

■ CNE Article

Women's Poorer Satisfaction With Their Sex Lives Following Gynecologic Cancer Treatment

Lucia Alves Silva Lara, MD, PhD, Jurandyr Moreira de Andrade, MD, PhD, Flavio Donaire Consolo, and Adriana Peterson Mariano Salata Romão, MD, PhD



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Gynecologic cancer treatment can lead to anatomical changes in the genitalia that may impair sexual response. As a result, the authors aimed to assess women's self-perceptions of their sex lives following gynecologic cancer treatment and the impact of such treatment on sexual function. Thirty sexually active women were examined. At the first meeting with a physician sex therapist, women were asked about their satisfaction with their sexual activities prior to and after gynecologic cancer treatment, either with a partner or alone, and how many times per month they had sexual intercourse prior to the cancer diagnosis and after treatment. Women reported significantly worse sex lives and a significantly lower frequency of sexual relations following cancer treatment. All participants reported pain on vaginal penetration and feeling uncomfortable in discussing their sexual difficulties with the oncologist. The findings show that women experienced impaired sexual function, as well as poorer quality of sexual function, following gynecologic cancer treatment. Nurses should provide basic guidelines about sexual function to all patients who undergo treatment for gynecologic cancer.

Lucia Alves Silva Lara, MD, PhD, is a professor in the Sexual Medicine Service, Human Reproduction Sector, in the Department of Gynecology at the Faculty of Medicine of Ribeirão Preto in São Paulo; Jurandyr Moreira de Andrade, MD, PhD, is a professor in the Sector of Oncology in the Department of Obstetrics and Gynecology at the University of São Paulo; Flavio Donaire Consolo is a student in the Department of Gynecology and Obstetrics at the Faculty of Medicine of Ribeirão Preto; and Adriana Peterson Mariano Salata Romão, MD, PhD, is a psychologist in the Department of Gynecology and Obstetrics at the University of São Paulo, all in Brazil. The authors take full responsibility for the content of the article. The authors did not receive honoraria for this work. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the authors, planners, independent peer reviewers, or editorial staff. Lara can be reached at luciaalvess@yahoo.com.br, with copy to editor at CJONEditor@ons.org. (First submission June 2011. Revision submitted September 2011. Accepted for publication September 25, 2011.)

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Diagnosis of gynecologic cancer can have a strong negative psychological impact (Levin et al., 2010) and lead to reduced self-esteem, negative feelings about one's own body, relationship difficulties, perceived loss of sexual attractiveness, and other issues (Crouch, 1999; Tang, Lai, & Chung, 2010). That situation may be aggravated by anatomical changes caused by surgical treatment, as well as those resulting from radiotherapy (Wenzel et al., 2005). Gynecologic cancer treatments also can disrupt the synthesis and action of sex steroids, neurotransmitters, and neuropeptides that are involved in sexual function (Lara, Rosa e Silva, Romao, & Junqueira, 2008; Lara et al., 2009), thus impairing the sexual response. In fact, women with gynecologic cancers often present with psychological problems and sexual dysfunctions that compromise their quality of life (Kim et al., 2010; Reis, Beji, & Coskun, 2010).

Previous research has estimated that sexual dysfunction occurs in about 50% of women with gynecologic cancer (Audette & Waterman, 2010) and is common particularly in women treated for locally advanced cancer of the cervix, who may experience fi-

brosis and narrowing of the vagina. Those patients also may have impaired innervation of the genitalia (Plotti, Calcagno, Sansone, Angioli, & Panici, 2010), resulting in reduced pleasure sensitivity and negative feelings about sex (Plotti et al., 2011). In addition, pain during coitus is common (Bergmark, Avall-Lundqvist, Dickman, Henningsohn, & Steineck, 1999) because of the atrophy caused by the hypoestrogenism that follows surgical ablation of the ovaries, radiotherapy, or chemotherapy. A controlled study of 50 women who underwent surgery for gynecologic cancer reported a 60% increase in complaints about sexual relations, mainly reduced desire and dyspareunia because of dryness, shortening, and decreased elasticity of the vagina following surgery (Aerts, Enzlin, Verhaeghe, Vergote, & Amant, 2009). Those complaints were common particularly in patients who underwent more radical surgeries (Serati et al., 2009).

Earlier detection of gynecologic cancer and advances in neoadjuvant treatment have led to the use of less radical surgery and significantly increased survival rates (Hwang et al., 2001). Therefore, a growing need exists to prevent and address sexual complaints in those patients to improve their quality of life (Ratner, Foran,