Critical Conversations: How to Talk About Sex With Your Breast Cancer Patients
Conflict of Interest Disclosure

Don S. Dizon, MD

I have no financial relationships with a commercial entity producing healthcare-related products and/or services relevant to the material I am presenting today.
LEARNING OBJECTIVES

1. To characterize the incidence and significance of sexual health in patients with cancer

2. To describe the relationship between intimacy and intercourse for women and men

3. To outline what providers can do to address sexual health issues in patients with cancer
Incidence of sexual problems

Breast cancer: 50-90%
Gynecologic cancer: 25-90%
Hematologic malignancies: 25-30%
Prostate cancer: 27-80%
Bladder cancer: 60%
Colorectal cancer: 70-80%
Head and Neck cancer: 50-60%
Sexual dysfunction is a long-term issue

- Impacted population: >12 million cancer survivors
- Livestrong 2010 Survey (n= 3129)
  - Predominantly white (90%) and female (60%)
  - Educated (54% with bachelor’s or graduate degree)
  - Majority diagnosed before 40 years
  - Most prevalent- breast, colorectal, lung

Livestrong Survivor Survey Final Report. Available at: www.livestrong.org/pdfs/3-0/LSSurvivorSurveyReport_Final
• Sexual functioning and satisfaction ranked THIRD most frequently reported physical concern.
  • Reported as a lot in 29%
  • Reported as a little in 37%
  • Of those reporting, less than half received medical care.

The Livestrong Survivor Survey

Livestrong Survivor Survey Final Report. Available at: www.livestrong.org/pdfs/3-0/LSSurvivorSurveyReport_Final
Significant emotional concerns associated with sexual health (% rated as a lot/a little):

- Sadness and depression (9/36)
- Personal appearance (14/39)
- Stigma (6/31)
- Personal relationships (15/56)
Sexual Health is not *just* about intercourse

Intimacy
Sensuality
Body image
Arousal
Desire
Climax
Satisfaction
After a diagnosis of cancer, sexual health in men and women is impacted in a very similar way.

True or False
Cancer affects male and female sexuality differently.
## Breast Specific Sensuality

<table>
<thead>
<tr>
<th>Chest play is a part of my sexuality</th>
<th>BCS</th>
<th>MRM</th>
<th>MRM with Recon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before surgery</td>
<td>83%</td>
<td>87%</td>
<td>93%</td>
</tr>
<tr>
<td>After surgery</td>
<td>73%</td>
<td>59%</td>
<td>76%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I am satisfied with my surgical outcome</th>
<th>BCS</th>
<th>MRM</th>
<th>MRM with Recon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>48%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Breast Specific Sensuality

Lumpectomy

37.7
62.3

Mastectomy and Reconstruction

40
60

N= 180

Breast Specific Sensuality

Lumpectomy

- Pleasurable: 20
- Neither: 52
- Unpleasant: 28

Mastectomy and Reconstruction

- Pleasurable: 20.4
- Neither: 51
- Unpleasant: 28.6

n = 174
p = 0.007

Approach to treatment

**Vaginal Health**
- Address Genitourinary Symptoms of Menopause (GSM)
- Vulvar and vaginal moisturizers
- Vaginal laser therapy
- Hormonal treatment

**Sexual Health**
- Address ways to make sexual activities more pleasurable
  - Lubricants, Lidocaine, Dilators
- Address desire
  - Sensate focusing, Flibanserin (?)
Treatment for GSM
Vaginal moisturizers

Part of routine gynecologic health
Benefit for sexual comfort
Many types:
  • Polycarbophil-based
  • Vitamin E
  • Natural oils (coconut, olive)
    • Apply externally only
  • Parabens free (Luvena)
Vaginal laser therapy

Fractional microablative CO2 laser therapy x3

Salvatore, et al:

- Patients: 77 postmenopausal women with vulvovaginal atrophy (VVA)
- Intervention: 3 treatments over 12 weeks
- Comparator: None
- 12-week Outcomes with treatment compared to baseline:
  - Significant improvement in function
  - Significant improvement in physical and mental domains in QOL

Vaginal laser therapy after breast cancer

Pieralli, et al, 2016:

Patients: 50 women with dyspareunia associated with an oncologic menopause

Intervention: CO2 laser therapy

Comparator: None

Outcomes:

• Significant improvement in dyspareunia (by VAS)
• Significant improvement in vulvovaginal atrophic symptoms (by VHI)
• Satisfaction persisted at 11 months follow-up for 52% of patients

