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0:00:06.3 Jennifer Rogers: From the California Prevention Training Center in San Francisco, this is Speaking Frankly, the state of sexual health. We know good sexual health doesn't just happen. It's created. In this series, we're starting the conversations we should already be having. We'll speak with experts in the field about sex, stigma, and all of the other factors that shape our sexual health in our everyday lives. I'm Jennifer Rogers.

0:00:30.6 Jennifer Rogers: Hey, y'all. This is Jennifer Rogers, thanks for joining us for another episode of Speaking Frankly. So today is actually our last episode of season two, and I'm so excited and really proud of our show. We have been going for the past eight months, and we have almost 2000 downloads at this point. And I just wanna say a special thank you to you all because we absolutely could not have done it without you being there to listen and engage with us. So a million thank yous. If you listen to 10 episodes or if you listen to 10 minutes of an episode, thank you for supporting us and for taking your valuable time to tune in. I wanna share some news with y'all, this is not only the last episode of season two, but it's actually my last episode of hosting and producing this show. I am going to be refocusing my efforts on supporting the un-housed community, still staying within UC San Francisco, but I'm gonna be focusing my efforts elsewhere.

0:01:44.4 Jennifer Rogers: And it's really bittersweet. I have not shared this with y'all, but sexual health really strikes a deep chord for me. My mom was a young mother when she had me, her mom was a young mother when she had her first child. And both of them grew up in rural Mexico. I'm first generation American on my mom's side. And my mom nor my grandma got any form of sexual health education, like zero. So when my mom had me, she said explicitly, "We are not having history repeat itself." So she dedicated herself to making sure that talking about my body... Talking about my sexual health when it was appropriate, was not shameful, it was normal, and it was treated as natural. So that's how I grew up, and I am so thankful for that. It not only gave me a better understanding of myself and my body, but it gave me a closer relationship with both of my parents, and I'm over the moon that that is the way that it happened, and that my mom really consciously decided to break that cycle.

0:03:00.9 Jennifer Rogers: But I know that not everybody has that, and that's what drives my work. As a communicator in this public health space, I know that language, or at least I believe that language is transformative, it can plant seeds of change, it can prompt people to think differently, it can break down stigma, and I have tried to do that with this podcast. So if you've been listening in regularly, just thank you so much for making this happen, like you made this happen, and I hope that the guests that we've had on and the perspectives that we've taken and we've talked about, we've explored together, have given you something to chew on and have given you something of value. That's all I can hope for. So anyway, I am so grateful that you're here to celebrate my last episode and the last episode of this season.

0:03:57.3 Jennifer Rogers: All that said, I'm really happy to announce Dr. Rosalyn Plotzker as our guest for this episode. She's a physician and an assistant professor in the Department of Epidemiology and Biostatistics at UC San Francisco. She's gonna be talking about her work to prevent anal cancer. A lot of people are familiar with cervical cancer, if you have a cervix, you've probably had a Pap smear, which is fantastic. But a lot of people are not familiar with the fact that HPV, the human papillomavirus can also cause cancers in the anus. Dr. Plotzker's gonna speak with us about early detection through anal cancer screening, and we're so grateful that she is here. She's so passionate about this, she's such a rockstar, she has so much empathy and thoughtfulness toward the people that she serves. I just love working with her. And I hope you enjoy our conversation today. So without further ado, let's get into the conversation, and I will turn it over and let y'all hear a conversation with Rosalyn. Thanks so much y'all. Be well.

0:05:09.2 Jennifer Rogers: So thank you so much, Dr. Plotzker for being with us again. That's super fun to have you back. So can you just introduce yourself and share what you're doing around anal cancer prevention.

0:05:22.2 Dr. Rosalyn Plotzker: Yeah, of course, and thank you Jen. It's always so much fun to record these with you, so I'm really happy to be back. So in this round, I am going to be talking about anal cancer and specifically about anal cancer prevention. In addition to my role as a faculty person for the California Prevention Training Center, I was also very, very lucky to join a practice at UCSF that's called the ANCRE Clinic, which stands for the Anal Neoplasia Clinic, Research, and Education Center. I say lucky because it genuinely was a struggle. This clinic has been doing anal cancer prevention for about three decades, and it's really a pioneering clinic, so this has actually been going on for quite some time, although it is emerging generally in medicine, and so I have been training with the clinicians there, and now I provide high-resolution anoscopy as part of my work.

0:06:27.3 Jennifer Rogers: So can you define that last word?

