

Cancer Screening for Trans and Gender Diverse People

Dr Alison May Berner (she/her)

Academic Clinical Lecturer & Honorary Consultant in Medical Oncology

Specialty Doctor in Adult Gender Identity Medicine

Clinical Lead for the UK Cancer & Transition Service



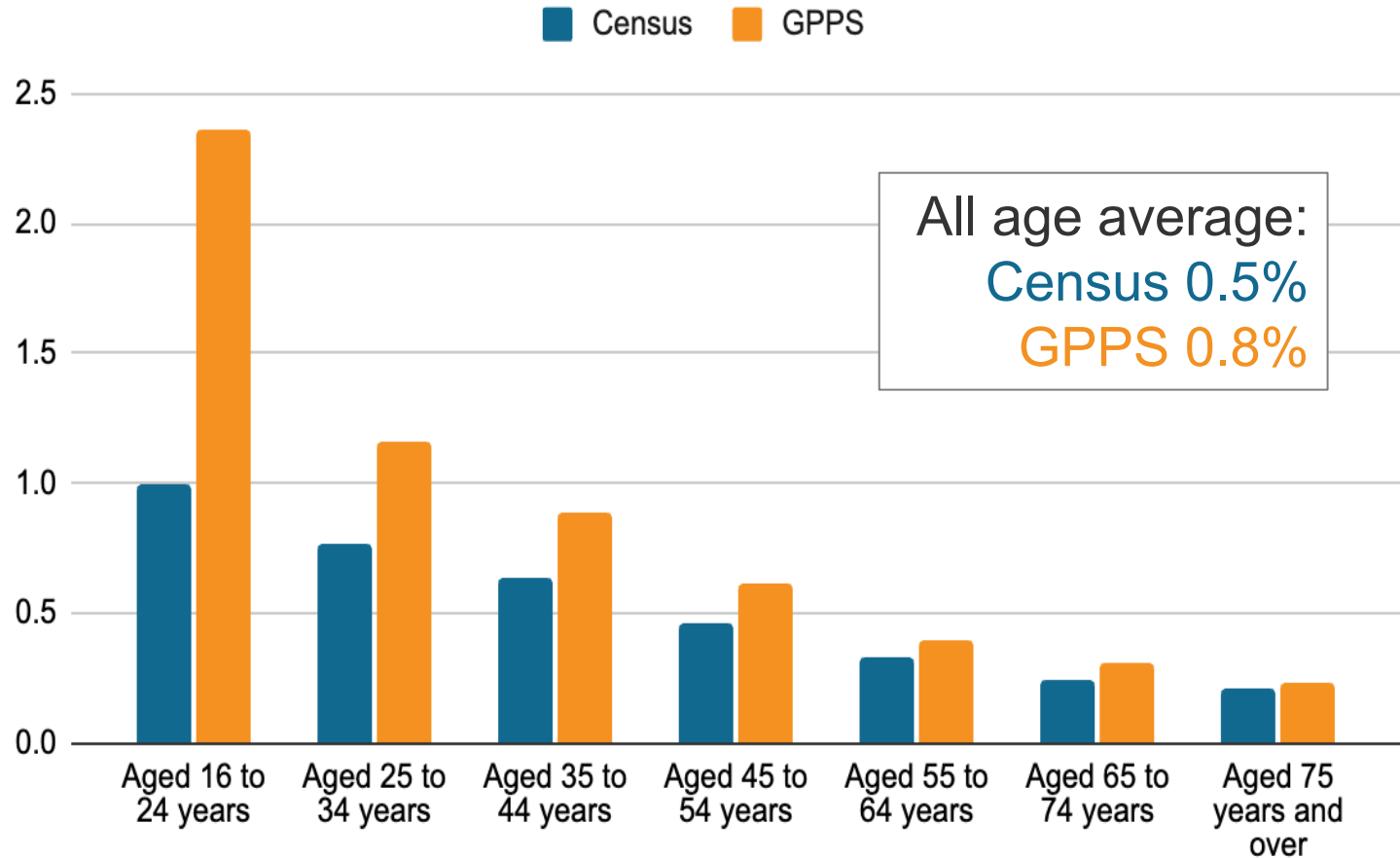
With thanks to Stewart O'Callaghan Founder & CEO, OUTpatients: LGBTIQ+ Cancer Charity for use of parts of their slide deck

