Prostate cancer survivorship and psychosexual care

SANCHIA S. GOONEWARDENE, VERONICA NANTON, ANNIE YOUNG AND RAJ PERSAD

With increasing numbers of prostate cancer survivors, it is vital that follow-up care meets their needs. The authors propose that psychosexual education and rehabilitation should become a standard element of survivorship care.

Although the age-standardised incidence rate of prostate cancer has risen by 16% in the past 10 years, the mortality rate has fallen by 13%. As a result of improved diagnostics and treatment, there are a significant number of younger patients with cancer diagnoses and prolonged life expectancies. Psychosexual concerns are the most significant problem encountered by survivors of prostate cancer. There is a potentially large negative impact on sexual function after radical therapy for prostate cancer.

CURRENT FOLLOW-UP CARE
Healthcare systems are tardy at acknowledging survivors as a separate category of patients requiring care. Current follow-up care focuses on treatment of acute disease only. A national patient consensus meeting concluded that patients are open to new approaches in care and support.

Meeting the needs of men potentially cured of prostate cancer, including psychosexual and chronic medical comorbidities, is important to patients and their carers. If those needs are not addressed, the consequences and subsequent interventions may place a significant burden on the healthcare system. Addressing psychosexual concerns is central to survivorship care, as with the right medical treatment options, survivors may be able to gain their pre-treatment sexual performance. Quality of life, wellbeing and mental health are further supported by successes in these treatments.

PSYCHOSEXUAL CARE AND INFLUENCE ON QUALITY OF LIFE
Improvement in quality of life among prostate cancer survivors has been a goal of cancer management for years. One study examining changes in quality of life over time reported a decrease in sexual functioning. Another found that survivors report being significantly concerned about sexual functioning, yet few seek help for sexual problems.

Men who have undergone radical prostatectomy experience greater stress on their relationships than those receiving external beam radiation. This could be because they are in the younger age group, and as a result, have greater concerns and are more sexually active. Psychosexual concerns vary by age and by receipt of nerve-sparing surgery. In two retrospective cohort studies, men receiving nerve-sparing surgery at age 39–54 were more likely to report erections firm enough for intercourse than older men and men receiving non-nerve-sparing surgery. In addition, it has been found that ‘more motivated’ patients experience greater distress from their sexual dysfunction postoperatively.
Postoperative management of patients who have had a radical prostatectomy should take the patient’s individual psychosexual care into account.9

PROSTATE CANCER TREATMENT-RELATED PSYCHOSEXUAL SEQUELAE
Psychosexual concerns comprise psychological, emotional and physical factors. Therefore a biopsychosocial approach to understanding psychosexual concerns is helpful.10 This entails understanding not only the biology behind psychosexual concerns, but also psychosocial reasons as to why psychosexual concerns occur.

Radical therapy
After radical prostatectomy, most men never regain preoperative levels of erectile function without further treatment.12 This is compounded by an ageing physical function, worsening sexual function for men. A recent focus group study found that sexual problems were associated with a variety of common physical adverse effects such as cardiovascular comorbidity.11 Post radical therapy, side-effects include reduced penile length, loss of desire and loss of orgasmic satisfaction.10

Radiotherapy
Patients with no psychosexual concerns pre-treatment can develop psychosexual concerns up to 14 months after radiotherapy.12 Patients receiving localised radiotherapy still had psychosexual concerns at 3 years following radiotherapy (47.6% at 1 year and 19% at 3 years).12 Psychosexual concerns include lack of ejaculation in 2–56%,13 dissatisfaction with sexual intercourse in 25–60%,14 decreased libido in 8–53%15 and decreased sexual desire in 12–58% of survivors.16 The presence of comorbidities, such as hypertension, diabetes, history of transurethral resection of the prostate and higher age, has also been shown to influence erectile function.17

Brachytherapy
The effect of brachytherapy on psychosexual concerns is also well documented.17 Several brachytherapy-related psychosexual concerns. The cause is thought to be related to the underlying pathology of plaque formation. Psychosexual concerns include erectile dysfunction. Taken together, concerns after seed implantation affected 30–64% of men.18

Combination therapy
Psychosexual concerns after combination radiotherapy and brachytherapy affect 63% of survivors. Talcott and colleagues (2001) concluded that patients who had received combined treatment had a higher likelihood of concerns.18 Potency rates were higher at 5 years with brachytherapy alone compared with combined therapy (76% versus 56%).14

ASSESSMENT OF PSYCHOSEXUAL CONCERNS
To date, there is no gold standard for screening for psychosexual concerns in prostate cancer survivors. Patient self-reported assessments have had questions added regarding sexual concerns to standardised findings. However, several psychometrically valid screening measures have been developed, and a recent review of sexual function measures for cancer populations pointed to three brief, self-administered tools appropriate for broad use: the University of California at Los Angeles Prostate Cancer Index/Expanded Prostate Cancer Index Composite20 and the International Index of Erectile Function, which is the most commonly used scale.