0:06:29.5 Dr. Rosalyn Plotzker: Oh, yeah, of course, of course.

0:06:34.5 Jennifer Rogers: Inquiring minds want to know, 'cause I do not know what that means.

0:06:35.8 Dr. Rosalyn Plotzker: Yeah, what that means... So essentially, I think the easiest way to explain anal cancer screening is that it's analogous to cervical cancer screening, so the same way that people go to a gynecologist to get a Pap test to screen for cervical cancer, you can also do a Pap test in the anus to screen for anal cancer, and if that is abnormal or if there's another reason that you need to have more of a work-up, you get what's called high resolution anoscopy, which is essentially looking at the anus with a camera, the same way that you would for a cervix if you had an abnormal Pap smear.

0:07:14.4 Jennifer Rogers: That's super, super helpful, thank you. I love the analogy to a Pap smear because a huge swath of the population will be able to relate to that. Who would need this? Because it is something, as you acknowledged earlier, that while it may have been being researched for a very long time, it's not in the mainstream dialogue to have done... So who would need this?

0:07:38.2 Dr. Rosalyn Plotzker: That's such a good question. And the answer is technically, we don't know because there aren't specific guidelines out. That's actually something that I'm working on with a group that's called the International Anal Neoplasia Society, so that's a group of providers who are trying to create guidelines on this, but they don't exist yet. What we do know based on the research that's been accumulating, is that anal cancer is much more common if you have a patient who is immunocompromised, so that would include people who are living with HIV, especially men who have sex with men and trans women who have sex with men. That is a group that is especially at risk for anal cancer.

0:08:22.5 Dr. Rosalyn Plotzker: The rates are about what the rates were for cervical cancer before there were Pap smears, which is one reason I say they're so analogous besides the physiology around it. People living with HIV, also men who have sex with men in general, are at a slightly increased risk, and so for a lot of people who are providing gay men's health, they'll do anal Pap smears as part of that, and if you have a person who's had another HPV-related cancer, especially if you have somebody who's had vulvar cancer in the past, or vaginal cancer or cervical cancer, they would also be really good candidates to get screened for anal cancer because it's the exact same mechanism from the exact same virus, so those are all people who could really benefit from this.

0:09:14.4 Dr. Rosalyn Plotzker: And then the last group is a question mark group, but I think it's worth considering, are people who have what's called inflammatory bowel disease or IBD, and that's basically Crohn's or ulcerative colitis. That's another group that sometimes people are thinking about for anal cancer screening, and other people who are on any type of immunosuppressive therapy, if you're taking a medication that suppresses your immune system, that could increase your risk. If you've had a solid organ transplant and you're on immunosuppressive therapy for that, that's another group. So there's all these different groups, and I think the last group that I haven't mentioned are people who have really bad anal or genital warts, which is interesting because warts don't become cancer, so warts do not go on to become cancer, but if you have warts, those are caused by HPV, and if you have one strain of HPV, it's possible you have another strain of HPV that could cause cancer, and because you have warts, we can see that your immune system isn't doing a great job of controlling that HPV, and that's why you're developing warts. So if you also have a high-risk strain of HPV, your immune system might not be great at controlling that strain of HPV too.

0:10:35.1 Dr. Rosalyn Plotzker: So it's a little bit of a signal. That's also something that we're figuring out through research, but some people, if they have a patient who has really bad warts, we'll refer them to our clinic for further workup.

0:10:46.4 Jennifer Rogers: This is fascinating.

0:10:47.8 Dr. Rosalyn Plotzker: I know!

0:10:49.2 Jennifer Rogers: Thank you for this. So I don't know if you remember, but one of the first conversations I had with you, like three years ago when I first started, was about HPV in the kitchen. HPV while we were conversing in the kitchen.

0:11:00.1 Dr. Rosalyn Plotzker: When we were in the kitchen.

0:11:01.4 Jennifer Rogers: It's a tricky, tricky virus.

0:11:06.8 Dr. Rosalyn Plotzker: Yeah.

0:11:08.0 Jennifer Rogers: It's so interesting, so I'm gonna ask you some questions to get into the weeds on this a bit more. So first of all, I think it's really important to say that when we think of anal sex socially, I think that there's a stereotype still that it's... For partners who are gay, for folks who identify as gay, or folks who I think are in the queer community, and we just know that that's not true, so I think it's really important to acknowledge that, that like everybody can consensually engage in anal sex if they want to and there's obviously absolutely nothing wrong with that. But that said, why is there an increased risk for folks who are engaging in anal sex more frequently, if I understood you correctly?

