The Psychosexual Care of Women affected by Gynaecological Cancers: A learning resource for healthcare professionals

Module 6: Treatment

Table of contents

6.1. General principles
6.1.1. Evidence & principles for interventions

6.2. Framework for intervention

6.2.1. Levels of intervention & care

6.3. Responding to specific psychosexual sequelae

6.3.1. Managing myths
6.3.2. Managing emotional distress
6.3.3. Managing body image concerns
6.3.4. Managing loss of desire
6.3.5. Managing dyspareunia
6.3.6. Managing vaginal stenosis
6.3.7. Managing vaginal dryness
6.3.8. Managing changes in orgasm
6.3.9. Managing bladder & bowel concerns

6.4. Managing concerns for specific populations

6.4.1. Enhancing sexual intimacy at end of life
6.4.2. Psychosexual challenges for young women
6.4.3. Psychosexual challenges for older women

6.5. Module 6 assessment

6.6. Supporting learning resources

Learning outcomes

- Develop and implement evidence-based psycho-educational programs for women experiencing mild to moderate psychosexual effects from gynaecological cancers and their partners.
- Develop women’s ability to self-manage when responding to the psychosexual sequelae of gynaecological cancers.
- Demonstrate advanced skills in communicating with women and their partners about specific psychosexual sequelae of gynaecological cancers.

Rationale

- To get the best outcomes, treatment needs to be based on the best available evidence and tailored to individual circumstances.
- Strategies to promote self-management can help women and their partners better adjust to the effects of gynaecological cancer and its treatments.
Key concepts

- The principles for choosing interventions, including promoting self-management.
- Evidence-based approaches relevant to specific psychosexual sequelae.
- Evaluating outcomes of psychosexual care interventions.

Activities & examples

Video

- Anna’s story (full)
- Anna’s story part 1: Meet Anna
- Anna’s story part 2: Understanding beliefs
- Norma’s story (full)
- Norma’s story part 1: Meet Norma
- Norma’s story part 2: Overcoming barriers
- Norma’s story part 3: Responding to psychosexual concerns
- Susan’s story (full)
- Susan’s story part 1: Meet Susan
- Susan’s story part 2: Understanding concerns
- Susan’s story part 3: Counselling for psychosexual concerns
- Susan’s story part 4: Advanced disease concerns
- Susan’s story part 5: Responding to psychosexual concerns

Activities

6.1.1 Activity 1: Cochrane review - consider its findings
6.2.1 Activity 2: Reviewing the program’s framework
6.3.1 Activity 3: Myths & misconceptions
6.3.2 Activity 4: Identifying needs & supportive communication
6.3.3 Activity 5: Interventions for body image issues
6.3.4 Activity 6: Interventions for loss of sexual desire
6.3.5 Activity 7: Interventions for managing dyspareunia
6.3.6 Activity 8: Evaluating evidence of dilator use
6.3.7 Activity 9: Implementing the treatment algorithm
6.1. General principles

Health professional responses to psychosexual sequelae of gynaecological cancers need to be based on a comprehensive sexual health assessment.

Responses need to consider a range of factors including:

- the woman and her partner’s individual clinical, social and psychological circumstances
- the woman and her partner’s preferences and wishes
- a critical understanding of available evidence.

Objectives

- Identify general principles for providing psychosexual care for women with gynaecological cancers.
- Review the evidence base for psychosexual interventions for women with gynaecological cancers.
6.1.1. Evidence & principles for interventions

Evidence base for interventions

Three Cochrane reviews have considered sexual dysfunction following cancer treatment. However, the majority of interventions included in these reviews are based on expert opinion or from comparative and case control studies.

The majority of these studies are also drawn from populations other than from the population base of women with gynaecological cancers. For example, interventions for managing vaginal dryness have more commonly been evaluated in a breast cancer population.

With gynaecological cancer, few of the interventions recommended by health care providers are based on highlevel evidence.[1]

Although the empirical evidence is lacking, management principles for women with gynaecological cancers can be drawn from broader sexual therapy literature.[2]

Summary of Cochrane Reviews on Psychosexual Interventions

<table>
<thead>
<tr>
<th>Review 1[3]</th>
<th>Considered interventions for the physical aspects of sexual dysfunction in women following pelvic radiotherapy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Identified 32 studies, although only 4 met the inclusion criteria.</td>
<td></td>
</tr>
<tr>
<td>- The strongest evidence was for using topical oestrogens and benzydamine to help alleviate the symptoms of acute radiation vaginitis. (Level of evidence 1c.)[4][5][6]</td>
<td></td>
</tr>
<tr>
<td>- Vaginal dilators were seen to reduce radiation induced stenosis. (Level of evidence 2c.)[7]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A case series reported there may be a role for hyperbaric oxygen and surgical reconstruction. (Level of evidence 3c.)[8][9][10][11]</td>
</tr>
</tbody>
</table>

Visit: Interventions for the physical aspects of sexual dysfunction in women following pelvic radiotherapy
Considered interventions for sexual dysfunction following treatment for cancer.

- Only one study focused on women with gynaecological cancer. It looked at how effective using vaginal lubricating cream (dienesterol 0.01%) was after radiotherapy for cervical cancer.
- There was some evidence that this cream reduced sexual dysfunction. \[12\]

Visit [Interventions for sexual dysfunction following treatments for cancer](#).

Reviewed interventions to treat or prevent psychosexual problems that can be experienced by women after gynaecological cancer treatment.

The review identified 5 randomised controlled trials of a medical or psychological intervention.

- One trial suggested short-term benefit from one regimen of low-dose brachytherapy over another (this modality is no longer in widespread use).
- A second trial suggested short-term benefit of vaginal dienoesterol cream in women after pelvic radiotherapy.
- Studies of a clinical nurse specialist intervention, psychoeducational group therapy and a couple-coping intervention didn't show statistically significant benefits.

The authors concluded there was no convincing evidence to support the use of any interventions for psychosexual dysfunction in women treated for gynaecological cancer. \[13\]

Visit: [Interventions for psychosexual dysfunction in women treated for gynaecological malignancy (review)](#).

**Principles for intervention**

Sexual dysfunction in women with gynaecological cancer can result from a number of different causes or influences. This means that:

- Treatment often needs to be multimodal, combining interventions specific to the underlying cause or causes of the problem. \[14\]
- Interventions need to be tailored to individual needs, preferences and circumstances. This requires an appreciation of personal and contextual issues.
A comprehensive sexual health assessment is needed to ensure interventions are appropriate for individual women and their partners.

For more information: Module 5

Couples who have previously had difficulties with their sexual relationship may find discussing sexual issues challenging and confronting.

It’s essential to let a woman and her partner explore options that are acceptable to them, their values and their previous activities.

You shouldn’t assume that women who don’t have partners or older women aren’t interested in sexual expression and sexual activity.

For some women, there may be significant concerns relating to resuming sexual activity with a new partner following a gynaecological cancer diagnosis.

Sensitive questions let a woman discuss issues and concerns relating to her sexuality.

References

1. Evidence-Based Practice for Symptom Management in Adults with Cancer: Sexual Dysfunction. Author: Shell, J (2002).


   Churchill Livingstone Elsevier, Edinburgh

3. Interventions for the physical aspects of sexual dysfunction in women following pelvic radiotherapy. Authors: Denton AS, Maher EJ.


   Authors: Pitkin RM, VanVoorhis LW (1971).
5 Use of topical benzydamine in gynaecology (abstract only) Authors: Bentivoglio, G & Diani, F (1981).
   In: Clinical and Experimental Obstetrics & Gynecology, 8(3): 103–110.

6 Topical Benzydamine in the treatment of vaginal radiomucositis
   Authors: Volterrani, F, Tana, S & Trenti, N (1987).

7 Prevention of vaginal stenosis in patients following vaginal
   brachytherapy Authors: Decruze, SB, Guthrie, D & Mangani, R (1999).

8 Hyperbaric oxygen as an adjunctive treatment for delayed radiation
   In: Undersea and Hyperbaric Medicine, 23(4): 205-213.
9 Vaginal reconstruction in the fibrotic pelvis Authors: Hyde, SE & Hacker, NF (1999).

In: Gynecologic Oncology, 77(2): 293-297.

