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Editorial

Sexual rehabilitation medicine in a female oncology setting

Abstract

Comprehensive oncological care has recently expanded not only to include diagnosis and treatment but survivorship medicine as well. Tertiary health care facilities are now developing multidisciplinary survivorship programs that focus on helping cancer patients live active, fulfilled lives while dealing with the potentially damaging and longstanding sexual ramifications of cancer and cancer therapy.

As part of a growing trend, health care institutions are establishing specialized sexual health programs to address cancer patients' sexual needs using functionalized survivorship curricula. Such programs provide individual or couples management to men and women who suffer from sexual dysfunction as a result of a cancer diagnosis and/or treatment. Using the Sexual Health Program at the Memorial Sloan-Kettering Cancer Center as a prototype for the development of future sexual health programs, this article will discuss the specific components and benefits of such programs. An effective program focuses on 4 key issues—clinical care, patient education and support, medical and scientific research, and medical education and training for health care professionals and providers. This article will discuss how sexual health programs benefit the female cancer patient (it should be noted, however, that these programs, such as the one at our institution, are usually available for either sex).

Keywords: Sexual health; Cancer; Female; Survivorship; Quality of life

Introduction

Cancer, the second leading cause of death among adults in the United States, is estimated to affect 1 in 3 individuals in their lifetime, either through their own diagnosis or that of a loved one [1]. According to data from The American Cancer Society, the National Cancer Institute estimated that in 2005 there were approximately 9.8 million people living with cancer [1], some in remission and others actively in treatment. This number is expected to increase as baby boomers age and become more likely to develop cancers.

Cancer has become a manageable chronic medical illness, not unlike hypertension or diabetes. According to the American Cancer Society, the 5-year relative survival for all cancer patients diagnosed between 1995 and 2000 is 64%, an increase from 50% for those diagnosed between 1974 and 1976; the increase is attributable to early detection and improved and innovative therapies [1]. Patients are living longer, stronger, and healthier lives in spite of their cancer, allowing them to remain active, productive members of society. Comprehensive oncological care has recently expanded not only to include diagnosis and aggressive treatment but also to include the critical phase of survivorship medicine—helping cancer patients live active, fulfilled lives while dealing with the potentially detrimental and longstanding ramifications of therapy. According to one thought process, coined by the Lance Armstrong Foundation, survivorship actually begins at the time of diagnosis; the health care team, including the clinician, should immediately attempt to comprehend the side effects of cancer care and help minimize suffering and potential long-lasting side effects [2]. Since technological and pharmacological breakthroughs are increasing life span, many health care providers are shifting their focus to help cancer patients live vigorous, dynamic lives while minimizing side effects of cancer therapeutics and maximizing quality of life.

Health care institutions are increasingly establishing specialized sexual health programs to address cancer patients' sexual concerns using functionalized survivorship curricula. Such programs provide individual or couples management to men and women who suffer from sexual dysfunction as a result of a cancer diagnosis and/or treatment. A functionalized, formalized program enriches the lives of both male and female cancer survivors and also recognizes the potentially altered dynamics a couple might experience as a result of one partner having cancer. Such a program recognizes the expanded definition of the cancer survivor to also include the unaffected spouse or significant other.

The primary goal of the Sexual Medicine Program at the Memorial Sloan-Kettering Cancer Center (MSKCC) is to treat patients who suffer from sexual dysfunction as a result of their cancer diagnosis or treatment. The individual sexuality programs have been structured to include a unique core of health care personnel, namely a sexual medicine urologist, a sexual medicine gynecologist, a certified sex therapist, and

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other mental health professionals who are interested in sexual health in the oncology patient.

Our sexual health program comprises the following key components: (1) clinical care of the patient or couple afflicted with sexual dysfunction; (2) patient education and support; (3) research endeavors to advance the field of sexual medicine, particularly as it relates to the cancer patient and/or his/her partner; and (4) the education and training of health care personnel.

