Female sexual dysfunction (FSD) is a common side effect of cancer and cancer treatments. Assessing for sexual dysfunctions in women with cancer is a vital component of helping women to have better, more satisfying sexual experiences. FSD is not widely addressed in most healthcare facilities or by healthcare providers, but it is a topic that all providers should be discussing with their female patients.

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58-year-old Caucasian female named M.R. had a radical cystectomy for treatment of a recurrent aggressive high-grade carcinoma of the bladder about a year ago. M.R. is self-conscious about her urostomy bag and feels that her husband no longer finds her attractive. The few times she attempted sexual intercourse with her husband, she had to stop because of vaginal dryness and pain with penetration. She feels embarrassed to talk about her sexuality and is resigned to not being able to have sex anymore.

During M.R.’s follow-up appointment, the nurse conducted a typical assessment, but did not ask about M.R.’s sexuality. The nurse reported to the physician that the patient was doing well with the urostomy and had no complaints at this time. The physician proceeded to ask the patient about the urostomy, her bowels, and her overall health status. The visit was concluded and the physician told the patient he would see her back in six months for a checkup. Neither the nurse nor the physician asked M.R. about her sexual health.

Female Sexual Dysfunction

Unfortunately, M.R.’s experience is common for women treated for cancer. Female sexual dysfunction (FSD) is a side effect of cancer and cancer treatments including surgery, chemotherapy, radiation, and the use of other medications. Although all cancers have the potential to affect sexual functioning, the following cancers pose the greatest risk for sexual side effects: bladder, breast, cervical, colon, ovarian, rectal, uterine, and vaginal (Mayo Clinic, 2011). The alterations that occur may be physical, emotional, or hormonal in nature (Mayo Clinic, 2010). FSD can be categorized into four broad disorders: orgasm disorder, sexual arousal disorder, sexual desire disorder, and sexual pain disorder (American Psychiatric Association, 2000). Each disorder is described in more detail in Table 1.

Treatments

Various treatment options for FSD are available, including medications, devices, education, counseling, and support groups. Newer therapies such as Internet- and telephone-based support groups offer a wider range of patient access to interventions for treating FSD (Reese, Porter, Somers, & Keefe, 2012; Wiljer et al., 2011). Some of the medications used are vaginal moisturizers such as Replens®, KY® liquebeads, and vitamin E gel caps, which can be used to address issues of vaginal dryness (American Cancer Society, 2011); estrogen or androgen therapy for hormonal imbalances (Mayo Clinic, 2010); and testosterone and Viagra® for low libido (Jordan, Hallam, Molinoff, & Spana, 2011). In addition, topical estrogen can help improve vaginal blood flow, increasing lubrication and effecting vaginal tone and elasticity (Mayo Clinic, 2010), and antidepressants, such as Wellbutrin® (bupropion) and dehydroepiandrosterone have been shown to increase sexual desire (Kingberg, 2011). Vaginal dilators, instruments that gradually increase in size to help stretch the vagina to allow for finger or penile insertion, can be used for vaginal narrowing (Basson et al., 2003).

Education and counseling also can be beneficial in treating the emotional distress that leads to FSD. A study evaluating the effectiveness of sexual health counseling on adolescents and young adults with cancer demonstrated that counseling can provide benefits including more cancer-related sexual knowledge, an increase in confidence, an improvement in perception of body image, and a decrease in concerns about expressing affection and feeling attractive to one’s partner (Canada, Schover, & Li, 2007).

Assessment

Assessing for sexual dysfunctions in women with cancer is vital to help
women have more satisfying sexual experiences. In a study of ovarian cancer survivors, 100% of women felt it was the healthcare professionals’ responsibility to initiate conversations about sexuality and sexual dysfunction (Wilmoth, Hatmaker-Flanigan, Laloga, & Nixon, 2011). Several models are available for healthcare providers to use as a guide when assessing and discussing FSD with their patients (see Figure 1). In addition to using those models, questionnaires are available to assess for FSD. Table 2 describes some of the commonly used sexual dysfunction questionnaires.

### Nurses’ Role

Oncology nurses can be patient advocates by analyzing, counseling, and responding to patient needs and preferences (Vaartio-Rajalin & Leino-Kilpi, 2011). Nurses analyze needs by conducting thorough FSD assessments and providing counseling about possible sexual dysfunctions that their patients may encounter. Then, they respond to those needs by helping to communicate patient wishes to the physicians and allowing the patient to be actively involved in developing their treatment plan (Vaartio-Rajalin & Leino-Kilpi, 2011). Often, nurses are able to use laymen’s terms to help patients understand complex scenarios and treatment processes. With the numerous questionnaires and assessment guides available, oncology nurses have the tools available to analyze their patients’ needs and conduct appropriate sexual health assessments. The problem lies in the preconception that discussing sex is taboo and, therefore, should be avoided (Sbitti et al., 2011).

