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Female Sexual Health: Effects After Surgery and Treatment Options

12/9/22

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Agenda

- Menopausal effects on sexual function/genital tissue
- Screening for symptoms
- Genitourinary Syndrome of Menopause
 - First line non-hormonal treatments
 - Pharmacologic treatment
- Pelvic floor dysfunction
- Hot flashes
- Changes in libido

Note: Even though this presentation is titled Female Sexual Health, I want to recognize and support the gender diversity of all individuals with cancer seeking sexual healthcare.

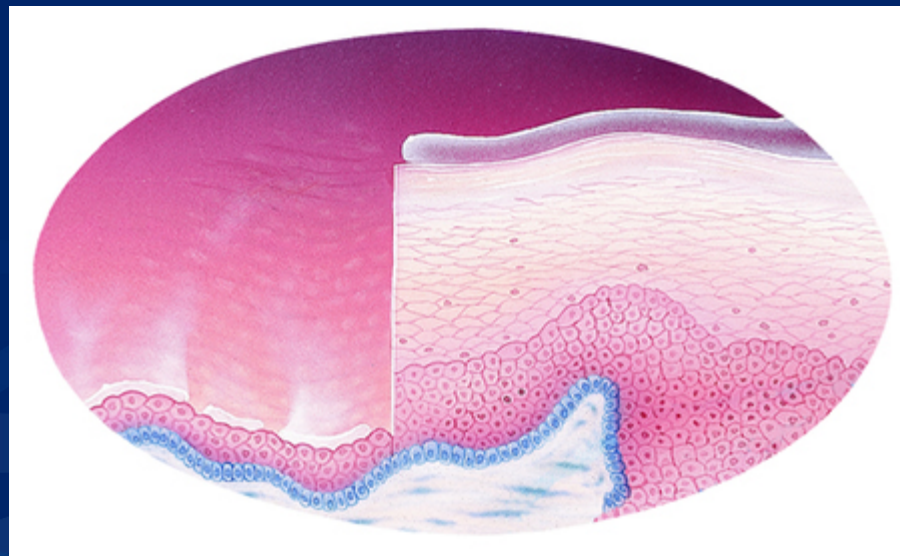
Premature Menopause

Treatment effects

- S/p bilateral oophorectomy
- Combination of hysterectomy and pelvic radiation therapy
- Similar effects s/p gonadotoxic chemotherapy and endocrine therapy causing estrogen deprivation

Causes

- Hormonal, physical, and psychological consequences that affect sexual wellbeing



https://www.uptodate.com/contents/search?search=atrophic%20vaginitis&sp=0&searchType=PLAIN_TEXT&source=USER_INPUT&searchControl=TOP_PULLDOWN&searchOffset=1&autoComplete=false&language=&max=0&index=&autoCompleteTerm=&rawSentence=

Menopause

- **Hot flashes**
- Depression
- Poor sleep
- **Decreased libido**
- **Vaginal dryness**



<https://tabythagirl.wordpress.com/tag/meme/>

Screening for Sexual Function/Satisfaction

- Formal instruments
 - FSFI
 - Desire, arousal, lubrication, orgasm, satisfaction, pain
 - Sexual activity questionnaire
 - Self-report of sexual activity
 - Female sexual distress scale
 - Sexual function questionnaire
 - Desire, physical arousal-sensation, physical arousal-lubrication, enjoyment, orgasm, pain and partner relationship
- Not all patients are sexually active, concerns are more about daily comfort
- Screen patients at all visits!

Genitourinary Syndrome of Menopause (GSM)

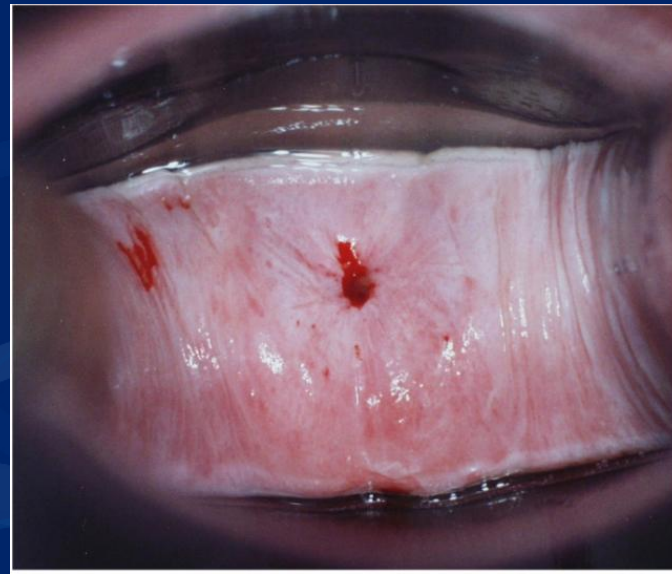
Genital symptoms: vulvovaginal dryness, burning, irritation

