Sexual Health in Women After Cancer Diagnosis

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October 22, 2024

ISSWSH WEBINAR

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Disclosures

- Astra Zeneca, Pfizer, Breast Cancer Index, Gilead, Lilly

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Case 1

- 46 yo female diagnosed with Stage II breast cancer that was estrogen receptor positive, progesterone receptor positive, and HER2 negative and 2 lymph nodes positive
- She has bilateral mastectomies, sentinel lymph node biopsy with reconstruction, chemotherapy, and radiation
- Her endocrine therapy is ovarian suppression and an aromatase inhibitor, letrozole

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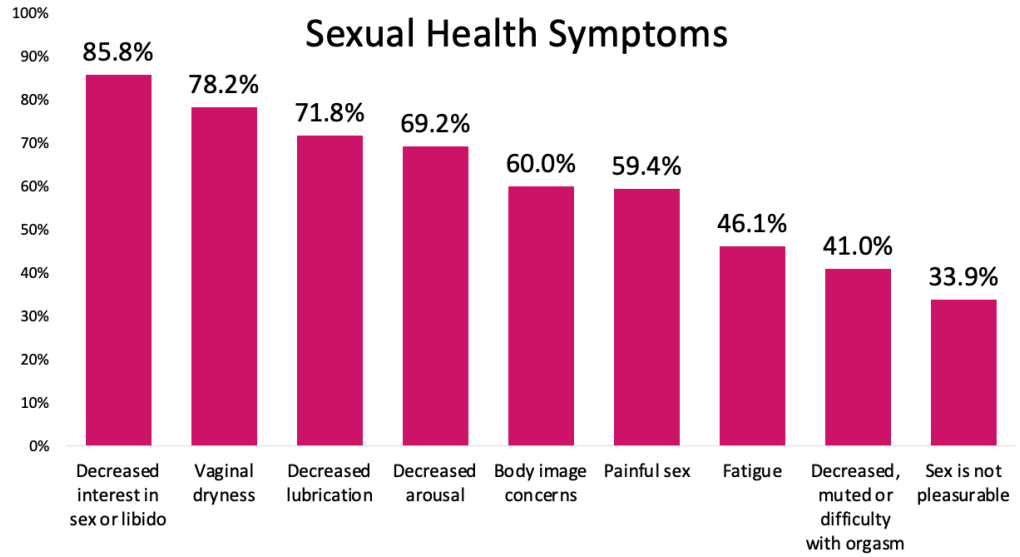
Case 1, cont

- 2 years after her diagnosis, she presents with symptoms of pain with penetrative intercourse
- It feels like “razor blades” and “glass shards”
- This has lead her to dread having sex with her husband.
- They tried a drugstore lubricant once, but it burned
- He is present and says “I don’t want to hurt her”

Women's Insights on Sexual Health after Breast Cancer: WISH-BREAST

- 89.5% - breast cancer diagnosis or treatments caused a moderate to great deal of change to sexual health
- 85% - sexual health changes caused a moderate to great deal of distress
- 73% - did not receive information about sexual health from their healthcare team
- 71% of those who did discuss sexual health initiated the conversation themselves



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Laila Agrawal et al. Women's insights on sexual health after breast cancer (WISH BREAST). *JCO* **42**, 12132-12132(2024).

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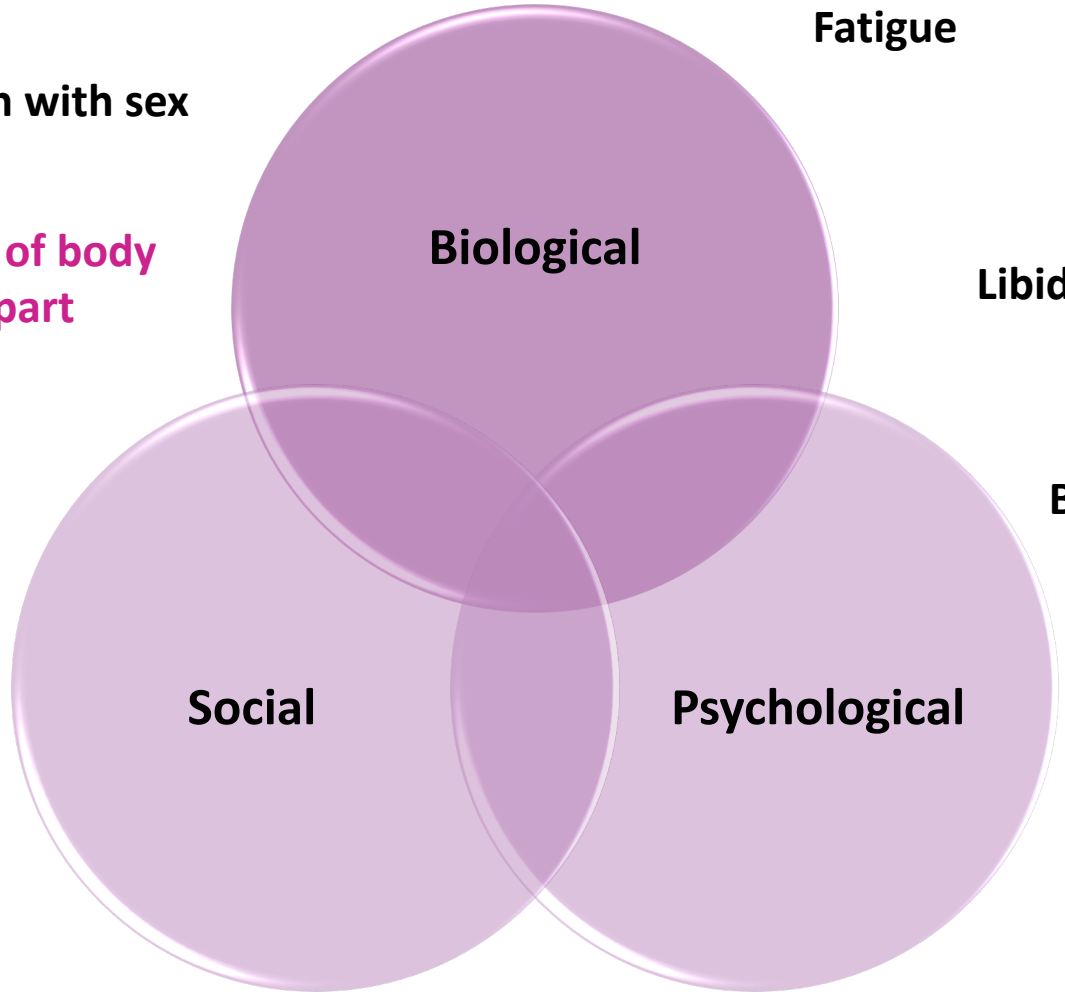
Bio-psycho-social model of sexual health



