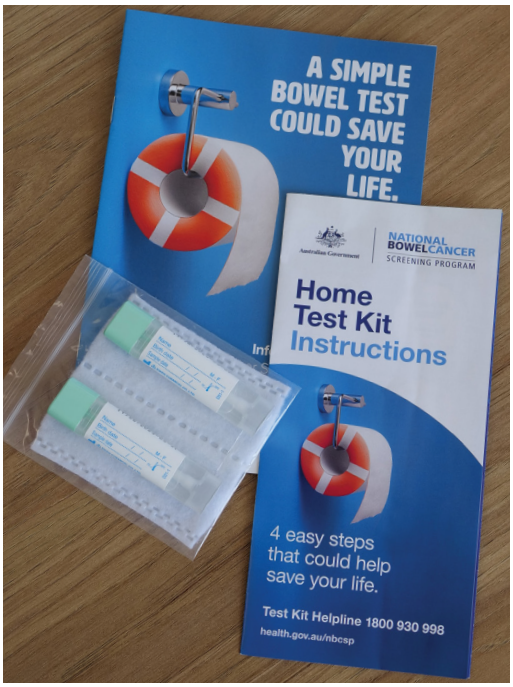
Cancer screening in LGBTQIA+ populations



Matthew J Ruhl

Background
Lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual/aromantic (LGBTQIA+, the plus referring to other sexuality and gender diverse groups) peoples in Australia experience lower levels of cancer screening and preventive activities when compared with the general population. This is especially the case for transgender and gender diverse (TGD) peoples, who experience additional barriers to access and discrimination above the rest of LGBTQIA+ peoples.

Objective
This article seeks to enhance cancer screening engagement among LGBTQIA+ individuals by addressing underscreening within these populations and offering strategies for improvement within primary care, including specific examples relevant to TGD peoples.

Discussion
Enhanced, individualised patient assessment, education and practitioner recommendations for cancer screening and prevention – supported by practitioner upskilling, LGBTQIA+ inclusivity training and the development of safer healthcare environments – may increase participation in screening programs, ultimately leading to earlier detection and better cancer outcomes.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING, INTERSEX, ASEXUAL/AROMANTIC AND OTHER SEXUALITY AND GENDER DIVERSE (LGBTQIA+) POPULATIONS (noting some peoples are not well included in the literature and may not feel well aligned with the acronym, such as intersex peoples) experience healthcare differently to the wider population, with heteronormativity, minority stress, discrimination, uncertainties in finding safe spaces and practitioners, and other systemic and individual barriers, all influenced by intersectionality.[1,2] Intersectionality is a term coined to describe the multiple overlapping and multiplying oppressions faced by many individuals,[3] which might, for example, include gender, sexuality, ethnicity, disability and so on, and may further contribute to screening barriers.

For transgender and gender diverse (TGD) peoples, there is insufficient evidence as yet to determine the effect of gender-affirming hormone therapy (GAHT) on long-term cancer risks.[4–6] Many guidelines, including those regarding cancer screening and prevention, are based on large population studies that either do not include or do not acknowledge LGBTQIA+ individuals, making clear guidance for these peoples difficult.[6] Many cancer registries do not specifically consider TGD peoples, which also limits their applicability.[7] As a result, most guidance is extrapolated on the basis of known risk factors and, for TGD peoples, which organs or tissues they possess.[5,6]

Uptake of cancer screening is influenced by practitioner recommendation;[8] this is specifically seen in TGD patients.[9] Consideration of individual patient barriers, including patient education and test acceptability, may improve uptake. Some discomforts may be negotiated by prior preparation (eg cervical screening in transgender people with a cervix, discussed below) or prior communication (eg a call or letter to a provider), potentially improving the likelihood of patient engagement.

Aim

This paper aims to provide an overview of LGBTQIA+ populations' engagement with, and uptake of, current cancer screening programs in Australia, with discussion of screening programs and what this means for TGD patients, including barriers to screening, and practice modifications to improve screening.

Overarching principles

Recognising each patient as an individual when determining appropriate preventive and

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screening activities is essential. This is also the foundation to building rapport, delivering tailored education, promoting positive healthcare behaviours and addressing potential barriers to accessing healthcare. LGBTQIA+-specific educational materials should be provided, where available.[10] Use of appropriate and preferred anatomical terms for individual patients is also recommended, such as chest tissue rather than breast tissue.[10,11] Practitioner flexibility, to adapt and work collaboratively with each patient, is therefore ideal.

