GUIDELINES FOR SEXUAL HEALTH CARE FOR PROSTATE CANCER PATIENTS:

RECOMMENDATIONS OF AN INTERNATIONAL PANEL

Guidelines for sexual health care for prostate cancer patients: Recommendations of an international panel

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ORIGINAL RESEARCH & REVIEWS

ONCOLOGY

Guidelines for Sexual Health Care for Prostate Cancer Patients: Recommendations of an International Panel

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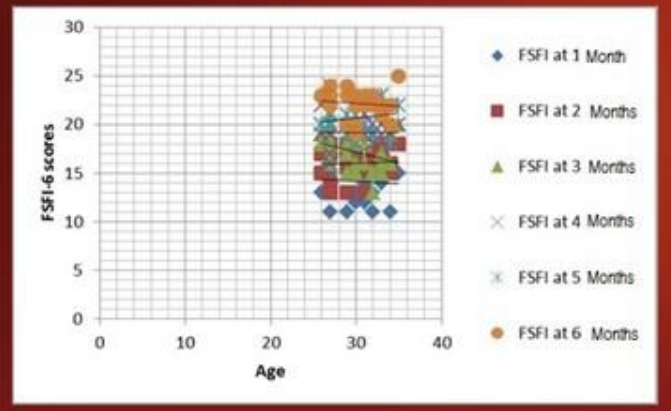


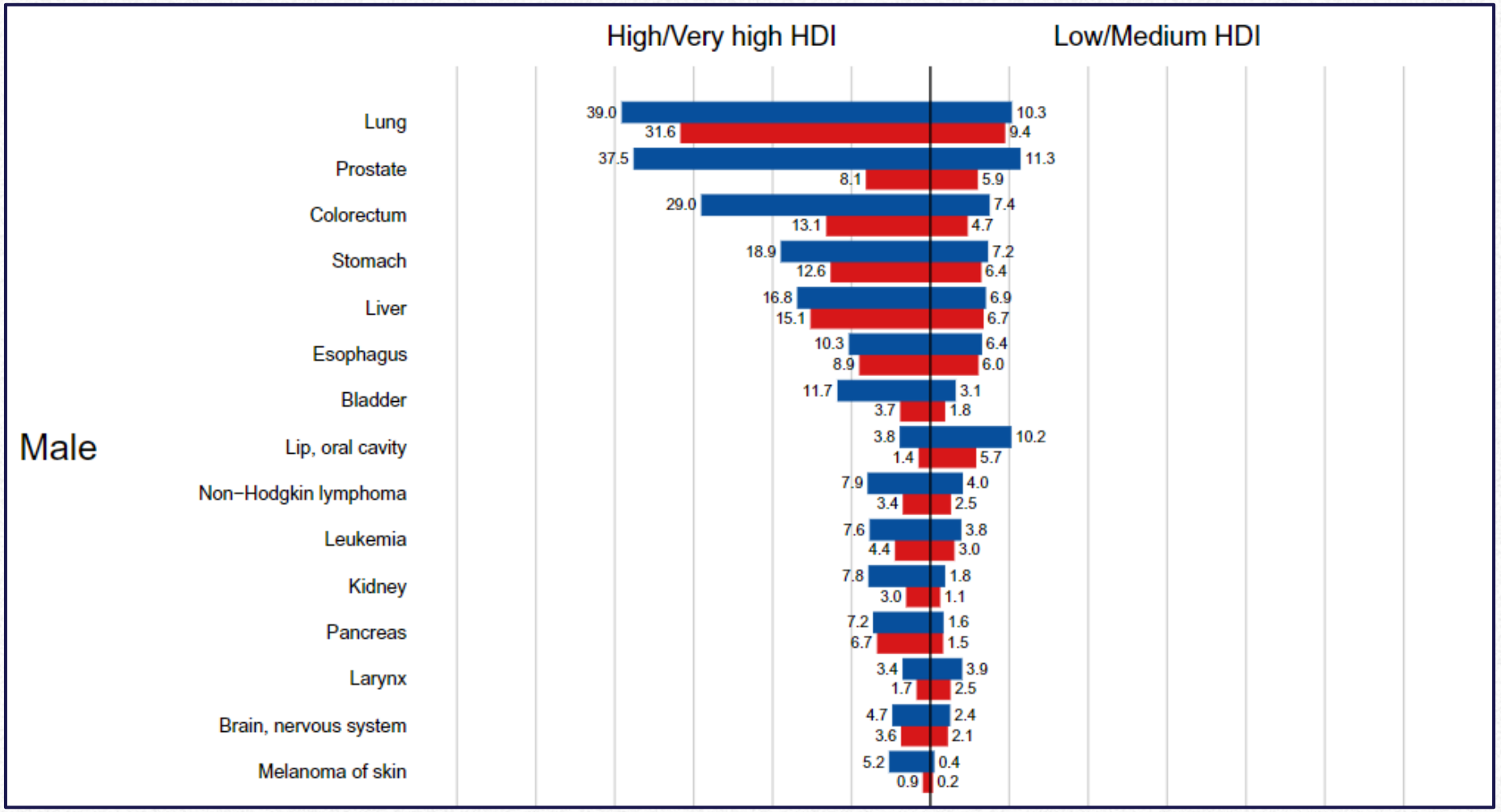
An Official Journal of The International Society for Sexual Medicine