11 The treatment of pelvic soft tissue radiation necrosis with hyperbaric oxygen Authors: Williams, JA, Clarke, D, Dennis, WA, Dennis, EJ & Smith, ST (1992).

In: Cochrane Database of Systematic Reviews, Issue 4.

In: Cochrane Database of Systematic Reviews 2009, Issue 3.

In: Journal of Sexual Medicine, 3: 646-649.

Activities & examples

Activity 1: Cochrane review - consider its findings

1. Look at the most recent Cochrane review by Flynn et al (2009). Interventions for psychosexual dysfunction in women treated for gynaecological malignancy (review) a. Summarise the key recommendations.
   b. List areas needing more research.

2. Explain what specific strategies you can use in your practice to ensure that you provide a tailored approach to psychosexual care for a woman with gynaecological cancer and her partner.
6.2. Framework for intervention

The nature and impact of a woman's psychosexual concerns can vary considerably. Some women experience little or no distress, while others have complex, long-term problems.

Health professional responses to these concerns should reflect the type of needs experienced by the couple.

A range of needs-based frameworks for intervention are described in the literature and in other sections on this website.

Objectives

- Describe strategies for identifying psychosexual care interventions appropriate for a woman's needs.
- Discuss the key elements of universal, extended and specialised psychosexual care.
- Outline the core capabilities needed by health professionals to provide universal, extended and specialised psychosexual care.
6.2.1. Levels of intervention & care

Deciding what interventions to provide for a woman will depend on her needs, as well as your own level of knowledge and skill. The framework for intervention on this page is centred around the needs of experiences of women with gynaecological cancers.

It incorporates three tiers, with each tier representing differing levels of need based on the complexity or severity of the psychosexual concerns experienced by women affected by gynaecological cancers and their partners. Within each tier, the associated health services and interventions that may be required to address these needs and concerns, and the capabilities required of health professionals to address these needs are described.

Deciding whether a woman and her partner’s needs are mild, moderate or severe, and what level of care is required depends a great deal on how the woman herself and her partner describe his or her distress.

However, expressing concerns about sexuality may be difficult for some women and their partners. Health professionals should therefore observe for signs of distress that may not be expressed by the woman herself.

The three levels described in the framework are based on the Tiered Model of Psychosocial Care and include universal, extended and specialist care.\[1\]

Universal care

All women need access to information and support relating to both the actual and potential psychosexual sequelae of cancer.

Modules 1 and 3 contain information that helps health care professionals offer the broadest level of care relevant for all women affected by gynaecological cancers.

For more information: Module 1 | Module 3

Extended care

Women with mild to moderate psychosexual effects from gynaecological cancers may need additional clinical and supportive interventions that help address specific causes.
Many of the interventions described in this module address issues for women experiencing mild to moderate levels of distress. Many health professionals with the appropriate education can use these interventions.

**Specialised care**

Women with gynaecological cancer with severe distress may need additional, specialised support.

Many of the interventions described in this module address issues for women experiencing this level of distress.

Women with this level of distress may also need additional support from health care professionals with expertise in counselling and gynaecological cancer.

**References**

1 Adapted from: Psychosexual service for people adversely affected by cancer and its treatment Author: White, I (2011).

In: Asia-Pacific Journal of Oncology, 6(S3): 231
Activities & examples

Activity 2: Reviewing the program's framework

1. Review the framework developed for this program.
   a. Identify the types of needs experienced by women at the different levels and the types of interventions relevant to these needs.
   b. Identify the services that may be appropriate for each level of need.
   c. Identify which level of service / intervention you can provide.

6.3. Responding to specific psychosexual sequelae

A range of psychosexual sequelae is described in this module.

These sequelae can be psychological or social in origin, such as fears, distress and needing information.

They can also result from complex anatomical and physiological changes.

There are general principles of care that may apply to all women. However, the various aetiologies and contributing factors for specific sequelae means different interventions may be needed to address problems.

Objectives

• Identify interventions appropriate for specific psychosexual concerns.
• Discuss the evidence that underpins interventions for providing psychosexual care interventions.
6.3.1. Managing myths

Identifying a woman's misconceptions about her disease and its treatment is critical.

These misconceptions may create barriers to manage the symptoms of treatment side-effects, which may affect a woman's quality of life. [1]

To deal with misconceptions, consider the following:

- Talk with her to get an insight into her level of understanding of her cancer and its potential consequences.

These conversations need to be treated with a high level of sensitivity to help her feel comfortable giving you the information.

- Give her factual information to counter specific misconceptions. This will help her develop accurate expectations. [2]
- Give her information that specifically targets common misconceptions. These misconceptions include:
  - in a monogamous relationship, an HPV diagnosis means someone has cheated
  - resuming sexual intercourse will trigger a recurrence of cancer
  - a sexual partner can be exposed to radiation within a previously irradiated vagina
  - a sexual partner can catch cancer during sexual intercourse.

For more examples of common myths and misconceptions:

Module 1: Myths about sexuality

- Give her information targeting common misconceptions about managing symptoms, such as pain.

This may help her:

- feel more comfortable about taking pain medication
- feel less concerned about addiction
- become better able to communicate openly about pain with her health care professional. [2]
References

1. Psychosocial interventions and quality of life in gynaecological cancer patients: A systematic review
In: Psycho-Oncology, 18(8): 795-810.

2. United we stand? The effects of a couple-coping intervention on adjustment to early stage breast or gynecological cancer

Activities & examples

Activity 3: Myths & misconceptions

Watch the case study, then answer the related questions in this activity.

Meet Anna

Watch the video - Anna

1. List the myths and misconceptions Anna has. How would you address these with her.

6.3.2. Managing emotional distress

There is a range of sources of distress for women with gynaecological cancers.

4.3. Psychological factors contributing to psychosexual sequelae

To manage emotional distress associated with psychosexual sequelae of gynaecological cancer, the first step is to identify the source of distress.

Addressing information needs in relation to all aspects of the disease, treatment and prognosis will be important for reducing emotional distress. To address information needs relating to psychosexual concerns, depending on the woman's clinical and personal circumstances, she may want information relating to:
• female reproductive anatomy and function
• the range of vaginal lubricants available
• how to use vaginal dilators and vibrators.

A recent Cochrane review of 5 studies found no convincing evidence to support using any psychosocial interventions for psychosexual dysfunction in women treated for gynaecological malignancy. [1] However, the quality of studies reviewed was limited.

A more recent literature review of psychological interventions for the sexual sequelae of cancer similarly identified 27 empirical studies, with only 19 of these involving randomised controlled trials. [2]

This latter review suggested moderate support for the effectiveness and feasibility of psychological interventions for sexual dysfunction after cancer. [2]

Depending on the source of distress, consider the following interventions:

• providing information
• offering supportive communication and counselling
  - reducing specific fears and anxieties.

Some women may need more specialised counselling and therapeutic intervention.

**Offering information to a woman & her partner**

Communication between a woman and a health care professional is vital. It can positively affect a woman’s anxiety levels and her ability to resume sexual relationships.

For more information on developing supportive communication strategies: Module 3

Giving a woman information and addressing any specific fears and concerns about cancer and sexuality may improve her mood and reduce her fears. [3] [4]

Giving a woman information before her treatment, when anxiety is typically at its highest, can have positive results. [5]
Offering support to a woman & her partner

Supporting individual and couple-coping strategies may alleviate a woman's distress. [6] [7] [8]

Developing coping strategies can help women take a more active role in solving the daily problems they face.

Effective techniques may include:

- Progressive muscle relaxation and deep breathing techniques. This may alleviate physical tension that often comes with anxiety and promote mental calmness.
- Imagining personally pleasing images in great detail and challenging negative, unhelpful thoughts. These effective techniques help reduce anxiety and promote a positive outlook.
- A range of specific counselling techniques, including mindfulness based techniques and/or cognitive behavioural techniques. These may also be helpful for women needing additional support.

A woman who does not have a current partner may also need support to address concerns about establishing new relationships in the future.