Organ- and tissue-specific screening is currently recommended; for example, if a patient has a cervix, then application of population-based screening recommendations for cervical cancer should be recommended.[5] Some risk factors may influence additional specific screening or cancer vigilance, such as medication and meningiomas.[12] Table 1 briefly summarises the recommendations for LGBTQIA+ cancer screening.

National cancer screening programs

Australia has four national screening programs, as follows.[13–16]

Breast cancer

Breast cancer affects TGD peoples less often than cisgender females but more often than cisgender males, potentially because of TGD peoples' lower lifetime exposure to oestrogen and progesterone when compared with cisgender females.[6,17,18] Of people aged 50–74 years who live in Victoria and are eligible for breast screening, 22.6% of LGBTQI+ peoples have never had a mammogram, compared with 10.4% of the non-LGBTQI+ population.[19] It was found that 60% of transgender women, 52% of transgender men and 42% of gender diverse people had 'little concern' for developing breast cancer, which may indicate a need for increased patient education.[20] Other international breast screen programs, such as in Canada, show lower screening rates for TGD peoples than for the general population.[21]

Many patients will be happy to engage with screening; hence, it should not be assumed there is a barrier. Clinician recommendation and/or a reminder may be all that is needed. Screening recommendations should consider age at which GAHT was commenced, duration of GAHT and whether the patient has had 'top surgery' (such as mastectomy,

Table 1. Summary of considerations for cancer screening among LGBTQIA+ peoples

Overarching considerations		• Treat every patient individually • Be cautious of assumptions – patients may be keen to engage with screening • Be aware of some of the barriers to screening for LGBTQIA+ peoples, and where possible, support the patient to navigate these discreetly and comfortably • Practitioner recommendation improves screening engagement; educate patients appropriately on cancer risks and the relative benefits of screening tests • Ask about preferred terms for body parts, knowing many patients will be content with anatomical terms • In most cases, the recommendations of the national cancer screening programs may be followed without alteration for LGBTQIA+ peoples
Vaccination		• Assess vaccination status for oncogenic infections: – HPV – Hepatitis B • Recommend vaccination where appropriate – Be aware of free vaccination catch-up programs for higher-risk populations that may be offered in some states and territories
National cancer screening programs	**Breast cancer**	• Ask about GAHT duration and commencement age, and whether the patient has had chest surgery • Ask about screening engagement for people with breast tissue and aged 40–74 years • Recommend screening to those aged 50–74 years if not yet engaged • Explain that screening providers may enquire about GAHT as it may increase breast tissue density
	Cervical cancer	• Ask about screening engagement for people with a cervix aged 25–74 years • Recommend screening if not yet engaged • Review HPV vaccination, and consider catch-up vaccination if required, as above • Consider self-collection, and/or other collection modifications, to suit patient needs, including intravaginal oestrogen
	Bowel cancer	• Ask about screening engagement for people aged 45–74 years • Recommend screening if not yet engaged
	Lung cancer	• Assess for smoking, and recommend cessation • Recommend screening as per the National Lung Cancer Screening Program guidelines

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Table 1. Summary of considerations for cancer screening among LGBTQIA+ peoples (cont'd)

Other cancer surveillance	**Prostate cancer**	• Consider PSA screening for people with a prostate after discussion of the relative benefits • For people with a prostate on GAHT, especially anti-androgens, be aware that their baseline PSA level will be lower than in cisgender men, and consider upward trends of the PSA even if the laboratory cut-off is not reached – Consider discussion or referral to an affirmative urologist if results are concerning or the patient is symptomatic
	Skin cancers	• Discuss universal skin cancer prevention precautions • Assess skin cancer risk, and recommend self-checks or medical checks as appropriate
	Genital cancers	• For people with a uterus, assess abnormal uterine bleeding with prompt referral to an affirmative gynaecologist following consideration of duration of GAHT, serum testosterone level and testosterone administration method • For people with a neovagina, discuss vigilance for lesions and consider HPV vaccination • Recommend regular testicular self-examination for people with testes
	Anal cancer	• For most Australians living with HIV, HRA is not available. In these individuals, annual assessment for anal cancer should consist of history and symptom assessment, DARE and peri-anal examination, commencing from age 18 years • Where HRA is available, annual anal cytology ± HRHPV testing with referral for HRA should commence from age ≥35 years for gay, bisexual and other men who have sex with men and transgender women, and from age ≥45 years for other people living with HIV

DARE, digital anorectal examination; GAHT, gender-affirming hormone therapy; HIV, human immunodeficiency virus; HPV, human papillomavirus; HRHPV, high-risk human papillomavirus; HRA, high-resolution anoscopy; LGBTQIA+, lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic and other; PSA, prostate-specific antigen.

