AUA Update Series 2020
Lesson 35 Volume 39

Caring for the LGBTQI Urology Patient*

Learning Objective: At the conclusion of this continuing medical education activity, the participant will be able to describe how providing care for LGBTQI patients may differ from heterosexual patients and why this patient population deserves further study. The participant will be able to characterize overarching psychosocial and cultural differences among LGBTQI patients that influence their health care, and will be able to address LGBTQI patients.

Billy H. Cordon, MD
Disclosures: Boston Scientific, Coloplast: Consultant/Advisor
Assistant Professor
Director of Urologic Reconstruction, Trauma & Prosthetics
Columbia University Division of Urology at Mount Sinai Medical Center
Miami Beach, Florida

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Release date: November 2020

Expiration date: November 2023

American Urological Association
Education and Research, Inc.
1000 Corporate Boulevard
Linthicum, MD 21090

Key Words: sexual and gender minorities

INTRODUCTION

The term "LGBTQI" refers to lesbian/gay/bisexual/transgender/queer/intersex. The term "queer" was originally a pejorative term against people of same-sex orientation, particularly gay men, that was later reclaimed by the LGBT community as an umbrella, non-cisgender, non-heteronormative and non-homonormative term to include all members of sexual and gender minorities.[1] **Often LGBTQI patients are lumped into a single category, although they are all very different. Furthermore, a gay male has more in common with a heterosexual male than he does with a transgender male or lesbian.** This Update serves as a primer for taking care of LGBTQI patients with a urological focus and not as an all-encompassing guide. Data on LGBTQI patients are currently limited. However, a movement to decrease health care disparities for this group has led to ongoing and increased research.

Recently the CDC's National Center for Health Statistics added questions regarding sexual orientation to its National Health Interview Survey. **According to the 2013 data collected on 34,557 adults aged 18 or over, 96.6% of adults identified as straight, 1.6% as gay or lesbian, and 0.7% as bisexual.[2] The remaining 1.1% of adults identified as "something else," stated, "I don't know the answer" or refused to provide an answer.** This is consistent with other recent and large data sets, which estimate 1%–2.3% of adults identify as gay or lesbian and 0.7%–2.9% as bisexual.[3]

There is great variability in sexual expression among LGBT individuals, and it can be helpful to understand their sexual behaviors. Often their expression will not completely correlate to their orientation. For example in 1 study 70% of self-identified lesbians reported engaging in sexual relationships with men, and as many as 6% of lesbians reported a male partner within the last year.[4] Additionally there is a population of men who identify as heterosexual who engage in sexual activities with other men. Data from the 2011–2013 National Survey of Family Growth comparing sexual orientation to sexual behavior in adults 18–44 years old are summarized in figure 1.[5] **For these reasons in the medical literature we often use "men who have sex with men" and "women who have sex with women" to describe same-sex behavior.** Throughout this Update for simplicity we will use LGBT, MSM and WSW to describe non-heteronormative sexual and gender minorities.

There are certain psychosocial factors of the LGBTQI community we should understand that ultimately are intertwined in various facets of health care and call for a more sensitive approach. These factors will be explored in more depth below as they emerge in relation to urological care. Briefly LGBT patients are more likely to engage in higher risk taking behaviors, have multiple sex partners, have increased substance abuse rates, and at baseline have increased rates of depression and/or suicide.[6–8] Additionally they are less likely to be in stable relationships, less likely to have social support systems and less likely to have access to medical care.[9,10] It is within this context of psychosocial factors that we will take care of LGBT patients. These factors will influence everything, for example from risk factors for LUTS to decreased health related quality of life outcomes after prostate cancer treatment.