Ensuring that women and their partners have access to emotional support may reduce patient distress. [7]

Partners are essential in offering emotional support. However, it's important to recognise that a partner's individual response to stress will interact with the woman's. [9]

This means couples are coping with the stress together. [10] Strategies may include:

- Promote communication that conveys a shared view of the stress as ‘our problem’. A communal approach to coping is critical to a couple's coping. [11]
- Educate couples in supportive communication. [12] This involves:
  - teaching couples to validate and empathise with each other's thoughts and feelings
  - identifying behaviours they can do, or say, to help each other cope
  - helping each other recognise and challenge negative thoughts about stressful cancerrelated situations and practice more helpful thoughts.
• The ‘sensate focus technique’ is an effective behavioural program designed to help couples overcome sex performance anxiety. 

The technique calls on a couple to complete homework assignments that involve structured touching. With this technique, each partner is asked to give or receive pleasure without having intercourse.

For a more detailed description of sensate focus exercises: 6.3.3. Managing body image concerns

• Support groups may also help, as they give women the opportunity to establish relationships with others who can greater empathise with the woman's own (sexual) experiences and who can normalise the woman's feelings. 

Groups with former cancer patients offer examples of cancer survival. Combining these factors can improve general well-being and / or reduced anxiety levels.

Managing fears of resuming sexual intercourse

It's common for women to be anxious about becoming sexually active after treatment for any pelvic cancer.

Some women may avoid sexual activity due to fears that their partner may reject their new (cancer-altered) body.

Some partners may be reluctant to engage in sexual activity, because they're afraid they'll cause pain. This can be misinterpreted by the woman as a lack of interest by the partner.

Some women may fear their partner will leave them if they are not sexual with their partner. They may choose to endure physical pain through intercourse to rescue / keep the relationship.

Specific suggestions described under 'body image concerns' will be helpful in managing fears of resuming sexual intercourse. 6.3.3. Managing body image concerns

References

Interventions for psychosexual dysfunction in women treated for gynaecological malignancy (review) Authors: Flynn, P, Kew, F & Kisely, SR (2009).
In: J Cancer Surviv, 4: 346-360.

3 Sexual rehabilitation for women with gynecological cancer: information is not sufficient Authors: Robinson, JW, Scott, CB, Faris, PD (1994).
In: Can J Hum Sex, 3: 131-142.

4 Psychoeducational group increases vaginal dilation for younger women and reduces sexual fears for women of all ages with gynecological carcinoma treated with radiotherapy Authors: Robinson, JW, Faris, PD & Scott, CB (1999).
In: International Journal of Radiation Oncology, Biology, Physics, 44(3): 497-506.

5 A quantitative approach to the distress caused by symptoms in patients treated with radical radiotherapy Authors: Munro, AJ & Potter, S (1996).

In: Psycho-Oncology, 16(11): 971-979.

In: J Clin Nurs, 10(2): 221-229.

8 United we stand? The effects of a couple-coping intervention on adjustment to early stage breast or gynecological cancer Authors: Scott, JL, Halford, WK & Ward, BG (2004).

9 Changes in coping with chronic stress. The role of caregivers' appraisals of coping efficacy Authors: Gignac, MAM & Gottlieb, BH (1997).
Editors: Gottlieb, BH.
In: Coping with chronic stress (pp. 245-267).
11 **Coping as a communal process**


12 **United we stand? The effects of a couple-coping intervention on adjustment to early stage breast or gynecological cancer**


13 **Human sexual inadequacy**

In: Boston: Little, Brown.

14 **Sex and relationships**

Author: Spence, SH (1997).
Editors: Halford, WK & Markman HJ.
In: Clinical handbook of marriage and couples interventions (pp. 73-105).
From: Chichester, NY: Wiley.

15 **One-to-one volunteer support programs for people with cancer: a review of the literature**


---

**Activities & examples**

**Activity 4: Identifying needs & supportive communication**

1. Describe how you'd assess the information needs of a woman with psychosexual effects of gynaecological cancer.
2. Make a list of the key principles of supportive communication when interacting with a woman with psychosexual effects of gynaecological cancer.

3. Jennifer is a 42-year-old woman who's divorced. She's recently undergone a radical hysterectomy for cervical cancer. Since she was diagnosed, she has met a new partner. Consider her information and support needs relating to her fears about resuming sexual activity with her new partner.

6.3.3. Managing body image concerns

Women with gynaecological cancer can experience a range of body image concerns.

4.3.5. Altered body image

Some women report feeling 'less feminine' after their reproductive organs have been removed. [1] Other women may feel uncomfortable being naked, either alone or with a partner.

These feelings can contribute to difficulties with sexual relationships.

Health care professionals can help reduce these effects through a range of supportive communication and counselling strategies. They can also provide advice on ways the woman can enhance a positive perception of herself and her body as a source of pleasure.

It's recommended women discuss their fears about their body image with the person they relate to the most (for example, their partner). [2]

Evidence suggests that supportive communication between couples improves the way they see themselves sexually and their perceptions of how their partners see them. [3]

Some interventions to address body image concerns can be delivered by all health professionals. For example, encouraging women to experience their body as a source of pleasure is another important step in the healing process.

For example:

• A manicure or pedicure is non-threatening to most women and can help her relearn that touch can be pleasurable.
• Spending time in a warm bath with soft music playing can help the woman learn from her own touch what feels pleasurable to her. (Use hypoallergenic bath products and lotions to avoid irritation or allergic reactions.)

• A therapeutic massage by a trained therapist may be helpful when the woman feels ready for another person to touch her.

The sensate focus technique

The sensate focus technique is a way to reintroduce intimacy into the relationship and potentially improve a woman’s body image. [4] [5] [6]

SENSATE FOCUS EXERCISES

Adapted from: My body myself: Body image and sexuality in women with cancer (Katz, 2009)

These exercises can help increase communication and closeness between two people when touch is either painful or unpleasurable. They can be performed with a partner (when available) or alone.

In these exercises, partners take turns touching each other following the steps described below.

In the following descriptions, it’s assumed the one doing the touching is a man and the one being touched is a woman. However, homosexual couples can also do these exercises.

Basic rules before starting

1. Decide who’ll be the first giver.
2. Establish whether clothing will be worn. This is optional and many women prefer to remain clothed. Until they’re comfortable, women may find that it helps to wear a camisole or other nightwear to bed to conceal a surgical scar.
3. Find a location that’s comfortable for both people, preferably not the bed.
4. Lights may be dimmed and soft music can be played.
5. The use of pillows or a comforter can increase comfort.
6. Baby oil, lotions or powder can be used.
7. The woman needs to communicate what feels good and what doesn’t feel good.
The couple should begin with facial caressing. The giver usually sits and the receiver lies flat on her back with her head resting on the partner's thighs.

With the hands well lubricated, the giver begins by stroking the chin, then the cheeks, the forehead, and temples.

It's then time for the couple to reverse roles, with the woman touching her partner's face.

After this, each person tenderly massages the rest of their partner's body. The roles should be reversed periodically.

**Divide the exercises into 4 progressive stages.** Each stage should be done in order before moving to the next. All stages should be repeated each time the couple performs these exercises.

**First stage:** Limit touching and stroking to the areas of the body that are not sexually stimulating. Breasts and genitals shouldn't be touched.

**Second stage:** The entire body including breasts and genitals can be touched without intent to cause arousal (erection or vaginal lubrication).

**Third stage:** The prior stages are repeated. Both the penis and clitoris are stroked and the vaginal opening can be gently probed with a finger.

**Fourth stage:** The first 3 stages are repeated. Using a lubricant can be helpful, especially for the woman's genitals. When the man's erection is firm enough to attempt penetration, the couple may want to insert the penis into the vagina.

For more information: 6.3.2. Managing emotional distress

**Developing a positive list for reference**

Women should develop a list of likeable qualities about themselves that help reinforce and maintain a positive body image.

1. Women begin by writing a list of 5 qualities they believe significant others probably like about them (for example, they're funny, devoted, thoughtful).
2. Add to that 5 more qualities they personally like about themselves.
3. Next, list 5 physical features they like about themselves and why.
4. Follow this by 5 things they are grateful for.
5. Finally, list 5 personal achievements they are proud of.

Women should keep the list close by and read it often. [7]

Cognitive Behavioural Therapy

Some evidence suggests that Cognitive Behavioural Therapy (CBT) benefits patients' body image, at least in the short-term. [8] [9]

Particularly useful techniques include:

- challenging negative thoughts related to body image
- keeping a thought diary to heighten awareness of any maladaptive thought patterns.

