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Experiences and concerns of lesbian, gay, or bisexual individuals with colorectal cancer

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Abstract

Purpose/Objectives—To identify the experiences and needs of LGB survivors of colorectal cancer (CRC) and to expand the current understanding of LGB survivorship by obtaining in-depth knowledge of survivorship among individuals with a cancer other than breast or prostate.

Research Approach—We developed an interview guide and conducted qualitative semi-structured individual telephone interviews.

Setting—Participants were recruited using social media, flyers, word of mouth, and by contacting LGB and cancer organizations during a 4 month recruitment period.

Participants—Eight LGB individuals with a diagnosis of stage III CRC between 2009 and 2014.

Methodologic Approach—All interviews were audiotaped and then transcribed verbatim. Thematic analysis performed by more than one analyst was used for the interview transcripts.

Findings—Participants described experiences with social support and isolation, cancer care from a LGB perspective, and substantial economic impacts of their cancer diagnosis. Participants struggled with health insurance coverage, employment, and housing during and after their treatment for CRC.

Conclusions—In addition to issues about sexual identity disclosure, and social support, there are economic impacts of CRC on LGB men and women that are likely critical to healthy survivorship.

Interpretation—Attention should be paid to the economic impact of CRC on LGB individuals in addition to social support and sexual identity disclosure. Oncology nurses could play an important role in determining the economic and social needs of CRC patients, accepting the often non-traditional support networks of LGB individuals, and facilitating disclosure of a LGB identity.

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Keywords

colorectal cancer; cancer survivorship; sexual minority; patient experience; qualitative methodology

Introduction

Colorectal cancer (CRC) is the third most common cancer in men and women, yet CRC survivorship is understudied. To our knowledge, CRC survivorship among lesbian, gay, or bisexual (LGB) individuals has never been studied, despite research indicating LGBs have greater risk factors for CRC (Institute of Medicine, 2011; The President's Cancer Panel, 2007), as well as higher CRC incidence, prevalence, and mortality (Boehmer, Ozonoff, & Miao, 2011; Fredriksen-Goldsen, 2011) than the general population. Recently, a few studies of LGB's overall cancer survivorship included colorectal along with other cancers (Margolies & Kamen, 2015; Matthews et al., 2015), yet LGB's experiences were not analyzed by cancer type. Currently what is known about LGB cancer survivorship stems primarily from studies of breast or prostate cancer (Boehmer & Elk, 2015; Simon Rosser et al., 2016). Studies of survivorship by sexual orientation are inconsistent, with some indicating LGB and heterosexual survivors have similar quality of life, while others concluded LGB survivors have worse quality of life compared to heterosexuals (Boehmer, 2015; Boehmer, Miao, & Ozonoff, 2011; Simon Rosser et al., 2016; Ussher et al., 2016). Reasons for these inconsistencies in study findings are unclear, and given that studies mostly focused on prostate and breast cancer, patients' gender and cancer type are confounded. We sought to expand the current understanding of LGB survivorship by focusing on a cancer other than breast or prostate. Since CRC survivorship has never been studied among LGB individuals, this study's purpose was to identify the experiences and needs of male and female LGB survivors who have a diagnosis of CRC. Our goal for this initial study was to determine the issues most salient to LGB CRC survivors to: (1) ensure that the identified issues were included in future research about quality of life among CRC cancer survivors; (2) raise awareness of the experiences faced by LGB individuals in cancer care settings; and (3) provide preliminary data for survivorship care models that address the needs of LGB survivors.

Methods

The study was approved by the Institutional Review Board at Boston University.