Genitourinary syndrome of menopause

Menopausal symptoms

Breast/nipple sensation

Weight changes

Hair loss

Relationship concerns

Intimacy

Communication

Pain with sex

Loss of body part

Fatigue

Sleep disturbance

Libido

Orgasm

Arousal

Body image

Fear of recurrence

Mental Health

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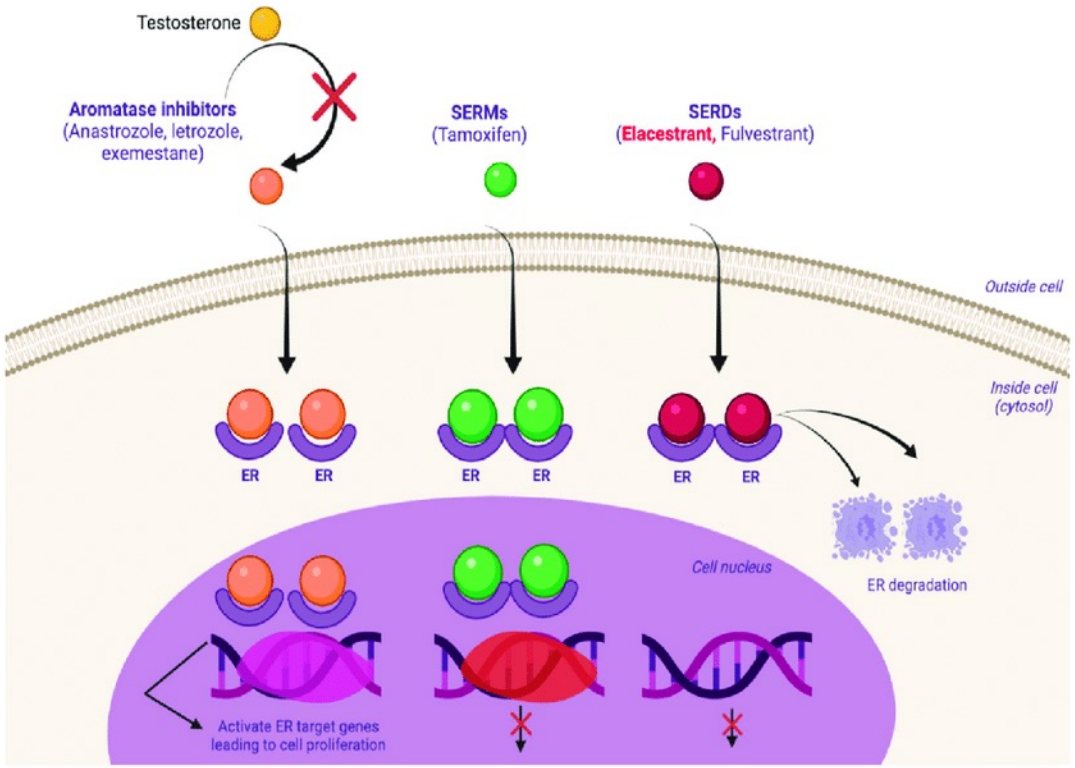
Tamoxifen and Aromatase Inhibitors



Tamoxifen

- Selective estrogen receptor modulator
- Effective in pre- and post-menopausal women
- Uterine cancer (1 in 500) and blood clot (2%) risk

Aromatase inhibitors

- Block aromatization of androgen into estrogen
- Often more effective than tamoxifen
- Bone density loss

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International Journal of Molecular Sciences. 22. 7812. 10.3390/ijms22157812.

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Vaginal moisturizers

Natural Oil Moisturizers	
Coconut oil	Apply to external vulvar tissue
Olive oil	Apply using finger in the vaginal canal
Vitamin E, D	Comes as a suppository, oil, or capsule. To use the capsule, break it open and apply the oil to the vagina.
Vaginal Moisturizer Products	
Luvena®	Hormone, glycerin, and paraben free
Replens®	Use applicator to insert into vagina
Hyaluronic Acid Containing Products	
HyaloGyn®	Comes with applicator or as suppository
Revaree®	Hyaluronic acid containing suppository
Good Clean Love®	Hyaluronic acid containing vaginal gel

Hyaluronic acid (HLA)

- ER+ breast cancer and endometrial cancer survivors
- Single arm study
- Vaginal HLA 3x/week
- Increased to 5x/week if no response

Table 4.

Change in Vulvovaginal Health Outcomes from Baseline to T3 and from Baseline to T4

	Baseline to T3 Comparison[1]			Baseline to T4 Comparison[2]		
	T1 n (%)	T3 n (%)	p value[3]	T1 n (%)	T4 n (%)	p value[3]
Vaginal Dryness						
None	2 (2.50%)	44 (55.0%)	<0.001	2 (3.03%)	49 (74.2%)	<0.001
Mild	17 (21.2%)	24 (30.0%)		13 (19.7%)	9 (13.6%)	
Moderate	21 (26.2%)	11 (13.8%)		18 (27.3%)	6 (9.09%)	
Severe	40 (50.0%)	1 (1.25%)		33 (50.0%)	2 (3.03%)	

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Support Care Cancer. 2020 May 2;29(1):311–322.

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HLA vs vaginal estrogen

- Pilot randomized trial of vaginal estrogen vs HLA in women with GSM
- Results
  - Vaginal estrogen 96% improvement
  - Vaginal HLA 91% improvement
  - The VAS score, total VSI score, total FSFI score, and vaginal pH improved over time; however, improvement did not differ between study arms.
  - No treatment-related serious adverse events occurred.

