, hepatitis B can be sexually transmitted. I offer vaccination as appropriate. Hepatitis B is not a chronic infection anyone wants, and we have a good vaccine. So, it's important to make sure people are immune. Current guidelines are to screen all adults from 18 to 79 for hepatitis C once and you repeat screening based on risk factors or if you see abnormal liver labs, don't miss this as a potential. And if the liver labs are markedly elevated, do you realize there is this window period. It can be three or more months before they have a positive antibody. And you can always look for a viral load itself if you suspect an acute infection of hepatitis C because it can take a while for the antibody to turn positive.

Gayge Maggio:

And so, I have a couple graphs here. The window periods for HIV and this does get kind of complicated. So, this top graph here is the days after the infection. So, zero is the day they're exposed, and then you see the days as it goes on when various things peak and come down to whatever levels. So, your HIV viral load is a minimum of 10 days to detect and as a maximum probability of detection at 33 days because that's when you have incredibly high viral loads with HIV. As it climbs after initial infection, the immune system does begin to recognize, and it begins to fight it. Obviously, it's not an infection that people clear on their own, but what will happen is a viral load will come back down to kind of a steady state and then climb again as the immune... When years later when the CD4 count, those T-cells have gotten very low.

Gayge Maggio:

So, you have very, very high viral loads with acute infection, which is when people are most contagious. The 4th Gen panel, which is probably if you're ordering a blood test that you're sending out for HIV, is probably your default. It looks for that p24 antigen. It looks for IgM and it looks for IgG. It's more than 50% at 18 days and it's greater than 99% at 45 days. This is the one you send to the lab, not the rapid test. Even the modern rapid tests have a slightly longer window period. So, prior to 10 days is the eclipse period. So, if someone says they were exposed to HIV seven days ago, you can of course do testing to see if they contracted HIV for an earlier exposure, but you'll need to let them know that this test, you're not going to be able to get an accurate result and they should come back.

Gayge Maggio:

Anyone with an exposure, a potential exposure in the last month, I like looking for a viral load. I also like looking for a viral load if I suspect HIV exposure and see flu-like symptoms. Those symptoms of acute HIV infection, which include sore throat, swollen lymph nodes, fevers, muscle aches, rash. In people who are at high risk for HIV, do not forget acute HIV. It is even in people who are experiencing HIV often miss because it's a flu-like illness. And also remember post-exposure prophylaxis is possible less than 72 hours after a potential exposure. If you don't do it, know the best way to get it. Here in New York emergency rooms will have people come in, they will give them the first dose there and give them another two to four days dosing and give them a list of clinics that do post-exposure prophylaxis to kind of take that up and finish the 28-day period.

Gayge Maggio:

So, if it's not something your clinic does, make sure you know where people can get it. And I'm guessing emergency rooms are likely an option where you are as well. So brief overview of PrEP We're not going to talk about the specifics of it in this presentation, but you want to assess all patients for HIV exposure risk. So, the criteria we give for PrEP, if you're having condom-less sex with partners of unknown HIV status, so penetrative sex, either vaginal or anal and you don't know your partner's HIV status, you have an HIV positive partner who is not consistently virally suppressed. Remember if someone has an undetectable viral load because they're on HIV medications, they cannot transmit. Anyone who's had a bacterial STI in the past 12 months, anyone who has multiple partners, anyone who uses recreational drugs during sex, anyone who injects any substances, any past or current use of non-occupational post-exposure prophylaxis if they identify as at risk or they may be at risk in the future.

Gayge Maggio:

So, if someone says they want PrEP, they feel like they're going to be at risk of HIV, you want to talk and explore that, but they may just not be comfortable telling you what the risk factor is. So don't kind of dismiss those concerns. So, I did include our New York State DOH guidelines. I know San Francisco also has those, and I'm sure California as a whole, the State Department of Health does. So, you can look into those. So, we currently have two oral medications and one injection available. I'm not going to go give the brand names here. The first one, emtricitabine/tenofovir disoproxil fumarate, you do not need to remember that. FTC/TDF is what we always refer to it, is the oldest one. And then there's emtricitabine/tenofovir alafenamide, which is a different variant of tenofovir. Those are the oral medications.

