World Cancer Congress
Paris, November, the 3rd 2016

Resuming sex after cancer

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Epidemiology

- Mainly cancers of :
  - Prostate
  - Bladder
  - Rectum and anus
  - Cervix, uterus, vulva, vagina
  - Many breast cancers

→ about the half of newly diagnosed cancers

Treatments

- Mainly cancers of :
  - Prostate
  - Bladder
  - Rectum and anus
  - Cervix, uterus, vulva, vagina
  - Many breast cancers

→ about the half of newly diagnosed cancers

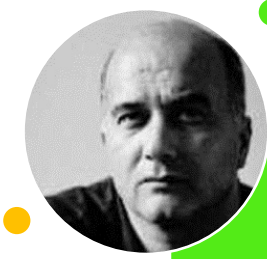
- Surgical treatments: radical prostatectomy, cystectomy, proctectomy, vaginectomy
- Pelvic radiotherapy (external or interstitial)
- Hormonal treatments and chemotherapy in women (dyspareunia)

Let's have a look at 4 cases illustrating current practices in sexual rehabilitation

Is it optimal ?

Couple with a history of prostate cancer

Cervical cancer



Rectal cancer

Prostate cancer

Grégoire is a 51 years old architect. He is divorced, then met a 39 years old partner. He is very stressed as he was treated 1 month ago for a CaP by radical prostatectomy with bilateral preservation of neurovascular bundles

Return to the Baseline is far from the rule

- Even if one takes only men under 60 years with excellent erections, REAL return to the basic EF is observed in only 20% to 25% (Schauer et al., 2015)

	N	Score	Follow-up (yrs)	% returning to the baseline without drug
Dalkin et al, 2008	116	UCLA PCI	5	26%
Parker et al., 2011	434	UCLA EPIC	5	24%
Levinson et al., 2011	568	UCLA EPIC	2	27%
Nelson et al., 2013	180	IIEF EF	2	22%

What is the determining factor of the outcome ?

- Not the technique:

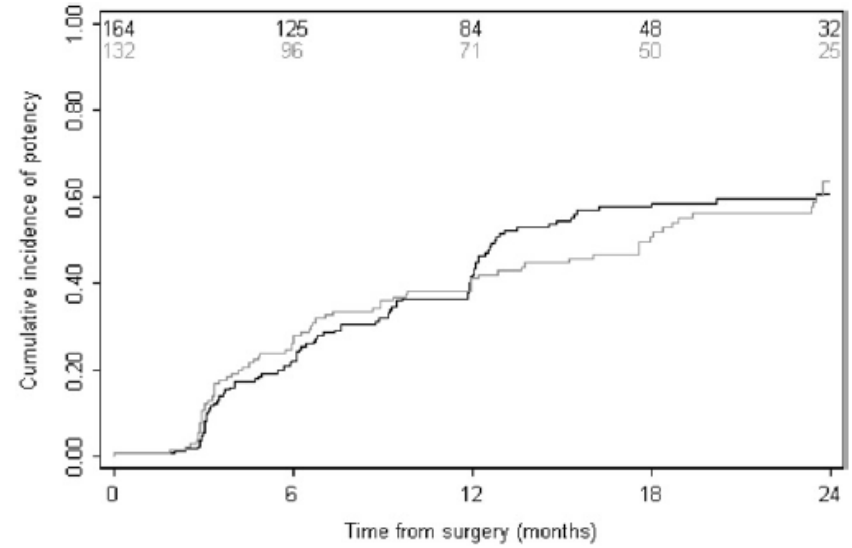


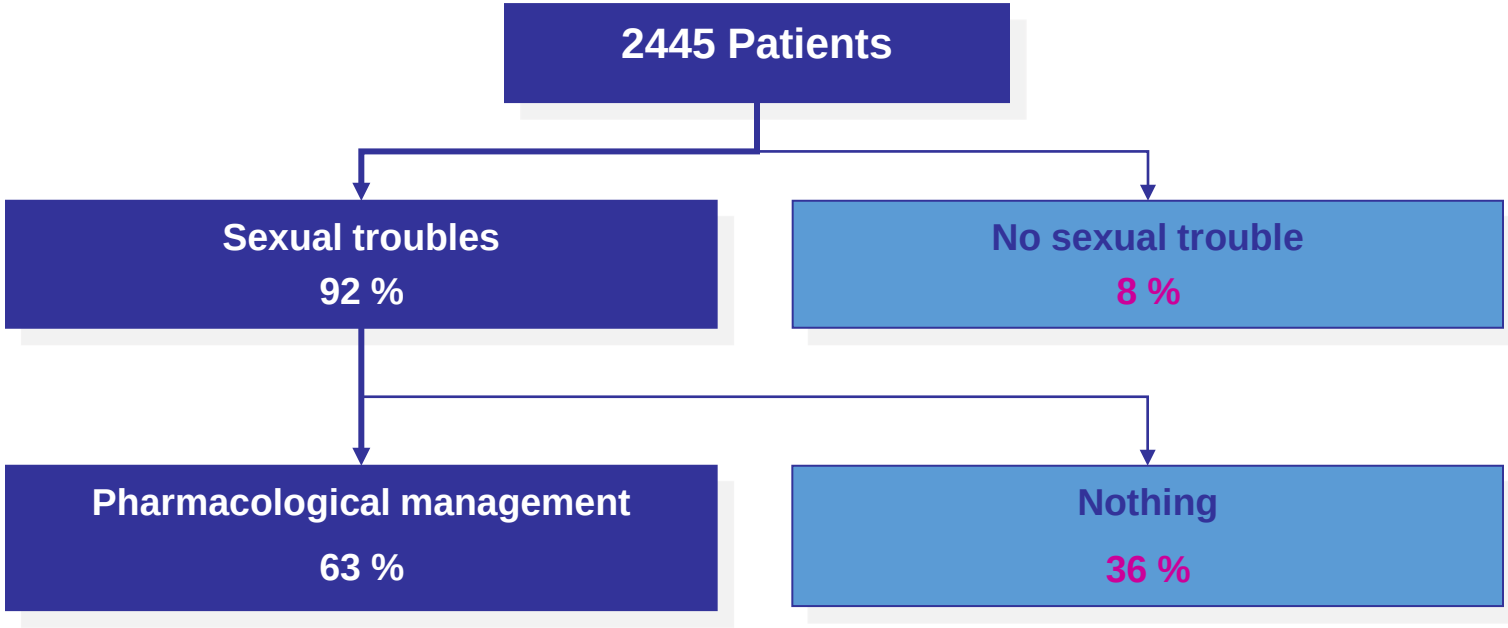
FIG. 5. Cumulative incidence of overall potency by operation type. Black lines indicate RRP, gray lines indicate LRP.