0:11:53.7 Dr. Rosalyn Plotzker: It's interesting. It's not necessarily... Receptive anal sex for men is a risk factor or cis men or trans women, essentially, that just has to do with anatomy. If you have a person who goes to the gynecologist who has a vagina and has receptive vaginal sex, then there's a lot of research out there that considers the vagina and the rectum to almost be a single compartment. For people who have a vagina and have receptive vaginal sex, you do not need to have anal sex to be at risk for anal cancer. So actually, among cis women who... Or trans men who are diagnosed with anal cancer, there isn't really a relationship between having receptive anal sex and developing anal cancer down the road, and that's just because the anatomy is so close together that if you have HPV and it's vaginal HPV, it's very easy for the HPV to move to the anus, because those two spots are so close together.

0:13:02.8 Dr. Rosalyn Plotzker: Even when you're wiping when you go to the bathroom, we tell people wipe from front to back, you can actually move the HPV backwards, so it's an anatomical thing. If you think about the anatomy and the distance between a penis and a rectum, it's farther, and so among people who are HIV negative, who don't have receptive anal sex, for men who have sex with women, the rates of anal cancer are actually lower than they are for women, so if you're just looking at the general population, there's a slightly increased risk for anal cancer among women compared to men.

0:13:39.6 Jennifer Rogers: So it seems more like it's... The likelihood increases if one is a receptive partner of any type of sex. With a penis.

0:13:47.6 Dr. Rosalyn Plotzker: Yeah, that's a great way to put it, so if you have receptive sex...

0:13:52.0 Jennifer Rogers: Receptive sex, right.

0:13:52.6 Dr. Rosalyn Plotzker: If you have receptive sex, whether it is anal or vaginal, if you have a vagina...

0:13:58.2 Jennifer Rogers: Or both, right?

0:14:00.3 Dr. Rosalyn Plotzker: Or both, yeah, exactly.

0:14:03.8 Jennifer Rogers: Okay.

0:14:04.3 Dr. Rosalyn Plotzker: But it really just has to do with the likelihood that HPV is able to get to the anus.

0:14:07.6 Jennifer Rogers: Gotcha, okay, got it. So I've read statistics that they say, and correct me, please. Upwards of 90% of sexually active people will have some sort of HPV, some strain... So the flu has many different strains, and so this helps me understand it in my head, and so HPV, there's strain 16 and 18 and different strains. And so some can be in the cancer-causing potential category and some strains are going to be benign. Can you tell me more about that? And correct me if I'm totally off base.

0:14:45.8 Dr. Rosalyn Plotzker: No, that was a great way of explaining it. Basically, I mean, there literally are hundreds of strains of HPV. The strains that are able to infect the anus are what we call mucosal strains, but really the point is that there are two buckets that we think about with HPV when it comes to anal cancer. There are strains that can cause warts, and there are strains that can cause cancer, so like you said, the ones that can cause cancer, 16-18 are the most common ones, but there's a handful of them. When we do HPV testing, which we do, there are tests specifically for 16, specifically for 18. So essentially with HPV, there are two main buckets that you think of, you have what's called high-risk HPV, which can go on to cause cancer, and you have low-risk HPV, which can go on to cause warts, and the intermediary step for both of those is called dysplasia, but there's high-grade dysplasia for high-risk, there's a low-grade dysplasia for low-risk, and sometimes that low-grade dysplasia will go on to cause warts, and sometimes a high-grade dysplasia can go on to cause cancer, and that can take decades.

0:15:55.1 Dr. Rosalyn Plotzker: You could have high-grade literally for decades, and then at some point, decades down the road, you develop anal cancer. There are two categories of HPV, and like you said, 16 and 18 are the main ones that are associated with cancer, but there are other ones that are called high-risk, non-16, non-18 kind of... That's kind of like the general term that they use when they're doing tests, and then the low-risk ones are 6 and 11.

0:16:22.5 Jennifer Rogers: Given that, I would be thinking, "Okay, well, how do I prevent this virus? Can I prevent it, given that statistically, it sounds like most people will get it in their lifetime... " Yeah, so how would one prevent it or try to prevent it, or should we try to prevent it?