Recruitment and Procedures

Community-based purposive sampling was employed in recruiting LGB participants for the study, using social media, flyers, word of mouth, and by contacting approximately 35 LGB and cancer organizations during a 4 month recruitment period (September 2014 to December 2014). The recruitment message for the study asked potential participants to contact the research team by email or by phone. Participants were eligible for the study if they met three criteria: 1) 5 years or less since diagnosis of colorectal cancer; 2) cancer at stage III or lower at the time of the interview; and 3) self-identified as sexual minority. Thirteen individuals

contacted the research team and were screened for eligibility. Five individuals did not meet eligibility criteria for the study because their diagnosis was greater than 5 years ago or they were diagnosed with anal cancer; the remaining eight individuals screened eligible. Recruitment continued until no new themes were identified in the interviews. After informed consent was obtained from eligible participants, telephone interviews were conducted, which were audio-recorded and lasted between 30 to 45 minutes. We used a semi-structured interview guide, comprised of questions about survivors' current well-being, interactions with the health care system and providers, and about their perceptions of their cancer experience as sexual minority individuals. At the end of each interview, sociodemographic information was collected using structured questions. Interviews were transcribed verbatim by a professional transcription service. After transcription, the first author reviewed each transcript with the audio recording to verify its accuracy.

Analysis

Summary statistics of the screening and sociodemographic data were calculated.

The interview transcripts were analyzed by two of the authors using procedures and principles of qualitative data analysis (Strauss & Corbin, 1990; Ulin, Robinson, & Tolley, 2005). Specifically, each transcript was coded inductively and deductively consistent with the domains laid out by the interview guide. To apply qualitative rigor, two of the authors, discussed differences in coding, then recoded and made refinements in codes to capture the interviewees' meanings and experiences. The finalized codes were then grouped into higher level domains, which had as the underlying structure lower level codes; e.g., under the domain economic impact we grouped housing and employment. Because we were interested in general themes of participant experiences (e.g. colostomy), by design, we retained a theme when at least three of the eight participants addressed it, excluding infrequent or single occurrences of themes from further analysis. Finally through ongoing discussion between two of the authors and with input from the third author, the illustrative quotes for each theme were selected for the text.

Results

Participant characteristics

We completed telephone interviews with eight individuals who had a diagnosis of stage III CRC within the past five years; two had since had a recurrence and four were currently undergoing treatment. On average, participants were 49 years of age, four were women and four were men. Six reported as lesbian or gay and two as bisexual; six self-reported as non-Hispanic White, one as white Hispanic, and one as American Indian. Two of the participants reported being retired, three unemployed, and three employed. Of the employed, two were currently on leave through the Federal Family and Medical Leave program. All of the participants reported having health insurance at the time of the interview, yet health insurance coverage had not been stable for most since the time of their diagnosis. With respect to participants' economic situation, two reported having enough money for bills and extras, one having just enough to pay the bills, three reported having had to cut back on

expenses in order to pay their bills, and two reported not having enough money to pay their bills.

All participants first grounded their remarks about their experience with CRC by describing their diagnosis and treatment as distressing and difficult. Many participants talked about a “new normal” after cancer. Participants described common symptoms during and after treatment including fatigue, neuropathy, wounds after surgery, difficulties adjusting to stomas, changes in appetite, and what one woman described as the “cancer fog.”

Three major themes emerged from the data: 1) social support and isolation; 2) the economic impact of CRC; and 3) LGB identity and CRC care.

Social support/isolation

Social support was an issue for survivors at the time of treatment and once treatment was completed. One 55 year old woman described the support she received during her treatment saying:

Actually in many ways, the church is my support network. But, it's kind of in a weird way that they're my support network when I'm there. But, when I'm not there, they're not, you know what I mean. (...) it was kind of like an arm's length support.

A 64 year old male participant who was still in treatment at the time of the interview, reported on the three days per week of treatment, when he was not allowed to leave his home:

I wish I did [have visitors]. But, no one, you know, most people I know, they're either working or, you know, people...I think tend to be a little more involved in their own self and a little more involved in what they want to do.(...) You know, the support is there, if I really need it. Say a ride to a procedure where I'm going to be given IV sedation or something like that, usually I can get it, but in terms of support while I'm doing treatment, coming over here... my friends are kind of missing on that. And that's a little disappointing.

