

Peer Review File

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Reviewer #1

Overall, this is a very important piece and there is a pressing need for this kind of document to be available to urologists caring for sexual minorities. A few minor edits below:

Response: We thank the reviewer for this kind and positive assessment.

Comment 1: Page 9, line 8 "NIH officially recognizes SGM as health disparity populations, meaning that compared with cisgender, heterosexual patients, SGM patients, on average, have higher burden of illness, poorer experiences in treatment, and worse outcomes." - cite a source for this statement

Response: As requested, a citation has been added.

Comment 2: Page 9, line 18 "SM men are disproportionately under-represented" - I had to read this several times to understand what you were conveying (there are fewer people who identify as SM men than SM women). I'd recommend re-wording this line.

Response: As requested, we have reworded and expanded this for readability

Comment 3: Page 10, line 2 - how did you arrive at the change in percentage from 2 to 5%?

Response: This is a rough informal estimation (since Williams Institute does not make its data available for sub analyses). If the oldest cohort of SM men is about half the size of the other aged cohorts, and if 3.9% of men identify as gay or bisexual, then half of that is approximately 2%. This also matches the comparison of the population estimates for 65year old+ where HET population is twice the size of the SGM population. The next aged cohort is 21% of the male SM population, which confirms that within ten years, this rate should double (to match the average of 3.9%). In addition, we changed 5% to 4% to match the average.

Comment 4: Page 11, line 8 - "...mutual support and love" - would cite where this assertion of having different support systems comes from.

Response: As requested, citations added.

Comment 5: Page 12, lines 4-11 (first full paragraph), citations for each of the statements here.

Response: As requested, citations added.

Comment 6: Page 12, lines 13-21 - citations for the assertions here.

Response: As requested, citations added.

Comment 7: Page 13, line 22: in addition to the six quantitative studies cited, there is an additional quantitative study, to make the total seven- A Pilot Study Assessing Aspects of Sexual Function Predicted to Be Important After Treatment for Prostate Cancer in Gay Men: An Underserved Domain Highlighted.

Response: Thank you for bringing this recent publication to our attention. We have added the Amrasekera et al. study to the list and changed six to seven.

Comment 8: Page 14, line 19 - would change "at the clinic level is needed" to "at the clinic level are needed"

Response: Oops. Thank you for spotting this error. We apologize and have corrected it.

Reviewer #2

This is an important and timely paper on prostate cancer in SGM patients. There are several strengths to the paper including the practical and concise information for clinicians in Table 3 and

explanations of sexual health and behaviors among gay and bisexual men. Table 1 provides compelling evidence that SGM patients may not be well counseled about sexual function prior to treatment and as such expectations may not be well managed.

Response: We thank the reviewer for this positive assessment.

However, there are weaknesses to the manuscript that must be addressed before a thorough review can be conducted. In the current format the organization of the paper is challenging to follow. It is unclear what type of review was conducted (narrative, scoping, systematic) and the associated methods. It is unclear why the 3 studies were chosen to be highlighted. It is a challenge to see the connection between the introduction, the presentation of the studies (and this section meanders back and forth between presenting information and points that would belong in a discussion). Below are some suggestions to strengthen the paper.

Response: We have restructured the introduction and description of methods to clarify why we undertook this selective review.

Comment 1: Is this a review and if so what type?

Response: To advance the field, this is a selective review limited to the three largest quantitative studies conducted to date. This is appropriate for two reasons: (1) In the last five years, there have been at least four reviews of the qualitative and quantitative literature on prostate cancer in SM (two by our team). These reviews summarize the literature combining results from quantitative studies with anecdotal reports. (2) The purpose of this review is to advance the field by detailing the main findings emerging from the quantitative literature (and their implications for clinical practice). We have restructured the introduction to make this more clear.

Comment 2: Cultural humility is now the suggested term and it seems the title and other points in the manuscript should reflect this (c.f. Alpert, Ash, et al. "What Exactly Are We Measuring? Evaluating Sexual and Gender Minority Cultural Humility Training for Oncology Care Clinicians." *Journal of Clinical Oncology* 38.23 (2020): 2605-2609.)

