ESMO
GOOD SCIENCE
BETTER MEDICINE
BEST PRACTICE

SEXUALITY AND INTIMACY AFTER CANCER

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OBJECTIVES

- Understand the incidence and significance of sexual health in patients diagnosed with cancer
- Understand the relationship between intimacy and intercourse for women and men
- Understand what providers can do to address sexual health issues in their patients with cancer

SEXUAL DYSFUNCTION IS A LONG-TERM ISSUE

- Impacted population:
  >12 million cancer survivors
- Livestrong 2010 Survey (n=3129)
  - Predominantly white (90%) and female (60%)
  - Educated (54% with bachelor's or graduate degree)
  - Majority diagnosed before 40 years
  - Most prevalent- breast, colorectal, lung

Livestrong Survivor Survey Final Report.2010. Available at: https://d1un1nybq8gi3x.cloudfront.net/sites/default/files/what-we-do/reports/LSSurvivorSurveyReportfinal_0.pdf. Accessed May 2017

THE LIVESTRONG 2010 SURVEY

- Sexual functioning and satisfaction ranked THIRD most frequently reported physical concern
  - Reported as a lot in 29%
  - Reported as a little in 37%
  - Of those reporting, less than half received medical care

- Survivors expressed significant emotional concerns related to sexual health (% rated as a lot/a little):
  - Sadness and depression (9/36)
  - Personal appearance (14/39)
  - Stigma (6/31)
  - Personal relationships (15/56)

Livestrong Survivor Survey Final Report.2010. Available at: https://d1un1nybq8gi3x.cloudfront.net/sites/default/files/what-we-do/reports/LSSurvivorSurveyReport_final_0.pdf. Accessed May 2017

SEX IS NOT CONFINED TO PENILE–VAGINAL INTERCOURSE

- Intimacy
- Sensuality
- Body image
- Arousal
- Desire
- Climax
- Satisfaction

Picture credit: simplemarriage.net

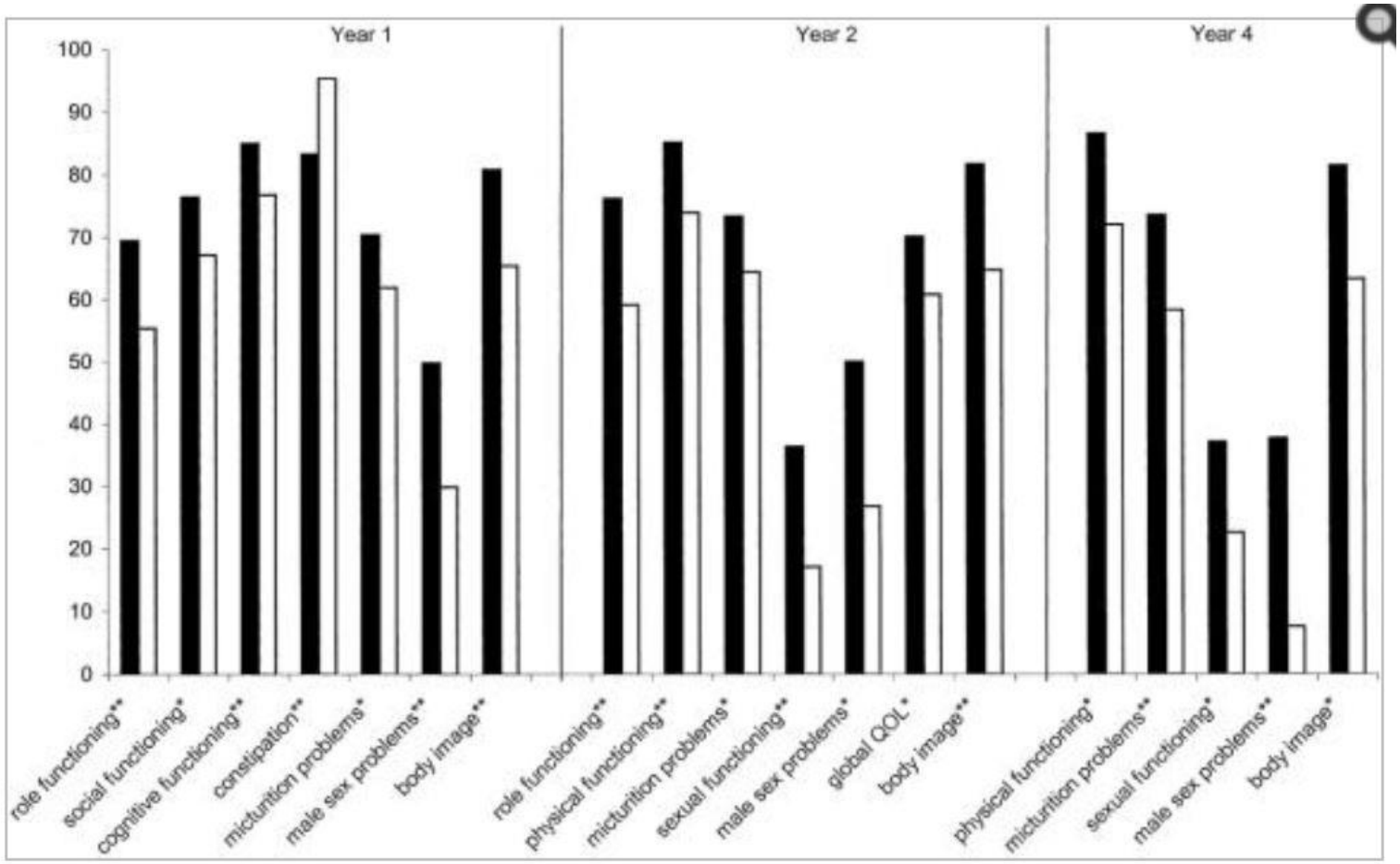
INCIDENCE OF SEXUAL PROBLEMS

- Sexual health is impacted regardless of cancer type:
- Across all cancers → 60%[1] in women; up to 80%[2] in men
  - Breast cancer: up to 90%[2]
  - Gynaecologic cancer: 78.4%[1]
  - Non-Hodgkins Lymphoma (Up to 64% in women, 49% in men)[3]
  - Prostate cancer (40-82% with localised disease)[4,5]
  - Rectal cancer (70-80%[6] in men; 30-45%[7] in women)
  - HSCT recipients (51% in men, 66% in women)[8]

Image by Tina Franklin. Attribution 2.0 Generic (CC BY 2.0)

1. Majorino MI, *et al.,* Endocrine 2016; 54:329-41; 2. Avery JC, *et al.,* J GI Oncol 2014; 5:388-94;
3. Kim JR, *et al.,* Ann Hematol 2017; 96:739-47; 4. Wortel RC, *et al.,* J Sex Med 2016; 13:1695-1703;
5. Bessaoud F, *et al.,* Bull Cancer 2016; 10:829-40; 6. Saito S, *et al.,* Eur J Surg Oncol 2016; 42:1851-58;
7. Gilbert A, *et al.,* Int J Rad Onc Biol Phys 2015; 92:555-67; 8. Dyer G, *et al.,* Br J Haematol 2016; 172:592-601.