Menopause31(9):750-755, September 2024

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Vaginal lubricants

Fun Fact	Water based	Silicone based	Oil based
Can be used with condoms	YES	YES	NO
Can be used with silicone sex toys	YES	NO	NO
Stain sheets	NO	YES	YES
Sticky	YES	NO	NO
Long lasting	NO	YES	YES
Can be used in water	NO	YES	YES

Vaginal pH is 3.5-4 – pH of lubricant should be similar
Avoid petroleum jelly or baby oil
Flavored, “tingling”/warming, or glycerin containing lubricants can cause vaginal irritation

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Local hormones

Medication	Brand Name	Starting dose	Maintenance dose	Cost (Good Rx)
Vaginal creams				
17β-estradiol	Estrace	0.5-1 g/day x 2 weeks	0.5-1g, 1-3 times per week	$50
Conjugated estrogens	Premarin	0.5-1 g/day x 2 weeks	0.5-1g, 1-3 times/week	$400
Vaginal inserts				
Estradiol hemihydrate	Vagifem	10 µg insert once per day x 2 weeks	1 insert twice per week	$50
17β-estradiol caps	Imvexxy	4 or 10 µg/day x 2 weeks	1 twice per week	$200
DHEA (prasterone)	Intrarosa	6.5mg daily	Daily	$200
17β-estradiol vaginal ring	Estring	2 mg releases 7.5 µg/day x 90 days	Changed every 90 days	$500
SERM				
Ospemifene	Osphena	60 mg/day	60mg/day	$200

Bober, 2019

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Are Vaginal Hormones Safe in Breast Cancer?

- No randomized controlled trials
- A large Finnish observational study identified no elevated risk of de novo breast cancer associated with the use of vaginal ET
- No increased breast cancer risk in healthy participants in the Women's Health Initiative (WHI) observational study despite a very large sample size and duration of follow-up
- In one nested case-control study, local ET was not associated with an increased risk of recurrence in women with a history of breast cancer

Lyytinen, 2006; Crandell, 2018; Le Ray, 2012

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JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

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

Jeanne Carter, Christina Lacchetti, Barbara L. Andersen, Debra L. Barton, Sage Bolte, Shari Damast, Michael A. Diefenbach, Katherine DuHamel, Judith Florendo, Patricia A. Ganz, Shari Goldfarb, Sigrun Hallmeyer, David M. Kushner, and Julia H. Rowland

Author affiliations and support information (if applicable) appear at the end of this article.

Published at jco.org on December 11, 2017.

J.C. and J.H.R. were Expert Panel co-chairs.

Clinical Practice Guideline Committee approved: August 24, 2017.

Editor's note: This American Society of Clinical Oncology Clinical Practice Guideline provides recommendations, with comprehensive review and analyses of the relevant literature for each recommendation. Additional information, including a Data Supplement with additional evidence tables, a Methodology

ABSTRACT

Purpose

The adaptation of the Cancer Care Ontario (CCO) guideline Interventions to Address Sexual Problems in People With Cancer provides recommendations to manage sexual function adverse effects that occur as a result of cancer diagnosis and/or treatment.

Methods

ASCO staff reviewed the guideline for developmental rigor and updated the literature search. An ASCO Expert Panel (Table A1) was assembled to review the guideline content and recommendations.

Results

The ASCO Expert Panel determined that the recommendations from the 2016 CCO guideline are clear, thorough, and based upon the most relevant scientific evidence. ASCO statements and modifications were added to adapt the CCO guideline for a broader audience.

Recommendations

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 (three to five times per week) in the vagina, at the vaginal opening, and on the external folds of the vulva for symptom relief in female patients with cancer and survivors.[151]

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.***

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Finally, clinic
current or a

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.**

ASCO Quali *story 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 or 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.*

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 659 • March 2016 *(Reaffirmed 2020)*

Committee on Gynecologic Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice. Member contributors included Ruth Farrell, MD. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

The Use of Vaginal Estrogen in Women With a History of Estrogen-Dependent Breast Cancer

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- Nonhormonal approaches are the first-line choices for manag
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remedies.
- The decision to use vaginal estrogen may be made in coordination with a woman's oncologist. Additionally, it should be preceded by an informed decision-making and consent process in which the woman has the information and resources to consider the benefits and potential risks of low-dose vaginal estrogen.
- Data do not show an increased risk of cancer recurrence among women currently undergoing treatment for breast cancer or those with a personal

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adverse effects of cancer therapies or of natural menopause in survivors. Obstetrician–gynecologists and other health care providers frequently face the challenge of understanding and addressing these issues among an increasing cohort of women cancer survivors who experience urogenital symptoms, either from cancer therapy or

Data do not show an increased risk of cancer recurrence among women currently undergoing treatment for breast cancer or those with a personal history of breast cancer who use vaginal estrogen

Consensus Recommendations

Management of genitourinary syndrome of menopause in women with or at high risk for breast cancer: consensus recommendations from The North American Menopause Society and The International Society for the Study of Women's Sexual Health

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Abstract

The objective of The North American Menopause Society (NAMS) and The International Society for the Study of Women's Sexual Health (ISSWSH) Expert Consensus Panel was to create a point of care algorithm for treating genitourinary syndrome of menopause (GSM) in women with or at high risk for breast cancer. The consensus

TABLE 4. *Treatment options for management of GSM in specific patient populations*

General guidelines
- Individualize treatment, taking into account risk of recurrence, severity of symptoms, effect on QOL, and personal preferences
- Moisturizers and lubricants, pelvic floor physical therapy, and dilator therapy are first-line treatments
- Involve treating oncologist in decision making when considering the use of local hormone therapies[a]
- Ospemifene, an oral SERM, has not been studied in women at risk for breast cancer and is not FDA-approved for use in women with or at high risk for breast cancer
- Off-label use of compounded vaginal testosterone or estriol is not recommended
- Laser therapy may be considered in women who prefer a nonhormone approach; women must be counseled regarding lack of long-term safety and efficacy data

Women at high risk
- Local hormone
- Observational

Women with ER-po
- Tamoxifen is a
- therapies in wo
- Women with p
- candidates for

Women with ER-po
- AIs block conv
- concern
- GSM symptom
- Women with se
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Women with triple-negative breast cancers
- Theoretically, the use of local hormone therapy in women with a history of triple-negative disease is reasonable, but data are lacking