BARRIERS TO PSYCHOSEXUAL CARE
Cultural norms that support silence around sexual topics may hinder patients from seeking help or initiating communication with providers.21 There is a need for a pathway managing sexual concerns with cancer survivors. Treatment is optimised when it is targeted towards not only a survivor’s physical needs but also their relationship status and their experience of self-efficacy. More intensive intervention such as couples counselling also helps in sexual rehabilitation. If survivors are single, older, widowed or divorced, it can be easy to assume that potency is no longer required. Assumptions cannot be made; psychosexual support should be offered to the majority of patients.

PSYCHOSEXUAL SUPPORT
It is vital that psychosexual education and rehabilitation become a standard element of survivorship care. This can be done as part of a pathway. Given the challenges that survivors face throughout their cancer journey, it is regrettable that so many suffer silently from sexual dysfunction because they are unaware of available solutions.21 Psychosexual concerns are not often fully addressed as part of survivorship care. This is central to providing holistic survivorship care.

Psychosexual interventions
There are limited interventions addressing psychosexual concerns in this cohort.22 Most intervention studies include psychoeducation regarding coping with the sexual side-effects of prostate cancer treatment, but outcomes were not measured. This highlights the psychosexual concerns of this cohort, but not how to address them.
A randomised control trial to improve sexual functioning in this cohort was conducted. Men were randomised to either a ten-session group behavioural intervention or a control group. Men who participated in the intervention reported improved sexual functioning compared with controls.  

An earlier randomised control trial set out to improve sexual rehabilitation for patients treated for localised prostate carcinoma and their partners. Fifty-one couples were randomised into a four-session sexual counselling programme. The programme offered education about the effects of prostate cancer treatment and treatments for erectile dysfunction, communication and promotion of intimacy. Participants were given behavioural exercises to be done at home. This demonstrated significant improvement in psychosexual impairment. At the 6-month follow-up, however, sexual functioning began to decline. This demonstrates the importance of an ongoing intervention to treat psychosexual concerns.

Other types of interventions using information on psychosexual concerns have been conducted with 90 survivors and 45 couples in a prostate clinic. Participants were given information on the sexual side-effects of prostate cancer treatment and erectile dysfunction treatments, and were counselled on selecting treatments and increasing their sexual repertoire, and encouraged to schedule return visits as needed. With this programme, patients had significantly better attitudes toward their partners and were more satisfied with this intervention. However, very few patients scheduled follow-up appointments, thus making it difficult to evaluate long-term effects of the treatment. The study was limited because no data were collected on the sexual functioning of partners or couples.

In a US study, only 23% of men with prostate cancer had received written material relating to psychosexual support. A possible explanation may be that immediate treatment for the cancer was the first priority and dealing with psychosexual concerns was an issue that could be addressed later. In another study, couples were randomised to attend four sessions of counselling together versus the patient alone. The sessions included education about prostate carcinoma, sexual function and medical treatment options, as well as sexual communication and stimulation skills. In both groups, partners completed behavioural homework. As a result of sexual counselling, patients demonstrated significant gains in sexual function and satisfaction and increased utilisation of treatments for psychosexual concerns. In conclusion, this shows the positive effect of a formal psychosexual care assessment and intervention.

**Psychosexual concerns in prostate cancer survivors are a critically important area to study, as there is a significant, unaddressed gap in care.**

**CONCLUSIONS**

Psychosexual concerns in prostate cancer survivors are a critically important area to study, as there is a significant, unaddressed gap in care. This leads to unaddressed issues of psychosexual concerns, side-effects of treatment and acute and chronic comorbidity, which are all essential areas to investigate in detail as highlighted by the systematic reviews. Yet this is not addressed in current care. This research is central to furthering survivorship care and, if successful, developing guidance for prostate cancer survivorship pathways.

**Declaration of interests:** none declared.