- The outcome depends on bilaterality of preservation.
  - bilateral preservation 30 à 85%
  - unilateral preservation 15 à 55%

Touijer et Al J Urol 2008, Kellog Parsons et Bennett Urology 2008

Dubbelman et al Eur Urol 2006

92% of operated patients experience postoperative sexual disorders. Among them, 36% are not supported for sexual disorders.



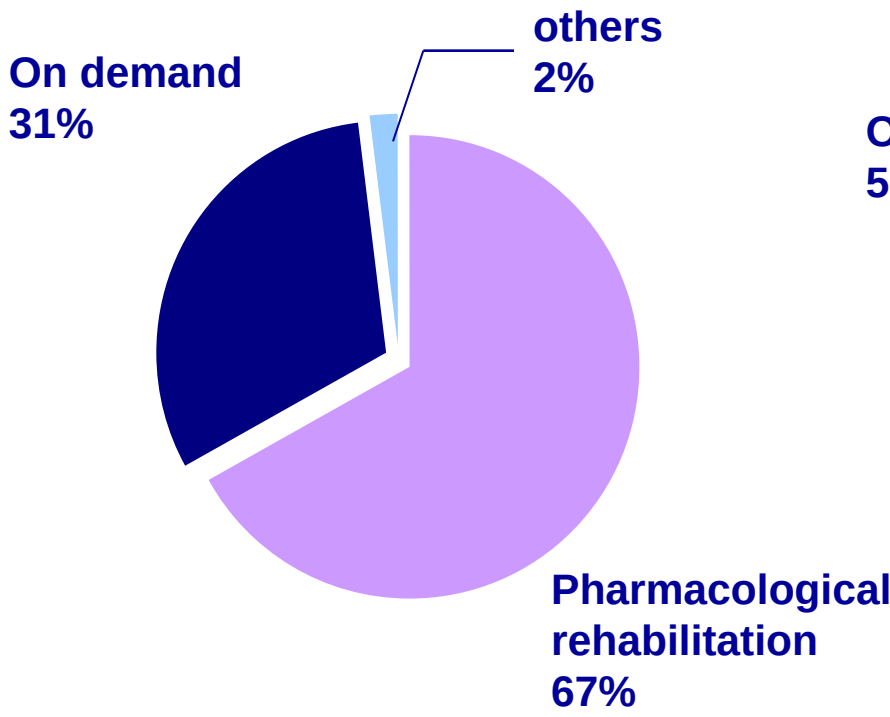
Practices in France in 2008 (535 urologists)

- **inclusion criteria:** The first 10 patients seen in consultation and operated within 12 months
- Cohort of **2644 patients**