Women with metastatic disease
- QOL, comfort, and intimacy may be a priority for many women with metastatic disease
- Use of local hormone therapy in women with metastatic disease and probable extended survival may be viewed differently than in women with limited survival when QOL may be a priority

Women with ER-positive breast cancer on AI
- Women with severe symptoms [when nonhormone treatments failed] may still be candidates for local hormone therapies after review with the woman's oncologist vs switch to tamoxifen

Faubion, Menopause 2018

Study 1: Danish Observational Cohort Study

- National cohort of postmenopausal women (1997-2004) with early-stage invasive estrogen receptor-positive breast cancer, who received no treatment or 5 years of adjuvant endocrine therapy
- 8461 women who had not received vaginal estrogen therapy (VET) or MHT before BC diagnosis
  - 1957 and 133 used VET and MHT, respectively,
  - Median follow-up was 9.8 years for recurrence and 15.2 years for mortality.
  - The adjusted RR of recurrence was 1.08 (95% confidence interval [CI] = 0.89 to 1.32) for VET
  - The adjusted hazard ratios for overall mortality 0.78 (95% CI = 0.71 to 0.87) for VET
  - **Aromatase inhibitor subgroup (1.39 [95% CI = 1.04 to 1.85 in the subgroup receiving adjuvant aromatase inhibitors])**
- Limitations: HER2 status not known, doses of vaginal estrogen not known, many patients did not receive endocrine therapy

J Natl Cancer Inst. 2022;114(10):1347-1354.

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Study 2: Safety of Vaginal Estrogen Therapy for Genitourinary Syndrome of Menopause in Women With a History of Breast Cancer

- US health research network
- 42,113 with diagnosis of GSM after breast cancer (2009-2022)
  - 5% received vaginal estrogen
- 10,584 patients had a history of positive estrogen receptor breast cancer
  - 3.9% received vaginal estrogen
- Risk of breast cancer recurrence was comparable between those who received vaginal estrogen and those who did not.
- Overall population (risk ratio 1.03, 95% CI 0.91–1.18)
- Positive estrogen receptor (risk ratio 0.94, 95% CI 0.77–1.15) status analyses

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Obstet Gynecol. 2023 Sep 1;142(3):660-668. Epub 2023 Aug 3.

Study 2: Concurrent aromatase inhibitor

- Among the 2,111 women in the vaginal estrogen group, 91 received aromatase inhibitor prescriptions
- Risk of breast cancer recurrence was significantly higher in women receiving concurrent vaginal estrogen and aromatase inhibitor compared with vaginal estrogen only
- 77.8% compared with 15.6% (RR 5, 95% CI 3.05–8.19)
- Limitations: Small number of patients on aromatase inhibitor, did not control for stage of cancer, missing data for aromatase inhibitor use, estrogen receptor status

Obstet Gynecol. 2023 Sep 1;142(3):660-668. Epub 2023 Aug 3.

Study 3: Vaginal Estrogen Therapy Use and Survival in Females With Breast Cancer

- 49 237 females with breast cancer from 2 large cohorts, one each in Scotland and Wales, of females aged 40 to 79 years
  - 2010-2017 in Scotland and 2000-2016 in Wales
- 5% used vaginal estrogen therapy (VET)
- In VET users there was no evidence of a higher risk of breast cancer–specific mortality in the pooled fully adjusted model **(HR, 0.77; 95% CI, 0.63-0.94)**
- Sensitivity analyses identified no increased risks were observed in females with estrogen receptor–positive breast cancer (HR, 0.88; 95% CI, 0.62-1.25) or females using aromatase inhibitors **(HR, 0.72; 95% CI, 0.58-0.91)**
- Limitations: Did not assess recurrence

JAMA Oncol. Published online November 2, 2023. doi:10.1001/jamaoncol.2023.4508

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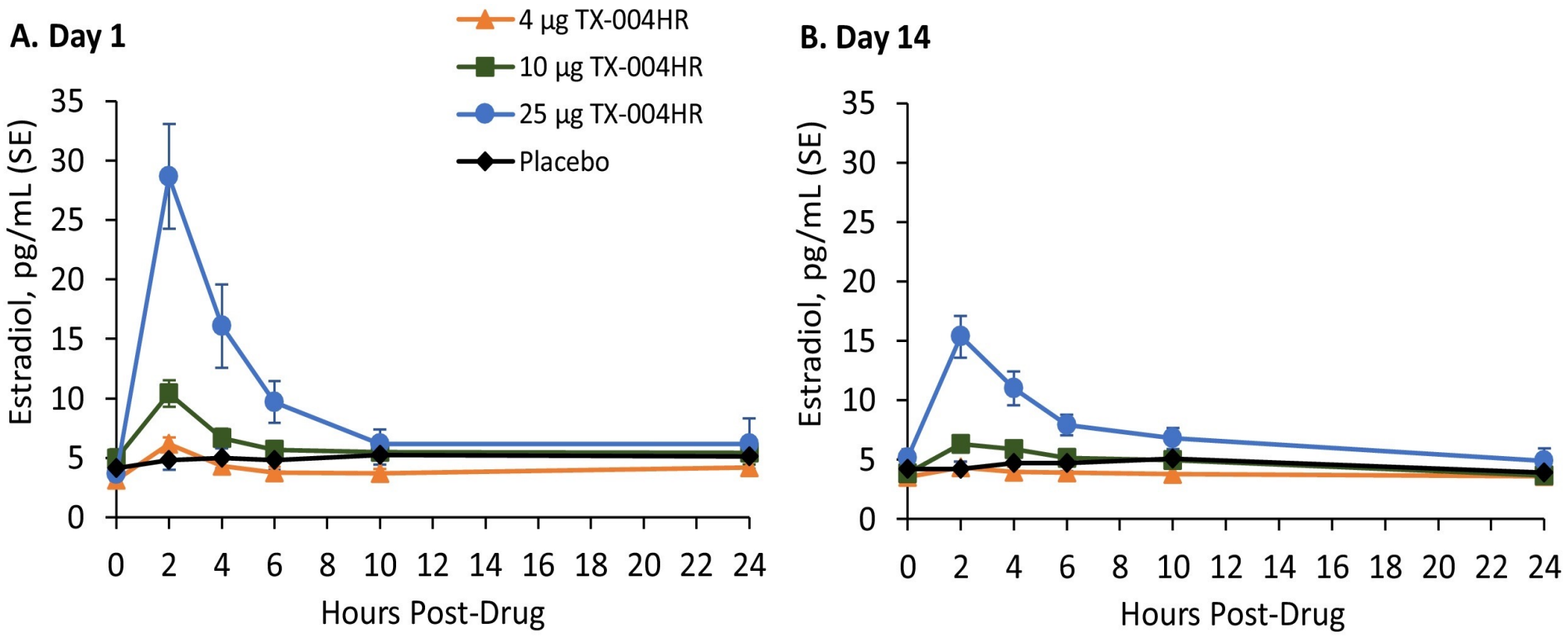
Is local vaginal estrogen systemically absorbed?



