Interventions to Address Sexual Problems in People with Cancer: American Society of Clinical Oncology Clinical Practice Guideline Adaptation of Cancer Care Ontario Guideline
Introduction

• Sexual health is an integral component of quality of life across the lifespan.

• Sexual problems commonly include decreased desire, arousal disorders, pain (largely in women), and erectile dysfunction (in men). In addition to cultural and religious influences, sexual function is affected in a multifactorial way by one’s overall health (the patient’s and that of his/her partner), partner relationships, previous sexual history, medications, fatigue and stress, mood, view of sexual self, body image, incontinence and hormonal changes.

• Cancer can independently affect sexual function by the nature of the disease and its treatment, and/or resulting changes in health, body image or view of sexual self, and altered relationships secondary to illness.

• In 2016, Cancer Care Ontario (CCO) released guideline recommendations regarding interventions to improve sexual function in individuals with cancer.

• The American Society of Clinical Oncology (ASCO) has adapted the CCO guideline recommendations.
ASCO Adaptation Methodology

The ASCO Clinical Practice Guidelines Committee adaptation review process includes:

• a methodological review by ASCO guidelines staff
• a content review by an expert panel
• final endorsement approval by ASCO CPGC.

The full ASCO Adaptation methodology supplement can be found at:
www.asco.org/survivorship-guidelines

CCO Guideline Methodology can be found at:
https://www.cancercareontario.ca/en/content/interventions-address-sexual-problems-people-cancer
Clinical Questions

What is the effectiveness of pharmacological interventions, psychosocial counseling, or devices to manage sexual problems after cancer treatment?

More specifically, issues in men and in women were examined separately.
Target Population and Audience

Target Population
This guideline is applicable to adult (≥ 18 years of age) men and women (and their partners) of all sexual orientations living with cancer of any type. For the purposes of this guideline, men and women who were previously treated for a childhood cancer were not included.

Target Audience
Health care practitioners, such as oncologists, urologists, gynecologists, primary care providers, surgeons, nurses, physiotherapists, social workers, counselors, psychologists, psychiatrists, and sex therapists/counselors, and advanced practice providers, such as physician assistants and nurse practitioners.
Summary of Recommendations

For all people with cancer

Recommendation 1: It is recommended that there be a discussion with the patient, initiated by a member of the healthcare team, regarding sexual health and dysfunction resulting from the cancer or its treatment. The conversation *could* include the patient’s partner, *only if the patient so wishes*. This issue should be raised with the individual at the time of diagnosis and continue to be re-assessed periodically throughout follow-up. The Expert Panel believes that this is a vital recommendation. The recommendations that follow cannot be used unless someone has taken the initiative to ask.

It is recommended that there be access to resources or referral information for the patient (and partner).

*ASCO Qualifying statement: The Expert Panel believes that introduction of the topic of sexual function should be held with the patient alone, with the option of later partner inclusion if desired by the patient. Discussions should be congruent with the patient’s literacy level, cultural/religious beliefs and sexual orientation. This discussion should be offered at varied points of treatment and survivorship to assess or address any changes.*
Summary of Recommendations

Women:
Condition: Sexual Response
Recommendation 1: The Expert Panel believes that psychosocial and/or psychosexual counseling should be offered to women with cancer, aiming to improve elements of sexual response such as desire, arousal, or orgasm. Current evidence does not support one type of psychosocial or psychosexual counseling to be superior to another.

Clinicians may offer flibanserin to premenopausal women who are experiencing hypoactive sexual desire disorder.\(^1,2\)

CCO Qualifying Statement: It is the opinion of the Expert Panel that any kind of regular stimulation (including masturbation) would likely be of benefit for improving sexual response, regardless of the stimulation used.

ASCO Qualifying Statement: It should be noted that flibanserin has not been evaluated in women with a history of cancer or those on endocrine therapy. In addition, the risk benefit ratio for this medication is uncertain.
Summary of Recommendations

Condition: Body Image

Recommendation 2: It is recommended that psychosocial counseling be offered to women with cancer and body image issues.

If a woman is partnered, evidence indicates that couples-based interventions are effective when compared with usual care.

No recommendation can be made for or against group therapy (with or without exercise) for women with body image issues.

ASCO Qualifying Statement: Clinicians should assess for body image issues early and often in the cancer care continuum and should take into account cultural and/or religious variations. Patients with preexisting depression and/or body image issues may at a higher risk of susceptibility.

