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Interventions to Address Sexual Problems in People with Cancer

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Interventions to Address Sexual Problems in People with Cancer

Section 1: Recommendations

This section is a quick reference guide and provides the guideline recommendations only. For key evidence associated with each recommendation, see Section 2.

GUIDELINE OBJECTIVES

To examine effective strategies/interventions to manage sexual function side effects as a result of cancer diagnosis and/or treatment with the aim of decreasing distress, and improving quality of life for cancer survivors and their partners.

TARGET POPULATION

This guideline is applicable to adult men and women (and partners) of all sexual orientations living with cancer of any type. For the purposes of this guideline, men and women who were previously treated for a childhood cancer were not included.

INTENDED USERS

Healthcare practitioners such as oncologists, radiation therapists, urologists, gynaecologists, primary care providers, surgeons, nurses, physiotherapists, social workers, counsellors, psychologists and psychiatrists.

PREAMBLE

When first approaching this guideline, the Working Group chose to focus the guideline on sexual disorders that are known to arise in people with cancer. Sexual problems commonly include decreased desire, arousal disorders, pain (in women), and erectile dysfunction (in men). Sexual function is impacted in a multifactorial way by one's overall health (the patient and his/her partner), partner relationships, previous sexual history, medications, fatigue and stress, mood, body image, incontinence, and hormonal changes. Cancer can independently affect sexual function via changes in health, cancer treatment, body image, and changes in relationships.

The Working Group further chose to organize the guideline by conditions commonly seen in the clinic. The Working Group believed that criteria such as those listed in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* were not a good fit for this patient population and instead chose an *a priori* list of conditions, which we believed aligned well with common problems. It is hoped that this pragmatic approach will make the guideline easier to use for practitioners. The conditions include: sexual response, body image, intimacy and relationships, altered sexual function and satisfaction, vasomotor symptoms (women), and genital symptoms (women). Sexual response includes decreased desire, arousal, and alternate sensation in orgasm or anorgasmia for both sexes, and in men also includes erectile dysfunction and the absence of ejaculate. Body image conditions include those associated with urinary or fecal incontinence, ostomy, alopecia, mastectomy and lumpectomy, and changes in penile and testicular size and shape. Intimacy and relationship issues include the degree of comfort or closeness, and degree of sharing and communication with a partner. Sexual function and satisfaction encompasses the overall function of how the body reacts to sexual response and the satisfaction a person feels as a result of an intimate or sexual experience. Vasomotor symptoms are usually described as night sweats, hot flashes, and

flushes. Genital symptoms in women include pelvic pain, vaginal dryness, and vaginal stenosis.

Interventions are organized by type, namely pharmacological, psychosocial counselling, or a device. Psychosocial counselling interventions are a group of nonpharmacological therapeutic interventions, which can address the psychological, sexual, social, personal, educational, or relational needs of a patient. However, these interventions may be provided in many different ways using various methods and techniques. In this guideline, all psychosocial or educational interventions are considered together. Further research is required to determine the key features of a psychosocial intervention that provide the most effective strategies in reducing sexual dysfunction.

It is important to acknowledge that men and women may have pre-existing difficulties with sexual response, sexual function, body image, intimacy, and relationships. This may complicate assessment and management.

Finally, while this guideline focuses on interventions, the most important thing a provider can do is to ask their patients if they are having any sexual health problems, if they would like to discuss these problems further, and if they would like information or a referral for help.

Note on the generalizability of disease site-specific evidence: The evidence to support the recommendations in women is primarily from studies including women with breast cancer and a small number of women with gynecological cancer. Similarly for men, the data are primarily from studies including men with prostate cancer and a few studies of men with colorectal cancer. The Expert Panel believe the results of these studies are generalizable and have merit for patients with all cancer types.

Note on implementation: The authors of this guideline encourage the users to read the Discussion section as it has a significant amount of clinical information regarding references and additional resources for clinics and physicians.

RECOMMENDATIONS

For all people with cancer

Recommendation 1
It is recommended that there be a discussion with the patient, initiated by a member of the healthcare team, regarding sexual health and dysfunction resulting from the cancer or its treatment. Ideally, the conversation would include the patient's partner, if partnered. This issue should be raised at the time of diagnosis and continue to be re-assessed periodically throughout follow-up. The Expert Panel believe that this is a vital recommendation. The recommendations that follow cannot be used unless someone has taken the initiative to ask. It is recommended that there be access to resources or referral information for the patient (and partner).

Women:
Condition: Sexual Response

Recommendation 1
The Expert Panel believe that psychosocial counselling should be offered to women with cancer, aiming to improve elements of sexual response such as desire, arousal, or orgasm. Current evidence does not support one type of psychosocial counselling to be superior to another. No recommendation can be made for pharmacological interventions.
Qualifying Statements
It is the opinion of the Expert Panel that any kind of regular stimulation (including masturbation) would likely be of benefit for improving sexual response, regardless of the stimulation used.

Condition: Body Image

Recommendation 2
It is recommended that psychosocial counselling be offered to women with cancer and body image issues. If a woman is partnered, evidence indicates that couples-based interventions are effective when compared with usual care. No recommendation can be made for or against group therapy (with or without exercise) for women with body image issues.

