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Management of sexual side effects in the surgical oncology practice: A nationwide survey of Dutch surgical oncologists

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Abstract

Background: Sexual function is an important factor in quality of life, but at risk after several surgical cancer treatments. Our aim was to identify the practice, responsibility, attitudes, knowledge and barriers of surgical oncologists towards providing informed consent on sexual side effects and sexual counselling.
Methods: A 31-item questionnaire was sent to all 437 members of the Dutch Society for Surgical Oncology (NVCO).
Results: The majority of 165 responding surgical oncologists (85.5%) stated that discussing sexual function is their responsibility, 13.0% thought it to be somebody else's responsibility. During informed consent of a planned surgical procedure, sexual side effects are mentioned by 36.6% of surgeons in more than half of the cases. Counselling sexual function was performed by 9.2% of the surgeons in more than half of the cases. Older surgeons (≥46 y) and male surgeons discuss sexual concerns more often ($p = 0.006$ *v* $p = 0.045$). Barriers most mentioned included advanced age of the patient (50.6%), not relevant for all types of cancers (43.8%), lack of time (39.9%) and no angle or motive for asking (35.2%). Additional training on counselling patients for sexual concerns was required according to 46.3%.
Conclusion: Surgical oncologists do not routinely discuss sexual concerns. Informed consent includes limited information about possible complications on sexual function. Surgeons consider themselves responsible for raising the issue of sexual dysfunction, but consider advanced age of patients, lack of time and no angle or motive for asking as major barriers. Results emphasize the need for raising awareness and providing practical training.

Keywords: Surgeons; Cancer; Sexuality; Sexual dysfunction; Informed consent; Quality of life

Introduction

Cancer patients commonly experience sexual problems, regardless of cancer origin or age of onset.[1,2] The occurrence and degree of sexual dysfunctions are subject to the localization of the disease and the sort of treatment. Surgery is known to be of considerable influence for sexual functioning and is frequently part of a cancer treatment. The primary aims of surgical cancer treatment are cure and survival, however, consequences such as poor bowel and bladder function, a (temporary) stoma, physical weakness, pain, scars, nutrition related problems and body-image issues are serious and in many cases influence the sexual functioning. The adverse impact of surgical

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treatment to sexual function is an underestimated problem and may arise as a result of physical, psychological and social changes. Sexual health encompasses functioning across these particular domains and is hence defined as "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity…".[3] Many circumstances may cause sexual issues in cancer patients, such as general physical debility, somatization, change in lubrication, erectile dysfunction, ejaculation disorder, depression, anxiety and decreased desire.[4] Changes may result from direct effects of the surgery on physical function (e.g. nerve damage), due to indirect effects of the surgery on psychological function (e.g. mastectomy or stoma impacting body image and desire) and some changes may be due to broader effects of cancer and its treatment across any of the domains (e.g. fatigue, loss of libido, illness, social stress and loss of sexual partner). Sexual dysfunction has a great impact on the quality of life of cancer patients, and with improving prognosis attention for sexual health is being acknowledged as an important excellence indicator of comprehensive care.[1,4,5] Gradually, as oncology treatment objectives are extending towards improved quality of life, evidence has increased on the treatment-related sexual burden and the corresponding need for information.

Previous surveys have documented sexual side effects are associated with a range of cancers. For example, in an Australian survey, 85% of 1965 patients with breast cancer reported changes to sexual well-being, with 68% wanting information on such changes.[6] Only 16.6% of these participants had spoken about sexual well-being with their surgeon, of which only 43% was satisfied with this consultation. Mastectomy with or without reconstruction both have a significant impact on body image and sexual function in comparison to women who had a lumpectomy.[7] Three years after mastectomy, feelings of sexual attractiveness and comfort during sexual activity are significantly decreased, as well as the feeling exists that the partner's sexual interest has decreased.[8] One-third of patients who have undergone major head and neck carcinoma treatment reported substantial problems with sexual interest and intimacy.[9] Colorectal surgery also often results in sexual dysfunction; approximately half of the women reported sexual dysfunction and the percentage of dysfunction in preoperatively potent men varied from 5% to 88%.[10] Predictors for sexual dysfunction following colorectal surgery include preoperative radiotherapy, a stoma, complications during or after surgery and a higher age.[10] After rectal surgery, specific sexual issues in women are libido 41%, arousal 29%, lubrication 56%, orgasm 35%, and dyspareunia 46%, and in men libido 47%, impotence 32%, partial impotence 52%, orgasm 41%, and ejaculation 43%.[11] Men with a colostomy reported erectile dysfunction in 79% of the cases, though a (temporary) colostomy affects sexual function in many ways.[12] Patients with rectal cancer who have undergone surgery, considered sexual function an important overall outcome. However, only 9% of women and 39% of men remembered talking about the sexual side-effects of surgery preoperatively.[11] Among patients with gynaecologic, breast or colorectal cancer, 37% received information about how surgery possibly affects their body image and sexual well-being.[13]

When it comes to bringing up the subject during a consultation with a physician, patients experience several barriers.[14,15] Nonetheless, the great impact of sexual dysfunction on quality of life indicates it is important for health care providers to inform patients on sexual side effects and detect if a patient is experiencing any problems.[16] Knowing that most patients will not initiate a conversation about sexuality, health care providers carry the responsibility to address this issue.[1] Well-informed patients have an advantage in coping with consequences of surgery as complications are better tolerated if they are anticipated.[17]

So far, in the last decades research mainly focused on counselling of sexual concerns by oncology nurses. In the position of having frequent contact with patients and providing medical and emotional support, oncology nurses play a significant role in detecting and discussing personal issues, including sexual concerns. However, physicians are the patients' primary responsible medical attendant and source of information concerning treatment and side effects. To our knowledge, extensive information concerning the presumed role of the surgeon in sexual counselling is not available yet. Aim of this study was to evaluate current practice, attitude and opinions of Dutch surgical oncologists towards information provision and communication about sexual issues. By identifying barriers, ideas about responsibilities and the potential need for additional training; recommendations can be made for improvement of sexual health care for surgical cancer patients.

Materials and methods

Study design

A cross-sectional survey was performed among surgical oncologists practicing in the Netherlands. All surgeons and surgical residents registered as a member of the Dutch Society for Surgical Oncologists (NVCO) received a questionnaire by postal mail in August 2013 (n = 437). An information letter and a post-paid return envelope were added. A reminder was sent after 6 weeks, a second reminder 13 weeks after the initial mailing. All data were collected anonymously.

Questionnaire design

The questionnaire was developed by the authors and has been shown to be applicable in several studies conducted by our research group.[18–21] The questionnaire comprised 31