acknowledging 'mastectomy' is a term rarely used in the TGD community), though broadly, cisgender recommendations for screening apply.[17,18] State-based guidance is described in Table 2. Screening via private referral is also possible if required. Patients should be counselled that they may be questioned about their GAHT as it increases breast tissue density, which may make interpretation difficult.[17]

Cervical cancer

Only 38.9% of eligible TGD peoples in Australia have been screened for cervical cancer.[22] Many transgender men have never had a cervical screening test (CST),[20,23] and nearly 9 out of 20 TGD people with a cervix have never had a CST recommended by a health professional.[23] Dysphoria from CST collection may be a significant barrier for some patients,[23] though many patients will be comfortable to proceed and may simply benefit from a routine reminder.

The human papillomavirus (HPV) is the causative agent for most cervical cancer within LGBTQIA+ populations as for within the broader population.[17,24] HPV vaccination should be encouraged within the usual schedule on the National Immunisation Program, or recommended if not previously accessed,[18] and CST offered per the National Cervical Screening Program Guideline (the Guideline).[15]

The Guideline comments on some of the barriers to a CST and recommends asking patients about anatomy terms (eg some patients may prefer terms other than vagina and cervix, such as front hole, though many will find anatomical terms acceptable) and includes a link to letter templates that describe many of the techniques that can be considered to increase patient comfort during a CST.[15] A fact sheet is also available.[25] Topics include self-collection (where appropriate), self-insertion of the speculum and use of the smallest speculum, and patient preferences regarding positioning, environment and discussion during the test.[15] The Guideline also guides clinicians to further national information and resources on engaging LGBTQI+ peoples in cervical screening.[26]

Given the test can be physically uncomfortable because of atrophy, patients presumed female at birth (PFAB) taking masculinising GAHT may be offered intravaginal oestrogen beforehand if needed, which decreases the discomfort from atrophy and increases result quality, similar to postmenopausal cisgender women.[27] Not all patients will require this, especially if self-collecting, but suitable options include an oestradiol 10 microgram pessary or an application of estriol 0.1% cream daily for 2 weeks prior to the test, ceasing 1–2 days beforehand.[15]

Bowel cancer

The National Bowel Cancer Screening Program (NBCSP) shows low levels of engagement across the entire population; only 40% of the eligible 6 million people invited to participate between January 2021 and December 2022 returned their envelopes.[16] LGBTQ+ engagement is mostly unknown, though a 2017 Victorian survey found similar engagement levels to the non-LGBTQ+ population.[19] The prevalence of colorectal cancer is not known to be different between LGBTQIA+ peoples and the rest of the population (except possibly for anal cancers[12]), so screening should be recommended for all LGBTQIA+ peoples per the program guidelines.[6]

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Table 2. State- and territory-based BreastScreen service recommendations for asymptomatic breast cancer screening for LGBTQIA+ peoples

State/Territory	Specific information for LGBTQIA+ patients	Specific Information for TGD patients	Eligibility criteria		
			Transgender women	Transgender men	Non-binary peoples
Australian Capital Territory[49]	No	Yes	Recommended 2-yearly if aged 50–74 years and on GAHT ≥5 years Not recommended if not on GAHT/on GAHT <5 years	Recommended 2-yearly if no chest surgery[A]	Recommended 2-yearly if PFAB and no chest surgery[A] Recommended 2-yearly if PMAB, aged 50–74 years and on GAHT ≥5 years
New South Wales[50]	No	Yes	Recommended 2-yearly if aged 50–74 years (from 40 years if Aboriginal and/or Torres Strait Islander) and on GAHT ≥5 years Not recommended if not on GAHT/on GAHT <5 years	Recommended 2-yearly if aged 50–74 years (from 40 years if Aboriginal and/or Torres Strait Islander) and no chest surgery[A]	Recommended 2-yearly if aged 50–74 years (from 40 years if Aboriginal and/or Torres Strait Islander), PFAB and no chest surgery[A] Recommended 2-yearly if aged 50–74 years (from 40 years if Aboriginal and/or Torres Strait Islander), PMAB and on GAHT ≥5 years
Northern Territory[51]	No	No	Not applicable		
Queensland[52]	No	Yes	Breast screening offered to people PFAB, or those who present or identify as female (while meeting age criteria)		
South Australia[53]	No	No	Not applicable		
Tasmania[54]	No	Yes	Recommended 2-yearly if aged 50–74 years and on GAHT ≥5 years Not recommended if not on GAHT/on GAHT <5 years	Eligible if no chest surgery[A]	Eligible if PFAB and no chest surgery[A] May be of benefit 2-yearly if PMAB, aged 50–74 years and on GAHT ≥5 years
Victoria[55]	Yes	Yes	Eligible 2-yearly if aged 50–74 years and on GAHT ≥5 years Not recommended if not on GAHT/on GAHT <5 years	Recommended 2-yearly if no chest surgery[A]	Recommended 2-yearly if PFAB and no chest surgery[A] Recommended 2-yearly if PMAB, aged 50–74 years and on GAHT ≥5 years
Western Australia[56]	Yes	Yes	Not recommended	Recommended 2-yearly if no chest surgery[A]	Eligible 2-yearly if PFAB and no chest surgery[A]

