Approaches to Intervention and Management Strategies of Sexual Dysfunction in H&N Cancer

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Disclosures

• I have no financial relationship with any pharmaceutical companies or commercial interests to disclose.
Objectives

1. Understand factors affecting sexual function after treatment for H+N cancer
2. Review interview approaches to clarify sexual concerns
3. Understand bio psycho social interventions to support male and female sexual functioning in patients with H+N cancer
Sexual Dysfunction in Head and Neck Cancer

- 24-100% of patients report a negative impact of head and neck cancer and its treatment on sexuality
- Sexual functioning is important to patients in their long term recovery after treatment
- There is an increasing prevalence of HPV associated oropharyngeal carcinomas
- Younger age at diagnosis and favorable treatment response of HPV+ tumors means more patients may face late complications of head and neck cancer treatment including sexual dysfunction

Factors Affecting Sexual Function in Head and Neck Cancer

- Disfigurement, change in body image, depressive symptoms and functional impairments can affect sexual functioning
- Functional changes affecting swallowing, range of motion of shoulders, head and neck, limited jaw opening (trismus)
- Sensory changes affecting smell/taste, reduced saliva production (xerostomia) can interfere with sexual function
- Stigma, self-blame for behaviors associated with cancer risk (smoking, alcohol)

Factors Affecting Sexual Function in Head and Neck Cancer

- Partner as caregiver to patient vs. lover
- Ongoing lifestyle factors such as heavy alcohol consumption and ongoing smoking may contribute to sexual difficulties
- Medication side effects, including opiate analgesics, antidepressants affect sexual function


Sexual Dysfunction: Assessment

- Screen as part of general functional inquiry
- “Many patients will have changes in their sexual functioning after treatment for head and neck cancer. Have you noticed any sexual difficulties that you would like to address?”
- May be helpful to schedule a dedicated appointment
- Seek invitation from patient to proceed with assessment
- “Would it be alright to ask in more detail about your sexual functioning to know best how to help?”
- Invite patient to bring their partner
- Reassure both there is time to speak without their partner present
- Make time to see each member of the couple individually to ask about self-stimulation, sexual difficulties in previous relationships
Assessment of Sexual Function in Men

- How is libido? Does the world still seem like a sexual place? Fantasies?
- Introduce a rating scale to ask about erections
  - Scale of 0-10
  - 6= bendable, but able to help the erection into the vagina with your hand
  - 7-8= penetration with no difficulty
  - 9-10= rigid, firm, like when you were a teenager
- Morning erections? Self-stimulation? (Motivations?, Frequency?) With partner?

- What are their reasons for being sexual with their partner?
- Who is the one to initiate? How often are they sexual?
- What is part of the sexual repertoire?
- Hand-genital stimulation?
- Oral-genital stimulation?
- Intercourse? Difficulties with timing of orgasm? Rapid vs. Delayed?

- Sexual difficulties for their partner?
- Can their partner be orgasmic?
- How have they reacted to the sexual difficulty?
- How has their partner reacted?
Assessment of Sexual Function in Women

• How is libido? Does the world still seem like a sexual place? Fantasies?
• Motivations for self stimulation?
• How often is self-stimulation?

• What are their reasons for being sexual with their partner?
• Who is the one to initiate? How often are they sexual?
• What is part of the sexual repertoire?
• Hand-genital stimulation?
• Oral-genital stimulation?
• Intercourse? Pain with penetration? Changes with lubrication?

• Sexual difficulties for their partner?
• Can their partner be orgasmic? Too rapid? Delayed?
• How have they reacted to the sexual difficulty?
• How has their partner reacted?
Sexual Dysfunction in DSM5

Men
• Premature Ejaculation
• Delayed Ejaculation (Generalized, Situational)
• Erectile Disorder (Generalized, Situational)
• Male Hypoactive Sexual Desire Disorder
• Substance/Medication Induced Sexual Dysfunction (both M, F)

Women
• Female Orgasmic Disorder
• Female Sexual Interest/Arousal Disorder
• Genito-Pelvic Pain/Penetration Disorder
• **Genitourinary Syndrome of Menopause (Not DSM)