SPECIAL ISSUES: STOMAS



Black = no stoma
White = stoma

Engel J, *et al.*, Quality of Life in Rectal Cancer Patients: A Four-Year Prospective Study. Ann Surg 2003;238(2):203–13. https://insights.ovid.com/pubmed?pmid=12894013. Accessed June 2017

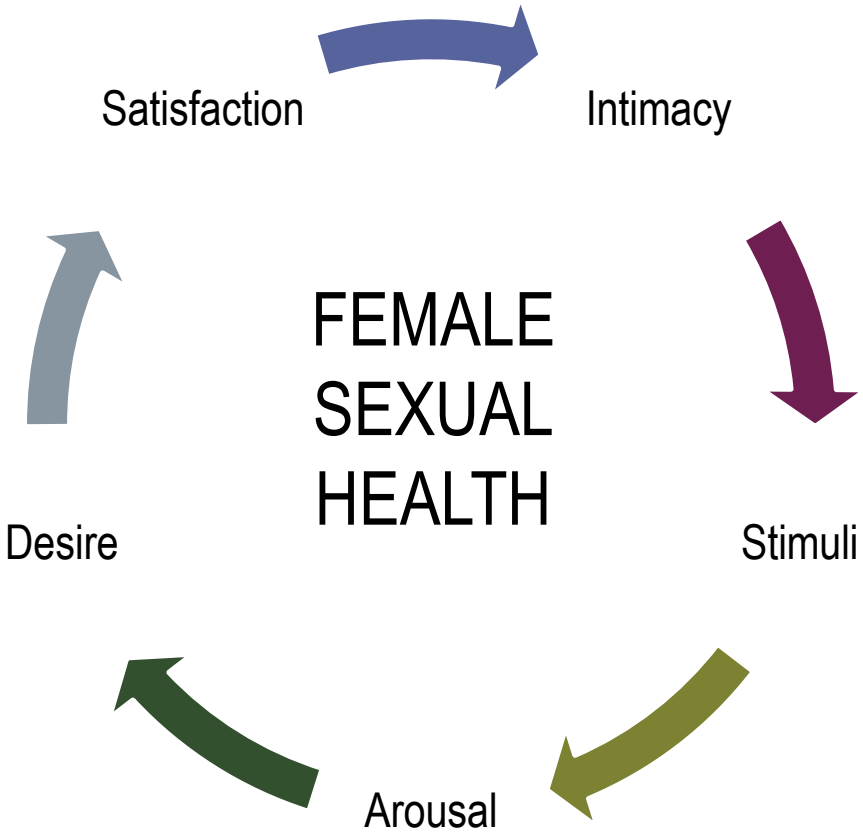
SPECIAL ISSUES: MUCOSAL GVHD

- Common complication after transplantation
- Seen acutely, but can be a chronic issue
  - For women[1]:
    - Impacts 25 to 49% of women after allo transplant
    - Median onset 7-10 months, but can develop much later
    - Must do a pelvic exam to diagnose!
  - For men[2]:
    - Genital skin changes reported by at least 20% when asked
    - Erectile dysfunction present in 65%
    - Sexual discontent reported by 60%

1. Ciavattini A and Clemente N, Anticancer Res 2015; 35:13-7; 2. Mueller SM, *et al.,* Biol Blood Marrow Transpl 2013; 19:1574-80.

FEMALE SEXUAL HEALTH AFTER CANCER

BASSON MODEL OF FEMALE SEXUAL HEALTH



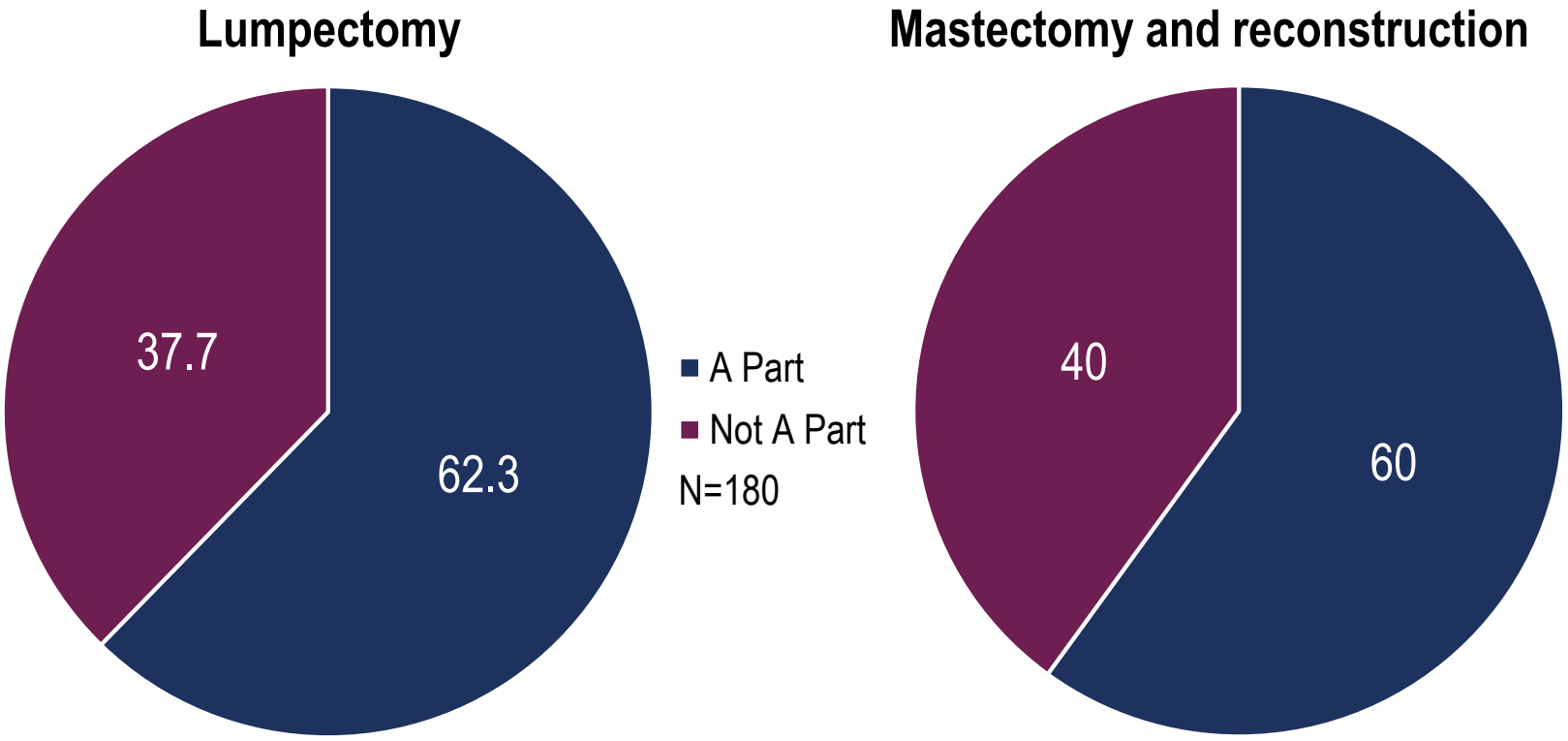
Basson R, Obstet Gynecol 2001;98:350-3.

BREAST SPECIFIC SENSUALITY

	BCS	MRM	MRM with Recon
Before surgery, chest play was part of my sexuality (n=262)	83%	95%	93%
Chest play is a part of my sexuality after surgery (n= 253)	74%	47%	77%
I am satisfied with my surgical outcome	80%	48%	67%