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Summary of Recommendations

Condition: Intimacy/Relationships

Recommendation 3: It is recommended that psychosocial counseling be offered to women with cancer aiming to improve intimacy and relationship issues. If a woman is partnered, evidence indicates that couples-based interventions are effective when compared with usual care.

ASCO Qualifying Statement: The Expert Panel views partner involvement in all cases to be the choice of the patient.
Condition: Overall Sexual Functioning and Satisfaction

Recommendation 4: The Expert Panel believes that psychosocial counseling directed at the individual or couple, or delivered in a group be offered to women with cancer who have problems with overall sexual functioning. Physical exercise or pelvic floor physiotherapy, in addition to psychosocial counseling, may also be of benefit.

Current evidence does not support a specific psychosocial counseling intervention to improve sexual functioning and satisfaction.

**Health care providers should screen cancer patients for overall sexual functioning and satisfaction and a diagnosis should be established when there are physical issues playing a contributing role.**

All patients should be offered education and symptom management based on the patient’s diagnosis. For patients having persistent concerns such as physical issues, a gynecological exam would be ideal. For those continuing to have relationship issues and/or distress, mental health counseling should be an option.

ASCO Qualifying Statement: The ASCO Expert Panel believes patients can still benefit if counseling is provided by licensed counselors available at the medical center even if specialized therapists (e.g. sex therapists) are not available.
Summary of Recommendations

Condition: Vasomotor Symptoms
Recommendation 5: For women with vasomotor symptoms, hormone therapy is the most effective intervention. For women unwilling or unable to use hormonal therapy, alternatives exist: for example, paroxetine, venlafaxine, gabapentin, or clonidine.

Having a hormone-sensitive breast cancer is a contraindication to using systemic hormone therapy.

Psychosocial counseling (cognitive behavioral therapy) and/or clinical hypnosis may provide a benefit and reduce vasomotor symptoms and should be offered.3-6

CCO Qualifying Statement: The Expert Panel emphasizes that women with non-hormone-sensitive cancers who develop vasomotor symptoms from their cancer treatment should be counselled to consider hormone therapy until the average age of menopause, approximately 51 years, at which point they should be re-evaluated. Risks typically cited for hormone therapy are derived from studies of post-menopausal women. Beyond the age of 51 years, hormone therapy is an individual therapy with few risks for symptomatic patients in their 50’s. It should be intermittently evaluated for long-term use.

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Summary of Recommendations

When not contraindicated, estrogen therapy alone (oral, transdermal, or vaginal) is recommended for women who have had a hysterectomy, as it has a more beneficial risk/benefit profile.

Paroxetine and fluoxetine should not be offered to women with breast cancer taking tamoxifen. Adverse events of clonidine include hypotension, light-headedness, headache, dry mouth, dizziness, sedation, and constipation. Sudden cessation can lead to significant elevations in blood pressure.

ASCO Qualifying Statement: The use of systemic hormone therapy is not necessarily contraindicated in patients with other hormone-sensitive cancers like endometrial and ovarian cancer. Clinicians should discuss all options, including integrative approaches, with their patient, outlining the benefits and risks of each.

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Condition: Genital Symptoms
Recommendation 6: The Expert Panel believes that, for women with symptoms of vaginal and/or vulvar atrophy, such as dryness, the following stepwise approach should be followed:

Lubricants for all sexual activity or touch, in addition to vaginal moisturizers to improve vulvovaginal tissue quality, may be tried first. It should be noted that moisturizers may need to be applied at a higher frequency (3 – 5 x per week) in the vagina, at the vaginal opening and on the external folds of the vulva for symptom relief in female cancer patients/survivors.  

For those who do not respond or whose symptoms are more severe at presentation, low-dose vaginal estrogen can be used. For women with hormone-positive breast cancer who are symptomatic and not responding to conservative measures, low dose vaginal estrogen can be considered after a thorough discussion of risks and benefits.

Lidocaine can also be offered for persistent introital pain and dyspareunia.

For women with current or a history of breast cancer who are on aromatase inhibitors and have not responded to previous treatment, clinicians may offer vaginal dehydroepiandosterone.
Summary of Recommendations

Finally, clinicians may offer the selective estrogen receptor modulator ospemifene to postmenopausal women without current or history of breast cancer who are experiencing dyspareunia, vaginal atrophy or other vaginal pain.\textsuperscript{13-15}

Clinicians should offer pain relievers to women on aromatase inhibitors who are experiencing arthralgia that interferes with intimacy.

