Dealing with sexuality in our patients with chronic diseases and cancer

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University Hospitals Utrecht & Rotterdam
Consultant in oncosexology
The Netherlands
Our short trip for today:

1. A different approach to this area
2. Some figures of our potential caseload
3. Why paying attention to sexuality and intimacy
4. What can / should we physicians actually do?

Disclosure:
I have no connection to the pharmaceutical industry
Our short trip for today:

1. A different approach to this area
A change in approach and a change in consequences!

Disease
Sexual dysfunction

bio-
psycho-
social
causes

a pro-active responsibility!
Sexology achievements in the Western World

1960s-1970s sexual liberty
1980s-1990s physicians became interested
1990s-2000s pharmaceutic treatment for sexual dysfunctions

Much attention for common sexual disturbances of ‘common people’.
Many ‘less common people’ are the average population of the physician!

Groups with a lot of unmet sexual needs. These groups (& these unmet needs) deserve our attention.

Why don’t they get attention?
- Not interesting for the Pharma companies?
- Not ‘sexy’ to work with them?
- They don’t ask for cure & care for their sexual disturbances!
Our short trip for today:

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4. What can / should we physicians actually do?
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- Same risk factors as for genital arousal dysfunction
- Cardiovascular medication → many sexual side effects

CV symptoms → low energy → low desire → low O₂ → pain during sex → low O₂ → lowered erectile capacity

Fear to die during sex (in patient and/or partner)
Chronic cardiovascular diseases 5.3% >75%

Conclusion: Pro-active inquiring about sexuality !!

‘Many patients with this condition experience changes in their sexuality. How is that with you?’

IC1: Basic Sexual Therapy for physicians. Dealing with sexuality in Chronic Disease & Cancer
16th World Meeting on Sexual Medicine. Sao Paulo 8-12 October 2014 Woet Gianotten
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<th>women</th>
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<td>end stage renal failure</td>
<td>&gt; 95%</td>
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<td>hemodialysis</td>
<td>63%</td>
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- **Metabolic changes**: low T & high Prolactin
- **Fatigue & No desire**
- **Fear for rejection**
- **Touching new kidney**: dyspareunia
- **Side effects of immunosuppressants**: oral infection → kills kissing
- **Hypertension**
- **Anaemia**
- **Antihypertensive med.**: → various SD’s
Conclusion: Pro-active inquiring about sexuality !!

"Since you started this treatment, how did it affect your sexual life?"
Chronic disease prevalence in adults | Sexual disturbances estimated prevalence
--- | ---
Chronic cardiovascular diseases | 5.3% | > 75%
Chronic kidney diseases | 1.2% | 60-70%
Chronic lung diseases | 2.0% | 65%

Chronic disease prevalence in adults

Partner scared: ‘He becomes so blue!’

COPD ± much cardiovascular comorbidity

Not enough O₂

Disappearing erection

PE (‘saved by ejaculation’)

Bad smell and disturbing noises

Low desire in partner

Low desire in partner
**Chronic disease prevalence in adults** | **Sexual disturbances estimated prevalence**
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**COPD and asthma**

**Medication:**
- Sympathicomimetics
- Parasympathicolytics
- Inhalation corticosteroids
- High dose corticosteroids
- Antibiotics

- Agitation $\rightarrow$ sex pos or neg
- Dry mouth $\rightarrow$ no kissing
- Oral candida $\rightarrow$ no kissing
- Lowering T $\rightarrow$ less desire
- Vaginal candida
Conclusion: Pro-active inquiring about sexuality !!

“I guess that your partner’s lung disease also influences your sexuality and intimacy. Are you aware that such troubles can be discussed here and that there will be solutions?”

Chronic lung diseases 2.0% 65%
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- IBD: irregular stool & diarrhoe

Chronic high pelvic floor tension

Superficial dyspareunia

Inflamed bowel

Deep dyspareunia
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- **Stoma**
  - Damage to nerves for erection / lubrication
  - Disturbed sexual identity
  - Fear for bad smell and noises during orgasm (when the bag tends to fill up)
Conclusion: Pro-active inquiring about sexuality!!

"Many patients with the same disease experience sexual disturbances. Besides most are scared to bring up that topic. So maybe good to spend some time and address sexuality and intimacy??"
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- Damage to great vessels ➞ erection disturbed
- Same to cavernous vessels ➞ erection disturbed
- Peripheral neuropathy ➞ orgasm problems
- Autonomic neuropathy ➞ retrograde ejaculation
- Plus metabolic syndrome ➞ low T ➞ low desire
- In female ➞ depression ➞ low desire

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**Thyroid diseases**

- **Hypothyroid function**
  - Decreased sexual desire
  - Delayed ejaculation

- **Hyperthyroid function**
  - More ED
  - More PE
Conclusion:
Pro-active inquiring about sexuality !!

"Your disease probably will alter part of your sexual function. Since there are many solutions, shall we pay attention to those consequences?"
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**Pain**

**Influences desire & relationship**

**medication**

- Long-term high dose opioids → interfere with gonadal T → low desire
- Corticosteroids → can interfere with gonadal T
  → oral candida → no kissing
Conclusion:
Pro-active inquiring about sexuality !!

