

Is there a sexual life after treatment of cancer?

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Cancer has surpassed heart disease as the leading cause of death in most western countries. The occurrence of cancer is increasing due to the growth and aging of the population, and to well-known risk factors (smoking, overweight, physical inactivity, urbanization) (1). Although there is a clear decrease in overall cancer mortality rates, mainly in developed countries, cancer still remains a major public health problem.

Due to modern surgical techniques, improved chemotherapeutical drugs and sophisticated radiation techniques cancer is slowly becoming a chronic disease. More people live longer or are cured. Therefore quality of life (QoL) in general and sexual functioning in particular have become very important for cancer patients. Several studies suggest that the patients' perception of their own health status may also provide independent prognostic information together with traditional biomedical data (2). Incorporating QoL measures and outcomes in cancer research to supplement the more traditional clinical endpoints has provided valuable information to guide clinical decision-making (2). If many years ago most of the protocols on cancer treatment did not incorporate QoL evaluation, at present clinical trial groups, such as the European Organisation for Research and Treatment of Cancer (EORTC), routinely include QoL assessment and sexual functioning into their protocols. With the introduction of sildenafil (Viagra®) in 1998, media attention to erectile and sexual dysfunction has made sexual problems in men more normative and has increased acceptance of help-seeking. Nevertheless, sexual functioning in cancer patients is not routinely addressed (3,4).

Biological factors such as anatomic alterations (rectum amputation, penile amputation), physiological changes due to hormonal status manipulations and secondary



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effects of medical intervention may preclude normal sexual functioning in both men and women even when sex desire is intact (4). Despite the life-threatening nature of cancer might result in the assumption that sexual activity is not important to patients and their partners this is not true (4). Side effects of the treatment such as nausea, vomiting, fatigue, hair loss together with disfiguring surgery can result in adverse effects on sexuality. Negative emotional states such as anxiety, depression, anger, often present in cancer patients, may disrupt sexual activity as well. The presence of a stoma poses further problems to the patient and the partner. Anxieties about odour, stomal breaking and leaking,

and potential discomfort all make this a difficult situation requiring empathy and specialised counselling. Training of stomal therapists in sexual counselling is mandatory to ensure good outcomes. Nurses have a dominant role in the delivery of acute cancer treatment and side effects management (5). However, sexual difficulties are frequently considered a late effect of treatment and there has been limited systematic research on late effects compared to the assessment and management of acute toxicity (6). As a result, the evidence base for clinical assessment and intervention for sexual difficulties in oncology is largely restricted to the pharmacological management of erectile dysfunction in men or the provision of dilators to prevent vaginal stenosis and shortening after pelvic radiotherapy in women (6). Nurses need to have a biophysiologic knowledge on the anatomy and physiology related to sexuality and about the effects of cancer and its related treatments on sexual functioning (5). Studies performed in both specialist cancer treatment centres and in primary care show consistently that there is lack of proactive communication on sexual matters, even although the doctors may have thought that the patients might experience a sexual problem (5,6). Sexuality in general, and in relation to cancer in particular, should be an integral part of training at undergraduate and postgraduate level (4). For the general public there are now many good publications and websites. This information should be readily available at all treatment centres. Cancer clinics may offer advantages when a specific consultation for sexual function and dysfunction in cancer patients is organized. At Erasmus MC Cancer Institute, Rotterdam, The Netherlands, we have set up in 2000 such a specific consultation where patients are counselled and, if needed, treated for their sexual dysfunctions. Its advantage is that it is settled in the same clinic where the patient receives the oncological treatment, and that the physician skilled in sexual counselling and treatment is also skilled in oncological treatments (4). Furthermore, there is a strict collaboration with other health care providers, including medical specialists, physiotherapists, psychologists, medical sexologists, nurses. Every stage of management, from initial diagnosis to treatment to the survivor stage has a variety of psychosocial stressors for the patient, partner, and other loved-ones (7). The cancer management team needs to continuously address, counsel, and educate about sexual function throughout the course of the cancer patient's life (7). The 3rd International Consultation on Sexual Medicine in 2009 appointed for the first time a committee on chronic illness (including cancer) and sexual medicine.

The recommendations of the committee are very useful to help develop research programmes on oncology and sexual medicine (3). The International Society for Sexuality and Cancer (ISSC; www.issc.nu) was founded in 2002 to heighten awareness about sexuality in cancer patients by fostering research, encouraging training and increased service provision, and providing a forum at international meetings for discussion (4).

The papers in this issue deal with prostate cancer, gynaecological, rectal and breast cancer, broadening the interest from urologists to oncologists, psychologists, oncological nurses, gynaecologists, surgeons, and more. They provide evidence based information on the incidence, pathogenesis and extent of iatrogenic sexual dysfunctions following cancer treatments. Also pharmacologic, surgical, and psychological approaches to managing sexual dysfunctions in cancer survivors and their partners have been addressed. I am very grateful to *Translational Andrology and Urology*, and in particular to the Editor-in-Chief Prof. Lue, for giving me the possibility of addressing such an important topic and to dedicate an entire issue to it. The great majority of oncology professionals are scared to address sexuality and the great majority of sexological professionals are scared by cancer (4). It is time that cancer specialists and sexologists better understand each other. Cancer affects quantity and QoL. The challenge for physicians and other health care professionals is to address both components with compassion (4). If we accomplish this, the answer to the question "Is there a sexual life after treatment of cancer?" is definitely yes.

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Footnote

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References

1. Torre LA, Bray F, Siegel RL, et al. Global cancer statistics, 2012. *CA Cancer J Clin* 2015;65:87-108.
2. Efficace F, Bottomley A. Toward a clearer understanding of the prognostic value of health-related quality-of-life parameters in breast cancer. *J Clin Oncol* 2005;23:1335-6; author reply 1336.

3. Sadowsky R, Basson R, Krychman M, et al. Cancer and sexual problems. *J Sex Med* 2010;7:349-73.
4. Incrocci L. Talking about sex to oncologists and cancer to sexologists. *J Sex Med* 2011;8:3251-3.
5. Wilmoth MC. Life after cancer: what does sexuality have to do with it? 2006 Mara Mogensen Flaherty Memorial Lectureship. *Oncol Nurs Forum* 2006;33:905-10.
6. White I. Evidence-based cancer care: sexuality. *Eur J Cancer Care* 2005;14:289-99.
7. Incrocci L. CSSH Supplement of the JSM. *J Sex Med* 2013;10 Suppl 1:1-2.

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