Outline

- Background
- Gender affirming care
- Screening
- Inherited Cancer Risk
- Active Cancer
- UK Cancer & Transition Service
- Questions



What % of the UK population is trans?



Potential Impacts of Cancer for Trans Patients

QUALITY OF CARE & EXPERIENCE

- Anticipated discrimination
- Experienced discrimination
- Misgendering
- “Trans broken arm syndrome”
- Poor communication between healthcare teams (pass-the-parcel)
- Lack of accurate information
- Lack of inclusive information
- Lack of inclusive systems
- Long waits for gender-affirming care and early discharge

ADJUSTMENTS TO CARE

- Altered screening
- Risk/benefit discussions about stopping/pausing hormones
 - In hormone sensitive cancers
 - With drug interactions
- Appropriate hormone replacement
- Use of risk profile to use (male/female or menopause status) for risk calculators and treatment decisions
- Radiotherapy planning following gender affirming surgery
- Cancer surgery following gender affirming surgery
- Gender affirming surgery after cancer treatments

ADDITIONAL NEEDS

- Psychology
- Psychosexual counselling
- Fertility
- End-of-life
 - Hormones and surgeries in terminal illness
- Chosen vs biological family / estrangement
- Financial needs / debt

Avoidance & Mistrust

27% of trans people 'always' or 'often' avoid GP visits for appointments like cancer screening

57% of trans people avoid healthcare even when unwell

45% of trans and **55% of non-binary** people feel their GP does not understand their needs

Gender- affirming care



Gender-affirming care

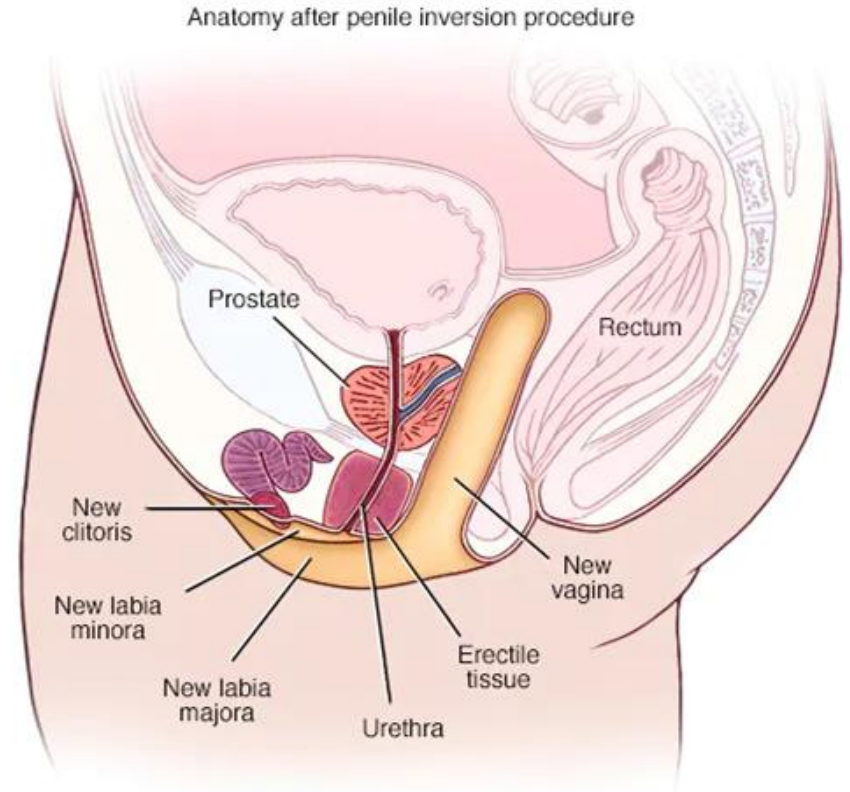
Trans women

Hormone therapy

- Oestradiol
 - Gel
 - Patch
 - Oestradiol valerate
- GnRH analogue
 - or
- Finasteride
- *Progesterone*