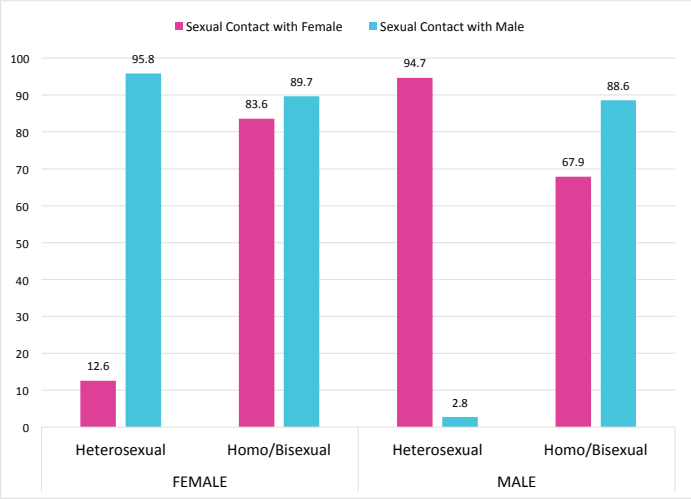

Figure 1. Sexual contact among men and women 18–44 years of age in United States, 2011–2013, based on self-identified orientation. Homosexual and bisexual respondents have been grouped together. Sexual orientation and sexual behavior are closely associated but not perfect. In this survey 12.6% of "straight" women reported same-sex contact, and 2.8% of "straight" men reported same-sex contact. Data Source: CDC/National Center for Health Statistics, National Survey of Family Growth, 2011–2013.

TALKING TO LGBT PATIENTS

A long history of stigmatization and homophobia has led to health care disparities for LGBT patients and a mistrust of medicine as an institution by the community. Often patients themselves have had a negative prior experience and so may be reluctant in disclosing their sexual orientation or may feel uneasy about discussing their sexual concerns.[11] In order to provide adequate care, patients need to be honest with the provider and it is incumbent on us to make them feel comfortable, without feeling that they are being judged.

Taking care of LGBT patients does not end or begin with the provider, but encompasses the institution, the office, nurses and ancillary staff from the moment a patient checks in. Patients most of the time will not self-identify if not directly asked for fear of judgment.[12] Although at times the patient and/or provider may think sexual orientation is of no consequence, the patient's sexual behaviors can actually be important more often than one would think. Even as sexual health care providers, we do a poor job of asking or inquiring about patient's sexual

ABBREVIATIONS: AD (anodyspareunia), CDC (Centers for Disease Control and Prevention), ED (erectile dysfunction), LGBT (lesbian, gay, bisexual, transgender), LGBTQI (lesbian, gay, bisexual, transgender, queer, intersex), LUTS (lower urinary tract symptoms), MSM (men who have sex with men), MTF (male to female), PD (Peyronie's disease), PDE5-I (phosphodiesterase-5 inhibitor), PE (premature ejaculation), PrEP (preexposure prophylaxis), PSA (prostate specific antigen), STI (sexually transmitted infection), UTI (urinary tract infection), WSW (women who have sex with women)

behaviors.[13] We should not assume we will offend the patient by asking. We should ask in a routine, matter-of-fact way without judgment. Examples of some questions that may be used to elicit a sexual history are shown in figure 2. **When interviewing a patient, using the term "partner" early on may clue the patient in that you are not judgmental to non-heteronormative relationships.** By starting with "women" when asking "women, men or both," it prevents potentially insulting the heterosexual male patient. The MSM patient will simply be relieved and/or happy you are asking. "How often do you not wear protection?" gets a more honest answer than, "Do you always practice safe sex?" These questions should come off as routine history taking questions without any judgment. It may take practice and time for you as a provider to become comfortable asking. Patients will sense whether you're uncomfortable and will reflect that emotion. We must feel comfortable in order to make them feel comfortable.

SEXUAL BEHAVIOR AND HEALTH

Knowing specific sexual behaviors can be more important than labels themselves. Don't assume anything regarding patients and sex. **For example although anal intercourse is more often practiced by MSM, there are some MSM who *do not* practice anal intercourse and there are some heterosexual men who *do* practice anal intercourse.** Additionally some lesbians may still engage in intercourse with men. Sexual behaviors pose different risks to patients and it is important to understand these at times, regardless of labels.

Sexually transmitted infection screening in MSM. Most would assume STI screening is simple; however, even something as "simple" as STIs can differ significantly. We will demonstrate some of these differences before diving into the more complex sexual dysfunction that is laden with psychosocial complexities.

