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Assessment Of The Importance Of Sexuality In Breast Cancer Survivors And The Level Of Interest In Treating Sexual Dysfunction In The Medical Consultation

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Introduction*: Sexual dysfunction caused by BC and its various forms of treatment is present in up to 60% of patients. Currently, sexuality is still a topic that is neglected, and physicians often avoid dealing with it due to lack of time, knowledge and expertise in addressing it.* ***Objectives****: To assess the sexual health of BC survivors and their degree of interest in receiving medical help to address and treat their sexual problems.* ***Materials and Methods****: The study included patients diagnosed with early breast cancer attended at the Mastology Unit of the Oncology Department of the Hospital de Clínicas. The questionnaire selected is the one used at the University of Chicago Medical Oncology Clinic.* ***Results****: Two hundred patients were included, most were over 50 and had a partner, 160 patients (80%) were sexually active in the last 12 months and 140 (87%) had sexual problems. The majority (136 patients, 68%) reported that sexuality was important in their lives, 174 (87%) were interested in receiving support to address their sexual difficulties, and 146 (73%) considered it likely that they would address these with a physician. However, only 58 (29%) had sought medical help to treat them, and most were dissatisfied with the care received. Eighty percent (160) would be willing to participate in a program aimed at confronting sexual problems.* ***Conclusions:*** *Our results reveal the need for medical care regarding the sexual health of patients diagnosed and treated for BC. Future studies should focus on developing and assessing the success of specific interventions in the treatment of sexual dysfunction in these patients and, more importantly, designing strategies for its prevention.*

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I. Introduction

Breast cancer (BC) in Uruguay, as in the rest of the world, is by far the most frequent cancer in women and also the leading cause of death from cancer (1,2). The prognosis for this disease has improved in recent years, which means that the medical oncologist is required to become increasingly involved in the management of the long-term adverse effects of the different treatment modalities. In this regard, it is known that both the disease and its treatment can reduce patients' quality of life, and therefore the delayed consequences of BC and its treatments have become an area of growing interest. Numerous research studies have shown that breast cancer and its various forms of treatment: surgery, radiation therapy (RT), chemotherapy (CT) and hormone therapy (HT) can lead to problems with body image and affect women's sexuality. Body image issues may interfere with sexual desire, feelings of attractiveness or femininity and patients'quality of life. Sexual dysfunctioncaused by the disease and its various modes of treatment is present in up to 60% of women diagnosed with BC (3). Studies that include women with and without cancer show that women consider sexuality to be an important part of their life and health and believe it is relevant and necessary to discuss their sexual disorders with their physician (4). A study conducted by Hill et al. involving 261 patients diagnosed with gynecologic cancers (breast, ovarian, uterine and vulvar) showed that 41% of the patients were interested in receiving medical support to resolve their sexual difficulties, but only 7% of them had received such support (5).

Despite the above and the fact that multiple studies demonstrate the presence of sexual dysfunction in women with BC, little is done in routine clinical practice to address this problem. At present there are still myths and taboos related to sexuality, and this is a topic that tends to be neglected, leading to physicians often omitting to treat it, claiming lack of time, knowledge and expertise in addressing it (3). In this context, a survey involving gynecologists and medical oncologists showed that 98% of physicians believed that sexual problems should be discussed, but only 21% actually discussed these problems with patients (6).

In view of the above, we believe that the comprehensive care of patients diagnosed and treated for BC should consider their sexuality and approach it seriously and in conjunction with the patient and her partner.

II. Objectives

To assess whether there is any sexual dysfunction in BC survivors.

To assess the degree of patients' interest in receiving medical help to address and treat sexual dysfunctions related to the diagnosis and treatment of the disease.

To assess whether patients sought medical help to resolve sexual dysfunctions related to the diagnosis and treatment of BC and the degree of satisfaction with the care received.

