

Commentary

Cervical cancer screening in transgender men and non-binary people with a cervix

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Abstract

Mortality from cervical cancer is projected to decline over the next several years; however, this estimate relies on the inclusion of all eligible individuals in screening processes. This requires a robust understanding of barriers to routine screening, especially in at-risk populations such as transgender men and those across a trans-masculine spectrum. Barriers include miseducation surrounding screening protocols, distrust in the healthcare system, and histological inadequacy of samples obtained. These barriers can be addressed through proper education of both practitioner and patient, appropriate signage and outreach, and adjustments to clinical practices to meet evolving guidelines.

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Introduction

In the era of modern medicine, it can be tempting to place a healthy amount of reliance on preventative health protocols and regimes, and there have certainly been drastic benefits seen from implementation of routine screening and vaccination programs. Cervical cancer is one such example, and mortality from cervical cancer is projected to continue declining over the next several years (1). Still, this hardly equates to the diagnosis being eliminated. This projected decrease relies on both continued HPV vaccination programs and participation in screening practices by all eligible individuals. When the more minute details of this plan are examined, cracks start to appear. One of the largest gaps is the inclusion of transgender men (TM) and non-binary individuals with a cervix in these programs. It is becoming more broadly recognized that cervical cancer screening should be conducted in everyone with a cervix regardless of gender, and, while Ontario Cancer screening guidelines have changed their verbiage to reflect this, practical data show that this is not implemented equally (1,2). This commentary aims to highlight the importance of cervical cancer screening in all individuals with a cervix, covers details that are glossed over in medical school curricula (3), and primes readers to future developments in the field.

Cervical cancer screening in transgender men

Cervical cancer screening practices should be applied uniformly to all individuals with a cervix, including in TM with a cervix. It has been previously reported that approximately 21% of TM have undergone gender-confirming total hysterectomies, thus 79% of patients require regular cervical cancer screening. These screening practices should be offered to TM patients regardless of history of penetrative vaginal intercourse (1). This is in part since HPV vaccination rates are lowest in TM, with a prevalence of only 20% (4). Overall, TM patients are up to 18% less likely to receive routine cervical cancer screening in comparison to cis women. This can be due to lack of education on the part of both patient and practitioner, discomfort or distrust in the healthcare system, or exclusion from systemic screening programs that use patients' health records if they've legally changed their sex to male (5).

The rate of inadequate samples in TM is eight times greater than for cis females (6). This is attributed to scant cellularity and vaginal atrophy from use of androgen therapy. Temporary use of vaginal estrogen one to two months prior to the examination can be considered after discussion between the patient and their healthcare provider. Following an inadequate result, the average length of time before a repeat sample is taken has been found to be significantly longer for TM when compared to cis females, further increasing the risk for a true abnormal cytology finding to go undetected for a longer period (6).

Inclusive healthcare strategies

There are several steps that can be taken by healthcare providers to combat this issue. Care should be taken to create a structurally affirming clinic environment. This includes the entire duration of the patient experience, from front-of-house signage to the procedure itself to follow-up afterwards. A safer and more supportive clinic space can be developed by encouraging cultural competency training for all staff, ensuring that indicated pronouns and names are used and that gender-neutral bathrooms are available, and avoiding cisgender assumptions (for example, on intake forms, and for clinic names such as “Women’s Health” clinics). Practitioners should take care to minimize patient distress during sensitive exams. Important considerations include the use of neutral language (Table 1) and trauma-informed care and examinations, as well as the use of non-interfering lubricant and a smaller-sized speculum as needed (6). It is important for practitioners to recognize that pelvic exams hold the potential for re-traumatization of TM patients in addition to the physical discomfort of the exam. This can come from heightened emotions related to gender dysphoria due to the exam itself, language used, or the menstrual-like spotting that is common after a cervical cancer screening (6).

Table 1. Examples of non-sexualized language for use during pelvic examinations

| <i>Gendered/Negative Connotation</i> | <i>Neutral/positive connotation</i> |
|--|---|
| Vulva | External pelvic area |
| | Outer genitalia |
| Labia | Outer folds |
| Vagina | Genital opening, frontal pelvic opening, internal canal |
| Uterus, ovaries | Internal organs |
| Pap smear | Cancer screening |
| | Cancer, HPV-related cancer |
| Period/Menstruation | Bleeding |
| Stirrups | Footrests |
| “Scoot down until your bottom touches my hand” | Ask patient to move to the end of the table |
| “Open your legs” | “Let your legs drop to either side” |
| | “Point your knees to the wall” |
| “Blades of the speculum” | “Bills of the speculum” |
| “I’m going to insert the speculum” | “Opening the speculum” |
| “You’re going to feel a little poke” | “You may feel some pressure” |

Adapted from Potter et al. (7,8)

HPV DNA testing

Practitioners and medical trainees alike should be aware of alternate options to Pap smear screening, and that provincial guidelines around cervical cancer screening are quickly evolving. Emerging evidence reveals that HPV DNA testing is more sensitive than traditional testing with Pap smears (9). It can be self-collected and is thus less invasive, providing a more comfortable experience for some patients. While self-swab HPV tests are not yet approved in most provinces, this is expected to change in the next years. Ontario Cervical Cancer guidelines already acknowledge that this change is coming and that recommendations will be shifting. There is not yet a timeline in place, however, and this remains an area of future advancement. Current guidelines do not specifically include transgender patients as a patient population where testing beginning at the age of 21 is indicated; instead, inclusion criteria in accordance to the most recent provincial guidelines should be applied to these patients (2).

Conclusion

Trans health remains an overlooked aspect of the medical school curriculum, and the changes that are made for current students will take years to be fully implemented. It is essential for practitioners to remain updated on current guidelines and barriers to implementation to adequately treat their patients. TM are less likely to be up to date on cervical cancer screening, and barriers to this are multifactorial, including inadequate histology of samples, avoidance on part of the patient, physician experience, and education of both parties. Strategies to address these barriers include prioritizing affirming clinic experiences for patients and ensuring practices reflect updated guidelines.

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Author biographies

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