Clinicians may suggest the use of skin protectants/sealants applied to the external folds of the vulva in women using pads for leakage and/or discharge.

Vaginal dilators may be of benefit in the management of vaginismus and/or vaginal stenosis and can be offered to anyone having pain with exams and/or sexual activity. This is particularly important for women treated with pelvic (or vaginal) radiation therapy. Ideally, benefit is greatest when started early and should not be recommended based on sexual activity or sexual orientation, but rather to all women at risk for vaginal changes to be proactive in their sexual and vulvovaginal health.
Cognitive behavioral therapy and pelvic floor (Kegel) exercises may be useful to decrease anxiety and discomfort and can lower urinary tract symptoms.

The Expert Panel believes that pelvic floor physiotherapy may be beneficial for patients experiencing symptoms of a potential pelvic floor dysfunction including persistent pain, urinary and/or fecal leakage. Clinicians may refer patients to an urologist or urogynecologist for further evaluation and treatment of urinary incontinence or to a colorectal surgeon for fecal incontinence.

ASCO Qualifying Statement: There is limited supportive data on the use of vaginal dehydroepiandrosterone in women with a history of cancer or on endocrine therapy so the risk/benefit for this population is not fully known. Ospemifene has not been evaluated in women with a history of cancer nor on endocrine therapy and therefore the risk/benefit is not known for this population. A thorough discussion outlining the uncertainty should be had with the patient.
Summary of Recommendations

Men:

Sexual Response
Recommendation 1: It is recommended that phosphodiesterase type 5 inhibitor (PDE5i) medications be used to help men with erectile dysfunction.

Men who do not respond to PDE5i medications should consider alternate interventions such as a vacuum erectile device (VED), medicated urethral system for erection, or intracavernosal injection.

There may be some benefit to initiating the use of any of the above interventions earlier after cancer treatment rather than later. *Introduction prior to treatment initiation may be of benefit to some men.*

*Surgical interventions, including penile prosthesis implantation for erectile dysfunction, can be offered to patients who are not responding to conventional medical therapy or reporting side effects with such therapy.*
Summary of Recommendations

Clinicians may refer patients to an urologist for evaluation and treatment of stress urinary incontinence.

CCO Qualifying Statement: The Expert Panel believes that men are best served by being offered a combination of psychosocial counseling with the aim of greater adaptation toward long-term use and PDE5i medication adherence together with PDE5i treatment. For men who are partnered, psychosocial counseling should be directed at the couple.

Men should be aware that it might take a long time for medications to work and that PDE5i medications might not work for all men, especially in those with preexisting comorbidities. Clinicians should discuss with patients the appropriate duration of use and alternative options, e.g. surgery, if the medications fail to work satisfactorily.

It is the opinion of the Expert Panel that any kind of regular stimulation (including masturbation) would likely be of benefit for improving sexual response, regardless of the stimulation used.

Contraindications include the use of nitrates in any form. Common acute side effects of PDE5i medications include headaches, flushing, dizziness, upset stomach, nasal congestion and dyspepsia.

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Summary of Recommendations

Genital Changes
Recommendation 2: It is recommended that a VED be used daily to prevent penis length loss. There may be some benefit to initiating the use of VEDs earlier after cancer treatment rather than later. Early treatment with PDE5i medications may also be beneficial for this outcome.

Intimacy/relationships
Recommendation 3: The Expert Panel believes that individual or couples counseling should be offered for those wishing to improve relationship or intimacy issues. Current evidence does not support a particular intervention to improve intimacy or relationships.

ASCO Qualifying Statement: The opportunity for partners to be involved should be offered, rather than being viewed as a necessary condition.

Overall Sexual Functioning and Satisfaction
Recommendation 4: It is recommended that psychosocial counseling be offered to men with cancer (and partners) to potentially improve sexual functioning and satisfaction. It is also recommended that the use of pro-erectile agents and devices be considered, recognizing that most of the benefit is specifically for erectile dysfunction. With men who have sex with men, additional education may need to be provided on the changes in erection and alternative ways to maintain sexual intimacy.
Summary of Recommendations

Body image, including such issues as weight changes, disfigurement, scarring, and hair loss should be discussed and normalized in men.