0:16:44.5 Dr. Rosalyn Plotzker: I mean, we should try to prevent it 'cause it's preventable... I mean, I am a preventive medicine doctor, that is my specialty is prevention, so... Yes, please. Get your vaccines. There's a vaccine for HPV, it's a Gardasil vaccine, but it basically covers nine strains of HPV, it doesn't cover all of them, but it covers the two most common ones that cause warts, it covers 16 and 18, and then it also covers five additional high-risk strains. So that is a vaccine that's an option for prevention, it's recommended in childhood, but you can get it up to age 45. So if you've had HPV in the past, I don't think there's anything wrong with getting the vaccine if you're eligible for it, that's fine, 'cause it could protect you from strains you might not have been exposed to yet. Unfortunately, condoms don't protect you from HPV, they lower the risk of transmission, but they don't actually do a great job of protecting you 100%. Not that you shouldn't use condoms, please use condoms. Prevent other STDs.

0:17:53.6 Jennifer Rogers: Right. That's not what you're saying. That's not what... Wear the condoms.

0:17:56.8 Dr. Rosalyn Plotzker: Wear a condom, prevent other STDs. But for HPV, if you are concerned that, let's say you have a partner and you know that your partner has HPV and you think "I'll use a condom, so I will not get HPV," that doesn't really work, but if you're vaccinated that can provide some protection.

0:18:16.8 Jennifer Rogers: So a couple of questions. When I was a teen and young adult, this didn't exist, and I remember when it came out, I was like, "Damn it. That's so unfortunate." And...

0:18:29.1 Dr. Rosalyn Plotzker: Oh, the vaccine.

0:18:29.2 Jennifer Rogers: The vaccine didn't exist. Gardasil didn't exist. And then just more recently, I know that they came out with the one for older adults, so why is there an age limit? Why does the vaccine go only to 45?

0:18:44.0 Dr. Rosalyn Plotzker: Oh, this is such a good question. You've got a lot of good questions today. The first reason has to do with FDA approval, they're looking at the vaccine at different age groups, and they're prioritizing the younger ones, so you can make the most difference if you vaccinate somebody before there's an opportunity for exposure, and so when they were developing the vaccine they're like, "Okay, first and foremost, we need to make sure that this is safe, and we can give it to people who may not be sexually active yet, so that we can prevent HPV down the road." So they prioritized younger people for that reason, and I have to admit, I'm not involved in these trials, and so I don't know the nitty-gritty details, but from what I understand, a lot of it has to do with a combination of looking at safety and prioritizing groups, and so you're gonna prioritize people who are younger, and then I'm also thinking practically that if people are... By the time they're in their 40s, are pretty much exposed to HPV at this point.

0:19:50.1 Dr. Rosalyn Plotzker: Thinking about how much help this vaccine has to offer for those groups. And like I said, I think that there's no harm in getting it and that if you haven't been exposed to certain strains, it will protect you from those, especially if you're going to have new sex partners, but also it takes decades and decades for anal cancer to develop potentially. So if you are a... Let's say you're a 75-year-old person and you don't have HPV, hypothetically if you were to be exposed to HPV, there's less time for that HPV to go on to become dysplasia and then become cancer. Not that it couldn't happen, but that there's just less time for it to happen. So I think that that's another way that they think about it is that this is really a long game that you have to play.

0:20:47.1 Jennifer Rogers: Yeah. That feeds into my next question is, are there symptoms? So it sounds like in the bucket of strains that can cause and not necessarily will cause warts, warts would be the symptom.

0:21:02.0 Dr. Rosalyn Plotzker: Yep. Exactly.

0:21:03.0 Jennifer Rogers: Small skin-colored bumps in the pubic region or vulva area or penile area...

0:21:11.0 Dr. Rosalyn Plotzker: Or in the anus.

0:21:12.0 Jennifer Rogers: Or in the anus.

0:21:12.9 Dr. Rosalyn Plotzker: Oh, can we do a little anatomy break?

0:21:15.0 Jennifer Rogers: Oh, yes. Please, please. Oh, I love, love, love. Go. Yep, let's do it.

0:21:19.1 Dr. Rosalyn Plotzker: Okay. You'd be surprised how many people are curious about anal anatomy. There are so many questions.

0:21:24.9 Jennifer Rogers: Love it.

0:21:25.1 Dr. Rosalyn Plotzker: So basically when you think about the anus, you think about the outside and the inside. So the external part is called the perianus, which means the skin that's around the anus. So that's like when babies get diaper rash, when you get... When people get Brazilians, that's what gets waxed. There's the skin that's a few centimeters around the anus and so that's called the perianus and then the entrance to the anus is the verge, which is literally when you go from the perianus into the anus and then you have the anal canal.

