Acta Scientific Cancer Biology

Volume 2 Issue 6 August 2018

Review Article

Psychosexual Impositions in Gynaecologic Cancer Patients - A Perspective

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Received: May 23, 2018; **Published:** July 10, 2018

Abstract

Gynaecologic malignancies primarily affect sexual organs in a woman, which can have exponential effects on one's sexuality. Various concepts of body image, sexual self-esteem, sexual relationships, communication, intimacy and sexual function is affected in more than one ways. Surgery, chemotherapy and radiation therapy have gamut of side-effects incorporatiing the psychosexual behaviour of a woman in unique ways. Involvement of a multidisciplinary team including gynaecologic oncologist, medical and radiation oncologist and psycho-oncologist at various phases of treatment including pre-treatment counselling, tackling the myths while on treatment, taking care of side-effects post-treatment and the long-term side effects and opening up to the pertinent issues of sexuality is an important component of a holistic treatment for gynaecologic malignancies.

Keywords: Psychosexual; Sexuality; Body Image; Gynaecologic Cancer

Cancer survivors are prone to develop long-term side-effects that can alter their sexual being which persists for many years after the treatment [1]. There is controversy whether the symptoms and diagnosis of cancer per se can have an effect on sexuality, but the gamut of armamentorium of multimodal therapy used to treat malignancies can have a negative impact on an individual's sexuality.

Sexuality is not a mere ability to physically perform the act of sex, but is a multifaceted comprising of biological, socioeconomic, psychological and spiritual paths [2]. Woods [3] defined sexuality as a composite of sexual function, sexual self-concept and sexual relationships. Gynaecologic malignancies primarily affect sexual organs in a woman, which can have exponential effects on one's sexuality.

Various concepts that comprise of sexuality and their effects by oncology treatment is discussed below:

Body image

Body image has been linked to feelings of feminity, physical attractiveness and cancer treatment can negatively affect it by inducing weight loss, hair loss, scarring etc [4]. An altered perception of sexual self concept occurs due to loss of feminity, which is reported in both quantitative and qualitative studies [5,6].

The component of sexual self concept is referred to as sexual esteem [7]. Physical changes caused by cancer and its treatment can have a negative sexual view on the patient [8]. Various clinical and psychological variable have been found to be associated with sexual impairment such as women who under radiotherapy had poorer percieved appearance and negative sexual self-schema [9].

Sexual relationships

Sexual relationships are defined as relations where one's sexuality is shared with another [10] and they are potentially affected by gynaecological cancer diagnosis causing difficulty in forming and maintaining them.

Communication

Communicating one's thoughts, perceptions and feelings with relationships has been revealed as a very challenging aspect in dealing with the effects of cancer and its treatment on sexuality [11]. Women wish that sexuality gets discussed in an open manner to help them improve their sexual relations [12].

Intimacy

There has been reported a fall in intimacy within relationships during the course of cancer treatment and thereafter [13]. The basic reason for this can be because overall decrease in physical contact, which can cause distress within relationships. Intimate expressions like hugging, kissing etc. rather than an engagement in sexual intercourse have been reported as a desire expressed by women undergoing cancer treatment [14]. The diagnosis of cancer can lead to strengthening of personal bonds as this is the time they stand by each other to focus on their family and relationships [15].

Sexual function

It is defined as "the ability of an individual to give and receive sexual pleasure" [3]. Kaplan [16] suggests that the sexual response cycle consists of three stages: desire, arousal and orgasm. Gynaecological malignancies are all associated with different treatments which alter sexual functioniing in multiple ways. Studies have suggested that sexual functioning gets impaired upto 2 years post completion of treatment [17].

Sexuality is a pivotal part of a woman's wellbeing and its dysfunction a serious concern of healthcare professionsals. Lack and knowledge and open communication can add to the already dwindling sexual identity during such times. Therefore, a timely information is an essential component for increased satisfaction and promotion of sexual well being. This information is not limited to the act of physical intercourse for gynaecological cancer patients. A holistic approach addressing inormation related to affects of cancer and its treatment - including surgical, chemotherpay and radiation related changes that can occur and their effects on the sexual well being of the patients is needed at all steps, before, during and after the treatment is over.