Asia Pacific Society for Sexual Medicine (APSSM); European Society for Sexual Medicine (ESSM); Latin American Society for Sexual Medicine (SLAMS); Middle East Society for Sexual Medicine (MESSM); Sexual Medicine Society of North America (SMSNA); South Asian Society for Sexual Medicine (SASSM); International Society for the Study of Women's Sexual Health (ISSWSH)

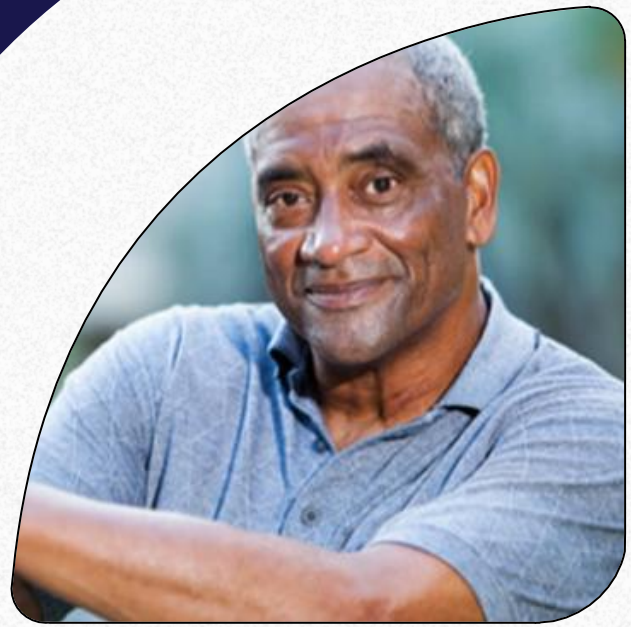
ELSEVIER

Background

Global Cancer Incidence and Mortality



Sung et al., CA CANCER J CLIN 2020



Men and Partners Experience Negative Consequences of Treatment.

- Sexual dysfunction is the most commonly reported health-related quality of life outcome following therapies for prostate cancer, affecting men, partners and their relationships.
- National origin, ethnicity, and race affect perspectives on gender roles, sexual orientation, relationships, culture-driven health beliefs, disparities in access to healthcare, and uptake of healthcare offered.

These are the first sexual health guidelines that have been developed for the care of cancer patients.

POLL-Questions

Instructions

- Scan the QR code with your device or go to www.issm.info/movember
- This poll gathers insights to improve sexual health guidelines and resources in prostate cancer care through the ISSM and Movember partnership.

Scan the QR code

or go to

www.issm.info/movember

What is your professional role?

a. Urologist
b. Oncologist
c. Radiation oncologist
d. Nurse
e. Sexual health counselor
f. Psychologist
g. Other

Where are you located?

a. Type your Country

Do you see prostate cancer patients in your practice?

a. Fewer than 20 per year
b. 20-50 per year
c. 50-100 per year
d. More than 100 per year

How comfortable are you discussing sexual health and rehabilitation with your prostate cancer patients?

a. Very comfortable.
b. Somewhat comfortable.
c. Neutral.
d. Somewhat uncomfortable.
e. Very uncomfortable.

Do you talk to your patients about the sexual side-effects of treatment and rehabilitation before treatment?

