CLINICAL VIGNETTE

Pelvic Inflammatory Disease in a Male Patient: The Importance of Understanding the Transgender Patient

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Background

With the implementation in May 2016 of Section 1557 of the Affordable Care Act, any health program (including health care providers and insurance companies) receiving funding from the US Department of Health and Human Services is subject to the nondiscrimination clause. Discrimination, as it relates to gender identity, can include both blatant and subtle or unintentional discrimination. The National Transgender Discrimination Survey found that 19% of transgender and gender non-conforming (TGNC) individuals reported having been refused care due to their transgender status with people of color being disproportionately represented.[1] However, discrimination towards TGNC patients may also include failing to refer to a patient by their preferred name and/or gender.[2]

At the heart of the issue is a lack of familiarity by many health care providers with the TGNC patient experience. Patients not uncommonly report having to educate their providers about their gender experience and identity.[3,4] As medical care for gender transitions is now a mandated benefit for private and public insurance plans in many states, the importance of health care providers gaining familiarity with the various medical and surgical options available for gender transitions is more urgent. The need for more robust education at all levels of medical training, from medical school through faculty and community physicians, has been previously described.[5,6]

The author presents a case highlighting several issues that are central to the care of TGNC populations and illustrates the importance of further education to all health care providers and staff. The transgender population is an understudied population. Previous articles have attempted to describe sexual behaviors and sexually transmitted infections in the TGNC population,[7] but to the author's knowledge, this is the first article focusing on pelvic inflammatory disease in a fully-transitioned transgender male.

Case Presentation

A 27-year-old male presented to walk-in urgent care with a chief complaint of "follow-up abnormal labs." The patient reported a 3-4 day history of fever to 100.0 degrees Fahrenheit, generalized achiness, night sweats, lower abdominal discomfort, and progressive tenderness and enlargement of inguinal lymph nodes. He denied respiratory symptoms, vomiting, or diarrhea. The patient had been seen four days prior by his primary care physician when the tender and enlarged inguinal lymph nodes were first noted to be present. He was otherwise asymptomatic at that time. He was requesting review of laboratory results from this previous visit.

Past medical history was significant for gender transition, bipolar 1 disorder, hypothyroidism, and migraine. Past surgical history included partial mastectomy with chest contouring and genital reconstruction. Specifically, this patient's genital reconstruction involved metoidioplasty (mobilization of the testosterone-enlarged clitoris to create a phallus) with preservation of the ovaries, uterus, vagina, and vaginal introitus. Medications included testosterone cypionate intramuscularly, sertraline, oxcarbazepine, levothyroxine, and eletriptan.

On social history, the patient identified as a heterosexual transman. He was married to a cisgender (non-transgender) woman. Approximately one month prior to this visit, the patient engaged in an unprotected sexual encounter with a new partner who was known to be HIV-positive. The patient could not clearly recall the details of the sexual encounter due to alcohol intoxication but penetration of the patient's genital (vaginal) opening was suspected. He experienced genital (vaginal) discharge for a few days following the encounter, but this resolved spontaneously. His only other reported sexual partner in the preceding three months was his wife.

On physical exam, the patient was normotensive with a heart rate of 90 and a temperature of 99.4. He was generally well-appearing.

Prior to performing the remainder of the physical examination, the examiner discussed with the patient suspicion that he may be experiencing pelvic inflammatory disease (PID). The clinical diagnostic criteria for PID were reviewed, highlighting the importance of a bimanual pelvic examination in evaluation of his symptoms. He agreed to proceed.

External genital exam was significant for the results of his metoidioplasty, and notable amine odor. Bimanual exam with a single finger confirmed left adnexal tenderness. There was no right adnexal tenderness or cervical motion tenderness. There was no appreciable vaginal discharge. There was bilateral

inguinal tender lymphadenopathy up to 15 mm. The remainder of the physical examination was unremarkable.

Review of laboratory values from his visit four days prior showed a positive chlamydia PCR from a vaginal swab. Gonorrhea PCR, fourth-generation HIV antibody-antigen assay and RPR were all negative. The remainder of laboratory values were normal, including complete blood count.

The patient was diagnosed with pelvic inflammatory disease. Treatment was guided by local public health department recommendations. He received an intramuscular injection of ceftriaxone and was prescribed a two-week course of metronidazole and doxycycline. Partner notification and treatment was discussed; his wife, also a patient of the health system, was prescribed azithromycin for empiric treatment of chlamydial infection, and he agreed to notify his other known partner.

The patient reported improvement in all symptoms within one day of treatment and complete resolution by the end of his antibiotic course.

Discussion

This case highlights several issues, which are specific to the care of transgender individuals.