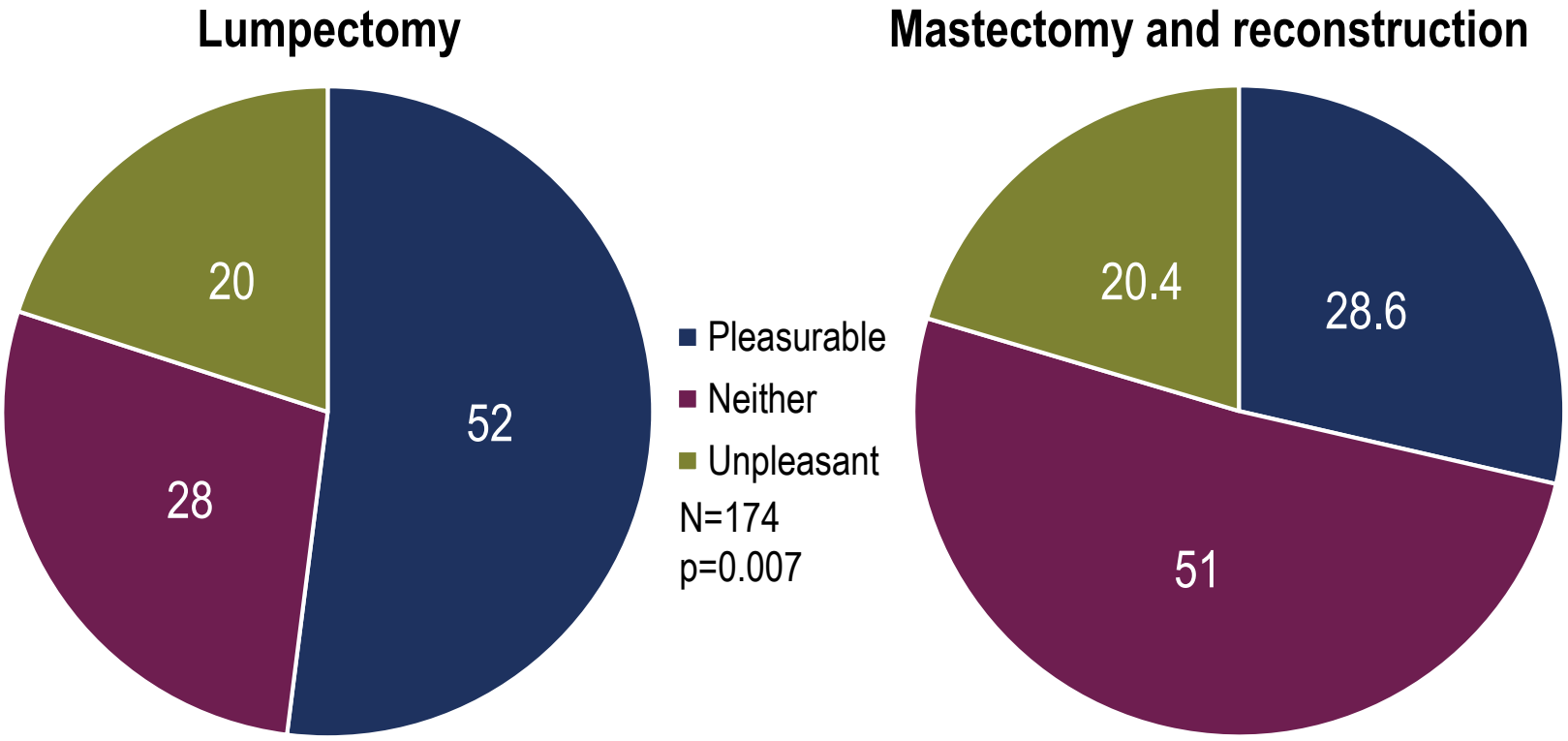
Gass JS, Onstad M, *et al.* Ann Surg Oncol. Epub 12 June 2017

BREAST SPECIFIC SENSUALITY



Onstad M, Gass JS, *et al.,* Am Soc Br Surgeons 2016; Abstr 324

BREAST SPECIFIC SENSUALITY



Onstad M, Gass JS, *et al.,* Am Soc Br Surgeons 2016; Abstr 324

APPROACH TO TREATMENT

- Vaginal Health
  - Address Genitourinary Symptoms of Menopause (GSM)
    - Vulvar and vaginal moisturisers
    - Vaginal laser therapy
    - Hormonal treatment
- Sexual Health
  - Address ways to make sexual activities more pleasurable
    - Lubricants, Lidocaine, Dilators
  - Address desire

TREATMENT FOR GSM

NON-HORMONAL THERAPY: VAGINAL MOISTURISERS

- Part of routine gynaecologic **health**
- Benefit for sexual comfort
- Many types:
  - Polycarbophil-based
    - Loprinzi, 1997[1]: RCT *vs.* placebo → Significant improvement in dyspareunia in 60% (40% with placebo)
  - Vitamin E
  - Natural oils (coconut, olive)
    - *Apply externally only*
  - Parabens free[2]

1. Loprinzi CL, *et al.,* J Clin Oncol 1997; 15:969-73; 2. Nohynek GJ, *et al.,* Toxicol Letter 2013; 223:295-305.

NON-HORMONAL THERAPY: VAGINAL LASER THERAPY

- Fractional microablative CO2 laser therapy x3
- Salvatore, *et al*.:
  - Patients: 77 postmenopausal women with vulvovaginal atrophy (VVA)
  - Intervention: 3 treatments over 12 weeks
  - Comparator: **None**
  - Outcomes with treatment compared to baseline:
    - Significant improvement in function at 12 weeks (measured by FSFI)
    - 17 of 20 women regained a normal sexual life at 12 weeks
    - Significant improvement in physical and mental domains in quality of life (measured using SF-12)

Salvatore S, *et al.,* Climacteric 2015; 18:219-25.

VAGINAL LASER THERAPY AFTER BREAST CANCER

- Pieralli A, *et al*., 2016:
  - Patients: 50 women with dyspareunia associated with an oncologic menopause
  - Intervention: CO2 laser therapy
  - Comparator: **None**
  - Outcomes:
    - Significant improvement in dyspareunia (by Visual Analogue Scale)
    - Significant improvement in vulvovaginal atrophic symptoms (by Vaginal Health Index)
    - Satisfaction persisted at 11 months follow-up for 52% of patients
- Promising technology
  - No randomised trials
  - No data for women on ongoing anti-oestrogen therapy

Pieralli A, *et al*., Arch Gynecol Obstet 2016; 294:841-6.

HORMONE THERAPY AFTER CANCER

- Vaginal oestrogen appears to be safe, especially if not breast cancer
  - Multiple small studies
  - RE: BREAST CANCER: No **association** between vaginal oestrogen and outcomes
    - LeRay, 2012: Women who relapsed (n=917) *vs*. Women who remained without evidence of disease (n=8885)
      - Concomitant vaginal oestrogen and Endocrine tx: RR 0.78, 95% CI 0.48-1.25
      - Sequential: RR 0.97, 95% CI 0.22-4.18

Vassilopoulou-Sellin, R, Gynecol Oncol 1997; 65:89.
Dew, JE, Climacteric 2003; 6:45.
LeRay I, *et al.,* Breast Ca Res Treat 2012; 135:603.

ACOG CLINICAL OPINION

- Nonhormonal approaches are the first-line choices during or after treatment for breast cancer
- For women with ER+ breast cancer experiencing urogenital symptoms, vaginal oestrogen should be **reserved** for those patients who do not benefit from nonhormonal remedies
  - This decision must be coordinated between the oncologist and other providers
  - It must be preceded by an informed decision-making and consent process
- Data **do not show** an increased risk of cancer recurrence among women currently undergoing treatment for breast cancer or those with a personal history of breast cancer who use vaginal oestrogen to relieve urogenital symptoms

http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Use-of-Vaginal-Estrogen-in-Women-With-a-History-of-Estrogen-Dependent-Breast-Cancer

ORAL HT AND CANCER: A SUMMARY

- Oral HT can be given in women with cancer, not considered hormonally driven
  - Routinely done after ovarian, endometrial, cervical cancer
- Oral HT, however, may not be safe after HR+ breast cancer

ORAL HT AND BREAST CANCER

- HABITS (HT after breast cancer: Is it Safe)
  - Design: Open-label RCT
  - Patients: Stage 0-2 breast cancer, <4 nodes involved (n= 497)
    - Tamoxifen adjuvant treatment OK, but not an AI
  - Intervention: HT (2-years)
    - **Choice determined by local practice**
    - **Sequential E-P combination preferred for women with an intact uterus**
    - **Medium-potency E for women s/p hysterectomy**
  - Comparison: Best symptomatic management without hormones

Holmberg L, Iversen OE, Rudenstam CM, *et al.,* JNCI 2008; 100:475-82.

