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Review Article

Maintaining sexual health throughout gynecologic cancer survivorship: A comprehensive review and clinical guide

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HIGHLIGHTS

- Sexual dysfunction is a prevalent, yet under-recognized and under-treated morbidity of gynecologic cancer treatment.
- A comprehensive review of sexual problems experienced by gynecologic cancer survivors is presented.
- A practical, evidence-based approach to sexual health concerns in patients during and after treatment is discussed.

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ABSTRACT

Objective. The diagnosis and treatment of gynecologic cancer can cause short- and long-term negative effects on sexual health and quality of life (QoL). The aim of this article is to present a comprehensive overview of the sexual health concerns of gynecologic cancer survivors and discuss evidence-based treatment options for commonly encountered sexual health issues.

Methods. A comprehensive literature search of English language studies on sexual health in gynecologic cancer survivors and the treatment of sexual dysfunction was conducted in MEDLINE databases. Relevant data are presented in this review. Additionally, personal and institutional practices are incorporated where relevant.

Results. Sexual dysfunction is prevalent among gynecologic cancer survivors as a result of surgery, radiation, and chemotherapy—negatively impacting QoL. Many patients expect their healthcare providers to address sexual health concerns, but most have never discussed sex-related issues with their physician. Lubricants, moisturizers, and dilators are effective, simple, non-hormonal interventions that can alleviate the morbidity of vaginal atrophy, stenosis, and pain. Pelvic floor physical therapy can be an additional tool to address dyspareunia. Cognitive behavioral therapy has been shown to be beneficial to patients reporting problems with sexual interest, arousal, and orgasm.

Conclusion. Oncology providers can make a significant impact on the QoL of gynecologic cancer survivors by addressing sexual health concerns. Simple strategies can be implemented into clinical practice to discuss and treat many sexual issues. Referral to specialized sexual health providers may be needed to address more complex problems.

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1. Introduction

Gynecologic cancers are estimated to comprise over 94,000 new cancer cases in the U.S. in 2015. The most common site of diagnosis is uterine cancer followed by ovarian, cervical, and vulvar cancer [1]. In 2014 there were 14.5 million cancer survivors living in the U.S., 14% of which were gynecologic cancer survivors, and this number is anticipated to grow to almost 19 million by 2024 [2]. With the growing number of gynecologic cancer survivors, attention to survivorship and quality of life (QoL) is crucial to the comprehensive care of patients.

According to the World Health Organization, sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality [3]. Sexual dysfunction refers to problems during any phase of the sexual response cycle. The prevalence of sexual dysfunction in the general U. S. population is approximately 40% [4,5], but can approach 90% in gynecologic oncology patients [6], with associated poor psychosocial adjustment and QoL [7]. Gynecologic malignancy and treatment with surgery, chemotherapy, and/or radiation directly affect the sexual and reproductive organs. Sexual morbidity affects gynecologic cancer patients immediately following treatment [8] and during long-term survivorship [9,10].

Despite the high prevalence of sexual dysfunction in gynecologic cancer survivors, attention to sexual health issues by healthcare providers has been suboptimal. Patients feel they would benefit from more information regarding the effects of treatment on sexual health before therapy and desire counseling from a provider post-treatment to address sexual health concerns [11,12]. Seventy-four percent of long-term gynecologic cancer survivors believed physicians should regularly ask about sexual issues, but 64% stated a physician never initiated the conversation during their care [10]. Understanding, evaluating, and treating the sexual health issues encountered during treatment and survivorship are crucial to the comprehensive care of gynecologic cancer patients.

Many survivors are older women and some clinicians believe that sexual health issues are less important to these women. Research indicates this is not true. Lindau and colleagues investigated the sexual activity, behaviors, and sex-related problems of over 3000 U.S. adults 57 to 85 years of age and found that the majority of older adults engage in intimate relationships and regard sexuality as an important part of life [5].

The following related topics are beyond the scope of this review (although also critically important): sexual health concerns related to infertility, sexuality in patients undergoing risk-reducing bilateral salpingo-oophorectomy (BSO), breast cancer survivorship, and partner-related sexual dysfunction. This article will focus on the sexual health issues faced by gynecologic cancer survivors and discuss treatment options for the most common problems.

2. Impact of gynecologic cancer on sexual health

2.1. Endometrial cancer

Endometrial cancer is the most common gynecologic malignancy in Western countries, and it is estimated 54,870 new cases will occur in the United States in 2015 [13]. The majority will occur in postmenopausal women and surgery is the primary treatment for most patients. Standard surgical approach includes hysterectomy, BSO, with surgical staging with selective pelvic and para-aortic lymphadenectomy. Minimally invasive surgery has widely replaced laparotomy as the preferred surgical approach, providing improved blood loss, postoperative pain, complications, and length of hospital stay [14,15] without compromising survival [16].

Many women with early-stage disease can be observed following surgery, but even in the absence of adjuvant therapy, patients are at risk of having sexual dysfunction. Onujiogu et al. reported a prospective evaluation of the prevalence of sexual dysfunction in early-stage (I–IIIa) endometrial cancer patients 1 to 5 years from primary surgical treatment ($N = 72$) [6]. Eighty-nine percent of participants had some form of sexual dysfunction determined by the Female Sexual Function Index (FSFI) score of <26 and pain was the most commonly affected domain. Only 18% of participants received adjuvant radiation therapy, suggesting that sexual dysfunction is prevalent among patients treated with surgery alone [6]. A prospective study by Aerts et al. investigated sexual adjustment in surgically treated endometrial cancer patients compared to women who underwent a hysterectomy for benign indications and healthy controls ($N = 84$ in all groups) [17]. There was no difference in reported sexual function in endometrial cancer patients before and after surgery. Furthermore, no difference in sexual function occurred in relation to the type of surgery (laparoscopy v. laparotomy) or the performance of lymphadenectomy. However, compared to healthy controls endometrial cancer patients reported more sexual dysfunction before and after surgery. Endometrial cancer patients had significantly more entry dyspareunia at 1 year compared to patients who had a hysterectomy for benign indications, and decreased sexual arousal, desire, and entry dyspareunia at 2 years compared to the healthy controls. Differences found between these three groups should be interpreted with caution as they were significantly different in age, menopausal status, education, and hormone replacement therapy use which could influence reported outcomes [17].

For patients with higher risk of recurrence and higher stage disease, adjuvant therapy in the form or radiotherapy and/or chemotherapy is typically recommended. The Post-Operative Radiotherapy in Endometrial Cancer (PORTEC-2) investigated the outcomes and adverse effects of vaginal brachytherapy (VBT) compared to external beam radiotherapy (EBRT) for the treatment of high-intermediate risk endometrial cancer [18]. No difference in vaginal recurrence was found between the treatment groups, but less gastrointestinal side effects were reported in patients who received VBT. Longitudinal QoL assessment at 5 years showed there were no differences in sexual function between VBT and EBRT patients. However, when compared to an age-matched control population, participants in the study reported significantly more vaginal dryness and lower sexual interest, activity, and enjoyment [19].

Several small cross-sectional studies have not shown a difference in sexual function in endometrial patients undergoing hysterectomy and VBT compared to women who received hysterectomy alone [20,21] or compared to a healthy postmenopausal control [22]. Nonetheless, Quick et al. showed that compared to before the diagnosis of cancer, the majority of patients felt their vagina was smaller and reported

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