Hormone therapy after cancer

Vaginal estrogen is safe
No known impact after breast cancer
LeRay, 2012:
• Patients: Women with recurrent BC (n=917)
• Intervention: Use of vaginal ERT (concomitant or sequential)
• Comparator: Women free of BC (n=8885)
• Outcomes:
  • Concomitant ERT and Endocrine tx: RR 0.78, 95% CI 0.48-1.25
  • Sequential: RR 0.97, 95% CI 0.22-4.18

Vassilopoulou-Sellin, R. Gynecol Oncol 1997; 65:89
Dew, JE. Climacteric 2003; 6:45
ACOG Opinion

1. Nonhormonal approaches are the first-line choices during or after treatment for breast cancer.

2. Reserve vaginal ERT for women who do not benefit from #1.
   - Collaboration important
   - Shared decision making critical

3. Data do not show an increased risk of recurrence after breast cancer with use of vaginal estrogen

Oral HT and Breast Cancer

- HABITS (HT after breast cancer: Is it Safe)
  - Design: Open-label RCT
  - Patients: Stage 0-2 breast cancer, <4 nodes involved (n= 497)
    - Tamoxifen adjuvant treatment OK, but not an AI
  - Intervention: HT (2-years)
    - Choice determined by local practice
    - Sequential E-P combination preferred for women with an intact uterus
    - Medium-potency E for women s/p hysterectomy
  - Comparison: Best symptomatic management without hormones

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>HT arm</th>
<th>Non-HT arm</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. with follow-up</td>
<td>221</td>
<td>221</td>
</tr>
<tr>
<td>Follow-up in years, median (range)</td>
<td>4.1 (0.01–7.8)</td>
<td>4.0 (0.2–7.7)</td>
</tr>
<tr>
<td>Time in years between primary treatment and randomization, median (range)</td>
<td>2.1 (0.1–23.2)</td>
<td>2.2 (0.1–26.5)</td>
</tr>
<tr>
<td>Age In years, mean (range)</td>
<td>55.6 (42–75)</td>
<td>54.8 (38–74)</td>
</tr>
<tr>
<td>Node positive, No. (%)</td>
<td>44 (19.7)</td>
<td>42 (18.8)</td>
</tr>
<tr>
<td>Hormone receptor positive, No. (%)</td>
<td>139 (62.3)</td>
<td>122 (54.5)</td>
</tr>
<tr>
<td>Hormone receptor status unknown, No. (%)</td>
<td>64 (28.7)</td>
<td>75 (33.5)</td>
</tr>
<tr>
<td>Breast preserved, No. (%)</td>
<td>127 (57.0)</td>
<td>126 (56.3)</td>
</tr>
<tr>
<td>On HT before diagnosis, No. (%)</td>
<td>115 (51.6)</td>
<td>115 (51.3)</td>
</tr>
<tr>
<td>On adjuvant tamoxifen at randomization, No. (%)</td>
<td>75 (33.6)</td>
<td>75 (33.5)</td>
</tr>
<tr>
<td>Follow-up clinic visits for breast cancer, median</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

The HABITS Randomized trial

The HABITS Randomized trial

221 women followed according to ITT. 218 records checked in 2005/2006
11 women never exposed to HT

First events of breast cancer:
Local recurrence n=17
Ipsilateral axilla n=1
Contralateral cancer n=11
Distant metastases n=10
Breast cancer death n=0
Total breast cancer events n= 39
Death by other causes n=3

221 women followed according to ITT. 220 records checked in 2005/2006
39 women exposed to HT

First events of breast cancer:
Local recurrence n=4
Ipsilateral axilla n=1
Contralateral cancer n=4
Distant metastases n=8
Breast cancer death n=0
Total breast cancer events n= 17
Death by other causes n=0

HR (95%CI) of a new breast cancer event

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of events (No. of women in subset)</th>
<th>HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All women</td>
<td>56 (442)</td>
<td>2.4 (1.3 to 4.2)</td>
</tr>
<tr>
<td>All women, adjusted</td>
<td>52 (416)</td>
<td>2.2 (1.0 to 5.1)</td>
</tr>
<tr>
<td>Hormone receptor positive</td>
<td>37 (268)</td>
<td>2.6 (1.3 to 5.4)</td>
</tr>
<tr>
<td>Hormone receptor negative</td>
<td>19 (174)</td>
<td>1.8 (0.7 to 4.8)</td>
</tr>
<tr>
<td>Tamoxifen</td>
<td>18 (153)</td>
<td>4.7 (1.4 to 16.2)</td>
</tr>
<tr>
<td>No tamoxifen</td>
<td>38 (289)</td>
<td>1.9 (1.0 to 3.6)</td>
</tr>
<tr>
<td>HT before diagnosis</td>
<td>26 (230)</td>
<td>2.3 (1.0 to 5.3)</td>
</tr>
<tr>
<td>No HT before diagnosis</td>
<td>26 (186)</td>
<td>2.2 (1.0 to 5.1)</td>
</tr>
<tr>
<td>Node negative</td>
<td>30 (282)</td>
<td>2.4 (1.1 to 5.4)</td>
</tr>
<tr>
<td>Node positive</td>
<td>18 (110)</td>
<td>2.3 (0.8 to 6.4)</td>
</tr>
</tbody>
</table>
The HABITS Randomized trial