0:22:00.0 Jennifer Rogers: Like the actual entrance?

0:22:02.1 Dr. Rosalyn Plotzker: Right.

0:22:02.5 Jennifer Rogers: Okay.

0:22:02.6 Dr. Rosalyn Plotzker: So you have the anal verge, you have the perianus, and those areas are very sensitive, they have a lot of nerve endings. And so when you are experiencing symptoms, this is where I get into it, when you experience symptoms, if you have itching or pain or things like that, then that would be something that you would probably notice more with the perianus. Same with warts. Then inside the anus you have the anal canal, which is divided into... There's the distal canal, which is more innervated and then you go up to the proximal canal, which is closer to the rectum and so the whole anus is about one to two inches. It's actually not that long. And then beyond that is where you get into the rectum, which is just part of the colon. The last part of the colon is the rectum. So when you have symptoms, you could have a whole range. You could have itching, you could have bleeding and the bleeding is confusing because sometimes people often have hemorrhoids as well, so they could think it's a hemorrhoid that happens all the time and they couldn't...

0:23:09.0 Jennifer Rogers: And this is regardless of any strain?

0:23:12.1 Dr. Rosalyn Plotzker: Yes, yes.

0:23:13.0 Jennifer Rogers: It could present this way.

0:23:14.6 Dr. Rosalyn Plotzker: Yep, yep.

0:23:15.1 Jennifer Rogers: Okay. Got it.

0:23:16.1 Dr. Rosalyn Plotzker: And the thing that's tricky is that when you have the precursors, so if you have a cancer precursor or a wart precursor, there aren't symptoms for that. If you have an early cancer or you have cancer, then you might notice a mass, you might notice some discomfort, but the things that precede that, which is what we look for when we do high resolution anoscopy, those are typically asymptomatic, which is why we do screening.

0:23:44.0 Jennifer Rogers: Right. So when do folks need to be screened?

0:23:49.0 Dr. Rosalyn Plotzker: Another tough question. [chuckle]

0:23:52.0 Jennifer Rogers: Darn, sorry. [laughter]

0:23:53.0 Dr. Rosalyn Plotzker: No, no, it's good. No, no, this is why... This is really interesting.

0:23:56.0 Jennifer Rogers: This is why we're doing this. Yeah.

0:23:57.0 Dr. Rosalyn Plotzker: This is why we're doing this 'cause we don't know the answers. People with screening, it varies from practice to practice. Typically when you are screening, there's different ways that people approach screening. One is just to do the Pap test and for people with HIV, there are some groups that do a swab once a year and then... It depends on the risk factor. In our clinic, once you come to our clinic, it's usually because there's something abnormal. And then we will have people come back for follow-up and monitoring anywhere from every six months to every year and then if consistently you aren't having any problems, we might space that out to every two years, but at this point, there isn't a ton of guidance about how often people need to be seen.

0:24:47.9 Jennifer Rogers: And I know that you said that some of your colleagues are working on creating that guidance. Is that correct?

0:24:54.0 Dr. Rosalyn Plotzker: Yeah. So I am super, super lucky for a million reasons, but one of them is that I get to participate in a taskforce that is through the International Anal Neoplasia Society and that is with one of my mentors, I call her my anal sensei, Naomi Jay.

0:25:12.1 Jennifer Rogers: That's fantastic.

0:25:13.6 Dr. Rosalyn Plotzker: Yeah.

0:25:14.0 Jennifer Rogers: Love it.

0:25:14.1 Dr. Rosalyn Plotzker: Everyone needs a anal sensei. So yeah, Naomi Jay is also a provider at the clinic and invited me to join this International Anal Neoplasia Society taskforce to work on creating a guidance because there really isn't one. The CDC's new treatment guideline just came out with something which is basically to do a digital rectal exam, oh my gosh, which I haven't even mentioned. So some places in addition to doing a Pap test will do a digital exam where they feel on the inside and they're basically just feeling to see if they feel any lumps or bumps or anything that's concerning.

0:25:49.0 Jennifer Rogers: Okay.

0:25:50.6 Dr. Rosalyn Plotzker: And if they feel something, then they'll refer the patient either to us or some people will refer them to get a colonoscopy. So that's the International Anal Neoplasia Society and the CDC's STI treatment guidance, which came out very recently this summer now includes a recommendation to do a digital exam, but they actually don't recommend doing a Pap test explicitly.

0:26:16.6 Jennifer Rogers: And why is that?