Maturitas 2017 9951-58DOI: (10.1016/j.maturitas.2017.02.008)

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Table 2. Summary of prescribing recommendations for vaginal oestrogens[3,8,9,27]

Type of breast cancer[A]	Vaginal oestrogen use
Hormone receptor negative	• Can be prescribed
Hormone receptor-positive breast cancer in women currently taking tamoxifen	• Can be prescribed
Hormone receptor-positive breast cancer in premenopausal women currently taking GnRH agonist with tamoxifen	• Can be prescribed (Stopping the GnRH agonist might also improve symptoms and can be considered after discussion with the woman and her oncology team)
Hormone receptor-positive breast cancer in women currently taking aromatase inhibitors	• Oncologist consultation recommended • Consider switch to tamoxifen • If tamoxifen contraindicated, not tolerated or not preferred, consider vaginal oestrogens after a discussion of the potential risks and benefits with each individual woman, in consultation with her oncology team. Start with a 12-week trial and consider longer-term use if significant improvement in symptoms
Hormone receptor-positive breast cancer in premenopausal women currently taking GnRH agonist with aromatase inhibitor	• Oncologist consultation recommended • Consider switch to tamoxifen+GnRH and, if no improvement, stop the GnRH agonist and continue tamoxifen alone (after discussing the potential risks and benefits with the woman and her oncology team) • If tamoxifen contraindicated, not tolerated or not preferred, consider vaginal oestrogens after a discussion of the potential risks and benefits with each individual woman, in consultation with her oncology team. Start with a 12-week trial and consider longer-term use if significant improvement in symptoms
Hormone receptor-positive breast cancer in women who have completed or stopped adjuvant endocrine therapy (usually 5–10 years after diagnosis)	• Can be prescribed

[A]Recommendations are similar for women with early- and advanced-stage breast cancers.

GnRH, gonadotropin-releasing hormone.

Aust J Gen Pract. 2024 May;53(5):305-310.

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Vaginal estrogen and breast cancer

ER+ on tamoxifen

- Can be prescribed

ER+ on aromatase inhibitor

- Consult with oncologist

ER+ completed treatment

- Can be prescribed

ER negative

- Can be prescribed

Aust J Gen Pract. 2024 May;53(5):305-310.

DHEA and Aromatase Inhibitors

Alliance Trial

- Postmenopausal women with breast or gynecologic cancer
- Participants could be on tamoxifen or aromatase inhibitors (AI's)
- Women were randomized to 3.25 versus 6.5 mg/d of DHEA versus a plain moisturizer (PM) control
- Estradiol was significantly increased in those on 6.5 mg/d DHEA but not 3.25 mg/d ($p<.05$; $p=.05$, respectively), and not in those on AI's.

NCCTG N10C1 (Alliance). *Support Care Cancer*. 2018;26(4):1335-1343.

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Case 1

- After discussion of risks and benefits of vaginal estrogen with her medical oncologist, she elected to start a low dose vaginal estrogen
- She was prescribed a 4 microgram vaginal estrogen insert

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Case 1

- After 3 months, she returned for follow-up appointment
- Vulvar vaginal dryness was improved. She did not have the sensation of “razor blades” anymore with the use of lubrication
- She still reports pain with vaginal penetration, deeper inside the vagina
- She also reports concerns with orgasm. Nipples and breast were a big part of arousal and orgasm for her and after bilateral mastectomies sensation is completely gone
- “I have zero desire”

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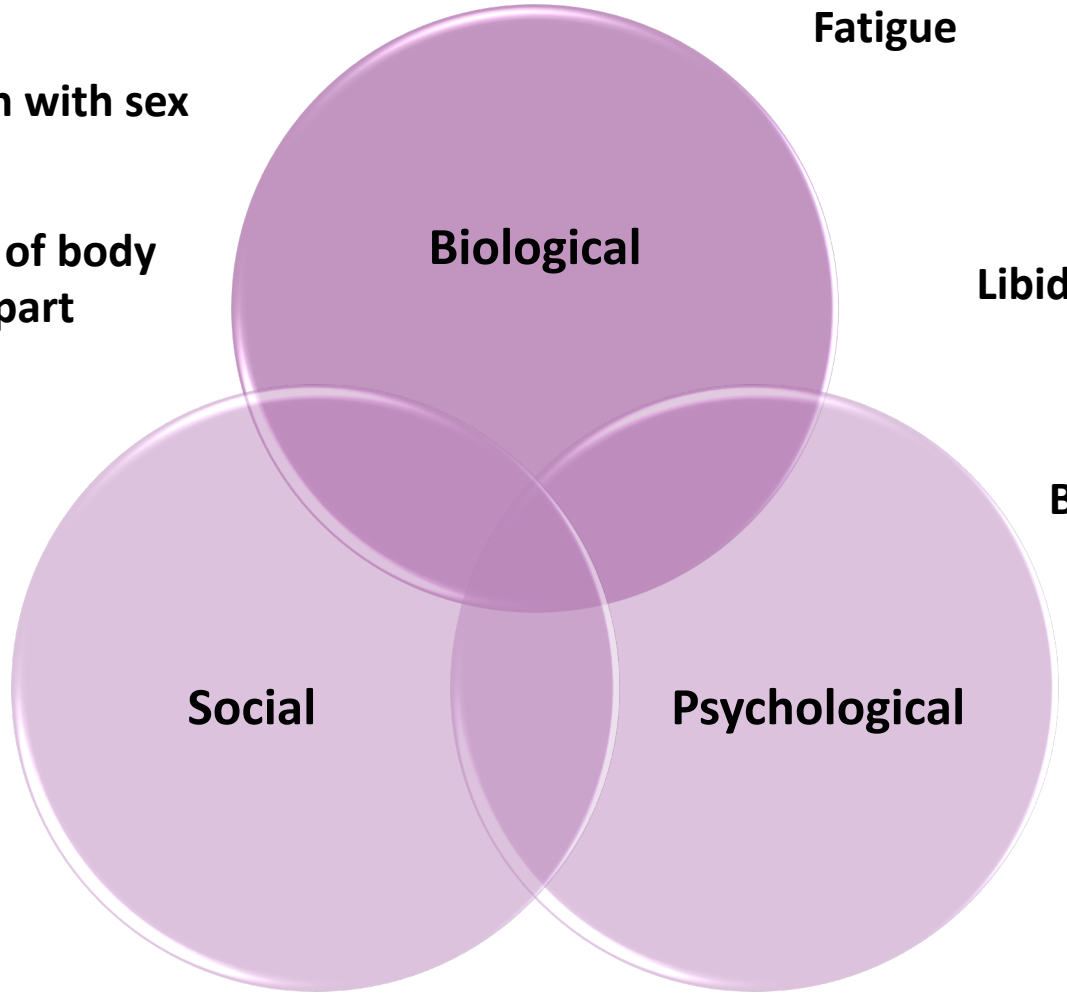
Bio-psycho-social model of sexual health



