

Sexuality and Fertility: Talking with Your Male and Female Patients about Their Options

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Financial Disclosure

- I have no significant relationships to disclose

Outline

- Fertility and Cancer
- Sexuality and Cancer

Fertility and Sexuality: Two sides of the same coin? Or completely separate coins?

- Common:
 - anatomy
 - Society
 - Culture
- Different:
 - Motivations
 - Desires
 - Priorities

Providers should recognize that discussing fertility and discussing sexuality are entirely different discussions

Case Presentation

- 17 year-old male
 - high school athlete
 - presents with worsening shortness of breath and postprandial emesis
 - Exam: shallow breath sounds, right nontender testicular mass
 - Chest X-ray: mediastinal mass
 - Labs: beta-HCG 50,525 AFP 21,000 LDH 860
 - CT scan: Liver metastases, mediastinal mass, retroperitoneal adenopathy
 - Pathology of testicular mass: mixed germ cell tumor

Question

- He requires chemotherapy, consisting of Bleomycin, Etoposide and Cisplatin. With regard to fertility:
 - A. He is too young to worry about that right now, so better not to bring it up.
 - B. He can be cured and we need to start immediately. There is no time to discuss fertility preservation.
 - C. He should know what treatment can do and his options to preserve fertility now.
 - D. He'll probably die of this; why bother.

Case Presentation (2)

- 26 year-old female, G1P1
 - Presents with left pelvic pain
 - Emergent laparotomy: LSO
 - Labs: AFP 568 CA-125 381
 - Final pathology: Grade 3 immature teratoma

Question

- She requires further treatment but tells you she wants more children in the future. You tell her:
 - A. She has not had the right surgery performed and needs to have her other ovary removed as well formal ovarian cancer surgery.
 - B. She can keep her other ovary but she needs chemotherapy and needs it asap.
 - C. She needs to know what options are available to her to keep her fertility.

Regarding fertility and cancer:

- I am aware of ASCO's Clinical Practice Guidelines regarding preservation of fertility for patients with cancer.
 - A. Yes
 - B. No
- I have read the ASCO Guideline in Fertility Preservation
 - A. Yes
 - B. No

Fertility and Cancer

- Preservation is key because having biologic children is important
- It is imperative that issues related to future fertility be discussed
- To address this issue, ASCO published clinical guidelines on this topic:

ASCO SPECIAL ARTICLE

American Society of Clinical Oncology Recommendations on Fertility Preservation in Cancer Patients

Stephanie J. Lee, Leslie R. Schover, Ann H. Partridge, Pasquale Patrizio, W. Hamish Wallace, Karen Hagerty, Lindsay N. Beck, Lawrence V. Brennan, Kutluk Oktay

Scope of Problem

- Four percent of patients diagnosed with cancer in 2005 were under 35
 - Approximately 50,000 patients affected
- Fertility preservation as a *quality of life* issue
 - 75% of childless patients yearn to be parents
 - 80% of teen girls want children in the future
 - Lack of any discussion can cause prolonged anger and grief
- Preservation should be discussed *before* treatment
 - Options for future fertility depend on what happens prior to start of therapy
- **30-50% of patients do not recall these discussions prior to treatment**

S Lee, LR Schover, et al. J Clin Oncol 2006; 24:2917-31.

Why isn't fertility routinely discussed?

- Counseling around cancer and treatment focuses on big issues: survival, treatment options, an *life-threatening complications*
- Data related to risk from *individual agents* used in treatment is poor
- Cancer providers may *assume* costs are prohibitive
- Cancer providers may *conclude* the prognosis is **too poor** to warrant this discussion
- Too much to discuss in too little time

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What you need to know

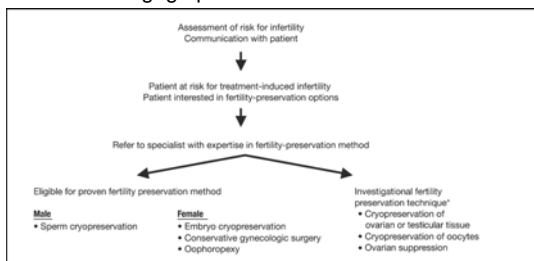
- Fertility in the cancer patient is an interdisciplinary endeavor
 - Do not take on alone
 - Discuss and refer
 - Social work
 - Reproductive Endocrinologist
 - Medical Oncologist
 - Surgeon
 - Primary Care Physician
 - Patients will look to their primary oncologist for advice and guidance

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But for cancer patients---

FERTILITY MAY BE A SYMBOL OF HOPE AND THEIR FUTURE

How to engage patients



S Lee, LR Schover, et al. J Clin Oncol 2006; 24:2917-31.