Surgery

- Vaginoplasty
- Vulvoplasty
- Orchiectomy



Gender-affirming care

Trans men

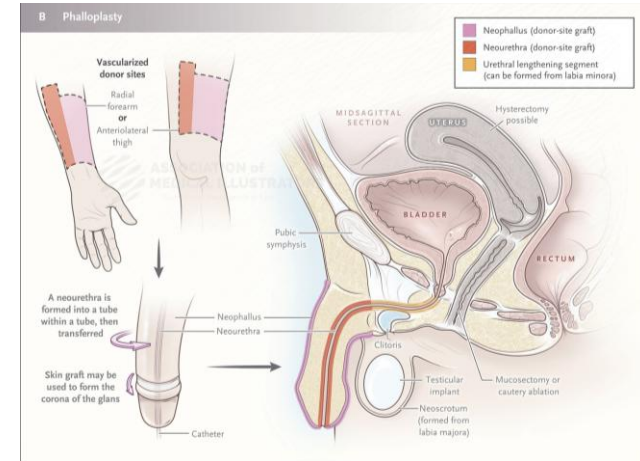
Hormone therapy

- Testosterone
 - Gel
 - Injection
- GnRH analogue

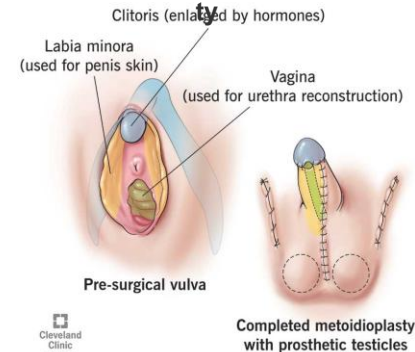
(Progesterones as contraceptives)

Surgery

- Chest masculinisation
- Phalloplasty
- OR
- Metoidioplasty
- Hysterectomy
- Vaginectomy



Metoidioplasty



Barriers in the cancer pathway

Awareness

Screening

GP appt

Emergency

Diagnosis

Treatment
decisions

Treatment

End of Life

Living with

Living beyond

	Transmasculine		Transfeminine	
	vs Cis M	vs Cis W	vs Cis M	vs Cis W
Obesity	1.39*	1.17*	1.02	0.88*
Current smoker	1	1.23*	1.05	1.3*
Former smoker	1.27*	1.21*	1.11*	1.11*
Current alcohol use	0.95*	0.98	1	1.04
Former alcohol use	1.33*	1.27*	1.13	1.15
Dyslipidaemia	0.94	1.31*	1.12*	1.53*
Diabetes	1.24*	1.29*	1.05	1.24*
HIV	2.4*	4.41*	3.29*	6.02*
Hepatitis C	1.27	2.21*	1.71*	3.1*
Hepatitis B	1.05	1.23	1.48	1.78*

Prevalence of cancer risk factors among transgender and gender diverse individuals: a cross-sectional analysis using UK primary care data

Brown, J., Pfeiffer, R. M., Shrewsbury, D., O'Callaghan, S., Berner, A. M., Gadalla, S. M., Shiels, M. S., & Jackson, S. S. (2023). Prevalence of cancer risk factors among transgender and gender diverse individuals: A cross-sectional analysis using UK primary care data. *British Journal of General Practice*, 73(732), e486–e492. <https://doi.org/10.3399/BJGP.2023.0023>