Clinical Case: Peter and Tammy

- Peter is a 53 year old man, works as letter carrier
- HPV+ SCC of L lateral tongue with 2 positive lymph nodes on PET staging
- Surgically managed with L lateral glossectomy, L neck lymph node dissection
- Chemotherapy and radiotherapy post-surgery
- He presents for follow up and mentions that he and Tammy have been struggling “in the bedroom”
Clinical Case: Peter and Tammy

- Past Medical History:
  1. Hypertension
  2. Type 2 Diabetes
  3. Dyslipidemia

- Medications:
  1. Atorvastatin
  2. Metformin
  3. Ramipril

- Allergies: NKDA
A Case: Peter and Tammy

- Kissing was a favorite part of their intimacy and sexual relationship that has no longer been possible for Peter.
- Erections have been less reliable for Peter, with infrequent morning erections, 6/10 ("bendable") erections with self-stimulation once per week, and 5-6/10 (rarely able to have penetration) with Tammy.
- He can no longer provide oral-genital stimulation for Tammy, and feels unable to meet her sexual needs.
- Although he continues to self-stimulate 1-2x per month, he reports a lower libido, and less urge for partnered sexual activity.
A Case: Peter and Tammy

• Tammy is 55y.o. and went through menopause at 51y.o. and has noticed increased dryness and discomfort with penetration when they are able to have intercourse
• She is able to be orgasmic using her own touch when they are sexual, and self-stimulates for sexual release 1/month
• Peter used to approach Tammy more often to be sexual but during his treatment and recovery from H+N cancer, he stopped approaching her, they have not been sexual in 9 months
• She hasn’t wanted to put pressure on him and hasn’t brought up being sexual, but misses their sexual life together
• Before Peter’s H+N cancer they would be sexual 1-2x per month
A Case: Peter and Tammy

• Peter says: “I don’t feel the urge like I used to, and I don’t want to start anything I can’t finish.”

• Peter asks: “Is it safe to be having sex after a cancer that was caused by a sexually transmitted infection?”

• Tammy says: ”We were in survival mode for so long, just getting through all the appointments and treatments. Now we’re stuck in a rut, how do we get our sex life started again?”
Sexual Behaviors Change Significantly

- 50% of patients with HPV+OSCC reported concern over sexual transmission of HPV to partners
- HPV+ and HPV- OSCC patients report decreases in frequency of intercourse and oral sex
- Abstaining from intercourse reported by 34% at 6 months vs. 10% at baseline, and abstaining from oral sex reported by 80% at 6 months vs. 25% at baseline

Address Stigma Around HPV Transmission

- 7% of adults 14-69 have oral HPV infection, 1% have HPV type 16, which is associated with oropharyngeal SCC
- Partners of patients with oral HPV+ve OSCC have a low prevalence of oral HPV infection (they may have cleared the infection)
- Partners of patients with oral HPV positive cancer have low absolute risk of HPV associated malignancies (12/100 000)

Address Stigma Around HPV Transmission

- HPV is an STI that is very common (10% men 3.6% women) and can be transmitted through oral sex
- HPV infection does not indicate infidelity or promiscuity
- Your partner has already been exposed to the HPV infection you have and you do not need to change your sexual behavior

What About Peter’s Libido?

Masters and Johnson Model of Sexual Response


The Basson Model of Sexual Response


Clarify Motivations for Being Sexual

• While appearing obvious, clarifying and reminding patients of the multiple positive reasons for being sexual can help shift away from a goal oriented stance to one of exploration, shared pleasure and a focus on intimacy.

• There are hundreds of reasons and motivations for having sex, most common reasons include: attraction, to experience pleasure, to express love, to feel desired by your partner, to strengthen the relationship, to feel closeness to your partner.