For example in MSM, aside from screening for HIV, syphilis, urethral gonorrhea and chlamydia, screening should also include anorectal swabs and oropharyngeal swabs for gonorrhea and chlamydia if the patient engages in anal receptive intercourse and oral intercourse, respectively, with other men. City clinics or providers who cater to LGBT patients and communities will often obtain the additional swabs but otherwise most practices miss this point. **According to CDC guidelines, MSM should be screened at least annually, regardless of condom use, at all contact points, i.e. urethra, rectum and pharynx.[14] Additionally MSM who are deemed higher risk, such as those who have multiple sex partners, should be screened more frequently, i.e. every 3–6 months.** In contrast, screening of *heterosexual men* is indicated in high prevalence clinical settings such as adolescent clinics, STI clinics or correctional facilities. It is likely that in heterosexual men screening occurs less often as men get older and testing is more likely to occur only if symptomatic.

Something even more likely to get missed is giardiasis. Although the first reported association of giardiasis and homosexuality was published in 1978,[15] there currently exist no recommendations for screening for this protozoan infection despite multiple reports over the years of MSM populations presenting with giardia. **Giardiasis is spread via the fecal-oral route and infections occur even with a small inoculum of cysts.[16] Infections do not always present with severe diarrhea, but rather can have mild symptoms, lay indolent and become a chronic infection with ongoing malabsorption.** These chronic infections may go undetected, allowing inoculation of other sex partners. Polymerase chain reaction testing is more sensitive than microscopy testing and should be used for detecting giardia when suspected.[17]

Another pathogen transmitted ano-orally is shigella. Shigellosis is recognized by the CDC as a pathogen that afflicts MSM that can be transmitted via sexual contact. Shigella outbreaks among MSM have been reported since 1999 and, unlike routine shigellosis, MSM are more likely to contract strains with antibiotic resistance. Various strains resistant to ciprofloxacin, ceftriaxone and azithromycin have been detected.[17] Given the potential for antibiotic resistance, polymerase chain reaction should *not* be used when shigella is suspected in adults, and instead stool cultures with susceptibility to guide appropriate antibiotic coverage are preferred. **Additionally both providers**

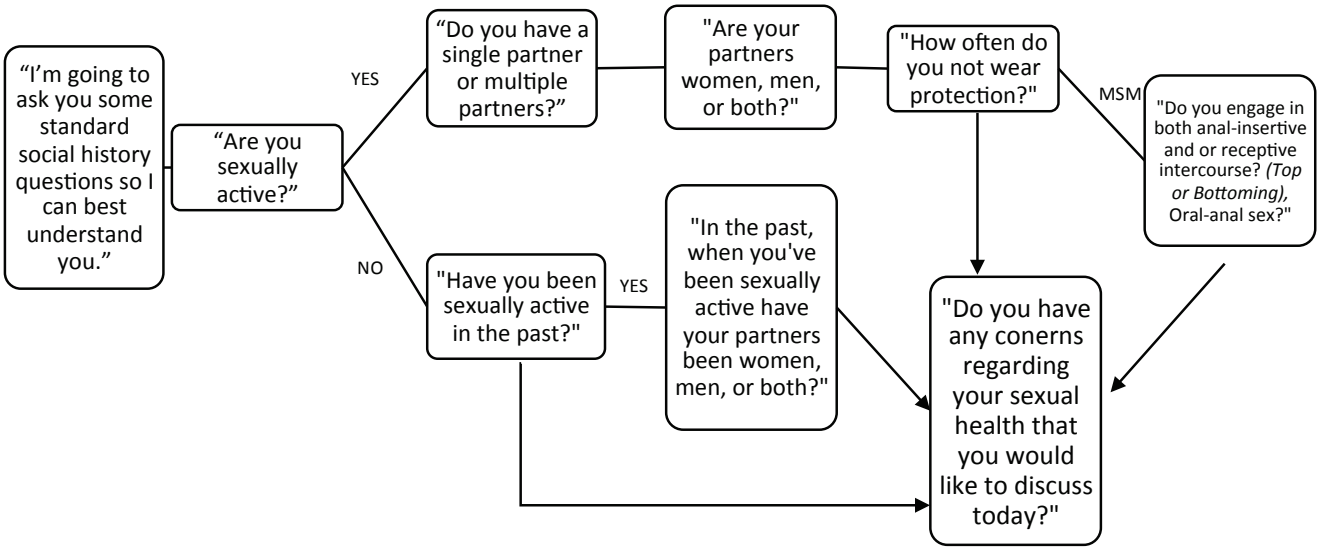

Figure 2. Suggested questions to use when eliciting sexual history in order to obtain information regarding sexual behaviors in non-judgmental manner.