Genitourinary syndrome of menopause

Pain with sex

Fatigue

Sleep disturbance

Menopausal symptoms

Loss of body part

Libido

Orgasm

Arousal

Breast/nipple sensation

Body image

Weight changes

Fear of recurrence

Hair loss

Mental Health

Relationship concerns

Intimacy

Communication

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Case 1

- Referral to pelvic floor physical therapy for pelvic floor dysfunction
- Use of vaginal dilators
- Discussion of spontaneous vs reactive desire
- Referral to sex therapist
- Review medication list
- Sensate focus, mindfulness
- Flibanserin data after breast cancer

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Study of flibanserin in women with breast cancer

- 37 women with breast cancer on endocrine therapy
- Flibanserin 100mg at bedtime for 24 weeks and were followed for 52 weeks
- Improvement in the sexual domains of desire, arousal, lubrication, orgasm, satisfaction, and pain
- Scores declined after discontinuing the medication
- Less pain and distress with sexual intercourse, increased number of sexually satisfying events
- Sleep improved from 6.7 hours to 7.7 on flibanserin, then decreased to 5.5
- A larger randomized placebo-controlled study is still needed

Journal of Clinical Oncology 41, no. 16_suppl (June 01, 2023) 12015-12015. Published online May 31, 2023.

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Case 1 updates

- Working with pelvic floor physical therapist and regular use of vaginal dilators resolved her pain with vaginal penetration
- Anti-depressant medication changed from SSRI to buproprion
- Worked with sex therapist on body image, rediscovering pleasure, desire
- Couples counseling with partner
- With these interventions, she reported significantly improved satisfaction in her sexuality

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Case 2

- 55 year old female diagnosed with rectal cancer
- Treatment: Chemo/XRT, chemotherapy, surgery with ostomy
- 1 year post treatment with no evidence of disease
- She presents to clinic an reports that she and her husband attempted to have sex for the first time since her diagnosis and it was extremely painful and penetration was impossible. “I think it’s closed”

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Stats: Colorectal Cancer

- 75% of patients with CRC experience sexual concerns
- 1/3 cease sexual activity due to dysfunction
- 11% of women with colorectal cancer recalled discussing sexuality with medical team (20% of men)
- 81% of women with CRC stated it was somewhat-to-extremely important to discuss sexual issues with their provider

J Sex Med. 2023 Mar 31;20(4):439-446. Sex Med Rev 2019 Apr; 7(2): 202-222

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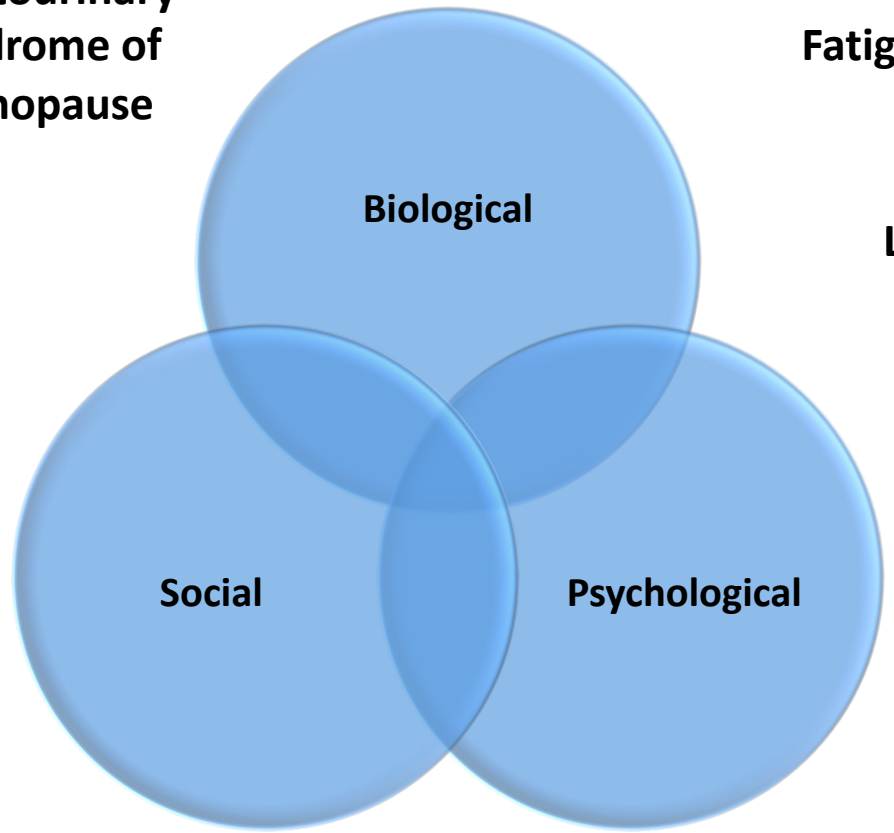
Biopsychosocial framework: Colorectal Cancer



