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LGBTQ+ Care for the Internist

LGBTQ+ 101

Jonathan S.Appelbaum, MD, FACP,AAHIVS
New Hampshire Chapter ACP Meeting
October 25, 2019





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Disclosures

Consulting: Merck and Viiv Healthcare



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Learning Objectives

- Identify disparities and health issues of LGBTQ+ patients
- Compare and contrast specific sexual health needs of LGBTQ+ patients
- Describe how to overcome barriers to provide better care to LGBTQ+ people



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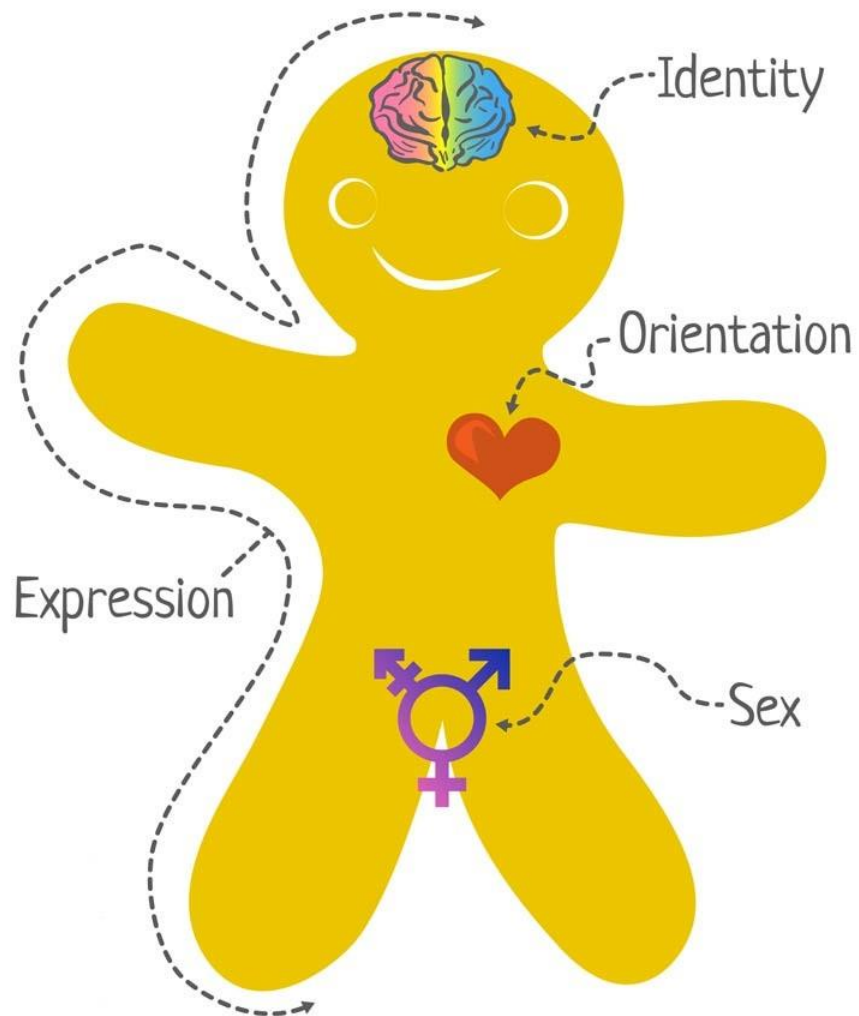
Knowing the Vocabulary

- Sexual Orientation
 - Homosexuality
 - Heterosexuality
 - Bisexuality
- Gender Identity (Sex vs. Gender)
 - Cisgender
 - Transgender
 - Transsexual
- Fluidity: Queer/Questioning



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The Genderbread Person



Gender identity is how you, in your head, think about yourself. It's the chemistry that composes you (e.g., hormonal levels) and how you interpret what that means.



Gender expression is how you demonstrate your gender (based on traditional gender roles) through the ways you act, dress, behave, and interact.



Biological sex refers to the objectively measurable organs, hormones, and chromosomes. Female = vagina, ovaries, XX chromosomes; male = penis, testes, XY chromosomes; intersex = a combination of the two.



Sexual orientation is who you are physically, spiritually, and emotionally attracted to, based on their sex/gender in relation to your own.