Specific Talking Points

- Consider the individual, their disease, and treatment plan
- Patients expressing interest in fertility preservation should be referred ASAP
- Ensure patients know about available resources, such as LAF, Komen
- The most success has been seen with sperm banking for men and embryo freezing for women
- Future pregnancy and fertility preservation *thus far* has not been linked with recurrence
- In general: there is no increased risk to children

S Lee, LR Schover, et al. J Clin Oncol 2006; 24:2917-31.

Options for men and women

- Sperm cryopreservation
 - Up to 25 years for viability
- Cryopreservation of testicular tissue or suspension of stem cells prior to puberty
 - *Experimental*
- Cryopreservation of embryos
 - Donor sperm vs. Partner's sperm
- Cryopreservation of ovarian tissue prior to puberty
 - *Experimental but 5-6 reports of success*
- Cryopreservation of the whole ovary for auto-transplantation
 - *Experimental*

Options after cancer

- All is not lost
- Options are wide
 - Recovery of natural fertility
 - Use of cryopreserved tissue
 - Social parenthood
 - Adoption
 - Gestational surrogacy
 - Step-parenthood

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Now... let's talk about sex



Case Presentation (1)

- 51 year-old female, history of breast cancer
 - Diagnosed at 40 with Stage I breast cancer
 - Excision and sentinel node biopsy
 - Radiation therapy to breast
 - New infiltrating ductal carcinoma in 2001, T1cN1M0
 - Mastectomy
 - CEF
 - Tamoxifen for 2 years, then Anastrozole (currently)
- Complains of vaginal dryness

Question

- In response to her complaint, I would:
 - A. Refer her back to her primary care physician or gynecologist for physical exam and discussion
 - B. Prescribe estrogen and discuss testosterone supplementation
 - C. Refer for biofeedback
 - D. Perform a tailored history and pelvic exam

Case Presentation (2)

- 58 year-old male
 - Diagnosis: Stage I prostate cancer, Gleason 7 in 2006
 - Treatment: Neoadjuvant androgen ablation then radiation therapy (External and interstitial)
- Prior to diagnosis: no sexual problems
- Now complains of: anorgasmia, lack of libido
- PE: No palpable prostate

A McCullough. Rev in Urol 2003; S1:41-48.

Question

- In response to his complaint, I would:
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 - C. Initiate a PDE5 inhibitor
 - D. Perform a tailored history

Sexual Myths

- The average penis size
- The average ejaculate amount
- G spot
- Female Ejaculation



LITTLE DO MOST PEOPLE KNOW,
THE HEART WASNT THE TINMAN'S
FIRST ORGAN OF CHOICE.

The Average Penis Size

- 1996 SF Study of both flaccid and erect penis measurements
 - n= 80 normal men
 - Flaccid: 3.5 inches +/- 0.9 inches
 - Erect: 5.1 inches +/- 1.1 inches erect
- Take Home Point
Size doesn't mean performance....
Ask any woman

Too much is never enough?

- 2-5 ml up to one teaspoonful
- Each milliliter of semen
 - contains 50-150 million sperm
 - Normal ejaculate 100-700 million sperm
- Take Home Point
A little goes a long way.....

The G spot: Myth or Truth??

- Named after Grafenberg
- *Minority* of women say they have one
- In truth: it is an area of heightened sensitivity on the front wall of the vaginal about 3-5 cm (1-2 inches) from the vagina entrance
- Pressure can trigger desire to urinate but it is also reported to be sexually arousing and trigger an orgasm that is different from clitoral stimulation
- Take home point

To feel it is to believe it

Females can ejaculate?

- When properly stimulated, the G-spot can swell and lead to orgasm
- During orgasm, there may be an ejaculate through the urethra
 - Emanates from periurethral glands?
- Approximately 10–40% of women ejaculate
 - Quantity varies
- Take Home point

They sure do!

