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:

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

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

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
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

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

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
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.

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**

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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.

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*
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.

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED TREATMENT</th>
<th>ALTERNATIVES (use only if recommended regimens are contraindicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYPHILIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Primary, secondary or early latent (&lt;1 year)</td>
<td>• Benzathine penicillin G 2.4 million units IM once</td>
<td>(For penicillin-allergic non-pregnant patients only) • Doxycycline 100 mg orally twice a day for 14 days OR • Tetracycline 500 mg orally 4 times a day for 14 days</td>
</tr>
<tr>
<td>Late latent (&gt;1 year) or latent of unknown duration</td>
<td>• Benzathine penicillin G 2.4 million units IM for 3 doses at 1-week intervals (total 7.2 million units)</td>
<td>(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</td>
</tr>
<tr>
<td>All suspect syphilis cases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call the STD Program at (617) 983-6940 for past titers and treatment.</td>
<td></td>
<td></td>
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<tr>
<td>Neurosyphilis</td>
<td>• 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</td>
<td>(Procaine penicillin G 2.4 million units IM once daily PLUS probenecid 500 mg orally 4 times a day, both for 10-14 days)</td>
</tr>
<tr>
<td>Ocular syphilis</td>
<td>• Benzathine penicillin G 50,000 units/kg IM once, up to adult dose of 2.4 million units</td>
<td>No specific alternative regimens exist.</td>
</tr>
<tr>
<td>Adult Primary, secondary or early latent (&lt;1 year)</td>
<td>• Benzathine penicillin G 50,000 units/kg IM once, up to adult dose of 2.4 million units</td>
<td></td>
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<tr>
<td>Late latent (&gt;1 year) or latent of unknown duration</td>
<td>• Benzathine penicillin G 50,000 units/kg IM once, 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)</td>
<td></td>
</tr>
<tr>
<td>Congenital syphilis</td>
<td>See complete CDC guidelines.</td>
<td></td>
</tr>
<tr>
<td>HIV Infection</td>
<td>Same stage-specific recommendations as for HIV-negative persons.</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergio should be desensitized and treated with penicillin. Treatment is the same as in non-pregnant patients for each stage of syphilis.</td>
<td></td>
</tr>
</tbody>
</table>

GONOCOCcal infections

<table>
<thead>
<tr>
<th>ADULTS, ADOLESCENTS AND CHILDREN &gt;45 KG</th>
<th>Pharyngeal, Urogenital, Rectal</th>
<th>Ceftriaxone 250 mg IM once PLUS³</th>
<th>Azithromycin 1 g orally once</th>
</tr>
</thead>
</table>

Note: Use of an alternative regimen for pharyngeal gonorrhea should be followed by a test-of-cure 14 days after treatment.³ For urogenital or rectal infections ONLY, and ONLY if ceftriaxone is not available: ⁴ • 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: • Gemiifloxacin 320 mg orally once OR • Gentamicin 240 mg IM once PLUS ³ • Azithromycin 2 g orally once

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.