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Case 1: Joseph

Joseph is a 19 y/o DC freshman

- 3 days of dysuria and discharge
- Healthy, all immunizations UTD
- Takes no meds
- EtOH on weekends, some marijuana, no IDU

What additional history do you need?



- Sexual history:
 - “questioning”
 - First same-sex sexual encounter last weekend when he was drunk
- Substance use history



- After physical exam, what labs?
 - Urine NAAT for GC/chlamydia
 - Other sites depending on sexual activity
 - For MSM, 3-site testing should be considered
 - RPR
 - 4th generation HIV Ag/Ab
- Would you refer for counseling?
 - “coming out”
 - Substance use



What about PEP/PrEP

- PEP

- window if 72 hrs after sexual activity
- Only high risk: receptive anal/vaginal>insertive anal/vaginal>oral
- Requires 28 d of THREE antiretroviral drug

- PrEP

- High risk:
 - MSM (anal), partner unknown serostatus, serodiscordant couples, mult. partners
 - Heterosexual: mult. partners, serodiscordant
 - IDU



PrEP

- HIV-negative (should use 4th gen Ag/Ab test)
- Safety labs
- Only give 3-month supply
 - Recheck HIV test and STI screen each visit
- We now have TWO drugs available for PrEP
 - Additional, longer-acting meds in the pipeline



Treatment

- What treatment would you give Joseph?
- Would you treat now or wait for culture results?
- If cultures are positive, what about partner notification?
- What counseling would you give Joseph regarding sex?



Case 2: Julian

- Julian is a 62-year-old man infected with HIV for 25 years seen for follow up. His last HIV RNA was < 20 copies/ml and CD4 count 525.
- **Current medical conditions:** Hypertension, type 2 DM, hyperlipidemia
- **Medications:** ART (dolutegravir + tenofovir alafenamide/emtricitabine), metformin/sitagliptin, lisinopril, aspirin, atorvastatin
- **FH:** Brother lives in another city, no children. Father died of MI at age 52, mother is in a nursing home with Alzheimer Disease



Case 2: Julian

- **SH:** Lives alone, MSM but rarely sexually active. Former smoker, social EtOH, occasional poppers and marijuana, no injection drugs, works at a local bank. Has few friends outside of work.
- **ROS:** Some chest tightness when he runs, occasional ankle edema at the end of the day, has ED and decreased libido, has insomnia—reports early morning awakening



Exam

- Overweight male, looks stated age
- BP 152/92, P 76, RR 12, afebrile
- HEENT: no thrush, no adenopathy
- Lungs: clear
- Heart: S4 S1 S2 grade 1/6 systolic murmur at upper RSB, no radiation
- Abdomen: no tenderness, no organomegaly
- Ext: good pulses, 1+ edema bilaterally



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Baseline Labs

- CD4 655 cells/mm³
- HIV RNA undetectable
- CBC, CMP normal
- TC 225 mg/dL, HDL-C 35 mg/dL
- HBA1C 7.8%
- Total testosterone 156 ng/dL (normal > 250 ng/dL)



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Polling Question

More than half of those infected with HIV are now over the age of 50, soon over 60. Why do you think that almost 20% of NEW HIV infections occur in people over the age of 50?

- a. Lack of provider awareness
- b. Decreased screening
- c. Lack of targeted prevention strategies
- d. Perceived lack of risk factors
- e. All of the above