Clinicians should check testosterone levels, even if patient has a cancer that is not typically associated with hormone changes. Options should be discussed when testosterone levels are within normal range, but patient or clinician feels supplementation can have a clinical benefit and is not contraindicated.

CCO Qualifying Statement: Psychosocial counseling could be used to help couples integrate interventions into their usual sexual activities.

Condition: Vasomotor Symptoms
Recommendation 5: Men with vasomotor symptoms should be offered medication for symptomatic improvements. Options would include venlafaxine, medroxyprogesterone acetate, cyproterone acetate, and gabapentin. Acupuncture may be a suitable alternative, as may be other integrative medicine options such as slow breathing techniques and hypnosis as evidence demonstrates clinical benefit in women.
Psychosocial counseling (cognitive behavioral therapy) may provide a benefit and reduce vasomotor symptoms and should be offered.

ASCO Qualifying Statement: Evidence supporting the clinical effectiveness of various integrative medicine techniques exists for women experiencing vasomotor symptoms. The ASCO Expert Panel feels extrapolation to male patients is reasonable and an option for men suffering from vasomotor symptoms.
Discussion

- The Expert Panel strongly recommends designation of a specific treatment team member to query and discuss with each patient any impact of cancer or cancer treatment on his/her sexuality.

- All patients should be provided with disease and treatment-specific education and symptom management.

- Clinicians should initiate a discussion with the patient at the time of diagnosis and inquire about function periodically across treatment and into follow-up.

- This guideline and its recommendations are patient focused and inclusion of others, such as a partner, is the prerogative of the patient.

- Furthermore, clarification should be made about the difference between sex counseling and sex therapy. However, absence of a specialized sex therapist should not be a reason for lack of discussion.

- Discussions should be congruent with the patient’s literacy level, cultural/religious beliefs and sexual orientation.
A key barrier to the delivery of optimal sexual care of cancer patients and survivors is lack of awareness of who or what may be available to address sexual problems or concerns when raised.

Clinicians are encouraged to conduct a ‘landscape’ review of key personnel and local resources to address sexual health within and proximate to their practice as a first step.

The American Cancer Society (http://www.cancer.org) and the National Cancer Institute (http://www.cancer.gov) both have comprehensive patient informational booklets about sex after cancer. International resources are also available and include the MacMillan Cancer Support Community in the UK (http://www.macmillan.org.uk), the Cancer Council of Australia (www.cancercouncil.com.au) and the Scientific Network on Female Sexual Health and Cancer (http://cancersexnetwork.org/).

Professional organizations also exist to help clinicians identify and facilitate connections with specialists in various areas of expertise.
Different diagnoses need different management

- The ASCO Expert Panel noted the importance of broadly recognizing that different sexual problems will have different management strategies.

- It is important to consider both the physical as well as psychosocial care appropriate for each of these.

- Further, attention needs to be given to the fact that sexual satisfaction is not dependent on (and should not be narrowly defined as) the ability to engage in intercourse.

- Consideration should be given to the multiple ways of achieving sexual satisfaction for oneself, with or without a partner.
Overall sexual functioning and satisfaction for women recommendation

• The Expert Panel noted that current recommendations did not address the important role of symptom management and its impact on the sexual response.

• Improved symptom management can be associated with improvement in the domains of the sexual response.  

• To this end, any underlying physical issue contributing to sexual dysfunction should be identified and managed.
Sexual response for men recommendations

• Body image is important to men’s sexual health.

• Issues such as weight change, increase in breast size, disfigurement, scarring, and hair loss should also be discussed and normalized in men.

• Normalizing these issues may help men reach a new comfort level with body image and functioning following their cancer.

• In considering potential physical contributions to men’s sexual function, clinicians should check testosterone levels, even if the patient has a cancer that is not typically associated with hormone changes.

• Additional management options not covered in the CCO guideline warrant further discussion, including surgical interventions for ED.
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Additional Resources

More information, including a Data Supplement with a reprint of all CCO recommendations, a Methodology Supplement, slide sets, and clinical tools and resources, is available at

[www.asco.org/survivorship-guidelines](http://www.asco.org/survivorship-guidelines)

Link to CCO guideline:

[https://www.cancercareontario.ca/en/content/intervention-s-address-sexual-problems-people-cancer](https://www.cancercareontario.ca/en/content/intervention-s-address-sexual-problems-people-cancer)

Patient information is available at [www.cancer.net](http://www.cancer.net)
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References