ADVANCING EXCELLENCE IN TRANSGENDER HEALTH

Eliciting a Sexual History and Addressing STIs for Transgender and Non-Binary People

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Disclosures

- I have no financial disclosures.

Learning objectives

1. Outline the components of a comprehensive sexual history.
2. Demonstrate the use of inclusive sexual history questions.
3. Describe an approach to screening for sexually-transmitted infections for transgender and non-binary people.

Eliciting an Inclusive Sexual History

Why elicit a sexual history?

- Sexual health is an integral part of overall health.
- Patients want to discuss sexual health with their clinicians.
- Several disparities that affect sexual and gender minority populations relate to sexual health.
- Multiple primary care interventions hinge upon the sexual history (STI screenings, vaccines, PrEP).

Common pitfalls

A 25-year-old transgender woman presents to establish primary care after moving to the area. On the registration form, she identifies her gender as "woman" (the form does not include transgender options or ask about sex recorded on the birth certificate).

- Provider: "...Are you sexually active?"
- Patient: "Yes."
- Provider: "How many partners do you have?"
- Patient: "One."
- Provider: "Do you use any form of contraception?"
- Patient: "No."
- Provider: "Do you want to become pregnant?"
- Patient: "There's no chance of pregnancy...I'm trans, and my partner is a cis man..."

Tips for eliciting the sexual history

1. Make it routine, confidential, and free of assumptions related to age, anatomy, gender, ability.

2. Explain to patients why it is important.

3. Ask about sexual function and satisfaction, not just STI or pregnancy “risk.”

Tips, continued

1. Ask open ended questions, at least initially.

2. Normalize “less desired” responses: “Many people do not use condoms every time they have sex. How often do you use condoms?”

3. Mirror patients’ language, if possible.

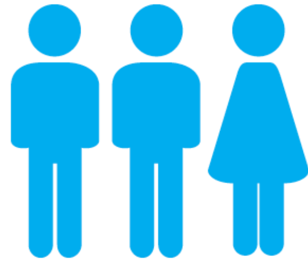
4. Don’t be so concerned about asking something in the “right” way that the conversation becomes a robotic rather than a professional but natural interaction.

Tips, continued

1. Consider giving patients the option to answer questions indirectly: "I recommend screening for gonorrhea and chlamydia at all sites that might have been exposed. For example, if someone puts their mouth on another person's penis, I would test the mouth…Which of these sites should you have tested today?"

2. Tone and rapport matter as least as much as the questions themselves.

A comprehensive sexual history consists of the 5 Ps.



Partners

Practices

Past History of STDs

Protection from STDs

Pregnancy Plans

Getting started

- “I’d now like to ask some questions about your sexual history in order to ensure that I recommend the best preventive care for you.”
- “Have you had sex in the past year?”
- “When I use the word sex, I mean…”

Obtaining more information

- “How many people have you had sex with in the past year?”
- “What is (are) the gender(s) of the people you have had sex with?”
- “What types of sex do you have? For example…”
- “Has anyone put their penis in your rectum?” (or some other similarly specific question, if necessary)

Obtaining more information

- “Some surgeries can change the genitals or affect sexual function. Have you had any such surgeries?”
- “Do you ever have sex when you’re drunk or high?”
- “Do you ever trade sex for drugs, money, or something else that you need?
- Have you ever had an infection spread by sex, like chlamydia or herpes?

Obtaining more information

- "Have any of your partners in the past year told you they've had an infection?"
- "As far as you know, do any of your partners have HIV?"
- "How often do you use condoms for sex?"
- "How do you decide when to use condoms?"

Obtaining more information

- “What is your approach to avoiding STDs?
- “Are you interested in having children?”
- Has anyone forced or threatened you into having sex you did not want?

In general, please avoid:

QUESTIONS	DOWNSIDES
Are you sexually active?	No timeframe, vague
Do you have a girlfriend, husband, etc?	Assumes heterosexuality
Do you have sex with men, women, or both?	What about trans and/or non-binary people?
Do you use protection?	Protection is more than condoms – PrEP, OCPs, etc.
You haven't had other partners, right?	Conveys a judgement and leads to a "correct" answer
Have you had insertive/receptive anal intercourse?	Patients may not understand these terms

When should you elicit a comprehensive sexual history?