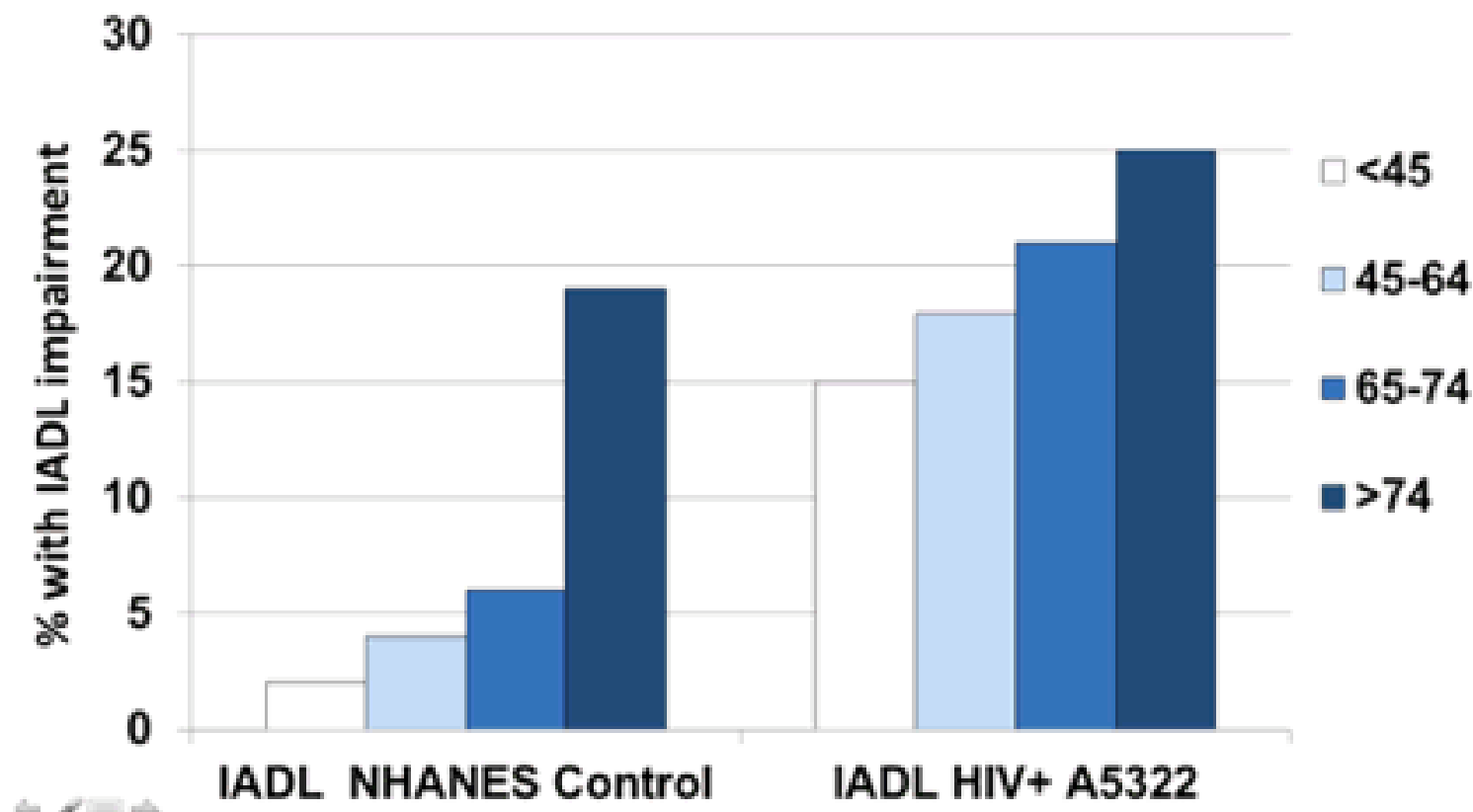
Does Julian have CAD?

- **He has multiple risk factors**
- **Can we calculate his cardiac risk?**
 - Both FRS and ACC/AHA underestimate risk in patients with HIV
 - ACC/AHA 10-yr risk of CAD would be 37.2%
- **How would you approach the evaluation and treatment of his chest pain?**



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Impairment by Age, Compared to NHANES Controls