BACK TO THE TOPIC...

Are Sexuality Issues Addressed?

- Healthcare professionals feel unprepared to deal with these problems and most (94 %) were unlikely to discuss the problems with patients
- Nurses unlikely to ask
- Only 14-35% of ED patients get asked about sexual health by their primary physician.

Haboubi, N. H. J. & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. *Disability and Rehabilitation*, 25(6), 291-296. Matocha, L. K., & Waterhouse, J. K. (1993). Current nursing practice related to sexuality. *Research in Nursing & Health*, 16(5), 371-378. McKinlay J.B., Dignartolo L., Glasser D., Swensen M., & Shirai M.F. (1999). Inter-racial differences in the epidemiology of male erectile dysfunction. *The International Journal of Clinical Practice*, 102, 35.

Approach to Patients: PLISSIT

- P=Permission
- LI-Limited information
- SS=Specific Suggestions
- IT=Intensive Therapy

Annon, J. (1974). *The behavioral treatment of sexual problems*. Honolulu, HI: Enabling Systems.

Don't Assume it's all due to cancer!

- Chronic medical illness (cancer, cardiovascular, neurologic, metabolic, & endocrine)
- Psychiatric illness (schizophrenia, depression, bipolar disorder)
- Pelvic trauma or surgery (blunt trauma, prostatectomy)
- Spinal cord or head trauma/surgery
- Radiotherapy (brachytherapy, radiation beam)
- Medication (antihypertensives, antidepressants)
- Smoking, alcohol and recreational drug use
- Sedentary lifestyle

Jardin A et al., Recommendations of the 1st International Consultation on Erectile Dysfunction. Plymouth, UK: Plymouth Distributors, 2000:711-726.

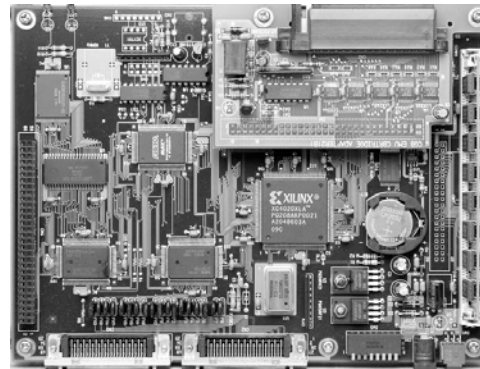
Drugs that may Effect Sexual Function

Prescription Drugs

Antihypertensives
 Antidepressants
 H2 blockers
 Anti androgens
 Antihistamines

Recreational Drugs

Smoking (cigarette/mj)
 Alcohol
 Cocaine
 Opiates / Methadone
 MDMA (Ecstasy)



Male Sexual Dysfunction

Male Anatomy



Sexual Response in Men

- Excitement
- Plateau
- Orgasm
- Resolution

Male average time: 2.8 minutes

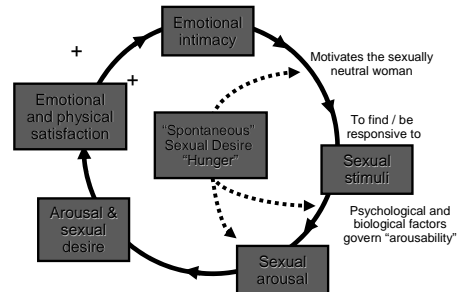
- Female=avg. 13 minutes
- Masters, W. & Johnson, V. (1966). Human Sexual Response. Boston: Little, Brown.

Male Sexual Dysfunction

- Desire disorder-
 - decreased libido
- Ejaculation Disorders:
 - Retarded (delayed)
 - Rapid Ejaculation-occurs too late or too early during sexual relations
- Pain Disorders:
 - muscle or tissue (eg Peyronie's Disease)

Female Sexual Dysfunction

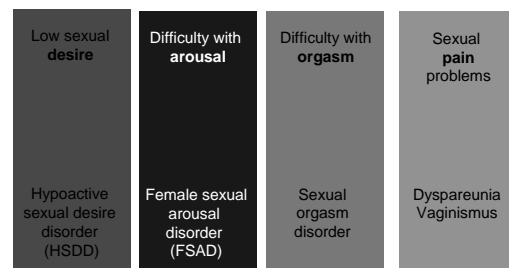
Female Sexual Response Cycle: Basson Intimacy-based Model