Gayge Maggio:

And we have cabotegravir is a long-acting injectable. And FTC/TAF, that's second one I mentioned, is only an option for people who do not have a vagina. The tenofovir levels in vaginal tissue do not get high enough. You may see this. It's per New York State and San Francisco Department of Public Health guidelines based on studies that were done that male

assigned at birth, people who are not on gender affirming hormone therapy can do on demand PrEP only with FTC/TDF. Any other medication and any other category of patient have to take it consistently every day or get their injection consistently to be effective. So, within the last, if you have an HIV exposure within the last 72 hours, you need to make sure they get nPEP either or referred for it as per what your protocols are at your clinic.

Gayge Maggio:

And that is not PrEP NPEP is a complete HIV regimen for 28 days. PrEP is not a full regimen, it's only a partial one. So, there's additional medication in nPEP. So, it's important to know the difference. But full discussion of how to prescribe PrEP and do the monitoring is a different talk, but if you don't do it at your clinic, good to at least know who's at risk and who to refer and know who prescribes PrEP to be able to refer those patients if you don't do it yourself. And so, there are some barriers in transgender patients. There are concerns over the impact in gender affirming hormone therapy. There aren't. The only drug interaction here is estradiol reduces the blood levels of tenofovir. So dosing needs to be more consistent to be effective. And that's why if someone's on estradiol, they cannot do on demand, but it does not lower the levels of either estradiol or testosterone. So, it's not going to impact their progress of their gender affirming hormone therapy. So that's kind of a myth you can dispel.

Gayge Maggio:

And then there's fears about health risks of FTC/TDF. I've seen law firm advertisements on social media and a heavy advertising push for the newer one, FTC/TAF. FTC/TDF is now generic. FTC/TAF is brand name only. Insurance is only going to cover FTC/TAF if there's a contraindication for FTC/TDF. All drugs have side effects. These are all very generally very safe medications. Some people may benefit from one over the other, but they're not unsafe. There's a lot of fear spread about it, and I don't feel enough is being done to dispel that. Obviously, there are serious health risks with contracting HIV, and we wouldn't want someone to avoid a medication that would help them avoid HIV infection.

Gayge Maggio:

Trans-masculine patients are often assumed to not be at risk or not adequately screened. And also, your trans patients may not have seen public health materials directed at them that indicate that PrEP may be an appropriate option for them. Here in New York City are kind of PrEP ad campaigns and that we had several years ago at this point in bus shelters and in the subway did feature a variety of people of many races and various genders and people who could be read as trans, people could be read as cis, but that's not always. Initially PrEP had the highest uptake initially in cisgender white gay men, 25 plus. Hopefully we're getting better at getting out to people who do not fit that category. But definitely want to make sure to know that anyone of any identity can be at high risk for HIV. And we want to make sure that people who are at high risk for HIV have access to PrEP and realize it is an option for them. And providers may not assess or offer PrEP to transgender patients.

Gayge Maggio:

... and providers may not assess or offer prep to transgender patients. So, for your transgender patients, get a good idea of what their HIV risk is likely, and if you prescribe prep, offer it to them, and if you don't prescribe prep, refer them to someone who does if they're interested and would benefit.

Gayge Maggio:

Okay. So, for our third, I think this is our last question. One of your patients, a 28-year-old non-binary person who was assigned female at birth, who is on testosterone cypionate 50 milligrams, subcutaneous, which is another way that testosterone injections can be given, weekly, for the past year. They recently called the clinic for emergency contraception due to condom failure during intercourse. They are particularly concerned about being proactive about contraception as their menses ceased six months into gender-affirming hormone therapy. They want to know what options are available to them.

Gayge Maggio:

Tell them that, A, because of interactions with testosterone, only non-hormonal options are available to them. Tell them that, B, testosterone, or transgender status does not impact their contraceptive options. All options are available to them. Tell them, C, that because of interactions with testosterone, non-hormonal and progestin-containing options are available to them, but not estrogen-containing options. D, testosterone alone is effective contraception because their menses have ceased. They do not need to worry about further contraception. Then if we can open up the poll.

Nicole Nguyen:

All right, the poll has just been opened. 60 seconds. All right, another 10 second. All right, I'm going to go ahead and close the polls.

Gayge Maggio:

Okay, so the answer to this is neither testosterone nor transgender status impact contraceptive options. Testosterone will not impact the effectiveness of hormonal contraception, nor will hormonal contraception impact the effectiveness of testosterone. When I do my counseling as part of the informed consent for hormone therapy, I always tell patients that, yes, hormone therapy can impact fertility and you do need to take that into account, but gender-affirming hormone therapy is not an effective means of contraception. Even if menses have ceased, patients should not assume that pregnancy is not possible, and of course testosterone is contraindicated in pregnancy. However, I do get to tell them, in terms of contraception, any contraception option absent any other complicating factors is an option for them. So, unless there's other contraindications unrelated to gender-affirming hormone therapy, all of them are an option and we can really kind of do that discussion based on preferences and what suits them best.