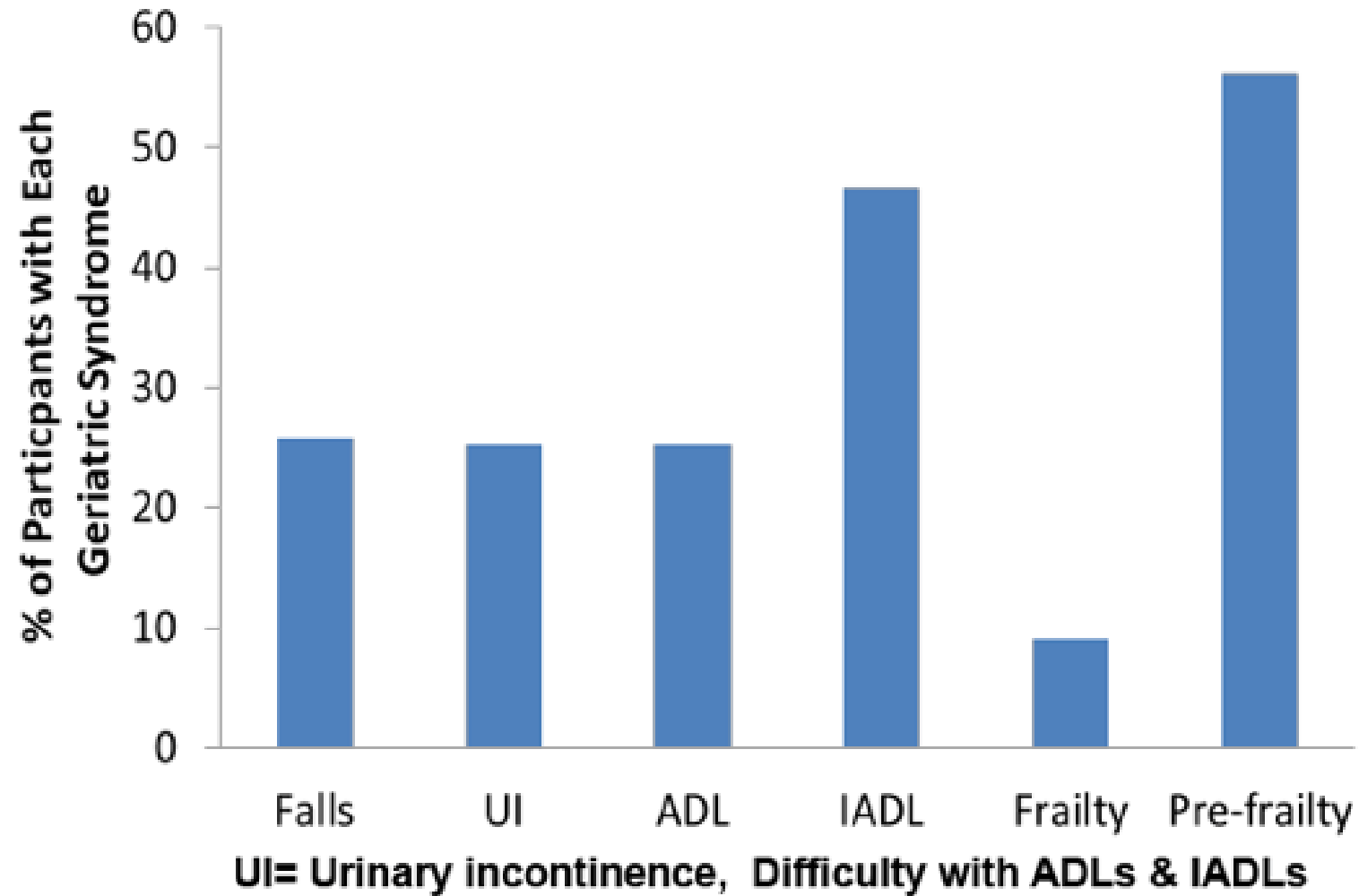


KM Erlandson, K Wu, R Kalayjian, S Koletar, B Taiwo, FJ Palella Jr, K Tassiopoulos and the A5322 Team
7th International Workshop on HIV and Aging, September 26-27, Washington, DC



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Figure 1. Frequencies of Geriatric Syndromes





Multimorbidity

Definition: multiple chronic conditions that interact to worsen health outcomes

- More common in older patients with HIV due to intersection of disease, lifestyle risk factors, polypharmacy, chronic inflammation and immune activation
- Associated with increased mortality, frailty
- Impact of single disease treatment impacts overall health of patients with multimorbidity

“the whole is more than the sum of the parts”



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Does HIV Accelerate Aging?

Conditions: CAD, osteoporosis, frailty, dementia

- For (accelerated)
 - Multivariate analysis indicates HIV is an independent risk factor
- Against (accentuated):
 - Higher excess and age-adjusted rates, but did not occur earlier than general population



Back to Julian

Behavioral Health

- His PHQ-2 screen positive:
 - Complete PHQ-9
- Depression associated with HIV, hypogonadism, diabetes
- What factors contribute to this:
 - Social isolation
 - Stigma: HIV, internalized homophobia
 - Age
 - SES, education?