Sexual Response Cycle: Motivations

- Help your patient or the couple remind themselves of reasons to be sexual in spite of barriers
- Normalize that many couples, men and women, do not start out being sexual from a place of spontaneous desire or “horniness”
- Starting out being sexual due to motivations and reasons and tapping into responsive desire is common in long term relationships
- closeness/intimacy
- feels good
- sexual release
- express love
- meet partner’s needs

Motivations

Outcomes: Emotional, Physical

Sexual Stimuli and Context

Spontaneous Desire

Arousal, Responsive Desire

Mind Processing Stimuli

Physical Arousal + Mental Arousal
Sexual Context

• What did they used to do to prepare themselves, to feel sexual?
• How do they prepare the room? Music? Temperature? Blankets, pillows, textures?
• Homework: Encourage couple to schedule a time to be sexual
• Removes uncertainty of who will initiate
• Allows couple to start from place of motivation rather than waiting for “the urge”
- closeness/intimacy
- feels good
- sexual release
- express love
- meet partner’s needs

- both prefer weekend mornings
- Peter brushes his teeth and uses a moisturizing mouthwash
- Tammy prefers to have showered
Mental Arousal: Thoughts That Interfere

- Couples can become goal focused with their sexual functioning, compounding distress
- Sex is only successful if:
  - We both reach orgasm
  - We are able to have intercourse
- Cognitive distortions:
  - Mind reading partner’s distress or concern (ex. re: ED)
  - Catastrophizing (our sex life is over, I can’t satisfy her)
- Loss of sexual self-view
- Changes in roles as patient and caregiver vs. lovers
- closeness/intimacy
- feels good
- sexual release
- express love
- meet partner’s needs

Motivations

Outcomes: Emotional, Physical

Spontaneous Desire

Arousal, Responsive Desire

Physical Arousal + Mental Arousal

Sexual Stimuli and Context

Mind Processing Stimuli

Peter:
- comparing thoughts
- missing what used to be possible
- spectating regarding erection firmness
- watching to see if Tammy is having pain
- self-conscious about breath, appearance
- loss of sexual self-view

Tammy:
- stepping out of caregiver role
- worries about pain
- doubts about her contribution to ED “is it me?”
- mind wandering, “to do list”
Motivations

Outcomes: Emotional, Physical

Spontaneous Desire

Arousal, Responsive Desire

Physical Arousal + Mental Arousal

Mind Processing Stimuli

Sexual Stimuli and Context

-closeness/intimacy
-feels good
-sexual release
-express love
-meet partner’s needs

-scheduling a time
-will not occur if you wait for “the urge”
-what do they do to prepare themselves to feel sexual?
-to prepare the room?

Peter:
-comparing thoughts
-missing what used to be possible
-spectating regarding erection firmness
-watching to see if Tammy is having pain
-self-conscious about breath, appearance
-loss of sexual self-view

Tammy:
-stepping out of caregiver role
-worries about pain
-doubts about her contribution to ED “is it me?”
-mind wandering, “to do list”
-ve outcomes
- pain
- sense of failure
- comparing
- conflict
→ contribute to ongoing avoidance of sexual activity
+ve outcomes
- pleasure
- exploration
- connection
→ support
more
responsive
desire
Addressing Peter’s ED: PDE5 Inhibitors for Erectile Dysfunction

- Sildenafil 25-100mg PO PRN 1 hour prior to intercourse
- Tadalafil 5mg PO daily, or 10-20mg PO PRN 2 hours prior to intercourse (longer half-life)
- Vardenafil 10mg PO PRN 45-90min before planned sexual activity
- Avanafil 50-100mg PO PRN 30 min before sexual activity
Barriers to PDE5i

• Cost
• Side effects are generally well tolerated, but facial flushing, headaches can be bothersome
• Contraindicated with nitrate medications (nitro spray, nitro patch etc.) due to risk of hypotensive crisis
• Sildenafil must be taken on empty stomach, tadalafil absorption unaffected by food
Next Steps After PDE5i: Vacuum

• Consider use of a vacuum device to support erectile function ex. Osbon ErecAid, Encore ImpoAid, etc.
• Mechanical or battery operated
• Requires practice and some dexterity
• Draws venous blood into the corpora cavernosa so erection may be more cool to the touch or darker in appearance
• Crura of corpus cavernosa do not fill with blood, may hinge at base
• Tension band required to maintain erection once vacuum removed, band must be removed after 30min
Vacuum Device
Next Steps After PDE5i: Intracavernosal Injection

- PGE$_1$, Bimix, Trimix compounded preparations
- Require comfort with self-injection of the penis
- Risks with any injection of infection, bruising, bleeding, ICI causes small increased risk of Peyronie’s disease with repeated trauma to tunica albuginea, risk of priapism
- Burning discomfort experienced by some men with PGE$_1$
Addressing Tammy’s Pain With Penetration: Clarify Cause