The Bottom Line: For women with breast cancer, compared to no HT, HT (x2y) results in:

- A significantly increased risk of a breast cancer event (HR 2.4, 95% CI 1.3-4.2)
- 5-year cumulative incidence was 22 versus 8%
- Significance of risk seems limited to HR+ breast cancer
- Unknown impact on mortality (no deaths recorded)

- Study *underpowered* to assess different preparations of HRT
  - E2 alone compared to continuous combined regimen: HR 1.4 (95% CI 0.55-3.3)

Vaginal estrogen therapy: preparations

- **20 mcg**
  - E2 tablet (Vagifem®)
  - 10 mcg, qd x 14d, then twice weekly

- **52.5 mcg**
  - E2 ring (Estring®)
  - 2 mg / 90 d, approx 7.5 mcg/d

- **200 mcg**
  - CEE cream (Premarin®)
  - 0.5 g cream (0.3 mg CEE) twice weekly

- **200 mcg**
  - E2 cream (Estrace®)
  - 2-4 g x 14 d, then 1 g cream (100 mcg E2) twice weekly

* 0.5 g CEE cream is approximately bioequivalent to 1 g estradiol cream.
Ospemifene

A Vaginal SERM
FDA Indication: The treatment of moderate to severe dyspareunia (secondary to vulvovaginal atrophy)

Breast Cancer

OSPHENA 60 mg has not been adequately studied in women with breast cancer; therefore, it should not be used in women with known or suspected breast cancer or with a history of breast cancer.
Dehydroepiandrosterone (DHEA)

• RCT (Alliance N10C1)
  • Patients: Women with breast or gyn cancer (n=441)
  • Intervention: Vaginal DHEA (3.25 v 6.5 mg)
  • Control: Placebo
  • Results:
    • Positive impact in all arms
    • DHEA: Significant impact in sexual function
      • +0.3-0.6 points on FSFI
    • Side effects: voice change, headache
    • No evidence of clinically important systemic estrogenic activity.

Prasterone

• FDA Approved for treatment of GSM related sexual dysfunction
• RCT: 200 postmenopausal women
  • History of cancer was exclusionary
  • Placebo vs DHEA at 0.25%, 0.5% or 1.0%

Treating for sexual comfort
Vaginal Lubricants

Two varieties:

- Water-based
- Silicone-based

Limited comparative studies

- Hebernick, 2011: Double-blind trial comparing these in >2400 women
- No difference in pleasure or satisfaction found
- For penile-anal intercourse: Preference towards water-based lubricant (versus none at all)
Natural oils as a lubricant?

• Coconut and olive oil commonly used, instead of lubricants
• OVERCOME study (n= 25):
  • Pelvic Floor Relaxation Exercises (by PT at W0, W4)
  • Polycarbophil-based vaginal moisturizer
  • Olive Oil during sex
• Results:
  • Max benefit = 12 weeks
  • PFR Exercises helpful in 93%, Vaginal moisturizer in 88%, Olive Oil in 73%

Topical Lidocaine for vestibular tenderness

• Goesch, et al: RCT, 46 breast cancer survivors (median pain with penetration score 8 out of 10)

• Method:
  • Saline or 4% aqueous lidocaine to vulvar vestibule (3m before penetration)
  • 1-month blinded then open-label (all patients) for 2-months
  • Measurement: twice-weekly tampon insertion or intercourse
  • Place on cotton swab, hold at vestibule for 30s

• Results with lidocaine:
  • At one month had less pain (median score 1 vs 5)
  • After open-label: 90% comfortable penetration
  • 17/20 who were abstinent at entry resumed penetrative intercourse.

Goetsch MF, Lim JY, Caughey AB. J Clin Oncol. 2015 Jul 27
Vaginal dilators for vaginismus
Flibanserin for desire?