Prevention and Screenings

- Colon cancer screening (A): over age 50, with at least 10-year life-expectancy
- Vaccinations: PCV 13, PPSV 23, influenza, zoster, Tdap, hepatitis
- AAA screening: Not until age 65
- Lung cancer (B): > Age 50, more than 30 pack-yr
- Osteoporosis: More later
- Prostate: Controversial
- HCV (B), syphilis (A)
- Advance directive



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Julian: Geriatric Approach to Care

Biopsychosocial

- Consider multimorbidity
- Prioritize his care:
 - Evaluate his CAD and depression before multiple preventative procedures
 - Engage community services
- Evaluate and balance the risk-benefit of interventions:
 - Treatment of hypogonadism balanced against increase risk of CAD



Case 3 – The First Visit

- Abigail & Elizabeth (ages 62 and 64) present to your office for a new patient visit
- Relocated to your community from the city seeking a quieter life
- Readily share with you their long-term relationship of 20 years



Negotiating an Agenda

- Abigail wants to discuss her right knee pain
 - Knee pain
 - Weight management
- Elizabeth has no particular complaints
 - hypertension and dyslipidemia
 - history of smoking
- Abigail wants to discuss some concerns she has about Elizabeth



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Reflection Question

How would you approach this situation?



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What should be your focus?

- USPSTF recommendations
- Lifestyle modifications for Abigail
- Abigail's concerns about Elizabeth and related issues
- Supporting your new patients and their relationship



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Just like any other woman

- Breast cancer screening
- Cervical cancer screening
- Colon cancer screening
- HIV testing
- Cardiovascular health (blood pressure, lipids)
- Depression
- Hepatitis C screening
- Immunizations



Impact on Health by Sexual Orientation

LB women have a greater prevalence of risk factors for breast cancer¹⁻³

- Nulliparity, lower rates of abortion, fewer pregnancies, lower rates of breastfeeding, and older age at first childbirth
- Higher rates of obesity, smoking, and alcohol

Rates of breast cancer⁴

- Greater age-adjusted risk for fatal breast cancer (RR=3.2, CI 1.01-10.21)
- No difference in overall risk for mortality

1. Cochran SD, Mays VM, Bowen D, et al.. *American journal of public health*. Apr 2001;91(4):591-597.

2. Case P, Austin SB, Hunter DJ, et al.. *Journal of women's health*. Nov 2004;13(9):1033-1047.

3. Brandenburg DL, Matthews AK, Johnson TP, Hughes TL *Women & health*. 2007;45(4):109-130.

4. Cochran SD, Mays VM. *Journal of women's health*. May 2012;21(5):528-533.



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Improving Abigail's Diet

Patient concerns

- Neither woman is working now
- Finances are tight
- Meals often consist of frozen meals or fast food
- Express concerns about affording fresh fruits and vegetables, healthy proteins, and whole grains

