Sexual Health After Cancer Therapy

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There are more than 14.5 million cancer survivors in the United States in 2016.[1] Although there are no definitive statistics, in one survey of cancer survivors, 46% reported sexual health problems related to the diagnosis and treatment of cancer, and 71% said that they had received no care for sexual dysfunction.[2] The impact of prostate cancer treatments on erectile dysfunction (ED) is well known. However, the review by Voznesensky et al[3] highlights the fact that treatment of men with other malignancies, including bladder, testicular, colorectal, and those treated with marrow or peripheral stem cell transplant, can also play havoc with erectile function. The authors explain the anatomy and physiology of normal erections and explain how surgery, radiation, chemotherapy, and hormonal therapy can cause ED, dry ejaculation, climacturia (leaking urine during orgasm), or anorgasmia (difficulty reaching orgasm). They provide a thorough discussion of the standard approaches to ED and conclude that patients should be referred to urologists for treatment of cancer-related ED.

A Complex Issue

Sexuality is complex, and sexual function after diagnosis and treatment of cancer is even more complex. In addition to the physical and physiologic problems, psychological, relational, and cultural aspects of sexuality must be taken into account. What research has now made clear is that the partner plays a crucial role in coping with the impact of cancer treatments on the quality of life of the patient, a perspective that was not mentioned by Voznesensky et al.[3] An excellent review that underscores the role of the sexual partner in managing ED of any cause was recently published and is applicable to patients with cancer as well.[4]

The review by Voznesensky et al[3] assumes that the goal of treatment of ED is the return of erectile function and ability to have coital sex. However, there is now a strong trend in the field toward a more holistic approach to sexuality that incorporates more than penetrative activities. Because libido, erection, and orgasm all are separate (but often interlinked processes), sexual intercourse is just one of an array of options for a fulfilling sexual life. Often, nonsexual intimate activities and/or nonintercourse sexual activities can be most gratifying for the patient and the partner.[5]

Other caveats specific to treatments for ED that were not discussed by Voznesensky et al[3] should be mentioned. Almost 75% of patients discontinue use of oral agents after 1 year, commonly because of lack of efficacy despite achieving an erection.[6] Another frequent concern of those suffering ED, especially after radical prostatectomy, is urinary incontinence and climacturia. These problems can factor into a patient's or partner's willingness to pursue sexual activities that depend on erectile function. Although Voznesensky et al[3] are enthusiastic about the penile implant option on the basis of satisfaction of the patient and the partner, few men with prostate cancer chose a penile implant.[7] When all ED approaches fail, if penetrative sex is a high priority, discussion about use of an external penile prosthesis may be of interest.[8] However, it is also important to include the option of sexual activities that do not rely on erectile function.[9]

ASSOCIATED CONTENT

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Integrating Sexual Health Care Into Oncology Practice

Given the complex needs of patients and partners after cancer therapy that results in ED or other adverse sexual health outcomes, a multidisciplinary team with an integrative approach provides the best care. Such a team could include a sexual health clinician, urologist, psychologist, pelvic floor physiotherapist, and endocrinologist who have an interest in and understanding of the impact of specific cancer treatments on sexual function. Although such clinics are available in some large cancer centers, these resources are scarce and not generally available, nor are they always reimbursable. Despite the fact that there is now considerable research demonstrating the benefit of addressing the emotional and sexual health of the patient and his partner, this integrative approach has not been adopted as a routine part of usual care.

As oncology health care providers, we need to do more to begin to tackle the complex issues related to the sexual health of our patients and their partners. We must acknowledge and recognize the important role of sexual health in the quality of life of our patients and their partners and that they are interconnected. We must initiate discussions regarding sexuality as a component of obtaining informed consent for treatment, not only with surgery and hormonal therapy but also with radiation and chemotherapy treatments. Voznesensky et al[3] noted that cisplatin-based therapy for testicular cancer can result in ED, yet how frequently do oncologists mention ED as an adverse effect of chemotherapy?

During follow-up after cancer therapy, questions about sexual health need to be incorporated into the review of systems. Patients often do not spontaneously note problems with their sex life and prefer health care providers to initiate the discussion because of embarrassment, fear, or other reasons.[8] However, health care providers often feel ill-equipped to deal with sexual health issues, are embarrassed themselves, and often lack resources to offer patients and their partners if they do identify a problem. A recent review provides interested clinicians with insight and in-depth guidance on how to promote sexual recovery after treatment of prostate cancer, advice that can reasonably be applied to those with ED related to treatment for any malignancy.[8]

Because of this gap in knowledge and resources, oncologists must play a role in how best to integrate sexual health care into medical education as well as into usual practice. Although it is doubtful that oncologists are able provide this care, they must insist that this expertise be made available to their patients and partners and work collaboratively with sexual health clinicians and others as needed. Similarly, given the complexity of sexuality after cancer treatments, it is unrealistic to expect the urologist alone to provide the integrative approach required to deal with the reality of ED and other problems (eg, low libido, urinary incontinence, difficulty reaching orgasm) that affect sexual health in patients with cancer. It is our experience that improving the sexual quality of life of patients with cancer and their partners goes beyond treatment of ED. JOP

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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