

SEXUAL PROBLEMS IN CANCER SURVIVORS

Sexual function is profoundly disrupted by cancer treatment but there is a deafening silence when it comes to addressing sexual function in survivors. Most patients are disappointed by the lack of information and support from medical professionals. The loss of sexual function adds a burden that is only magnified by the shame and embarrassment. Patients assume that sexual dysfunction cannot be addressed and doctors give a message that “nothing can be done.”

Several studies have examined medical professional’s barriers to communication about sexual health needs of their patients. Barriers may be categorized as being related to patient characteristics, provider characteristics, and system issues.

Patient characteristics refer to a range of assumptions about a patient’s sexuality based on age; sex; partner status; sexual orientation; prognosis; economic and social class; and religious, cultural, and ethnic background. Provider characteristics refer to the training, experience, knowledge, and attitudes of the provider. Finally, system issues include lack of time and resources.

Prostate Cancer :The relative 5-year survival rate for men diagnosed with localized prostate cancer approaches 100%. The combination of the increase in diagnosed cases, increasing survival rates, and the decreasing age at diagnosis has made sexual dysfunction following prostate cancer treatments, a progressively more pressing issue.

Radical prostatectomy (RP), has major impact on sexual function. During surgery, the seminal vesicles are removed and the vas deferens is cut, which causes dry orgasms and urinary incontinence during orgasm. This is associated with poor satisfaction with orgasms and the avoidance of sexual activities. In addition, the cavernous nerves may be affected during surgery, which can cause erectile dysfunction (ED) in 50% to 80% of men. The first-line treatment for ED is often oral medications because they are effective and noninvasive. Although radiation therapy patients experience different functional trajectories compared to prostatectomy patients.

Radiation therapy, in all forms, is associated with sexual dysfunction, with outcomes impacted by factors such as radiation dose and location. Androgen-deprivation therapy (ADT) is associated with a range of marked sexual side effects, including severely decreased libido, elevated ED, and lower levels of sexual activity. In addition, treatment-related side effects such as body feminization, hot flashes, fatigue, and decreased mood and self-esteem also greatly impact sexual health among men who choose hormone therapy. Use of targeted cognitive-behavioral interventions reduce relationship distress, and improve coping skills and self-esteem.

Testicular Cancer : Testicular cancer is the most common cancer among men between the ages of 20 and 34 years, which is the age at which men are in their sexual prime and likely to start a family. Cancer impacts their orgasm intensity and frequency, causes problems with ejaculation, libido and ED. Their sexual function appears to reach a low point about 3 months after treatment and tends to recover over the course of 1 year. A significant concern for many men with testicular cancer is fertility. Testicular cancer survivors have various fertility options, including sperm cryopreservation.

CANCERS THAT AFFECT MEN AND WOMEN

Head and neck cancer survivors report lowered self-esteem and body image as a result of treatment-related side effects which negatively impact their intimate relationships. These survivors report decline in the frequency of sex, feeling less attractive, reduced libido, and decreased overall satisfaction with their sexual relationships. In particular, women and patients who are diagnosed with more advanced-stage disease, who undergo surgery, or whose treatment cause more extensive disfigurement are at elevated risk for sexual dysfunction. The majority of these patients do not discuss implications of their disease and treatment on body image. Open communication about possible sexual side effects of treatment between providers and patients is associated with improved psychosocial adjustment.

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For the majority of **bone marrow transplant patients**, distressing sexual problems are present several years after transplantation and include difficulty obtaining an erection, ejaculation, and orgasm for men. Concerns persist about body appearance, vaginal dryness, and painful intercourse and orgasm for women. Many survivors and their partners may feel hesitant or even fearful to resume sexual activity after bone marrow transplantation given concerns about immunosuppression, such as coming in contact with germs. These concerns may prevail even after survivors have been cleared by their medical team to resume sexual activity.

Colorectal cancer surgery often causes damage to the sympathetic and parasympathetic nerves and results in erectile and ejaculatory disorders in men and dyspareunia, decreased libido, and changes in the orgasm in women. Therapies recommended for prostate cancer survivors, such as the use of sildenafil appear to be adequate for a number of male colorectal cancer survivors who suffer from ED following treatment. Likewise, therapies recommended for breast and gynecologic cancer survivors, such as the use of water-based lubricants, vaginal moisturizers, and vaginal dilators can also be recommended for female colorectal cancer survivors who suffer from vaginal dryness and/or stenosis after radiation. More specific to colorectal cancer survivors are the negative emotional reactions to the colostomy, such as poor body image and reduced self-esteem, which are commonly present and may negatively impact intimacy. Survivors and their partners should receive information on deodorants to minimize odor as well as on foods that are likely to cause stronger odors, gas, or diarrhea. They should also receive information on pouch covers and suggestions such as changing positions to avoid pain during intercourse and emptying the stoma before sexual activity.

Difficulty with sexual function, loss of desire, changes in body image, and disruption of emotional relationships are primary and pervasive sexual complications of **breast cancer** from diagnosis through all stages of treatment and into survivorship. Chemotherapy, radiation, surgery, and adjunctive hormonal therapy, whether delivered alone or in combination with each other, all have the potential to negatively impact sexual function. Younger age is the most salient predictor of lower sexual function. Common problems relate to sexual desire, arousal or lubrication problems, problems with orgasm, and problems with pain or dyspareunia. Conceptually, losing one or both breasts would seem to be one of most dramatic ways to damage a woman's core sense of femininity, body integrity, and attractiveness.