- As part of a comprehensive medical history at an initial visit
- For any chief complaint that may relate to sexual health*
- At most visits, for those taking PrEP or at high risk for STIs
- Periodically (annually?) for established patients

*Many chief complaints warrant a sexual history: Examples

EXAMPLE	RATIONALE
Diarrheal illness	Sexually transmitted GI pathogens
Mono-like illness	Could be acute HIV
Undifferentiated febrile illness	Could be syphilis, HIV, etc.
Desire for gender-affirming hormone therapy	Hormones can impact sexual function
Substance use disorder	May impact sexual risk; potential for transactional sex

Are patients more honest with computers?

Studies of CASI versus clinician history in sexual health clinics show that CASI users more commonly disclose:

- Sex with same-gender partners
- Oral sex
- Transactional sex
- Higher numbers of sexual partners

Ghanem KG, Sex Transm Infect, 2005; Kurth AE, Sex Transm Dis, 2004; Tideman RL, Sex Transm Infect, 2007

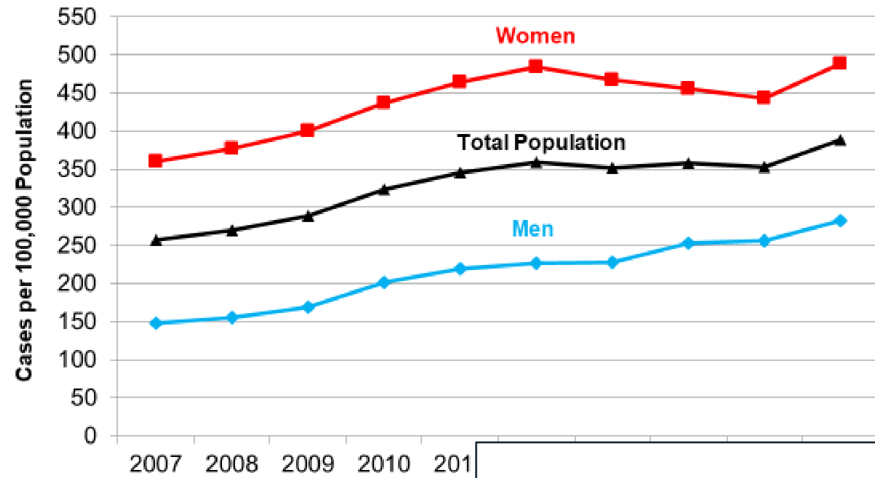
Addressing STIs

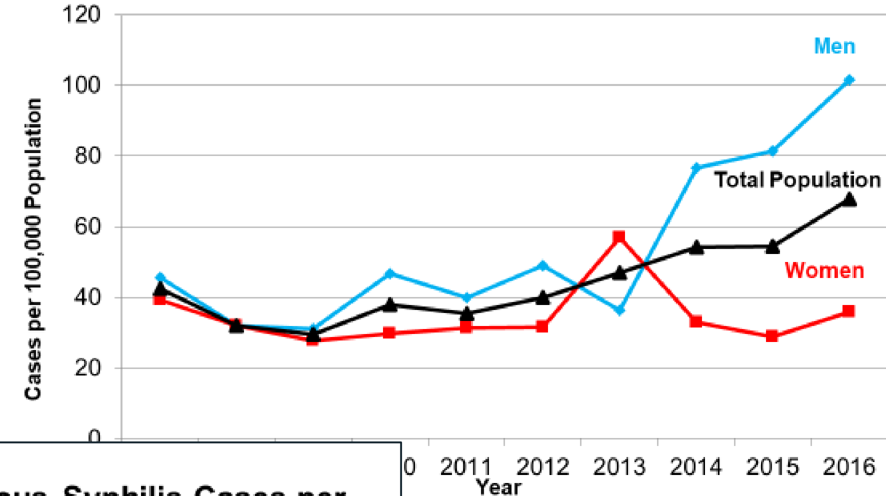
Limitations of research

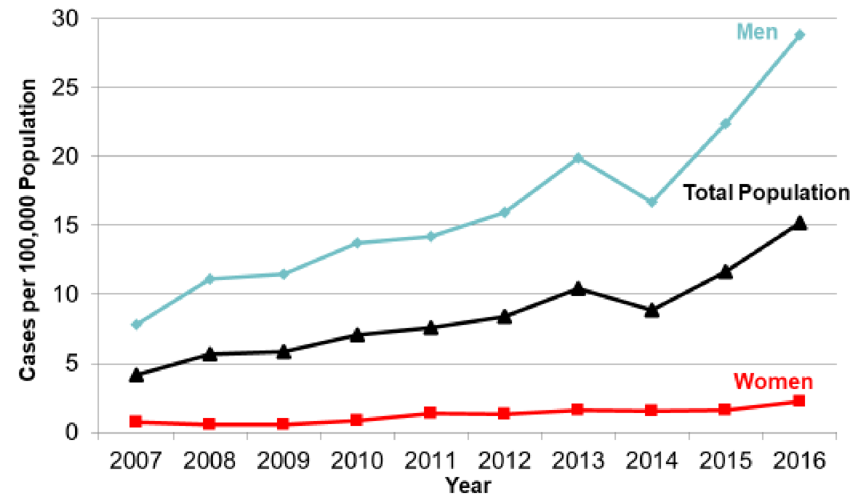
1. Reliance upon convenience samples
2. Conflation of transgender and LGB groups, especially trans women and MSM
3. Lack of data about non-HIV STIs
4. Lack of data about STI vulnerability and test performance in surgically-modified genitalia

Case

- A 39-year-old transgender man presents for preventive care.
- **Past medical history:** Hysterectomy, breast removal, syphilis, HCV (cured)
- **Medications:** TDF-FTC, testosterone, cholecalciferol
- **Social history:** Lives alone, smokes marijuana, works for a pharmaceutical company
- **Sexual history:** Oral and receptive anal sex without condoms with 3 cisgender men in the past year


Incidence Rate of Reported Chlamydia Cases per 100,000 Population by Gender, Massachusetts, 2007–2016
Women
Total Population
Men
Cases per 100,000 Population
