

# PROSTATE HEALTH:

CARE, TREATMENT FOR PROSTATE CANCER IN  
2SGBQ MEN & TRANSFEMININE INDIVIDUALS

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**GMSH**  
GAY MEN'S SEXUAL HEALTH ALLIANCE

## **ABOUT THIS FACTSHEET**

This fact sheet is for frontline, outreach staff, public health staff, others providing sexual healthcare and care to the communities of Two-Spirit, gay, bisexual, and queer men (2SGBQ) and transgender women. Prostate cancer is a serious concern for all persons assigned male at birth (AMAB) and/or born with a prostate. In Canada, prostate cancer represents the most common cancer (i.e., malignancy) among those assigned male at birth.<sup>1,2</sup>

# WHAT IS THE PROSTATE, WHERE IS IT AND WHAT DOES IT DO?

## WHAT IS THE PROSTATE?<sup>3-5</sup>

The prostate is an organ in the reproductive system of individuals assigned male at birth (AMAB)—a group which includes, amongst others, cis men, trans women, and some nonbinary people. In the shape of an upside-down triangle (inverted cone), the prostate is normally about the size of a walnut (30 grams), but can enlarge with age and with certain medical conditions, including benign prostatic hyperplasia (BPH), a noncancerous enlargement of the prostate), acute prostatitis (AP, an inflammatory condition bacterial infection of the prostate gland that may be caused by bacterial infection), and prostate cancer.

In transfeminine individuals on hormones, the prostate can shrink if they take feminizing hormones and/or testosterone blockers (anti-androgens).<sup>6-8</sup>

Note that the prostate is not removed in vaginoplasty,<sup>9</sup> meaning that AMAB individuals who undergo this procedure can experience the same prostate-related health problems as in those who do not undergo it. Transfeminine individuals and non-binary AMAB people on feminizing hormone therapy can be similarly affected by non-cancerous (benign) issues such as an **enlarged prostate** or **prostatitis**—but prostate-related issues are thought to be less likely than in cis men.<sup>10-12</sup>

## WHERE IS THE PROSTATE?<sup>3,8,13-15</sup>

The prostate is found in the pelvis and surrounds part of the urethra (the tube that carries urine [pee] and semen [cum] throughout the urinary and reproductive systems, including out through the penis).<sup>3,13</sup> It is near the rectum—the part of the bum further inside the body after the anus (the outermost part of the gastrointestinal tract)—and is close to the bladder.<sup>3,14</sup>

Here is a diagram of the reproductive system of people with prostates (PwPs) who have not undergone vaginoplasty.<sup>15</sup> In PwPs post-vaginoplasty, the prostate is located in front of (anterior to) the neovagina.<sup>8</sup>

## ROLE IN EJACULATION (CUMMING)<sup>3,4,16</sup>

The prostate helps with ejaculation (expelling semen out of the penis) by producing fluid and using its muscles to push semen out of the body.<sup>3,4,16</sup> The fluid makes semen more watery and more easily able to flow out of the urethra.<sup>16</sup> In addition, it provides material that helps sperm survive longer in the vagina or front hole and increase its chances of reaching an egg to fertilize.<sup>3,4,16</sup>

Recall that AMAB individuals who have undergone vaginoplasty will

still have a prostate,<sup>9</sup> and it may produce fluid on sexual arousal. However, the body will not produce sperm as the testicles are removed (either in advance of, or at the time of, vaginoplasty surgery).<sup>6</sup>

## **ROLE IN URINATION (PEEING) <sup>14</sup>**

When you pee, the central zone muscles of the prostate close the ducts of the prostate to not allow urine to enter.

## **THE PLEASURE CENTRE?<sup>14,17</sup>**

The prostate is popularly regarded as the major pleasure centre in PwPs who receive penetrative anorectal stimulation (people who 'bottom'), but the prostate may be just one of many such spots. In a 2023 study, PwPs noted favourable stimulation in many parts of the anus (the entrance) and rectum (located slightly deeper than the anus); one of the two most common sites for receiving pleasure was the anterior (front) wall of the rectum, which is close to the prostate. Other accounts exist where people report a loss of pleasure and more pain after either having their prostate removed or having undergone radiation treatment for prostate cancer.