Transition related cancer risk changes

1. de Blok, C. J. M., Wiepjes, C. M., Nota, N. M., van Engelen, K., Adank, M. A., Dreijerink, K. M. A., Barbé, E., Konings, I. R. H. M., & den Heijer, M. (2019). Breast cancer risk in transgender people receiving hormone treatment: Nationwide cohort study in the Netherlands. *The BMJ*, 365, l1652. <https://doi.org/10.1136/bmj.l1652>
2. de Nie, I., de Blok, C. J. M., van der Sluis, T. M., Barbé, E., Pigot, G. L. S., Wiepjes, C. M., Nota, N. M., van Mello, N. M., Valkenburg, N. E., Huirne, J., Gooren, L. J. G., van Moorselaar, R. J. A., Dreijerink, K. M. A., & den Heijer, M. (2020). Prostate Cancer Incidence under Androgen Deprivation: Nationwide Cohort Study in Trans Women Receiving Hormone Treatment. *The Journal of Clinical Endocrinology & Metabolism*, 105(9), e3293–e3299. <https://doi.org/10.1210/clinem/dgaa412>

Trans Adults

Transmasculine

- 1/5 of the breast cancer risk of cis women¹

Transfeminine

- 1/5 of the prostate cancer risk of cis men²
- 46x breast cancer risk of cis men¹
 - 1/3 of the risk of cis women*

***Potential for over-estimate for UK as less progestogen use**

HPV

Trans women have higher rates of HPV, HPV-associated precancer, & HPV-associated cancer¹⁻⁵

Trans men similar rates to cisgender women^{5,6}

Cervical Screening

Trans men and non-binary people

- are less likely to have ever been screened or be up-to-date⁷
- face multiple barriers to screening⁸

Barriers

Male gender marker on healthcare records

Experienced or anticipated stigma and discrimination

Poor provider understanding of trans health

Female-centred screening information materials

Dysphoria related to the screening procedure, information, or correspondence

Facilitators

The availability of trans specialist services

Accommodating non-specialist healthcare providers

Improved screening information

Ability to self-sample for HPV

Ability to access a call and recall system

1. van der Sluis WB (2016) *Sex Trans Dis*,
2. Singh et al. (2019) *Sex Trans Dis*,
3. Uaamnuichai et al (2021) *Sex Trans Dis*,
4. Mohr et al. (2021) *EJOGRB*,
5. Pils et al. (2022) *eClinicaMedicine*
6. Reisner et al. (2018) *PloS One*.

7. Peitzmeier (2014) *Am J Prev Med*
8. Berner et al. (2021) *BJGP*

Cervical Screening

Usual age thresholds apply

Invitations

		Cervix	No cervix
Registration	M	Not invited unless manually added Request via GP	Not invited
	F	Invite sent	Invited but not needed <u>Remove from list</u>

**Trans men
and non-
binary people
who were
assigned
female at
birth**

**Trans men
and non-
binary people
who were
assigned
female at
birth**

Breast Screening

Usual age thresholds apply

Invitations

		No top surgery	Top surgery
Registration	M	Not invited Request via GP	Not invited
	F	Invite sent	Invited not but needed

**Trans women
and non-
binary people
who were
assigned
male at birth**

Breast Screening

Usual age thresholds apply

Invitations

		Registration	
		M	F
Breasts	No breasts	Not invited Request via GP	Not invited
		Invite sent	Invited not but needed

More information



<https://outpatients.org.uk/tnbgd-screening/>

Measures to improve cervical screening comfort:

- Double appointments to increase time
- Allowing a partner present
- Pain relief prior (paracetamol)
- Muscle relaxants prior (lorazepam)
- Verbal relaxation exercise
- Digital exam to locate cervix first
- Topic oestrogen
- Use of the smallest size speculum
- Water-based lubricant
- Allowing self-insertion of the speculum

National guidelines recommend patients request breast screening via their GP if not registered “F”

- You may struggle to make find the correct clinic.
- Patients may end up in one-stop or high risk clinics.

