


EDITORIAL

The physical and psychological sexual well-being of women with pelvic malignancy: how can we understand and improve our practice?

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J Med Radiat Sci **67** (2020) 100–101

doi: 10.1002/jmrs.402

In this issue of the *Journal of Medical Radiation Sciences*, Summerfield et al.¹ report the results of a nationwide survey capturing practices and education around the management of radiation therapy-induced vaginal adhesions and stenosis (RTVAS) across New Zealand. The authors rightly argue the significance of this work in the light of the current lack of high-level data to guide management of RTVAS. Their results, perhaps not unsurprisingly, illustrate both homogeneity and heterogeneity in practice. Consistent recommendations were reported with respect to the indications for RTVAS management and start time of intervention with dilator use. However, a marked diversity of practice was observed in terms of the recommended duration of dilator use and the spectrum of clinical staff providing care and education for RTVAS. They conclude these data may inform the potential development of a future national RTVAS management guideline with further research warranted to elucidate patterns of practice worldwide.

We are in strong agreement with the authors regarding the significance of this report. The authors and editor are to be congratulated on addressing an issue that negatively impacts a significant number of women treated for pelvic tumours and for highlighting the pressing need for further research to explore practice around the globe. Despite variable estimates, the evidence indicates RTVAS to be a common toxicity in women with pelvic malignancy treated with radiation therapy. The incidence appears to be highest in women undergoing definitive treatment for locally advanced cervical cancer; data from the EMBRACE trial report vaginal stenosis as the most frequently observed vaginal toxicity in women undergoing radical chemoradiation

and brachytherapy.² Although less commonly cited in the literature, RTVAS following pelvic RT for rectal and anal cancer is also well recognised.^{3,4} There is little doubt that RTVAS can have a significant detrimental effect on women's well-being and quality of life, impacting negatively on their sexual health and causing psychological and physical distress with implications for limiting physical examination in the post-treatment surveillance period.^{5,6,7} Despite this, there is currently a marked paucity of research around RTVAS to guide clinical practice, this being the first report of its kind from New Zealand and the most up to date from the Asia Pacific region. Research largely supports what clinicians treating pelvic tumours anecdotally report; that RTVAS is not well understood; and that practice and education are highly variable, not only between regions but also between individual clinicians. As such, women at risk of RTVAS following radiation therapy for any given pelvic tumour are receiving non-evidence-based care that is largely determined by their geographic location. Thus, the publication of this study (and others) focussing on RTVAS management and education are important steps in rectifying variability and likely quality in practice.

Notably, Summerfield et al¹ report that all responding New Zealand centres provide female pelvic patients with vaginal dilators, irrespective of sexual activity. This finding highlights the variability of practice around the world in terms of dilator use in the management of RTVAS. Several studies have reported that sexual activity is an influencing factor in the recommendation of dilator usage, and conversely, sexual activity has also been a factor in the lack of recommendation of dilator usage.⁸ As stated by the authors, given the 'intimate and ethically

complex nature of the dilator intervention', there is a clear need for further research to inform a more reliable and consistent evidence base for dilator use.

Moreover, the benefit of vaginal dilator provision in the absence of accompanying holistic support with respect to sexual rehabilitation post-treatment is debatable. This highlights a wider issue around the need for improved sexual health discussions in cancer care. As oncologists, data show we infrequently take a comprehensive sexual history, nor do we reassess sexual health in the immediate post-treatment follow-up period and into survivorship.⁹ Similarly, patients are often unlikely to broach the subject with us. This is despite the fact that sexual health is of great importance to many women living beyond cancer.⁹ Interventions at various echelons can be considered to address this. In the clinic, adopting a multidisciplinary approach in collaboration with specialist nurses, psychologists and primary care physicians may provide the best strategy for comprehensive psychosexual support from diagnosis to survivorship. Attention should also be given to widening the breadth of teaching with respect to sexual health within specialist Radiation Oncology training curricula as well advocating for and facilitating research studies evaluating the impact of cancer and its treatment on sexual well-being.

Many barriers no doubt exist both at a clinician level and patient level, but this study highlights that the onus is absolutely on us as gynaecologic oncologists to gain a better understanding of our patients' sexual health and to use this to optimise the quality of care we deliver, notably in the setting of RTVAS.

We acknowledge the well-known limitations of qualitative survey data with respect to reliability, validity, sampling and response bias. However, such methodology provides the most efficient means to capture representative real-world experience and to thereby provide justification for robust research studies with high-quality patient-reported outcome measures (PROMS) that will ultimately drive positive changes in clinical practice.

In summary, Summerfield et al make an important contribution to the limited body of literature around RTVAS practice and management. Survivorship care should prioritise sexual health and recognise the potential negative impact of RTVAS on the physical and psychological well-being of women with pelvic malignancy. A comprehensive sexual health evaluation should be part of the routine workup of patients with

pelvic malignancy, both at diagnosis and following definitive treatment with oncologists educated as to the resources, therapies and support available. A multidisciplinary approach is recommended to provide the most comprehensive care in this challenging but critically important aspect of women's health beyond a cancer diagnosis.

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