Gayge Maggio:

And it's also always possible that infertility may persist at the cessation of gender-affirming hormone therapy. There was a small study done that was high quality that did not show that being common, so patients on testosterone should definitely not assume that they don't have to worry about contraception if they are engaged in pregnancy-causing activities. So, we have to kind of counsel that balances of kind of doing that kind of contradictory. It could cause infertility, but don't assume you can't get pregnant. So, testosterone contraindicated in pregnancy, cessation of menses if they did become pregnant would increase length of time it would take for a pregnancy be noticed, particularly if they believe they can't become pregnant.

Gayge Maggio:

And testosterone is not a contraindication, it doesn't impact effectiveness. So, we're really getting to... You're really discussing the evidence, the benefits, what various forms of contraception' benefits and kind of drawbacks are, just like you are with any other patient, but there are additional concerns... May have additional concerns related to dysphoria. Everyone is different. The idea of taking something containing estradiol or other estrogens can trigger dysphoria, and gender stuff could be very gender coding. Especially if they have to take an oral contraceptive on a regular basis, it can kind of a gender coding of... That can be triggering.

Gayge Maggio:

Menses can often be a significant source of dysphoria. And of course, so this is a good use of some of the contraceptive methods to cease menses for patients not on testosterone, or those who are on a low dose that's not sufficient to suppress menstruation. So, you will see some of your patients who, for various reasons may want to do what we call low-dose testosterone, may not have, even after a prolonged period of time on testosterone, if they're on a low dose, menses may not stop. And rather than increasing their dose of testosterone, they may want, even if they are not currently at risk of pregnancy, might want to use a contraceptive method to suppress menstruation. Good options for that that you can try are continuous oral contraceptives, skipping that placebo week, a progestin-containing IUD, depot medroxyprogesterone injection, or the levonorgestrel implant, can all be effective options.

Gayge Maggio:

And so, you also need to talk about comfort around procedures and ease of starting, stopping. Those are all valid concerns. What is it like to take or get this method of contraception? Some trans-masculine patients can be completely fine having an IUD placed, and some, just the process of going through it, having the idea of an IUD in place may just be a deal breaker. Some patients might be fine with doing the implant, but others may not like the idea of something that they have to come in the office and have an office procedure to stop. The depot medroxyprogesterone might be appealing because it's just an injection so it's not as big of a deal, but they have to come into the office every three months. Once it's in you have to just kind of wait for it to wear off. So, all very individual concerns.

Gayge Maggio:

And also, for the IUD implants, this is not something we all do. There might be more concerns around who's performing the placement or removal. Is it you? Is it someone within your clinic, an outside referral? In terms of logistics and patient comfort level, if you're at a clinic where IUDs and implants aren't done and patients are interested, you refer out, make sure you have a good trans-friendly outside referral. Our practice, we're a larger FQHC, we don't do enough IUDs and implants for every provider to do enough frequently enough to kind of keep our skills sharp, so we have just a few people who do them that we all refer to, but they're in the clinic.

Gayge Maggio:

I can add that I haven't placed an IUD in I think seven years now, so I tell my patients, "You don't want me doing that, I'm a bit rusty. But I'm going to refer... There's these few providers that do them." They do all of them. They may have met them at an urgent care appointment or something before, they know that they work at the clinic, they know that I personally work with them and know them and talk to them often, so I know who they are, and my patients trust me.

Gayge Maggio:

So, it's a little different than just saying, "Hey, here's a list of clinics in New York City that do this." You want to make sure that you can vouch for where you're sending them, and so those of you in kind of larger clinic systems that might have a referrals department, you kind of want to keep track. One thing to ask them to keep track of is, who is trans-friendly? And that doesn't just apply to this, that applies to everything that you're going to refer out for.