Response: We agree. We thank the reviewer for the excellent article by Alpert et al. and have restructured the paper in light of its conclusions. Specifically, we have removed references to cultural competence. Also, we tried to fit "Cultural Humility" into the title but found it awkward. So, we simply removed "culturally competent" from the title.

Comment 3: It is unclear why the manuscript is targeted at Urologists and Andrologists in general and not more specifically to oncology?

Response: Thank you for spotting this. We started by targeting this towards urologists. The only reason we added Andrologists in the title was that the title of the journal is "Translational Andrology and Urology." In light of this comment, we replaced Andrologist (who do not often see prostate cancer patients) with oncologist in the title (who often do see prostate cancer patients).

Comment 4: The references are abundant but some are old and some relate to book chapters rather than similar studies in higher impact peer-reviewed journals. For examples - these systematic reviews are not included. (Quinn, Gwendolyn P., et al. "Cancer and lesbian, gay, bisexual, transgender/transsexual, and queer/questioning (LGBTQ) populations." *CA: a cancer journal for clinicians* 65.5 (2015): 384-400; Lisy, K., Peters, M. D., Schofield, P., & Jefford, M. (2018). Experiences and unmet needs of lesbian, gay, and bisexual people with cancer care: A systematic review and meta-synthesis. *Psycho-oncology*, 27(6), 1480-1489.; King, A. J. L., et al. "Prostate cancer and supportive care: a systematic review and qualitative synthesis of men's experiences and unmet needs." *European journal of cancer care* 24.5 (2015): 618-634.

Response: In the summary of methods, we now reference the Quinn et al. and Lisy et al. reviews as well as two others specific to prostate cancer in SM men. As the King et al. review is not specific to SM, it was not included.

Comment 5: Pg 7 - the summary of methods states "all used similar and validated measures" - this does not provide enough information to allow the reader to understand why these studies were chosen and how they were reviewed.

Response: We have inserted a parenthetical comment noting that the primary measures are the EPIC and SF.

Comment 6: Where do the data come from in table 1.

Response: The source of the data in Table 1 has been added. (It's from the *Restore-1* study).

Comment 7: table 2 doesn't asked about partners gender identity. If a person is engaging in sexual acts with a transmen with a vagina, the question asked in this format won't disclose risk.

Response: The reviewer questioned if asking the questions in this format would prevent a person engaging in sexual acts with a transmen with a vagina from disclosing risk. Actually, the questions as worded would work (although the added burden of disclosing the identity of the partner is still on the patient). When we wrote the paper from which this table was taken, the focus of the study was to help clinicians address the risk for SM patients. As this table is reproduced from one published, we do not feel comfortable changing it. Instead, we added a footnote noting this as a limitation.

Comment 8: Table 3 needs citations for each of the suggestions.

Response: The source of these suggestions is now cited.

Comment 9: There is limited attention to the case of transwomen with prostate cancer.

Response: This is a limitation of the literature; there are simply no quantitative studies of transwomen with prostate cancer. The team and our transgender experts discussed at length whether to limit the review to only SM or to keep it as SGM, noting the absence of literature. In the end, we felt clinicians would be best served by keeping SGM in the title and noting the absence of literature rather than not addressing this at all. We have rewritten a paragraph in Question 5 to confirm the "invisibility" of this population in the literature. The paragraph highlights biological, behavioral and structural factors that may contribute to this invisibility. To the best of our review, there are no studies of transwomen with prostate cancer (beyond single case reports).

Comment 10: Multiple studies highlight the need for training of the entire team as sometimes microaggressions and discrimination occur before the patient even sees the physician.

Response: We agreed with this statement so much that we took the liberty of adding it in at the end of the manuscript (see Question 21).

Comment 11: The inclusion of information on the need to create an environment in the clinic that is welcoming to SGM patients should be added.

Response: It has been added (see Part 3. Addressing a Cultural Divide)