"Your disease and your medication tend to cause many sexual changes. However, we also have solutions for that. Shall we pay attention to that area?"
Cancer patients / survivors: 4.4% of adult population
The course of cancer recovery
diagnosis

\[ \pm 4.4\% \]

\[ \pm 0.1\% \]

\[ \pm 4.0\% \]

real survivors

\[ \pm 0.2\% \]

‘chronic disease’

\[ \pm 0.1\% \]

palliative phase

\[ \pm 4.4\% \]

%% of adult population
### Sexual consequences

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<th>Cancer of the</th>
<th>Percentage with disturbed sexuality</th>
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<td>Breast</td>
<td>35% - 50%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>50%</td>
</tr>
<tr>
<td>Blood &amp; Lymph</td>
<td>50-70%</td>
</tr>
<tr>
<td>Colon / Rectum</td>
<td>30% - 85%</td>
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<tr>
<td>Cervix</td>
<td>60-80%</td>
</tr>
<tr>
<td>Ovary</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>Bladder</td>
<td>&gt; 80%</td>
</tr>
<tr>
<td>Prostate</td>
<td>45% - 100%</td>
</tr>
<tr>
<td>All Cancers</td>
<td>&gt; 50%</td>
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‘guesstimates’

Not very relevant when having the patient in your office!
Cancer patients & survivors

High percentage of sexual disturbances

patients don’t start the discussion on sexuality

Conclusion: Pro-active inquiring about sexuality!!
Simplified basics of sexual function & its disturbances in cancer (treatment)

- Endocrine
- Circulation
- Nerves / Neurotransmitters

Desire, excitement, arousal, orgasm
Simplified basics of sexual function & its disturbances in cancer (treatment)

Damaged by:
Chemotherapy
(Pelvic) Radiother.
Castration
Hormonal Therapy
Simplified basics of sexual function & its disturbances in cancer (treatment)

Damaged by:
Surgery (arteries & nerves)
(Pelvic) Radiother.

- endocrine
- circulation
- nerves / neurotransmitters

- desire
- excitement arousal
- orgasm
Simplified basics of sexual function & its disturbances in cancer (treatment)

Damaged by:
- Surgery (nerves)
- SSRI's & SNRI's

- desire
- excitement
- arousal
- nerves / neurotransmitters
- orgasm
Two examples of sexuality disturbed by cancer treatment

Blood & lymph cancer

- Complete body irradiation
- Chemotherapy

Gonadal damage & adrenal damage

Low T → No desire
→ Fatigue
→ Low mood
2 examples of sexuality disturbed by cancer treatment

**Blood & lymph cancer**

- Complete body irradiation
- Chemotherapy

When combined with allogenic stem cell transplantation:

⇒ chronic Graft vs Host Disease
⇒ causing penile changes
⇒ causing vaginal strictures & changes
2nd example of sexuality disturbed by cancer treatment

Breast cancer

- Mastectomy

Rx

Loss of erogenetic zone

Damage to female identity

'My husband doesn't want sex with me anymore!'
Rather easily treated by psychoeducation!
Unmet needs

Here lies our faithful
Sexlife
10 Jan 1988
21 March 2011
Our short trip for today:

1. A different approach to this area
2. Some figures of our potential caseload
3. Why pay attention to sexuality & intimacy
4. What can / should we physicians actually do?
Why pay attention to sexuality in patients with chronic disease & cancer?

1. Sexuality is more than only sexual function
   It is also sexual identity and sexual relationship

2. For many people (but not for all) sexuality is a very relevant aspect in their quality of life.
   This goes for the patient but also for the partner!

3. Many sexual disturbances are the result of our medical interventions
   → we are responsible for dealing with the side effects we cause!
Why pay attention to sexuality in patients with chronic disease & cancer?

4. Patients want that the professionals starts the discussion on the topic of sexuality / intimacy

5. Sex has various direct benefits
   better sleep
   relaxed muscles
   less pain
   less depression
   less anxiety

?? neuroregenerative function ??
Our short trip for today:

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What can physicians do?

**Acknowledge** the disturbance.
With some explanation
This is sometimes already enough

**Don’t be scared about lack of expertise**
As a medical or psychosomatic professional,
you know much more than the average couple!

Patients / couples will understand /accept
that you are not a professional sexologist.
Working to solutions: Toolbox for sexual disturbances

fatigue:
- change timing
  (NB testosterone is highest in the morning)
- change responsibility
  the partner could do the job!

worked muscles:
- a vibrator could do the job

pain:
- adapt pain medication to sexuality
- adapt positions

sexual side effects of medication:
- Are adaptations possible?
NB Do you dare to recommend masturbation? It can be very intimate (and very exciting) for partners to watch and being watched during masturbation!

‘Good-enough’-sex is far better than no ‘Perfect-sex‘ at all!
Working to solutions: Toolbox for sexual disturbances

- less desire: more seduction
- less erection:
  - increase stimuli
  - visual
  - partner’s explicit excitement
  - genital
  - vibrator
  - lubrication (oil / silicone)
  - erection medication
No approach in medical care deserves the term holistic as long as sexuality and intimacy have not been addressed!

woet @ gianotten.com