Gayge Maggio:

So, kind of to wrap up and summarize all of this is important because trans people experience pervasive discrimination in both healthcare and larger society, leading to difficulty trusting medical providers and contributing to issues of access. So, while there are medical differences for some trans people because of hormone therapy, I think the bigger takeaway is to remember to think about the discrimination trans people experience. What that means when they're coming into your clinic, just like... Or may mean, don't presume anyone's had a certain experience but do realize that this is a common experience for trans people, and common enough that even trans people who haven't personally experienced a traumatic event in a healthcare environment are going to be wary. So go into the room knowing that it could be harder to build a good, trusting patient-provider relationship. And you want to use sensitive open-ended non-judgmental questions for taking your sexual health inventory. I think that is also something that transfers very well to your cisgender patients. I think we should do that with all our patients.

Gayge Maggio:

You want to do screenings based on the body parts present and activities engaged in, not somebody's gender identity or sexual orientation. Because don't presume what a certain label

means about someone's life. And do this in a way that reinforces rather than negates patient identity. It's one thing to ask someone who, on the surface, their gender identity and sexual orientation together makes it sound like they couldn't become pregnant, asking them if they engage in any activities that can cause pregnancy. It's one thing to ask that question in a way that they know that you kind of screen for everyone because you don't want to make presumptions, it's another thing to really just kind of assume that that same person who, once you know that they're a straight trans man who is in a monogamous relationship with a cis-female partner to constantly ask them if they're engaging in activities that could cause pregnancy. There's a difference here. It's about knowing your patient.

Gayge Maggio:

And prep, an option for trans-feminine and trans-masculine people, less options available overall than for cis men who have sex with men because of the impacts of estriol on tenofovir levels and also because of concentrations of tenofovir being lower in vaginal tissue. And while gender-affirming hormone therapy can reduce fertility or cause infertility, it's not an effective method of contraception. Neither testosterone nor transgender status eliminates any contraceptive options. And for your trans-feminine patients, they should know that just because they are on gender-affirming hormone therapy doesn't mean they can't cause pregnancy. Contraception options should be determined on patients' particular needs, wants and medical history.

Gayge Maggio:

And so, I just wanted to give you a few useful resources. Some of these go beyond the scope of this talk to more broad things about trans health. I really think UCSF's gender-affirming health program guidelines for the primary and gender-affirming care of transgender and gender non-binary people are excellent. They include everything from gender-affirming hormone therapy to what sort of primary care screenings is needed. They're very in depth, they're excellent, kind of a standard reference. WPATH is the World Professional Association for Transgender Health. They set the standards of care for trans health. They just released version eight of their standards of care this year. Those can be found there. It's quite long, it cites a lot of research, it covers many topics. Definitely not something you need to read cover-to-cover to be able to provide good healthcare to trans people, but research you should know that's out there and is available to you.

Gayge Maggio:

A good paper that was published is Contraception Across the Transmasculine Spectrum by Chance Krempasky, who is one of my coworkers, Miles Harris, Lauren Abern and Francis Grimstad, covers the topic we talked about for contraception, so a really good reference. And then our New York State Department of Health has the AIDS Institute. Their STI guidelines and their prep guidelines are excellent if you want more information on those. So, a lot of good information out there. So, it is just after 4:00 o'clock, I wanted to open it up for questions and discussion, so let me see if I can see the-

Gayge Maggio:

Okay, so let me look through these questions. Okay. "What is the best way to document transgender in a medical chart?" That is really going to depend on your EMR. I have recent experience with two different EMRs because we just... I mean I've experience with more than two, but we recently switched EMRs, and our last EMR, it was kind of, I felt like it was held together with duct tape. We were having to use the legal name field for the chosen name and the preferred name field for the legal name. But things you want to look for: you want to be able to document. I like to be able to document chosen name, and I want that to be the one that shows up in my appointment schedule, I want it to be the first name I see, and then I want to have a legal name because obviously that's important for sending prescriptions, pharmacy. Ideally, you don't have to be changing or selecting anything to get the right thing to go to the right place. That's the ideal situation.

Gayge Maggio:

Then I like to see sexual orientation, gender identity, legal sex, sex assigned at birth, and I like... Our new EMR has a parts inventory that you can go check yes or no for parts present. And then you can check plus or minus for parts present at birth, and then you can check parts that were hormonally present through gender-affirming hormone therapy, and then parts present surgically. So that is kind of pretty exhaustive. It also has a field that, in addition to sexual orientation, you can select genders of partners. So, you can have cisgender men, cisgender women, transgender women, transgender men, non-binary, other. So, it lets you do multiple choices there.

