Sexuality in cancer management

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Abstract

Cancer diagnosis is a dramatic turning point in human's life. It impacts on the patient's trust on his/her body, the future, the ability to cope with the challenges the disease carries with it, and the struggle to survive. It reshapes life's priorities. Given the focus on the survival strategies, sexuality is usually neglected. Physicians tend to consider it as a minor issues, in comparison to the major questions every cancer conveys. Patients either marginalize it or do not dare to raise the issue. The "collusion of silence" persists in the majority of clinical settings all over the world.
Specifically, cancer diagnosis and treatment may variably affect three major dimensions of women's and men's sexuality: sexual identity, sexual function and sexual relationship [1-3]. Several biological factors modulate the final outcome: age at diagnosis, site of cancer; recurrences; pregnancy-related problems during or after cancer and infertility, when chemotherapy and/or radiotherapy cause permanent gonadal damage; the potential appearance of lymphedema (specifically after breast or genital cancer surgery), and side-effects of surgery (conservative vs radical) [2], radio or chemotherapy and hormonotherapy (tamoxifen and aromatase inhibitors, in women, antiandrogens in men, Gn-RH analogues in both genders); medical and sexual comorbidities [1,2]. Iatrogenic premature menopause, after childhood or adolescent cancers, or cancers in the women's fertile age, may add a further burden to the recovery process, from the physical, emotional and relational point of view, and should be competently addressed [2].
Sexual intimacy may be dramatically affected by loss of desire and depression, difficulties in getting mentally and physically aroused, dyspareunia because of the vaginal dryness (in case of menopause), and orgasmic difficulties, for biological and psychosexual factors in women. By loss of desire, erectile deficits and/or ejaculatory problems in men.
Studies indicate that couple's *emotional intimacy* may be reinforced by the sharing of solidarity the couple has when facing cancer diagnosis and treatment. *Physical intimacy* and *physical satisfaction* appear to be more variably affected, depending first on the affected organ and stage of cancer. They can be maintained, or even improved, when cancer diagnosis and treatment carries a good prognosis, has not caused major endocrine impairment, and have enhanced the sense of being alive and the motivation to live a full life. They can be worsened when cancer affects key sexual organs (such as the breast, the uterus, the vulva, or prostate); when surgery is radical; when chemo and radiotherapy causes secondary symptoms and impairs the biological basis of the physical response, with a variable impact according to the treatment protocol and the medical and sexual comorbidities it may cause or contribute to.
Health care providers, and particularly the oncological team in this specific field, should improve their skills in understanding and listening to sexual concerns, addressing the basic biological issues that cancer raises for the individual and couple's sexuality.
This presentation will focus on the multidisciplinary approach to sexual issues in the context of cancer management.

References

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