



Original article

Sexuality and quality of life in women with a prior diagnosis of breast cancer after risk-reducing salpingo-oophorectomy



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ABSTRACT

Objectives: To investigate the prevalence of sexual dysfunction in women with a history of breast cancer following risk-reducing salpingo-oophorectomy (RRSO). A secondary objective was to examine the effect of a prior diagnosis of breast cancer, and other factors, on sexuality and quality of life (QoL) outcomes. **Study design:** Cross-sectional study of 119 women who underwent RRSO between 2009 and 2014.

Main outcome measures: Data were collected via a questionnaire comprising demographic information and validated measures of sexual function, sexual distress, relationship satisfaction, body image, psychological stress, menopause symptoms and general quality of life.

Results: Sixty out of 119 participants who underwent RRSO had a history of breast cancer. Eighty percent of women with breast cancer had female sexual dysfunction (FSD) and 82% had hypoactive sexual desire disorder (HSDD) after RRSO. Bilateral mastectomy was associated with higher rates of HSDD ($p = 0.028$) and higher body image self-consciousness (BISC) during sexual activity ($p = 0.011$). Breast reconstruction was associated with higher relationship satisfaction (RAS) scores ($p = 0.004$). Compared to Tamoxifen, aromatase inhibitors (AI) were significantly associated with reduced lubrication ($p = 0.041$), arousal ($p = 0.004$), orgasm ($p = 0.002$) and greater dyspareunia ($p = 0.027$). Prior diagnosis of breast cancer was not associated with the prevalence of FSD ($p = 0.532$).

Conclusions: High rates of FSD and HSDD occur in women with breast cancer following RRSO. Low relationship satisfaction, bodily pain, bilateral mastectomy and the use of aromatase inhibitors were associated with poorer sexual function. Women had similar sexual outcomes and QoL after RRSO, regardless of breast cancer history.

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Introduction

Ovarian cancer is a highly lethal malignancy, often diagnosed at an advanced stage, and as a consequence it is ranked the fifth leading cause of cancer death in American women [1]. The

population lifetime risk of ovarian cancer is 1.3% [1], however women with BRCA1 and BRCA2 gene mutations have significantly higher lifetime risks of up to 40% and 18% respectively [2]. The lifetime risk of breast cancer in BRCA1 mutation carriers is up to 87% [3] and up to 49% in women with BRCA2 mutations [2]. With the absence of an effective screening test, current guidelines recommend that women at increased risk of ovarian cancer due to germline mutations undergo the prophylactic removal of their ovaries and fallopian tubes, in a procedure known as risk-reducing salpingo-oophorectomy (RRSO), by age 40 or once child bearing is complete [4]. While some women may opt for bilateral salpingectomy with delayed oophorectomy in order to preserve ovarian function, this has not been validated as an effective preventative

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measure for ovarian cancer and is currently not recommended [5]. The prophylactic removal of the ovaries can negatively impact sexual function with the sudden onset of menopause, and its associated symptoms and psychological sequelae [6,7].

Breast cancer is the most commonly diagnosed cancer in women worldwide, with 1.67 million new cases estimated in 2012 and 4.6% lifetime risk [8]. A breast cancer diagnosis and its treatment can also significantly impact sexual function. It is estimated that approximately 50–70% of women with breast cancer experience sexual problems [9,10]. The high rate of sexual problems may be due to a combination of treatment-induced physical and menopausal symptoms, body image issues, relationship changes, and psychological stress [10–12]. These risk factors, combined with the limited range of non-hormonal treatments available for sexual difficulties [13], may predispose women with breast cancer to higher rates, and greater severity, of sexual dysfunction after RRSO.

The primary objective of this study was to investigate the prevalence of sexual dysfunction in women with a prior history of breast cancer following RRSO, and compare this to women without a previous diagnosis of breast cancer. Secondary objectives were to describe the effects of mastectomy, breast reconstruction, and anti-estrogen therapy on the sexual function and quality of life (QoL) outcomes of women with a previous diagnosis of breast cancer after RRSO.

Methods

Study design

A cross-sectional study of women who had undergone RRSO was undertaken. Participants were asked to complete a comprehensive questionnaire.

