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The effects of pre-operative menopausal status and hormone replacement therapy (HRT) on sexuality and quality of life after risk-reducing salpingo-oophorectomy.

Tucker PE[1], Bulsara MK[2], Salfinger SG[3], Tan JJ[4], Green H[5], Cohen PA[6].

Maturitas. 2016 Mar;85:42-8.

http://www.ncbi.nlm.nih.gov/pubmed/26857878

Abstract

OBJECTIVES:

Investigate the effects of pre-operative menopausal status and HRT use on sexual outcomes following risk-reducing salpingo-oophorectomy (RRSO).

STUDY DESIGN:

Cross-sectional study of 119 women who underwent RRSO between 2009 and 2014.

MAIN OUTCOME MEASURES:

Data was collected via a questionnaire and serum test for testosterone and free androgen index (FAI). The questionnaire comprised demographic data and validated measures of sexual function, sexual distress, relationship satisfaction, body image, psychological stress, menopause quality of life and general quality of life.

RESULTS:

Rates of sexual issues were similar despite menopause status at operation. Women who were pre-menopausal at operation (mean age=44 years ± 5) had significantly higher rates of sexual distress (p=0.020), dissatisfaction with sex life (p=0.011) and bothersome sexual menopause symptoms (p=0.04) than women who were post-menopausal (mean age=55 years ± 7). Pre-menopausal women reported higher psychological distress from surgery (p=0.005) and poorer emotional (p=0.052) wellbeing. HRT use reduced the rates of dyspareunia (p=0.027) and the severity of sexual menopausal symptoms (p=0.030). Androgen levels were not significantly associated with desire or arousal scores.

CONCLUSIONS:

Regardless of menopausal status at operation, women experienced the same sexual issues at equivalent rates. However, pre-menopausal women reported higher sexual distress and dissatisfaction with sex life. Pre-menopausal women also had greater psychological distress and poorer emotional function.

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Discussing Sexuality With Women Considering Risk-Reducing Salpingo-oophorectomy: An International Survey of Current Practice in Gynecologic Oncology.

Tucker PE[1], Bulsara MK, Salfinger SG, Tan JJ, Green H, Cohen PA.

Full Article: Int J Gynecol Cancer. 2016 Jul 26

Abstract: http://www.ncbi.nlm.nih.gov/pubmed/27465883

OBJECTIVE:

To determine how frequently gynecologic oncologists discuss sexuality with women considering risk-reducing salpingo-oophorectomy. Secondary objectives were to assess the availability of resources, and the barriers to discussing sexuality.

METHODS:

Members of the Australian Society of Gynaecologic Oncologists, International Gynecologic Cancer Society, and Society of Gynecologic Oncology were invited to complete an online survey. Questions addressed frequency of, and barriers to, discussing sexuality, and availability of resources related to sexual issues.

RESULTS:

Three hundred eighty-eight physicians in 43 countries responded from 4,006 email invitations (9.7%). Ninety-one percent reported discussing sexuality preoperatively, and 61% discuss it with every patient. Factors associated with higher rates of discussion were female sex (P = 0.020), higher level of training (P = 0.003), time in practice (P = 0.003), and consulting more risk-reducing salpingo-oophorectomy patients per month (P = 0.006). Commonly discussed issues were vasomotor menopausal symptoms (91%) and vaginal dryness (85%). Eighty-eight percent of respondents believed that sexuality should be discussed preoperatively, and most felt that it is their responsibility (82%). Fear of causing distress was the most common barrier to discussing sexuality (49%). Twenty-four percent felt that they did not have adequate training to discuss sexual function.

CONCLUSIONS:

Although most respondents believed that discussing sexuality should occur preoperatively, only 61% discuss this with every patient. Resources specifically relating to sexuality are limited. The most common barrier to discussing sexuality was fear of causing distress. Nearly one quarter of gynecologic oncologists felt inadequately trained to discuss sexual function.

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How does adjuvant chemotherapy affect menopausal symptoms, sexual function, and quality of life after breast cancer?

Marino JL[1], Saunders CM, Emery LI, Green H, Doherty DA, Hickey M.

Menopause. 2016 Jun 6.

Abstract: http://www.ncbi.nlm.nih.gov/pubmed/27272225

OBJECTIVE:

The aim of the study was to determine the association between adjuvant chemotherapy for breast cancer and menopausal symptoms, sexual function, and quality of life.

METHODS:

Participants attended a menopause clinic with a dedicated service for cancer survivors at a large tertiary women's hospital. Information about breast cancer treatments including adjuvant chemotherapy was collected from medical records. Menopausal symptoms were recorded with the Greene Climacteric Scale and Functional Assessment of Cancer Therapy, Breast Cancer, and Endocrine Symptom Subscales. Sexual symptoms were recorded using Fallowfield's Sexual Activity Questionnaire. Quality of life was measured with Functional Assessment of Cancer Therapy scales.