550
500
450
400
350
300
250
200
150
100
50
0
2007
2008
2009
2010
N=218,469; 443 cases missing gender have been redistributed by pro
Data Source: MDPH, Bureau of Infectious Disease and Laboratory Sc
Population Source: US Census Bureau, Population Division, Intercens
Estimates of the Resident Population (2010-2016), Release dates: Oc


Incidence Rate of Reported Gonorrhea Cases per 100,000 Population by Gender, Massachusetts, 2007–2016
Men
Total Population
Women
Cases per 100,000 Population
120
100
80
60
40
20
0
2011
2012
2013
2014
2015
2016
Year
ted by proportional distribution of cases with known gender by year
aboratory Sciences, data are current as of 6/16/17 and subject to change;
on, Intercensal Estimates of the Resident Population (2007-2009) and
se dates: October 2012 and June 2017, respectively


Incidence Rate of Reported Infectious Syphilis Cases per 100,000 Population by Gender, Massachusetts, 2007–2016
Men
Total Population
Women
Cases per 100,000 Population
30
25
20
15
10
5
0
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Year
N=5,666; 7 cases missing gender have been redistributed by proportion of cases with known gender by year
Data Source: MDPH, Bureau of Infectious Disease and Laboratory Sciences, data are current as of 6/16/17 and subject to change;
Population Source: US Census Bureau, Population Division, Intercensal Estimates of the Resident Population (2007-2009) and
Estimates of the Resident Population (2010-2016), Release dates: October 2012 and June 2017, respectively

STIs are more than the “big three.”

Parasites

- *Giardia lamblia*
- *Entamoeba histolytica*
- Ectoparasites

GI bacteria

- *Shigella*
- *Campylobacter*

Viruses

- Human papillomavirus
- Herpes simplex virus
- Hepatitis A
- Hepatitis B
- Hepatitis C

2015 sexually transmitted disease treatment guidelines. Available at: https://www.cdc.gov/std/tg2015.

Some transgender groups face a high burden of STIs.