Select the most significant one:

a) No, I don't have enough time.
b) No, I don't feel I know enough about it.
c) No, I believe patients are not ready, they are focused on their cancer diagnosis.
d) Yes, briefly.
e) Yes, in detail.
f) Yes, including discussions on rehabilitation options.

In your practice, who talks to patients about the sexual side effects and rehabilitation?

Select all that apply:

a) No one.
b) Nurse.
c) Sexual health counsellor.
d) Psychologist.
e) Social worker.
f) Peer counsellor (e.g., another patient).
g) I do (the HCP).
h) Other

Would you feel more comfortable talking to patients about sexual side effects if you had…?

Select the most important factor:

a) More information or training on how to approach the topic.
b) A detailed handout to provide patients.
c) A video patients could watch on their own.
d) Access to a team of experts for referrals.
e) Other

Do you refer patients to specialists for sexual health and rehabilitation?

a. Yes, routinely
b. Yes, but only if the patient asks for it
c. No, I manage this aspect of care myself
d. No, I am not sure where to refer them

Do you include partners in your discussions about sexual side-effects

a. No
b. If they are there
c. If the patient asks for it
d. Usually
e. Always

Do you ask patients about their sexual orientation?

a. No,
b. Only if I suspect they might be gay.
c. Yes, I routinely ask.

Do you ask patients about their gender identity?

a. No, I don't routinely ask.
b. Yes, I routinely ask.

Do you discuss how religious or cultural backgrounds may influence attitudes toward treatment-related sexual problems and rehabilitation?

a. Yes, routinely.
b. No, I don't address this topic.
c. Sometimes, if it seems relevant to the patient.
d. Rarely, unless the patient brings it up.

What do you think are the main barriers to addressing sexual health in prostate cancer care?

(Select all that apply)

a. Lack of time during consultations
b. Insufficient knowledge or training on the topic
c. Patient discomfort or reluctance to discuss it
d. My own discomfort discussing the topic
e. Lack of accessible resources or specialists for referrals
f. It is not prioritized in our care protocols
g. Other

Do you currently have access to any tools or resources that support conversations about sexual health with prostate cancer patients?

a. Yes, sufficient resources
b. Yes, but limited resources
c. No, I don't have any resources
d. I'm not sure what's available

Do you know about the resources available for addressing sexual health and rehabilitation in prostate cancer care?

a. Yes
b. Somewhat
c. No

Do you know about the collaboration between ISSM and Movember?