and the LGBT community need education regarding shigella as a potentially sexually transmitted infection. For adults with suspected shigellosis clinicians should culture feces, obtain sex histories, discuss shigellosis prevention and choose treatment, when needed, according to antimicrobial drug susceptibility.[18]

Preexposure prophylaxis. **PrEP is the use of antivirals in HIV negative individuals to prevent acquisition of HIV.** Most often emtricitabine/tenofovir disoproxil fumarate (Truvada PrEP®) is used. However, more recently emtricitabine/tenofovir alafenamide (Descovy®) has been approved for PrEP. It is important for clinicians to be familiar with PrEP and not to stigmatize patients on it. **Despite the major advances in HIV treatment and care, we as a society have continued to stigmatize sexual behavior for the past 30 years, and ironically PrEP itself has also been stigmatized.[19]** PrEP is stigmatized for a few reasons. Truvada itself is also used in the treatment of HIV, and HIV negative patients may be confused for HIV positive. Its mere association with HIV can lead to a fear by patients of being confused for HIV positive. Additionally and more complex, PrEP is stigmatized because it technically facilitates the same *socially unacceptable behavior* that might lead someone to acquire HIV, i.e. unprotected sex. PrEP users are stigmatized for seemingly wanting to engage in "high risk" sexual behavior. **The irony is that PrEP offers more protection against HIV than do condoms. Sex with PrEP is statistically "safer" sex when it comes to HIV infection risk. The slow uptake and adoption of PrEP have been recognized to be due to its stigma.[18]**

Patients deemed at high risk for HIV acquisition may be offered PrEP, usually by their primary care provider, or may present to your clinic already on PrEP. **Patient adherence with PrEP has dramatically decreased the risk of acquiring HIV, has been found to be 99% effective and has *not* been clearly found to increase risk taking behavior.[20–22]**

The CDC has recommendations regarding indications, screening protocols, prescribing and monitoring involved with prescribing PrEP that are beyond the scope of this Update. However, providers should be aware that this is available, that some of their LGBT patients may be on these antivirals, and that these antivirals do not indicate HIV infection (which is often misdocumented in the chart) and may actually be a reflection of a responsible patient who is playing an active role in prevention. With regular 3-month visits required for PrEP it not only makes patients more committed to their own health care, but also increases access points by health care providers, allowing them to intervene on a variety of health issues, if needed, more often. Depending on which part of the country patients may be in, anecdotally patients have had difficulty in finding a provider willing to prescribe PrEP or have been met with antagonistic and judgmental remarks from health care providers when inquiring about PrEP.

SEXUAL DYSFUNCTION IN MSM

Research on sexual function in MSM is limited. In the past MSM have been excluded from large clinical trials studying sexuality in order to have a homogeneous population. Most research in MSM to date involved patients with HIV. Sexual dysfunction may be different between HIV positive and HIV negative MSM groups.

MSM are more likely to be in an open relationship or some variation of a "monogamish" relationship and have multiple sex partners. Because of this, sexual dysfunction may lead to more stress and/or anxiety with potential new encounters than that experienced by heterosexuals in stable monogamous relationships.[23–25] MSM are more likely to enhance or extend sexual experiences, are more likely to incorporate illicit drugs into sex and have higher rates of riskier behavior, including group sex and condomless sex.[26–29]

Erectile dysfunction. **ED appears to be more prevalent in MSM.** High rates of PDE5-I use have been reported in MSM, with some studies reporting use as high as 46%.[30] Barbonetti et al performed a systematic review and meta-analysis of ED.[31] The pooled odds ratios indicated that homosexual orientation was associated with 1.5 higher odds of reporting ED. Admittedly few studies met their inclusion criteria, and all the studies included did not evaluate men using a clinical assessment but were based on patient self-reporting. Even when taking into account publication bias, the pooled estimate still found a higher rate of ED in homosexual men compared to heterosexuals. Another study that surveyed medical students also indicated higher self-reported rates of ED for homosexual men compared to heterosexuals.[32] However, when accounting for partner/relationship status, that difference disappeared. This would tend to suggest that being in a stable relationship is protective against ED. Other studies suggest that being in a steady relationship, whether monogamous or open, is protective against having ED.[33, 34] Interestingly on multivariate analysis having the passive/bottom role or versatile role was associated with reporting more ED than the active/top role.[34] Anodyspareunia was also associated with less ED.