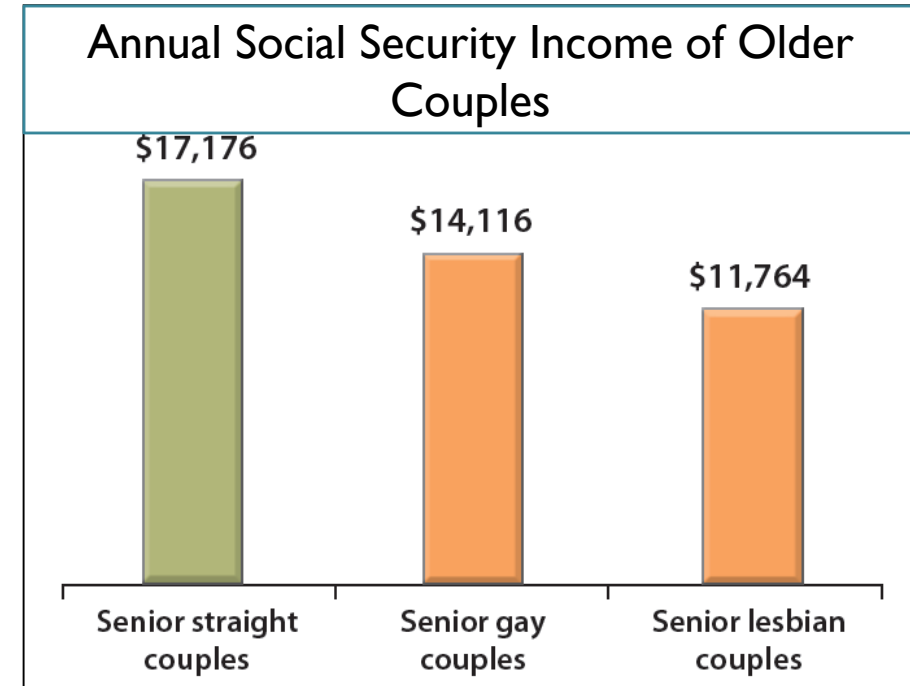
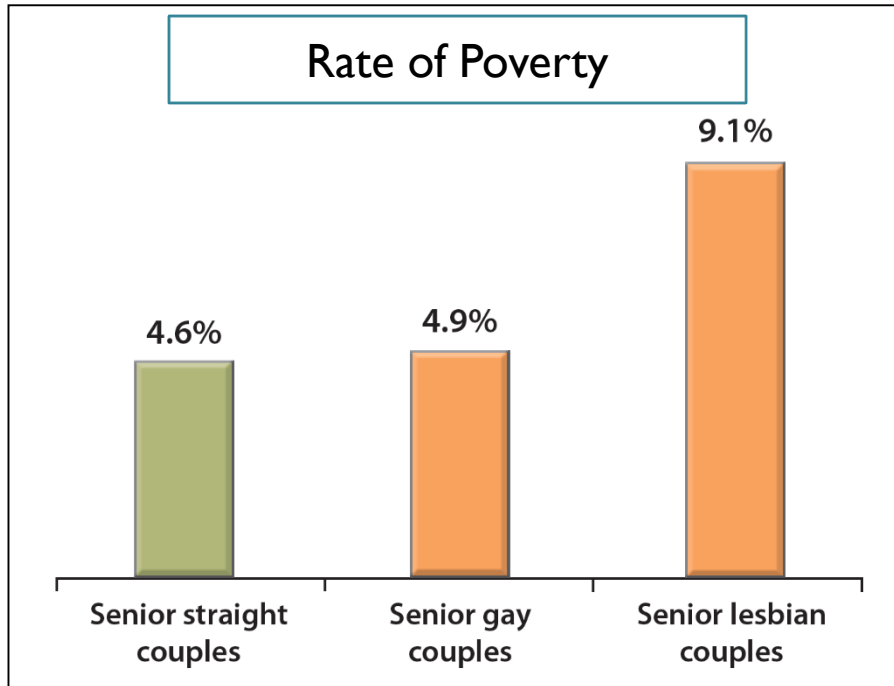
Provider perspective

- Understand local resources and appeal to multidisciplinary team



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Demographics of Older Adults





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Elizabeth's New Diagnosis

- Abigail shares concerns about Elizabeth's impaired memory and disorientation
- MoCA shows "cognitive impairment"
- You suspect early vascular dementia
- Family support is lacking



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Reflection Question

How should you advise them
regarding future health care?



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The Health Implications of Legal Protections

- Abigail and Elizabeth are not legally married
- Deprived of many health-related benefits of this recognition
 - Helps protect and promote the mental & physical health of lesbians and gay men
 - Helps protect and promote the health of children being raised by lesbians & gay men
 - Helps protect and promote the health of aging lesbian & gay individuals

Gay and Lesbian Medical Association. Same-Sex Marriage and Health.

<http://glma.org/document/docWindow.cfm?fuseaction=document.viewDocument&documentid=146&documentFormatId=236>. Accessed 10/14/19.



Case 4: Jamie – A New Patient

- 60-year-old transwoman
- Transitioned 35 years ago. Has had both “top” and “bottom” surgery
 - No longer on gender-affirming HT
- Happily married to 2nd husband – who does not know her history
- Several episodes of gross hematuria, treated as UTIs in past



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Evaluation and Work-up

- What physical exam would you do?
- What lab tests would you order?