THE HABITS RANDOMISED TRIAL

Characteristic	HT arm	Non-HT arm
Patients with follow-up, n	221	221
Follow-up in years, median (range)	4.1 (0.01-7.8)	4.0 (0.2-7.7)
Time in years between primary treatment and randomisation, median (range)	2.1 (0.1-23.2)	2.2 (0.1-26.5)
Age in years, mean (range)	55.6 (42-75)	54.8 (38-74)
Node positive, n (%)	44 (19.7)	42 (18.8)
Hormone receptor positive,n (%)	139 (62.3)	122 (54.5)
Hormone receptor status unknown,n (%)	64 (28.7)	75 (33.5)
Breast preserved,n (%)	127 (57.0)	126 (56.3)
On HT before diagnosis,n (%)	115 (51.6)	115 (51.3)
On adjuvant tamoxifen at randomisation,n (%)	75 (33.6)	75 (33.5)
Follow-up clinic visits for breast cancer, median	6	6

Holmberg L, *et al.*, J Natl Cancer Inst 2008;100:475–82

THE HABITS RANDOMISED TRIAL

221 women followed according to ITT.
218 records checked in 2005/2006
11 women never exposed to HT

First events of breast cancer:
Local recurrence n=17
Ipsilateral axilla n=1
Contralateral cancer n=11
Distant metastases n=10
Breast cancer death n=0
Total breast cancer events n=39
Death by other causes n=3

221 women followed according to ITT.
220 records checked in 2005/2006
39 women exposed to HT

First events of breast cancer:
Local recurrence n=4
Ipsilateral axilla n=1
Contralateral cancer n=4
Distant metastases n=8
Breast cancer death n=0
Total breast cancer events n=17
Death by other causes n=0

Holmberg L, Iversen OE, Rudenstam CM, *et al.,* JNCI 2008; 100:475-82.

THE HABITS RANDOMISED TRIAL

HR (95%CI) of a new breast cancer event with HT

Characteristic	No. of events (No. of women in subset)	HR (95% CI)
All women	56 (442)	2.4 (1.3–4.2)
All women, adjusted	52 (416)	2.2 (1.0–5.1)
Hormone receptor positive	37 (268)	2.6 (1.3–5.4)
Hormone receptor negative	19 (174)	1.8 (0.7–4.8)
Tamoxifen	18 (153)	4.7 (1.4–16.2)
No tamoxifen	38 (289)	1.9 (1.0–3.6)
HT before diagnosis	26 (230)	2.3 (1.0–5.3)
No HT before diagnosis	26 (186)	2.2 (1.0–5.1)
Node negative	30 (282)	2.4 (1.1 –5.4)
Node positive	18 (110)	2.3 (0.8–6.4)

ESMO

Holmberg L, Iversen OE, Rudenstam CM, *et al.,* JNCI 2008; 100:475-82.

THE HABITS RANDOMISED TRIAL

The Bottom Line: For women with breast cancer, compared to no HT, HT (x2y) results in:

- A significantly increased risk of a breast cancer event (HR 2.4, 95%CI 1.3-4.2)
- 5-year cumulative incidence was 22 *versus* 8%
- Significance of risk seems limited to HR+ breast cancer
- Unknown impact on mortality (no deaths recorded)

- Study **underpowered** to assess different preparations of HRT
  - E2 alone compared to continuous combined regimen: HR 1.4 (95%CI 0.55-3.3)

Holmberg L, Iversen OE, Rudenstam CM, *et al.,* JNCI 2008; 100:475-82.

VAGINAL OESTROGEN THERAPY: PREPARATIONS

E2/WEEK	
20 mcg	• E2 tablet • 10 mcg, qd x 14d, then twice weekly
52.5 mcg	• E2 ring • 2 mg / 90 d, approx 7.5 mcg/d
200 mcg*	• CEE cream • 0.5 g cream (0.3 mg CEE) twice weekly
200 mcg	• E2 cream • 2-4 g x 14 d, then 1 g cream (100 mcg E2) twice weekly

*0.5 g CEE cream is approximately bioequivalent to 1 g estradiol cream.

WHAT ABOUT…

Ospemifene?

- What is it? A Vaginal SERM
- FDA Indication: The treatment of moderate to severe dyspareunia (secondary to vulvovaginal atrophy)

cancer; therefore, it should not be used in women with known or suspected breast cancer or with a history of breast cancer.

OSPHENA™ (ospemifene) tablets, Prescribing Information. Shionogi Inc. Florham Park, NJ. Available at: https://www.duchesnayusa.com/files/pdf/osphena_prescribing_information.pdf. Accessed May 2017

WHAT ABOUT…

Estriol

- Brief-acting oestrogen
- Studies date back to 1987
- Available as 0.005% estriol gel (50 mcg of estriol)
- Typical use: Daily x3 week, then BIW x12
- Cano, 2012: Compared to placebo in postmenopausal women (**NO HISTORY of cancer**), significantly improved dryness and global symptoms

Cano, *et al.,* Menopause 2012; 19: 1130-39.

VAGINAL DEHYDROEPIANDROSTERONE?

- ASCO 2014: Barton DL, *et al.*
  - RCT (Alliance N10C1)
    - Women with breast or gynaecologic cancer (n=441)
    - Vaginal DHEA (3.25 v 6.5 mg) *versus* placebo
    - Results:
      - All 3 arms had improvement in symptoms
      - At 12 weeks, DHEA improved sexual satisfaction significantly
        - » Effect size based on FSFI: +0.3-0.6
      - Side effects with DHEA: voice change, headache

Barton DL, *et al.,* J Clin Oncol 2014; 32:5s (Abstr 9507)

TREATING FOR SEXUAL COMFORT

VAGINAL LUBRICANTS

- Two varieties:
  - Water-based
  - Silicone-based
- Limited comparative studies
  - Double-blind trial comparing these in >2400 women[1]
    - No difference in pleasure or satisfaction found
    - For penile-anal intercourse: Preference towards water-based lubricant (*versus* none at all)

1. Herbenick D, *et al.*, J Sex Med 2011: 8: 202-212.

NATURAL OILS AS A LUBRICANT?

- Coconut and olive oil commonly used, instead of lubricants
- OVERCOME study (n= 25):
  - Pelvic Floor Relaxation Exercises (by PT at W0, W4)
  - Polycarbophil-based vaginal moisturiser
  - Olive Oil during sex
  - Results:
    - Max benefit = 12 weeks
    - PFR Exercises helpful in 93%, Vaginal moisturiser in 88%, Olive Oil in 73%

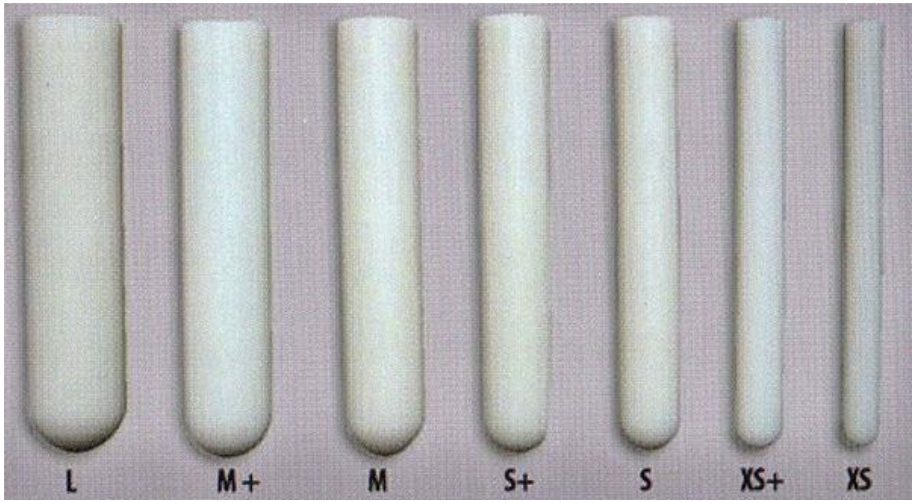
ESMO

Juraskova I, Jarvis S, Mok K, *et al.,* J Sex Med 2013; 10:2549-58.