Although specific reasons for the different rates of ED between MSM and heterosexuals are hard to elucidate, various theories exist, ranging from psychological reasons such as competing masculinity, fears of HIV or anxiety perhaps with disclosing one's own status to biological reasons. In the era of PrEP HIV related anxiety ED should be less of an issue. Additionally perhaps individuals with varying degrees of erectile function self-select their sexual roles. Interestingly both AD and less ED is associated with the "top" role. **Certainly erectile rigidity required for anal penetration is likely higher than that needed for vaginal penetration.[11]** It is estimated that 20% more rigidity is required for anal penetration, and so patients may report unsatisfactory erections earlier on than heterosexual men. Furthermore, if MSM are engaging in enhanced or prolonged sexual experiences with substance abuse, they may require or want higher erectile function to perform.[35, 36]

Premature ejaculation. There is no clear relationship between sexual orientation and PE. However, there are no validated instruments to measure PE in MSM. Some studies suggest the incidence of PE is likely similar to heterosexual men or less,[31] while some estimate the true prevalence of clinical PE to be near 5%.[37] It is difficult to clearly define PE given potential differences in expectations of MSM, particularly if they tend to engage more often in group sex. **Additionally PE in MSM may occur not only with insertive anal intercourse, but in the receptive bottom while not stimulating his penis**. **PE in MSM would have to be defined in the context of these varying roles.**

Anodyspareunia. **Anal intercourse is practiced by both homosexual and heterosexual couples.** Also, although a greater proportion of MSM practice anal intercourse, not all do. Laumann et al estimated that about 20% of MSM do not engage in anal intercourse at all.[38] A certain proportion of men will suffer from AD. Although it is not uncommon, it can be

due to a variety of issues including psychological, physiological and/or situational. Vansintejan et al in 2013 adapted the Female Sexual Function Index pain domain for anal intercourse by substituting vaginal for anal and found that a large proportion of men suffer from AD.[39] In a large sample of 1752 Belgian MSM Vansintejan et al found 68% had recently engaged in receptive anal intercourse. Of those 59% suffered some AD, with 44% reporting that the pain was acceptable and 2% reporting that the pain was severe. Predictors included younger age, decreased frequency of sex, decreased number of partners, inadequate lubrication and lack of oral/digital stimulation. Participants rated inadequate lubrication and lack of oral or digitoproctic stimulation prior to penetration as the most important factors predicting pain.

Anal foreplay with adequate lubrication is essential in reducing AD. Foreplay is essential in allowing the anal sphincter to slowly accommodate the partner's penis while reducing anxiety and muscle tension. There is likely a difference in mild to moderate or situational AD vs AD that is lifelong, severe or nearly constant. Damon and Rosser evaluated AD and found that 13% of MSM had lifelong or severe AD that was troublesome to the individual.[40] This is more consistent with that seen in women with dyspareunia. Additionally Damon and Rosser found that a large proportion of these individuals will restrict themselves to only the active role in order to avoid AD.

Many MSM will use nitrites or "poppers" to decrease AD. Given the high use of PDE5-Is in MSM, it is important to educate patients on the dangers of mixing nitrites with PDE5-Is, as combining them could lead to severe hypotension. The predictors of AD in the survey by Vansintejan et al are possibly a reflection of a learning curve regarding "bottoming."[39] However, aside from the inherent factors related to the sphincter mechanism, other anorectal conditions such as anal fissures and trauma can lead to AD. Some MSM will opt to play the active or top role and avoid AD all together.