• Provoked Vestibulodynia
  – Q tip test/physical exam to confirm
  – Self-exploration, use of mirror, mindfulness

• Vaginismus
  – Use of vaginal dilators
  – Pelvic floor physiotherapy

• Genitourinary syndrome of menopause
  – Hormonal and non-hormonal treatments
Genitourinary Syndrome of Menopause: Hormonal Treatments

- Suggest patient review treatment options with their family doctor

Local estrogen treatments:
1. Estradiol vaginal tablets 10mcg PV QHS week 1, then twice weekly ongoing
2. Esrtragyn vaginal cream (estrone 0.1% cream) 0.5g PV daily
3. Premarin vaginal cream (conjugated estrogens 0.625mg/g) 0.5g PV twice weekly
4. Estradiol vaginal ring (estradiol 2mg total, released as 7.5mcg daily over 3 months) one ring inserted vaginally q3months

Local DHEA treatment:
1. Prasterone vaginal insert 6.5mg PV QHS

Archer et al. Comparison of intravaginal 6.5mg (0.50%) prasterone, 0.3mg conjugated estrogens and 10μg estradiol on symptoms of vulvovaginal atrophy, The Journal of Steroid Biochemistry and Molecular Biology, Volume 174, 2017, pg 1-8.
Genitourinary Syndrome of Menopause: Non-Hormonal Treatments

Vaginal Moisturizers:
1. Replens (polycarbophil + oil based ingredients), condom compatible, gel applied via vaginal insert, every 3 days
2. Repagyn (hyaluronic acid), vaginal suppository inserted nightly

Vaginal Lubricants:
• Coconut oil, sweet almond oil (not condom compatible)
• Over the counter water based or silicone lubricants
Peter and Tammy: How to Move Ahead

• Restarting a sexual relationship after a long period of abstinence/avoidance can be difficult
• Sensate focus can be a safe, structured way for couples to reconnect physically, build communication skills
Partner Sensate Focus

- 5 min to set up, clothes are off
  - ex. comfortable temperature, favorite blankets/pillows/textures, music
- 10 minutes as giver of touch
- 10 minutes as receiver of touch
- 5 min debrief
- Phase 1 (~4 weeks) exclude sensitive areas, ex. breasts, genitals
- Phase 2 include all areas of the body
- No goal of arousal or orgasm, couple agree to no intercourse during sensate focus sessions
Sensate Focus vs. Being Sexual

Sensate Focus
- No goal of arousal
- No goal of orgasm
- No goal of intercourse
- Exploring with touch
- Comfort directing partner/giving and receiving feedback

Sexual Activity
- Often goal focused, intercourse and orgasm as definition of success
- Couples often report limited repertoire/fixed routine, no exploration
The Case: Peter and Tammy

- Peter starts using Tadalafil 5mg PO daily, notices firmer morning erections, erections with self-stimulation and reports more reliable erections for intercourse of 7/10 firmness
- He and Tammy practice sensate focus, and Tammy has felt more comfortable guiding his touch (hand over hand) or guiding Peter holding a vibrator to be able to get close to the point of orgasm if intercourse is not possible, her own touch is still required to trigger orgasm
- They schedule a time to be sexual once per week
- Tammy has started using a vaginal moisturizer for comfort and coconut oil for lubrication when they attempt intercourse
Consider Your Local Referral Resources

• Build relationships with local sex therapists, psychologists, counsellors who are comfortable working with couples or individuals facing sexual difficulties after H+N cancer treatment
• Consider referral to pelvic floor physiotherapist for vaginismus or pain with penetration
• Local mindfulness resources
Resources: Books

by: Dr. Paul Johannides
-helpful for couples in expanding their sexual

“The Elusive Orgasm”
By: Dr. Vivienne Cass
-description of anatomy and multiple factors
involved in female orgasm with self-stimulation
and in partnered context

“Better Sex Through Mindfulness”
By: Dr. Lori Brotto
-explores use of mindfulness to help with low
desire and sexual difficulties
Resources: Books

“Come as You Are”
By: Dr. Emily Nagoski
-an exploration of female desire

“Mating in Captivity”
by: Esther Perel
-discusses factors affecting desire in long term relationships
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