An anatomic survey is of great importance in the care of a transgender individual. Each individual's gender transition will be unique. A person may choose to transition gender only socially, expressing their affirmed gender through name and pronoun preference, style of dress or hair, and/or mannerisms. They may seek legal name and gender marker change. The individual may choose to transition medically, through use of cross-sex hormone treatments. Surgical transitions, often referred to as gender affirmation surgeries, may involve genital and reproductive tract modification ("bottom surgery"), breast augmentation or partial mastectomy with chest contouring ("top surgery"), facial feminization surgery, chondrolaryngoplasty ("tracheal shave"), and/or other body contouring procedures. In order to provide appropriate care, it is important to discuss and document in detail which surgeries have been performed and which organs are currently present.

As in this case, the anatomic survey may help to guide differential diagnosis and associated evaluation and management. For patients being seen for preventive care, current anatomy guides appropriate screening, though data to inform these decisions are sparse. For instance, transgender women who are taking estrogen need to be monitored for breast cancer risk. Transgender men who have had chest surgery often have residual breast tissue to aid in contouring; appropriate breast cancer monitoring for this population remains unclear. A number of resources are available to review current data and provide best practice guidelines.[8-10]

Transgender individuals, especially those who have not undergone gender affirmation surgery, may feel discomfort with their genitals and breasts. These exams should be limited whenever possible, and a discussion should take place to assess the patient's comfort prior to performing any such exam. Using gender-neutral terminology, such as "genital" or "chest" exam may help to ease discomfort.[11]

Surveys of TGNC patients have shown that medical providers' lack of knowledge and cultural competency about TGNC patients is a known significant barrier to care for many patients. Patients may feel discomfort in discussing aspects of care related to gender and gender transition. However, patients also report concerns that providers are overly focused on gender-related issues when these elements are not relevant to the care of the presenting concern.[12] It has been shown that revealing one's TGNC status may increase the patient's experience of discrimination, and some patients opt not to share this information with health care providers.[1] Thus, when a patient's gender transition is not relevant to the presenting concern, detailed questioning need and should not take place as this can increase patient discomfort and distrust.

Providers, as well, may experience discomfort in discussing or addressing gender-related issues in TGNC patients, due to a lack of knowledge and experience. Thomas and Safer described a simple educational intervention, which raised resident-physicians' willingness to assist transgender patients in hormone therapy.[5] However, improved provider comfort does not necessarily correlate with improved patient experience. Conversely, the provider acknowledging discomfort can enhance the patient-provider dynamic. Self-reflection by the provider and a nonjudgmental approach may allow a more productive interaction.[13]

No assumptions should be made regarding the sexual orientation of transgender individuals. Some individuals' sexual orientation changes through the process of transitioning gender.[14] Sexual practices are often affected by emotional feelings about one's body and side effects of hormone treatments or surgery. A detailed sexual history, when relevant to the nature of the visit, is important in determining the appropriate care. This may include obtaining details about the anatomy of both the patient and their partner(s), as well as locations of penetration, to ensure testing of the appropriate anatomic locations as well as addressing risk of pregnancy. Transgender men on testosterone therapy who have not undergone hysterectomy/oophorectomy may still become pregnant as testosterone does not reliably suppress ovulation.[15]

Capturing information regarding gender identity in the health record has been a challenge. Many electronic health records (EHRs) have a single sex/gender field, which drives a broad variety of decision tools. The sex field may drive administrative needs, such as patient matching for billing purposes, or room assignments for hospital admission. The same field may drive clinical tools, such as health maintenance reminders and normative lab value ranges, though interpretation of lab values may be further clouded in patients who are on cross-sex hormone treatment.[16] Importantly, the sex field may also determine how patients are referred to in face-to-face interactions and how gender and pronoun information is reflected in medical notes.

Ideally, EHRs should have three separate sex/gender fields: gender identity, legal sex, and assigned sex at birth. Gender identity should inform face-to-face interactions, and the

population of gender and pronoun information into medical notes. Notably, some TGNC patients prefer gender-neutral pronouns such as they/them/theirs, and ideally pronoun preference should be captured as a separate field. Legal sex can assist with patient matching for billing purposes. Assigned sex at birth may more appropriately determine normative lab value ranges and health maintenance reminders, and when it differs from gender identity, it may prompt the provider to complete a full anatomic inventory to further inform care. Deutsch and Buchholz have provided excellent recommendations on the collection of gender identity data in EHRs.[17]

With the expansion of coverage for transition-related care and a growing emphasis on nondiscrimination, a heightened sensitivity to gender-related health care issues is imperative. Nondiscrimination recommendations suggest that TGNC patients should be admitted to hospital areas based on their gender identity and personal preference, as well as the presenting medical concern. The patient presented above had chosen his particular gender affirmation surgery explicitly to preserve his reproductive options in anticipation of one day becoming pregnant and delivering. Health care systems need to be enhanced to allow such patients to be cared for in a welcoming and safe environment.

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Submitted February 16, 2017