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Chronic Obstructive Pulmonary Disease in the LGBTQI+ Population

To the Editor:

We read with great interest the article by Krishnan and colleagues (1), “Race and Sex Differences in Mortality in Individuals with Chronic Obstructive Pulmonary Disease,” recently published in *AnnalsATS*.

The authors examined, by race and sex and underlying mechanisms, mortality differences in chronic obstructive pulmonary disease (COPD). They used Medicare claims among REGARDS (Reasons for Geographic and Racial Differences in Stroke) cohort participants to identify COPD and found no race and sex differences in all-cause mortality. For all race and sex groups with COPD, the most common cause of death was cardiovascular disease (CVD).

Krishnan and colleagues concluded that CVD comorbidity management, especially among Black individuals, may improve mortality outcomes, as Black women with COPD more frequently die of CVD (1). We sadly note that the authors do not mention sexual and gender minorities (SGMs). Unfortunately, the study seems to confirm the invisibility of the LGBTQI+ (agender, asexual, bisexual, gay, gender diverse, genderqueer, genderfluid, intersex, lesbian, nonbinary, pansexual, queer, and transgender people) population in the analyzed data. In this regard, we would like to remind readers that SGMs represent approximately 10% or more of the U.S. population. Yet the LGBTQI+ population, which should not be considered as a whole but divided into its

various specific components, is a population at greater risk for both COPD and CVD (2, 3). Data and results from studies not including LGBTQI+ people perpetuate disparities for SGM populations (4). There is the urgency to also consider the LGBTQI+ population in studies together with the need to increase and improve the delivery of health care for SGMs. Protocols and guidelines for caring for LGBTQI+ patients are poorly defined. Furthermore, data on targeted screening, as well as validated reference data for laboratory and imaging/diagnostic testing or information on the efficacy of drugs and their adverse effects, are lacking among SGMs. To identify and characterize the population of interest is the first and most critical step to better understand and eliminate health disparities and deliver culturally competent care. To promote equality of care and provide patient-centered care, it is essential to collect and document patients’ sexual orientations and gender identity information in healthcare settings, but to date, most healthcare organizations have yet to implement this aspect. To better understand the unique needs of the LGBTQI+ population, more research is needed, and the availability of data is critical. To enhance data availability for analysis of the LGBTQI+ population, it is necessary to improve data collection and analysis methods incorporating claims and other sources, such as surveys and electronic health record data among others (5).

Unfortunately, at the moment, the collection and availability of data relating to sex and gender identity are still a critical point. The LGBTQI+ community has historically experienced bias, discrimination, and perceived inadequate or inappropriate care (6). Reduction of this barrier can begin involving the whole scientific community, which must include LGBTQI+ populations in studies, trials, protocols, and guidelines. ■

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Reply: Chronic Obstructive Pulmonary Disease in the LGBTQI+ Population

From the Authors:

We thank Sirufo and colleagues for their thoughtful comments regarding our recently published study (1). They point out that our study of race and sex differences in causes of mortality in subjects with chronic obstructive pulmonary disease (COPD) does not include further analysis of our population on the basis of sexual orientation and gender identity (SOGI). Our analysis was conducted using data from the REGARDS (Reasons for Geographic and Racial Differences in Stroke) cohort, which did not collect baseline information regarding participants' gender identities and sexual orientations (2). Because of this, we were unable to further

characterize our finding of increased cardiovascular disease mortality among Black women compared with White women with COPD on the basis of gender identity. We agree with Sirufo and colleagues that a discussion of this limitation is important and would be consistent with Sex and Gender Equity in Research guidelines (3).

The lack of adequate SOGI data collection is widespread and concerning and needs to be addressed. SOGI data are missing from many observational cohort studies, national public health surveillance programs, and electronic health records (4). The sparsity of SOGI data is particularly glaring given that contrary to clinician beliefs, most patients are comfortable disclosing this information (5). The need to collect SOGI data is vital in respiratory epidemiology, especially considering the higher prevalence of tobacco use in the LGBTQI+ community because of targeted marketing and discrimination (6).

Despite being unable to address differences in all-cause and cause-specific mortality in our REGARDS COPD population according to SOGI, we agree with Sirufo and colleagues that future research to identify these differences is important. Doing so will help create and prioritize targeted interventions to improve the health of individuals in the LGBTQI+ community with COPD. ■

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Supported by National Heart, Lung, and Blood Institute grant T32 HL134629 (J.K.K.).