III. Materials And Methods

The survey participants were patients over 18 years of age, diagnosed with early BC (E I-III), attended at the Mastology Unit of the Oncology Service of the Hospital de Clínicas in the period June 2018- 2020, who had completed treatment with CT at least 12 months earlier. All the patients signed an informed consent form, by which they agreed to participate in the study and answer the questions asked in the survey, also authorizing the use of the information that resulted from this research.

The following data were collected primarily: age, marital status and treatment received (type of breast surgery and whether they received CT, RT and/or HT).

The survey asked whether or not the patient had a partner and whether or not she had been sexually active during the last year.

The presence of sexual dysfunction (lack of interest in or desire for sexual activity, vaginal dryness, dyspareunia, difficulty in achieving orgasm) was also investigated through questions 1 and 2 shown in Table 1.

In addition, questions were included to find out the patients' interest in addressing sexual problems related to the diagnosis and treatment of the disease, the number of patients who had sought advice to resolve these, and the level of satisfaction with the support received to resolve such problems. Questions 3 to 7 presented in Table 1 were used for this purpose.

The questionnaire selected was the one used at the Medical Oncology Clinic of the University of Chicago, USA. It was designed following the guidelines of the National Project on Social Life, Health, and Aging and other large population studies on sexual activity and problems (5).

Ethical Aspects

The study was conducted in accordance with international ethical standards for biomedical research – the MERCOSUR rules on the regulation of clinical trials and the Declaration of Helsinki – and with the research regulations approved by the National Ethics Commission in 2019.

IV. Results

Two hundred patients were enrolled. The majority (150 patients, 75%) were over 50 years old. One hundred and thirty-six patients (or 68%) had a partner. Of the total patients included, 66% (132)had been treated with sectoral mastectomy, 80% (160) had received adjuvant RT, and 83% (166) had received adjuvant HT.

Most of the patients included (152 patients, 78%) were sexually active in the previous 12 months and 108 (54%) in the previous 4 months.

Patients who were sexually active in the previous year were younger than those who were not sexually active: only 23% of sexually active patients were over 65 years old. Among patients who were not sexually active, those over 65 years of age accounted for 77%.

Furthermore, among patients with a partner, most of them were sexually active (84%), so only 16% of patients with a partner were not sexually active.

Regarding local treatment, patients without sexual activity had more conservative surgeries (77% vs. 63%) and had more frequently received adjuvant RT (90% vs. 78%) than sexually active patients.

As for systemic treatment, the number of patients receiving adjuvant polychemotherapy (PCT) was higher among sexually active patients (56% vs. 43%), while patients without sexual activity received HT more frequently (100% vs. 78%). The rest of the characteristics are shown in Table 2.

Among the 156 patients who were sexually active in the past year, more than half (136 patients or 87%) had sexual problems defined as: lack of interest in or desire to have sex, vaginal dryness, dyspareunia, or difficulty in achieving orgasm; these problems were present for half the time or more for a period of months or longer. The remaining results for sexually active patients can be found in Table 1.

The majority (106 patients, 68%) of sexually active patients consider sexuality to be very important or important in their lives and only 3% consider it to be somewhat important. Eighty-seven percent of the patients (135) were interested in receiving care to address their sexual difficulties, and 73% (114) considered it likely that they would address these problems with a physician. However, only 47 patients (30%) had recently sought

medical help to treat problems in the sexual sphere, and most (41%) were dissatisfied with the care they received.

Most of the patients (126, or 81%) would be willing to participate in a program aimed at confronting the sexual problems of women diagnosed with BC.

V. Discussion

Despite the fact that sexuality is part of the psychosocial life of women, problems in the sexual sphere are less frequently treated in the medical consultation than other sequelae of the disease and/or its treatments. There are multiple reasons for this, among which the following stand out: that it is a topic of (relatively) little importance at the time of diagnosis, the shortage of time dedicated to the consultation and the embarrassment that the patient may experience, preventing her from raising the problem openly, among others. However, there is no evidence in the literature or in clinical practice that patients feel displeased or aggrieved by medical attention given to sexuality; on the contrary, inquiring about this aspect demonstrates the physician's concern for the well-being of his/her patient and her partner (7-8).