Breast-conserving surgical procedures and reconstructive surgery have become a standard part of breast cancer care, and it is generally understood that breast-conserving surgery and breast reconstruction are essential in helping women maintain a positive body image. Women who undergo breast reconstruction are typically left with complete lack of breast sensation, including nipple sensation. The nipple has been shown to be the most sensitive area of the breast, and loss of nipple sensation is akin to losing a key erogenous zone for many women. Although their breast shape may be restored, the loss of feeling is not. There is growing attention now being paid to the use of nipple-sparing mastectomy; however, although the nipple and areola may be left in place when breast tissue is removed, sensation is no longer intact.

Younger women who undergo abrupt chemotherapy-related menopause are at the highest risk for sexual problems. In particular, the intensive estrogen deficiency that comes with chemotherapy-induced menopause often leads to severe vaginal dryness and vaginal atrophy, which makes penetration painful. Painful intercourse due to vaginal dryness is one of the most common sexual problem after breast cancer.

Endocrine therapy including selective estrogen receptor modifiers, aromatase inhibitors (AIs), and ovarian suppression treatment now plays an important role in breast cancer treatment for both premenopausal and postmenopausal women. Tamoxifen has been used as systemic adjuvant treatment for over 40 years, and primary side effects are hot flashes, fatigue, and nausea. Regarding sexual function, tamoxifen use has been associated with vaginal dryness and low desire. Recent research has attempted to provide early intervention, with evidence indicating that sexual counseling within the first year of AI use can help women maintain stable sexual function. Radiation can result in skin fibrosis, additional loss of sensitivity in the skin, and fatigue, all of which can contribute to low desire. It has been suggested that interventions need to actively involve women's partners in order to produce lasting benefits on sexual functioning. All women should receive information about nonhormonal vaginal moisturizers, water-based vaginal lubricants, pelvic floor strengthening (Kegel) exercises, and the value of maintaining blood flow to vaginal tissue to prevent vaginal atrophy.

The effect of surgeries on the **genitals** can impact a patient's self-esteem and body image. Sexual problems are quite prevalent in **ovarian cancer** patients, with 80% reporting problems with vaginal dryness, 75% reporting problems reaching

orgasm, and 62% reporting pain or discomfort during penetration. Women who receive chemotherapy are also likely to experience decline in sexual function. There is limited information of the sexual outcomes associated with vulvar cancer treatment. Moreover, psychoeducation may be particularly useful in decreasing some of the distress associated with sexual changes after gynecological cancers.

Cancer during **childhood and adolescence** can have a tremendous impact on the patient's psychosexual development. Treatment puts these young patients at risk for significant sexual dysfunction and infertility. For both sexes, there are medical options for fertility preservation that should be discussed with the patient and parents as soon as feasible.

DISRUPTION OF INTIMACY AND RELATIONAL CONSIDERATIONS

Women's perceptions of their partner's reactions to their appearance after cancer consistently predict their own acceptance of their self-image and of their sense of femininity. Moreover, women often do not feel comfortable voicing this aspect of their cancer experience with their partners out of a fear of rejection. Similarly, male patients tend to avoid conversations with their wives about their sexual challenges that result from cancer treatment. This interpersonal silence can quickly become the "**elephant in the room**," and over time, disruptions in intimate functioning can become more difficult to address.

COMMUNICATION ABOUT SEXUAL PROBLEMS

Patients will rarely initiate conversation on this topic for fear of embarrassing their doctor. As medical professionals, we must speak up or refer patients to counsellors for sexual dysfunction. One straightforward model that has been proposed is the **BETTER** model which stands for the following:

1. **Bring** up the topic.
2. **Explain** that you are concerned with quality of life, including sexual health.
3. **Tell** patients that you will help find appropriate resources as needed.
4. **Timing** needs to be taken into consideration, including letting patients know that they can ask for information at any time point.
5. **Educate** patients about expected sexual side effects.
6. **Record** your assessment in the patient's medical record.

One method of gaining information and assessing how patients are doing relative to others is to use a brief screening inventory in one's oncology practice. It is imperative for oncologists to raise the topic of sexual health after cancer. However, we recognize that it is not easy to feel comfortable or competent bringing attention to a problem when next steps are unclear. Like any other skill, communication about sexual problems needs practice, but with repeated efforts comes mastery.

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CONGRATULATIONS - DR. SUDHIR KUMAR RAWAL

Dr. Sudhir Kumar Rawal was awarded the “**Golden Robot Surgical Award 2025**” at the 7th International Prostate Cancer Symposium & World Urologic Oncology held at Mount Sinai, New York. The prestigious international award recognized his exceptional contribution to advancing robotic surgery in oncology, both in India and globally. This honour acknowledged his pioneering role in robotic cancer surgeries, innovation in complex uro-oncological procedures, and leadership in introducing and expanding tele-surgery and minimally invasive robotic techniques in cancer care.

Robotic surgery fundamentally transformed the approach to cancer treatment by enabling greater precision, faster recovery, and improved quality of life for patients. This recognition reflected the collective efforts of teams in India who worked relentlessly to bring advanced surgical care to patients and to place Indian oncology on the global map.



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