Female sexual dysfunction (FSD) is a common side effect of cancer and cancer treatments. Assessing for sexual dysfunctions in women with cancer is a vital component of helping women to have better, more satisfying sexual experiences. FSD is not widely addressed in most healthcare facilities or by healthcare providers, but it is a topic that all providers should be discussing with their female patients.

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Female Sexual Dysfunction

Unfortunately, M.R.’s experience is common for women treated for cancer. Female sexual dysfunction (FSD) is a side effect of cancer and cancer treatments including surgery, chemotherapy, radiation, and the use of other medications. Although all cancers have the potential to affect sexual functioning, the following cancers pose the greatest risk for sexual side effects: bladder, breast, cervical, colon, ovarian, rectal, uterine, and vaginal (Mayo Clinic, 2011). The alterations that occur may be physical, emotional, or hormonal in nature (Mayo Clinic, 2010), and antidepressants, such as Wellbutrin® (bupropion) and dehydroepiandrosterone have been shown to increase sexual desire (Kingberg, 2011). Vaginal dilators, instruments that gradually increase in size to help stretch the vagina to allow for finger or penile insertion, can be used for vaginal narrowing (Basson et al., 2003).

Education and counseling also can be beneficial in treating the emotional distress that leads to FSD. A study evaluating the effectiveness of sexual health counseling on adolescents and young adults with cancer demonstrated that counseling can provide benefits including more cancer-related sexual knowledge, an increase in confidence, an improvement in perception of body image, and a decrease in concerns about expressing affection and feeling attractive to one’s partner (Canada, Schover, & Li, 2007).

Assessment

Assessing for sexual dysfunctions in women with cancer is vital to help...
women have more satisfying sexual experiences. In a study of ovarian cancer survivors, 100% of women felt it was the healthcare professionals' responsibility to initiate conversations about sexuality and sexual dysfunction (Wilmoth, Hatmaker-Flanigan, Lalogia, & Nixon, 2011). Several models are available for healthcare providers to use as a guide when assessing and discussing FSD with their patients (see Figure 1). In addition to using those models, questionnaires are available to assess for FSD. Table 2 describes some of the commonly used sexual dysfunction questionnaires.

### Nurses’ Role

Oncology nurses can be patient advocates by analyzing, counseling, and responding to patient needs and preferences (Vaartio-Rajalin & Leino-Kilpi, 2011). Nurses analyze needs by conducting thorough FSD assessments and providing counseling about possible sexual dysfunctions that their patients may encounter. Then, they respond to those needs by helping to communicate patient wishes to the physicians and allowing the patient to be actively involved in developing their treatment plan (Vaartio-Rajalin & Leino-Kilpi, 2011). Often, nurses are able to use laymen’s terms to help patients understand complex scenarios and treatment processes. With the numerous questionnaires and assessment guides available, oncology nurses have the tools available to analyze their patients’ needs and conduct appropriate sexual health assessments. The problem lies in the preconception that discussing sex is taboo and, therefore, should be avoided (Sbitti et al., 2011).

A great way to broach the topic of sexuality is to include questions about FSD on a patient questionnaire or to simply ask the patient. Two examples of ways to start the conversation include, “Women undergoing this procedure often have questions or concerns about sexuality. Is there anything you would like to talk about?” (Katz, 2005, p. 240), and “Many cancer patients, or survivors, notice changes or problems in their sex lives after cancer treatment. Do you have any problems or concerns related to sexuality that you want to talk about?” (National Cancer Institute, 2011, p. 18). This type of questioning lets the patient know it is okay to talk about their sexual problems. Often women are embarrassed to bring up the topic of sex. In a study with ovarian cancer survivors, a woman stated, “It is hard for me to get the courage to bring up the topic” (Wilmoth et al., 2011, p. 704). Another woman stated, “Maybe they should talk about it every time and then when patients are ready to hear it, they will hear it” (Wilmoth et al., 2011, p. 704). If nurses bring up FSD at every visit, the woman will begin to understand that it is part of the nurses’ assessment and she will have more opportunities to talk about it when she feels comfortable (Wilmoth et al., 2011).

In the example with M.R., the nurse and the physician failed to ask about FSD. Because of the psychological and physical aspects of her surgery, including a shortened vagina, M.R. experienced problems with sexual desire disorder, sexual arousal disorder, and sexual pain disorder. Treatment options available for M.R. include sexual health counseling and support groups, vaginal moisturizers or topical estrogen, and vaginal dilators. Sexual health counseling and support groups may help M.R. find ways to feel sexy again and be less self-conscious about her urostomy bag. Vaginal moisturizers or topical estrogen may help with the vaginal dryness and pain she is experiencing. Lastly, the vaginal dilators will help stretch the vaginal tissue, making penetration easier and less painful. All of those therapies may help M.R. to resume sexual activity. This is an example of why FSD assessments should be a vital part of the nursing assessment at every visit.

### Conclusion

The existing research has shown that FSD is a problem many women with cancer will encounter. It also shows that women expect their healthcare providers to broach the subject of sexuality and sexual dysfunction...
instead of having to bring it up themselves (Wilmoth et al., 2011). FSD is a topic that is not widely addressed in most healthcare facilities or by healthcare providers, but it is a topic that all providers should be discussing with their female patients. Nurses are at the forefront of medical care and generally have more time with their patients than other healthcare providers; therefore, they have an excellent opportunity to conduct the FSD assessments. The assessments done at each visit may not be as in-depth as the initial one, but some type of brief assessment is warranted. That gives patients the opportunity to engage in conversations about sexuality and sexual dysfunctions when they feel comfortable to do so (Wilmoth et al., 2011). In summary, patients with cancer are at increased risk of having a sexual dysfunction, and healthcare professionals need to discuss these problems in hopes of helping the patients overcome their dysfunction and lead a more fulfilling sexual life.

**References**


TABLE 2. Female Sexual Dysfunction Questionnaires

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Number of Items</th>
<th>Categories Measured</th>
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<tbody>
<tr>
<td>Brief Index of Sexual Functioning for Women</td>
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<td>Sexual desire disorder, sexual arousal disorder, orgasm disorder</td>
</tr>
<tr>
<td>Changes in Sexual Functioning Questionnaire</td>
<td>35</td>
<td>Sexual desire disorder, sexual arousal disorder, orgasm disorder</td>
</tr>
<tr>
<td>Derogatis Interview for Sexual Functioning</td>
<td>25</td>
<td>Sexual desire disorder, sexual arousal disorder, orgasm disorder</td>
</tr>
<tr>
<td>Female Sexual Functioning Index</td>
<td>19</td>
<td>Sexual desire disorder, sexual arousal disorder, orgasm disorder</td>
</tr>
<tr>
<td>Golombok Rust Inventory of Sexual Satisfaction</td>
<td>28</td>
<td>Sexual desire disorder, orgasm disorder, sexual pain disorder</td>
</tr>
<tr>
<td>Sexual Interest and Desire Inventory—Female</td>
<td>13</td>
<td>Sexual desire disorder, sexual arousal disorder, orgasm disorder</td>
</tr>
</tbody>
</table>

Note. Based on information from Meston & Derogatis, 2002.


