BY JEANNINE WALSTON

Sexuality after breast cancer

"Sexuality is an important aspect of human life and relationships. Not to address it adds one more loss to cancer," says Debbi Hampton, a 51-year-old breast cancer survivor from Tennessee, who speaks from experience.

After a modified radical mastectomy in 1994, Hampton says she focused on living and raising her 10-year-old daughter, who is now 19. She also adjusted to seeing herself without breasts. Crying after not finding a dress that fit her properly, Hampton decided to reclaim how she looked and felt before cancer, describing breast reconstruction as "a reunion with self."

Four years later, a recurrence brought up more challenges with sexuality. Hampton didn't want to lose her breasts again. The hormonal changes from her treatments also posed new problems. She found comfort in her breast cancer support group, where members talked openly about sexual concerns. After consulting with a gynecologist and a psychiatrist, who prescribed estradiol vaginal tablets and topical testosterone, Hampton says, "I got my sex life back!"

IMPACTS OF BREAST CANCER TREATMENTS

Chemotherapy disrupts female sexuality more than other treatments, explains Patricia Ganz, MD, professor of health

services and medicine and director of the Division of Cancer Prevention and Control Research, Jonsson Comprehensive Cancer Center, Los Angeles.

"Chemotherapy can cause premature menopause. This may result in ovarian failure, diminished androgens such as testosterone, libido changes, and lubrication problems. Vaginal dryness occurs independent of age," says Dr. Ganz.

Chemotherapy is most likely to trigger menopause for women who are close to its natural onset, but it can happen to younger women too. For women of childbearing age and their partners, fertility loss from premature menopause can be devastating.

Postmenopausal women diagnosed with breast cancer who stop taking hormone replacement therapy because of its association with cancer can experience dramatic hormonal changes. "This challenge affects a large number of healthy, aging women," notes Dr. Ganz.

The Breast Cancer Prevention Trial, a study of 13,000 healthy, high-risk women, suggests that the hormonal agent **Nolvadex**® (tamoxifen), which works by blocking estrogen from binding to tumor receptors, increases vaginal discharge, hot flashes, and night sweats. Overall, however, Dr. Ganz describes the side effects of tamoxifen as "fairly limited."

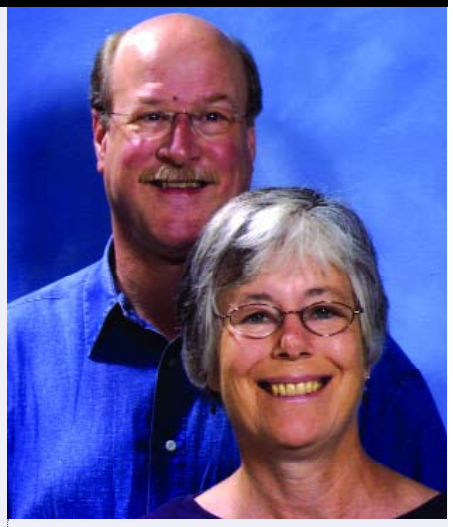
She does have concern for the side effects of aromatase inhibitors, which include **Arimidex**® (anastrozole), **Femara**® (letrozole), and **Aromasin**® (exemestane). This newer class of hormonal agents shuts down the production of female hormones estrogen and progesterone in postmenopausal women. Unlike tamoxifen, there is little risk of developing uterine cancer and blood clotting with aromatase inhibitors. But women taking aromatase inhibitors for long periods of time may be at a higher risk of developing osteoporosis.

Radiation is another type of breast cancer treatment that can impact sexuality by possibly causing tiredness, nausea, skin changes, and hair loss. Some women report that these side effects are a detriment to sexual health.

Studies comparing breast-conserving surgery with

BY KATHIE DEVINY

A NEW KIND OF *intimacy*



Paul Collins and Kathie Deviny

"When I'm taking care of you, it feels like **taking care of myself."** —PAUL COLLINS

My husband Paul loathes everything associated with illness. Paul would rather throw off the covers when he's hot and throw them back on when he's chilled. He'll heat up a can of soup for me when I'm sick, but only because he's hungry and doesn't know how to cook anything else.

As a result, I've been the one who cleans up after our cat, Harry. Whenever I hear Paul retching, I grab the rags and water, knowing he's discovered hairballs, vomit, or other substances that Harry occasionally deposits on the carpet.

When I discovered the lump in my breast, Paul's response, like mine, was disbelief. After obtaining my promise to see the doctor right away, he left me to it. But once I had the breast cancer diagnosis, he declared, "This is our illness, not just yours. From now on I'm going to be involved in every part of your treatment."

He was with me when I discussed options with the surgeon. He was with me when I had the lumpectomy and for the postsurgical appointments. His support made me feel safe and cared for. But it was what Paul did the day after surgery that rose above the call of duty.