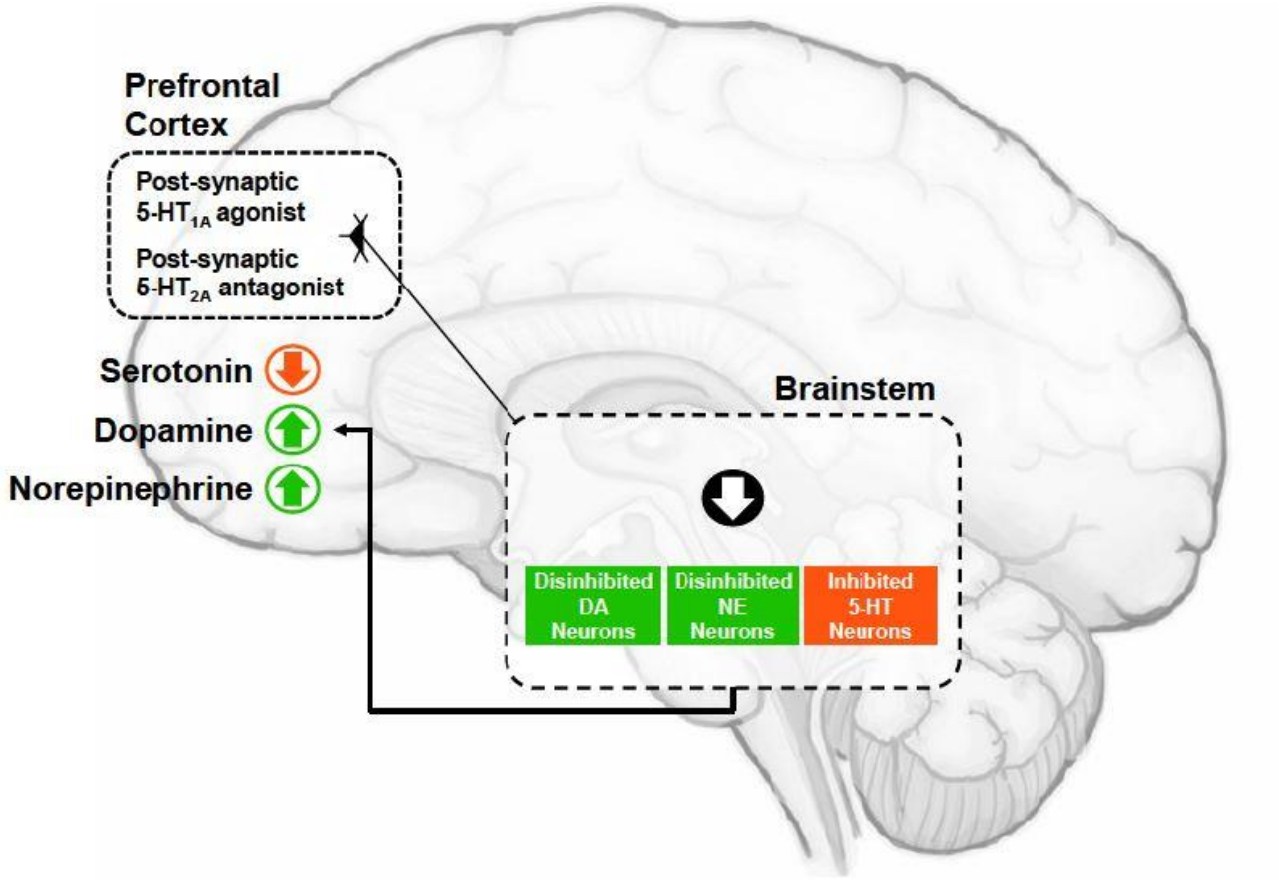
TOPICAL LIDOCAINE FOR VESTIBULAR TENDERNESS

- RCT: 46 breast cancer survivors (median pain with penetration score 8 out of 10)
- Method:
  - Saline or 4% aqueous lidocaine to vulvar vestibule (3m before penetration)
  - 1-month blinded then open-label (all patients) for 2-months
  - Measurement: twice-weekly tampon insertion or intercourse
  - Place on cotton swab, hold at vestibule for 30s
- Results with lidocaine:
  - At one month had less pain (median score 1 *vs*. 5)
  - After open-label: 90% comfortable penetration
  - 17/20 who were abstinent at entry resumed penetrative intercourse

VAGINAL DILATORS FOR VAGINISMUS



FLIBANSERIN FOR DESIRE?



http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/DrugSafetyandRiskManagementAdvisoryCommittee/UCM449088.pdf

FLIBANSERIN: RESPONDER ANALYSIS

Percent responders in the pivotal Phase 3 studies by anchoring the efficacy endpoints to the Patient Global Impression of Improvement (PGI) – FDA analysis

Endpoints	Study 71			Study 75*			Study 147		
	FLI 100 mg	Placebo	Trt. Diff	FLI 100 mg	Placebo	Trt. Diff	FLI 100 mg	Placebo	Trt. Diff
SSEs (standardised)	41%	29%	12%	43%	33%	10%	44%	34%	10%
FSFI desire domain	55%	40%	15%	54%	40%	14%	58%	48%	10%
FSDS-R Item 13	55%	43%	12%	49%	40%	9%	62%	49%	13%

*Excluded two sites

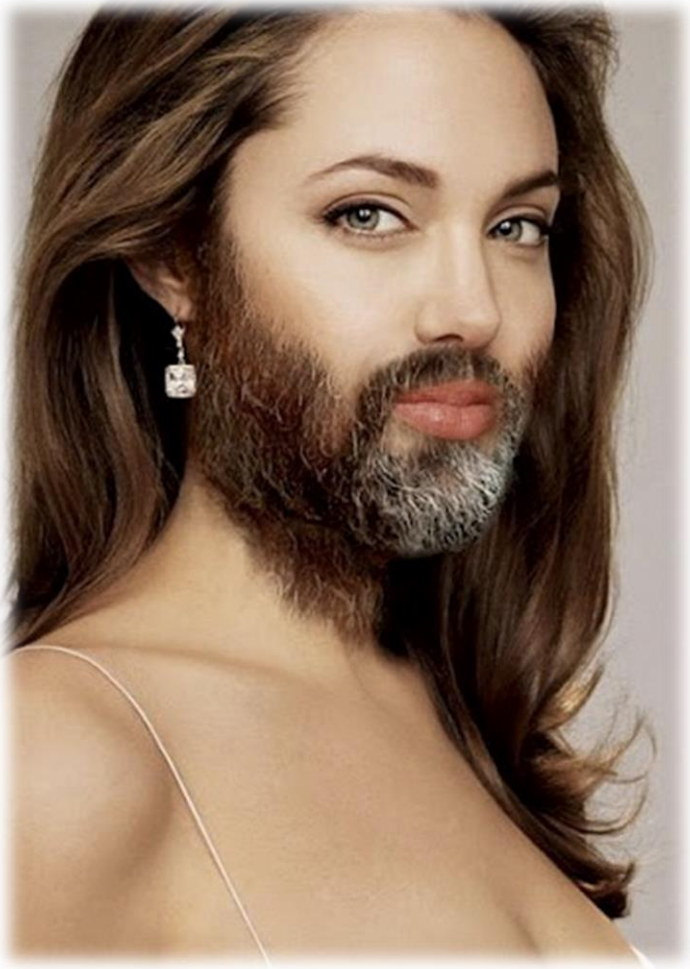
Flibansering FDA Briefing Document. BRUDAC and DSaRM Advisory Committee. June 4, 2015.
http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/DrugSafetyandRiskManagementAdvisoryCommittee/UCM449088.pdf
Accessed Jun 2017

PDE-5 INHIBITORS?

- No data in this population
- Women without cancer: No more effective than placebo[1]
- Cochrane systematic review in 2007:
  - Only data available for men with ED after prostate cancer
  - Poor quality clinical trials

Basson R, McInnes R, Smith MD, *et al.,* J Womens Health Gend Based Med 2002; 11:367

TESTOSTERONE TO IMPROVE SEXUAL HEALTH?