In this regard, a study conducted at the University of Chicago showed that a discussion with the physician about sexual problems caused by cancer and its treatments was associated with lower sexual morbidity among survivors who achieved greater longevity (7).

The present study explores the need to address problems in the sexual sphere in routine clinical practice and to provide medical help to treat them.

Two hundred patients were enrolled, most of whom (75%) were 50 years of age or older. Of the total, 68% lived with a partner.

As is the case internationally, most of the patients included in our study had an active sex life (152 patients, or 78% in the last year, and 108 patients, or 54% in the last 4 months) despite the complications related to the diagnosis and the different treatment modalities (3).

Sexually active patients were younger (only 23% active over 65 years old vs. 77% of this same category being non-active) and more frequently had a partner than those without sexual activity (84% had a partner vs. 16% of patients who also had a partner but no sexual activity). This is consistent with what was reported by Lindau S.T. et al. in a study evaluating the prevalence of sexual activity and dysfunction among 3005 patients with an age range of 57 to 85 years old and showing that the prevalence of sexual activity decreases with age (4).

Among the 156 patients who were sexually active in the past year, more than half (136 patients or 87%) had sexual problems. This is compatible with what was reported by Harirchi I. et al. in a prospective study whose objective was to evaluate sexuality in patients diagnosed with BC, showing that the percentage of patients presenting sexual dysfunction increases after the end of treatment; in the study referred to, 84% of the patients presented sexual dysfunction after the end of treatment (9). This is consistent with a deterioration of body image and sexuality in these patients up to six years after diagnosis, which can have a negative impact on their sexuality (10).

The majority (106 patients, 68%) of these patients consider sexuality to be very important or important in their lives and only 3% consider it somewhat important.

Eighty-seven percent of patients (135) were interested in receiving support to address their sexual difficulties, and 73% (114) considered they were likely to address them with a physician; these figures are higher than those reported in other studies, where 20-40% of patients showed interest in addressing their sexual problems with the health care team (5,11).

This could be explained by the fact that our study included only female patients diagnosed and treated for BC and the results were assessed among sexually active patients, whereas the study published by Huyghe E. et al. (11) included sexually active patients of both sexes diagnosed with various types of cancer (leukemia, lymphoma, colon cancer and BC and gynecologic cancers), and the study published by Hill EK et al. (5) included women diagnosed with gynecologic cancers (ovarian, uterine, vulvar and breast) but did not take into account whether or not they were sexually active, which could introduce a bias in the responses, considering the difference in the populations surveyed.

It is clear that our results reveal a high interest of patients diagnosed with BC in receiving medical help to treat problems in the sexual sphere. However, very few patients (47 patients, or 30% of those sexually active) had sought medical help to treat such problems, evidencing a significant discrepancy between the need for and request for care in this group of patients. This could be linked to the myths and taboos that still exist today in relation to sexuality, which mean that it is a subject that is still avoided by both physicians and patients.

A significant proportion (41%) of the patients who sought counseling for their sexual problems were dissatisfied with the support they received, which could be explained in part by the fact that not all members of the medical team were trained to deal with this issue. Furthermore, 16% of sexually active patients had no partner and 15% of patients with sexual dysfunction (20 patients) had no stable partner; this suggests that

marital status should not be used to determine which patients want or need help in discussing their sexual problems. We should keep in mind that among patients diagnosed and treated for BC there are not only heterosexual women with stable partners, but also women without stable partners and lesbians who may be subject to stigma at the time of consultation and may not disclose their sexual activity to the physician, further isolating them from relevant care (12,13).