0:26:17.9 Dr. Rosalyn Plotzker: I'm not 100% sure. I think it might have to do with evidence that this is actually helpful. The cytology or Pap test, it's not the best test in the world, honestly. There are plenty of times where I'll do a Pap and the Pap test will come back as low grade. So you'll have your low risk screen or your low grade changes, but then when I look with the camera and I see something and I biopsy it, it comes back as a high grade lesion, which is a precursor. So that can happen and vice versa, sometimes the swab will pick up on something that is high grade, but when I look with my own eyes, I see a lesion and it turns out that it's a low-grade lesion, so maybe there is something that's high grade that is in there, that isn't visible.

0:27:04.7 Jennifer Rogers: Right. So it's really a combination of the two methods...

0:27:06.2 Dr. Rosalyn Plotzker: So you need both. Yeah.

0:27:10.0 Jennifer Rogers: To attack it. I know...

0:27:10.2 Dr. Rosalyn Plotzker: Yeah, exactly.

0:27:10.2 Jennifer Rogers: I'll just share my own experience. That's exactly what happened to me. They did, they saw a low grade, but when they ended up taking an actual... Like a biopsy, it was high grade. And so we had to work with that. Okay, so it's a combo.

0:27:28.0 Dr. Rosalyn Plotzker: It's a combination, it's a probability game, and it's not an easy exam to do. When I was learning how to do it, it took me a long time to get the dexterity in my hand right to see the entire anus. It's much harder than doing a cervical exam because the cervix is this fixed thing that you can just look at, and the anus is something where there's lots of tissue and it kind of folds on top of each other and you have to open the folds up, so it actually is... It's pretty tricky. I was really surprised how tricky it was when I started doing it. I should also, by the way, give a quick shout-out to another mentor who is an amazing mentor since I mentioned Naomi Jay, which is Dr. Michael Berry, who is... Seriously, I couldn't have asked for a better... More patient, caring mentor. I can't mention Naomi Jay without also mentioning Michael Berry. And Joel Palefsky, who is el jefe of our clinic and also is a really good leader. I wanna mention everyone at my clinic, you can see whenever... I'm really gonna start gushing and talk about everybody.

0:28:37.5 Jennifer Rogers: Well, I love that. That's great, yeah.

0:28:39.0 Dr. Rosalyn Plotzker: But I mean, that's... I'm not just at this clinic for their anuses, also for my colleagues.

[laughter]

0:28:47.5 Jennifer Rogers: Oh my god, okay, so that's a great segue. My perspective on this podcast, part of me is always to try our best to talk about topics that are just like this. And I love and appreciate so much that you, A, wanna talk about this work because just... The word anus turns people off. Anal sex turns people off, when you're talking about it. And we know that people are turned on by it though, a lot of folks, so because we know it's happening, right? And so it just isn't something that needs to be in the shadows, and I'm wondering... Given the place where we are culturally, what are your thoughts about where we've been in terms of stigma around anal sex, where we are and where we're going... Do you know what I mean?

0:29:39.7 Dr. Rosalyn Plotzker: No, totally, and that's actually another reason I'm very passionate about this work. I think of it the same way I think of anal cancer as analogous to cervical cancer happens theologically. I also think that there's a very, very strong parallel between thinking about a world where people didn't care about women's health. This is very similar, people not caring about gay men's health. And imagine a world back where gynecology wasn't really prioritized once a woman had a baby, that was it. And there wasn't much interest or value in a reproductive tract. And that obviously is rooted in a lot of misogyny and historical things that do not value women's health, and that has all kinds of political underpinnings.

0:30:33.4 Dr. Rosalyn Plotzker: And so now I do think that there is a very, very important role for medicine to support people who are part of the queer community, and particularly people who are part of the gay community who haven't been getting good medical care, and this really relates to back when there was the AIDS crisis, and this is when a lot of gay men's health started to gain a lot of traction. That was much more tragic. But continuing on that legacy, I think that both acknowledging the importance of people's sexuality and also acknowledging that this is a person who has health care needs as a result of this perfectly acceptable and normal behavior is something that we have a moral imperative to do as doctors.

0:31:24.8 Dr. Rosalyn Plotzker: And I can tell you that there have been patients who I've talked to, who have expressed stories where they feel that their health care needs related to their sexuality are not met, and that's a major problem. I do think that this is important from a healthcare perspective, but also important in terms of just supporting people who are having anal sex. There shouldn't be stigma, and that eventually the same way... Eventually eventually eventually, this will be normalized the way that getting a Pap smear is normalized, the way that getting up colonoscopy is normalized. Or getting a breast exam for that matter. Breast cancer used to be incredibly stigmatized in...