Peyronie's disease. **In the single study evaluating MSM and PD, the MSM group presented in a similar fashion to the non-MSM group.[41]** Of MSM 92.9% were self-conscious about their penis and 92.9% were dissatisfied with their penis size. Additionally these patients had presented on average to at least 2 prior physicians with complaints of PD, perhaps reflecting their proactiveness or, one might argue, distress regarding their sexual health.

No validated questionnaires currently exist for PD in MSM, as the Peyronie's Disease Questionnaire is inclusive of only vaginal penetration. **PD is known to be associated with high rates of anxiety and depression in heterosexuals.[42] One might further suspect higher rates of anxiety/depression in patients who engage in sex with multiple partners vs those in monogamous relationships.** Additionally penile length loss that often occurs with PD may be particularly more distressing for MSM.

Penile length. **Several studies suggest that penile length plays a more important role for MSM compared to heterosexuals.[43–46]** Some studies even suggest a difference in size between the 2 groups.[44] More importantly studies have found that perceived size can affect psychosocial health and can play a role in sexual behaviors. A study by Grov et al indicated that MSM with an "above average" penis fared better on a multifaceted score of psychosocial adjustment compared to those with a penis considered "below average."[46] It was also noted that they reported higher rates of viral skin contact related STIs such as herpes and human papillomavirus. Additionally perceived penile length has been shown to be associated with sexual role. Respondents with "above average" penis size reported more of the *top* role and those with "below average penis size" reported more of the *bottom* role. This can have implications in risk factors regarding STIs, as anal receptive intercourse has a higher risk of HIV acquisition compared to anal insertive intercourse or *topping*. Another study found that MSM with larger penises reported having more difficulty finding comfortable condoms and therefore had higher rates of unprotected insertive anal intercourse.[45]

Prostate cancer in MSM. Screening for prostate cancer despite its controversies should be discussed in all men regardless of sexual orientation. **It is estimated that 1 in 6 MSM will be diagnosed with prostate cancer and/or 1 in 3 same-sex male couples will be affected by prostate cancer.[47] A lot of health care disparities exist in prostate cancer for MSM. Previously lower rates of PSA screening were found in MSM; however, more recently some data suggest that MSM are getting screened more often.[48]** It is hypothesized that in the era of PrEP MSM may be more vigilant regarding their own health and interact with their health care providers more frequently. **Despite these more recent changes, MSM have historically had decreased medical access and psychosocial support compared to heterosexuals.[49] They suffer worse disease specific and general health related quality of life outcomes, and score worse in urinary and bowel function quality of life evaluations, although they have better sexual functioning scores.[50, 51]** Overall, they are less satisfied with medical care and experience more anxiety with potential new sexual encounters given they are less likely to be in monogamous relationships.[50]

Finally, treatment of prostate cancer can have effects on anal receptive intercourse. Changes in anatomy, rectal wall fibrosis related to radiation, changes in sensation and potential AD may disproportionately affect MSM who *bottom*. It is difficult for us as providers at this time to counsel patients regarding these potential changes in sexual function/satisfaction given the paucity of data and lack of validated questionnaires.

SEXUAL DYSFUNCTION IN WSW

Even less data exist regarding sexual function in women who have sex with women. Data are limited by heterogeneity in studies and lack of population based studies. Evidence suggests that the development of same-sex sexuality in women is different than in men, and sexual orientation in women tends to be more fluid than it is for men,[52] often changing over time. Furthermore, recent large studies have consistently indicated higher rates of bisexuality reported in women compared to men.[2, 3]

Some data suggest that WSW experience less sexual dysfunction compared to heterosexual women. In a survey of medical students WSW reported lower rates of high risk female sexual dysfunction (using a modified Female Sexual Function Index).[32] The specific domains with the greatest difference involved the pain and orgasm domains. Although the exact reason for these differences is hard to discern, it is possible that WSW experience less pain and more orgasm with same-sex partners than with other partners. WSW also tended to have more lifetime partners than heterosexual women. Overall rates of sexual satisfaction were similar. Another study also indicated higher scores of arousal and orgasm for WSW compared to heterosex-

ual women.[53] This difference remained even when controlling for confounding effects. A recent systematic review corroborates the above studies.[54] **It appears that WSW tend to suffer less orgasmic disorders compared to heterosexual women. Several studies suggest lower rates of female sexual desire/arousal disorders compared to heterosexual women. Finally, it should be noted that WSW also engage in a variety of sexual activities including penetrative intercourse. Therefore, they are also subject to potential genitopelvic pain/penetration disorders similar to heterosexual women.**