Gayge Maggio:

That's pretty exhaustive, obviously I don't get that on every patient, every visit, and we're also kind of having to update everyone's chart because we just changed over, but it's much better than our old system that just had sexual orientation, a legal name, a name, and preferred name field, and then it had sex assigned at birth which got complicated with recording legal sex. So, it's definitely variable on your EMR. And one thing you can do to make your practice more trans-friendly is talk to whoever's in charge of health information to, what does your EMR currently look like and what can you do with it to customize it, to get more of that info in?

Gayge Maggio:

Okay. "How can I increase rates of cervical cancer screening for trans male patients? I provide counseling and encourage it, but I see a significant gap in screening among my trans male patient population and want to improve access and adherence to prevent healthcare." Absolutely. That's a project. 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.

Gayge Maggio:

And then one thing I'll often do is when we talk about scheduling a physical, so if I am having a visit and we're kind of scheduling our next gender-affirming hormone therapy follow-up and I'm saying, I'm like, "Oh, it looks like you'll be due for a physical then. When we do the physical, when was your last cervical cancer screening? Okay, it sounds like you're due. Can I put a note that we'll revisit that then..." describe what the options are so they can think between the two visits which one they want to do? I found that having kind of it both noted for me and noted for them, kind of bringing it back up and maybe taking action on the agenda for the visit is helpful. Sometimes, and oftentimes, non-ideal doing a physical and cervical cancer screening in the same visit can take a lot of time.

Gayge Maggio:

Sometimes we also have people who have sessions that are specifically for doing that cervical cancer screening, doing general, we call it gen sessions, gender health sessions, or genital health sessions, but more of a gyn session, urgent care, so that's the only appointments they're doing. That makes those appointments more accessible because they don't fill up as fast. So, someone who, they might not want to schedule, or they might not have an upcoming physical, they might not want to schedule with me. They might go home and think about it and now they can call when they think, actually, yeah, I want to do that, and they can schedule it. They won't necessarily get the appointment with me, but they'll get the appointment somewhere else in the clinic. But it is a challenge.

Gayge Maggio:

I think it's a challenge keeping up to date on routine health screenings with anyone, but I think for our trans patients, it is lower, and I think just trying to find new ways to offer it, I really think talking about the self-swab helps, even though a lot of my patients do elect for the pelvic exam. I think knowing that when they come into that visit, if they decide that they're not comfortable, they can still do the self-swab and get the screening done. Also helps them say, "Hey, let's try it." Knowing that if they come in and then we're getting set up and they don't feel comfortable, we can say, "Hey, no, we don't have to do this. We can do the self-swab." I think that's helped a little bit, but it is challenging.

Gayge Maggio:

So, people can... Any progress on self-collection HPV for cervical cancer screening. Yeah, HPV self-swab, like we talked about, is a great option. It works really well. I always kind of very casually explain to my patients, "I'm not expecting you to be able to get cervical cells." I explain to them the new guidelines, which does... You need to be willing to have that conversation and explain kind of what you're actually looking for with the HPV and the pap smear. So, you do

have to have time for those conversations. But yeah, HPV self-swab works great. Can be much more comfortable for patients.

Gayge Maggio:

"Where can we access training resources for law enforcement interactions with transgender communities?" I don't know of any off the top of my head. I'll see if I can find any when the Q and A goes out, and if so, I can include those if I can't look for some. And I think that's also going to be very kind of local. I think in larger cities there are kind of community liaison officers that may publish resources from their perspective, and you may also have community organizations that are organizing around interactions between the trans community and law enforcement. So that would also be a good thing to search for your particular community.

Gayge Maggio:

Self-swab for HPV... Oh, this is coming up. So, yeah, so what we do is the patient just needs to get into the vaginal canal and swab, and then what they do is they are going to kind of swish that swab around in the same solution used for the pap, and you're going to send it to the lab with an order that it's HPV only.

Gayge Maggio:

"If a patient is fearful attending clinical visits due to immigration status, what steps would you recommend for this patient to access care?" We kind of make it clear that that doesn't need to be discussed if they don't want to. We're in New York City, so we do have people from various countries with various immigration statuses. We offer sliding scale, which doesn't single out people who aren't able to get insurance. For our HIV-positive patients, obviously they, even regardless of immigration status, they qualify for the AIDS Drug Assistance Program, ADAP. We make it clear that that agency does not share that information. It's very important to stress that, "I'm not recording this in the note." Any sort of social stressors they have, they can tell me as little or as much as they want. We can figure out ways if they're not comfortable with something going in the note what the best thing to put in is. But it obviously is a challenge. We also very much make sure that our building security do not look like police. We try to create an environment where people know that law enforcement of any-

Gayge Maggio:

An environment where people know that law enforcement of any sort is not going to show up outside of an emergency situation. And we've been also lucky with 911 calls for medical emergencies that we don't have law enforcement showing up. We have fire and paramedics, so people know that they're not going to, almost never going to have interactions with law enforcement.