Sexual symptoms: lack of lubrication, pain

Urinary symptoms: urgency, dysuria, recurrent UTIs



<https://www.beautifulcervix.com/project/age-25-entire-cycle/>



<https://oacapps.med.jhmi.edu/OBGYN-101/Text/Pap/Atrophy.htm>

First line treatment of GSM

- Moisturizers
 - Polycarbophil
 - Hyaluronic Acid
 - Oil based products (Coconut oil, vitamin E)
- Lubricants with all sexual activity
 - Water-based
 - Silicone-based
 - Oil-based (not compatible with condoms)
- Vulvar irritants: benzyl alcohol, benzocaine, chlorhexidine, propylene glycol, glycerin, parabens, latex, lanolin; avoid warming, flavors, spermicides, bactericides
- Osmolality of product can be associated with mucosal irritation
 - WHO recommends osmolality of vaginal products not to exceed 380mOSm/kg
- Other topical recommendations
 - Aquaphor as a skin protectant/moisture sealant
 - Note: ointments often more tolerable than cream-based products

Pharmacologic treatment of GSM

- Among individuals with history of hormone sensitive cancer, there is uncertainty about the safety, leading many patients with bothersome symptoms to remain untreated with negative consequences on quality of life
- Vaginal Estrogen
- Vaginal DHEA
 - Vaginal Prasterone 6.5mg PV QHS- FDA approved- caution use in suspected/known BCA
 - Elevations in DHEA, T, estradiol but all remained in lowest half or quartile of postmenopausal range. *Additional studies needed*
- Vaginal Testosterone **Not FDA approved*
- SERM (Ospemifene): 60mg PO once daily, side effects include hot flashes and increased risk of VTE **Not FDA approved in patients with breast cancer*
- Topical Lidocaine- 5% lidocaine ointment for introital/insertional pain
- Vaginal laser treatments **Not FDA approved*

Vaginal Estrogen

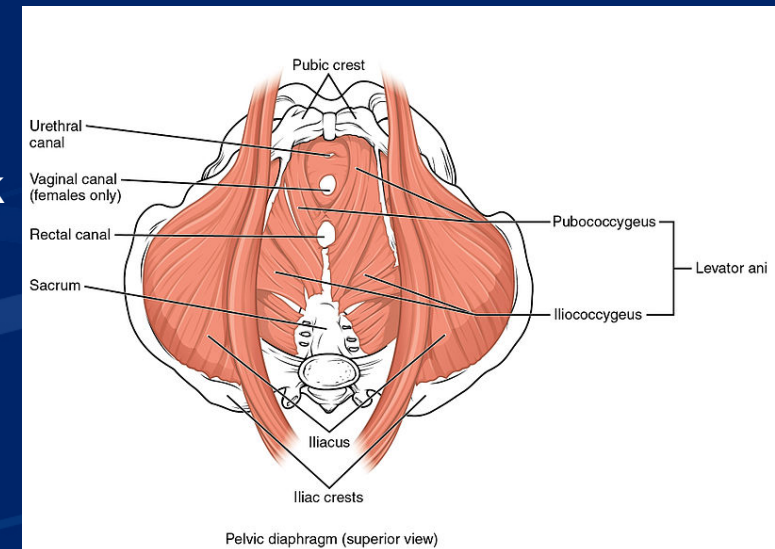
- **Estradiol capsule**
 - Newest; FDA approval in 2018
 - Lowest dose formulation, available in 4 and 10mcg twice weekly
- **Estradiol tablet**
 - 10 mcg tablet PV QHS x 2 weeks then 2x/wk
- Vaginal Ring
 - Delayed release ring placed in upper vagina x 90 days releasing 7.5mcg per day
- Creams – higher concentration, larger surface area, overuse concerns
 - 17 β Estradiol cream
 - Conjugated equine estrogen

Pelvic floor dysfunction

- **Common regardless of cancer diagnosis, affecting >30% of women**
- **Increases with age**
- **Pelvic surgery and radiation may exacerbate an underlying problem or cause scarring**
- Non-relaxing “high tone” pelvic floor & pelvic floor laxity
- Pelvic floor dysfunction symptoms may include pelvic pain, problems with defecation, urination, sexual function
- *High tone pelvic floor often seen in women with sexual pain*