In addition to the tumor, the surgeon removed 19 lymph nodes to see if the cancer had spread—it had, to five of them. Afterwards, I was left with a tube dangling from the draining wound in my armpit, ending in a bulb that collected the rose-colored lymph fluid.

Every six hours, "someone" had to remove the bulb, pour the contents into a measuring cup, record the amount of fluid, dispose of the contents, and reconnect everything. Given the dual nature of the discharge as blood and body fluid, I assumed this someone would be me.

Awakening from a nap, I beheld an apparition—Paul looming above me with rubber gloves on his hands. He carefully emptied the bulb, measured the contents, entered the pertinent information on an elaborate spreadsheet, and reinserted the bulb, all before I knew it. The cat and I stared at him, dumbfounded.

In six hours he did it again. Then over and over again. As luck would have it, my body decided it was going to drain a lot, so Nurse Paul was on duty for two weeks. It was hard to shower with the tube and bulb in the way, but my nurse took care of that by expeditious use of the washcloth.

After I started chemotherapy, Nurse Paul invested himself with quarantine authority. Our oncologist told us that midway between treatments my white blood cell count would be really low and I'd be susceptible to infection. He advised me not to be around crowds during that time. Each morning, my nurse told me whether today was a quarantine day. If it was, I was housebound.

Before he left for work, Paul asked about my plans, inserted rest breaks, and called from work to see if I was obeying. This may sound a little heavy-handed, but without the limits he set, I would have tried to do too much. When I disobeyed and "forgot" to rest or sneaked out to the store, the consequences were immediate.

Near the end of my treatment, I asked Paul how he was able to assume nursing duties so easily, especially the messy parts. He thought a long time.

"When I'm taking care of you, it feels like taking care of myself. But I'm glad you haven't thrown up on the carpet!"

Medical institutions should offer "proactive attention to educate women about common side effects from treatments."

. . . . .

Ursula Ofman, PsyD

mastectomy indicate both treatments may have similar effects on sexual health and functioning. Yet, breast-conserving surgery (see *CURE,* Fall 2003) may leave women with better body image, and therefore poses less impact on sexuality.

The **Pink** Pill?

Although years behind the progress made in sexual dysfunction for men, researchers are now recognizing it as an issue for women with recent findings showing the drug **Viagra**® (sildenafil citrate), which was put on the market in 1998 to treat male impotence, may work for women.

A study funded by Pfizer Inc., which markets Viagra, studied 202 postmenopausal or posthysterectomy patients with female sexual arousal disorder. After randomizing the women to receive either a flexible dose of Viagra or placebo, the women on Viagra reported significantly better sexual satisfaction and genital sensation during intercourse or stimulation compared to those not taking Viagra.

Numerous drug companies are currently investigating how to create a Viagra equivalent for women that will relax vaginal muscles and result in lubrication.

PREDICTORS OF SEXUAL HEALTH

Dr. Ganz, who studied factors influencing sexual health in women three years after their breast cancer diagnosis, found vaginal dryness was the main predictor of sexual dysfunction, according to results published in the August 1999 issue of the *Journal of Clinical Oncology*. Other important factors included emotional well-being, body image, quality of the couple's relationship, and sexual problems of the woman's partner.

With or without cancer, "these predictors of sexual health are universal for women," Dr. Ganz emphasizes. She explains there has been little research on men diagnosed with breast cancer and its potential sexual side effects.

Psychological distress because of cancer can also contribute to sexual dysfunction, leading to decreased sexual interest, challenges with arousal, and difficulty achieving orgasm. Fatigue, pain, and physical inactivity can also diminish sexual functioning.

VAGINAL PRODUCTS

For vaginal dryness, lubricants such as Astroglide® may be helpful during intercourse. Women who have dryness independent of sex may use an estrogen-free product such as **Replens**® (polycarbophil) a few times a week to increase moisture. **Estring**® (estradiol), which offers a slow local release of estrogen, has been effective for many women.

A testosterone supplement is another option, says Dr. Ganz. She notes women shouldn't use the more traditional estrogen creams because they can be absorbed into the bloodstream and lead to increased levels of estrogen that are possibly associated with an increased breast cancer risk.

Women experiencing vaginal dryness should consider discussing it with their healthcare provider. "Someone from the healthcare team should be knowledgeable and sensitized to these issues. Patients need to make their needs known," explains Dr. Ganz.

However, before using any products, Dr. Ganz recommends, "Psychological, relationship, and other issues such as fatigue should be addressed first."

BEHAVIORAL INTERVENTIONS

Ursula Ofman, PsyD, a sex therapist in New York City who works with cancer patients, believes women need to communicate sexual problems to their healthcare provider, other survivors, and especially their partner. Medical institutions should offer "proactive attention to educate women about common side effects from treatments," she says.

"Women are often reluctant to address sexual difficulties, and they need to talk about them. Women and their partners should discuss it outside of the bedroom with space for reflection and without pressure to act sexually," she adds.