Delivering CBT requires specialised training. Referral should be considered to psychologists or other health professionals including general practitioners with skills in these techniques.

Support groups

Support groups also offer women the opportunity to discuss their experience and fears about their body image.

The exposure to different perspectives on what constitutes 'beauty' lets women be comfortable with their own body image.

Discussing what 'beauty' means with friends and family may also help this process.

The structure, processes and effectiveness of support groups vary considerably. Consideration should be given to ensuring support groups are conducted according to recommended guidelines, such as through the relevant state and territory Cancer Councils.

For more information:

Cancer Council Australia: patient support
References

1. Post-treatment sexual adjustment following cervical and endometrial cancer: A qualitative insight

2. From Australian Gynaecological Cancer Foundation
A randomized trial of the effect of training in relaxation and guided imagery techniques in improving psychological and quality-of-life indices for gynecologic and breast brachytherapy patients
In: Psycho-Oncology, 16(11): 971-979.

3. Human sexual inadequacy
In: Boston: Little, Brown.

4. Sex and relationships
Author: Spence, SH (1997).
Editors: Halford, WK & Markman, HJ.
In: Clinical handbook of marriage and couples interventions (pp. 73-105).
From: Chichester, NY: Wiley.

5. A randomized trial of the effect of training in relaxation and guided imagery techniques in improving psychological and quality-of-life indices for gynecologic and breast brachytherapy patients
In: Psycho-Oncology, 16(11): 971-979.

6. Australian Gynaecological Cancer Foundation
Psychosocial rehabilitation of gynecologic oncology patients
Authors:

9. Psychotherapy in patients cured of gynecological cancers

Activities & examples

Activity 5: Interventions for body image issues

1. Consider a woman you’ve cared for who’s experienced body image issues as a result of her cancer and treatment. Describe the interventions you could use to address her concerns.

2. A woman has asked for your advice about finding a support group to help her deal with her feelings about how the cancer has affected her.
   a. Identify factors you would consider in referring a woman to a support group.
   b. Identify support groups in your local area that might be suitable for such a referral.

6.3.4. Managing loss of desire

Loss of desire can occur for many reasons. It’s important to base your interventions on a comprehensive sexual health assessment, to ensure they are relevant to individual circumstances. 4.1.3. Altered sexual desire

Loss of desire can be a frustrating experience for many couples. The couple may mourn this change and for some, it may mean the end of their usual sexual relationship. [1]

This may be especially challenging for older women and their partners who may not consider or desire alternatives to vaginal intercourse. Older women often appreciate information and education about sexuality. This is because for many, the information wasn’t available when they were younger.

Encouraging extended foreplay helps ensure sufficient arousal.

Encouraging intimacy can make women feel less anxious about penetrative sex.

Suggestions of intimacy include:

- going on dates
• massage
• showering or bathing together.

Conditions that aid sexual pleasure should be explored.

These can include:

• relaxation
• dreams
• fantasies
• deep breathing
• recalling positive experiences with the partner.

Although the woman may not feel spontaneous desire, if she's receptive to her partner touching and kissing her, she may experience feelings of arousal.

This is even when sexual activity is the last thing on her mind and assumes it all happens when time, place and mood are right.

Sensate focus exercises involve non-coital pleasuring based on principles of sensuous massage.

For a more detailed description of sensate focus exercises:

6.3.3. Managing body image concerns

The exercises let couples experience sexual expression and be physically close and intimate without the pressure and anxiety sometimes involved with anticipating intercourse.

It's important to alleviate symptoms that decrease sexual interest and desire. Medications that are known to have an adverse effect on desire should be changed if possible. [2] [3]

References


Activities & examples

Activity 6: Interventions for loss of sexual desire

1. Make a list of interventions you can use in your health care setting to help women with gynaecological cancer who are experiencing a loss of sexual desire.

6.3.5. Managing dyspareunia

Psychoeducational interventions

Dyspareunia can occur for many reasons. It's important to base your interventions on a comprehensive sexual health assessment, to ensure they are relevant to individual circumstances.

4.1.1. Dyspareunia

Many of the interventions described for managing loss of desire are relevant for women experiencing dyspareunia. This is because dyspareunia is often linked with loss of desire.

For example, encouraging intimacy can make women feel less anxious about penetrative sex and reduce tension in pelvic floor muscles.

For more information: 6.3.4. Managing loss of desire

If the woman finds intercourse painful, some couples may be willing to find alternative ways to bring each other to orgasm and express sexual intimacy.
This includes hugging and kissing, mutual masterbation or ‘outercourse’. (‘Outercourse’ is where the man puts his erect penis between the lubricated thighs of his partner and thrusts.)

Sensitive discussion about the woman and her partner’s sexual repertoire lets health care professionals decide whether to offer information on vaginal intercourse alternatives. These alternatives can include vibrators and oral and / or anal sex.

Supportive treatments

Encourage the use of vaginal lubricants and moisturisers.

For more information: 6.3.7. Managing vaginal dryness

Consider the use of vaginal dilators to prevent vaginal stenosis when it’s consistent with current evidence.

For more information: 6.3.6. Managing vaginal stenosis

Women who’ve had radiation therapy may feel an unpleasant stinging sensation when their partner ejaculates on the irradiated vaginal tissues. Condom use prevents this.

Physical interventions

Pelvic floor exercises increase control of tense pubococcygeus (pelvic floor) muscles and increase blood flow and lubrication to the vagina. [1]

PELVIC FLOOR MUSCLE (PFM) RELAXATION EXERCISES

Muscles in your body can tense or spasm when you experience pain or anticipate that something will be painful, such as inserting a vaginal dilator or having intercourse.

This can cause your PFMs to ‘switch on’ and contract tightly as a protective response.

There are a number of strategies that help keep the pelvic floor muscles relaxed.
Keeping pelvic floor muscles relaxed

- **Jaw relaxation**: Jaw clenching can also make a person clench their PFM. A person needs to keep their mouth open when inserting dilators. This means their PFM are more inclined to open.

- **Hand relaxation**: If the person’s hands grip the examination table, bed, or their partner, their PFM may also grip closed. The person’s hands need to be soft and relaxed so that their PFM are soft and relaxed.

- **Breathing freely**: When a person holds their breath their diaphragm will be rigid and so will their PFM. To help the PFM relax, the person should try exhaling with a wide opened mouth and sighing ‘haaaa’.

- **Staged insertion**: Anything going into the vagina should go in slowly in stages, approximately 1 cm at a time and coinciding with each breath out (that is, with the person letting go of their PFM).

If this is still difficult, the PFM contract-hold-relax exercises may also be used for staged penetration / dilation.

**The PFM relaxation exercises**

These exercises don’t strengthen the PFMs, they teach people how to relax them.

- **C = Contract** as if stopping the flow when urinating.
  Do a medium squeeze.

- **H = Hold**.
  Even hold for 10 seconds.

- **R = Relax**.
  Let the PFM release, fully feeling the relief of letting go.

Contract-Hold-Relax.
The person should try letting go / relaxing a little further each repetition.

**Changing positions**

Certain positions are more comfortable than others.

The woman on top, or the woman and her partner in a side-by-side position can help.
If the woman is on top rather than in the missionary position, she has control over both the depth of penetration and the rate of thrusting.

## Multi-step approach to managing dyspareunia

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Talk with a health professional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The woman should discuss with a health professional:</td>
</tr>
<tr>
<td></td>
<td>• her fears and concerns about penetrative intercourse - it may be helpful for her to draw a diagram to show how she perceives her vagina</td>
</tr>
<tr>
<td></td>
<td>• desires and fantasies about sexual activity</td>
</tr>
<tr>
<td></td>
<td>• desires and fantasies with her partner about sexual activity, including the enjoyable aspects of sexual life before being diagnosed with cancer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2</th>
<th>Vaginal stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The woman inserts her own fingers into her vagina, using lubrication. She should start with the little finger and increase to larger fingers when it's comfortable to do so. (This also allows the woman to be aware of the changes that have occurred following treatment.)</td>
</tr>
<tr>
<td></td>
<td>The woman’s partner then inserts his fingers, again using lubrication and starting with the smallest finger first.</td>
</tr>
<tr>
<td></td>
<td>Then, the woman can insert well lubricated dilators or vibrator. She should start with the smallest dilator or vibrator first. She can then gradually increase the size of the dilator as her confidence increases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3</th>
<th>Penile containment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The woman’s partner inserts his erect penis into her vagina but does not thrust.</td>
</tr>
</tbody>
</table>

| Step 4 | Penetrative intercourse |
References

Can stronger pelvic muscle floor improve sexual function?