Treatment:

- Pelvic Floor PT: education, manual therapy, exercises, biofeedback
- Vaginal Dilators
- Trigger point injections
- Vaginal diazepam use



https://www.physio-pedia.com/Pelvic_Floor_Muscle_Function_and_Strength

Dilators

Use at least 3x/wk with lubricant for 5-10 minutes

Indications:

- Pelvic floor muscle tension
- Prevent narrowing and scarring after pelvic radiation
- Build confidence prior to engaging in penetrative sex
- Menopause

- Other Devices
 - Silicone dilators
 - Curved tip dilators
 - Pelvic wand
 - Vibrators
 - Oh Nut
 - Elvie Pelvic Trainer
 - Milli Vaginal Trainer

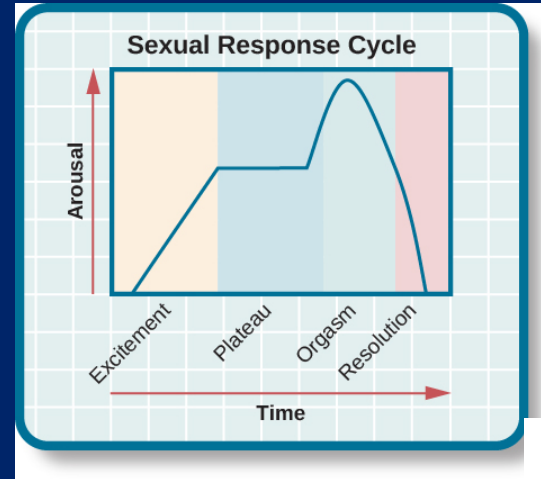


Hot flashes

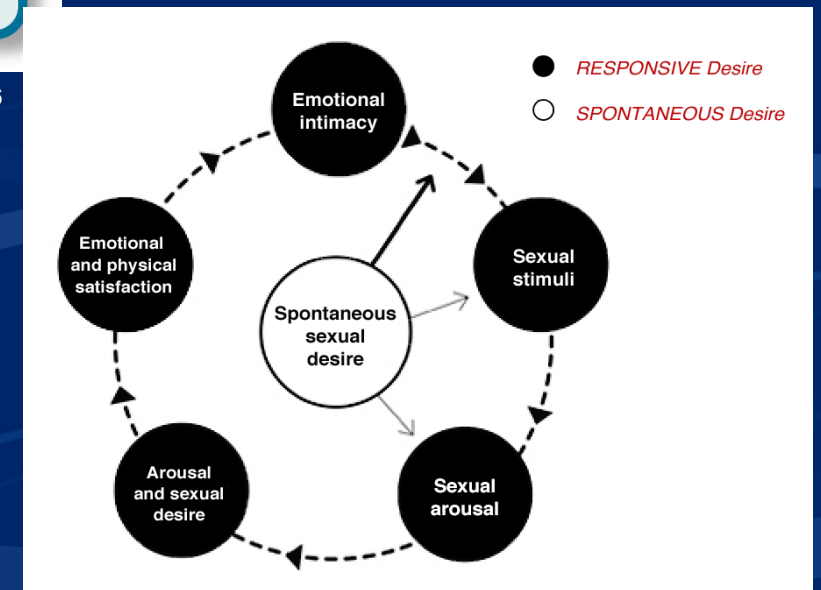
- Acupuncture
- Herbal supplements *caution, few are effective*
 - Swedish Flower pollen extract (Sérélys) has been beneficial, preclinical studies did not find estrogenic activity. No studies in cancer population
- Oxybutynin (Off-label use of hyperhidrosis)
 - ER: 5-10mg once daily
 - IR: 2.5mg once daily and titrate up to 5-10mg/day in 2 divided doses
- SSRIs
 - Paroxetine (FDA approved for treatment of vasomotor symptoms)
 - 7.5mg IR PO capsule once daily at bedtime
 - Interaction with TAM
 - Escitalopram and Citalopram (off-label use)
 - Escitalopram: 10 mg PO once daily, increase to 20 mg once daily after 4 weeks if symptoms not adequately controlled
 - Citalopram: 10 mg PO once daily; may increase dose to 20 mg once daily after 1 week.
 - No benefit with sertraline or fluoxetine
- SNRI
 - Venlafaxine (off-label use): *IR and ER hydrochloride*: Initial: 37.5 mg once daily; may increase dose after ≥1 week based on response and tolerability to 75 mg once daily for ER hydrochloride or 75 mg/day in 2 to 3 divided doses for immediate release
- Gabapentin (off-label use)
 - GABA Analog
 - IR: 100mg PO once daily at bedtime, can titrate up to 600 mg to 2.4 g/day in 2 to 3 divided doses
 - ER: 600 mg once daily at bedtime; increase gradually (eg, 600 mg every 3 days) to target dose of 600 mg in the morning and 1.2 g at bedtime