RESULTS:

The severity of vasomotor, psychological, or sexual symptoms (apart from pain) did not differ between those who had received adjuvant chemotherapy (n=339) and other breast cancer survivors (n=465). After adjustment for current age, time since menopause, and current use of antiestrogen endocrine therapy, the risk of "severe pain" with sexual intercourse was twice as common after chemotherapy (31.6% vs 20.0%, odds ratio [OR] 2.18, 95% CI 1.25-3.79). Those treated with chemotherapy were more likely to report "severe problems" with physical well-being (OR 1.92, 95% CI 1.12-3.28) and lower breast cancer-specific quality of life (OR 1.89 95% CI 1.13-3.18), but did not differ in other quality of life measures.

CONCLUSIONS:

In this large study of breast cancer patients presenting to a specialty menopause clinic, previous chemotherapy was not associated with current vasomotor or psychological symptoms. Severe pain with intercourse was significantly more common in those treated with adjuvant chemotherapy.

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Prevalence of sexual dysfunction after risk-reducing salpingo-oophorectomy.

Tucker PE[1], Bulsara MK[2], Salfinger SG[3], Tan JJ[4], Green H[5], Cohen PA[6].

Gynecol Oncol. 2016 Jan; 140(1):95-100.

Abstract: http://www.ncbi.nlm.nih.gov/pubmed/26545955

OBJECTIVES:

To determine the prevalence of sexual dysfunction in women after risk-reducing salpingo-oophorectomy (RRSO) and to assess factors which may influence sexual wellbeing following this procedure.

METHODS:

This work is a cross-sectional study of women who underwent RRSO at a tertiary gynecologic oncology unit between January 2009 and October 2014. Data collection involved a comprehensive questionnaire including validated measures of sexual function, sexual distress, relationship satisfaction, body image, impact of event, menopause specific quality of life, and general quality of life. Participants were invited to undergo blood testing for serum testosterone and free androgen index (FAI).

RESULTS:

119 of the 206 eligible women participated (58%), with a mean age of 52years. The prevalence of female sexual dysfunction (FSD) was 74% and the prevalence of hypoactive sexual desire disorder (HSDD) was 73%. Common sexual issues experienced included; lubrication difficulty (44%), reduced sexual satisfaction (41%), dyspareunia (28%) and orgasm difficulty (25%). Relationship satisfaction, the use of topical vaginal estrogen and lower generalized body pain were significantly associated with a decreased likelihood of sexual dysfunction. Serum testosterone, FAI, the use of systemic hormone replacement therapy (HRT), prior history of breast cancer, menopausal status at the time of surgery and hysterectomy did not correlate with sexual dysfunction.

CONCLUSION:

The prevalence of FSD and HSDD after RRSO was 74% and 73% respectively. Relationship satisfaction, low bodily pain and use of topical vaginal estrogen were associated with a lower likelihood of sexual dysfunction. There was no correlation between serum testosterone or FAI, and sexual dysfunction.

KEYWORDS:

Androgen levels; BRCA1; BRCA2; Breast cancer; Female sexual dysfunction; Female sexual function; Hypoactive sexual desire disorder; Lynch syndrome; Ovarian cancer; Prophylactic oophorectomy; Risk-reducing salpingo-oophorectomy

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Nature and severity of menopausal symptoms and their impact on quality of life and sexual function in cancer survivors compared with women without a cancer history.

Marino JL, Saunders CM, Emery LI, Green H, Doherty DA, Hickey M.

Menopause. 2014 Mar; 21(3):267-74.

Abstract: http://www.ncbi.nlm.nih.gov/pubmed/23860358

OBJECTIVE:

After cancer treatment, troublesome menopausal symptoms are common but poorly understood. Using standardized instruments, we measured differences in symptom nature, severity, impact on quality of life, and sexual function between cancer survivors and noncancer participants.

METHODS:

The Menopause Symptoms After Cancer Clinic operates within the general menopause service in a large women's hospital, providing menopause advice and management to women with menopausal symptoms and a cancer history. Menopausal symptoms were recorded using the Greene Climacteric Scale, past-week symptoms were recorded using the Functional Assessment of Cancer Therapy breast cancer subscale and endocrine symptom subscale, and sexual symptoms were recorded using Fallowfield's Sexual Activity Questionnaire.

RESULTS:

Cancer survivors (n = 934) and noncancer participants (n = 155) did not significantly differ by age at menopause (46 y) or age at first clinic visit (51 y). Cancer survivors were more likely than noncancer participants to be severely troubled by vasomotor symptoms (hot flushes and night sweats; odds ratio, 1.71; 95% CI, 1.06-2.74) and reported more frequent (6.0 vs 3.1 in 24 h; $P < 0.001$) and more severe ($P = 0.008$) hot flushes. In contrast, cancer survivors were significantly less troubled by psychological and somatic symptoms and reported better quality of life than noncancer participants. Groups did not differ significantly in physical or functional well-being, gynecologic symptom severity, or sexual function.

CONCLUSIONS:

Cancer survivors are more troubled by vasomotor symptoms than noncancer participants, but noncancer participants report greater psychological symptoms. Sexual function does not differ. An improved understanding of the nature and impact of menopause on cancer survivors can be used to direct management protocols.

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