## THE PROSTATE AND AGING

As PwPs get older, they are more likely to have prostatic conditions such as BPH, prostatitis, and prostate cancer.<sup>5,18,19</sup>

Screening for prostate cancer can be considered using the prostate-specific antigen (PSA) test alone, or in conjunction with a digital rectal exam (in which the clinician uses a finger through the rectum to feel for prostate growths)—guidelines vary. Per the Canadian Urological Association in 2022, the recommended age to consider starting for prostate cancer screening is around 50 years of age for those who are at average risk.<sup>20</sup> However, it is recommended that those at higher risk, including African, Caribbean, and Black (ACB) men, consider screening for prostate cancer earlier at age 45.<sup>2,21</sup>

### **BENIGN PROSTATIC HYPERPLASIA (BPH)**<sup>3,23,24</sup>

Benign prostatic hyperplasia (BPH) is a condition causing enlargement of the prostate. Depending on its severity, it may cause a degree of blockage of the urethra, possibly resulting in symptoms such as difficulty peeing or having a weaker stream of pee than normal. Additional symptoms may include peeing more often than usual, blood in one's pee (usually not visible to the naked eye but sometimes picked up on urine testing), and an inability to control your pee. The

risk of BPH increases with age and excess weight (abdominal obesity).

Based on how severely symptoms present, treatment strategies vary from keeping a watchful eye to medications and even surgery in more bothersome cases.

Check out the following link for more information on [BPH](#).

### **PROSTATITIS**<sup>5,25</sup>

Prostatitis is a painful inflammation of the prostate, which may be due to infection from bacteria or fungi. Prostatitis is seen more frequently in people living with HIV—even with normal CD4 counts—but it is not known why this disparity exists.

#### **Acute prostatitis (AP)**<sup>5,25</sup>

Infection and pain with potential fever are the hallmarks of acute prostatitis. Pain may occur around the tip of the penis, the area between the testes and the bum (the perineum) and rectum. Increased urgency to urinate, painful urination (dysuria), cloudy-looking urine, a weak stream of urine, and painful ejaculation are also possible. Clients should seek medical attention urgently in the case of fever, weakness, or muscle pain; the bacteria may be spreading quickly throughout the body and may require urgent treatment.

AP mainly occurs by bacteria traveling from the outside world up through the urethra and to the bladder. This can be facilitated by improper catheter use, for example. Prostate biopsy (usually done through the rectum) may also result in the spread of bacteria from the rectum to the prostate and may result in prostatitis. On clinical exam, the prostate may feel swollen, firm, and painful to the touch.

### **Chronic prostatitis (CP)** <sup>5,25</sup>

Prostatitis is considered chronic when symptoms have been present for at least three of the past six months. PwPs aged 50 to 59 years have a risk three times greater than that of PwPs between 20 and 39 years old. Unlike acute prostatitis, blockages to pee are uncommon and fever is not noted. Further, the prostate often feels normal, in contrast to many acute cases (as noted above).

Check out the following link for more information on [prostatitis](#).

## **PROSTATE CANCER**<sup>1,2,19,21,22,26</sup>

Prostate cancer occurs when prostate cells mutate and grow into nearby tissue, which can destroy it. From there, it can spread to other parts of the body. When prostate cancer is only found in the prostate, it is said to be 'localized,' whereas 'metastatic' is the term used when it has spread to other parts of the body. Localized prostate cancer has a greater chance of recovery

and features fewer symptoms than metastatic prostate cancer.

"Prostate cancer is the most common cancer among Canadian men (excluding non-melanoma skin cancers)"<sup>1</sup> and "the third leading cause of death from cancer in [PwPs] in Canada."<sup>1</sup> The estimated 5-year survival from prostate cancer is high in Canada at 91% and the death rate has been decreasing since 1995. Around 1 in 8 PwPs will be diagnosed with prostate cancer in their lifetime and 1 in 30 will pass away from it. Older PwPs living with prostate cancer usually die of other causes.