Authors: Lowenstein, L, Gruenwald, I, Gartman, I & Yardi, Y (2010).
In: Int Urogyn J Pelvic Floor Dysfunction, 21(5): 553-556.

Activities & examples

Activity 7: Interventions for managing dyspareunia

1. Describe the scope, role, indications and contraindications for each of the following interventions for managing dyspareunia:

   a. psychoeducational interventions
   b. supportive treatments
   c. physical interventions.

6.3.6. Managing vaginal stenosis

Vaginal stenosis is a common problem experienced by women undergoing pelvic radiotherapy, and women who have undergone some surgeries for gynaecological cancer.

Evidence on prevention and management strategies is controversial. This has led to a number of significant variations in practice across health care settings.

Using vaginal dilators - evidence

Some evidence suggests using vaginal dilators to prevent vaginal stenosis.\(^1\) The rationale proposed for using a dilator is that it:

- may assist with enabling sexual relations to continue or recommence post treatment
• may reduce the incidence of discomfort or painful intercourse
• may reduce potential difficulties with future partners if not in a sexually active relationship at the time of treatment
• allows the medical team to accurately examine and assess the vaginal vault or cervix as part of ongoing medical follow up, care and support
• offers the opportunity to discuss sexual fears / myths associated with pelvic radiotherapy.

Vaginal dilators may also help women as they learn to control tension and relaxation in their pelvic floor muscles. [2]

However, the consensus is that more research is needed before health care professionals can give women definitive guidance. [3]

Dilation may separate the adhesions formed by the denuded epithelium, thus possibly preventing stenosis. [4] It’s also possible that interfering with the vagina during the inflammatory phase of radiation treatment may:

• cause additional scarring
• promote additional damage, both physically and psychologically. [4]

The latest Cochrane review of studies into dilator use advises against using dilators during treatment. This is because of the lack of strong evidence for using the treatment. [5]

New Guidelines:

Using vaginal dilators - Australian practice

Evidence to support the use of vaginal dilators is equivocal. However, dilator use following pelvic radiation treatment is commonly recommended in Australia. There’s also wide variation in clinical practice and the information given to women on the subject. [6] [7] [8]
It is important for health professionals to consider the advantages and possible risks highlighted in the evidence reviews described above. Where a decision to use dilators is recommended, some of the following points are commonly recommended by experts in the field:

**When to use a dilator**

- Most commonly recommended for women undergoing radiotherapy.
- Women with gynaecological cancer whose vaginal depth or caliber has been reduced by surgery may benefit from using dilators.
- It’s unknown whether dilators can help postmenopausal women regain elasticity of the vagina. However, using dilators may give women confidence that they can have an object inserted into their vagina, including a speculum, without pain. [2]

**Timing dilator use**

There’s no clear evidence on the best time to start vaginal dilatation.

Some cancer centres encourage women to use dilators during treatment, but most centres advise women to start using dilators following their treatment.

Until there’s more research on dilator use, it’s common for health care professionals to advise women to use dilators after radiation treatment for an indefinite period and provide them with the rationale for dilator use. [6] [8]

**How to use a dilator**

For women who decide to use a dilator, the following is current best practice:[1]

The minimum a woman should use a dilator is 3 times per week for an indefinite period of time.

Dilators can be combined with sexual intercourse for frequent vaginal dilation. Tell the woman to find a private and comfortable place where she can relax and use the dilator.

She can use the dilator in the shower or bath if this offers her some privacy and / or relaxes her pelvic floor muscles. This will let her use the dilator more successfully. If applicable, encourage the woman to involve her partner.
• Before it’s inserted, a water-soluble lubricant should be rubbed on the dilator and around the entrance to the vagina.

• There are various positions the dilator can be used in. Advise the woman to either:
  • lie down on her back with knees slightly apart and bent
  • or, stand with a leg raised on the side of the bed or bath to insert the dilator.

• Inserting the dilator into the vagina requires a firm, gentle pressure. Advise the woman to insert the dilator as deeply as is comfortable, without forcing it.

• Once the dilator is inside the vagina it should be moved in a forward and backward motion, then a left to right motion. If possible, the dilator should be gently rotated using the handle.

• There’s a range of dilator sizes that can be used depending on the woman’s needs. It’s usual for a woman to start with the smallest size and move to the largest size in the days / weeks following treatment - depending on what’s comfortable.

• If the woman has manual dexterity problems or other physical restrictions, health care professionals should tailor dilator information to her needs. For instance, she may find it difficult to rotate the dilator.

• The woman should use the dilator for 5-10 minutes each time.

• The woman should be encouraged to use pelvic floor exercises when inserting the dilator.

• The dilator should be removed slowly and be rotated in a clockwise / anti-clockwise movement when being removed.

• Vibrator use may also be combined with dilator use.

• Slight vaginal blood loss is not uncommon when using dilators. If the woman experiences heavy vaginal blood loss, or pain, then she should seek advice and on-going follow-up and support from the appropriate health care professional providing care.

• Douching isn’t usually advised as a part of dilator treatment.

**Adhering to dilator use - the strategies**

A range of factors may influence a woman’s willingness to use a dilator.

These include:

• uncertainty about use
• negative experiences
• lack of time
• inability to find privacy
• association with sex aids.
To encourage the woman to follow advice on using a dilator, follow this guidance:

- Discuss stenosis and dilators before her treatment.
- When providing the woman with the dilator, talk to her about using it and give her written material on the subject. To avoid information overload, this should be done in a separate nurse-led consultation.
- Use ongoing examinations to monitor and encourage dilator use.
- Help the woman plan how to incorporate dilator use into her normal weekly routine.

References

1. **Best practice guidelines on the use of vaginal dilators in women**
   
   receiving pelvic radiotherapy  
   Author: National Forum of Gynaecological Oncology Nurses  
   (2005).  
   From: Owen Mumford.

2. **Simple strategies for vaginal health promotion in cancer survivors**  
   Authors: Carter, J, Goldfrank, D & Schover, LR (2010).  
   In: J Sex Med, 8(2): 549-559.

3. **Interventions for the physical aspects of sexual dysfunction in women following pelvic radiotherapy**  
   Authors: Denton, AS & Maher, EJ (2003).  
   In: Cochrane Database of Systematic Reviews, Issue 1.

4. **Sexuality in cancer and palliative care 1: Effects of disease and treatment**  
   Author: Rice, A. (2000).  

5. **Vaginal dilator therapy for women receiving pelvic radiotherapy**  
   Authors: Miles, T & Johnson, N (2010).  
   In: Cochrane Database of Systematic Reviews, Issue 9.

6. **Preventing vaginal stenosis after brachytherapy for gynaecological cancer: an overview of Australian practices**  
   Authors: Lancaster, L (2004).  

7. **Delivering sensitive healthcare information: challenging the taboo of women’s sexual health after pelvic radiotherapy**  
   Authors: Faithfull, S & White, I (2008).  
In: Int J Gynecol Cancer, 16: 1140-1146.

9 Turning a chore into a priority: barriers and facilitators affecting vaginal dilator use after radiation therapy for gynaecological cancer
Poster presented at COSA ASM Melbourne. 2010

Activities & examples

Activity 8: Evaluating evidence of dilator use

1. Review the reference here and answer the questions in this activity.

Vaginal dilator therapy for women receiving pelvic radiotherapy Author: Miles and Johnson In: Cochrane Review, 2010.

Critically evaluate the available evidence by answering the following questions.

• Is there enough evidence to support dilators use?
• Is there enough evidence to reject dilators use?
• Is the conclusion by the authors that ‘routine dilation during or soon after cancer treatment may be harmful’ based on empirical evidence?

2. After reading the above review, identify how and when you would present information about dilator use to a woman.

6.3.7. Managing vaginal dryness

The most effective solution for vaginal dryness is to use a product that adds moisture to the vaginal tissue.