[A] Chest surgery refers to bilateral mastectomy or similar procedure.

GAHT, gender-affirming hormone therapy; LGBTQIA+, lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic and other; PFAB, presumed female at birth; PMAB, presumed male at birth; TGD, transgender and gender diverse.

Anal cancer

Men who have sex with men (MSM) and who are also living with human immunodeficiency virus (HIV) have approximately 60 times the rate of anal squamous cell carcinoma (ASCC) when compared with the general population. High-risk HPV (HRHPV) is detected in 88% of ASCC.[28]

In Australia, the availability of high-resolution anoscopy (HRA) is currently extremely limited. For at-risk individuals who do not have access to HRA, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) recommends that anal swabs for HPV and cytology should not be collected. Instead, it is recommended that there be annual assessment of history and symptoms, an annual digital anorectal examination (DARE) and annual examination of the peri-anal region.[28] The screening recommendations apply to people living with HIV aged 18 years and over.[28]

Lung cancer

Recently implemented, the National Lung Cancer Screening Program includes screening by a practitioner-referred low-dose computed tomography (CT) scan on the basis of age and smoking history.[14] With higher smoking rates in Australian

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LGBT populations,[29] screening should be recommended where appropriate, especially given this program is more practitioner directed than the other three.

Cancer surveillance

Neither prostate cancer nor skin cancer have a program of coordinated screening, though both are common, and the discussion of screening and surveillance is recommended. They are discussed here to provide support for patient education.

Prostate

With multiple possible symptoms (and asymptomatic presentation), and some challenges in using prostate-specific antigen (PSA) as a screening test, screening for prostate cancer among cisgender men is considered on a case-by-case basis after a thorough discussion of the relative risks and benefits.[30] TGD people with prostate glands typically retain their prostate glands even following gender affirmative surgery (which many transgender people choose not to access, or are unable to access).[31] If DARE is subsequently required, noting that this is no longer a recommended part of prostate cancer screening, the prostate gland may sometimes be palpable only via their neovagina.[31]

Feminising GAHT lowers the risk of prostate cancer,[6,32,33] as anti-androgens used in GAHT may also be used in treating prostate cancer.[34] Feminising GAHT can also lead to a marked reduction in PSA, which can make interpretation of PSA results difficult.[31,35] TGD peoples with prostate glands who are not using GAHT have a risk of prostate cancer similar to cisgender counterparts.[31] Counselling and the offer of PSA screening should be essentially the same as for cisgender men, though there is no clear cut-off for PSA.[31,35]

Skin

LGBTQ+ peoples may have higher rates of sun exposure, ultraviolet tanning and sunburn when compared with the general population,[36] though this may not translate to clear increases in skin cancer.[37–39] International studies are unlikely to be generalisable to the Australian population because of their retrospective nature and our cumulative sun exposure and skin cancer risk profiles.[38,39] In the absence of further information, annual self-checks are recommended (noting they will miss lesions out of view), more frequently for higher-risk patients, with medical skin checks performed as needed on the basis of risk profile or discovery of concerning lesions.[40] Skin cancer prevention advice should be universal, especially for those at higher risk.[40,41]

A skin check for TGD patients may potentially provoke dysphoria, especially if requiring full exposure for whole-body photography; clear discussion of the examination and consideration of modifications, such as limited exposure of the body part being examined at the time, would be recommended.

LGBTQIA+-specific screening and surveillance

Some tumours merit special discussion in regard to LGBTQIA+ populations, as follows.

Meningioma and prolactinoma

Meningioma is a rare, usually benign, tumour of the meninges[12] associated with use of cyproterone acetate, a synthetic progestin, especially (though not exclusively[42]) higher cumulative doses over the lifespan – they may exert mass effects requiring treatment.[12,34] Transgender women taking cyproterone have a four times higher incidence of meningioma when compared with cisgender women.[34] Prolactinomas, which are similarly rare tumours,[5] have also been reported at four times the rate in transgender women when compared with cisgender counterparts.[34] Cyproterone[34] and a number of other medications (including GAHT) and health conditions[43] are known to cause hyperprolactinaemia.[44]

No specific screening for either tumour is recommended,[5,44] though patients and clinicians should be alert to the small increased risk as well as signs and symptoms of concern, such as visual field changes and galactorrhoea, with further investigation and referral as appropriate.

