Question 1:

This article focuses primarily on sexual pain and points out that this problem can spill over into other areas of sexual dysfunction such as libido, arousal, and anorgasmia. How do you manage patients with these sexual problems in the absence of pain?

Response from Drs. Coady and Kennedy:

Our responsibility as ob-gyns is to fully evaluate and treat any potential physical causes of sexual dysfunction. A complete sexual history is crucial to gain an understanding of what may have been present prior to cancer diagnosis and treatment and what may have worsened or began afterward. Careful physical examination is then necessary to evaluate for treatment-related effects that may have led to sexual dysfunctions. When issues other than pain are identified, such as hypoestrogenism, anatomical alterations (of the clitoris, for instance), or neurologic injury causing vulvar hypoesthesia, these mechanisms need be specifically addressed. With or without physical findings requiring treatment, a team approach with referral to (and ongoing communication with) additional professionals, such as a sex therapist knowledgeable about cancer treatments, is essential.
To achieve the goal of universal screening of women affected by cancer for sexual pain and dysfunction, we recommend the Sexual Symptom Checklist for Women After Cancer, developed by Bober et al (see Curr Opin Support Palliat Care 2016;10:44–54). It is short enough to be filled out quickly and reviewed with every patient. Optimally it would be completed serially, at time of cancer diagnosis, during and after treatment, and periodically in the survivorship period. In addition to picking up new problems, it can be useful for evaluating the effectiveness of interventions for sexual symptoms over time.

Response from Drs. Coady and Kennedy:

Question 3:
What role does sexual assault history assessment play in the work-up and treatment of these patients?

Response from Drs. Coady and Kennedy:

Along with baseline assessments of gender identity and orientation, partnership, and relationship quality, asking women affected by cancer about a history of sexual trauma and abuse is important. Unfortunately, sexual abuse is common in women in general. Those with sexual pain have similar rates. During the physical examination, engaging the patient as much as possible, for instance, using a hand mirror and the patient’s assistance in retraction, can make the experience less frightening and more physically comfortable. As clinicians caring for women with cancer and sexual concerns, we need to develop a referral team of mental health professionals in our communities. This team should include psychotherapists, sex therapists, couples counselors, and psychiatrists experienced in treating sexual assault and abuse (physical, emotional, psychological, and sexual), as well as anxiety, depression, suicidality, and other potential emotional consequences of a cancer diagnosis. Maintaining communication with the professional caring for the patient with a sexual abuse history is crucial to compassionate care for sexual pain.

Question 4:

We find in our practice that frequently the cause of sexual pain is multimodal. For example, a patient may have vulvar pain, muscular spasm, and hypoestrogenism. It can be hard to address all at once or know which is the primary problem. How would the authors address such a patient? Do you recommend a particular order for therapeutic interventions based on either type of therapy or nature of disorder?

Response from Drs. Coady and Kennedy:

Sexual pain is indeed often the end result of more than one physiologic mechanism. For instance, pelvic floor muscle overactivity is common as both a cause and an effect of pain, and is often missed. In practice we find it convenient to think of the pelvis in layers, and first address pain in the surface layer: the vulvar skin, external architecture, vestibule, and anus. If hypoestrogenic changes or dermatoses are present, treating these first will soothe the surface and strengthen it for the manual physical therapy that may be needed for deeper problems in the vaginal or anal canal, the surrounding myofascia, and/or pelvic nerves. It is important to reexamine the surface after 2–3 weeks of instituting a treatment to be sure it has improved enough for physical therapy to start. Working closely with an expert pelvic floor physical therapist helps with deciding if further interventions, such as injections for trigger points or nerve pain, are needed. Treatments for urethral, bladder, or anorectal pain are also easier for the patient once the surface is more comfortable.
Question 5:

Can you expand further on recommendations for survivors of childhood cancers or women with premature menopause related to cancer?

Response from Drs. Coady and Kennedy:

Female survivors of childhood cancer as well as adolescent and young adult cancer patients have special gynecologic challenges that include ovarian failure, infertility and endocrine changes, and premature menopause symptoms and ramifications. Before and during cancer treatments, ob-gyns can support their younger patients by addressing concerns such as contraception and menstrual suppression if risks exist for menorrhagia, and providing referrals for ovarian and fertility preservation. After cancer treatments and during the survivorship period, ob-gyns can assist their patients with endocrine evaluation, hormone therapy, and addressing treatment’s long-term adverse effects, as well as for sexual pain and dysfunction as discussed in our article. Mental health colleagues can help young patients navigate the unique psychosocial challenges and developmental issues they often face, such as autonomy from parents, family relationships, sexual identity, and disruptions in education, career, and family planning.

Question 6:

Significant challenges remain in managing sexual dysfunction from the aspect of both the patient and the provider. How do you help patients and providers to manage expectations of outcomes and have patience with the process? What can patients do to be a partner in their sexual dysfunction evaluation and treatment?

Response from Drs. Coady and Kennedy:

Sexual pain and resulting or coexisting sexual dysfunctions may be complex conditions, especially in the biopsychosocial context of cancer. Patients often feel overwhelmed by their cancer diagnosis, frustrated and saddened that on top of all the therapies they must undergo for cancer, there are more tasks to regain their sex life. It is important for ob-gyns to help patients maintain hope by emphasizing that the patient is not alone in her experience, many women struggle with these concerns, and the vast majority of women can improve their sexual pain and function. Importantly, if their pain and/or dysfunction is not “cured” in the usual meaning of the word, much healing and adjustment can take place, and patients (and couples) can and do regain confidence in their bodies and their sexuality. This process may take time and attention and is worthwhile.

On the practical level, patients need to be counseled that results are unlikely to be seen in one or two office visits and complete evaluation and treatment trials may require several visits. Ask that the patient become a partner in this process, sharing in treatment decisions and proactively observing and reporting on the changes she experiences. A trained and compassionate office staff can help the patient immensely by facilitating interval visits and testing. Delegate one staff member to assist with referrals, follow-ups, patient education, and support for women affected by cancer. Office nurses frequently have interest and insight in this area but remain an untapped resource in many busy practices. Patients who have already gone through cancer experiences are often very willing to volunteer as peer support in practices, as they do in larger medical institutions, and can be very helpful to other patients individually or via a support group.

If a patient’s history is complex, it may take the whole initial visit to review it and pertinent medical records. Discussing the patient’s individual goals for treatment is also important at the first visit. The in-depth physical examination may comprise most of the second visit. Therapies introduced may then need trial and error to find the best fit, which needs to be assessed at additional visits. A patient informed of this process will have realistic expectations of the project that she and her ob-gyn are embarking upon, lessening frustrations and disappointments that arise from expecting a rapid solution.
A multidisciplinary approach is almost always needed for sexual pain and dysfunctions, and patients may need encouragement to embrace this. Teamwork with an expert pelvic floor physical therapist is often invaluable. For low desire and arousal and orgasm problems, as well as emotional issues and role changes stemming from cancer diagnosis and treatment, ob-gyns need experienced talk and sex therapy colleagues on their team, who then communicate back regularly to discuss further physical treatments. Women affected by cancer benefit by reducing their stress, uncomfortable sympathetic nervous system overactivity, and bodily discomfort through integrative mind–body therapies such as yoga, qi gong, meditation, and mindfulness-based stress reduction. When their ob-gyns make specific referrals to instructors and professionals known to them, patients are more likely to appreciate the team approach, collaborate, and work steadily to improve their well-being.

References