

The sexuality clinic in the breast center: sex as a survivorship issue

D. S. Dizon, D. Thompson, C. Duffy, D. Wiggins

Center for Sexuality, Intimacy, and Fertility, The Program in Women's Oncology, Women & Infants' Hospital, Providence, RI, USA.

Abstract Breast cancer and its treatments can cause sexual dysfunction in up to 90% of women with the disease. Front line care providers often do not have the time or training to focus on this quality of life issue and the private nature of the topic can prevent women from pursuing help. By setting up a clinic specifically devoted to sexuality issues, breast cancer treatment centers can provide a place to address these issues and help patients deal with the after-effects of their treatment. As breast cancer survivor rates and disease-free intervals increase, the demand for a service that supports women returning to as near-normal a life as possible will only grow.

Introduction

Sexual dysfunction affects up to 90% of women treated for breast cancer, with some reports suggesting that nearly all women have some form of sexual complaint related to cancer treatment [1]. Still, the multifactorial nature of sexual dysfunction makes it difficult to explore or discuss such issues in the context of a routine medical or surgical follow-up visit. Nevertheless, sex is an important component of any woman's life, and the breast cancer survivor is no exception. It thus becomes the challenge within breast centers to provide resources for women wanting to reclaim this vital part of their own life.

Sexual issues and breast cancer treatment

All aspects of breast cancer treatment can cause changes to a woman's sexual milieu. Both lumpectomy and mastectomy can cause psychological

issues stemming from the changes in body image and self-esteem, and issues related to the surgery itself, such as neuropathic changes related to the surgery itself and lymphedema, which can cause discomfort during sexual activity. Almost any anti-cancer agent can also result in a lack of interest and loss of libido [2]. Anthracyclines and taxanes can cause alopecia and weight changes, both of which can impact body image. Chemotherapy agents in general can induce significant gastrointestinal side effects, such as nausea, vomiting, and constipation, which may significantly impact a woman's desire. For premenopausal women, it may cause amenorrhea and acutely induce menopause with all of its associated symptoms: vaginal dryness, memory problems, and hot flashes to name a few.

Endocrine therapy may impact sexual function as well, though research in this area has been conflicting and inconclusive. For example, the Breast Cancer Prevention Trial found only minor differences in sexual functioning among tamoxifen users versus those not on tamoxifen [3]. However, others demonstrated no changes in any phase of sexual response cycle for women on tamoxifen [4]. The impact of aromatase inhibitors (letrozole and anastrozole) on sexual function is even less clear and at this time, more trials are needed in order to specifically address the sexual ramifications of these agents.

Correspondence to: Don S. Dizon, MD, FACP, Assistant Professor, Alpert Medical School of Brown University, Director of Medical Oncology and Integrative Care, Co-Director, Center for Sexuality, Intimacy, and Fertility, Program in Women's Oncology, Women & Infants Hospital of Rhode Island, 101 Dudley Street, Providence, RI 02905, USA; E-mail: ddizon@wihri.org; Tel: 401-453-7520; Fax: 401-453-7529

Received: 10/09/08
Accepted: 29/10/08
BCO/802/2008/FO

Finally, breast radiation can induce local changes that impact sensitivity of the breast. Women may experience skin fibrosis, skin thickening, and sometimes mastalgia, any of which can affect a woman's desire or ability to enjoy sexual activity.

The sexuality clinic's role in the breast center

Too often, cure and control are the only goals in the mind of the oncologist and/or breast surgeon. Other issues such as sexuality, fertility, and routine medical follow-up are then relegated to other providers, such as gynecologists, primary care providers, nurses, or social workers. While routine follow-up visits should include a review of systems and as part of this, a screen for sexual problems, too often the breast center provider's volume and time limitations act more as barriers to a thoughtful exploration of problems related to sexuality. In addition, without a firm idea on whose 'job' it will be to follow-up on these issues, patients may be left feeling alone and unsupported.

Above all else, addressing sexual dysfunction is a unique issue, due to the very private and sensitive nature of the topic. In addition, oncologists may not feel they have the required background to counsel patients on sexual issues or may not feel comfortable. As such, separating these visits from routine medical care and placing these visits in a specific clinic arena becomes an ideal way for women who are interested in exploring these issues to get the help they are looking for.