Cultural and religious factors prevelant in the society also influence the willingness of patients to discuss issues related to sexuality and healthcare providers need to ne sensitive about them while addressing the women with gynaecological malignancies [13]. It is important to acknoledge the sociocultural norms shaping the experience and interpretation of sex of what is considered 'normal' vs. 'abnormal' by the patient, as this can deeply impact the experience one has.

Effects of surgery in gynaecological malignancies

Hysterectomy for a gynaecological malignancy can be associated with adverse vaginal changes, including shortening of vagina, damage to the pelvic nerves which can be associated with loss of sensitivity and orgasmic disruptions [17]. Also, oophorectemy can knock off the hormones leading to a loss of libido, lack of sexual desire, reduction of vaginal lubrication and an overall decreased sexual satisfaction [18]. Dyspareunia and vaginismus secondary to hysterectomy is associated with negative sexual interest.

Studies have also pointed put that women who underwent simple, modified radical or radical vulvectomy or pelvic exenteration experience depression related to negative body image, massive sexual disruptions, decreased perception due to removal of clitoris, difficulty in sexual arousal and orgasm as well [19].

Effects of radiation and chemotherapy

Radiation therpay can induce premature ovarian failure [20], can be associated with vaginal shortening, decreased vaginal elasticity, reduction of vaginal lubrication, genital numbness, secondary dypareunia, decreased sexual desire and anxiety about sexual intercourse [21,22].

Research related to chemotherapy in ovarian cancer also suggests women can achieve premature menopause, resulting in concerns about fertility, as well as difficulty in arousal and vaginal lubrication, difficulty in sexual desire and excitement [23]. Chemotherapy related sexual problems can compound with sexual problems, related to changes of self-esteem, a woman's physical appearance and feelings of feminity [24].

The Late Effects in Normal Tissues-Subjective, Objective, Management and Analytic Score (LENT SOMA) grading scale for vaginal injury due to radiation and/or chemotherapy is based on the assessment of subjective symptoms, observed clinical features, management strategies required and analytical tests [25]. A recent Cochrane review [26] concluded that there is no reliable high-level evidence to show that regular vaginal dilatation prevents radiation-induced vaginal stenosis. However, observational data [27] indicate that regular use of dilator following radiation therapy is associated with lower rates of self-reported vaginal stenosis. It has been postulated that the application of local estrogen or benzydamine [28] to treat acute radiation-related changes may prevent the development of later vaginal complications such as VS via the promotion of epithelial regeneration and anti-inflammatory effects.

Vaginal morbidity should be assessed at baseline, 3 monthly for first 2 years and then 6 months for subsequent 3 years until discharge from ongoing surveillance [29].

Women with gynaecological malignancies go through immense emotional turmoil and feel excessively dependent on their partner, resulting in engagement in sexual intercourse for the satisfaction of their partner rather than their own primary need. Juraskova., *et al*. [11] reported that despite their own difficulties, women re-

ported a need to provide their partners with sexual pleasure and, if they could not engage in coital sex they should not prevent their partner from seeking sexual pleasure elsewhere. Schultz., *et al.* [30] have suggested that if health professionals state information about sexual well being as important, the issue is given a legitimate priority and discussion of sexuality between women and their partners is normalised. Involvement of a multidisciplinary team including gynaecologic oncologist, medical and radiation oncologist and psycho-oncologist at various phases of treatment including pre-treatment counselling, tackling the myths while on treatment, taking care of side-effects post-treatment and the long-term side effects and opening up to the pertinent issues of sexuality is an important component of a holistic treatment for gynaecologic malignancies.

Conclusion

Involvement of a multidisciplinary team including gynaecologic oncologist, medical and radiation oncologist and psycho-oncologist at various phases of treatment including pre-treatment counselling, tackling the myths while on treatment, taking care of side-effects post-treatment and the long term side effects and opening up to the pertinent issues of sexuality is an important component of a holistic treatment for gynaecologic malignancies.

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Volume 2 Issue 6 August 2018