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- On exam:
 - Well appearing woman
 - Rectal: large irregular prostate
 - UA: gross hematuria
- PSA >500
- Cystoscopy: tumor invading bladder wall
- Underwent XRT with good results



Polling Question

A 28-year-old transwoman has come to your office to establish care. She recently moved to the area. She began taking estradiol and spironolactone 5 years ago and reports feeling well. She does not wish to undergo any gender-affirming surgery. She does not smoke, use alcohol or any recreational drugs.



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**What additional items need to be included
in your evaluation of this patient?**

- A. Organ inventory
- B. Pelvic and Pap smear
- C. Contraception discussion
- D. Surgical referral



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**What additional items need to be included
in your evaluation of this patient?**

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**BEST PRACTICES: HOW TO
PROVIDER BETTER CARE TO
YOUR LGBTQ+ PATIENTS**



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Creating a Caring and Inclusive Environment

- Are clinicians and staff taught about the health needs of LGBTQ+ people?
- Do LGBTQ+ employees feel respected and safe at work?
- Do forms reflect the full range of sexual and gender identity and expression?
 - **Use “Two-Step” process to collect gender information**





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2-Step Process for Obtaining SO/GI

- What was your gender assigned at birth?
 - Biologic sex
- With what gender do you currently identify?
 - Gender Identity



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Adding Affirmative Imagery and Content to Education and Marketing Materials





Taking a History

- The core comprehensive history for LGBTQ+ patients is the same as for all patients (keeping in mind unique health risks and issues of LGBTQ+ populations)
- Get to know your patient as a person (e.g., partners, children, jobs, living circumstances)
- Use inclusive and neutral language
 - **Instead of:** “Do you have a wife/husband or boy/girlfriend?”
 - **Ask:** “Do you have a partner?” or “Are you in a relationship?” “What do you call your partner?”
- For all patients
 - Make it routine
 - Make no assumptions
 - Not to be equated with learning about LGBTQ+ health



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Discomfort as a Barrier

“Ironically, it may require greater intimacy to discuss sex than to engage in it.”

The Hidden Epidemic
Institute of Medicine, 1997

Ask Screen Intervene



Making Patients Comfortable, Setting the Context

- *"I am going to ask you a few questions about your sexual health and sexual practices. I understand these are very personal, but also important for your overall health."*
- *"I ask these questions of all my adult patients. Like the rest of our visit, everything we discuss is confidential."*
- *"Do you have any questions?"*



Taking a Sexual History

- Ask about behavior and risk – **NOT about labels**
 - *Have you had sex with anyone in the last year?*
 - ***What gender is/are your sexual partner(s)?***
 - *How many partners did you have?*
- Ask about sexual health
 - *Do you have any concerns about your sexual function?*
 - *How satisfied are you sexually?*
 - *Have you had any changes in sexual desire?*
 - *Ask about sexual abuse and trauma and trading sex for money, etc.*
- Ask about reproductive health and desires
 - *Traditionally, discuss contraception*
 - *Discuss desires to have children and methods - surrogacy, adoption*



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Why gather data on sexual orientation and gender identity?

- Increases ability to screen, detect, and prevent conditions more common in LGBTQ+ people
- Helps develop a better understanding of patients' lives
- Patients may feel safer discussing their health and risk behaviors once they've been asked, even if they haven't disclosed
- Allows comparison of patient outcomes within health care organizations and with national survey samples of LGBTQ+ people

If we don't ask, who will?



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Polling Question

LGBTQ+ persons are a population of patients that are subjected to health disparities. Which of the following is the most common health disparity for lesbian and bisexual women?

- A. Bullying
- B. Access to quality healthcare
- C. Intimate partner violence
- D. Anorexia



LGBTQ+ persons are a population of patients that are subjected to health disparities. Which of the following is the most common health disparities for lesbian and bisexual women?