Given the complexities of the problems associated with sexual dysfunction, treatment requires a multi-modal and sensitive approach. Specifically, many health care providers wrongly assume that all of their cancer patients are involved in heterosexual relationships. Bisexual and same-sex relationships can also be impacted by cancer, and sexuality is as important to this group of people as to those in more traditional relationships. Health care providers must be sensitive to the sexual issues that women who have sex with women may be experiencing and intake office forms should be generic and unassuming. This highlights the importance of providers in a sexuality clinic maintaining an open mind. They must be willing to explore intimate issues with their patients non-judgmentally.

Breast centers must make the commitment to offer services to breast cancer survivors. The end of treatment for many women is being extended, especially in light of extended endocrine therapy and the use of extended trastuzumab treatment in the adjuvant setting. As such, patients are being seen further out from their index cancer diagnosis, and can come

to think of the breast center as their primary medical provider. As such, centers must embrace services aimed at this ever-growing population. When it comes to addressing sexual health, centers should consider initiating sexuality clinics either as stand-alone services or as part of a broader cancer survivorship program. The service can be done without hiring new staff, provided a team can be assembled from current center members interested in working with women complaining of sexual dysfunction.

A key portion of the clinic appointment should include screening forms that delve into medical history and current medications, gynecologic and breast history, and questions related to their pre-cancer sexual function. Screening for quality of life, depression, anxiety, and current sexual function using standardized instruments should be considered as well, especially since sexual function may be affected by stressors or an untreated (or unrecognized) psychological issue. The treatment team should be multidisciplinary as follow-up can involve the assistance of other specialists for individual or couple counseling, sex therapy, or psychiatric evaluation.

At the Program in Women's Oncology we established Rhode Island's first Center for Sexuality, Intimacy, and Fertility. Our mission is to provide female cancer survivors the opportunity to meet with a provider during a visit aimed at exploring their issues and concerns in an honest and non-judgmental way. As part of our intake questionnaire, women are screened using the Female Sexual Function Index (FSFI), European Organization for the Research and Treatment of Cancer (EORTC) Quality of Life Questionnaire, and the Beck Depression Inventory. This serves the dual purpose of assessing the degree of sexual dysfunction, if it is associated with underlying symptoms of depression, and how it may relate to global quality of life. They are seen in a 60 min consultation with one of two attending providers, and patients have immediate access to social workers, psychiatrists, and gynecologic specialists based at Women and Infants' Hospital, in order to ensure that women's needs are being addressed as comprehensively as possible, all the while keeping in mind the multiple issues facing women in follow-up after breast cancer.

Conclusion

The quality of life of breast cancer survivors remains of paramount importance before, during, and after treatment. For those involved in the follow-up care of the woman with breast cancer, screening for sexual dysfunction should be a routine part of management. However, addressing sexual dysfunction adequately remains a challenge. To this end, establishment of

sexuality clinics or incorporating resources to handle such difficulties into a survivorship initiative can be effective. Moreover, it demonstrates to patients and to the community at large the commitment made to serve women with cancer, reinforcing the message that the patient is as important as her breast cancer prognosis.

References

1. Krychman ML. Sexual rehabilitation medicine in a female oncology setting. *Gynecol Oncol* 2006; **101**: 380–384.
2. Berglund G, Nystedt M, Bolund C, *et al.* Effect of endocrine treatment on sexuality in premenopausal breast cancer patients: a prospective randomized study. *J Clin Oncol*.
3. Day R, Ganz PA, Costantino JP, Cronin WM, Wickerham DL, Fisher B. Health-related quality of life and tamoxifen in breast cancer prevention: a report from the National Surgical Adjuvant Breast and Bowel Project P-1 Study. *J Clin Oncol* 1999; **17**: 2659–2669.
4. Mortimer JE, Boucher L, Baty J, Knapp DL, Ryan E, Rowland JH. Effect of tamoxifen on sexual functioning in patients with breast cancer. *J Clin Oncol* 1999; **17**: 1488–1492.