0:32:09.3 Jennifer Rogers: I did not know that.

0:32:10.8 Dr. Rosalyn Plotzker: Yeah, yeah, in the '20s and '30s and '40s, it was...

0:32:13.0 Jennifer Rogers: Oh, really?

0:32:13.2 Dr. Rosalyn Plotzker: Yup, there were people... I can tell you, my personal experience. My grandmother who passed away from breast cancer, did not want to go to a doctor because she was in denial because when you had a mastectomy, which was the only treatment back then, that was considered losing your womanhood. You lost your femininity, and then what was left? So I think that this is your identity and your body and being taken care of, all kind of being tied together in a way that's very important. For much more than the one inch or two inches that I'm looking at.

0:32:52.0 Jennifer Rogers: It sounds like what I'm hearing is this really unique opportunity for physicians in particular in this situation to be advocates, and not just as you say, for the small portion that you're actually swabbing of the body, but for the entirety of the human being... Right, 'cause the... As much as it seems like we've tried purposefully or not purposefully, like the psyche and the humanity sometimes seems to be removed from the physical body when we're talking about medical care, but what can your physician working in this space that is considered taboo by some... What can physicians and regular folk like myself do to help normalize it, like anal cancer or anything?

0:33:51.9 Dr. Rosalyn Plotzker: Just talk about it all the time... Just talk about it, it's not a big deal. Relax about it. You know what I mean? I think it's... I mean, I understand. It's personal, right?

0:34:01.2 Jennifer Rogers: Sure.

0:34:01.2 Dr. Rosalyn Plotzker: But I do think that this podcast is amazing, that you are recording this and asking me about it, and at this point, I've been hearing at work long enough that I just talk about it, it's no big deal, and then I remember that this isn't everyone else's world, but I think the more that you talk about it, like my mom knows way more about a cancer prevention than I bet she ever bargained for... Just talking about it, frankly, and having a good sense of humor about it and sort of putting it in there with like, "Yeah, I went to a meeting today, I had to do some anoscopy, and then I checked my email... " It's just part of a normal thing.

0:34:49.9 Jennifer Rogers: It'll be a normal thing, but I think what you're doing though is really strategic, right? I think people think about language is just... It is, on one hand, it can be benign, but language can also be so powerful and you're using it strategically to just drop it in there, and when you normalize that people might feel more comfortable asking questions about it and you know, who knows, they may go get a screening, because they've learned something from you or whomever speaking about it, so...

0:35:17.5 Dr. Rosalyn Plotzker: I do think that how you talk about it can be done well and not well, so I've learned over the past couple of years of doing this, that if I'm at a party and someone says, "What kind of clinic do you work in? Usually what I'll start with is I'll say," I do cancer prevention for HPV-related cancers", and then if they keep asking questions, then I can continue and say, "Oh, the type of HPV-related cancer that I am specifically working on is anal cancer." And then we go from there, but I think that for people who are not in medicine or healthcare, sometimes it does take a little bit of a gentle introduction rather than say, "I do anal cancer prevention," and then for some people, they just change the subject. Putting it into the context of like, "This is cancer prevention, it's related to HPV, and this is the body part that I am working on", people are pretty receptive to that line of thinking.

0:36:27.7 Jennifer Rogers: I like that, and then it also seems to take the focus away from whatever negative stereotype may exist because there's an association with the behavior of anal sex, that it's like, HPV can impact the vagina and the penis and the throat for that matter. Right?

0:36:55.5 Dr. Rosalyn Plotzker: And the throat, yep.

0:36:57.2 Jennifer Rogers: Right, and so I think when we think about it that way, it's... I don't know, it's somehow... It's less weighty or something? More normalized?

0:37:04.1 Dr. Rosalyn Plotzker: Yeah, yeah, it takes the focus off the thing that makes people uncomfortable and actually says, "Here's the actual issue, and that thing that made you uncomfortable is just really not that uncomfortable, it's just part of this bigger picture, which is cancer and cancer prevention."

0:37:23.1 Jennifer Rogers: I wanna ask you as we close. What would you like to share with us that we need to know more about? And what do you love most about your job?