- A. Bullying
- B. **Access to quality healthcare**
- C. Intimate partner violence
- D. Anorexia



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Special Thanks

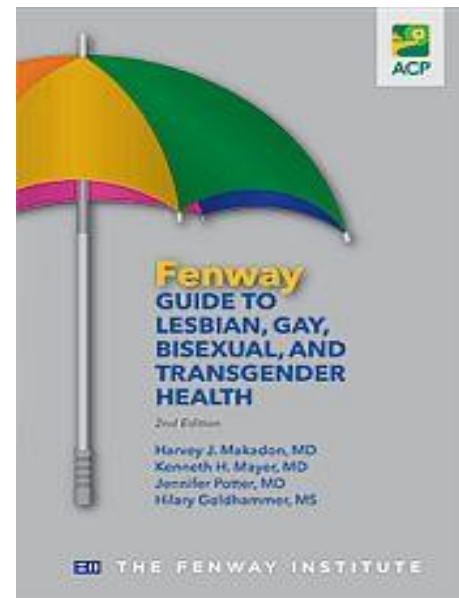
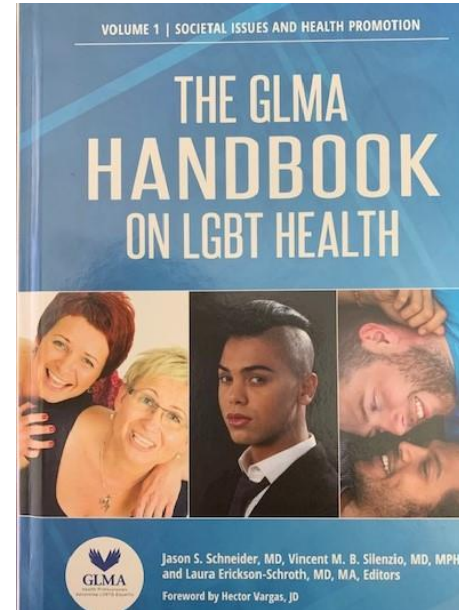
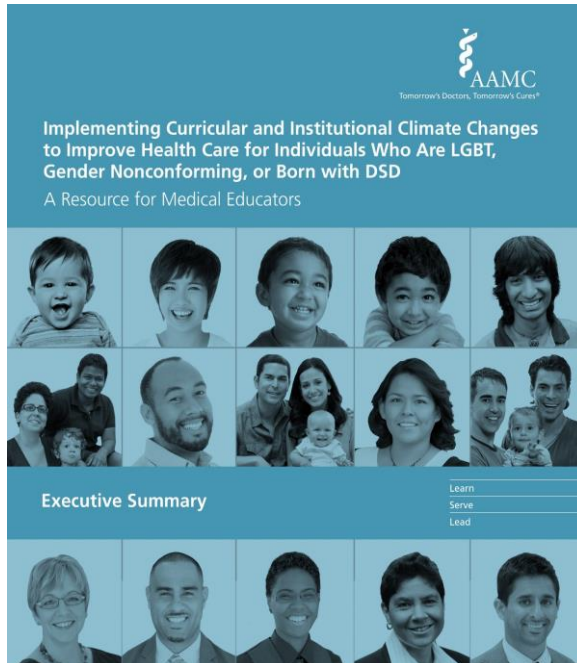
- AAMC AXIS Committee
- Jason Schneider, MD
- National LGBT Health Education Center

Remember: Monday, October 28 is
National Internal Medicine Day
#NationalInternalMedicineDay and #IMProud

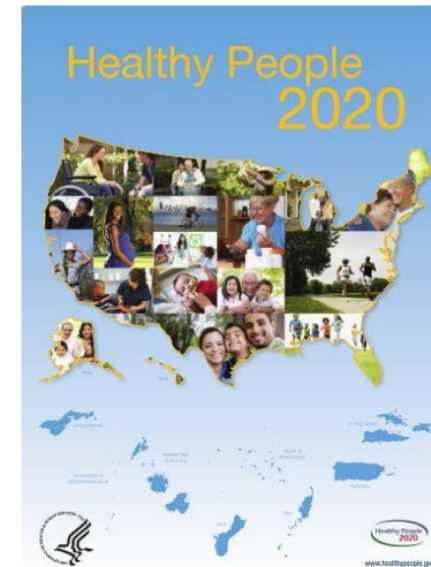


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Further



Information



NIH NATIONAL LGBT HEALTH
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