A 52 year old woman described feelings of social isolation when she was talking about her “new social life” after cancer. She said due to fatigue and other issues she is still experiencing after treatment she can't make plans with friends like she used to:

...even just going to dinner with friends, it's like -now, it's better, but during the course of treatment, it's like -you want to go to dinner, you know, it's. Okay, today's a good example. Today's Tuesday, do you want to go to dinner on Saturday? I don't know how I'm going to feel on Saturday. You know? Yeah, before I was, I think I would go, yeah, yeah, sure, let's go out on Saturday night. [Now] I don't know how I'm going to feel on Saturday. So I have [to think], is it a chemo week, is it a non-chemo week. All those things factor in and change it.”

Economic impact of CRC

Employment, health insurance, and housing are three ways in which LGB survivors reported being economically affected. Regarding employment, one interviewee was retired, one retired after their diagnosis, two reported losing their job as a result of their cancer diagnosis, and one reported having been forced to decline a full-time position due to cancer. For example, a 52 year old woman described losing her job:

I was a call center manager in a medical firm... [my employer] called me... [after being on long-term disability for treatment] and said, 'We got the latest notes from your doctor, and since your cancer treatment is not being completed in a timely fashion for us -We're going to have to rescind your employment, but you can keep your insurance and you can keep your, uh, your [long-term] disability.'

A 41 year old male said that "work was really one of the biggest sources of stress." He continued, saying:

Because I went on ... the FMLA (Family Medical Leave Act). Yeah. And I've almost used all of it, and now I have to do six months chemo. You know, once that runs out, if I'm still sick or if I still can't physically take myself to work, then, you know, there's a good chance that I'll lose my job. Then, if I lose my job, I lose my benefits that day."

A 44 year old woman reported that she worked in the tech industry in San Francisco and tried to work during her treatment. She was unable to attend work regularly and she said that her boss "got a little paranoid about that and... [she] was fired." Without an income after losing her job, she was forced to move in with family members in a different state who did not approve of her sexual orientation, far away from her social network.

A 55 year old female described how her cancer diagnosis limited her employment opportunities for teaching full-time:

Before I got cancer, so I was on my way to, but I hadn't yet gotten a fulltime position. And I had gotten my advance math endorsement. I had my full year [substitute teaching in] advanced math and I was hoping to get the [full-time] position, and then, I got cancer.

In addition to losing jobs and job opportunities due to the cancer diagnosis, one 41 year old participant talked about what he perceived as discrimination when he was looking for a job after his treatment ended. He, like many of the participants, was not able to work for nearly two years during his cancer treatment:

...trying to go back to work has been, has been difficult. How do you tell somebody that you were trying to get a job with why you were out of work in my particular case for you know, two and a half years, or whatever it's been, about telling them that I have cancer? And [that] it may recur. [That] I might not be able to finish this job... I may have more doctor's appointments along the way

He described a job interview experience:

I had an interview with this company and that company, whatever and everything would seem to be going great because... I have lots of experience, management, leadership and curriculum development in finance, and so I'd go through this and I would be talking to them and I was thinking oh this is going so, so great. And [then] they would get to the point of, you know, like, why haven't you worked since 2011? And I say oh, I had cancer. And then, I never hear from them again.

Ultimately, after working with a career counselor in his job search, he decided not to mention that he had cancer, and instead talked about some volunteer work and community work that he did during the time that he was in treatment.

Losing a job meant lost income but also concerns about **health insurance coverage**. Nearly all of the interview participants described how retaining health insurance was a struggle. Many recounted that they did not have health insurance when they first noticed symptoms, or that they did not have insurance in the years leading up to their diagnosis and therefore did not receive regular check-ups. A 44 year old female participant, who lost her job after her diagnosis and had to move in with family, also lost her health insurance:

I didn't have the insurance, and I was in Minneapolis a year and a half fighting through Medicare paper work. [I had] a port that [had] to get a monthly maintenance and I [didn't] have insurance, so then I [went] to an emergency room. Then, I have all these \$900 bills every single month... you know, I moved to, I went to different hospitals every time because I [didn't] think they were going to keep [maintain the port] for me when they see I didn't pay [the \$900].