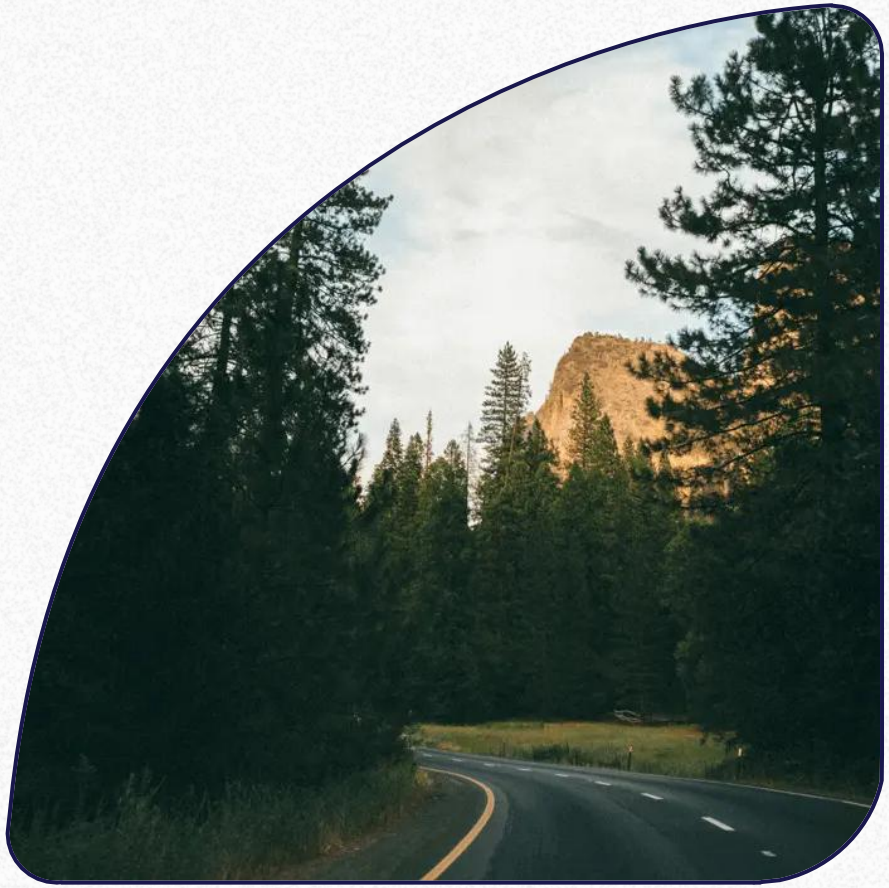
a. Yes
b. Somewhat
c. No

Would you be interested in receiving more information about the ISSM-Movember collaboration and how it could support your practice?

a. Yes, I would like to receive more information (please enter your e-mail)
b. Maybe, depending on the relevance to my practice.
c. No, I am not interested.

Methods

Methods



- A systematic literature was conducted, designed to reflect the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), using the Ovid MEDLINE, Scopus, CINAHL, PsychINFO, LGBT Life, and Embase databases (search dates 1995 through 2022).
- Evidence and recommendations strengths were aligned with AUA guidelines.
- 602 manuscripts were included in the review.
- The guidelines were developed by multidisciplinary international experts, patients and partners.

External Peer Reviewers

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Statements

- 47 statements in 9 sections.
- We will present selected sections.
- Statements generally focus on clinicians educating the patients and partners.

Case #1

- A 65-year-old married man with PSA 6, Gleason 3+4 PCa is accompanied by his son during the consultation.

Case #1

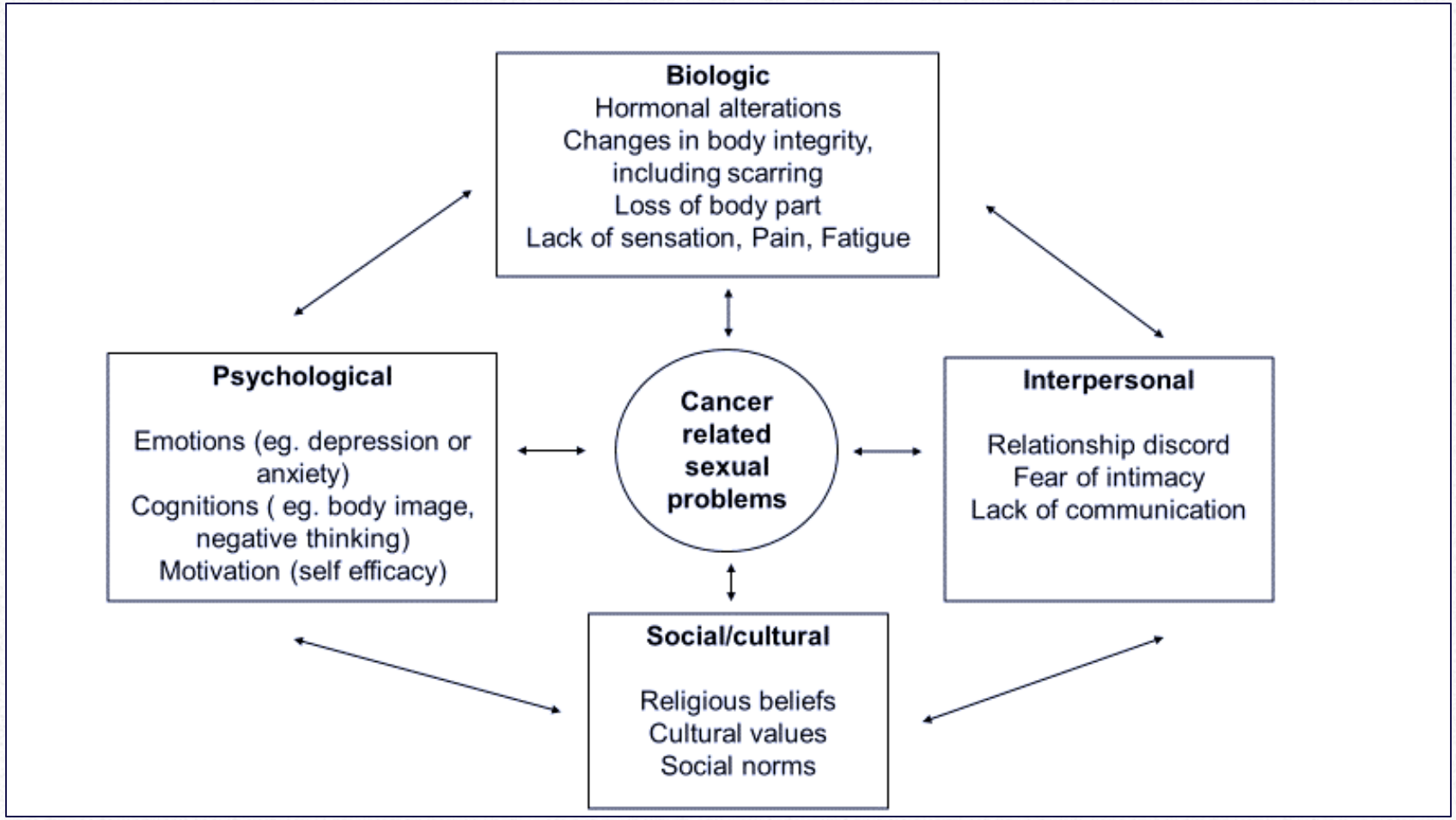
- A 65-year-old married man with PSA 6, Gleason 3+4 PCa is accompanied by his son during the consultation.
- He has normal erectile function and wants to understand how treatment may affect his sexual drive, erectile function, and ability to experience orgasm. However, his son is the one initiating the conversation, asking about general side effects of the treatment choices.