A great way to broach the topic of sexuality is to include questions about FSD on a patient questionnaire or to simply ask the patient. Two examples of ways to start the conversation include, “Women undergoing this procedure often have questions or concerns about sexuality. Is there anything you would like to talk about?” (Katz, 2005, p. 240), and “Many cancer patients, or survivors, notice changes or problems in their sex lives after cancer treatment. Do you have any problems or concerns related to sexuality that you want to talk about?” (National Cancer Institute, 2011, p. 18). This type of questioning lets the patient know it is okay to talk about their sexual problems. Often women are embarrassed to bring up the topic of sex. In a study with ovarian cancer survivors, a woman stated, “It is hard for me to get the courage to bring up the topic” (Wilmoth et al., 2011, p. 704). Another woman stated, “Maybe they should talk about it every time and then when patients are ready to hear it, they will hear it” (Wilmoth et al., 2011, p. 704). If nurses bring up FSD at every visit, the woman will begin to understand that it is part of the nurses’ assessment and she will have more opportunities to talk about it when she feels comfortable (Wilmoth et al., 2011).

In the example with M.R., the nurse and the physician failed to ask about FSD. Because of the psychological and physical aspects of her surgery, including a shortened vagina, M.R. experienced problems with sexual desire disorder, sexual arousal disorder, and sexual pain disorder. Treatment options available for M.R. include sexual health counseling and support groups, vaginal moisturizers or topical estrogen, and vaginal dilators. Sexual health counseling and support groups may help M.R. find ways to feel sexy again and be less self-conscious about her urostomy bag. Vaginal moisturizers or topical estrogen may help with the vaginal dryness and pain she is experiencing. Lastly, the vaginal dilators will help stretch the vaginal tissue, making penetration easier and less painful. All of those therapies may help M.R. to resume sexual activity. This is an example of why FSD assessments should be a vital part of the nursing assessment at every visit.

### Conclusion

The existing research has shown that FSD is a problem many women with cancer will encounter. It also shows that women expect their healthcare providers to broach the subject of sexuality and sexual dysfunction.

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**TABLE 1. Types of Sexual Dysfunction**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orgasm disorder</td>
<td>Lack of or decrease in the intensity of an orgasm</td>
</tr>
<tr>
<td>Sexual arousal disorder</td>
<td>Diminished or absent subjective (feeling excitement or pleasure) and/or objective (genital swelling or lubrication) sexual arousal</td>
</tr>
<tr>
<td>Sexual desire disorder</td>
<td>Diminished or absent desires in sex and sexual thoughts</td>
</tr>
<tr>
<td>Sexual pain disorder</td>
<td>Dyspareunia (painful penile-vaginal intercourse) or vaginismus (difficulty with vaginal entry of a penis, finger, or any other object)</td>
</tr>
</tbody>
</table>

*Note. Based on information from the American Psychiatric Association, 2000.*

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**5 A’s Approach**

- Ask
- Advise
- Assess
- Assist
- Arrange follow-up

**ALARM**

- Activity
- Libido or desire
- Arousal or orgasm
- Resolution
- Medical history

**BETTER**

- Bringing up the topic
- Explaining you are available to talk about sexuality
- Telling them you will find resources to address their issues
- Timing may not be appropriate now but they can ask about it at any time
- Educating them about the types of sexual dysfunctions that they may experience
- Recording assessments and interventions in the medical record

**PLISSIT**

- Permission—giving permission to discuss sexuality
- Limited—providing limited information for functioning sexually
- Specific—offering specific suggestions to help with sexuality
- Intensive—providing intensive therapy

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**FIGURE 1. Assessment Models**

*Note. Based on information from Andersen, 1990; Mick, Hughes, & Cohen, 2003; Park et al., 2009; Taylor & Davis, 2006.*
instead of having to bring it up themselves (Wilmoth et al., 2011). FSD is a topic that is not widely addressed in most healthcare facilities or by healthcare providers, but it is a topic that all providers should be discussing with their female patients. Nurses are at the forefront of medical care and generally have more time with their patients than other healthcare providers; therefore, they have an excellent opportunity to conduct the FSD assessments. The assessments done at each visit may not be as in-depth as the initial one, but some type of brief assessment is warranted. That gives patients the opportunity to engage in conversations about sexuality and sexual dysfunctions when they feel comfortable to do so (Wilmoth et al., 2011). In summary, patients with cancer are at increased risk of having a sexual dysfunction, and healthcare professionals need to discuss these problems in hopes of helping the patients overcome their dysfunction and lead a more fulfilling sexual life.

References