Lack of health insurance played a pivotal role in a male participant's story about how he was diagnosed with CRC:

Earlier in that year, in March 2012, I had severe abdominal pain. And I had no idea what the problem was. So, I went to the ER that night. And they gave me an ultrasound. I didn't have insurance at the time. And they told me I have IBS. So, I went... through the rest of the next six or eight months in that year of 2012 thinking I had IBS. And then, in October of 2012 when I had the same pain again, that was when they told me [about the cancer].

A female participant who worked as a substitute teacher talked about having to keep close track of when she was covered by health insurance because of the temporary nature of her employment:

I had no insurance all of last year. [This year] I had insurance for two months from May to June. And then, I didn't have it again and now I got it back again for October and now I'm good for next year. It was not a very fun two months there because...every day I was working, going to a doctor's appointment, working, and go to another doctor's appointment. It was horrible... trying to get the colonoscopy, trying to get all these things done in two months.

The only positive story about health insurance came from a retired 64 year old male participant. He talked about the Affordable Care Act (ACA) and how it has helped him financially:

“I was paying \$1571.85 a month for my insurance. When I switched to [name of insurance] on the Obama Care, the insurance exchange, the market place I qualified for a tax, a monthly tax subsidy and cost sharing. And my monthly premium was brought down to \$336.43. That was for the year 2014. With 2015, after I saw [doctor] at [cancer center] I realized that I needed to switch to a policy that would cover me there so that I could follow up with him. And then, my premium went from \$336.43 a month with name of insurance] to \$71.04 a month with [name of insurance]. So, that’s where I am now, \$71.04 a month. That really helps me survive tremendously by defraying those extra costs that I would’ve had.

Finally, **participants’ housing situation** was impacted by CRC. Participants described different impacts of CRC on their housing including the loss of, or risk of, losing their housing. Reasons for these impacts included changes in finances due to job loss, eviction, and being unable to live alone during treatment.

For one female participant the job loss she experienced nearly resulted in her losing her home:

I think they [people at the church] supported me to a tune of like \$19,000 over that year [during treatment]. [By] the end of July, I couldn’t work anymore, and then, I had my surgery in August, and so, I, I would’ve ended up homeless because there’s no way I could’ve paid rent without working.

A 44 year old female participant reported that she was evicted from her apartment and after losing her job, had to move in with family who did not approve of her sexual orientation, and with whom she did not have a good relationship. When he was diagnosed, a 41 year old male participant was living alone about six hours drive away from his mother. Shortly after his diagnosis, he moved in with his mother for the support:

When I was going through cancer treatment, I was living in a rural Eastern Washington with my mother as I was going through it.

LGB identity and CRC care

There were three aspects of this theme: 1) disclosure vs non-disclosure, 2) the need for providers to not make assumptions; and 3) the need for providers to realize that individuals’ social support networks might appear different or unconventional compared to heterosexual patients. Interview participants were more likely to talk about disclosing their sexual orientation to nurses and other medical personnel as compared to doctors. When asked about the level of openness she has with her medical providers, a 29 year old female described her relationship with her doctors as a “professional type relationship.” She went on to say:

I got pretty close with my nurses, because I spent the most time with my nurses. You know, we would chat about what’s going on in our lives [during treatment]. But, for my doctors, you know, when I see them through appointments, we really just talk about what’s going on medically.

A 55 year old female respondent reported that she did not remember “coming out” to any of her providers. She said:

I mean I might have to the oncologist because he's so cool. I might have been, you know, because when you, when the people that you don't think about, you come out and you don't even think about it. (...) Where like the surgeon, it never came up and I didn't feel comfortable bringing it up because it seemed like a non-issue to him.

Generally, respondents tended to feel that they were just as open with their providers as they were generally in their lives. As one 41 year old male said,

I'm the same way [as I am with others] with my physicians. I think it's extremely important for them to know who I am...so that they can, you know, [play] a more active role in my overall health.