Case #1

What do you do?

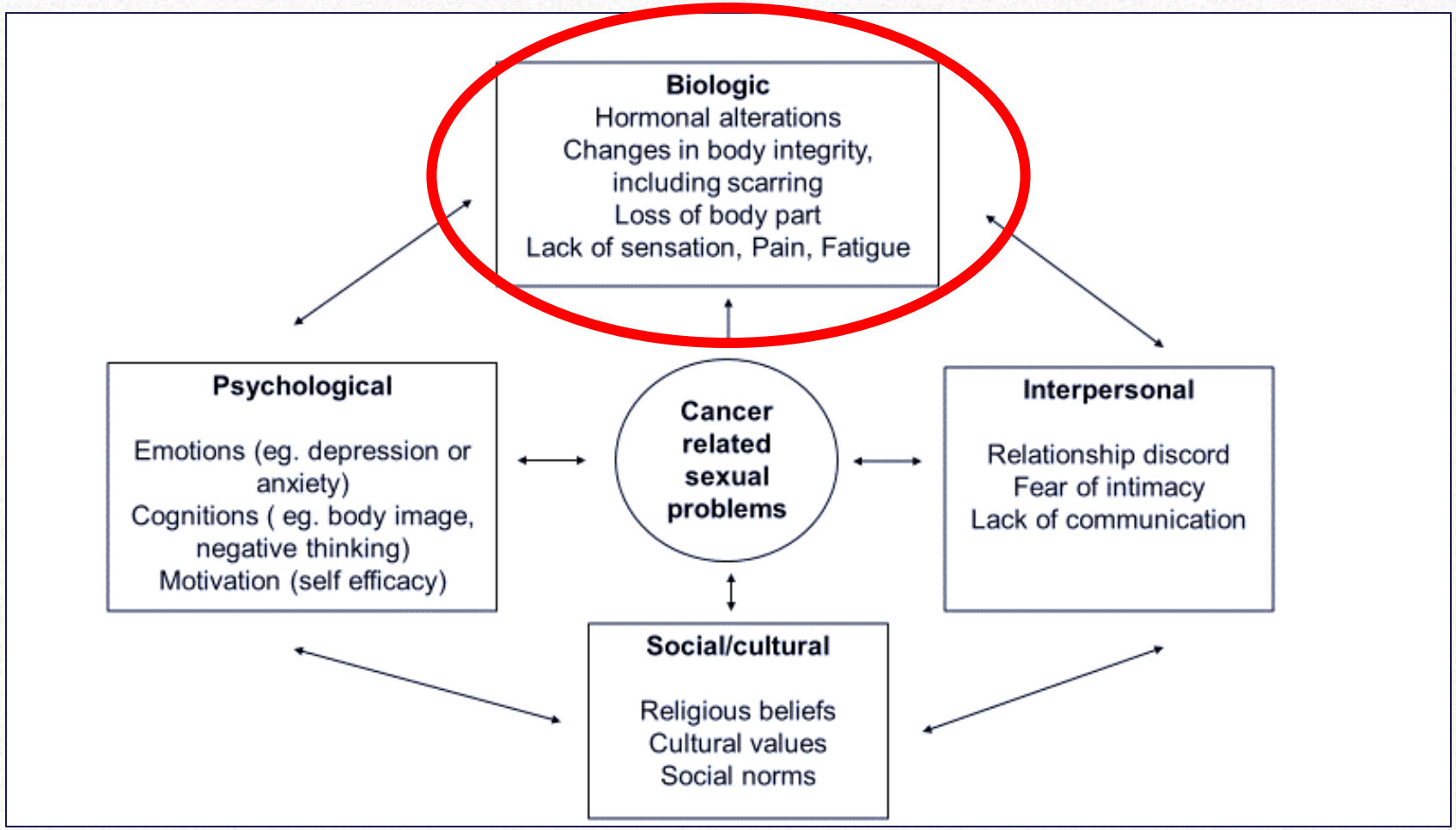
A. Ask if his son can step out and then discuss his actual sexual function privately.
B. Explain that side effects vary greatly and suggest discussing this after treatment.
C. Provide him with a brochure.
D. Emphasize that curing the cancer and ensuring survival are the most important priorities.
E. Inform him about all potential side effects openly.