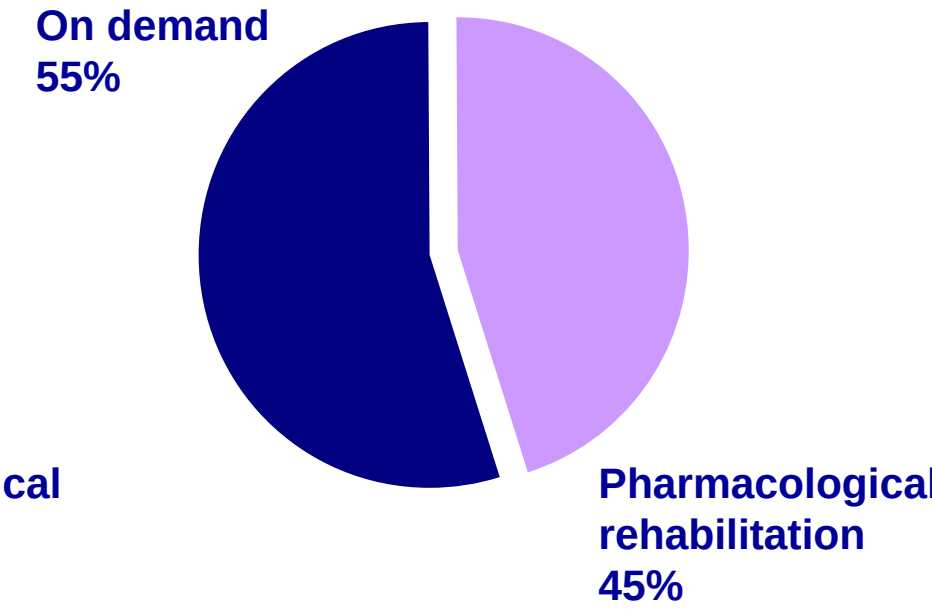
Giuliano F. J Sex Med. 2008

When rahab. is done, it is systematic for 1/3 urologists

Systematic in 38%



Occasional in 62%

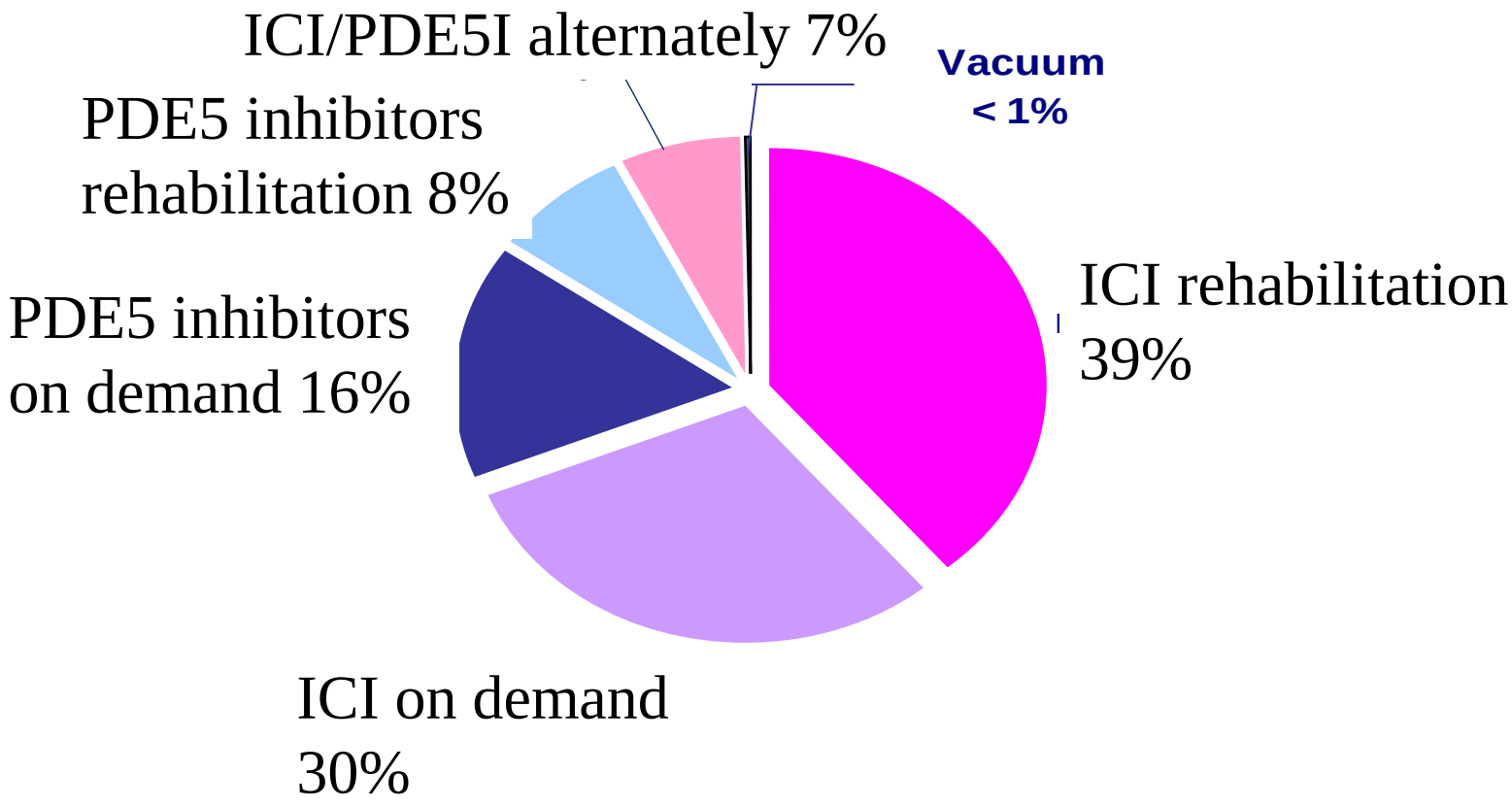


urologues n = **457**

Giuliano F. et al J.Sex. Med. 2008;5:448–457

There is no consensus about the protocol

1st line protocol



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When to start?

Tissue changes from the 2nd month

Iacono et la J Urol 2005

A.S.A.P.