0:37:38.3 Dr. Rosalyn Plotzker: Oh my God. Well, I don't know know what you need to know more about, but I can say that I've been talking for the last 40 minutes, but I feel like the thing I love most about my job is my patients, but I honestly, I love seeing my patients and having a chance to hear about how their life is going. And I am really lucky... One of the things I like about my job is that when I see patients, I get a good chunk of the time, because we have to do the procedure as well, so I get to have anywhere from half an hour to an hour to really talk with them and I think that's hands down the best part of the job and probably... I think that for a lot of doctors, that's why they go into healthcare 'cause it's just great taking care of patients, and so that's the easy... That's an easy answer there.

0:38:31.7 Jennifer Rogers: I love that and you're just so... The passion for the work you do, it just exudes from you and it's just really lovely to see, so...

0:38:42.3 Dr. Rosalyn Plotzker: Yay! Oh, another thing, another thing, actually, I thought of something that you should know.

0:38:46.1 Jennifer Rogers: Tell me.

0:38:46.7 Dr. Rosalyn Plotzker: Okay, another thing that you should know is that there is... I don't know if anyone listening is interested in research, but there's a research study that is going on now, and it's a multi-site research study looking to see if doing anoscopy where you find the lesion and then you... Oh, I didn't even say how we treat it, so one of the ways that we treat lesions is we basically zap them with a little electric current, so we burn off the tissue.

0:39:16.9 Jennifer Rogers: Wow.

0:39:19.0 Dr. Rosalyn Plotzker: So if there's a high grade lesion, we get rid of it before it can go on to become cancer, right?

0:39:25.9 Jennifer Rogers: So is that equivalent to a LEEP procedure? In cervical cancer?

0:39:30.1 Dr. Rosalyn Plotzker: Kind of. In cervical cancer a LEEP procedure is when you basically excise the lesion, meaning you cut it out. And for this one, it's kind of more like, even though you can freeze off warts that's like... It's called ablation, so the general term for destroying the tissue is called ablation, and so one of the things that we do at our clinic, if we do find a cancer precursor, one of the treatment options is to basically burn it off, and we do that it's an office procedure, it's not an operating room procedure, and we use local anesthetic, so it's actually not as scary as it sounds.

0:40:07.9 Dr. Rosalyn Plotzker: But anyway, so there's a research study right now that's going on to look at how effective that is in actually preventing anal cancer, and so for anybody who is interested in research out there, the study is called the Anchor Study, spelled A-N-C-H-O-R, like the anchor off a ship, not to be confused with our clinic, which is also pronounced ANCRE, but spelled differently. And so, if you Google Anchor Study, it's all about it. There's sites all over the country. Our clinic director, Joe Palefsky, is the principal investigator. It's specifically for people who have HIV, so it's something that's looking at that group. We're really excited to see the outcome and that'll give us some definitive answers about how well this actually works.

0:41:00.2 Jennifer Rogers: Okay. So we should all be looking up, Googling A-N-C-H-O-R study... Yes? Anchor Study. And to learn more about the work that you do at the ANCRE Clinic, where do folks go? Or if they're interested in making an appointment, right?

0:41:16.7 Dr. Rosalyn Plotzker: We get patients by referral because it's getting a follow-up, so what we do is the follow-up to something that's abnormal, whether it's an abnormal cytology or Pap, or sometimes people have warts and their doctor refers them to us 'cause the warts are very bad, or you have an abnormal colonoscopy, someone sees something during your colonoscopy. So, it's something that we do by referrals, but anybody who's listening who thinks that they might benefit from anal Pap, I would say start by talking to your primary care doctor, just asking them about it. If you go to a gynecologist, you could ask your gynecologist about it and let them know that you are interested. You can email me if you want to pick my brain.

0:42:03.1 Jennifer Rogers: Love that. Do you wanna put your email out there?

0:42:06.4 Dr. Rosalyn Plotzker: Oh yeah, my email's rosalyn.plotzker@UCSF.EDU.

0:42:10.9 Jennifer Rogers: Awesome, and we can put it in the show notes. So, if you have questions for Dr. Plotzker, please send them her way. So, thank you so much for being here. I really appreciate it, and this has been awesome. I certainly have learned a lot about the nuances of HPV. All right. Well, thank you so much and I appreciate your time.

0:42:36.1 Dr. Rosalyn Plotzker: I appreciate your time too. This was so fun as always.

0:42:39.9 Jennifer Rogers: Thanks again to our guest, Dr. Rosalyn Plotzker, physician and Assistant Professor in the Department of Epidemiology and Biostatistics at UC San Francisco. Speaking Frankly is produced by me, Jennifer Rogers and Laura Marie Lazar, and is edited by Podcast Prowess.