Impact of Cancer on Sexuality



Bober & Varella, Cancer, 2012

Impact of Cancer on Sexuality



Bober & Varella, Cancer, 2012

Guiding Principles

1. The healthcare provider plays an **ACTIVE ROLE** in routinely addressing sexual concerns in prostate cancer survivorship.
2. Sexuality and sexual recovery are **MULTI-DIMENSIONAL**.
3. The role of **GRIEF** and mourning in couples' recovery of sexual intimacy has emerged as a path towards a new sexual paradigm despite sexual dysfunction.
4. Men **RARELY** return to baseline sexual function after prostate cancer treatment.
5. Including the **PARTNER** in sexual health counseling, if both partners agree, is preferable when men are partnered.
6. Support by a **MULTIDISCIPLINARY** team of healthcare providers is needed to best assist support men and their partners who desire to recover sexual intimacy after prostate cancer therapy.

Part 1: The Impact of Prostate Cancer Therapies on the Biopsychosocial Aspects of Sexuality

Critical Statements

STATEMENT 1:

- A clinician-initiated discussion should be conducted with the patient and the **PARTNER** (if partnered and culturally appropriate), to educate them about **REALISTIC EXPECTATIONS** of the impact of prostate cancer therapy on the patient's sexual function, the partner's sexual experience, and the couples' sexual relationship.
- The clinician should promote **OPENNESS** and **INCLUSIVITY**, consider **CULTURAL CONT**EXT, and tailor counseling to the specific needs of patients who are heterosexual, gay, bisexual, or identify as men who have sex with men, and of transgender women and gender non-conforming patients.

(Strong Recommendation; Evidence Strength Grade C)

Critical Statements

STATEMENT 2:

- Patients and partners should be advised that **BIOPSYCHOSOCIAL** treatment for sexual problems can mitigate sexual dysfunctions and lead to the recovery of sexual intimacy.

(Strong Recommendation; Evidence Strength Grade C)

Critical Statements

STATEMENT 3:

- Patients and partners should be advised that psychological **DISTRESS**, including **GRIEF** and mourning about **SEXUAL LOSSES**, resulting from the sexual side-effects of prostate cancer therapies, can be experienced by patients after prostate cancer therapy and by their **PARTNERS** and that this distress can be mitigated with appropriate biopsychosocial rehabilitation strategies.