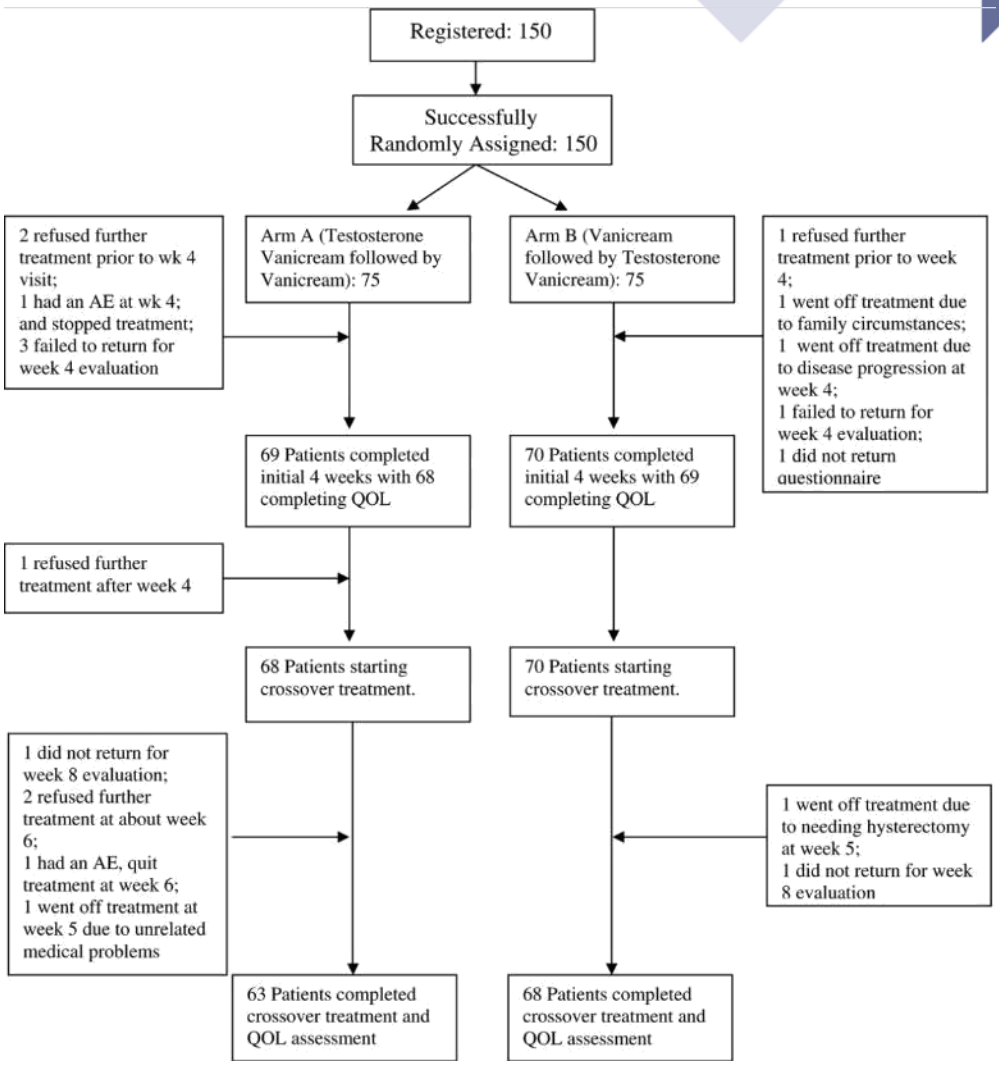
- Effective in women **without** cancer
  - Postmenopausal women: It improves interest and satisfaction in sex[1]
  - Women with HSDD: It is associated with an average increase of 4.4 sexual encounters per 4 weeks[2]
    - OR (benefit): 2.4
  - Women s/p TAH-BSO: It increased frequency of activity (p=0.03) and pleasure-orgasm (p=0.03)[3]

1. Floter A, *et al.,* Climacteric 2002;5:357-65; 2. Kingsberg S, *et al.,* J Sex Med 2007;4(Pt.1):1001-8; 3. Shifren JL, *et al.,* NEJM 2000;343:682-8.

NC02C3

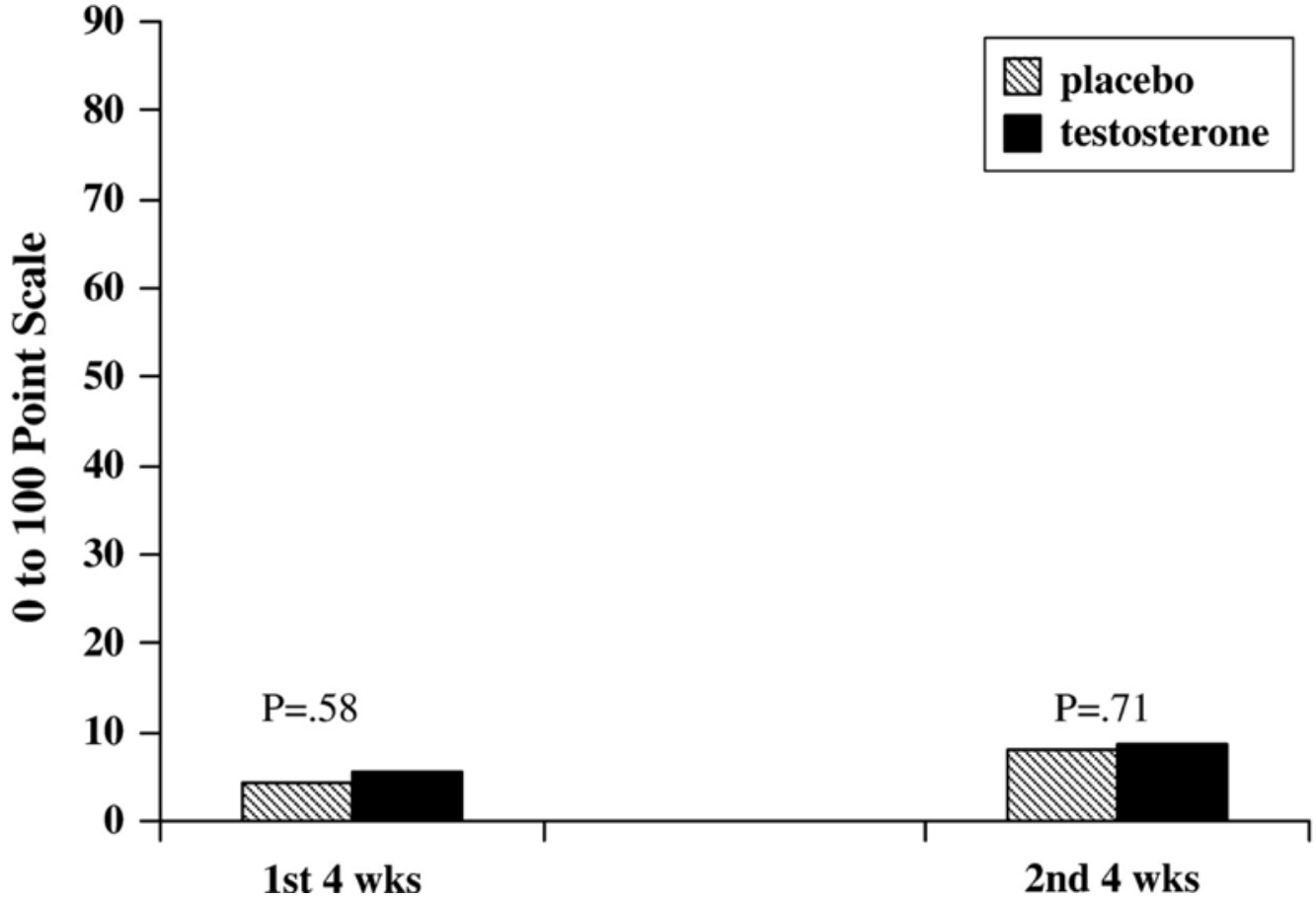
- Patients: 150 postmenopausal women, NED
- Intervention: 2% testosterone in Vanicream
- Comparator: Vanicream plus placebo
- Outcome: Improvement in sexual desire or libido

Trial design: Randomised Phase 3 trial with cross-over



Barton DL, *et al.*, Randomized Controlled Trial to Evaluate Transdermal Testosterone in Female Cancer Survivors With Decreased Libido; North Central Cancer Treatment Group Protocol N02C3J Natl Cancer Inst 2007;99(9):659-61. by permission of Oxford University Press

NC02C3



Barton DL, *et al.,* Randomized Controlled Trial to Evaluate Transdermal Testosterone in Female Cancer Survivors With Decreased Libido; North Central Cancer Treatment Group Protocol N02C3J Natl Cancer Inst 2007;99(9):659-61. by permission of Oxford University Press

TESTOSTERONE FOR WOMEN?