One of the limitations of the study is that we do not know what proportion of the patients were sexually active prior to diagnosis and at the start of treatment. Since it is known that in most of these patients sexual activity ceases or decreases after diagnosis and treatment (14), patients who had completed treatment with surgery, PCT and RT at least 12 months prior to answering the questions were purposely included. In the future we will design a study to assess the sexuality of the patients before the beginning of treatment and after the end of treatment, in order to estimate its variability.

Our work aims to highlight a problem that is avoided in routine clinical practice and to open the door to the design of programs that address sexuality in a serious, responsible and empathetic way to improve the quality of life of patients diagnosed and treated for BC. Finally, we should mention that there is evidence that if it is not possible to implement a program of care for these problems, the simple expression of empathy by the physician for such problems and the offer of reading material that allows a simple, patient-oriented approach to the subject has proved to be useful (3,24,25)

VI. Conclusions

Our results reveal the need for medical care regarding the sexual health of patients diagnosed and treated for BC. These patients need to be informed about the impact that the disease and its different treatment modalities can have on their sexual life.

To this end, it is necessary to train physicians in sexual health so they can identify, in routine clinical practice, sexual difficulties that may arise during the different stages of the disease.

We must emphasize how important it is that the entire medical team recognizes the importance of taking these problems into account and the training that is needed to address them, providing the necessary information to the patient and her partner when requested, since in most cases even brief sexual advice can be useful in rehabilitation.

Future studies should focus not only on identifying patients who need to address their sexual problems, but also on developing and evaluating the success of specific interventions in the treatment of sexual dysfunction in these patients and, more importantly, designing strategies for its prevention.

Table 1: Response to the survey among sexually active patients

Question	Response N (%)	Response N (%)	Response N (%)	Response N (%)	Response N (%)
Have you had any sexual problems during the last 12 months? For example: lack of interest in or desire for sexual activity, vaginal dryness, pain on intercourse, difficulty in achieving orgasm.	Always or almost always 31 (20)	Almost all of the time (more than half of the time) 34 (22)	Sometimes (half the time) 38 (24)	Rarely (less than half the time) 33 (21)	Never 20 (13)
How important is sex in your life?	Extremely important 28 (18)	Important 78 (50)	Moderately important 45 (29)	Somewhat important 5 (3)	NA
How interested are you in receiving support for your sexual problems?	Very interested 37 (24)	Somewhat interested 98 (63)	I am not interested 21 (13)	NA	NA
How likely are you to see a physician to address your sexual problems?	Very likely 58 (37)	Probable 56 (36)	Not very likely 23 (15)	Very unlikely 19 (12)	NA
Have you sought medical advice or help to treat your sexual problems?	Yes 47 (30)	No 109 (70)	NA	NA	NA
How satisfied were you with the care you received?	Very satisfied 33 (21)	Somewhat satisfied 59 (38)	Dissatisfied 64 (41)	Very dissatisfied 0	NA
Would you be interested in participating in a	Yes	No	NA	NA	NA

program aimed at confronting sexual problems?	126 (81)	30 (19)			

Table 2: Patient characteristics and treatment received

		Total n (%)	Sexually active n (%)	Sexually inactive n (%)
		200 (100)	156 (100)	44 (100)
Age	≤ 35 years old	4 (2)	3 (2)	0
	35− 50	46 (23)	45 (29)	3 (6)
	51− 65	78 (39)	72 (46)	7 (17)
	>65	72 (36)	36 (23)	34 (77)
Partner	With partner	136 (68)	131 (84)	7 (16)
	No partner	64 (32)	25 (16)	36 (83)
Surgical treatment	Sectoral mastectomy	132 (66)	98 (63)	34 (77)
	Total mastectomy	68 (34)	58 (37)	10 (23)
Chemotherapy	Yes	106 (53)	87 (56)	19 (43)
	No	94 (47)	69 (44)	25 (57)
Radiotherapy	Yes	160 (80)	122 (78)	40 (90)
	No	40 (20)	34 (22)	4 (10)
Hormonal therapy	Yes	166 (83)	122 (78)	44 (100)
	No	34 (17)	34 (22)	0

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