(Strong Recommendation; Evidence Strength Grade C)

Part 2: The Impact of Individual Prostate Cancer Therapies on Sexual Function

Statements 4 – 16

- Side-effects of surgery, radiation and hormonal therapy
- Difference between recovery/decline of erectile function, based on treatment type
- Likelihood of not returning to baseline erectile function
- Impact of treatment on sexual function, regardless of RP or RT approaches
- Additional sexual sequelae
- Fertility

(Strong Recommendation; Evidence Strength Grade B)
(Moderate Recommendation; Evidence Strength Grade C)

Part 3: Assessment of Sexual Dysfunction and Sexual Distress

Statements 17 – 20

- Assessment of all aspects of sexuality **PRE**-treatment and **THROUGHOUT** follow-up
- Assessment **TAILORED** to culture, ethnicity/race, orientation and gender identity
- Assessment of **PARTNER'S SEXUALITY** for designing support for the recovery of sexual intimacy
- Use of **VALIDATED** patient reported outcomes (PROs)

(Clinical Principle)
(Strong Recommendation, Evidence Strength C)

Part 4: Psychosexual Treatment

Statements 22 - 27

- Individualized sexual rehabilitation and psychosexual support to be available across the entire to **SURVIVORSHIP** continuum, tailored to prostate cancer therapy type; partnership status and cultural, ethnic, and racial context
- Grief **NORMALIZED** as a typical reaction to sexual losses
- Recognition of **UNIQUE NEEDS** of patients who are gay, bisexual, have sex with men, are transgender or do not identify as male or female
- **REFERRAL** for specialized treatment in sex therapy if support and education are insufficient
- Referral to group and online support

Part 5: Biomedical Treatment

Statements 28 - 42

Nerve sparing

- Nerve-sparing surgical treatment options, when available and oncologically safe, irrespective of baseline erectile function.

(Strong Recommendation; Evidence Strength Grade C)

Penile Rehabilitation

- Define the intent and goals of penile rehabilitation strategies on an individualized basis, including preservation of penile length, maintenance of corporal tissue quality, and early patient engagement in sexual recovery. Penile rehabilitation should not be equated with treatment for the recovery of unassisted erectile function

(Moderate Recommendation, Evidence Strength Grade C)
(Conditional Recommendation, Evidence Strength C)

Statements 28 - 42

Other Sexual Dysfunctions

- Offer discussion of other sexual dysfunctions, such as anorgasmia, dysorgasmia, climacturia, penile curvature, and suggest strategies for mitigation
- Insufficient evidence for pelvic floor rehabilitation's effectiveness in treatment of sexual arousal incontinence and climacturia

Testosterone Therapy

- Individualized offer of treatment with discussion of benefits and risks

(Expert Opinion) (Moderate Recommendation, Evidence Strength Grade C)
(Conditional Recommendation, Evidence Strength Grade C)
(Clinical Principle)

Part 6 & 7: Lifestyle Modification

Statements 21 - 43

- Optimizing overall and sexual health by **REDUCING/AVOIDING SMOKING**, engaging in **PHYSICAL ACTIVITY** and increasing **PLANT-BASED** food vs red and processed meat.

(Clinical Principle)

- Patients and partners should be informed about the importance of and benefits of **EXERCISE** for sexual health as a component of medical management related to ADT.

(Moderate Recommendation; Evidence Strength Grade C)

Part 8: Clinical Education

Statement 44

- Clinicians should be provided with **SEXUAL HEALTH EDUCATION** in interprofessional groups using case based/reflective learning approaches, adopting a biopsychosocial lens and incorporating attention to diversity and sexual minorities.

(Strong Recommendation; Evidence Strength Grade C)

SUMMARY OF GUIDELINES STATEMENTS

Sexual Health Care for Prostate Cancer Patients

MOVEMBER®

Pre-treatment Education and Assessment

Patient and partner education about the impact of PCa therapies on sexuality, realistic expectations of outcomes rehabilitation strategies and emotional response.

STATEMENTS #1, 2, 3, 7

Patient and partner education about impact of PCa therapies on sexual function and mitigation strategies, fertility and preservation strategies.

STATEMENTS #4, 5, 6, 8-16, 21

Baseline patient reported outcomes (PRO) evaluation of patient and partner sexual function, sexual distress, couple coping.

STATEMENTS #20

Fertility Preservation, Prostate Cancer Therapy

Post-treatment Biopsychosocial Assessment

Routine recurring assessment of patient sexual side-effects, patient and partner response to sexual side-effects of PCa therapies, couple coping, relationship.

STATEMENTS #17-19

Recurring PRO evaluation of patient and partner sexual function, sexual distress, couple coping.

STATEMENTS #20

Biopsychosocial diagnosis

All care is respectful of cultural, racial ethnic differences, sexual orientation and gender identity.

