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Cancer, Benign Gynecology, and Sexual Function—Issues and Answers

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ABSTRACT

Introduction: The diagnosis, treatment, and survivorship of cancer have a profound effect on the quality of life and psychological well-being of men and women. Indeed, the perturbation of sexual function because of neoplasm has far-reaching implications.

Aims: To explore the prevalence, pathophysiology, and treatment of sexual issues in persons with cancer and offer evidence-based recommendations regarding optimal prevention and treatment strategies.

Methods: A committee of multidisciplinary specialists was formed as part of the larger International Sexual Medicine Consultation working with urologic and sexual medicine societies over a 1-year period to review the result of chronic-illness management on sexual function and satisfaction. The aims, goals, data collection techniques, and report format were defined by a central committee.

Main Outcomes Measures: Expert consensus was based on evidence-based medical and psychosocial literature review, extensive group discussion, and an open presentation with a substantial discussion period.

Results: This summary evaluates contemporary literature concerning the prevalence, pathophysiology, and psychological impact of cancer diagnosis and treatment on sexual dysfunction. Evidence-based recommendations and guidelines for evaluation and management are presented.

Conclusion: The diagnosis and treatment of cancer have a significant negative impact on sexual function and satisfaction. Comprehension of baseline sexual function, role of psychological supports, and available treatment options could attenuate the heavy burden of decreased sexual function.

Key Words: Sexual Function; Cancer; Benign Gynecological Disease

INTRODUCTION

The impact of cancer and its treatments has wide-ranging effects on patients, partners, and families. Advances in surgical and medical treatment have greatly improved survival for patients with many types of cancer. The treatment of sexual dysfunction resulting from a medical condition, or commonly, from its treatment, has become an important component of medical care. Improved understanding of sexual physiology allows therapy of dysfunction that is more effective and the opportunity of preventing some disease-related or iatrogenic dysfunction.

In this article, we review the sexual dysfunctions associated with cancer and its treatment. We address prevalence, pathophysiology, and the psychosocial factors contributing to sexual problems. Recommendations regarding prevention and treatment of sexual sequelae during and after cancer management are included.

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RECOMMENDATIONS

Prostate Cancer

Active surveillance has less impact on sexual function compared with active treatment modalities (level of evidence [LOE] = 3, grade C).
Treatment of sexual dysfunction for patients on active surveillance (AS) should be the same as treatment for patients without prostate cancer (LOE = 3, grade C).
Psychosexual counseling to patients on the natural history of prostate cancer and treatment of erectile dysfunction (ED) should be considered the preventive strategy for sexual dysfunction during AS (LOE = 3, grade C).
Means to minimize ED after radical prostatectomy (RP) are recommended: refining surgical technique, including avoiding cautery to accessory pudendal arteries, and bilateral nerve-sparing RP (LOE = 3, grade C).
Because approximately 50% of patients after bilateral nerve-sparing retropubic RP might not begin any ED treatment postoperatively, the couple rather than the individual should be considered when sexual function and dysfunction are addressed (LOE = 3, grade C).
We recommend urologists carefully portray the risks and benefits of new technologies during preoperative counseling to minimize regret and maximize satisfaction (LOE = 3, grade C).
We recommend the definition of ED as advocated by the International Consultation on Sexual Medicine (LOE = 3, grade C).
We recommend using internationally validated questionnaires and prospective collection of data on sexual functioning, because time since radiotherapy is an important factor (LOE = 3, grade C).
The etiology of postradiation ED is more likely multifactorial (LOE = 2, grade C).
We recommend the discussion of sexual matters after radiotherapy with the patient and his partner (LOE = 3, grade C).
Phosphodiesterase type 5 inhibitors are effective in approximately half of patients (LOE = 1, grade A).
There is no evidence to support the use of phosphodiesterase type 5 inhibitors for the rehabilitation of postradiation ED (LOE = 4, grade D).

Bladder Cancer

The sexual impact of repeated treatment for superficial tumors with cystoscopy or intravesical chemotherapy is underinvestigated but presumed to be nominal (LOE = 3, grade C).
With cystectomy, type of urinary diversion does not predict sexual activity or function (grade C).
Nerve-sparing cystectomy has a positive impact on erectile function that could be enhanced with penile rehabilitation (LOE = 4, grade C).
Prostate-sparing cystectomy decreases ED but also increases local and distant recurrence rates (LOE = 4, grade C).

Bladder Cancer in Women

Radical cystectomy can have a negative impact on quality of life and sexuality in women (LOE = 3, grade C).
Sparing the anterior vaginal wall and/or neurovascular bundles might help preserve sexual function in women; however, larger prospective studies are needed (LOE = 4, grade C).
Non−muscle-invasive bladder cancer (NMIBC) can result in sexual problems. Patients with NMIBC and their partners would benefit from proper sexual information (LOE = 3, grade C).

Penile Cancer

Pretreatment education is recommended to minimize psychologically based sexual dysfunction, including confirmation that intercourse can occur with a short penis (LOE = 4, grade C).
Because penile cancer is a curable condition when diagnosis and treatment are implemented early, preservation of maximal penile shaft is advocated to allow continual sexual function (LOE = 2, grade B).
Whether penectomy is partial or complete, multidisciplinary follow-up is recommended (LOE = 3, grade C).
Brachytherapy has little effect on sexual functioning (LOE = 2, grade B).
Avoidance of nerve damage in retroperitoneal lymph node dissection surgery is paramount because it is the responsible, yet preventable, etiology for most cases of ejaculatory dysfunction (LOE = 3−4, grade C).
Because changes in body image appear to be associated with a negative impact on patients' sexual life and function, all men undergoing orchiectomy should be offered the option of testicular implantation (LOE = 3−4, grade C).