Vaginal stenosis

Genitourinary syndrome of menopause

Ostomy

Fatigue

Sleep disturbance

Menopausal symptoms

Incontinence

Libido

Orgasm

Arousal

Social impact of ostomy

Partners experience

Body image

Fear of recurrence

Stigma

Loss of intimacy

Mental Health

Communication

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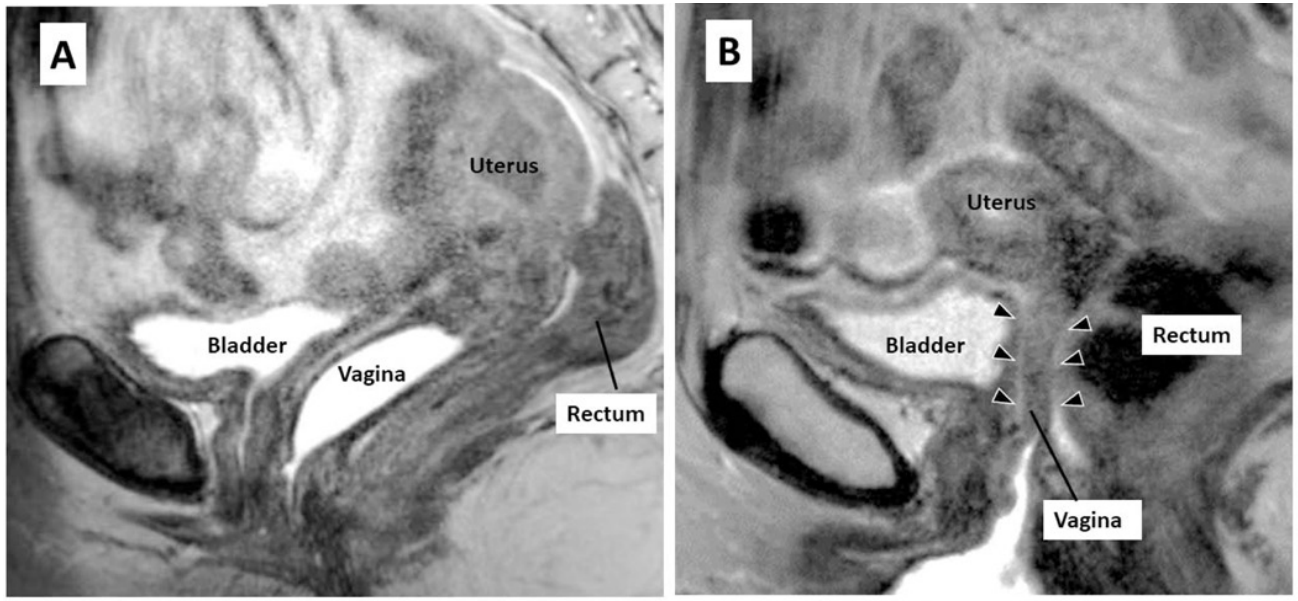
Vaginal Dilator Therapy

- Early effect: Vaginal shortening
- Late effects: Vaginal narrowing, stenosis, or agglutination



Damast S, Jeffery DD, Son CH, Hasan Y, Carter J, Lindau ST, Jhingran A. Literature Review of Vaginal Stenosis and Dilator Use in Radiation Oncology. Pract Radiat Oncol. 2019 Nov;9(6):479-491.

Vaginal Dilator Therapy (VDT)

- Patients should be provided with information about dilators prior to pelvic radiation
- Oncology nurses should provide practical and emotional support
- Start VDT four weeks after completing RT treatment (may vary)
- Perform VDT 2–3 times per week for 1–3 min (or 5-10 minutes) and to continue VDT for 9 to 12 months (or indefinitely)

Consensus Using the Delphi Method. *Int. J. Gynecol. Cancer.* 2014;24:1499–1506.

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Case 2: Update

- She was diagnosed with vaginal stenosis as a result of pelvic radiation and concurrent chemotherapy
- She was was in iatrogenic menopause
- She was prescribed vaginal estrogen, started vaginal dilator therapy, and worked with pelvic PT. She had some improvement, but still unable to have vaginal penetration
- In consultation with gynecological oncologist, underwent exam under anesthesia with lysis of adhesions
- With ongoing local hormone therapy and vaginal dilator therapy, was able to resume sexual activity

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MRT After Cancer

	Effect of MHT on cancer outcomes	Level of evidence	MHT use
Breast cancer: overall	Systematic review and meta-analysis (n=4050) found increased risk of recurrence with tibolone or MHT (HR 1·46)[46]	Moderate	Avoid MHT
Breast cancer: oestrogen-receptor-negative	Subgroup analysis found no increased risk of recurrence with tibolone or MHT (HR 1·19)[46]	Moderate	Consider MHT in specific patients*
Breast cancer: oestrogen-receptor-positive	Subgroup analysis found increased risk of recurrence (HR 1·80) with tibolone or MHT[46]	Moderate	Avoid MHT
Uterine sarcomas	European guidelines suggest avoiding MHT, might be oestrogen sensitive[48]	Very low	Avoid MHT
Ovarian cancer: low-grade serous and granulosa cell	European guidelines suggest avoiding MHT, might be oestrogen sensitive[48]	Very low	Avoid MHT
Low-grade, early-stage endometrial cancer	Systematic review found no effect on cancer outcomes[49]	Moderate	Consider MHT
Cervical cancer	One small retrospective study (n=120) found no effect on cancer outcomes;[50] European guidelines suggest offering MHT[51]	Very low	Consider MHT
Haematological cancer	One small study (n=130) showed no effect on cancer outcomes[52]	Very low	Consider MHT
Early cutaneous malignant melanoma	One small study (n=206) showed no effect on cancer outcomes[53]	Very low	Consider MHT
Colorectal cancer	One large prospective study (n=834)[54] and one national cohort study[55] reported improved cancer outcomes	Low	Consider MHT
Hepatocellular cancer	One case–control study (n=244) reported improved cancer outcomes[56]	Very low	Consider MHT
Ovarian germ cell tumours	European guidelines suggest offering on an individualised basis[48]	Very low	Consider MHT
Epithelial ovarian cancer	Systematic review found uncertain evidence for efficacy or safety of MHT[57]	Moderate	Consider MHT
Vaginal, vulval, and anal squamous cell carcinoma	Do not express oestrogen receptors, MHT thought to be safe[58]	Very low	Consider MHT
Kidney cancer	Meta-analysis suggests better cancer outcomes with MHT[59]	Low	Consider MHT
Lung cancer	Mixed evidence: prospective cohort study (n=727)[60] and SEER data (n=485)[61] showed improved cancer outcomes; retrospective study (n=498)[62] and RCT[63] showed increased mortality	Moderate	Consider MHT