- One RCT → No benefit when administered as a cream
- In general, not recommended
- Caveats:
  - Cream application doesn't work, but what about other types (e.g., transdermal)
  - Most patients on NC02C3 had breast cancer (generalisability?)

TREATING GENITAL GVHD

- Women:
  - Dilator therapy to prevent stenosis
  - If erosions/ulcers present → Topical steroids
    - Clobetasol propionate 0.05% (once daily at bedtime)
    - If no response → Topical cyclosporine or Tacrolimus ointment 0.01%
  - No erosions/ulcers (incl. once healed) → Topical oestrogen
  - For stenosis:
    - Agglutination or scars may require lysing
    - Dilators coated with steroids

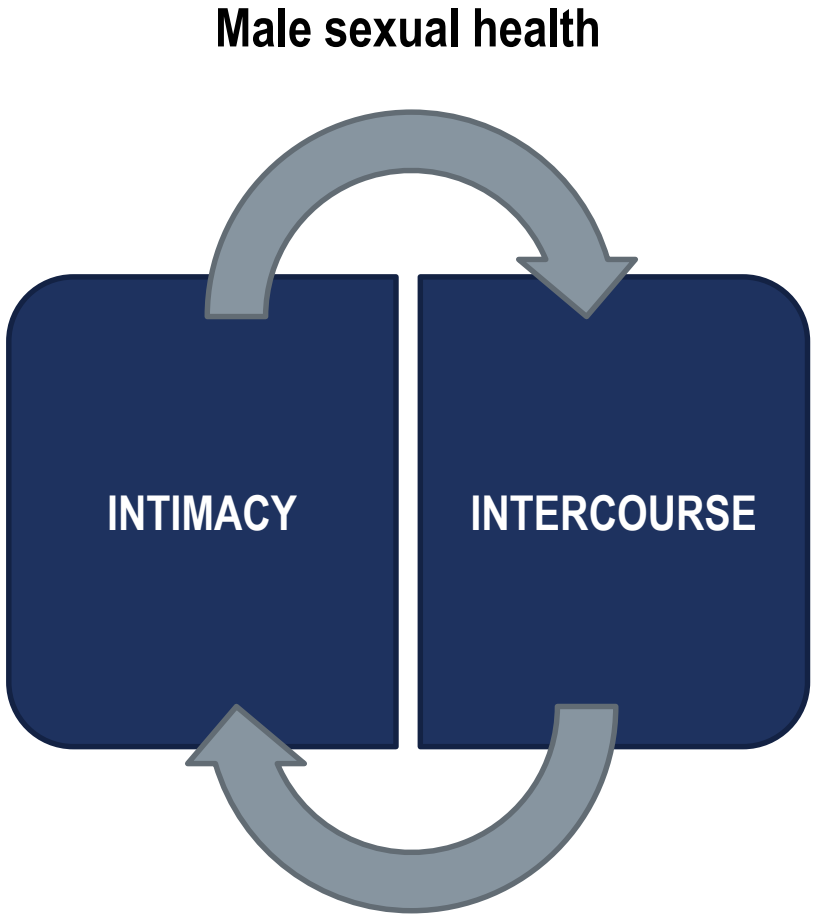
Ciavattini A and Clemente N. Anticancer Res 2015; 35:13-7.

MALE SEXUAL HEALTH: MORE THAN ERECTILE DYSFUNCTION

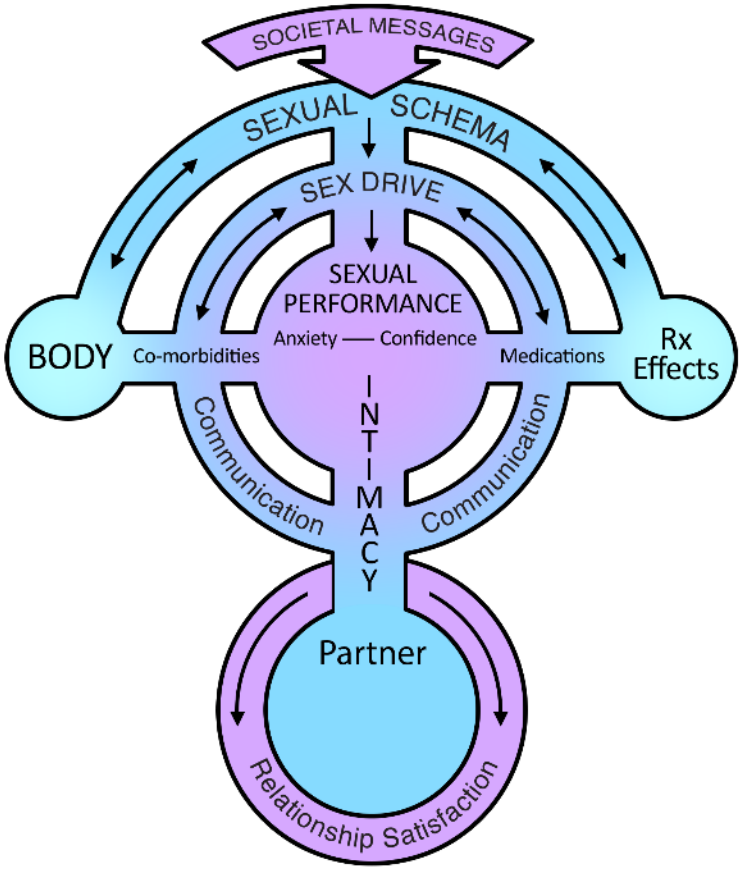
MOST COMMON FORMS OF SEXUAL DYSFUNCTION

- Erectile dysfunction (ED)
- Others:
  - Sexual bother
  - Orgasm/Ejaculatory disorder
  - Reduction in penile length

MALE SEXUAL HEALTH IS TYPICALLY SIMPLIFIED



KATZ-DIZON MODEL FOR MEN AFTER CANCER



MALE THERAPEUTICS

PDE-5 INHIBITORS FOR ED

- Sildenafil, Tadalafil, Vardenafil
- Most data from men with prostate cancer
- Bottom Line: Compared to placebo, these agents:
  - Are effective after radical prostatectomy with positive benefits in[1]:
    - Erectile function
    - Successful vaginal penetration
    - Successful intercourse
  - Have a positive impact after radiation therapy including in[2]:
    - Erection frequency
    - Firmness of erections
    - Maintenance of erections

1. Cui X, *et al.,* Andrologia. Published on-line 2/2015; 2. Yang L, *et al.,* Urologia Internationalis 2013; 90:339-47.

PDE-5 INHIBITORS: DOES DOSING MATTER ?

- Tadalafil RCT: 20 mg on-demand *vs*. 5 mg daily
- Patients: 52 men with prostate cancer treated with RT
- Results:
  - Both treatments effective, no differences seen
    - Positive scores for global efficacy: 86% *versus* 95% (p=0.27)
  - Daily dosing associated with better compliance (86 *versus* 100%)
    - Also associated with trend towards fewer side effects

Ricardi U, *et al.,* J Sex Med 2010; 7:2851-9.