STATEMENTS #22-25

Post-treatment Biopsychosocial Management

Penile rehabilitation treatments for ED.

STATEMENTS #28-36

Treatment for orgasmic dysfunction and climacturia.

STATEMENTS # 37 - 40

Testosterone supplementation

STATEMENTS # 41 - 42

Exercise

#43

Psychosexual support for patient and partner who are coping well or moderately well.

STATEMENTS # 22 - 24

Individual sex therapy for patient who is not coping well, experiencing loss of masculinity, sexual confidence.

STATEMENT # 26

Couple sex therapy for couples who are not coping well, experience anxiety or conflict re sexual adjustment, for whom psychosexual support is insufficient.

STATEMENT # 26

Referral to group or online/digital interventions as appropriate/available.

STATEMENT # 27

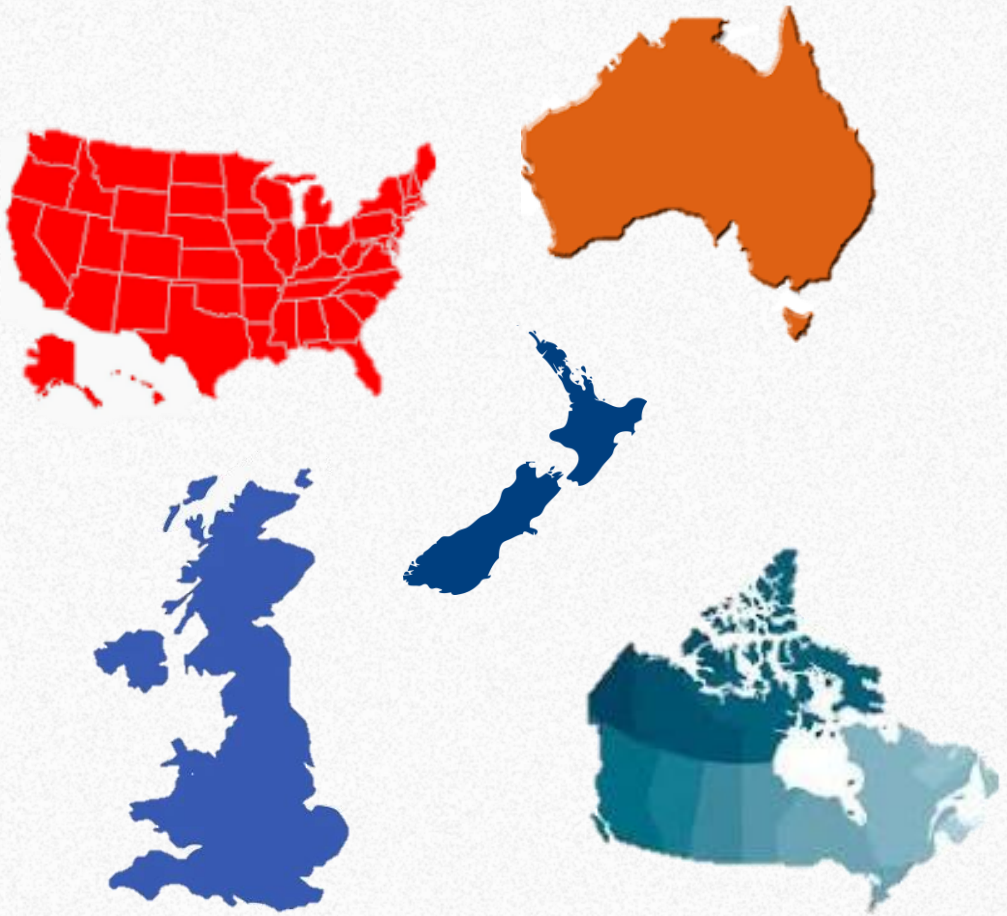
International Society for Sexual Medicine (ISSM)

Sexual Medicine Society of North America (SMSNA)

Society of Urologic Nurses and Associates (SUNA)

American Psycho-oncology Society (APOS)

European Association of Urology Nurses (EAUN)



Dissemination and Implementation

- Movember has approved $750K over 3 years to fund a global dissemination of the guidelines in partnership with ISSM.
- Efforts to implement the guidelines in several countries are under way Australia, UK, USA, Canada, New Zealand.

Questions?

THANK YOU

Help us improve!

Share your feedback on this session by scanning the QR code for a quick survey.