Evidence suggests vaginal moisturisers and lubricants can increase vaginal moisture, vaginal fluid volume, vaginal elasticity and a return to premenopausal pH. [1] [2]
Lubricant can benefit some women by preventing pain in tender, dry vulval areas (at least in the short term after cancer treatment). [3] There are 3 types of products for improving vaginal moisture. All are applied directly into the vagina and may be used concurrently. [4]

**Treatment algorithm for promoting vaginal health in cancer survivors**

![Treatment algorithm](image)

Figure 2: Treatment algorithm for vaginal health promotion in cancer survivors (adapted from Carter et al 2010).

[5]

**Non-hormonal vaginal moisturisers**

Non-hormonal vaginal moisturisers may provide relief from the uncomfortable symptoms of vaginal dryness.

These products come in a semi-liquid form and are usually applied 2 or 3 times per week. They're available from most pharmacies and can be bought online. [4]
Vaginal lubricants

Vaginal lubricants can provide lubrication to enhance the comfort and ease associated with sexual intercourse.

These products come as 'semi-gel' creams. They're also available from pharmacies and can be purchased online. [4]

Some products are not recommended as they have a high water content and dry quickly.

Silicon-based lubricants have significantly longer drying times. Women should be encouraged to try a range of different lubricants until they find the one that works best for them.

Vaginal oestrogens

Vaginal oestrogens are creams or pessaries containing low doses of the hormone oestrogen.

They're designed to help retain vaginal elasticity and replace moisture.

They’re used about twice a week, although they're usually used more intensively when commencing therapy.

Topical oestrogens available in Australia include creams and pessaries. None has been shown to be better than any other.[6]

A study comparing tablets with vaginal cream found both to be equivalent in relieving symptoms of atrophic vaginitis.

This study also found that women rated vaginal tablets more favorably than vaginal cream. [7]

When vaginal oestrogens are used, small amounts of oestrogen may be absorbed into the body.

The long-term safety of the use of vaginal oestrogens by women who should avoid oestrogens hasn't been determined.

The use of vaginal oestrogens for women who have potentially hormone sensitive cancers should be discussed with a specialist in Gynaecology.[8] The safety of topical oestrogen has not been established in women with a past history of breast cancer.[9][10][11]
Oil-based lubricants

Oil based lubricants shouldn’t be recommended during or immediately following treatment, because they can activate Candida infection in an irradiated area. [12]

Other products

Recommendations include:

- avoiding substances that can irritate or dry the vaginal region, such as soap, or products containing alcohol or perfume
- using a soap-free product such as aqueous cream to wash the vaginal area. Products containing petroleum jelly and baby oil can also cause irritation [4]
- wearing cotton underwear and avoiding nylon underwear, tight underwear and tight clothing. [4][13]

References

1 Comparative study: Replens versus local estrogen in menopausal women Author: Nachtigall, LE (1994).

2 Treating vaginal dryness in breast cancer patients: results of applying a polycarbophil moisturizing gel Authors: Gelfand, MM & Wendman, E (1994).


4 Vaginal dryness
Accessed 21/11/10 National Breast and Ovarian Cancer Centre (NBOCC)

5 Simple strategies for vaginal health promotion in cancer survivors
Authors: Carter, J, Goldfrank D & Schover, LR (2010).
In: J Sex Med, 8(2): 549-559.

In: Cochrane Database Systematic Reviews. 17beta-estradiol vaginal tablet versus conjugated equine estrogen vaginal cream to relieve menopausal atrophic vaginitis


Treatment of Sexual Problems in People with Cancer
National Cancer Institute (NCI)

Practical clinical guidelines for assessing and managing menopausal symptoms after breast cancer
Authors: Hickey, M (2008).

Vaginal Atrophy after Breast Cancer Australian Menopause Society.

Vaginal oestrogen therapy after breast cancer: Is it safe?

Intimacy and sexuality for the woman with breast cancer
Author: Hordern, A (2000).
In: Cancer Nursing, 23(3): 230-236.

Breast cancer and early menopause - a guide for younger women
Accessed 21/11/10 National Breast and Ovarian Cancer Centre (NBOCC)

Activities & examples

Activity 9: Implementing the treatment algorithm

1. Discuss how you could implement the treatment algorithm in this section in your clinical setting.
6.3.8. Managing changes in orgasm

Treatment for gynaecological cancer can result in changes in ability to reach orgasm.

4.1.4. Changes in ability to reach orgasm

Changes in all aspects of the sexual response cycle should be expected after multi-modality treatment for gynaecological cancer.

It’s not unusual for women to experience changes in the frequency and quality of their orgasm. [1]

After surgery for vulval cancer, loss of fatty tissue on the mons pubis and absence of the labia contribute to altered, absent or painful sensations.

Women who require removal of the clitoris as part of their treatment may lose the ability to orgasm.

Reduced sensation may be ameliorated by the use of vibrators, clitoral devices [2] and lubricants which produce a sensation of warmth, such as KY Warming Jelly®, on the vulval tissues.

Orgasm may be possible even for women who have undergone a clitoridectomy by stimulating the residual nerve endings in the clitoral bed.

For women distressed by an inability to orgasm after gynaecological cancer treatment, refer them to a sexual therapist for ‘orgasm retraining’. This can help them develop alternative areas of the body as erogenous zones.


In: Oncology Nursing Society, Pittsburgh.

2. Clitoral therapy device for treatment of sexual dysfunction in irradiated cervical cancer patients


Activities & examples

Activity 10: Identifying referral points

1. List specialist services that you may refer a woman to if she is distressed by changes in orgasm as a result of gynaecological cancer.
6.3.9. Managing bladder & bowel concerns

Gynaecological cancer and its treatment can lead to a range of bowel or bladder disturbances.\(^1\)\(^2\)\(^3\)\(^4\)

4.2.5. Bladder & bowel dysfunction

Promoting urinary & bowel control

- Empty the bladder just before sex.
- Try having sex in the shower or bath where any urine loss will be unnoticed (water can promote vaginal dryness, so a lubricant may be needed immediately before penetration).
- Try having intercourse in a side-lying or woman-on-top position to help control the depth of thrusting that can stimulate the bladder.
- If vaginal penetration causes bladder spasm or triggers incontinence, ‘outercourse’ may be preferred. Outercourse is any method of sexual stimulation that doesn’t involve vaginal penetration.
- Refer to a physiotherapist or continence specialist if problems are persistent.

Urinary tract infections (UTIs)

- Some women experience UTIs after penetrative intercourse. The effect on the urinary tract caused by pelvic radiation and lack of oestrogen after menopause can predispose the woman to urinary tract infections. The friction of penetration from vaginal intercourse can increase irritation, because the urethra is close to the vagina. Urinating immediately after sex will reduce the likelihood of this happening. Changes to the vaginal pH caused by oestrogen deficiency can activate UTIs.\(^5\) If the result is a painful infection, the woman may lose interest sex.
- Most common practice in Australia for urogenitary symptoms is application of vaginal cream around the urethral opening.\(^6\)

Stoma

- When engaging in sexual activity, the woman should ensure that the bag is empty and the seal is intact.
- Avoiding foods and drinks that cause gas or odour can help prevent leakage or inflation of the bag.
• Mini bags are available as are opaque bag covers. A smaller, closed pouch reduces the risk of leakage and is less bulky than the usual pouches.

• Using a belt or cummerbund will help stabilise the appliance.

• Some women find that wearing crotchless underwear conceals the stoma and appliance and lets them access their genitalia. Teddies and peignoirs can also help. However, a comfortable t-shirt serves the same purpose.

• Using alternative sexual positions may also help reduce discomfort and anxiety. The woman-on-top position prevents pressure on the stoma or pouch. The side-lying position on the side of the stoma allows the pouch to fall away and thus not come between the partners.

• Sexual difficulties in a woman with a stoma is often associated with concerns about body image or other sources of psychological distress. In addition to support and education, consider referring the woman and her partner for specialist sexual counselling.

References

1 Living with Bowel Problems following radiotherapy - A scoping study. Author: Wilson, J (2006).
Commissioned by: NACC - The National Association for Colitis and Crohn's Disease.


In: Cochrane Database of Systematic Reviews, Issue 4.

Activities & examples

Activity 11: Identifying strategies to ease concerns

1. Make a list of recommended strategies you would give to a woman who has concerns about the effects on sexual activity of the following:
   a. urinary incontinence
   b. stoma.