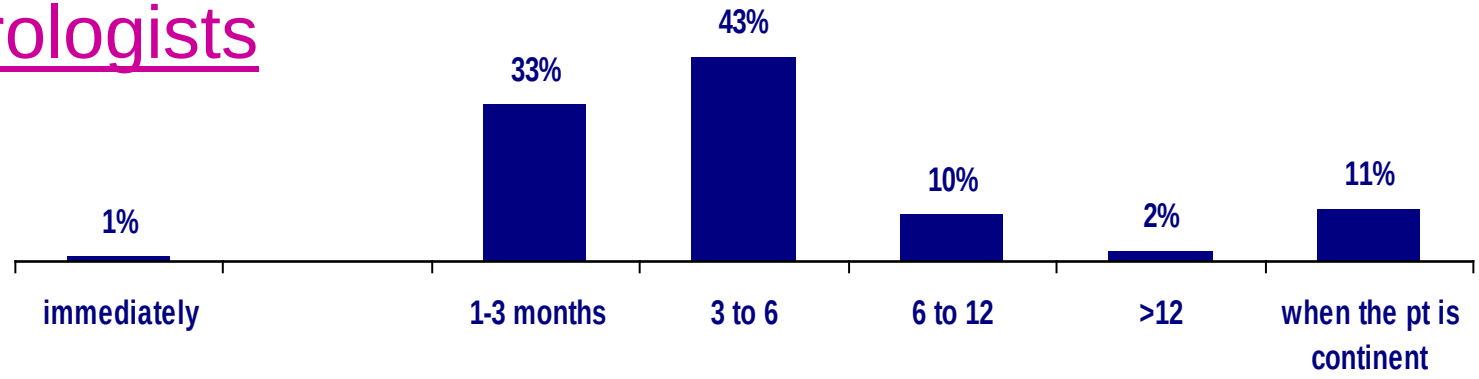
Recovering satisfying erections

- If intracavernous injections are started within 3 months: 73%
- later: 41%

Gontero et al J Urol 2003

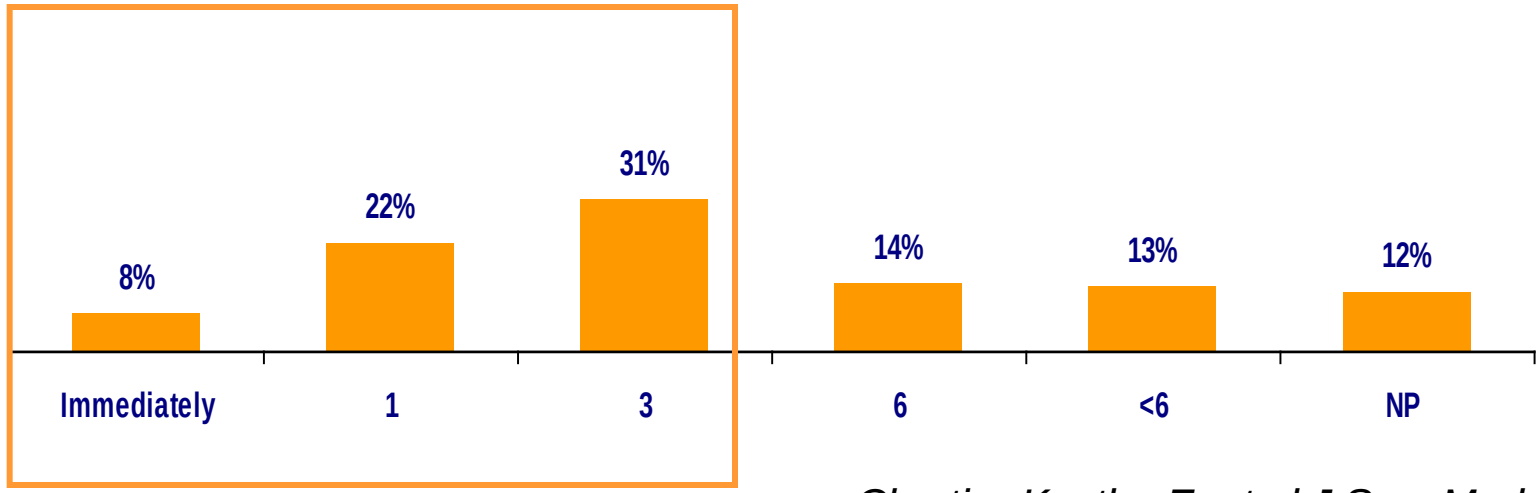
61% of patients want to begin rehab. within 3 months postoperatively, earlier than urologists usually think

