

Research Report

Risk-reducing Salpingo-oophorectomy consults and practices during the COVID-19 pandemic

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ABSTRACT

Objective: Investigate the impact of the COVID-19 pandemic on risk-reducing salpingo-oophorectomies (RRSO) consults.**Methods:** Survey sent out to 1,127 full members of the Society of Gynecologic Oncology in August 2021. Survey data included physician characteristics, practice location, and self-reported subjective and objective data about their RRSO consults.**Results:** We received 70 responses; half of the respondents were female; the mean age of respondents was 46 (range 35–65). 86% of providers transitioned RRSO consults to telehealth. There was no correlation between uptake of telemedicine by age ($R^2 = 0.09$) or gender ($p = 0.80$), but there was increased use in the West Coast region ($p < 0.01$). There was a small decrease in average time spent discussing sexual function over telehealth (35 s). Most providers felt comfortable discussing sexual health and function via telehealth.**Conclusions:** Overall, telemedicine is now commonly used for RRSO consults and physicians noted very few barriers to its uptake. Discussion of sexual function was similar between modalities, the loss of the pelvic exam or private setting did not affect the time providers spent discussing sexual health, however sexual health topics discussed were limited.

1. Introduction

For women with a genetic predisposition to tubo-ovarian carcinoma, national guidelines recommend prophylactic surgery before the natural age of menopause. The decision to undergo risk-reducing bilateral salpingo-oophorectomy (RRSO) is complex, requiring thorough consultation to discuss cancer prevention, risks, and changes in sexual function. Sexual function encompasses multiple domains including desire, arousal, lubrication, orgasm, satisfaction, and pain (Rosen et al., 2000). The side effects of surgical menopause can be a major consideration for those choosing RRSO, especially since an estimated 30% of the patients choosing to undergo RRSO are under the age of 40 (Campfield Bonadies et al., 2011). Counseling on expectations of sexual function and surgical menopause is an imperative part of the RRSO consult.

Over the course of the COVID-19 pandemic, telemedicine use has increased, diverging from the prior paradigm that all appointments

should be in-person to meet the standard of care (Contreras et al., 2020; Demeke et al., 2021; Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location [Internet], 2021). There is a paucity of evidence to suggest that in-person appointments impact survival in comparison to telemedicine (Gadducci et al., 2000; Salani et al., 2017; Mancebo et al., 2021). The aim of this study was to evaluate consult style (in-person vs. telehealth) and content of RRSO consults, specifically on sexual function; secondary objectives included understanding perceived barriers to conversations and collecting demographic data. Data was collected by surveying a group of practicing gynecologic oncologists and conducting subsequent in-depth interviews to assess differences in RRSO consults during the COVID-19 pandemic.

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2. Methods

2.1. Data collection

A survey was sent by email to 1,127 full members of the Society of Gynecologic Oncology (SGO) between August and September 2021. Only actively practicing gynecologic oncologists were invited to complete the survey. All survey data were collected anonymously via self-report regarding physician practices during the months of March 2020–February 2021. Responses from currently practicing US physicians who reported performing RRSO procedures each year were tallied. The survey assessed physician demographics, practice characteristics, and topics related to RRSO consultation visits.

2.2. Statistical analysis

Descriptive statistics were calculated including all responses for each question, and missing responses were noted. In cases where participants self-reported ranges for numerical values, an average for the range was calculated. Only providers who reported using telehealth were included in analysis of comparisons between time spent in-person versus telehealth. In two cases, the proportion of consultation visits held over telehealth did not align with the reported time spent on telehealth, therefore these data were considered incorrect and were excluded from the analysis.

Baseline characteristics were summarized using descriptive statistics. Linear correlations were calculated for continuous data with R^2 values reported. A two-tailed paired Student's *t*-test was used to assess changes among consults held in-person versus telehealth. Chi-squared and ANOVA tests were used to discern differences between physicians' gender, geographic location, and years post fellowship. ANOVA tests were performed when the number of observances in a category was above five. Physicians were asked to rank barriers to performing RRSO consults over telehealth. A binary variable was created from barrier ratings that were initially rated on a scale of 0–10. A barrier had an average of "≥4", while no barrier was "<4". *P* values less than 0.05 were considered significant.

All statistical tests were calculated using SPSS (IBM Corp. Released 2020. IBM SPSS Statistics for Mac, Version 27.0. Armonk, NY: IBM Corp) and JMP software (JMP, Version 16, SAS Institute Inc., Cary, NC, USA).

Survey respondents had the option to opt-in to a post-survey interview. All respondents who indicated interest were contacted for a follow-up interview. Interviews were held over phone or zoom. Interviews took an average of 25 min and were transcribed by members of the team. Transcripts were then uploaded to Dedoose (Version 9.0.17, web application for managing, analyzing, and presenting qualitative and mixed method research data (2021). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com) and individually coded by two separate members of the research team.

2.3. Study approval

This study was approved by Stanford's Human Studies Institutional Review Board with a waiver of written informed consent. Prior to taking the survey, participants were informed of the IRB approval, that the survey was entirely voluntary, and if there were any questions the contact information for participant's rights.

3. Results

3.1. Responses

We received 70 survey responses from active US gynecologic oncologists, for a response rate of 6%. Fifty-one percent of respondents were female, 26% male, and 21% did not disclose this information. The mean age of respondents was 46 (range 35–65). Most respondents were

white (61%), 6% were black, 7% Asian, 2.8% Asian-White, and 21% did not disclose their race. Most respondents were Non-Hispanic/Latino (74%). The largest proportion of responders was 5–9 years post-fellowship. [Table 1](#) lists participant characteristics.