6.4. Managing concerns for specific populations

When addressing sexuality in women with gynaecological cancer, it’s important to remember that the circumstances of each woman may change:

• her experience of the illness
• her expectations of her sexual life following treatment.

Clinicians may make incorrect assumptions about the sexuality of women with gynaecological cancer.

Allowing the woman to talk about the importance of her sexual life and the effects of treatments can improve her feelings of autonomy and control.

In Module 3, we reviewed some of the unique needs of particular populations. This included:

• 3.2.2. Women from culturally & linguistically diverse backgrounds
• 3.2.3. Indigenous women
• 3.2.4. Women from rural & remote regions
• 3.2.5. Women with disabilities
• 3.2.6. Mental health
• 3.2.7. Single women
You may wish to refer to the relevant sections of Module 3 to review how you would approach care for women in these circumstances.

**Objectives**

- Describe strategies for addressing psychosexual concerns for women with specific clinical and social needs.

**6.4.1. Enhancing sexual intimacy at end of life**

Women with gynaecological cancers who have progressive disease can have a number of unique concerns.

**3.2.9. Women with advanced disease**

In the final stages of the cancer trajectory, many health care professionals don’t consider sexuality to be important. Couples commonly avoid this topic, because the partner may feel selfish or demanding if he or she expresses a need for physical contact. The woman may feel that it’s abnormal to desire such contact at this time. [1]

Gentle questioning from the health care professional can help the woman and her partner discuss sexual intimacy and normalise the subject. It can also help highlight suggestions for alternative expression. Consider these main points when supporting a woman at the end of life and her partner;[2][3][4]

- Give couples private time using Do Not Disturb signs and by knocking and waiting for a response before entering the room.
- Remove extraneous equipment and encourage them to bring items from home to make their environment appear less clinical.
- Reassure the couple that kissing, stroking, massaging and embracing won’t cause physical harm and may actually help lead to relaxation and decreased pain. Having the partner help with bathing may be a non-threatening way to encourage touch if the partner fears causing pain or distress.
- Fatigue can decrease a woman’s ability to maintain her personal grooming. She’ll need help with showering, hair care and make up. Consider strategies, such as having hand mirrors within easy reach.
- Mouth care is paramount, particularly when oral issues can affect communication and kissing.
• Maintaining the woman’s dignity is essential when providing intimate care. Partners can be involved in providing personal care. However, some women prefer their partners not to shift to a carer’s role, because this accentuates the loss of sexuality.

• Ensure symptoms, such as pain, nausea and constipation are well managed and encourage women to take medication before starting sexual activity.

• Fatigue is often worse in the afternoon. Suggest that sexual activity could be a morning activity when energy levels are at their highest.

• Positions, such as the woman on her back, supported by pillows will be much more comfortable and less tiring.

References

1 Couples in palliative care
Authors: Cort, E & Monroe, BOD (2004).
In: Sexual and Relationship Therapy, 19(3): 337-354.

In: Oncology Nursing Society, Pittsburgh.

3 Sexuality in palliative care: patient perspectives
In: Palliative Medicine, 18(7): 630-637.

In: Medical Journal of Australia, 179(suppl 6): s8-s11.

Activities & examples

Activity 12: Discussing psychoeducational interventions
Watch the video - Susan’s story part 5: Responding to psychosexual concerns
1. Consider a woman you’ve cared for with advanced gynaecological cancer and discuss what psychoeducational interventions you’d provide.

6.4.2. Psychosexual challenges for young women

Young women with gynaecological cancer face a number of challenges to healthy sexual functioning.

They’re in a developmental life stage in which many establish long-term primary relationships and decide whether or not to have children. [1]

This can mean women’s experience of high levels of distress and sexual difficulties can persist into survivorship. [2]

One study reported that approximately two thirds of women with gynaecological cancer experience dissatisfaction with their overall sex lives and pain during penetration, and over 50% of women report low levels of sexual desire. [3]

Unique concerns for young women can include cancer related infertility and premature menopause.

Cancer related infertility

Women who’ve had reproductive organs surgically removed, or who receive some chemotherapeutic agents, will experience reduced or absent fertility. Depending on the treatment, the effects on fertility can be transient or permanent.

Trachelectomy, a more conservative surgery for early cervical cancer or fertility-sparing surgery may reduce the risk of infertility, although studies report an increased risk of miscarriage and preterm delivery. [4]

The emotional and physical impact of impaired or lost fertility can be complex and long lasting. Available therapies include assisted reproductive techniques including embryo cryopreservation, as well as more experimental techniques such as oocyte and ovarian tissue cryopreservation. [5]

Fertility related information is important at the time of diagnosis. [6]
Referral for psychological counselling should be routinely offered to all women who face potential infertility.\textsuperscript{5}

**Premature menopause**

Women who have treatment for gynaecological cancer often experience symptoms that are:

- more troublesome
- more persistent
- in greater number
- more acute. \textsuperscript{7}

In addition to supportive counselling, treatments can include:

- hormonal treatments for menopausal symptoms
- non-hormonal treatments for menopausal symptoms
- complementary and ‘herbal’ therapies for menopausal symptoms \textsuperscript{8} bioidentical hormones.

\textbf{Cancer Australia review of these treatments}

It’s also important to consider the long term health consequences of premature menopause. These include the potential for osteoporosis.

\textbf{Cancer Australia recommendations for reducing the risk of osteoporosis}

**References**

\textsuperscript{1} Sexual dysfunction related to the treatment of young women with breast cancer Authors: Bakewell, RT & Volker, DL (2005).


\textsuperscript{2} Cancer-related infertility in survivorship


\textsuperscript{3} Gynecologic cancer treatment and the impact of cancer-related infertility
Activities & examples

Activity 13: Dealing with fertility and menopausal concerns

1. Review the following reading and answer the questions.


   a. How would you describe options to a woman who was at risk of infertility as a result of treatment for gynaecological cancer?
   b. What options can you identify for referral to fertility specialist?

2. Review the weblinks here and answer the questions.

   **Treatment for menopausal symptoms after ovarian cancer.** (Cancer Australia, 2012)
   **What can help reduce the risk of osteoporosis?** (Cancer Australia, 2012)

   a. How would you describe treatment options to a woman who was experiencing menopausal symptoms as a result of treatment for gynaecological cancer?
b. How would you respond to a woman who asks whether she can take HRT for menopausal symptoms resulting from treatment for endometrial cancer?

c. What strategies would you recommend to a woman to promote bone health following premature menopause?

d. What options can you identify for referral for a woman who is experiencing severe and persistent menopausal symptoms?

6.4.3. Psychosexual challenges for older women

Although interest in sexual activity and frequency tend to decline with aging, sexual satisfaction remains high amongst older women.

Maturity and experience can make a woman capable of being emotionally intimate. This leads to greater levels of sexual intimacy. [1]

Being older may also help people cope with the loss of sexual activity in a relationship. [2]

The most salient factors related to the lack of sexual activity in older women is either ill health in themselves or in their partners or the absence of a partner. [3]

Comorbid disease and the medications used to treat these conditions often play a significant role in altered sexuality. [4]

Ill health tends to decrease mobility and tolerance for physical activity, including sexual activity. Also, body image changes brought on by illness and disability have an effect.

The fatigue that generally accompanies cancer treatment may have a greater impact on global physical functioning for older people with cancer than their younger counterparts. [5]

Finding alternatives to or adapting penetrative intercourse is a common suggested intervention for changed sexual functioning from disease or treatment.

This may be especially challenging for older women and their partners who may have a limited sexual repertoire and may not consider alternatives to vaginal intercourse.
Older women may never have masturbated and may not even know what this means. [6]

It’s important to be sensitive in such discussions and suggest alternative interventions, such as ways to enhance intimacy.

For more information: 6.3.4. Managing loss of desire

Older women often appreciate information and education about sexuality. This is because for many, the information wasn’t available when they were younger, which limited their choices. [7]

References 1 The impact of aging on sexual function in women and their partners Author: Kingsberg, SA (2002).

2 How important is sex in later life? The views of older people Authors: Gott, M & Hinchcliff, S (2003).
In: Social Science and Medicine, 56(8): 1617-1628.