Genital tract cancers

Given some gender affirming surgeries may include oophorectomy, hysterectomy and orchidectomy, consideration of cancers of these organs and related tissues, such as the endometrium, needs to be discussed on an individual basis.

There is little evidence to screen for endometrial or uterine cancer,[6] though symptoms such as abnormal uterine bleeding, discharge, pain and masses should be investigated,[17] ideally supported by an affirmative gynaecologist.[45] Menstruation typically ceases 3–6 months after beginning masculinising GAHT,[46] but it can persist past 12 months.[4] After ensuring adequate testosterone levels (10–15 nmol/L[4]; common reasons for ongoing menses include inadequate serum testosterone and topical administration methods[47,48]), investigation for abnormal uterine bleeding should proceed.[45] Ovarian cancer risk in TGD peoples is not considered higher than in their cisgender counterparts,[6] but investigation of symptoms should occur as for non-TGD peoples.[17] Masculinising GAHT may cause endometrial hyperplasia; while in theory this would increase the risk of subsequent endometrial cancer, this has not been supported by clinical evidence to date.[12]

For TGD women following gender affirmative surgery, neovaginal cancer has been reported, with squamous cell carcinomas and adenocarcinomas, depending on tissue source (skin or gastrointestinal tract, respectively); some are associated with HPV.[6] Screening, such as via self-examination, at routine intervals is recommended in the US.[6]

Routine testicular self-examination is recommended for people with testes, though the risk of cancer in transgender women is approximately similar to that in cisgender men.[37]

Supporting increased screening

Higher screening rates are, at least in part, linked to higher rates of patient engagement. This depends on creating safer spaces for LGBTQIA+ individuals – both through inclusive environments and through practitioner training and confidence. Promotion of a safer environment may be by posters and signs; practice forms and paperwork; the practice website; visible iconography, such as flags; and inclusiveness training for practice staff, including reception and administrative staff.[26] Training to improve cancer screening and prevention at a practice level for all communities is available,[10] for example, via the Primary Care Cancer Control Quality

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Improvement Toolkit.[8] Cervical screening engagement resources were mentioned above, which would also be suitable for practice nurses.[26] Clinician- and patient-centred information can be found via sites such as TransHub (www.transhub.org.au) and through work with communities of practice, in person or online.

Practice nurses may also be an untapped resource with significant potential for patient contact. Upskilling practice nurses to support cancer (and overall) screening and prevention, during management planning and via patient education, may be an effective and time-saving method to share the load in general practice while improving nurse autonomy and scope of practice.[1,18]

Conclusion

Cancer screening and prevention is a key function of the general practitioner in primary care. In LGBTQIA+ populations, including TGD peoples, this largely follows the same recommendations as the non-LGBTQIA+ population, although an individualised approach is required, with some specific caveats based on which organs and tissues the individual possesses. Multiple barriers to screening exist; these need to be explored on a case-by-case basis and addressed, where possible, via clinical flexibility and appropriate modifications, including upskilling of other practice staff. Improving uptake of appropriate cancer screening and prevention activities by patient education and recommendation, and by incorporating it within management plans, will better support early detection and improved cancer outcomes for LGBTQIA+ peoples.

Key points

- LGBTQIA+ peoples are broadly underscreened for cancers.
- GPs have a key role in providing patient education, recommendations and support to increase LGBTQIA+ patients' engagement with cancer screening.
- Upskilling for GPs and practice nurses in cancer screening, and LGBTQIA+-inclusive training for all staff, is available from a variety of sources.
- Organ- and tissue-specific individualised screening is recommended for TGD patients, though screening is in most regards similar to the cisgender population.
- An individual approach to exploring patient concerns and barriers to screening can be applied to all LGBTQIA+ patients, with application of a flexible practitioner response to address these concerns and barriers.

Author

Matthew J Ruhl FACRRM, MBBS, GradDipPH (Remote and Polar Medicine), GradCertMed(SRH), DCH, BSc, BEd, National Clinical Educator, Australian College of Rural and Remote Medicine, Brisbane, Qld; Lecturer, (Medical School/Faculty of Health, Medicine and Behavioural Sciences), The University of Queensland, Brisbane, Qld

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Correspondence to:
m.ruhl@acrrm.org.au

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