Urologists



Patients

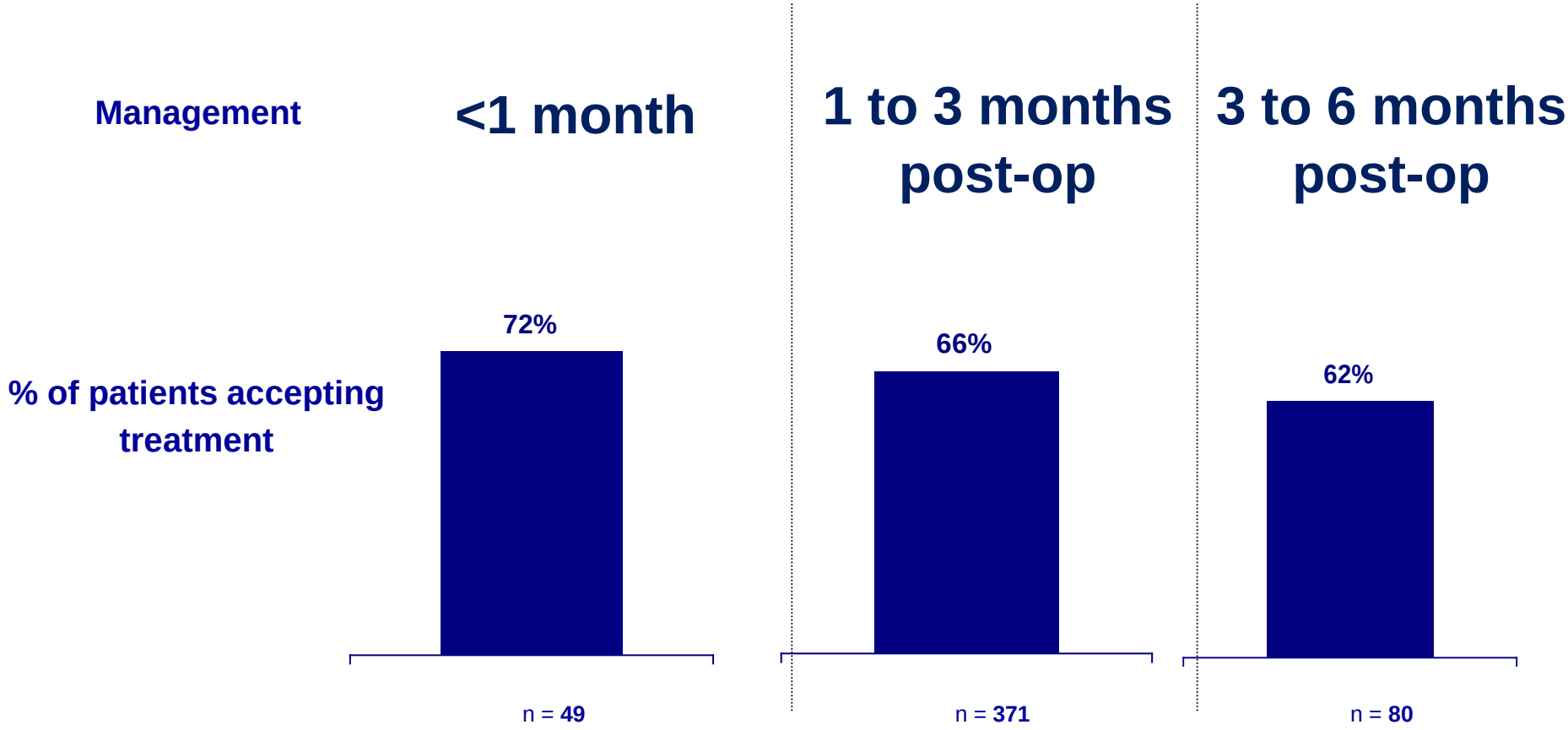
N= 535



N = 2644

Chartier-Kastler E. et al J.Sex. Med. 2008; 5(3):693-704

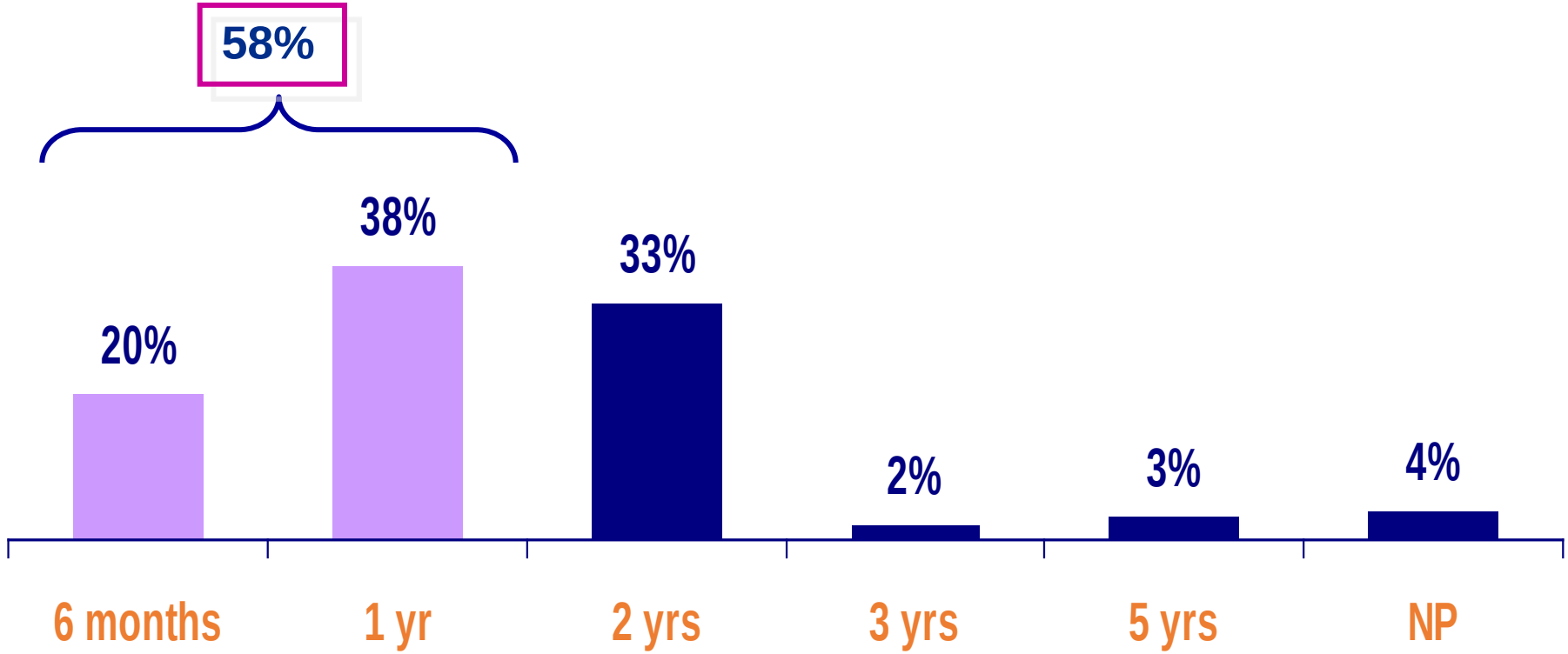
Patients accept better rehab. If it is proposed precociously



Urologists n = **500**

Giuliano F. et al J.Sex. Med. 2008;5:448–457

58% of French urologists believe that we must pursue the recovery of erectile function only 6 months to a year after surgery



Base urologues n = **518**

Giuliano F. et al J.Sex. Med. 2008;5:448–457

Grégoire is a 51 years old architect. He is divorced, then met a 39 years old partner. He is very stressed as he was treated 1 month ago for a CaP by radical rpostatectomy with bilateral preservation of neurovascular bundles

Rehabilitation is not proposed to all the pts

Often limited to pharmacological rehabilitation

Often too late,

Unsufficient duration

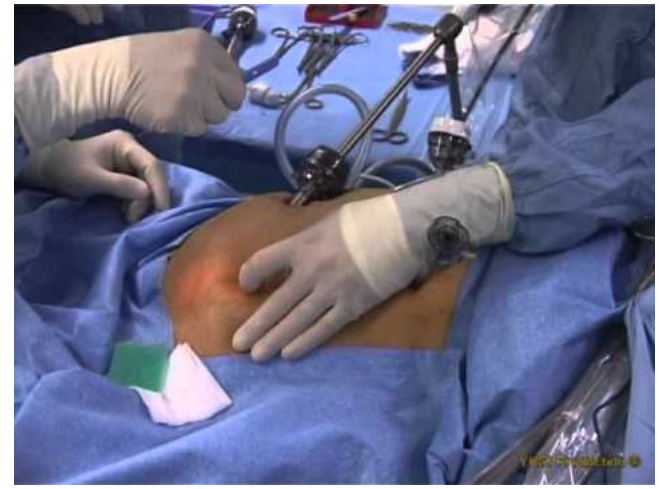
Many abandonments

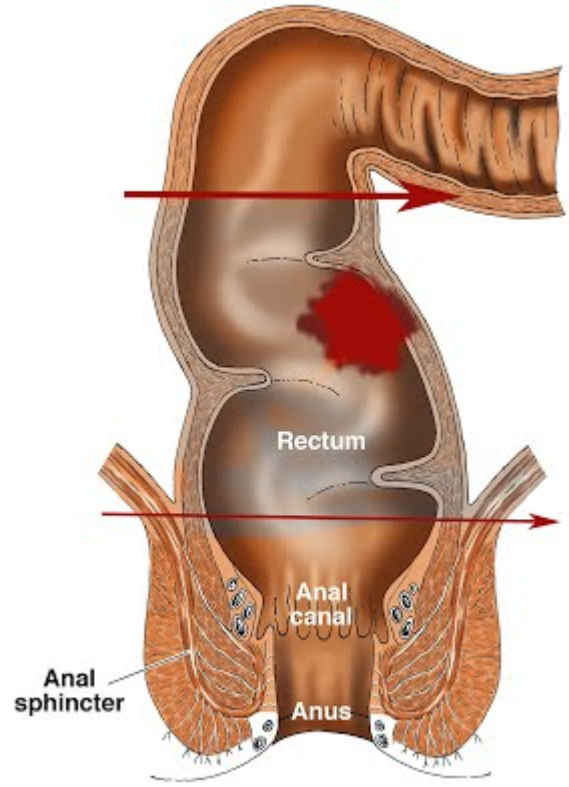
improvable

Jean Pierre is a 53 years old businessman. He was never informed about the risk of erectile dysfunction before to receive low anterior resection of the rectum. Now he is totally disappointed.