Gayge Maggio:

So, the guidelines, there was the new algorithm released by for the guidelines referencing regarding aid change for first pap. I think that was it, ACCSP that adopted it, but it was based on recommendations and research and that was within the last couple years. I can add in the q-and-a, I'll add a link to the latest cervical cancer screening guidelines.

Gayge Maggio:

So abnormal rectal pap, any sort of abnormal there, we're not doing HP with that, HPV testing with that. We're just looking for any sort of cellular changes. Those all tend to go to... We have an anal health specialist in clinic who does what's called a high-resolution endoscopy. It's very similar to a colposcopy so that we refer in-house for next steps to getting those kinds of samples. Very similar to a colposcopy. The transformation zone of the anus is very similar types of cells to the cervix. So, HPV has very similar effects on it.

Gayge Maggio:

So which professional organization provides the anal PAP guidelines? That would be, that's New York State Department of Health for us. I think that people outside of New York who are doing anal paps are using those guide guidelines, we do need wider adoption of those.

Gayge Maggio:

So, someone is asking if it they who... Important for physicians ask [inaudible 01:14:16] birth people if they have a uterus can get pregnant. So yeah, so you do want to kind of leave that space to do an organ inventory. I think asking if someone can cause pregnancy causing act... involved in activities that otherwise cause pregnancy, it's a good place to ask, well how are you avoiding pregnancy? "Well, I've had a hysterectomy." If you get to that before you do medical and surgical history, I tend to ask my medical and surgical history first. So generally, if I ask have you had any surgeries? The hysterectomy has already come up but definitely leave space.

Gayge Maggio:

But pap results state unable to provide interpretation due to unsatisfactory specimen accuracy for transplant. Do you assume they use; suggest they use vaginal estrogen and reap? I mean I also assess like then do they have atrophic vaginitis anyway that would benefit from it. I don't... Definitely it might help. I haven't seen solid data on it. But also, I do have some trans male patients even when I explain it's not systemically absorbed that are quite uncomfortable with the idea of that.

Gayge Maggio:

So, any thoughts on 211 PrEP and also STI PEP with doxycycline. So, 211 PrEP I have a subset of my patients who are eligible to do it who love it tends to be patients who are not... Have a partner that they're mutually monogamous with, who is also doing a good job with other... Are

generally mutually monogamous with other than maybe going to parties or something or are rarely sexually active and do great with it. I do have a fair set of patients who try it and then realize they're taking just as much PrEP as if they took it every day and just want to save themselves a headache. I think for the right person, so someone who is male assigned at birth, not on gender affirming hormone therapy, who is not having high risk encounters often it can be great if it's something they can keep track of and they do know at least two hours before they're sexually active that they're going to be sexually active.

Gayge Maggio:

As terms of PEP with doxycycline. I hope we get a guideline on that very soon. The data that was presented looks really good on; I think it was on PrEP with doxycycline. So hopefully that will get a guideline shortly. The data looks really promising. I hope we get guideline for it soon.

Gayge Maggio:

Okay, so PEP and nPEP. So, PEP is a more general term. You'll see kind of older references. We'll use PEP instead of nPEP. When they say PEP, they'll mean an occupational exposure. The N in nPEP is just non-occupational post-exposure prophylaxis. And honestly a lot more prophylaxis happens than post-exposure prophylaxis for a needle stick in the clinic.

Gayge Maggio:

Could you share more about combining T with estrogen containing contraceptives? Cumulative comp [inaudible 01:17:40] VTE risk. So, we don't see a ton of venous thromboembolism risk unless you're seeing hypocoagulability caused by very high red blood cell counts. I don't really see that with the T all that much so I'm not super worried about it. Obviously, my decision on whether an estrogen containing contraception an option for someone on T is pretty much the same as someone who's not on T. It's the other clot risks. So obviously migraine with Aura, I don't want to do that. Smoking and advanced age.

Gayge Maggio:

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 studies that address this please? So that paper I link to does address this, that there's not contraindications to it. So that paper that's in my resources section would be the resource to go to.

