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LETTER TO THE EDITOR

Detecting and discussing sexual problems during chemotherapy for breast cancer

To the Editor:

The breast is a unique symbol of femininity playing an important role in body image, self-esteem, as well as sexual pleasure and stimulation (1). Treatment of breast cancer through surgery, chemotherapy, radiotherapy, hormone therapy, or a combination may cause immediate or delayed side-effects that impair sexual function (e.g., dyspareunia, vaginal dryness, or reduced libido) (2, 3). If left unaddressed, sexual function problems may significantly impair patients' quality-of-life (QOL).

Physicians are not only responsible for treating and caring for patients, they are also gatekeepers to support services. For good reason, patient-physician interactions tend to focus on disease symptoms and side-effects during treatment periods, and consequently may omit to discuss certain aspects of quality-of-life including sexual function (4). Research suggests that discussion of sexual function may be disproportionately hindered by communication barriers (5).

In this study we examined the prevalence of dissatisfaction with sexual function during chemotherapy for breast cancer through patient self-report (Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire (6)). We then examined whether those reporting sexual dissatisfaction discussed this issue with their physician during outpatient consultations. Subsequently, we interviewed 10 patients and 10 health professionals about their opinions of routine assessment and discussion of sexual function to identify ways in which current practice could be enhanced.

Fifty-two patients completed the FACT-G questionnaire (mean age 53.4; S.D 10.15, 44% curative, 56% palliative). Twenty-six (50%) completed the satisfaction with sex-life item and of these 8 (15% of the total sample) reported dissatisfaction with sexual function. Older patients were more likely to omit completing the sex-life item.

Four consecutive outpatient consultations were audio-recorded for each of the 52 study patients. Physicians did not receive patients' FACT-G scores. Despite 15% of patients reporting dissatisfaction with sexual function, sexual problems were not discussed in any of the 208 consultations. Menopause and fertility issues were discussed in one consultation (33 year old patient). Relationships and partner support were discussed in 12 consultations.

Thematic analysis of interviews with patients identified that assessment of sexual function using PROMs was acceptable. One patient indicated that they found the questions a little embarrassing but they were not offended by being asked to answer them. Another patient said they were happy to answer sexual function questions as sexuality was an important aspect of their overall wellbeing. Two patients (one early stage, one metastatic disease) did not feel that sexual function was particularly relevant to their treatment. Both women however could see that the questions may be relevant to some

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breast cancer patients. Some of the interviewees said they would probably speak to a nurse if they had concerns about sexual function whereas other women felt they would deal with the issue themselves or with their partner. Women often felt that at the time of chemotherapy treatment sexual issues were not a particular priority but may be in the future if the problem persists.

Thematic analysis of interviews with 10 healthcare professionals (2 medical oncology consultants, 3 clinical oncology consultants, 2 registrars and 3 specialist nurses) identified several barriers to discussion of sexual issues. Physicians often regarded patients' age as a barrier. They felt older women may not want to talk about sexual issues particularly with a physician who was younger than them. Male physicians also said they would feel uncomfortable raising sexual issues with female patients. Specialist nurses did not raise any concerns in relation to age or gender; they did however indicate that stage of treatment could perhaps be a barrier to discussion. Specialist nurses suggested that women may not be concerned about sexual issues at the time of treatment and that it was an issue that would be more likely to be discussed during the follow-up period. Some healthcare professionals felt ill equipped to discuss sexual problems with patients, and cited a lack expertise and unclear referral pathways as barriers to discussion. Healthcare professionals acknowledged that sexual functioning was under-discussed in clinical practice but tended to expect patients to initiate discussion of this topic without prompting. Healthcare professionals agreed that screening using PROMs may facilitate and target discussion with patients experiencing difficulties.

In the current study 15% of patients undergoing chemotherapy for breast cancer reported sexual satisfaction problems. These problems were not discussed during oncology consultations. Patients and professionals acknowledged that satisfaction with sexual function was important to some patients during treatment, but identified several barriers to discussion. Using PROMs to screen for sexual problems may facilitate communication by identifying patients who are experiencing sexual difficulty and by providing healthcare professionals with a route to seeking permission to discuss the topic (7, 8). Improvements in communication skills training as well as improved referral pathways to effective sexual health services (9, 10) were identified as key areas for enhancing current practice.

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