Hypoactive sexual desire/Low Libido

- Address underlying cause
 - Exercise
 - Sleep
 - Mindfulness
 - Couples counseling/Sex therapy
- Bupropion
 - Off-label use for Selective serotonin reuptake inhibitor-induced sexual dysfunction
 - 12-hour extended release (sustained release): Oral: Initial: 150 mg once daily for the first 3 days; increase to 150 mg twice daily, based on response and tolerability
 - Interaction with TAM
- Newer pharmaceutical interventions
 - Flibanserin *Only FDA approved for pre-menopausal patients and for libido changes NOT due to medical conditions
 - Mixed 5-HT_{1A} Agonist/5-HT_{2A} Antagonist
 - 100mg once daily at bedtime, evaluate efficacy at 8 weeks
 - Bremelanotide *Only FDA approved for pre-menopausal patients and for libido changes NOT due to medical conditions
 - Melanocortin Receptor Agonist
 - SUBQ: 1.75 mg as needed, ≥45 minutes before sexual activity (maximum: 1.75 mg/24 hours). No more than 8 doses per month are recommended.



<https://opened.cuny.edu/courseware/module/63/student/?task=4>



<https://www.therelationshipblog.net/2016/08/female-sexual-responsiveness/>



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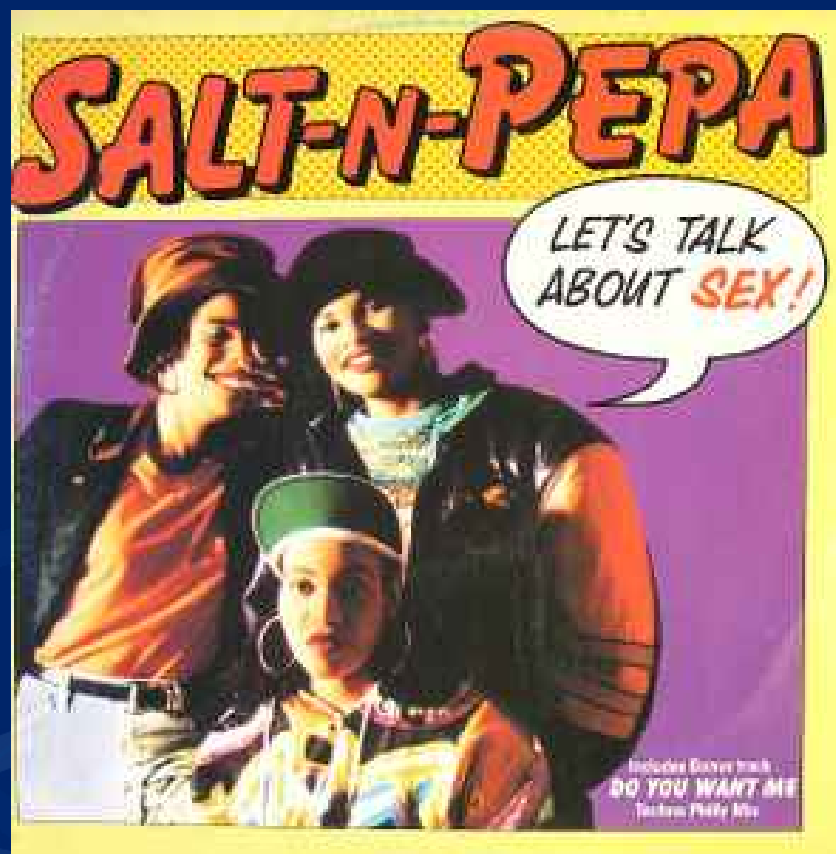
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Thank You!

Special thanks to Ashley Arkema NP
Email: chengm6@mskcc.org



<http://dodisoldmusic.blogspot.com/2010/08/salt-n-pepa-lets-talk-about-sex-cdm.html>

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