Gayge Maggio:

Does uterine atrophy affect IUD placement? I haven't heard a ton about that. Like I said earlier, I'm not the one doing IUD placement. I will get you a follow up response from kind of our clinical director for that because I myself am not, haven't placed an IUD in some time so I don't have as much hands-on experience with that.

Gayge Maggio:

If you test negative for an STI, generally do you recommend always testing somewhere STIs or as well. It depends on what type of sex they're having. I do default to offering three site testing and explaining why. I don't make someone volunteer that they want non genital site testing. But also, I'm in an LGBTQ health center. Were very... Both my patients and all the clinicians were all very used to not assuming people are only having sex in certain ways. Generally, we're not kind of doing this serially, they're happening at the same time the testing. So definitely make sure that... I would default to offering all three sites, explain why and then people can opt out if they don't want to do an anal swab or an oral swab, they can opt out.

Gayge Maggio:

Is there appropriate way to ask patients what body parts they have? I think you get kind of an idea. Sex assigned at birth, any past surgeries and then you can as you get into the, maybe I'm... I need to know, I often say, well you know what screenings you need depends on what body parts you have. Can we do like a body part inventory? Are you okay using conventional anatomical terminology for those parts?

Gayge Maggio:

So, any hormonal contraceptive method is okay for a trans male patient. And I think the second part of this question, should contraception always be part of the conversation? I think contraception should be part of the conversation. If earlier in the conversation you've kind of determined that they currently engage in pregnancy causing activities or it's a possibility on their future. If there's someone who doesn't feel that that's a possibility in their future and isn't currently, I will just kind of point out that hormones are not an effective means of birth control. So, if it changes in the future just come to me to talk about contraceptive options. But if possibility of pregnancy is on the table, you should talk about contraception. If they want to avoid pregnancy and definitely anyone on testosterone should avoid pregnancy while they're on testosterone. If they wish to become pregnant, they're going to have to temporarily stop testosterone.

Gayge Maggio:

I see someone mentioning the point about the EMRs and that their EMR only allows sex assigned... That Quest only takes sex assigned at birth and that they have to switch it when ordering labs sent to Quest. We, with our old EMR, when we were sending prescriptions for controlled substances to pharmacies outside of the ones located in our clinic, we would have to switch because we were using the name fields technically wrong. So, we would see people's chosen names instead of their legal names. We had to switch the name fields when we sent prescriptions for controlled substances to outside pharmacies. So unfortunately, you often have to do some workarounds and kind of good to know if you don't have trans patients when you do see kind of things that could cause issues with prescription filling or labs. Kind of good to find out from the lab what's going to happen with various information.

Gayge Maggio:

For the self HPV test. Like a, there's a question about if it's a swab versus brush or broom. It's a swab.

Gayge Maggio:

So did you say a TDF TAF should be avoided for prep in trans women as well as patients with vaginas. Trans women prevaginal... If they haven't had vaginal plasty can use TAF or TDF. Post vaginoplasty, I haven't seen any data. My gut would be to avoid TAF. I kind of always assume when there's no data post vaginoplasty on what drug levels in the neo vagina are going to look like. I kind of assume the worst-case scenario but any patient with a vagina should avoid TAF. But TDF is fine for everyone. The two variants on the oral prep.

Gayge Maggio:

So, foresight tests... There is a question about foresight testing for people with neo vagina. Data isn't clear for a recommendation on this, but data does demonstrate seminal vaginal flora for a neo vagina. So, in terms of when we do vaginal swabs for testing, I am looking for yeast. Bacterial vaginosis is controversial because of the different pH level but just... Unless I happen to be doing gonorrhea and chlamydia testing when I'm doing a pelvic exam on a CIS woman, I always go with just the urine GCCT there. So, I don't normally do swabs there for trans women with neo vaginas anyway. Only if there's a symptomatic complaint in the neo vagina.

Gayge Maggio:

The question about what EMR we use now because organ inventory is awesome, we just switched to Epic, which does seem to have a lot built in for trans health or at least the build we have. I know that with any EMR a lot of it is going to be the build you use determines what you have.

Gayge Maggio:

Laboratory use for HPV self-test. We tend to send things to BioReference unless the patient has an insurance reason to not use BioReference or we're having... So, for the HPV self-test, I've always sent it to BioReference. I don't think there's an issue with sending it to [inaudible 01:25:54] quests. Those are the three labs we have locally that we regularly work with. But I think all the ones I've sent have been BioReference because that's kind of our default. But it's just a matter of ordering HPV only. Don't order the reflex to pap because there won't be cervical cells to look at. So, I think that gets us through pretty much I think all the questions I think I might have skipped one or two that I wanted to do further work research on before checking for anything. So, I think we're good.