PSA

There is not national screening test for prostate cancer.

Cisgender men can request PSA and need an informed discussion about false positives and false negatives.

PSA on GAHT

Gender-affirming hormone therapy is lowered by gender-affirming hormone therapies and surgeries.

- Current guidelines recommend using an upper-limit of normal of 1ng/ul in this group
- Gender Identity Clinics may still request PSA on referral blood tests and patients still require discussion before this is done.
- Remember prostate stimulation can increase PSA for 24-48 hours!

TransPRIDE

Aim:

- - Establish accurate PSA reference ranges for trans and non-binary people with a prostate (TNBPP) receiving GAHT or post-orchidectomy.

Why It Matters:

- - PSA thresholds are based on cisgender men and may not apply to TNBPP.
- - Risk of missed prostate cancer diagnoses or unnecessary investigations.
- - Addresses health inequalities and improves inclusive prostate care.

Study Design:

- - Multicentre, prospective reference range study across UK sites.
- - Participants: TNBPP aged 40+, on GAHT and/or post-orchidectomy.
- - Procedures: Consent → Blood tests for PSA & hormones; optional biobanking; 6-month email check-in + call if issues.

Funders & Sponsor:

- - Funded by Movember and Prostate Cancer UK.
- - Sponsored by Queen Mary University of London.

Community Engagement:

- - Strong PPI input from OUTpatients and other trans-led organisations.
- - PPI shaped study design, advertising, and participant materials.

Key Milestones:

- - Recruitment target: 500 participants by mid-2027.
- - Database live: Autumn 2025.
- - First site activations: Autumn 2025.

Why Family History is Important

Tumour Suppressor Gene	Syndrome	Associated Cancer/Tumour Risks
<i>BRCA1, BRCA2</i>	Hereditary breast and ovarian cancer syndrome	Breast, ovarian, prostate, pancreatic
<i>MLH1, MSH2, MSH6, PMS2</i>	Lynch syndrome	Colorectal, endometrial, ovarian, prostate, stomach, urinary tract
<i>PTEN</i>	PTEN hamartoma tumour syndrome, Cowden syndrome	Breast, thyroid, endometrial, renal cell carcinoma
<i>TP53</i>	Li Fraumeni syndrome	Adrenocortical, breast, CNS, osteosarcoma, sarcoma
<i>CDH1</i>	Hereditary diffuse gastric cancer, hereditary lobular breast cancer	Gastric (diffuse), breast (lobular)
<i>STK11</i>	Peutz-Jeghers syndrome	Colorectal, gastric, breast
<i>APC</i>	Familial adenomatous polyposis	Colorectal, desmoid
<i>NF1</i>	Neurofibromatosis type I	Neurofibromas, malignant peripheral nerve sheath tumours, breast, brain
<i>PALB2</i>	N/A	Breast, ovarian, pancreatic
<i>ATM</i>	N/A	Breast
<i>CHEK2</i>	N/A	Breast

Keep Calm & Take a Family History

- Take a family history for cancer for all trans patients being referred to a GIC
 - Can inform screening/discussion of risk of interventions and save time later
- Get worried about lots of the following and at a young age:
 - Breast/ovary/prostate/pancreas
 - Colorectal/endometrial (and can be others!)
- Refer to local clinical genetics if concerned
 - Let them know if its urgent! (e.g. This person is about to be referred for top surgery)
 - Refer with details of past, current, and planned gender affirming treatments
- If you are not sure:
 - Discuss with local clinical genetics
 - Look at the CliniBee App
 - Or drop me an email!
- Genetic testing may not be indicated, and is not mandatory
- Hormone use is rarely discouraged by genetics



UK Cancer and Transition Service

Our Aim: To bring together patients and their care teams to **share our best practice and expert knowledge**, to **empower** patients to make the best decision for them.