Some respondents reported being "out" to their providers even though they did not recall actively disclosing their identity. A few respondents talked about living in a place where the culture is 'very open' when asked about disclosure to providers. As one 52 year old female reported:

I'm up here in, in the northern part of Colorado, and most of my providers are in Boulder. It's a fairly liberal little - it's a progressive place. (...) Not how I talk about, I, well, yeah, I, when I fill out my paperwork with any doctor if it says spouse, I put in [my partner's] name. I try and check married. [But] am I really that explicit about it? No, I think if you look at me, you'd probably pretty much have an idea.

The idea that disclosing one's sexual orientation was not relevant to cancer treatment was talked about frequently and equally by male and female participants. For example, a 64 year old male talked about his non-disclosure to an oncologist saying, "He is just such a wonderful doctor and just covers everything when he talks to you; I never really felt that my gayness was a factor in the sense of what I'm dealing with him." Respondents sometimes felt that if they were seeing a specialist or a provider only one time, the nature of the visit may not have warranted disclosure. The 64 year old male respondent above mentioned a provider that he only saw once, "I didn't feel that [my sexual orientation] was very much a factor in terms of what I needed to decide in my appointment with him, so it really wasn't brought up."

One male respondent did report actively disclosing to his surgeon on their first meeting:

During our first meeting, I told him that I had a very personal reason for wanting to stay intact. And the reason I used that word is because the tumor was at the top of my rectum and into my colon. And, [the doctor] right away said sexual activity in a, a very non-judgmental way and he said yes, you will still, there will still be a good portion of your rectum after all of this is said and done, and you might not want to try [anal sex] for [about] six months to a year to make sure everything [has] healed and everything. I appreciate that [he said that to me].

Interview participants frequently mentioned that they experienced times when their providers made heteronormative assumptions about them. A 55 year old single female

described a situation when her surgeon was explaining the treatment, and how it would impact her vaginal area:

When [my surgeon] says you can have sex again, I'm like have you looked at what my vagina looks like, try to put a hand up there. Part of my vaginal area is white. There is no, very little blood circulation there. Basically, it's been cooked [by the cancer treatment]. And so it's very painful. When you think about having sex with a woman, it's like, that's not good. That's gonna hurt; it's all I can think of like that's going to hurt. When [my surgeon] said [I could] have sex [it was] because his assumption is that it would be a penis. I didn't say anything. I didn't say anything because I know that was just [his] assumption. [That] kind of irritated the crap out of me because it's like because [my surgeon] made that assumption.

In addition to respecting their dignity, participants described providers not making assumptions as a way that they can make the patient feel more comfortable and build trust. Most interview participants talked about how LGB individuals often have less traditional support networks in general, and this applies to their experience in the health care system as well. Only two participants lived with a partner during their diagnosis and treatment. A 41 year old man said, "[I] gather support in non-traditional ways. Our families are not just the people that we're biologically related to." A married 52 year old woman said that including the person's support group is "imperative for that person's health and recovery."

Discussion

To our knowledge, this is the first study of CRC survivorship among LGB individuals. We found no gender differences in CRC's impact on LGB men and women and many of the experiences of LGB CRC survivors are consistent with earlier findings of LGB survivors with other cancers. This is an important finding in that most LGB survivorship studies have focused on breast and prostate cancer, which implies that gender and cancer type are confounded (Boehmer & Elk, 2015; Simon Rosser et al., 2016). Previous studies identified disclosure of sexual orientation to providers as a unique issue for LGB survivors (Boehmer & Case, 2004; Durso & Meyer, 2013; Stein & Bonuck, 2001) and our findings confirm this. Our participants made no efforts to actively conceal their sexual orientation and confided primarily with nurses rather than physicians. Our results suggest that if asked appropriately, LGB individuals are likely to disclose, and it may be helpful for cancer providers, including surgeons, to ask routinely about sexual orientation, preferably in a conversation with the patient or at least on an intake form. In a study of lesbians, when physicians asked about sexual orientation, 100% of them disclosed information about their sexual orientation (Steele, Tinmouth, & Lu, 2006). Providers asking about sexual orientation might also encourage those who may not consider their sexual orientation relevant to treatment to disclose their sexual identity (Boehmer & White, 2012). Knowing patients' sexual orientation allows for a shift in communication, and can help providers avoid heteronormative assumptions and language used in the context of providing care, as experienced by the LGB CRC survivors in this study.