Increased age, weight, height, blood pressure, testosterone (persistently elevated levels), poor overall health, and certain ethnic and family medical backgrounds (e.g., certain genetics, first-degree relatives with prostate cancer) have been associated with greater prostate cancer occurrence and/or faster progression of disease. Historically, Black PwPs are more likely to be diagnosed with prostate cancer in Canada, followed by white and then Asian PwPs.

While there is minimal data in Canada on higher incidents of prostate cancer in ACB PwPs, "research from the United States and Europe has shown that [new cases over time] and lifetime risk of developing prostate cancer among Black people are more than double than among their white counterparts."<sup>2</sup> Socioeconomic elements—gaps in healthcare access, for example—may also contribute to the disparity of prostate cancer

rates between racialized groups. This requires more research in the future. Using data from the U.S. may not reflect the reality of Canadian ACB PwPs due to a much greater percentage of these clients born in the U.S. compared to Canada (90% and 55.7%, respectively).

## SCREENING FOR AND DIAGNOSING PROSTATE CANCER

As discussed earlier, screening for prostate cancer is proactive and looks at PSA test results (with or without a digital rectal exam), in addition to monitoring for lower urinary tract symptoms, lower back pain and tenderness, and severe bone pain.<sup>27</sup> If screening test(s) for prostate cancer is/are positive, diagnostic tests for prostate cancer will be recommended, which may include one or more of transrectal ultrasound scanning (TRUS), prostate tissue biopsy, magnetic resonance imaging (MRI), bone scan, and computed tomography (CT).<sup>19,27-31</sup>

In the case of a prostate cancer diagnosis, the healthcare provider (HCP) can discuss with the client what was found, explain what the treatment plan would be, how well treatment works, and what the end result of therapy might look

like.<sup>27,28</sup> This provides the clients time to learn, research, find support, and discuss this topic further with their HCP or other specialists.

Screening and diagnostic test results are not always indicative of one's actual health: false negatives and false positives can occur.<sup>28</sup> As well, these tests are done by an HCP; self-testing for prostate cancer is not always conclusive for prostate cancer.<sup>4</sup>

### DIGITAL RECTAL EXAMINATION (DRE)<sup>4,8,30,32</sup>

DRE involves an HCP inserting a lubricated, gloved finger inside the of the bum (rectum to check the size and shape of the prostate), and whether it causes pain to touch around the area (which may be indicative of prostatitis). No special preparation is needed by the client. Bumps or hard areas on

the prostate may indicate cancer, but further testing is needed to confirm.

For transfeminine individuals with a vagina (i.e., post-vaginoplasty), a digital vaginal examination may be preferred to—or performed in addition to—DRE due to the anterior (front) position of the prostate relative to the vaginal wall.

## **PROSTATE-SPECIFIC ANTIGEN (PSA) TEST**

### ***What is PSA and what is the PSA test?*** <sup>33,34</sup>

Prostate-specific antigen, or PSA, is a protein made by prostatic cells. Most PSA is found in semen but there is also a small amount in the blood, which can be used as a marker for changes to the prostate tissue (including transforming cells into cancer) as well as to monitor for treatment success.

### ***Is the PSA test worth it?*** <sup>8,19,33,34</sup>

PSA is a sensitive test. However, using PSA tests to screen for prostate cancer is somewhat controversial due to its high rate of false positive results. Only about 25% of positive results are due to prostate cancer, meaning the “false-positive” rate is about 75%.<sup>34</sup> Regardless, studies have found that widespread PSA testing results in a 50% decrease in cancer-specific mortality (death) and a 64% decrease in prostate cancer-specific mortality.

Transfeminine individuals on feminizing hormones may have lower PSA levels compared to other

PwPs of their age, which should be taken into consideration when interpreting results for these clients.

### ***Does it always mean cancer?*** <sup>5,33,34</sup>

No. A higher than normal PSA level can be due to a number of things, including a benign (non-cancerous) enlarged prostate (BPH), some medications (e.g., testosterone therapy, certain medications taken for management of hair loss), infection (e.g. acute prostatitis), frequent bike riding, and physical damage to the area (e.g., from a catheter). In the case of AP, clients should wait at least one month after the infection resolves to avoid the PSA results being affected.