Variables Affecting Female Sexual Function

- General well being
- Subjective sexual experience
- Attractiveness of partner
- Sexual response
- Frequency of sexual activity
- Partner's sensitivity
- Subject's health
- Partners health

Categories of Female Sexual Dysfunction



Sexuality and Cancer

- 40-100% of cancer survivors affected:
 - >80% of radical pelvic surgery patients
 - 50-90% of Breast cancer survivors
 - 25% of Leukemia and Hodgkin's lymphoma patients
 - >50% of pelvic radiation patients

What can we do?

Treatment Strategies

- EDUCATION
- Medication
 - PDE5 inhibitors in men with ED
 - Vacuum devices, intraurethral injection in men
 - Estrogen for women
 - Testosterone?
- Structured sexual tasks
 - Sensate focusing, guided imagery, relaxation exercise
 - Fantasy exploration, skilled exercises
- Pain management
- Sexual devices
 - Self-stimulator/vibrators
 - Dilator therapy

Special Concerns of Cancer Patients

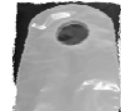
- Fatigue
- Pain
- Range of motion
- Shortness of breath
- Ostomies
- Finding comfort

Alternative ways of expressing Physical Love



- Emphasize Intimacy
 - Hugging
 - Hand holding
 - Kissing
 - Fondling
- Alternative Sexual Activity:
 - Manual Stimulation
 - Oral stimulation
 - Alternative Intercourse:
 - Intra-thigh
 - Intramammary
 - Anal

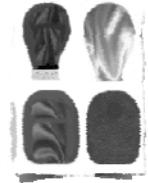
Sex is possible even after an ostomy: The Four P's



■ Prepare before sex

Problem	Foods associated with increased risk
Obstruction/ileus	Celery, coconut, corn, coleslaw, dried fruits, grapefruit, nuts, peas, popcorn, rice
Gas production/ odors	Legumes, cabbage, Brussel sprouts, avocados, artichokes, asparagus, broccoli, spinach, melons, apples, prunes, cheese, fish, eggs, carbonated drinks
Diarrhea	Cabbage, green beans, buttermilk, applesauce, tapioca, boiled rice, milk, yogurt

- Use a **pouch cover**
- Find a comfortable **Position**
- **Pleasure** by intimacy, not just intercourse.



Psychiatry and Psychology Counseling

- Individual
- Sex therapy
- Marital
- Individual
 - Cognitive behavioral
 - Psychoanalytical
- Couples
- Group



Resuming Sex after Cancer Treatment

- Whether short or long interval has passed without sex, the "first time" brings high expectations and some dread:
 - Will it be the same?
 - Will it hurt?
 - Will I feel anything?
 - Will I function?
 - Will my partner still be attracted to me?

Strategies to Reduce Anxiety

- Put a **priority** on time for sex when not exhausted and have privacy
- Start **gradually**: making out on the couch, back-rub, shared shower or bath, sensate focus
- Use lingerie or low lighting to feel less **self-conscious**
- **Agree** not to go on to intercourse even if all seems to be going well
- Goal is **pleasure**, not *performance*

Preparing for Partner Sex

- Get comfortable with physical scars and changes
- Look at and touch self
- If acceptable, try masturbation to find out about lubrication or erection, where sensitive areas are, how to reach orgasm
- For women: if orgasm is difficult, try vibrator

Conclusion: Addressing Sexuality



- ASK
 - PLISSIT MODEL
 - Permission
 - Limited information
 - Specific suggestions
 - Intensive therapy
- REFER
 - Draw on local expertise

Conclusions

- Cancer Survivors are a large group in our population.
- Attention to QOL is important.
- Sexuality is a human right.
- Do not ignore!

Conclusion: Key Points

- Ask permission of the patient
- Take the initiative
- Mix correct terminology with appropriate understandable language
- Convey a sense of trust/confidentiality
- Display a nonjudgmental attitude
- Provide education in multiple forms
- Ask questions about feelings
- Convey realistic hope

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