- why his surgeon did not addressed this risk ?
- What kind of rehabilitation to promote ?

- Abdominoperineal resection carries a higher risk of postoperative ED than low anterior resection
- ED is found in 48% of patients after abdominoperineal resection
- However, ED rates as high as 73% were reported after low anterior resection
- The permanent colostomy made after abdominoperineal resection has also been shown to alter the body image and increases the rate of postoperative sexual dysfunction but after low anterior resection, the risk of fecal incontinence is higher
- Surgical expertise is another factor potentially affecting ED rates with case series from high surgeon volume and high cancer center volume, reporting lower rates of ED
- most experienced surgeons are currently performing total mesorectal excision with preservation of the neurovascular bundles





- The situation after radical prostatectomy and proctectomy are close
- Rationale to transpose interventions developed for post-prostatectomy rehabilitation to patients with rectal cancers
- BUT few answers from literature

Our proposals

- Rehabilitation programs for these patients are complex and often require a multidisciplinary approach:
- Specifically trained health care professionnals
- Psychological evaluation and support of the patient and his/her partner are mandatory
- Moreover, they can enhance the response to pharmacologic therapy
- All the medications available can be proposed: PDE5 inhibitors, intra-urethral alprostadil, intra-cavernous alprostadil injection, vacuum
- Develop interventions for women

Michèle is a 53 years old Spanish teacher. She is married with 3 children. She underwent radiotherapy and brachytherapy plus hysterectomy for cervical cancer 10 months ago. She never resumed sex.

WOMEN'S PROBLEMS PRE VS POST CANCER

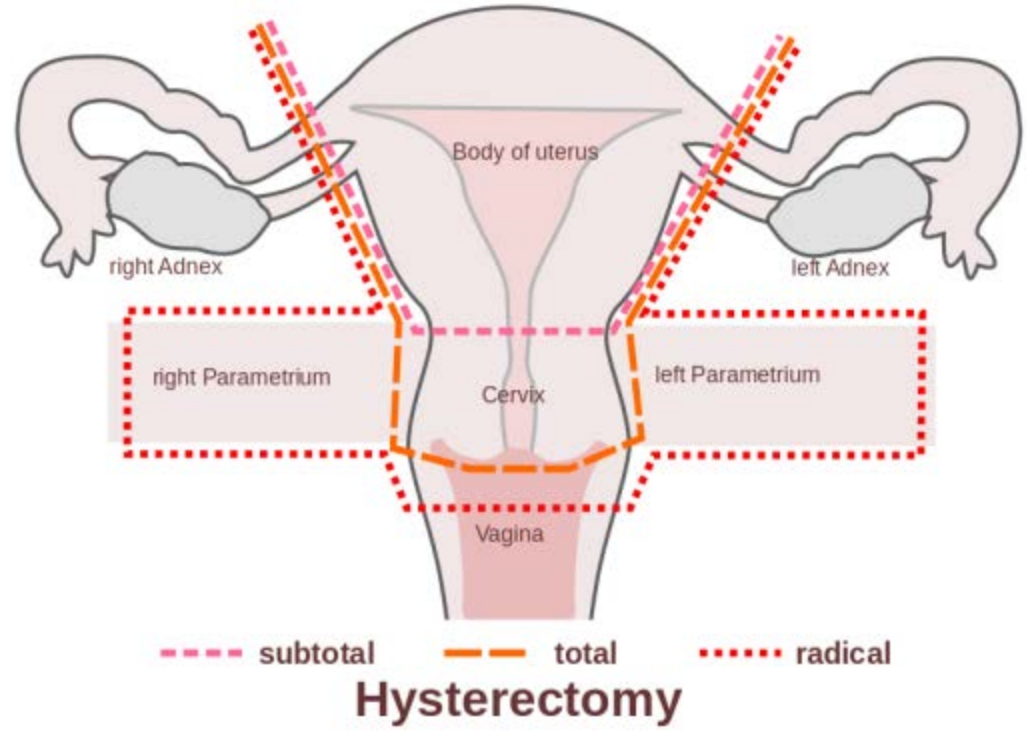
Problem	Pre & Post	De novo
Little or no desire to have sex	12%	45%
Lack of excitement & pleasure	9%	36%
Vaginal dryness during sex	13%	46%
Pain with sex	8%	33%
Trouble reaching orgasm/wea weak	14%	37%
Do not believe partner would be attracted to me	8%	16%

Sexual life after radical hysterectomy

Despite the loss of the upper vagina, most women can still enjoy sex without pain.

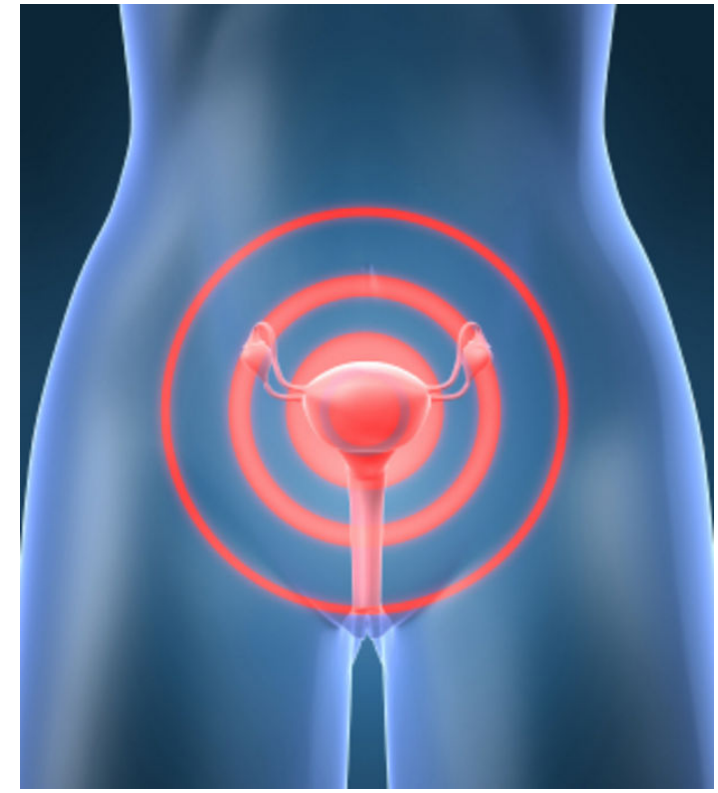
Autonomic nerves around the cervix are more important to urinate than for sexual function.