Self-disclosure is likely an issue for WSW similarly to MSM. Interestingly, one study found that bisexual women were less likely to disclose their sexual dysfunction concerns compared to homosexual women and heterosexuals.[55]

There is a concept, "bed death," occurring in lesbian couples who experience reduced sex drives or sexual expression. It is an idea suggesting that coupled lesbian women tend to quickly reduce the frequency of their sexual activity. This is based on older studies comparing rates of intercourse between lesbian couples, gay couples and heterosexual couples. However, a more recent study that broadens the definition of sex and examines several domains of sexual functioning, including behavioral (sexual frequency, both genital and non-genital stimulation), motivational (sexual desire) and cognitive-affective (sexual satisfaction, sexual anxiety, sexual esteem, automatic sexual thoughts) aspects of sexual minority women's sexual experiences, contradicts the concept of lesbian bed death. **When using a broad and multifaceted picture of sexual experience, the authors found that sexual minority women report their sexuality positively across multiple domains including satisfaction, and engage in some sexual activity on a regular basis.[56]**

TRANSGENDER AND PROSTATE CANCER

Transgender is the most appropriate term to describe someone whose gender from birth is incongruent with their gender identity or expression. For example someone who is assigned as male at birth but has a female identity is termed a transgender female/transgender woman or MTF. On the other hand, someone whose given gender at birth is congruent with their gender identity is a cisgender male or cisgender female.

One may argue that transgender patients and particularly transgender MTF patients suffer the most stigma and are the most marginalized of all LGBTQI individuals. They tend to have the highest rates of anxiety, depression and attempted suicide, and have the largest problems with access to care and finding providers that can address their needs appropriately.

Screening and diagnosis. Urologists will begin seeing more transgender patients as a greater acceptance of transgender spreads across the nation. **A particularly unique issue in transgender patients is prostate cancer. During gender affirming surgery the prostate is usually left behind. Prostate cancer in transgender patients is rare; however, it still exists.** The true incidence is difficult to ascertain, as many of these patients are likely missed or not getting screened. **Given the lack of data, organizations such as the Endocrine Society and the World Professional Association for Transgender Health recommend screening transgender patients with the same standards as cisgender men. However, this may be problematic in transgender women, and some argue for different screening protocols. Transgender women on hormonal therapy will often have castrate levels of testosterone at presentation. This may lead to differences in diagnosis and treatment.** It is suggested by 2 studies that a PSA threshold of greater than 1 ng/ml should be used as the upper limit of normal if patients are on hormonal therapy.[57,58]

How you perform a prostate biopsy will depend on whether the patient has undergone gender affirming surgery. A neovagina is often placed between the prostate and rectum. Therefore, if a transgender MTF needs to undergo a prostate biopsy, one may perform a *transneovaginal* ultrasound guided biopsy, similar to a transrectal ultrasound biopsy.[59] If the patient has not undergone gender affirming surgery, they may simply undergo a typical transrectal ultrasound biopsy.

Treatment concerns. If performing a radical prostatectomy, special considerations should be taken into account. Most obvious will be some of the anatomical surgical considerations if the patient has a neovagina. However, something less obvious to note is that patients on hormonal therapy will likely have very small prostates, which will make prostatectomy more difficult. **Additionally given that patients are already on "prolonged androgen deprivation therapy," one may argue their cancer is already castrate resistant. Patients are likely best served with surgery and/or radiation.** Theories regarding receptor mutation and estrogen as drivers of prostate cancer also exist.[59] Finally, sexual function, as in all populations, should not be ignored post-prostate cancer treatment and assumptions cannot be made. **Transgender females with a penis who have not undergone gender affirming surgery may still desire to maintain erectile function.** A lot remains to be discovered on this topic and within this community.