Background

Sexual problems are commonly overlooked patient concerns. For patients, issues relating to sexual health, intimacy, and a sense of connectedness are paramount as they progress from the time of their diagnosis, throughout treatment, and later into the survivorship phase of their illness [3,4]. As patients move from the acute phase of their sickness, healthy sexual functioning is often viewed as an imperative step toward reestablishing a patient's sense of "normality" and well-being [5]. Scientific outcome studies in the oncologic medical literature that focus on quality-of-life concerns have shown that sexual dysfunction is highly prevalent in the cancer population at large [6,7]. Anderson et al. reported that sexual-function-related morbidity occurs in approximately 90% of women with the most prevalent types of cancer [8]. Others have documented reports of post-treatment sexual dysfunction ranging from 30% to 100% [6,7]. It is estimated that approximately half of the women who survive breast or gynecological cancers report severe, long-lasting sexual and intimacy problems or concerns [6]. Breast cancer survivors often admit that sexual problems persevere as troublesome exceptions to their high level of functioning [6]. Most commonly, women complain of hypoactive desire disorder and dyspareunia [3,4,9–12]. According to the Second International Consultation on Sexual Dysfunctions in Men and Women, the revised definition of women's hypoactive sexual desire disorder is characterized as the diminished feelings of sexual interest, lack of motivation, and the absence of sexual fantasies or thoughts, which cause the patient distress [13]. Dyspareunia is characterized as painful intercourse that can be persistent and recurrent.

While sexual dysfunction is a common consequence of cancer diagnosis and treatment, sexual assessment and/or sexual counseling is not routinely provided in the oncology outpatient clinical setting [14]. Time constraints, physician embarrassment, a lack of sexuality training or skills to deal with sexually charged issues, or even perhaps a health care professional's own unresolved sexual dilemmas may play a role in not addressing sexual health concerns with patients [14]. Often, the old paternalistic thought process supersedes during cancer care, and sexuality is erroneously perceived as not important by the attending clinician or health care team. Patients may also have significant apprehensions or face barriers when addressing sexual concerns and intimacy problems [15]. Some barriers may include a patient's cultural or religious upbringing, fear of embarrassment, or fear of embarrassing one's clinician. Most patients, however, will ultimately welcome the opportunity to explore this essential aspect of human functioning.

Rationale for a sexual medicine program

For patients with partners, failure to evaluate and treat the couple or dyad may fail to optimize sexual rehabilitation and patient care. While the primary sexual complaints may lie with one partner, the sequelae of the patient's dysfunction generally affect both partners. For example, treating a breast cancer survivor's menopausal syndrome and vaginal dryness may lead to resolution of her atrophic vaginitis and painful dyspareunia; however, failure to address her partner's anxiety and concerns of how to incorporate breast foreplay into their new sexual repertoire without backlash fails to comprehensively deal with the complete sexual ramifications of cancer therapy. Treating the patient in isolation without addressing the downstream effects on the partner or significant other increases the likelihood of failing to accomplish the primary goal of the sexual medicine practitioner, which is the resumption of satisfactory sexual relations for the patient and partner.

The sexual health program at our institution is open to all cancer patients, regardless of age, ethnic background, socioeconomic status, gender, relationship status, sexual orientation, cancer type, or stage of diagnosis. All patients (heterosexuals, gays, lesbians, singles, and couples) can potentially benefit from this type of program. Individuals may explore means of preserving sexual function; navigating new dating and sexual relationships; addressing issues related to the disclosure of sensitive medical information, contraception, and fertility; and learning about sexually transmitted disease prevention. Cross-cultural sensitivity training and insight are required for health care staff at the Sexual Medicine Program since different ethnic minorities may often have firmly entrenched cultural or religious beliefs/taboos that will ultimately impact their ability to address sexual functioning.

The sexual health program at MSKCC was developed on the following cornerstones:

I. Clinical care: assessment, diagnosis, and treatment
II. Patient education and support
III. Research endeavors
IV. Health professional education and training

Clinical care: assessment, diagnosis, and treatment

The primary function of our sexual medicine program is to deliver superior patient clinical care-assessment, diagnosis, and treatment. Our program requires the availability of a sexual medicine urologist, a sexual medicine gynecologist, and access to mental health professionals for male and female psychosexual health assessment and treatment. Both the medical physician and the mental health care providers function in a closely knitted work environment and often in mutual consultation to collaborate on evaluations and treatment plans. An elaborate referral network for consultations for both physicians and ancillary health care providers exists in order to ensure that