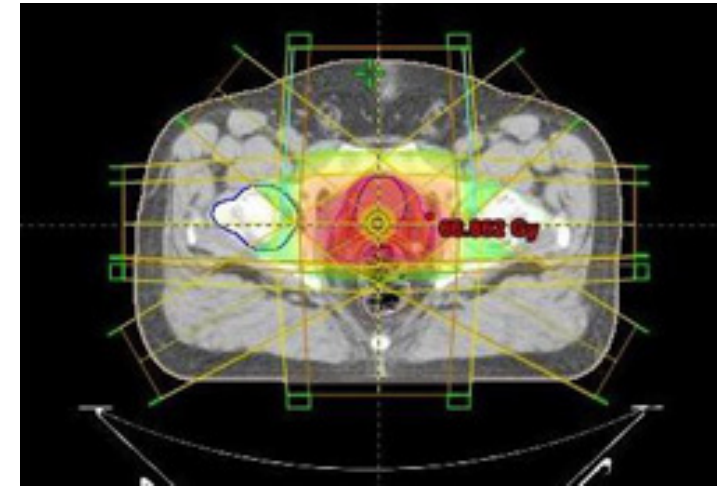
→ No doubt that radical hysterectomy makes better than radiation therapy.



Pelvic radiotherapy

- Causes progressive fibrosis of the vaginal walls.
- The loss of vascularization also aggravates the thinning of the vaginal mucosa due to ovarian failure.
- And later, may cause ulcers or stenosis of the vagina.
- Mucosa is also less sensitive to estrogen replacement .





Impact on female sexual experience

- Vaginal dryness, loss of elasticity and size
- Deep, but also superficial dyspareunia
- Blood stains after sex
- Risk of vaginal and urinary tract infections

How « typically » are prescribed dilators

Well, Madam, if you want to avoid atrophy of the vagina, you should have sex 3 times a week or use the dilator with a lubricant

Destination of the dilator …

Rehabilitation using vaginal dilators

- Use silicone dilators better accepted by women .
- Select several sizes.
- Teach the patient her anatomy and trigger zones.
- Teach the patient how to stretch and relax the muscles around the vagina.
- Give a list of moisturizers and vaginal lubricants.
- Show how to insert the smallest dilator.

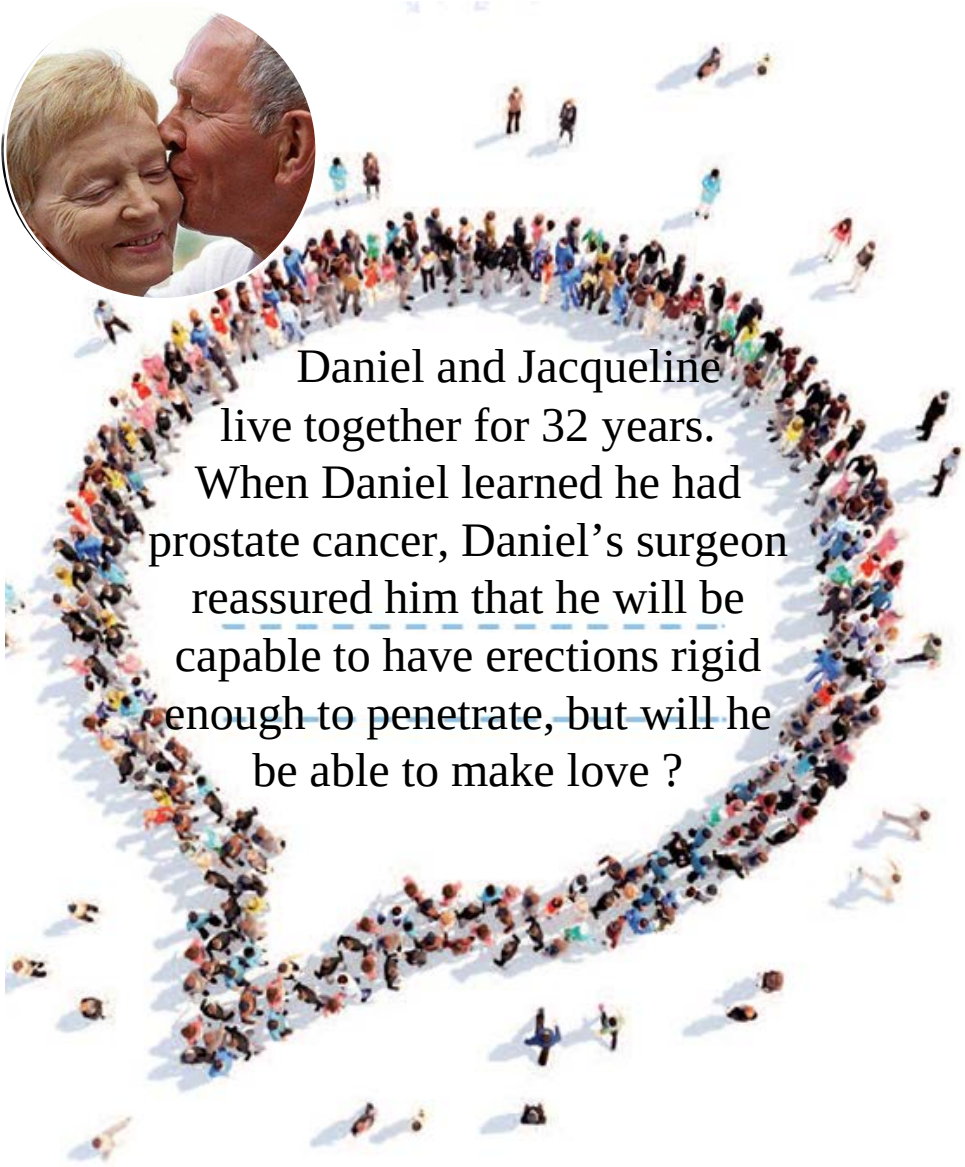
Michèle is a 53 years old Spanish teacher. She is married with 3 children. She underwent radiotherapy plus brachytherapy after hysterectomy for cervical cancer 10 months ago. She never resumed sex.