- **Prospective study of 230 transfeminine people New York City:**
  - Syphilis incidence 3.6% per year
  - Gonorrhea incidence 4.2% per year
  - Chlamydia incidence 4.5% per year
- **Retrospective study of 145 young people in Boston:**
  - Prevalence of syphilis 2.8%
  - Prevalence of gonorrhea and chlamydia 2.1% each
- **National survey of 857 transgender men:**
  - 16% reported a bacterial STI in the prior 6 months

1. Nuttbrock L, Bockting W, Rosenblum A, et al. Gender abuse, depressive symptoms, and HIV and other sexually transmitted infections among male-to-female transgender persons: a three-year prospective study. Am J Public Health. 2013;103(2):300.
2. Reisner SL, Vetters R, White JM, et al. Laboratory-confirmed HIV and sexually transmitted infection seropositivity and risk behavior among sexually-active transgender patients at an adolescent and young adult urban community health center. AIDS Care. 2015;27(8):1031.
3. Reisner SL, J Int AIDS Soc, 2019

CDC's 2015 STD Treatment Guidelines

"Clinicians should assess STD- and HIV-related risks for their transgender patients based on current anatomy and sexual behaviors. Because of the diversity of transgender persons regarding surgical affirming procedures, hormone use, and their patterns of sexual behavior, providers must remain aware of symptoms consistent with common STDs and screen for asymptomatic STDs on the basis of behavioral history and sexual practices."

My approach

- **Screen based on the sexual history, including:**
  - Syphilis and HIV serology
  - NAAT for gonorrhea and chlamydia at all exposed sites
- **Frequency:**
  - Every 3 months for those on PrEP or at very high risk
  - Otherwise annually or even less often, depending on the sexual history

Approach to the physical examination

- "Trauma-informed"
- Greet the patient while they are dressed
- Use a chaperone
- Describe what you intend to do in a step-by-step fashion
- Only examine what is necessary for the clinical issue at hand

Poteat T. Transgender people and sexually transmitted infections. UCSF Center for Excellence in Transgender Health. 2018. Available at: http://transhealth.ucsf.edu/trans?page=guidelines-stis.

What we know about gonorrhea and chlamydia testing in cisgender people

CIS WOMEN

- NAATs are preferred.
- Sensitivity of first-catch urine is 10% less than a vaginal swab.
- A self-collected vaginal swab performs as well as a clinician-collected swab.
- Vaginal swabs perform as well as endocervical swabs.

CIS MEN

- NAATs are preferred.
- Sensitivity of first-catch urine is the same as a urethral swab.

Papp JR, et al. Recommendations for the laboratory-based detection of Chlamydia trachomatis and Neisseria gonorrhoeae – 2014. MMWR. March 14, 2014/63(RR02);1.

Unanswered questions

- What is the risk of STIs in surgically-constructed vaginas and penises?
  - **Vaginoplasty techniques may involve urethral or colorectal mucosa, which is presumably susceptible to infection.**
- What is the optimal screening strategy for gonorrhea/chlamydia in the setting of genital reconstruction?
  - **Urine NAAT versus vaginal/urethral NAAT in vaginoplasty/phalloplasty?**
  - **Some experts consider urine NAAT preferred.**
- Do STIs present differently in reconstructed tissue?
  - **Case report of neovaginal gonorrhea presenting as coital bleeding**

1. Poteat T. Transgender people and sexually transmitted infections. UCSF Center for Excellence in Transgender Health. 2018. Available at: http://transhealth.ucsf.edu/trans?page=guidelines-stis.
2. Van der Sluis WB, Bouman MB, Gijs L, van Bodegraven AA. Gonorrhoea of the sigmoid neovagina in a male-to-female transgender. Int J STD AIDS. 2015;26(8):595.

A few reminders

- Neovaginas have no cervix, so cervical cytology is unnecessary.
- The prostate is not typically removed in gender-affirming surgery.
- The anoscope, rather than a speculum, may be most appropriate for examination of the neovagina.
- Transmasculine people taking testosterone may have vaginal atrophy, so use a small speculum for vaginal/frontal examinations.

Poteat T. Transgender people and sexually transmitted infections. UCSF Center for Excellence in Transgender Health. 2018. Available at: http://transhealth.ucsf.edu/trans?page=guidelines-stis.

Case, continued

- A 39-year-old transgender man presents for preventive care.
- **Past medical history:** Hysterectomy, breast removal, syphilis, HCV (cured)
- **Medications:** TDF-FTC, testosterone, cholecalciferol
- **Social history:** Lives alone, smokes marijuana, works for a pharmaceutical company
- **Sexual history:** Oral and receptive anal sex without condoms with 3 cisgender men in the past year
- **Laboratory results:** Rectal NAAT positive for *N. gonorrhoeae*

SUMMARY OF THE 2015 CDC SEXUALLY TRANSMITTED DISEASE (STD) TREATMENT GUIDELINES
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH (MDPH) – DIVISION OF STD PREVENTION (DSTDP)

These guidelines for treatment of STDs reflect recommendations of the **MDPH DSTDP** and of the **CDC STD Treatment Guidelines**. These guidelines focus on STDs encountered in outpatient settings and are not an exhaustive list of effective treatments. Please refer to the complete CDC document for more information or call the DSTDP. Clinical and epidemiological services are available through the DSTDP including staff to assist healthcare providers with confidential notification of sexual partners of patients with STDs and/or HIV infection. Please call the DSTDP for assistance at (617) 983-6940.