Setting

The study was conducted at the Department of Gynaecologic Oncology, St John of God Subiaco Hospital, which is a tertiary private hospital in Perth, Western Australia. This study was granted ethics approval by the St John of God Healthcare Human Research Ethics Committee (HREC) and the University of Notre Dame Fremantle HREC.

Participants

Potential participants were identified from the records of two consultant gynaecologic oncologists at St John of God Subiaco Hospital. Women were considered eligible to participate if they had undergone RRSO between January 1st 2009 and December 31st 2014 (6 months–73 months previously). Patients were excluded if they had; a suspected gynaecologic malignancy, major psychiatric illness, intellectual impairment or limited English language skills. A total of 206 women were identified as eligible and were invited to participate by letter and study brochure, followed by a phone call to discuss participation. Women who were unable to be contacted by phone were sent a paper copy of the questionnaire. Recruitment was undertaken between 1st February and 30th June 2015.

Data sources

Data was collected via a comprehensive questionnaire, which included several validated measurement tools regarding sexual function, relationship satisfaction, menopause symptoms and overall quality of life. Demographic details included: previous hysterectomy, previous breast surgery including reconstruction, current anti-estrogen treatment, and current hormone

replacement use. The questionnaire also included the following 8 validated questionnaires: Female Sexual Function Index (FSFI) [14]; Sexual Activity Questionnaire (SAQ) [15]; Female Sexual Distress Scale Revised (FSDS- R) [16]; Relationship Assessment Scale (RAS) [17]; Body Image Self-Consciousness Scale (BISC) [18]; Menopause-specific quality of life questionnaire (MENQOL) [19]; Short Form Health Survey (SF-36) [20]; and Impact of Event Scale (IES) [21].

Variables

The 19-Likert item measure of female sexual function, the validated Female Sexual Function Index (FSFI) [14], was used to determine the diagnosis of female sexual dysfunction (FSD) and Hypoactive Sexual Desire Disorder (HSDD). With an additional 0 category added to question 15, as recommended by Meyer-Bahlburg to allow for women not in a relationship, the FSFI total scores range from 1.6 to 36 [22]. A higher score in the FSFI indicates a higher level of sexual functioning. A cut-off score of 26.55 has been psychometrically validated to discriminate between sexually functional and dysfunctional women, with those scoring 26.55 or below being considered likely to have FSD [23]. The sub-score for desire has been evaluated in the diagnosis of Hypoactive Sexual Desire Disorder (HSDD), with those scoring 5 or less having a high likelihood of HSDD [24].

Bias

A potential source of bias in this study is non-response bias and attempts to minimize this included telephone and mail prompting. The potential of response bias was mitigated somewhat by the high participation rate (58%). Attempts to minimize the risk of information bias included the use of standardized and validated measures.

Statistical analysis

Statistical analysis was performed using the statistical software program Stata 14.0 (StataCorp. 2015. *Stata Statistical Software: Release 14*. College Station, TX: StataCorp LP). The primary objective of this study was to determine the prevalence of FSD and HSDD in women with a prior history of breast cancer who have undergone RRSO, using the FSFI cut-off score previously described, and compare this to women who have undergone RRSO without a previous diagnosis of breast cancer. A secondary objective was to determine the effects of mastectomy, breast reconstruction, and anti-estrogen therapy on the sexual function and quality of life outcomes of women with a previous diagnosis of breast cancer after RRSO. A generalised linear model was used to test for associations with continuous variables, such as the validated questionnaire scores, while logistic regression analysis was used to test for associations with binary variables, such as the diagnosis of FSD and HSDD. Two participants did not complete the questionnaire entirely and these data points were treated as missing.

Results

Patient characteristics

The 119 study participants did not differ in age, time since RRSO, and proportion with breast cancer compared to the 87 women who declined to participate (Table 1). Table 2 summarizes the characteristics of the study participants.

Women with a prior diagnosis of breast cancer completed the questionnaire an average of 6.5 years after diagnosis (range 1–29 years). The average age at diagnosis of breast cancer was 47 (range

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