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Managing menopause after cancer, Hickey, Martha et al. The Lancet, Volume 403, Issue 10430, 984 - 996

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Rebekah Kaufman, Laila Agrawal, Eleonora Teplinsky, Lauren Kiel, Oyepeju Abioye, Narjust Florez, From diagnosis to survivorship addressing the sexuality of women during cancer, *The Oncologist*, 2024

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Partnering with Oncology Teams

Education

- Provide educational offerings to clinicians and patient groups
- Education to medical trainees

Communication

- Make connections, attend tumor boards, meet navigators
- Ongoing discussion about evidence-based, guideline consistent care

Clinical care

- Resource for referrals
- Offer education and counseling for patients at diagnosis
- Electronic order sets

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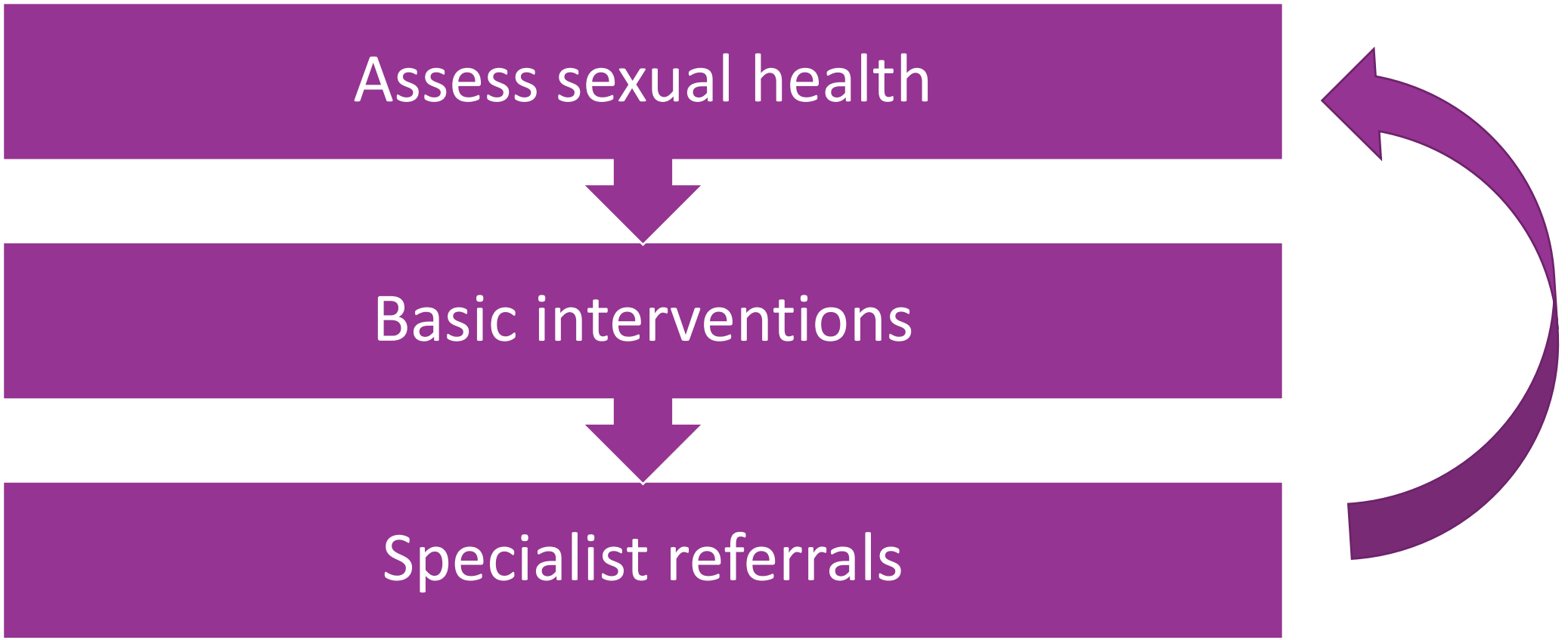
Addressing Sexual Health in the Oncology Clinic



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Basic Interventions in the Clinic

Intervention	Notes	Products
Vaginal moisturizers	Manage vulvovaginal dryness Use 3-5 times per week	Good Clean Love with hyaluronic acid, Hyalogyn, Revaree
Vaginal lubricants	Reduce discomfort with sexual activity or genital touch	Water based: Good Clean Love, Yes, Luvena Silicone based: Uberlube
Vaginal hormone	Address genitourinary syndrome of menopause	Estradiol cream
Pelvic floor therapy	Can help with incontinence and sexual concerns	Pelvic floor physical therapy referral
Vaginal dilators	Maintain vaginal elasticity, reduce vaginal stenosis, alleviate pain with sexual activity and pelvic exams	Intimate Rose, Soul Source

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Specialist Referrals

Concern	Referral
Psychosocial –sexual response, body image, social concerns, mental health, relationship concerns	Psychosocial counselor Sex therapist (assect.org)
Pelvic floor dysfunction – incontinence, dyspareunia	Pelvic floor physical therapist
Vulvovaginal symptoms Vaginal stenosis	Gynecologist, urogynecologist, urologist, or gyn-oncologist referral
Menopausal symptoms	Hormone specialist
Multiple sexual health concerns	Refer to a sexual health clinic

Sexual Health Programs

Assessment and identification of sexual health concern in the oncology clinic

Sexual health program – biopsychosocial assessement

Hormone therapy specialist

Gynecologist, urologist, urogynecologist, gynecological oncologist

Pelvic floor physical therapist

Psychosocial counselor
Sex therapist

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