Our Model:

- **Virtual** multidisciplinary team meeting (MDM) and clinic
 - In-clinic or telephone if needed
- Patient & full UCATS team are present:
 - Consultant medical oncologist and specialist in adult gender identity medicine
 - Consultant in sexual health and adult gender identity medicine
 - Consultant medical oncologist
 - Clinical nurse specialist:
 - Pharmacist
 - Consultant in palliative care
- Dial in options for patient's care teams / other experts
- Observers can join

Eligibility

- Gender diverse people **anywhere in the UK** with cancer now/in the past
- Regardless of where they source gender transitioning care

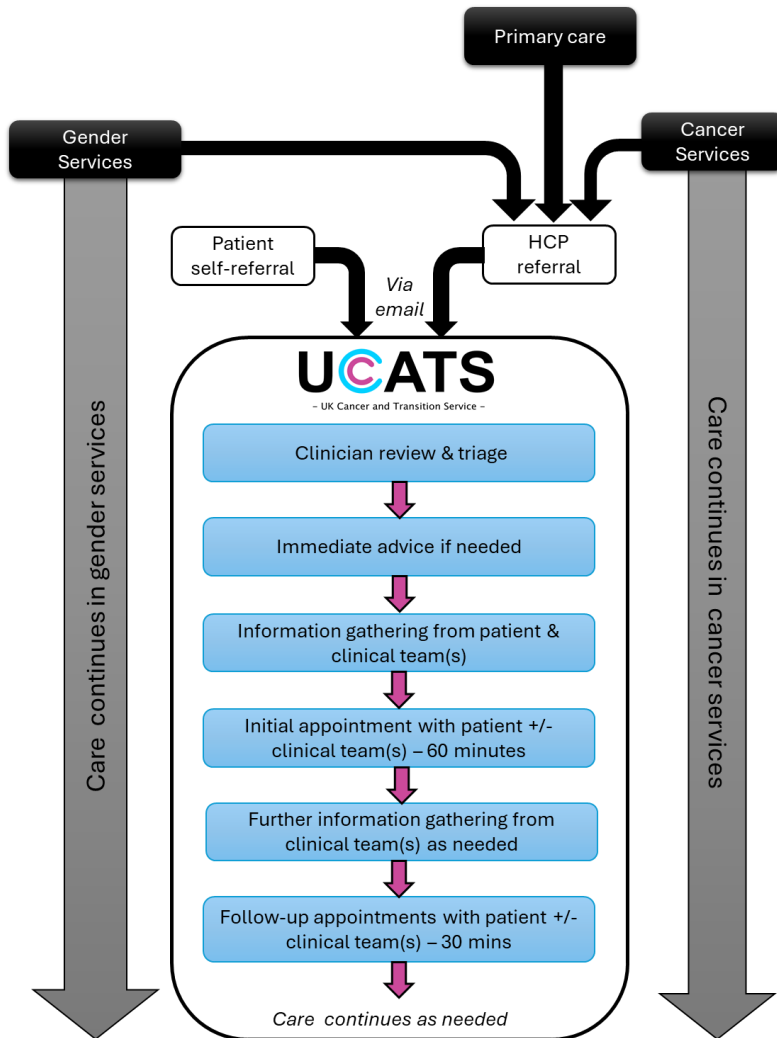
Referrals

- Self
- Any clinician involved in care

When

- Monday afternoon/evenings
- Fortnightly, moving to weekly

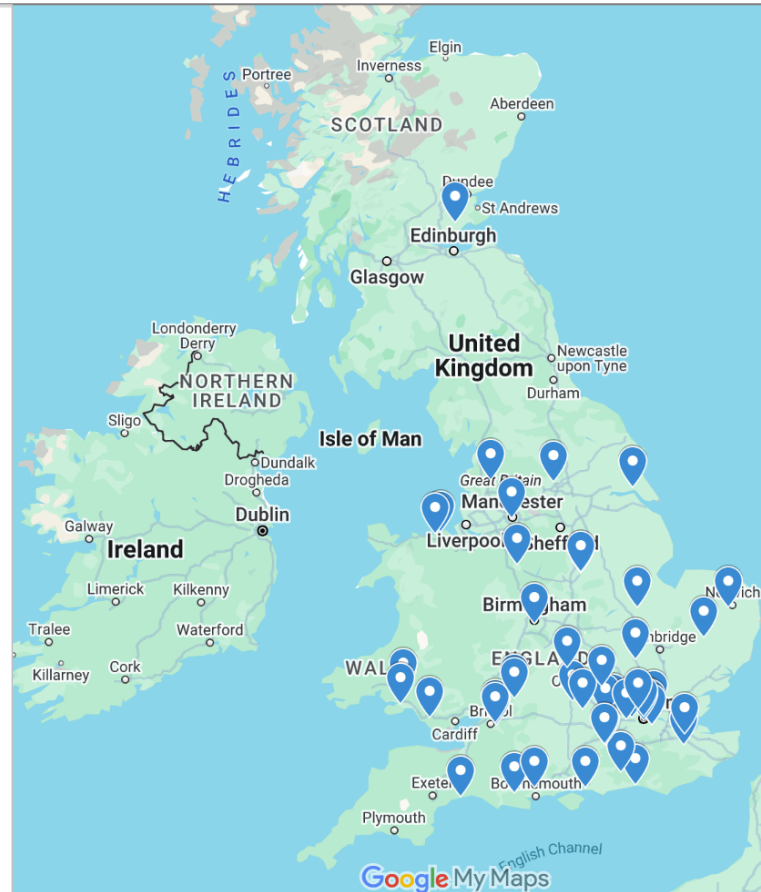
What we offer



- **Liaison** between all teams involved in the patient's care
- **Review of evidence**
- Letter of recommendations
 - **Supports clinicians**
- Help with **hormone monitoring**
- Ability to **fast-track** or coordinate gender affirming care when needed
- **Signposting** to other important services such as:
 - Psychotherapy
 - Psychosexual counselling
 - Peer support
- Advocacy across other services

A pie chart illustrating the distribution of cancer types among 1000 patients. The chart is divided into 14 segments, each representing a different cancer type and its percentage of the total. The segments are labeled with the cancer type and its percentage, with the labels placed outside the chart area. The colors