LUTS IN LGBT

Although treated similarly in all men, MSM may have unique factors that increase their risk of LUTS. MSM have higher rates of STIs, UTIs, HIV and depression, all of which have been found to be associated with LUTS.[60] MSM with a history of gonorrhea, UTI and prostatitis were more likely to report LUTS compared to their MSM peers. Similarly depression is more prevalent in the LGBT community and has been found to be a predictor of LUTS in MSM. HIV associated LUTS can be in part due to the proinflammatory state of HIV, increased UTIs and/or neuropathy of detrusor nerves.[61,62] In the contemporary era, in which HIV is largely controlled, the proinflammatory state is thought to contribute to increased LUTS.

When treating LUTS, potential effects on ejaculation should be considered. Ejaculation has been shown to be more important in MSM than in heterosexual men.[37] It has been hypothesized that ejaculation is an important sign of sexual gratification in MSM, and that in the early era of HIV seeing the ejaculate was an important aspect in sex given its potential for HIV transmission.[63] The potential ramifications regarding ejaculation with LUTS treatment are certainly important for MSM and should be discussed.

Women in general have a high prevalence of LUTS/incontinence. **It is hard to ascertain whether there is a difference in prevalence among WSW compared to heterosexual women.** WSW have higher rates of obesity,[64] which is a known risk factor for LUTS, but have lower rates of pregnancy, a risk factor for incontinence. **Regardless WSW should be screened and treated for LUTS/incontinence in a similar fashion to heterosexual women.**

DID YOU KNOW?

- When taking a sexual history, using the term "partner" early on may clue the patient in that you are not judgmental to non-heteronormative relationships.
- Sexual behaviors pose different risks to patients and it is important to understand these, regardless of labels.
- Patient adherence to preexposure prophylaxis has dramatically decreased the risk of acquiring HIV, has been found to be 99% effective and has *not* been clearly found to increase risk taking behavior.
- Premature ejaculation in men who have sex with men has to be defined in the context of varying sexual roles.
- Men who have sex with men suffer from worse health related quality of life outcomes after prostate cancer treatment.
- Women who have sex with women have lower rates of orgasmic or pain disorders.
- Unique challenges exist in diagnosis and treatment of transgender patients with prostate cancer.

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Study Questions Volume 39 Lesson 35

1. A 28-year-old man who has sex with men during a visit for STI testing asks whether treatment with PrEP is recommended. You advise that PrEP
   a. when taken consistently on a daily basis reduces the risk of HIV acquisition by 99%
   b. has reduced the stigma associated with HIV
   c. is only indicated for intravenous drug users
   d. is not recommended as it has many potential drug-drug interactions

2. A transgender female started hormonal therapy at age 53 and underwent bilateral orchiectomy 2 years later. At age 63 she has weight loss and diffuse bone pain. Imaging demonstrates retroperitoneal lymphadenopathy and osteolytic bone lesions. The next step is
   a. order a PSA and perform a prostate biopsy
   b. order a needle biopsy of the nodes
   c. perform a radical prostatectomy
   d. treat with enzalutamide as she is considered castrate resistant

3. Compared to heterosexual women, women who have sex with women report
   a. higher rates of orgasmic disorders and higher rates of genital pain disorders
   b. higher rates of orgasmic disorders and lower rates of genital pain disorders
   c. lower rates of orgasmic disorders and higher rates of genital pain disorders
   d. lower rates of orgasmic disorders and lower rates of genital pain disorders

4. A transgender MTF is in the emergency department complaining of a painful erection that began 4 hours ago. The emergency room physician calls you to discuss the patient. The next step is
   a. advise the emergency room physician that no treatment is necessary since she probably doesn't need her penis anyway
   b. advise that she be prescribed pain medications and anti-inflammatories and arrange outpatient follow-up
   c. see the patient, and after performing a history and physical reprimand her for using cocaine and trazodone
   d. see the patient, and after performing a history and physical discuss with her the potential complications resulting from priapism and the treatment of the priapism, and proceed with penile aspiration and injection if she so chooses

5. Compared to heterosexuals, MSM are often subject to more distress and/or anxiety regarding sexual dysfunction because
   a. they often don't have access to oral PDE5-Is
   b. they are less likely to be in a stable monogamous relationship
   c. they are ashamed to discuss their sexual concerns with their health care providers
   d. a lack of validated questionnaires to measure their sexual dysfunction may lead to underdiagnosis and treatment

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