Consistent with the literature on cancer survivorship, including LGB individuals, social support is a salient issue from the diagnosis, treatment, and beyond (Kamen, Smith-Stoner,

Heckler, Flannery, & Margolies, 2015; Liao & Brunner, 2016). LGB CRC survivors reported receiving support from friends and family when specifically asked, but longed for unsolicited support. In addition, the expressions of support described were more material than emotional or psychological, such as providing transportation or dropping food by but not staying to talk. As one participant observed, support received was often at “arm’s length.” Yet, study participants did not report asking for support unless it was something specific, like a ride to an appointment. The reports of isolation by the interviewed LGB CRC survivors raise concerns about whether support of LGB survivors varies by cancer type. Future studies should address whether LGB CRC survivors receive less support than LGB survivors of other cancers as well as heterosexual survivors.

The most novel findings of the study are the details describing how CRC affected these LGB survivors economically. To our knowledge, this is the first study of LGB cancer survivorship to report findings about the economic implications on LGB individuals’ lives. The major economic impacts of CRC reported by the study participants related to employment, health insurance and housing. Most of the LGB CRC survivors interviewed for this study experienced the loss of employment as a result of their cancer diagnosis due to either the illness itself, the side effects of treatment, and/or the length of treatment. Studies suggest that low economic status and poverty are more prevalent for LGB individuals compared to heterosexual individuals (Badgett, Durso, & Schneebaum, 2013; Brown, Romero, & Gates, 2016). Participants also recounted facing discrimination due to cancer in trying to re-enter the job market due to their history of CRC, the chance of recurrence, and the length of time they were out of the workforce. These findings raise questions about whether job loss and economic decline is greater for LGB cancer survivors compared to heterosexual survivors. Furthermore, most of the participants reported lack of health insurance either leading up to their diagnosis or thereafter, usually as a result of job loss. The one positive experience related to health insurance was a result of the Affordable Care Act, which many hope will bring an end to the longstanding inequity of LGB individuals being less likely to have adequate health insurance compared to heterosexual individuals (Buchmueller & Carpenter, 2010; Institute of Medicine, 2011). The third economic aspect that emerged from the interviews related to housing. In this study, the LGB CRC survivors reported changes in their housing situation as a result of loss of employment and income, but also because they were unable to live alone during treatment due to the length of treatment, the seriousness of the illness, or side effects of treatment.

There are several limitations to this study. First, the study was exploratory in nature and given the qualitative data and the nonprobability sample used, these findings can illuminate LGB survivors needs and concerns, yet do not allow for any generalization about LGB CRC survivorship. Rather we hope the findings identify factors, including the economic impact of CRC and the lack of available support, that should be studied in depth in future LGB cancer survivorship studies. Second, while participants were geographically distributed across the United States, the small sample size prohibited the identification of key factors in colorectal cancer care that may vary by availability of health and social service resources. Third, the themes identified were based on data collected from participants who self-reported having stage III CRC. The saturation in themes identified with relatively few participants interviewed is likely due to this lack of variability in stage of CRC in our sample. Different or additional

themes may have been identified with the inclusion of additional participants at other CRC stages and/or the use of a different data collection methodology (e.g., in-person, Internet). Finally, because a heterosexual comparison group was not included, we are unable to determine the extent to which the issues raised by participants in this study are unique to LGB CRC survivors.

Implications for Nursing

The findings of this study suggest that LGB CRC survivors have both economic and social needs, and oncology nurses and other health care providers can play an important role in the quality of life of CRC survivors. Attention should be paid to the economic impact of CRC on LGB individuals in addition to social support, heteronormative assumptions during cancer treatment and follow-up care, and the facilitation of sexual identity disclosure.