Nicole Nguyen:

Yeah, no I was trying to pencil in an extra 15 minutes, but you pretty much got through all the questions. I know there were some that asked for specific clinical guidelines. Let me just double-check. Oh, I think, what was Deborah? I had a question. Should this patient have HPV... Oh. If a pap is unsatisfactory and HPV self-test should be done? [inaudible 01:27:08] Yes [inaudible 01:27:08] a client who identifies a trans man.

Gayge Maggio:

So, I mean our current guidelines for cervical cancer screening, it is HPV reflex to pap. So, I think under the current guidelines, if you get an unsatisfactory pap, you have a positive HPV test. And I think then the question is with the type of HPV that you find, you have to look at the algorithm of does the result of the pap, how much does it change management before going back? But you should already, with the current guidelines before doing a pap, you should also have an HPV at the same time, the only no one's getting a cervical pap, without an HPV test anymore. It's either HPV reflux to PAP for HIV negative or COT testing for HIV positive people with cervixes.

Nicole Nguyen:

Well and the person who asked the question is clarifying that it's unsatisfactory because of testosterone changes.

Gayge Maggio:

So that is a thing that happens. But you would have the HPV results. So, depending on the risk of the strain of HPV, kind of look at the algorithm, figure out what the results are, you might want to consider that vaginal estrogen or you may for certain high-risk strains, it may be just referring to [inaudible 01:28:41], you'd have to look at the algorithm. I will include the current algorithms with the q-and-a.

Nicole Nguyen:

And then just so one asks document in, so are you aware of any readily available resource list of trans-friendly healthcare providers that could enroll, or I can help my patient locate a trans-friendly PCP therapist, et cetera?

Gayge Maggio:

There are a few different things out there that I've seen. I'd have to look. I think the more reliable stuff tends to be more local resources. Like here in New York City on the [inaudible 01:29:19] website we have a trans atlas that is specifically for New York City. I often think that the more local resources tend to be more up to date and tend to be more vetted. I have seen a few things online that people can just opt in, which I can certainly re-look for those and include

them with the link. But I tend to trust more local resources are more kept locally because those tend to be better vetted rather than something someone can just opt into.

Gayge Maggio:

And I also think it can... Unfortunately, just because some trans people may have a good experience with someone and this we find sometimes with our referrals because obviously our referrals department only refers to people, they know to be trans-friendly. Sometimes somebody might be trans-friendly but may be fat phobic or might be trans-friendly and may not treat a person with a particular disability well or may not get certain trans identities. That mileage may vary. So having, finding a list is a good starting point. But I think if you have a referrals department... Having that referrals department tracking patient experiences is really important because patients don't have just one piece to their identity. Oh, I think you just got muted.

Nicole Nguyen:

I'm so sorry. Yes, yes. I was like checking. See if I have any questions. But thank you so much. I think we got through pretty much all of them. I know there was some about specific guidelines, so I know, we will look into that and we'll get that out in the written q-and-a for sure along with these slides. So, I just want to conclude that there'll be a survey after this end and then we'll get you the link for the CME certificate, the recording, the slides q-and-a, everything will be sent out to in a follow up email in a few weeks. And then I just want to thank you so much for doing this. I know it's December, it's close to the holidays, but the feedback has been amazing. Everyone's really appreciative and found this information super helpful and I would like to share with their colleagues. So, they're asking for slides, but we'll get them out.

Gayge Maggio:

Thanks everyone for attending and thank you for all the great questions. Really wonderful to have so many people interested in this topic, and I hope you all take these slides, share them with your colleagues, talk to your colleagues about this and figure out what you can do in your clinic. Not only just on a patient-to-patient level, but also talking to your health information department, whoever's in charge of that, about how you can make your systems work better. Because I know that questions around EMRs and everything, it's not only just the specific company that makes the EMR, but also the build. And I am not the person to ask about how a bills can be customized. So definitely a lot of people at the clinic can have a big impact on trans care.

Nicole Nguyen:

Yes. Then so with that we're going to conclude our webinar. We'll get everything out. Thank you again everyone, and hope you have a great rest of your week and weekend. This is Friday. Today's Friday. And then a great happy holiday. Stay safe everyone. Thank you. Bye.