Condition: Intimacy/Relationships

Recommendation 3
It is recommended that psychosocial counselling be offered to women with cancer aiming to improve intimacy and relationship issues. If a woman is partnered, evidence indicates that couples-based interventions are effective when compared with usual care.

Condition: Overall Sexual Functioning and Satisfaction

Recommendation 4
The Expert Panel believe that psychosocial counselling directed at the individual or couple, or delivered in a group be offered to women with cancer who have problems

with overall sexual functioning. Physical exercise or pelvic floor physiotherapy, in addition to psychosocial counselling, may also be of benefit.

Current evidence does not support a specific psychosocial counselling intervention to improve sexual functioning and satisfaction.

Condition: Vasomotor Symptoms

Recommendation 5

For women with vasomotor symptoms, hormone therapy is the most effective intervention. For women unwilling or unable to use hormonal therapy, alternatives exist; for example, paroxetine, venlafaxine, gabapentin, or clonidine.

Having a hormone-sensitive breast cancer is a contraindication to using systemic hormone therapy.

Psychosocial counselling (cognitive behavioural therapy) may provide a benefit and reduce vasomotor symptoms and should be offered.

Qualifying Statement

The Expert Panel emphasizes that women with non-hormone-sensitive cancers who develop vasomotor symptoms from their cancer treatment should be counselled to consider hormone therapy until the average age of menopause, approximately 51 years, at which point they should be re-evaluated. Risks typically cited for hormone therapy are derived from studies of post-menopausal women. Beyond the age of 51 years, hormone therapy is an individual therapy with few risks for symptomatic patients in their 50's. It should be intermittently evaluated for long-term use.

When not contraindicated, estrogen therapy alone (oral, transdermal, or vaginal) is recommended for women who have had a hysterectomy, as it has a more beneficial risk/benefit profile.

Paroxetine and fluoxetine should not be offered to women with breast cancer taking tamoxifen. Adverse events of clonidine include hypotension, light-headedness, headache, dry mouth, dizziness, sedation, and constipation. Sudden cessation can lead to significant elevations in blood pressure.

Condition: Genital Symptoms

Recommendation 6

Women with symptoms of vaginal atrophy, such as vaginal dryness, should be managed in the same way as women without cancer. Vaginal moisturizers for daily comfort and/or lubricants with sexual activity may be tried. For those who do not respond or whose symptoms are more severe at presentation, vaginal estrogen can be safely used.

Vaginal dilators may be of benefit in the management of vaginismus and/or vaginal stenosis.

Cognitive behavioural therapy and exercise may be useful to decrease lower urinary tract symptoms.

The Expert Panel believe that pelvic floor physiotherapy should also be offered to women with pain or other pelvic floor issues.

Qualifying statement

For women with hormone-positive breast cancer who are symptomatic and not responding to conservative measures, vaginal estrogen can be considered after a discussion.

Men:
Sexual Response

Recommendation 1

It is recommended that phosphodiesterase type 5 inhibitor (PDE5i) medications be used to help men with erectile dysfunction.

Men who do not respond to PDE5i medications should consider alternate interventions such as a vacuum erectile device (VED), medicated urethral system for erection, or intracavernosal injection.

There may be some benefit to initiating the use of any of the above interventions earlier after cancer treatment rather than later.

Qualifying Statement

The Expert Panel believe that men are best served by being offered a combination of psychosocial counselling with the aim of greater adaptation toward long-term use and PDE5i medication adherence together with PDE5i treatment. For men who are partnered, psychosocial counselling should be directed at the couple.

Men should be aware that it might take a long time for medications to work.

It is the opinion of the Expert Panel that any kind of regular stimulation (including masturbation) would likely be of benefit for improving sexual response, regardless of the stimulation used.

Contraindications include the use of nitrates in any form. Common acute side effects of PDE5i medications include headaches, flushing, dizziness, upset stomach, nasal congestion and dyspepsia.

Genital Changes

Recommendation 2
It is recommended that a VED be used daily to prevent penis length loss. There may be some benefit to initiating the use of VEDs earlier after cancer treatment rather than later. Early treatment with PDE5i medications may also be beneficial for this outcome.

Intimacy/relationships

Recommendation 3
The Expert Panel believe that individual or couples counselling should be offered for those wishing to improve relationship or intimacy issues. Current evidence does not support a particular intervention to improve intimacy or relationships.

Overall Sexual Functioning and Satisfaction

Recommendation 4
It is recommended that psychosocial counselling be offered to men with cancer (and partners) to potentially improve sexual functioning and satisfaction. It is also recommended that the use of pro-erectile agents and devices be considered, recognizing that most of the benefit is specifically for erectile dysfunction.
Qualifying Statement
Psychosocial counselling could be used to help couples integrate interventions into their usual sexual activities.

Condition: Vasomotor Symptoms

Recommendation 5
Men with vasomotor symptoms should be offered medication for symptomatic improvements. Options would include venlafaxine, medroxyprogesterone acetate, cyproterone acetate, and gabapentin. Acupuncture may be a suitable alternative.