It is highly recommended to discuss your medical history with your HCP to better frame your PSA test results.

### ***Can I pick up a PSA test at the pharmacy and check out my level my home?*** <sup>35,36</sup>

Over-the-counter self-test kits are available in places like the UK but are not found in Ontario. It is also unknown if those products meet the standards of Health Canada. Also, even if your PSA was detected as higher than normal, a trip to the HCP would be needed for another PSA test and/or other diagnostic measures. It is best to get your PSA test through your HCP as you can make informed choices and discuss the results and avoid unnecessary stress.

## **TRANSRECTAL ULTRASOUND SCAN (TRUS)<sup>30</sup>**

TRUS is an ultrasound scan to look at the prostate and tissues around it. Using a probe that is placed inside the bum (rectum) and pressing on the area near the prostate, TRUS creates pictures of the organ using sound waves. TRUS can help guide a needle to perform a biopsy as well as determine the size and shape of the prostate.

## **BIOPSY<sup>19,28,30</sup>**

In the case of one or more abnormal test results (using imaging strategies listed above), a biopsy is typically done. In this procedure, a tiny portion of the prostate is cut out and examined under a microscope. Appearance of the cells can definitely diagnose the condition and may be used to inform treatment decisions. TRUS, MRI, and/or CT techniques can be used to help guide biopsy location.

Biopsy risks include infection/fever, pain, blood in the urine or semen, and urinary tract infection.

## **MAGNETIC RESONANCE IMAGING (MRI)<sup>19,30</sup>**

MRI creates images of the body through magnetic forces and radiofrequency waves. Currently, MRI is the best tool to estimate the volume of a prostate cancer tumour.

## **BONE SCAN<sup>31,37</sup>**

This tool is used in certain cases to assess for whether prostate cancer has spread to the bones. After being injected with a radioactive material, different cells in the body will proceed to absorb the substance at different rates which will be detected by a scanner. Areas where the dye has been absorbed in the bone may signify cancer.

## **COMPUTED TOMOGRAPHY (CT)<sup>30,38,39</sup>**

A CT scan combined the use of x-rays and computer technology to create pictures of the body. Cancer spread outside of the prostate can be examined using this method. Also, prostate cancer which has recurred (come back) after treatment can be found using CT. For certain scans, drinking a special fluid (contrast medium) beforehand is needed to show some organs more clearly. Additionally, CT can be combined with another imaging technique called positron emission tomography (PET) to provide more details about the cancer, but this is not standard testing for all clients.

## **TUMOUR MARKER TESTS<sup>30</sup>**

To learn of other tumour marker tests such as the 4K score, Prostate Health Index, and Prostate Cancer Antigen 3, read more [here](#).

## **SIGNS AND SYMPTOMS OF PROSTATE CANCER**

If you have increased urinary frequency, a slow, weak stream of pee, blood in your pee, blood in your semen, bone pain (particularly if in the lower back), unexplained weight loss, or problems achieving or maintaining an erection (erectile dysfunction [getting or staying 'hard']), get checked out by an HCP for possible prostatic issues.<sup>4,40</sup>

Symptoms are often nonexistent in localized prostate cancer, which is why some people choose to undergo prostate screening even if you are otherwise feeling fine.<sup>19</sup>

In the case of metastatic disease to other organs, tiredness (fatigue), bone pain, paralysis, and kidney failure alongside a substantially lower 5-year survival rate complicate the life of the client.<sup>19</sup>

## **TREATMENTS FOR PROSTATE CANCER AND THEIR SIDE EFFECTS**

Management options for prostate cancer include surveillance, medications, and surgery.<sup>19</sup> Specific management recommendations vary depending on individual factors as well as tumour-specific factors.<sup>37</sup>

Outcome success rates are impacted by the size, spread, and cellular makeup of the tumour(s) involved; for example, a smaller, localized, and more 'normal'-looking cancer will often be easier to treat.<sup>19</sup>

Moreover, whether the cancer has been diagnosed for the first time or has come back (come out of remission) will also affect expected treatment survival rates.<sup>37</sup>

### **SURVEILLANCE<sup>4,19,37,41,42</sup>**

Aggressive therapy is not required for every diagnosed case of prostate cancer. Keeping a watchful eye only is used for small, relatively low-aggression prostate tumours when paired with a low baseline PSA score. Periodic monitoring of PSA and consideration of biopsies are recommended for these clients.