3 Sexual desire in later life
Authors: DeLameter, JD & Sill, M (2005).
In: Journal of Sex Research, 42(2): 138-149.

4 Sexuality among older women Author: Gelfand, MM (2000).
In: Journal of Women’s Health and Gender-Based Medicine, 9: s52-s56.

5 Impact of age on quality of life in patients with rectal cancer

6 Counseling about sexuality in the older person Author: Szabo, P (2003).
In: Clinics in Geriatric Medicine, 19(3): 595-604.

7
Understanding older women’s health care concerns: a qualitative study Authors:

Activities & examples

Activity 14: Approaches for older women

Watch the video and complete the activity.

Watch the video - Norma's story

1. Consider an older woman with gynaecological cancer you’ve cared for.
   Describe what approaches you’d suggest to her if penetrative intercourse was no longer possible.
6.5. Supporting learning resources

**Sexual dysfunction in patients with gynecologic neoplasms: a retrospective pilot study**  
In: Journal of Sexual Medicine, 3(4): 646-649.

**Sexual dysfunction related to the treatment of young women with breast cancer**  
Authors: Bakewell, RT & Volker, DL (2005).  

**Human Sexuality and its Problems**  
Author: Bancroft, J (2008).  
From: Churchill Livingstone Elsevier, Edinburgh

**Women's sexual dysfunction: Revised and expanded definitions**  

**Chore or priority: Barriers and facilitators affecting dilator use after pelvic radiotherapy for gynaecological cancer**  

**Psychotherapy in patients cured of gynecological cancers**  

**Psychological interventions for the sexual sequelae of cancer: A review of the literature**  
Authors: Brotto, LA, Yule, M & Breckon, E (2010).  

**Psychosocial rehabilitation of gynecologic oncology patients**  
Authors: Capone, MA, Good, RS, Westie, KS & Jacobson, AF (1980).  

**Cancer-related infertility in survivorship**  
Simple strategies for vaginal health promotion in cancer survivors Authors:
In: J Sex Med, 8(2): 549-559.

Gynecologic cancer treatment and the impact of cancer-related infertility
In: Gynecologic Oncology, 97(1): 90-95.

Couples in palliative care
Authors: Cort, E & Monroe, BOD (2004).
In: Sexual and Relationship Therapy, 19(3): 337-354.

Couple coping with myocardial infarction: A contextual perspective on wives' distress Authors:

Sexual desire in later life
Authors: DeLameter, JD & Sill, M (2005).
In: Journal of Sex Research, 42(2): 138-149.

Interventions for the physical aspects of sexual dysfunction in women following pelvic radiotherapy
Authors: Denton, AS & Maher, EJ (2003).
In: Cochrane Database of Systematic Reviews, Issue 1.

A randomized, open, parallel-group study on the preventive effect of an estradiol-releasing vaginal ring (Estring) on recurrent urinary tract infections in postmenopausal women Author: Eriksen, B (1999).

Delivering sensitive healthcare information: challenging the taboo of women's sexual health after pelvic radiotherapy
Authors: Faithfull, S & White, I (2008).

Interventions for psychosexual dysfunction in women treated for gynaecological malignancy (review)
Managing menopausal symptoms in breast cancer survivors: results of a randomized controlled trial
Authors: Ganz, PA, Greendale, GA, Petersen, L, et al. (2000).

Sexuality among older women  Author:
Gelfand, MM (2000).
In: Journal of Women's Health and Gender-Based Medicine, 9: s52-s56.

Treating vaginal dryness in breast cancer patients: results of applying a polycarbophil moisturizing gel  Authors:

Changes in coping with chronic stress. The role of caregivers' appraisals of coping efficacy (PDF, 248kb)  Authors:
Gignac, MAM & Gottlieb, BH (1997).
Editors: Gottlieb, BH.
In: Coping with chronic stress (pp. 245-267).

How important is sex in later life? The views of older people Authors:
In: Social Science and Medicine, 56(8): 1617-1628.

Psychosocial interventions and quality of life in gynaecological cancer patients: A systematic review
In: Psycho-Oncology, 18(8):795-810.

Intimacy and sexuality for the woman with breast cancer  Author:
In: Cancer Nursing, 23(3): 230-236.

A patient-centred approach to sexuality in the face of life-limiting illness  Authors:
In: Medical Journal of Australia, 179(suppl 6): s8-s11.
An effective group psychoeducational intervention for improving compliance with vaginal dilation: a randomized controlled trial

Post-treatment sexual adjustment following cervical and endometrial cancer: A qualitative insight

Breaking the Silence on Cancer and Sexuality A Handbook for Healthcare Providers Author:
From: Oncology Nursing Society, Pittsburgh.

The impact of aging on sexual function in women and their partners Author:
Kingsberg, SA (2002).

Preventing vaginal stenosis after brachytherapy for gynaecological cancer: an overview of Australian practices
Authors: Lancaster, L (2004).

Sexuality and Body Image in Gynaecological Cancer Care A Guide to Practice Editors:
Lancaster, T & Nattress, K.
Author: Robertson, R (2005).
From: Ausmed Publications, Melbourne

Sexuality in palliative care: patient perspectives
In: Palliative Medicine, 18(7): 630-637.

A randomized trial of the effect of training in relaxation and guided imagery techniques in improving psychological and quality-of-life indices for gynecologic and breast brachytherapy patients
In: Psycho-Oncology, 16(11): 971-979.

Can stronger pelvic muscle floor improve sexual function?
Coping as a communal process

One-to-one volunteer support programs for people with cancer: a review of the literature

Human sexual inadequacy
In: Boston: Little, Brown.

The effect of a clinical nurse specialist in gynaecological oncology on quality of life and sexuality
Authors: Maughan, K & Clarke, C (2001).
In: J Clin Nurs, 10(2): 221-229.

Interventions for sexual dysfunction following treatments for cancer
In: Cochrane Database of Systematic Reviews, Issue 4

Vaginal dilator therapy for women receiving pelvic radiotherapy
Authors: Miles, T & Johnson, N (2010).
In: Cochrane Database of Systematic Reviews, Issue 9.

A quantitative approach to the distress caused by symptoms in patients treated with radical radiotherapy

Comparative study: Replens versus local estrogen in menopausal women
Author: Nachtigall, LE (1994).

Vaginal oestrogen therapy after breast cancer: Is it safe?

Sexuality in cancer and palliative care 1: Effects of disease and treatment Author:

'17beta-estradiol vaginal tablet versus conjugated equine estrogen vaginal cream to relieve menopausal atrophic vaginitis'
Authors: Rioux JE, Devlin C, Gelfand, MM et al. (2000).
In: Menopause, 7(3): 156-161.

Psychoeducational group increases vaginal dilation for younger women and reduces sexual fears for women of all ages with gynecological carcinoma treated with radiotherapy Authors: Robinson JW, Faris PD & Scott CB.

Sexual rehabilitation for women with gynecological cancer: information is not sufficient Authors:
In: Can J Hum Sex, 3: 131-42.

Impact of age on quality of life in patients with rectal cancer

Premature Ovarian Failure and Its Consequences: Vasomotor Symptoms, Sexuality, and Fertility
Author: Schover, LR (2008).
In: Journal of Clinical Oncology, 26(5): 753-758.

Clitoral therapy device for treatment of sexual dysfunction in irradiated cervical cancer patients (PDF, 280kb)

United we stand? The effects of a couple-coping intervention on adjustment to early stage breast or gynecological cancer
Evidence-Based Practice for Symptom Management in Adults with Cancer: Sexual Dysfunction
Author: Shell, J (2002).

Sex and relationships
Author: Spence, SH (1997).
Editors: Halford, WK & Markman, HJ.
In: Clinical handbook of marriage and couples interventions (pp. 73–105).
From: Chichester, NY: Wiley.

Counseling about sexuality in the older person Author:
In: Clinics in Geriatric Medicine, 19(3): 595-604.

Understanding older women’s health care concerns: a qualitative study Authors:

Vaginal dilation associated with pelvic radiotherapy: a UK survey of current practice Authors:
In: Int J Gynecol Cancer, 16(3): 1140-1146.

Treatment of Sexual Problems in People with Cancer
National Cancer Institute (NCI)

Australian Gynaecological Cancer Foundation

Vaginal dryness
Accessed 21/11/10 Cancer Australia