Study participants voiced feelings of isolation during and after treatment, as well as the fact that many LGB individuals obtain support from non-traditional networks such as close friends or ex-partners rather than spouses or immediate family (Grossman, Dugelli, & Hershberger, 2000). Nurses and other health care providers can help with these issues by being attentive to signs of social isolation and routinely asking about social support. They can also bolster existing support by accepting and welcoming LGB CRC survivors' relationships and social networks into clinical encounters. Additional research is needed to fully assess nurses' contributions to satisfactory clinical encounters for LGB cancer survivors and to deepen our understanding of how nurses can improve LGB cancer survivorship.

Economically, obtaining and maintaining health insurance coverage, employment, and housing were substantial concerns for all of the participants. The findings suggest that LGB CRC survivors may benefit from support and services such as routinely being asked about problems or concerns with health insurance, employment, and housing, assistance with navigating new health insurance marketplaces and paperwork, and referrals to appropriate services such as housing support or career counseling.

Disclosure of sexual identity and acceptance of disclosure by health care providers has been found to be associated with improved health outcomes and satisfaction with care (Durso & Meyer, 2013; Mosack, Brouwer, & Petroll, 2013). In this study, only one participant reported actively disclosing their sexual identity to a health care provider, but at the same time, none of the participants actively hid their identities. Nurses and other health care providers can facilitate disclosure by asking about identity routinely with all patients and collecting information consistently and appropriately on medical and social history forms. Finally, participants reported concerns during follow-up care related to providers making assumptions about their sexual identity. While encouraging disclosure may mitigate some of these concerns, health care providers can also help by undergoing training specifically to raise consciousness about these assumptions and how to change patient-provider interactions.

Conclusions

Research on CRC is rare, and research on CRC among LGB individuals is absent, which is a particular strength of this study. Many LGB CRC survivors' needs may not be fully addressed in their cancer and post-cancer care. Our findings suggest that in addition to issues around social support and disclosure of sexual orientation, there are economic impacts of CRC on LGB men and women that are likely critical to healthy survivorship.

Acknowledgments

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Knowledge Translation

- An approach that pays attention to the economic impact of CRC on LGB individuals may improve the quality of life for survivors.
- Attention should also be paid to social support, heteronormative assumptions during cancer follow-up care and the facilitation of sexual identity disclosure.
- Nurses have a special role to play in care given that LGB CRC survivors may be more likely to disclose their sexual identities and share concerns about quality of life issues with them as opposed to oncologists or surgeons.

Table 1

Demographics of LGB Colorectal Cancer Patients (n = 8)

Characteristic	% (n)
Stage of Cancer	
In situ	0% (0)
Stage I or II	0% (0)
Stage III	100% (8)
Year(s) Post-Diagnosis	
5 Years	12% (1)
4 Years	12% (1)
3 Years	0% (0)
2 Years	50% (4)
1 Year	0% (0)
< 1 Year	25% (2)
Has cancer recurred?	
Yes	25% (2)
No	75% (6)
Currently receiving treatment?	
Yes	50% (4)
No	50% (4)
Age (years)	
Mean	49
Median	48
Range	29–67
Gender	
Male	50% (4)
Female	50% (4)
Sexual Orientation	
Gay	50% (4)
Lesbian	12% (1)
Bisexual	25% (2)
Other	12% (1)
Hispanic Ethnicity	
Yes	12% (1)
No	88% (7)
Race/Ethnicity	
White, Non-Hispanic	88% (7)
African-American	0% (0)
American Indian	12% (1)
Employment Status	
Employed	37% (3)
Not employed	37% (3)

Characteristic	% (n)
Retired	25% (2)
Current Health Insurance	
Yes	100% (8)
No	0% (0)
Socio-Economic Status	
Enough money for bills and extras	25% (2)
Enough money to pay the bills	12% (1)
Have to cut back in order to pay bills	37% (3)
Not enough money to pay bills	25% (2)