PDE-5 INHIBITORS: DOES TIMING MATTER ?

REACTT trial: 20 mg on-demand *vs.* 5 mg daily Tadalafil *vs.* placebo

- Blinded Trial (BT) period → 9 months followed by
- Drug Free Washout (DFW) period → 6 weeks followed by
- Open-Label treatment (OLT) of 3 months

- Patients: 422 men with prostate cancer treated with nerve-sparing prostatectomy
- Results (On-demand and daily *vs.* placebo)
  - Back to baseline erectile function:
    - End of BT: 11 and 22% *vs.* 8%
    - Following DFW: No difference
    - After OLT: All arms showed near doubling of "back to baseline" reports
- Take home point: Early initiation helps with treatment-related ED

ESMO

Mulhall JP, *et al.*, J Sex Med 2016; 13:679-83

PDE-5 INHIBITORS: DOES TIMING MATTER ?

- What about if taken prophylactically?
- RTC of sildenafil vs placebo (started 3 days before treatment and then daily for 6 months):
  - Patients: 279 men, localised prostate cancer to undergo RT
  - Outcomes (sildenafil *vs*. placebo):
    - Mild to no ED at 12 months reported by 73 *vs*. 50% (p=.024)
    - Functional erections at 24 months: 82 *vs*. 56% (p=.045)

Zelesky MJ, *et al.*, J Urol 2014; 192:868-74.

PILLS ARE NOT ENOUGH

- Include the partner!
- Address expectations
- Exercise the penis: Nightly stretch
- Healthy (Healthier) Lifestyles is important
- Stress Reduction
- Erections are not needed for:
  - Intimacy
  - Orgasm
  - Climax

RELATIONSHIPS SUFFER WHEN MEN HAVE SEXUAL DYSFUNCTION

- For men with prostate cancer, ED is associated with:
  - Withdrawal from partner
  - Overall reduction in intimate encounters
  - Lowered rate of sexual contact
- Why?

Hamilton LD, van Dam D, Wassersug RJ. Psychooncology 2016; 25:832-31.

FOR MEN WHO DO NOT RESPOND TO PDE5 INHIBITORS:

- Address expectations:
  - Neural injury may take up to 4 years to heal
  - Scarring may be a more permanent issue
- Beyond oral medications:
  - Penile injection therapy (To corpus cavernosum)
  - Intraurethral suppositories
  - Vacuum pumps
  - Penis Prosthetic Devices
  - Any of these need a urological or men's health specialist
- Don't abandon:
  - Re-challenge every 2-3 months

YOUR ROLE IN THE SEXUAL HEALTH OF YOUR PATIENTS

WHY CLINICIANS DON'T TALK ABOUT IT

- We're too busy (you should bring it up)
- You're single
- You're too old
- You have metastatic disease
- You survived cancer!
- I don't want to go there

Figure: Wikipedia. Engraving based on a painting by FS Church.

THE ROLE OF THE CLINICIAN

- **Normalise** sexual health as a valid concern
  - Take a sexual history
  - Incorporate into the review of systems — At initial visit and during all follow-up
  - Refer!

APPROACHING SEXUAL HEALTH

I'd like to review how you are doing as it relates to both sexuality and intimacy. Would that be ok?

Are you (and your partner) having problems being intimate?

PERMISSION

Invites patient to enter into a discussion about sexual health

Some women complain that sex and intimacy are different now. In fact, it's pretty common. How has your experience been?

A common complaint is pain during intercourse. Is this something that is happening with you?

LIMITED INFORMATION

Normalizes that issues related to sexual health are common

If you have some trouble with vaginal dryness, it may help to use a lubricant before and during sex

SPECIFIC SUGGESTIONS

Offer advice that can be actionable and easy to incorporate if possible

It sounds like you might benefit from seeing an expert in sexual health. Can I suggest a referral?

INTENSIVE THERAPY

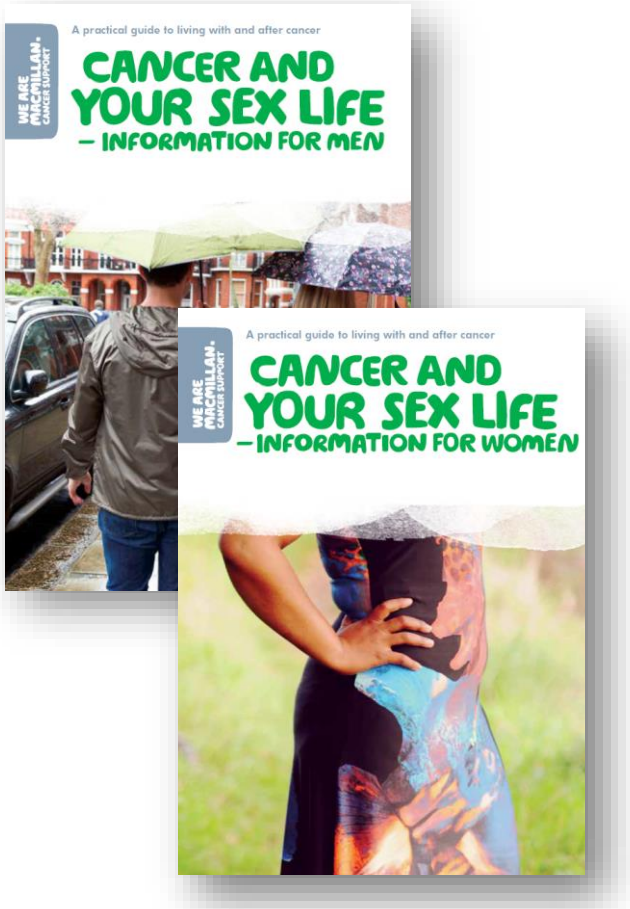
If one is not comfortable with issues brought up or does not know what to advise, offer expert consultation locally (if possible) or refer to educational resources

ESMO

Dizon D, *et al.,* Oncologist 2014;19:202–10

EDUCATION IS KEY

- Explore sexual health is a concept beyond intercourse.
- Re-examine what it means to be “sexual”
- Normalise their experience
- Encourage communication between partners



RECOGNISE IN YOURSELF:

- Your own personal comfort zone
- Your own sexual self-schema

https://be.macmillan.org.uk/be/s-616-relationships.aspx. Accessed May 2017

EMPHASISE THE TINCTURE OF TIME

- Re-defining sex after cancer is a process
- Pleasure is the goal, not performance
- Sexual homework:
  - Intimacy exercises
  - Communication exercises
  - Mandatory dates
  - Re-introducing sexual activities beyond penetrative intercourse

IT'S NOT ALL ABOUT INTERCOURSE

- Perz J, *et al.:* Views on sexual satisfaction were highly variable among patients, partners, and their clinicians
  - Clinicians tend to emphasise the importance of performance
  - Patients and partners expressed more nuanced view:
    - Intimacy as important and as satisfying as penetrative intercourse
    - Alternative forms of sexual expression were satisfying
    - Patients and partners want to navigate any physical impediments

Perz J, *et al.,* BMC Cancer 2013; 13:270.

CONCLUSION

- **Communication** – side effects, symptoms
- **Consultation** – seek help and advice proactively
- **Compromise** – e.g., alternatives to intercourse
- **Clarity** – define patient's needs in addition to acknowledging his/her partner's

AFTER CANCER…

Everyone deserves a sex life including:

- The young adult
- The older patient
- Patients in relationships
- Patients without a partner
- LGBTQ patients
- Patients with advanced or metastatic disease
- The oncologist

Photo credit: mrshustle.files.wordpress.com

CANCER IS A SOCIAL DISEASE

Your patient with cancer includes his or her partner

GOOD SCIENCE
BETTER MEDICINE
BEST PRACTICE

QUESTIONS?

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DRDONSDIZON

THANK YOU!