of the segments are: Breast (orange), Colorectal (green), Gynaecological (blue), Haematological (purple), Meningioma (light green), Multiple (dark blue), Neuroendocrine (brown), Prostate (dark green), Sarcoma (dark blue), Testicular (purple), Thyroid (green), Upper GI (light blue), Anal (dark blue), and an unlabeled segment (dark green).

Cancer Type	Percentage
Breast	35%
Colorectal	9%
Gynaecological	11%
Haematological	13%
Meningioma	2%
Multiple	3%
Neuroendocrine	2%
Prostate	13%
Sarcoma	3%
Testicular	3%
Thyroid	2%
Upper GI	3%
Anal	1%



Common Referral Scenarios

Management of breast cancer in trans men and non-binary people taking testosterone

- Testosterone therapy
- Endocrine therapy in oestrogen receptor positive cancers

Hormonal management of trans women with **prostate cancer**

- Appropriate hormone therapy

Safety of hormone therapy in trans men and non-binary people with **gynaecological cancers**

“Theoretical concerns”

Access to appropriate surgery in trans men and non-binary people with **breast cancer**

- Contralateral mastectomy
- Masculinizing chest surgery

Safety and feasibility of genital surgery following surgery and/or radiotherapy in **pelvic cancers**

Expedited access to gender affirming care in life-limiting illness – including to surgery

Safety of hormone therapy with thrombosis risk

Questions?

alison.berner@nhs.net

UCATS

– UK Cancer and Transition Service –



chelwest.ucats@nhs.net
[https://www.wearetransplus.co.uk/
uk-cancer-and-transition-service/](https://www.wearetransplus.co.uk/uk-cancer-and-transition-service/)