Managing Sexual Dysfunction

10 top tips

1. Libido can be affected by cancer and its treatment, irrespective of gender. Fatigue, stress and anxiety can all have an impact as well as some of the specific cancer treatments affecting hormone levels. The impact this has will vary from person to person, but it is important to communicate these potential side effects to patients to help empower them to acknowledge the issues and discuss possible treatments.

2. Prostate cancer is the most common cancer in men and most treatments can result in an element of Erectile Dysfunction (ED). This can be in combination with wider factors including co-morbidities (e.g., diabetes, high blood pressure), lifestyle factors (e.g. smoking) and emotional wellbeing which all need to be considered when offering treatment and support.

3. There are various treatment options when it comes to tackling ED, including oral medication, **vacuum pumps**, injections (Alprostadil) and implants. Personalised care including **shared decision making** should be at the heart of everything we do as healthcare professionals, so it is important to consider patient choice when discussing these options. Information provision is a fundamental element of this, so ensure you share access to good quality **information**.

4. Discuss good sexual health practices with patients. Men who have received pelvic radiotherapy should use a condom during, and up to one year following treatment, as damaged semen may cause abnormalities for a conceived child. Depending on patient and partner age, discuss contraception options to prevent pregnancy.

5. Sexual issues following treatment for cancer can affect both sexes but maybe it isn't addressed as proactively in women. Chemotherapy and hormone therapy can **lower oestrogen** levels causing symptoms including hot flushes, irregular or no periods and vaginal dryness which can make sexual intercourse painful.

6. Radiation therapy can cause physiological changes to the vagina such as stenosis, atrophy and inflammation. **Vaginal dilators** are the main course of treatment to manage stenosis and reduce discomfort or pain from sexual intercourse and potential scaring. **Vaginal lubricants** and moisturisers are also essential for managing the associated dryness of stenosis.

7. Self-stimulation (or masturbation) can be similarly affected following cancer treatment, especially as pelvic-specific treatment can have a greater effect for those with prostate, bowel or gynaecological cancers. Empowering patients to speak about this and signposting them to information could be useful for both **men** and **women**.

8. For women suffering from vaginal dryness or structural changes to the vagina, lubricants in the form of gels or liquids can be useful to make sexual contact easier and more comfortable. Use oil, water or silicon-based products but encourage patients to always check labels and instructions of any new products. If using a condom, avoid oil-based products as it can stop them working.

9. When it comes to increasing sexual desire, there is no one size fits all. **Psychosexual counselling** may be a useful tool to involve both the person living/recovering from cancer and their partner to address some of the issues that may arise from treatment. Signpost to **Relate**, which provides free sex therapy, but also recognise that counselling may not be appropriate or available for all, so supporting these conversations in Primary Care remains important.

10. What if you identify as LGBT or non-binary? It is recognised that health inequalities exist in cancer for the LGBT community and therefore they may be more reluctant to discuss sexual health with their primary care team. The **LGBT Foundation** is an excellent resource for more information and a place where additional advice and support can be found.

You can find more information about sex and cancer **here**

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