## MEDICATIONS<sup>19,37,43-50</sup>

Drug treatment can be used in localized and metastatic prostate cancer cases. The two medication groups mentioned in this factsheet will be hormone therapy and chemotherapy.

### *Hormone therapy*

The 'male' hormones, or androgens (including testosterone), are targeted in certain prostate cancer treatments. These medications work either by lowering the amount of androgens made or blocking their functions in the body. Certain classes of these hormone medications are luteinizing hormone-releasing hormone (LHRH) agonists or gonadotropin-releasing hormone (GnRH) agonists, LHRH antagonists or GnRH antagonists, androgen synthesis inhibitors, and anti-androgens.

An agonist is a molecule that binds to a target and activates it. An antagonist binds to its target to prevent other molecules from binding to it. In AMAB individuals, LHRH agonists and antagonists both work on the pituitary gland (in the brain) to block the downstream production of testosterone from the testicles. In contrast, androgen synthesis inhibitors block enzymes that the body needs to produce testosterone.

Due to the variety of hormone therapies, possible side effects and their frequencies vary. These side effects may include erectile dysfunction, low sex drive (low libido),

tiredness, feeling irregularly hot at times (hot flashes), mood swings, weight gain, higher fat content in the blood (hyperlipidemia), cardiovascular (heart and blood vessel) disease, fewer red blood cells in the body (anemia), low bone density disease (osteoporosis), and [more](#).

### *Chemotherapy*

There are also drugs that help kill or stop the growth of tumours. There are many possible side effects, including low blood counts, inappropriate immune system responses in the body (e.g. hypersensitivity reactions), upset stomach (gastrointestinal upset), and nerve damage, often in the hands and feet (peripheral neuropathy).

## SURGERIES AND PROCEDURES<sup>19,37,43,44,51-56</sup>

Procedures can help lower androgen levels, completely or partially remove tumours, improve the quality of life in a client even if a cure is improbable (palliative care), or lower the total mass of cancer before medications are used in the body. Ask your HCP whether any of these procedures are right for you.

**Orchiectomy** entails removing both testes in the body to lower androgen levels. The side effects are similar to those listed in the hormone therapy section above, though may be more likely to occur or may be more severe.

**Cryosurgery**, or cryotherapy, freezes cancer cells to death using liquid nitrogen. It is designated to treat

early stage, low-risk prostate cancer, used in palliative care, or used when clients are unable to undergo surgery or radiation therapy. Side effects of cryosurgery include erectile dysfunction, inability to control your pee (incontinence), rectal pain, and inappropriate connections between the anus and the skin around the bum (called a perianal fistula).

**Radical prostatectomy** removes the prostate and some tissue around it. It is used in localized prostate cancer cases where clients are younger than 75 years old and expected to live longer than 10 years more. Side effects include erectile dysfunction and the inability to control your pee (urinary incontinence).

**Radiation therapy** uses electromagnetic waves to destroy tumour cells. Types of radiation therapy for prostate cancer include external beam radiation therapy and brachytherapy. External beam radiation therapy is offered to clients older than 70 years of age who are more likely to have complications with surgery.

**Brachytherapy**, where small seeds are put near or inside the tumour, is an internal radiation therapy method. Side effects include erectile dysfunction, urinary incontinence, increased urinary frequency, dysuria, and pain in the bum (proctitis).

More detailed information about treatment options can be found at [Canadian Cancer Society, Treatment for Prostate Cancer](#); [Prostate Cancer Diagnosis Pathway Map](#), [Cancer care Ontario](#); [Prostate Cancer, National Library of Medicine, Prostate Cancer Treatment -Patient Version](#), [National Cancer Institute](#).