In Dr. Ofman's clinical experience, the best predictor of sexual function after cancer is sexual function before cancer. Research also reflects this tendency. "Women who have a good sex life before cancer adjust better after," she explains.

A major challenge to sexual functioning can be avoidance. "Getting sexually started again can be extremely difficult for women and men alike," notes Dr. Ofman. "Women and their partners need to develop comfort to explore sexually without expectation. Many couples learn

BY MELISSA WEBER

Male Sexual Dysfunction

While research suggests about half of breast cancer patients experience long-term sexual dysfunction, up to 90% of prostate cancer patients experience erectile dysfunction after radical prostatectomy and as many as 85% experience this side effect following external beam radiation. Research has also shown that up to half of testicular cancer patients report some type of sexual impairment.

Erectile dysfunction results when the blood supply and nerves of the penis have been damaged. But doctors are having success in reducing this outcome thanks to nerve-sparing techniques for prostate cancer surgery. Newer procedures and surgical instruments allow the preservation of nerves and muscles needed for a man to achieve an erection.

For those who require treatment to combat sexual dysfunction, the process is twofold: physiological and psychological. Men, just like women, can become anxious and even fearful of having sex after treatment. In order to resolve possible sexual avoidance, the National Cancer Institute suggests self-stimulation to allow "the individual to become comfortable with his/her sexual response and arousal without the added pressure of performance anxiety."

If improvement does not occur after several months, other methods can be used.

Viagra® (sildenafil) and **Levitra**® (vardenafil) are oral medications that work by increasing blood flow to the penis and allowing a man to achieve and maintain an erection during sexual stimulation. These drugs work by blocking the effect of an enzyme called phosphodiesterase 5, which helps relax the smooth muscles in the penile blood vessels, thus increasing blood flow.

Studies have shown that Levitra, approved in August 2003 for erectile dysfunction, helped up to 85% of men achieve improved erections. And studies with Viagra boast improvement in up to four out of five men; and, more specifically, 50-70% of men with erectile dysfunction brought on by a medical condition report an improvement with Viagra. Common side effects for both Levitra and Viagra include headaches, a flushing feeling, and indigestion. Men taking nitrates, such as nitroglyerin tablets for heart disease, should not take Viagra or Levitra. More information can be found at www.viagra.com and www.levitra.com.

Another medication used is penile injection therapy using a medicine called **Caverject**® (alprostadil). The medication is a prostaglandin that also relaxes the smooth muscles of the penile blood vessels. It is injected into the side or base of the penis, and many urologists teach men this procedure because the injection is needed only minutes before sexual activity. Side effects can include prolonged erection, burning, and scarring in the spongy tissue of the penis. More information can be found at www.impotent.com.

Similarly, alprostadil can be also inserted as a pellet into the urethra using the **MUSE** system. Though more convenient, this method may not be as effective. For more details on MUSE, go to www.vivus.com.

A penile prosthesis or implant provides men with an additional option. Surgically placed inside the penis, scrotum, and pubic area, the implant is pumped full of air or fluid from a small external device. There is no loss of sensation or ability to achieve orgasm, and a valve is used to release the erection.

Currently, numerous drugs are in the pipeline for treatment of erectile dysfunction, one of which is **Cialis**® (tadalafil). It apparently works for up to 36 hours.

Cialis is currently available by prescription in Europe and Mexico, and as of publication the drug is under review by the U.S. Food and Drug Administration with a decision expected soon. To learn more, visit www.icos.com.

sexual pleasure comes from new activities and routines."

Dr. Ofman encourages partners to be compassionate and gently inquisitive. "A supportive partner who is interested without placing demands helps women gain acceptance for feeling desirable and capable again."

Hampton's husband, Steve, says, "The hardest part for me was that my wife might become disappointed in herself. I learned to place Debbi's needs before my own and adjusted my expectations."

The need for psychological counseling depends upon the relationship. "Many couples dealing with sexual challenges resulting from cancer don't require sex therapy. It is more an issue of helping couples adjust to altered physical realities," says Dr. Ofman. "Some couples who feel stuck often overcome their problems after a few sessions."

For the Hamptons, the key was talking about sexual intimacy. "Without open communication, our relationship could have been destroyed," says Steve Hampton. Instead, they both affirm personal growth from their sexual challenges.

FOR MORE INFORMATION

Booklets by the American Cancer Society, including *Sexuality and Cancer: For the Woman Who Has Cancer and Her Partner* and *Sexuality and Cancer: For the Man Who Has Cancer and His Partner,* are available free of charge by calling 800-ACS-2345.

Sexuality and Fertility After Cancer by Leslie R. Schover, PhD, discusses sexual challenges after cancer, including the physical and emotional impact for breast cancer survivors. Communication issues are also addressed.