SEXUAL FUNCTIONING AFTER BREAST CANCER DIAGNOSIS

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Many issues in the field of oncology deal with quality of life. As more and more Americans are free of cancer years after diagnosis a particular issue is the quality of life. This is a crucial issue for some since their decision about treatment is predicated on what life will be like after treatment.

In an article published by Ganz et al, in the prestigious Journal of Clinical Oncology, the issue of sexual function after breast cancer diagnosis was investigate and analyzed.

Recently a study that evaluated women three years after breast cancer showed that sexual function was similar to age matched controls. Yet, there was poor sexual function in younger women who became menopausal because of chemotherapy and in general in all women who received chemotherapy. Sometimes chemotherapy stops the function of the ovaries. Hormonal production ceases and menopause occurs.

The rationale of sexual dysfunction after chemotherapy is little known. There are many issues that are feasible including pre-existing sexual problems, age related changes, and physiological changes such as diminished estrogen state causing hot flashes and poor vaginal lubrication. For older patients the withdrawal of hormonal replacement therapy is a frequent subject of concern. Women who have been on estrogen replacement prior to breast cancer diagnosis, are dissuaded from further such therapy since it may reactivate the cancer.

Vaginal symptoms may be exacerbated by Tamoxifen, an anti-estrogen oral medication administered to many women with breast carcinoma. Two groups of breast cancer survivors including 863 recruited in 1994 and 1995 and 1094 recruited between 1996 and 1997 were evaluated. All women had breast cancer and were one to five years since the diagnosis. They had completed local and systemic therapy and were felt to be disease-free not receiving any other medication.

There were special criteria to be part of this study. Patients had no other cancers in the past, went through the informed consent process and in general were in good health. To be eligible the patient had to have a partner and be sexually active within the last six months.

Using vaginal dryness as a symptom corresponded in lower rate of sexual interest. While having a new sexual partner since the diagnosis of breast carcinoma resulted in greater sexual interest rates.

Better mental health scores produced better sexual interest while poor body image scores yielded in less sexual interest. Statistical analysis found these all to be true even when controlled for patient age, ethnicity, type of surgery or time since diagnosis.

Statistically significant in adversely affecting sexual function was having chemotherapy resulting in more sexual dysfunction, more likely becoming menopausal or stopping female -hormonal replacement therapy after diagnosis. All resulted in a greater degree of sexual dysfunction in post-menopausal women.

Multiple regression analysis was performed to further analyze independent variables of sexual satisfaction. Having a partner with sexual problems created less satisfaction. This would be a surprise to few.

Partners with sexual problems had a greater impact on sexual function in younger women. Ceasing menstruation after diagnosis or having a history of hormonal replacement therapy that was discontinued at the time of breast cancer diagnosis resulted in lesser satisfaction compared

to already being post-menopausal and not taking hormonal therapy at the time of diagnosis.

In the second sample was found that African-American women had less dysfunction than Caucasian women. Similarly, more favorable mental health was associated with less dysfunction. Remaining pre-menopausal was related to less dysfunction compared to post-menopausal state or not taking hormonal replacement therapy.

Interestingly enough avoiding a mastectomy did not improve sexual function. This would fly in the face of body image data, however. Our group encourages women to undergo lumpectomy and radiation in lieu of mastectomy when possible. The oncology community feels similarly about this in general. It appears that the first issue concerning sexual dysfunction was vaginal dryness. Few remedies are effective for this condition in breast cancer patients since hormone replacement is considered taboo.

Most patients and nearly all physicians are reluctant to use hormonal replacement therapy after breast cancer diagnosis since it is often felt that the hormones are responsible for the development of the cancer itself. Further use may stimulate or re-activate the cancer. Some patients do, indeed, use topical hormones temporarily.

Researchers noted, "The quality of the partnered relationship was one of the most important predictors of sexual satisfaction."

Sexual problems in the partner contributed to patients' satisfaction significantly. The authors noted that only 8.9% of women who were sexually active at the time of breast cancer diagnosis were no longer active at the time of the survey. And 3.85 percent of women who were inactive at the time of breast cancer diagnosis were active at the time of survey.

The authors felt that pre-existing partners and function tend to predict post-diagnosis sexual activity. They feel that women for whom active sex life is important will likely be maintained.

Overall about 58% breast cancer survivors were sexually active and in a partnered relationship. It is felt that this is similar to other studies of healthy women. The quoted evaluation of post-menopausal women shows 64% being sexually active. The researchers conclude, "As with many studies, this research has raised as many questions as it has potentially answered."

Ongoing studies will tell us more about sexual function and its improvement in breast cancer patients.