## DOES PROSTATE CANCER AFFECT YOUR SEX LIFE?

Potentially, yes. The sexual consequences of prostate cancer may vary based on the tumour(s) and treatment effects.<sup>57,58</sup>

Below are some examples, but for a more comprehensive list, check out this [link](#).<sup>43</sup>

Everyone's body is different, so ask your HCP about stopping and starting sexual activity, particularly in the time during and after treatment.<sup>58</sup>

### **Libido (sexual desire)<sup>58</sup>**

An individual's appetite for sex may change due to prostate cancer and/or—more commonly—its treatment. This can be due to treatment side effects, tiredness, bodily changes, or other reasons. Speaking to your partner(s) and/or with a mental health professional may be helpful to assess and progress through this change.

### **ERECTION AND EJACULATION<sup>57,58</sup>**

Erectile dysfunction is common with several types of prostate cancer treatment. Ask your HCP if a PDE5 inhibitor (e.g., Viagra) or a cock ring may be helpful and safe for you to use.

Radical prostatectomy will stop ejaculations with semen. A 'dry orgasm' will result, where the feeling remains but no fluid comes out.

Radiotherapy can lower or completely stop any semen from coming out during orgasm in PwPs.

### **Receptive anal intercourse (RAI; bottoming)<sup>17,57</sup>**

Prostate cancer can make it feel as if there is less space in the rectum than before.

Radiotherapy may cause temporary or permanent issues, including sensitivity and/or scar tissue, to the anorectal (bum) area. During treatment and for about two months after, you may be advised to go without receptive anal sex. If it feels worse or just not the same after you resume, try using more lubricant, using a slower approach, and communicating with your partner(s) about how you are feeling throughout.

### **Urinary issues<sup>57</sup>**

Fear of losing control over when you pee can affect how you engage in sex or masturbation.

# PERSONAL HEALTH PROMOTION FOR 2SGBQ MEN AND TRANSFEMININE INDIVIDUALS AMAB

## BOTH 2SGBQ MEN AND TRANSFEMININE INDIVIDUALS<sup>19,54,59-62</sup>

### *Anal play, including receptive anal intercourse (RAI)<sup>4,57</sup>*

Prostate stimulation can temporarily increase your PSA levels. AMAB individuals who engage in receptive anal sexual activity (bottoming) should avoid these activities for a week before testing to reduce the risk of false-positive PSA results. This includes toys, fingering, and other stimulation as well.

For people who bottom but have had a prostate biopsy (taking a piece of the organ to test for cancer), wait around two weeks until any side effects of the biopsy have gone away to try receptive anal sex again.

### *Pelvic floor exercises<sup>63-65</sup>*

Urinary incontinence can be an issue for people with BPH or with previous prostate cancer treatments. By doing pelvic floor exercises for just three months, significant improvements in the number of times needed to go to the bathroom, urgency to pee, and personal confidence can result.

To perform pelvic floor exercises properly, it is important to find and activate the appropriate muscles. This factsheet on [Pelvic Floor Muscle Exercises](#) (or as a [PDF file](#)) guides the reader through the steps.

### *Living with HIV<sup>57,62,66</sup>*

Based on current research, the rate of prostate cancer is not more common in people living with HIV. This may be due to effective antiretroviral therapy improving the quality of life and extending the lifespan of people living with HIV. However, some medications for HIV infection may cause decreased bone density, which is a greater concern for people with prostate cancer due to overlapping side effects with prostate cancer treatment. Having an HCP who is educated in HIV and prostate care is helpful to have a well-rounded view of your care and to select HIV medications that do not increase your risk of bone-related issues.

The added burden of prostate cancer therapy can also be difficult for people living with HIV. However, there may be benefit for AMAB individuals living with HIV to discuss prostate screening in their 50s. To learn more, view this [short video by Dr. Amarasekaran](#), assistant professor of urology on the importance of considering screening and prostate cancer outcomes for people living with HIV.

