Quality of Life and Sexual Function of Patients Following Radical Hysterectomy and Vaginal Extension

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ABSTRACT

Introduction. Radical hysterectomy (RH) has negative consequences on sexual function due to a shortened vagina, vaginal dryness, and dyspareunia. Peritoneovaginoplasty aims to extend vagina by vesical peritoneum and anterior rectal wall to improve postoperative sexual function.

Aim. The aim of this study was to investigate whether vaginal extension can improve sexual function and quality of life and the problem of sexual dysfunction in early-stage cervical cancer survivors (CCSs) in China.

Methods. Case-control and questionnaire-based methods were employed. Thirty-one patients who had undergone vaginal extension following RH and 28 patients with matching factors after RH alone were enrolled in the study.

Main Outcome Measures. Both groups were assessed retrospectively by questionnaires at least 6 months after treatment. The European Organization for Research and Treatment of Cancer Quality-of-Life questionnaire cervical cancer module and the Sexual Function Vaginal Changes Questionnaire are validated measurements for disease- and treatment-specific issues.

Results. Vaginal length was 10.03 ± 1.26 cm and 5.92 ± 1.05 cm in study and control group, respectively ($P < 0.05$). In the study group, 67.7% patients and 64.3% of control group resumed sexual activity at the time of interview, averaging 6 months between treatment and sexual activity. While difficulty emptying bladder, incomplete emptying, and constipation were the most commonly reported symptoms, no significant difference was observed regarding pelvic floor symptoms. Reduced vagina size and shortened vagina was significantly more prominent in the control group, whereas both group presented with hypoactive sexual desire (88.1%), orgasm dysfunction (71.8%), and low enjoyment or relaxation after sex (51.3%).

Conclusion. Shortened vagina was significantly less reported in study group, while no difference was observed in other sex-related dimensions. Vaginal extension does not worsen pelvic floor symptoms. Sexual rehabilitation interventions are of significance and should be paid more attention to the CCSs in China. **Ye S, Yang J, Cao D, Zhu L, Lang J, Chuang LT, and Shen K. Quality of life and sexual function of patients following radical hysterectomy and vaginal extension. J Sex Med 2014;11:1334–1342.**

Key Words. Early-Stage Cervical Cancer; Quality of Life; Sexual Function; Radical Hysterectomy; Vaginal Extension; Questionnaire

Introduction

The increase in cervical cancer diagnoses of young patients has become a significant problem in the clinical practice of gynecological oncology. Approximately 15% of all cervical cancers and 45% of surgically treated stage IB cancers are found in women under the age of 40 [1].

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In a retrospective study of 1,557 cases of cervical cancer, Zhao et al. reported that the average age of cervical cancer onset in Chinese women gradually decreased over the past 50 years, from 56.27 ± 8.45 in 1955–1964 to 43.81 ± 8.9 in 1995–2004 [2]. Considering the age and sexual behaviors of these patients at the time of diagnosis, quality of life (QoL) and sexual function are important issues for cancer survivors and caregivers. Therefore, gynecological oncologists are faced with the challenge of treating the disease while maintaining patient QoL after treatment.

Radical hysterectomy (RH) has remained the standard treatment of early-stage cervical cancer with only slight modifications since its first application. The classic RH (Piver III/type C2) comports complete resection of parametrium and 20–30 mm of vagina; complications include voiding dysfunction, colorectal motility disorder, and sexual dysfunction [3,4]. According to the data from a large population-based epidemiological study, sexual function is the leading cause of symptom-induced distress after treatments for early-stage cervical cancer [5]. More importantly, 30% to 63% of cervical cancer patients are known to present with sexual problems as a result of surgery and radiation complications, including a shortened vagina, vaginal dryness, and dyspareunia [6–10]. In a recent cross-sectional questionnaire-based study, Tsai et al. reported that approximately 66.67% of Chinese cervical cancer patients present with sexual dysfunction after treatment [11]. Bergmark et al. [7] has published the largest series on sexual functioning in early-stage cervical cancer survivors (CCSs). They reported that patients experienced adverse vaginal changes (vaginal length, lubrication, and elasticity) after RH alone. A shortened vagina following RH seems to be a quite prominent issue in CCSs. Symmonds and Pratt first reported the surgical technique of vaginal extension following RH, which creates a neo-vagina using the edges of peritoneum (peritoneovaginoplasty) to elongate the vagina for the purpose of a better postoperative sexual function [12,13]. However, it is unknown whether this kind of reconstruction actually improves the quality of sexual life as it may worsen pelvic floor problems (voiding dysfunction and colorectal motility disorder). Therefore, the purpose of this study is twofold. First, we aim to assess whether vaginal extension can improve postoperative sexual function and QoL. Second, we aim to demonstrate the prevalence of sexual dysfunction and related issues of early-stage CCSs in China.

Materials and Methods

Collection of the Patients

Using our hospital's Cervical Cancer Database, cases of patients who undergone RH and vaginal extension from December 2008 to September 2012 were collected as study group. Patients of similar age, stage, and RH alone (no vaginal extension) during the same time interval were chosen as control group. Criteria for vaginal extension in our hospital include: voluntary young patients (<45 years old), International Federation of Gynecology and Obstetrics (FIGO) stage IB1and IB2 (usually with neo-adjuvant chemotherapy to make lesion less than 2 cm), and sexually active prior to diagnosis. In the process of obtaining consent for operation, all eligible women were given a consent form that included the option of vaginal reconstruction. The form was written in plain language that explained the surgical technique of vaginal extension, possible benefits (elongating vagina), and/or possible side effects (worsening the pelvic floor symptoms). It was the patient who made the final decision whether to have vaginal extension or not. Age, marital status, menopausal status, sexual status before diagnosis, time at diagnosis and treatment, histological type, FIGO stage, surgical technique, and follow-up outcomes of patients were collected. Histopathological results were independently confirmed by two gynecologic oncology pathologists, while stage was determined by two gynecologic oncologists with pelvic examination, according to the FIGO guideline [14]. In addition, surgical accessibility was assessed and all the surgeries were performed by the two gynecologic oncologists. Patients with positive pelvic lymph nodes, parametrial involvement, tumor size >4 cm, neo-adjuvant chemotherapy, and positive margins and/or deep myometrial invasion of the cervix after RH were given chemoradiation therapy.

Surgical Technique of Vaginal Extension

The vaginal cuff is sutured by lock-stitch suture following RH. Then, the anterior and posterior borders of the vagina are approximated to vesical peritoneum and anterior rectal wall, respectively, by interrupted suture with 2–0 absorbable suture. Next, anterior rectal serosa is approximated to vesical peritoneum at the level above the previous anastomosis (usually 3–4 cm), thus elongating the vaginal canal (illustrated by Figure 1). The resulting vaginal vault has a smooth surface lined by mesothelium cells.

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