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
SYPHILIS		
ADULTS Primary, Secondary or Early Latent (<1 Year)	• Benzathine penicillin G 2.4 million units IM once	(For penicillin-allergic non-pregnant patients only) • Doxycycline 100 mg orally 2 times a day for 14 days ***OR*** • Tetracycline 500 mg orally 4 times a day for 14 days
ADULTS Late Latent (>1 Year) or Latent Of Unknown Duration	• Benzathine penicillin G 2.4 million units IM for 3 doses at 1 week intervals (total 7.2 million units)	(For penicillin-allergic non-pregnant patients only) • Doxycycline 100 mg orally 2 times a day for 28 days ***OR*** • Tetracycline 500 mg orally 4 times a day for 28 days
NEUROSYPHILIS including OCULAR SYPHILIS	• Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days[1]	• Procaine penicillin G 2.4 million units IM once daily **PLUS** probenecid 500 mg orally 4 times a day, both for 10-14 days
CHILDREN Primary, Secondary or Early Latent (<1 Year)	• Benzathine penicillin G 50,000 units/kg IM once, up to adult dose of 2.4 million units	No specific alternative regimens exist.
CHILDREN Late Latent (>1 Year) or Latent Of Unknown Duration	• Benzathine penicillin G 50,000 units/kg IM (up to adult dose of 2.4 million units) for 3 doses at 1 week intervals (up to total adult dose of 7.2 million units)	
CONGENITAL SYPHILIS	See complete CDC guidelines.	
HIV INFECTION	Same stage-specific recommendations as for HIV-negative persons.	
PREGNANCY	Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergic should be desensitized and treated with penicillin. Treatment is the same as in non-pregnant patients for each stage of syphilis.[2]	
GONOCOCCAL INFECTIONS		
ADULTS, ADOLESCENTS AND CHILDREN >45 KG Pharyngeal, Urogenital, Rectal	• Ceftriaxone 250 mg IM once **PLUS**[3] • Azithromycin 1 g orally once	***Note:*** **Use of an alternative regimen for pharyngeal gonorrhea should be followed by a test-of-cure 14 days after treatment.**[4] **For urogenital or rectal infections ONLY, and ONLY if ceftriaxone is *not* available:** • Cefixime 400mg orally once **PLUS**[3] • Azithromycin 1 g orally once **OR in case of azithromycin allergy** • Doxycycline 100 mg orally 2 times a day for 7 days **For azithromycin allergy:** ♦ Ceftriaxone 250 mg IM once **PLUS**[3] ♦ Doxycycline 100 mg orally 2 times a day for 7 days **For cephalosporin allergy or IgE-mediated penicillin allergy:** ♦ Gemifloxacin 320 mg orally once ***OR*** ♦ Gentamicin 240 mg IM once **PLUS**[3] ♦ Azithromycin 2 g orally once

All Suspect Syphilis Cases: Call the STD Program at (617) 983-6940 for past titers and treatment.

ADV

https://www.mass.gov/files/documents/2016/07/sz/ma-std-tx-guidelines-2016.pdf

STI prevention for transgender people

1. Addressing socioeconomic factors that increase vulnerability
2. Vaccines – HAV, HBV, HPV
3. Condoms and risk-reduction counseling
4. PrEP for those at risk for HIV
5. STI screening and treatment – interrupting transmission prevents future infections

Take-home points

- The core sexual history does not differ between transgender/non-binary and cisgender patients.
- Rather than following a script, have a few opening questions in mind.
- Appropriate STI screening, vaccination, and PrEP all rely upon taking a sexual history.
- For the most part, testing and treatment for STIs is the same in transgender and cisgender people.
- Uncertainty exists regarding the clinical manifestations and optimal testing strategy for STIs affecting surgically-constructed genitalia.