## **Communication with your HCP, your sexual partner(s) and support groups<sup>57,59-62</sup>**

PwPs face lots of mental hurdles in dealing with prostate cancer, from feeling shame about not knowing much about prostate cancer, grief upon being diagnosed, issues with body image after treatment, and more. However, speaking with your HCP, discussing your wants and needs, and working together can empower you to take ownership in your healthcare decisions. This also applies to partner(s), where an honest environment can put you in the driver's seat when it comes to your sexual health and sexual desires. **Prostate cancer support groups** may also provide a helpful community atmosphere.

## **Diet<sup>19</sup>**

Studies on diet have mixed results but some patterns have been observed through different studies. Protective dietary choices against prostate cancer development or progression include the Mediterranean diet (e.g., olive oil, tomatoes), soy products, fish, and optimal levels of vitamin D. In contrast, high saturated fat intake, some vitamin supplements, high calcium intake, whole milk consumption, vitamin D deficiency, and high red meat consumption have been linked to a higher chance of prostate cancer onset, progression, or recurrence.

## **Medications<sup>19</sup>**

Regular statin (cholesterol-lowering drugs), metformin (used in diabetes and certain other conditions), or nonsteroidal anti-inflammatory drug (e.g., Advil/ibuprofen) use may lower prostate cancer risk. Talk to your HCP before using any of these.

## **TRANSFEMININE INDIVIDUALS POST-VAGINOPLASTY<sup>6,67-69</sup>**

Since the prostate is not removed in gender-affirming surgery (due, in part, to the risks of doing so), transfeminine individuals do retain this organ post-vaginoplasty. Some people who have undergone vaginoplasty report having a vagina that lubricates itself. This is potentially from prostatic fluid. The prostate can also serve as a sexual stimulation zone as it does in other PwPs.

Transfeminine people should talk to their HCPs about prostate health, particularly because some HCPs may forget about how prostate conditions may still affect them.

More research is needed on transfeminine individuals and prostate health.

## PERSONAL HEALTH PROMOTION

Prostate health care and prostate cancer can be scary, but you do not have to face it alone. Consider getting screened at the appropriate age, speak to your HCP if you have a family history of prostate cancer, take notice of any unusual symptoms (with respect to nighttime urination, repeated need to urinate, back pain and tenderness), and discuss challenges with achieving erection and ejaculation. There are many resources, treatment options, and support groups to stay informed, stay connected, and be proactive in your care.

# LEARN MORE ABOUT PROSTATE CANCER AND FIND A COMMUNITY GROUP NEAR YOU<sup>70</sup>

## INFORMATION PAGES<sup>57,71-75</sup>

- [Cancer Care Ontario](#)
- [Canadian Cancer Society](#)
- [Sexual and Gender diversity in Cancer Care](#), Princess Margaret Cancer Centre, University Health Network
- [Odette Cancer Centre](#), Sunnybrook Hospital
- [Prostate Cancer UK specific page for gay and bisexual men](#)
- [Prostate Cancer and Gay men, 24 hours online Support group](#)
- [Prostate Cancer Patient Empowerment Program](#)

## SUPPORT GROUPS AND HCP LOCATORS<sup>61,76-79</sup>

- Prostate Canada Network. An [interactive map of support groups](#), including a [GBTQ page](#)
- [Queering Cancer, Inclusive Cancer care](#)
- [Cancer Community Support](#)
- Rainbow Health Ontario's [service provider directory](#)
- Search for 'Physician' or 'Registered Nurse Practitioner' in the 'Healthcare Service Provider Type' box
- The Province of Ontario's page to [find a doctor or nurse practitioner](#)

## MORE RESOURCES<sup>21,64,66</sup>

- Gay & Bisexual Men Living with Prostate Cancer: From Diagnosis to Recovery. Jane M. Usser, Janette Perz, B.R. Simon Rosser. New York, NY: Harrington Park Press; 2018.
- Fact sheet: [Pelvic floor muscle exercises](#). Prostate Cancer, UK
- Video: Dr. Amarasekaran, on the importance of screening and outcomes for PLHIV. <https://www.youtube.com/watch?v=616nMGxvhlq>

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