So far, very little evidence of the effectiveness of vaginal dilators.

Most women do not use them.

Most women ignore how to proceed.

→ Pleads for intervention to improve patient motivation and for a multidisciplinary management.



Daniel and Jacqueline live together for 32 years. When Daniel learned he had prostate cancer, Daniel’s surgeon reassured him that he will be capable to have erections rigid enough to penetrate, but will he be able to make love ?

The couple is too often absent from most rehabilitation programs based more on the patient.

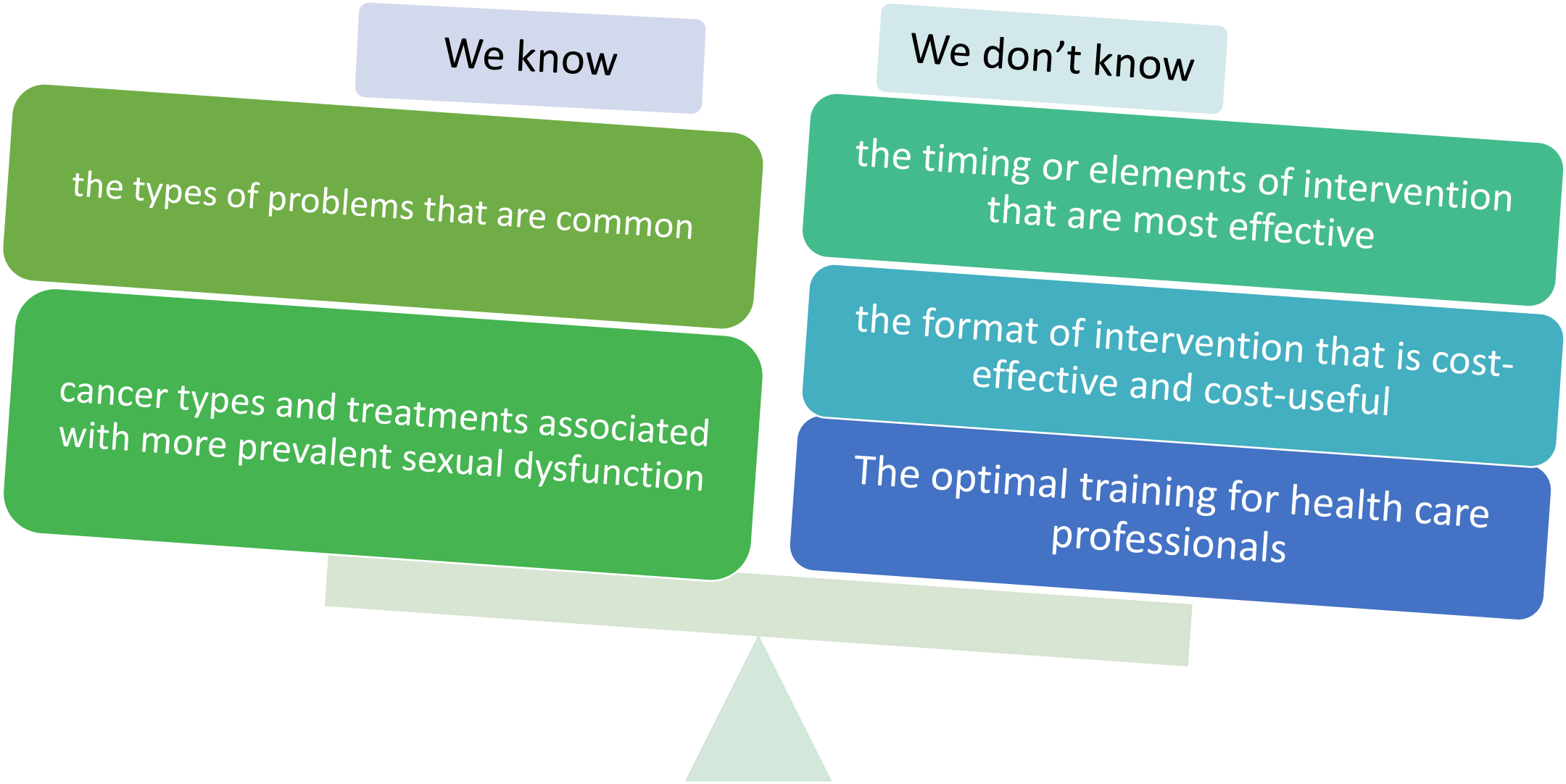
Yet we must never forget the couple.

Need to explain to women how to adapt their scripts and integrate the treatment of her husband inside

CONCLUSION : THE PROBLEMS OF SEXUAL REHABILITATION

- Most patients in Europe and in the US still do not get timely and accurate information on sexual consequences of their cancer treatment.
- Only a minority will be able to resume satisfying sex.
- In many countries, the absence of insurance coverage for mental health services, and more widely for all cares in the field of sexuality, limits patient adherence to programs.
- Media convey misconceptions : notably, they give impression that magic pills or new magic technology will solve all problems, which leads the patient to falsely imagine that the solution to all his problems is medication.

NEED FOR RESEARCH



Example of a website aiming to facilitate sex resuming after cancer

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