- FDA indication: Hypoactive sexual desire disorder in premenopausal women
- Dosing: 100mg DAILY Qhs
- Serious risks: Hypotension and Syncope (worse with strong CYPA34 inhibitors and alcohol). Most common = dizziness
- Sedation risk peaks 1-3h after dose, minimal after 6h

<table>
<thead>
<tr>
<th>Endpoints</th>
<th>Study 71</th>
<th>Study 75*</th>
<th>Study 147</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>FLI 100mg</td>
<td>Placebo</td>
<td>Trt. Diff</td>
</tr>
<tr>
<td></td>
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<td>Placebo</td>
<td>Trt. Diff</td>
</tr>
<tr>
<td></td>
<td>FLI 100mg</td>
<td>Placebo</td>
<td>Trt. Diff</td>
</tr>
<tr>
<td>SSEs (standardized)</td>
<td>41%</td>
<td>29%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>43%</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>44%</td>
<td>34%</td>
<td>10%</td>
</tr>
<tr>
<td>FSFI desire domain</td>
<td>55%</td>
<td>40%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>40%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>58%</td>
<td>48%</td>
<td>10%</td>
</tr>
<tr>
<td>FSDS-R Item 13</td>
<td>55%</td>
<td>43%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>49%</td>
<td>40%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>62%</td>
<td>49%</td>
<td>13%</td>
</tr>
</tbody>
</table>
PDE-5 Inhibitors?

• No data in this population
• Women without cancer: No more effective than placebo
• Cochrane systematic review in 2007:
  • Only data available for men with ED after prostate cancer
  • Poor quality clinical trials

Testosterone to improve sexual health?

- Effective in women **without** cancer
  - Postmenopausal women: It improves interest and satisfaction in sex.(1)
  - Women with HSDD: It is associated with an average increase of 4.4 sexual encounters per 4 weeks.(2)
    - OR (benefit): 2.4
  - Women s/p TAH-BSO: It increased frequency of activity (p=.03) and pleasure-orgasm (p=.03).(3)

Patients: 150 postmenopausal women, NED

Intervention: 2% testosterone in Vanicream

Comparator: Vanicream plus placebo

Outcome: Improvement in Sexual desire or Libido

Trial design: Randomized phase III trial with cross-over

NC02C3

Testosterone for women?

01.
One RCT → No benefit when administered as a cream

02.
In general, not recommended*

03.
* Preparations?
* Generalizability?
Your role in the sexual health of your patients
Why Clinicians don’t talk about it

• Too busy
• Assumptions based on:
  • Lack of partner
  • Age
  • Disease status
• You survived cancer!
• “I don’t want to go there”
The role of the clinician

- **Normalize** sexual health as a valid concern
  - Take a sexual history
  - Incorporate into the review of systems — At initial visit and during all follow-up
  - Refer!
Approaching sexual health

Permission
- Invites patient to enter into a discussion about sexual health
- "I'd like to review how you are doing as it relates to both sexuality and intimacy. Would that be okay?"
- "Are you (and your partner) having problems being intimate?"

Limited Information
- Normalizes that issues related to sexual health are common
- "Some women complain that sex and intimacy are different now. In fact, it is pretty common. How has your experience been?"
- "A common complaint is pain during intercourse. Is this something that is happening with you?"

Specific Suggestions
- Offer advice that can be actionable and easy to incorporate if possible
- "If you have some trouble with vaginal dryness, it may help to use a lubricant before and during sex."

Intensive Therapy
- If one is not comfortable with issues brought up or does not know what to advise, offer expert consultation locally (if possible) or refer to educational resources (Table 4)
- "It sounds like you might benefit from seeing an expert in sexual health. Can I suggest a referral?"

Education is key

- Explore sexual health is a concept beyond intercourse.
- Re-examine what it means to be “sexual”
- Normalize their experience
- Encourage communication between partners

RECOGNIZE IN YOURSELF:
- Your own personal comfort zone
- Your own sexual self-schema
Emphasize the tincture of time

Re-defining sex after cancer is a process

Pleasure is the goal, not performance

Sexual homework:

• Intimacy exercises
• Communication exercises
• Mandatory dates
• Re-introducing sexual activities *beyond* penetrative intercourse
Conclusion

01 Communication – side effects, symptoms

02 Consultation – seek help and advice proactively

03 Compromise – eg, alternatives to intercourse

04 Clarity – define expectations of patient and of partner
After cancer...

- Everyone deserves a sex life including:
  - The young adult
  - The older patient
  - Patients in relationships
  - Patients without a partner
  - LGBTQ patients
  - Patients with advanced or metastatic disease
  - The oncologist
Cancer is a social disease.

Your patient with cancer includes his or her partner.
Thank you for having me

Questions?

don.dizon@lifespan.org
Twitter: @drdonsdizon