Most respondents saw 100–200 patients per month and performed 10–20 RRSO consultation visits per year (median 15, range 2–75). [Table 2](#) lists baseline information on physician practices. Interviewees were from various centers located across the United States. Interviewees ranged from 9 to 31 years post-fellowship.

3.2. Telehealth Usage

During the pandemic, 85.7% of responders reported using telemedicine for at least some portion of their RRSO consults (42/49 responses). A one-way ANOVA revealed increased use of telehealth was associated with geographic location ($p = 0.01$), with significantly greater proportion of telemedicine in the West than the South West ($p = 0.004$) and than the South East ($p = 0.03$) ([Fig. 1](#)); however, its use was not associated with years-post fellowship ($p = 0.13$) or gender ($p = 0.80$). There was no difference between telehealth users and non-telehealth users by age ($p = 0.16$). The majority (58.6%) of physicians saw 10–50 patients per month via telehealth. Of those who used telehealth, the average percent of RRSO consults held via telehealth was 43% (range 0–100). The number of RRSO consults performed did not differ based on physicians' years post-fellowship ($p = 0.76$).

Interviewees discussed how telemedicine facilitated their use of multidisciplinary care. They described that frequently patients would meet with nutritionists, genetic counselors, breast care providers, menopause specialists and sex therapists in grouped telemedicine appointments. Many providers felt they were no longer apologizing for patients who spent extra time in waiting rooms. Providers noted telemedicine has improved accessibility for patients who live several hours away. One physician in the military found that "virtual appointments were perfectly fine...it was really key for the people in Japan." Others stated that "the transition for a gyn-oncologist was no problem at all", "it's a field that translates extremely well to telehealth because we typically don't do physical exams at that meeting. It's just an information session and answering questions," and "we switched rapidly to a hundred percent telehealth for those initial consults and we have not gone back...but most surgical pre-ops we do in person as a separate visit."

3.3. Barriers

Barriers to performing RRSO consults via telehealth were assessed on a ten-point scale, ten being most severe. Only the lack of conducting a physical exam was reported as barrier, with median score of 5, range 0–10 ($N = 35$). Other options were technological difficulties, inability to collect labs/imaging on the same day as the visit, inadequate time, and distress to the patient, seen in [Fig. 2](#). Physicians had the option to submit their own barriers; common statements included "lack of privacy" or "state mandates about telehealth". However, in an interview one provider noted difficulty with access for non-English speakers or those with low technology literacy. At the initial telemedicine appointment, there was not a system in place to coach the patient on how to set up the virtual platform. Another responder noted, "our state does not allow new patient visits virtually," consequently all new patient RRSO consults were performed in person. State regulations are integral to maintaining telehealth, as one interviewee stated, "If they change the rules around, then that would make it really difficult to continue because right now there is billing parity for telehealth".

3.4. Sexual function discussions

Providers discussed sexual functioning during 85.8% of their RRSO consults (median = 100%, range 10–100%). Fifteen percent of providers

Table 1
Physician Demographics.

Gender	n (%)	Age	n (%)	Race	n (%)	Ethnicity	n (%)	Years Post Fellowship	n (%)
Female	36 (51)	35–39	10 (14)	White	43 (61)	Non Hispanic/Latino	52 (74)	<5	10 (14)
Male	18 (26)	40–44	11 (16)	Black or African American	4 (6)	Hispanic/Latino	2 (2.8)	5–9	17 (24)
Unknown	15 (21)	45–49	9 (13)	Asian, White	2 (2.8)	Non-disclosed	15 (21)	10–14	8 (11)
		50–54	5 (7)	Asian	5 (7)			15–19	9 (13)
		>55	7 (10)	Non-disclosed	15 (21)			≥20	10 (14)
		Non-disclosed	28 (40)					Non-disclosed	15 (21)

Table 2
Baseline information on physician practice.

Practice Location	n (%)	Patients seen each month	n (%)	RRSOs per Year	n (%)	Patients seen each month via Telehealth	n (%)
Mid Atlantic	6 (9)	<100	16 (23)	<10	12 (18)	<10	20 (29)
Mid West	7 (10)	100–200	42 (61)	10–19	31 (46)	10–50	41 (59)
North East	11 (16)	201–300	9 (13)	20–29	17 (25)	51–100	5 (7)
North West	5 (7)	301–400	2 (1)	30–39	4 (6)	101–200	2 (3)
South East	8 (11)	Unknown	1 (<1)	≥40	4 (5)	>200	1 (1.5)
South West	11 (16)			Unknown	2 (3)	Unknown	1 (<1)
West	6 (9)						
Unknown	15 (21)						

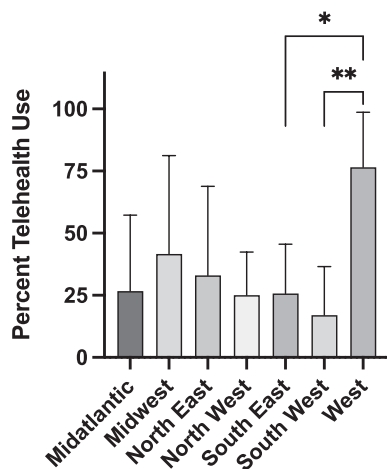


Fig. 1. Percent of RRSO consults held via telemedicine by geographic location. Comparisons done with ANOVA and p-values were determined with post-hoc Tukey’s test. * P < 0.05, ** P < 0.01. N = 44.

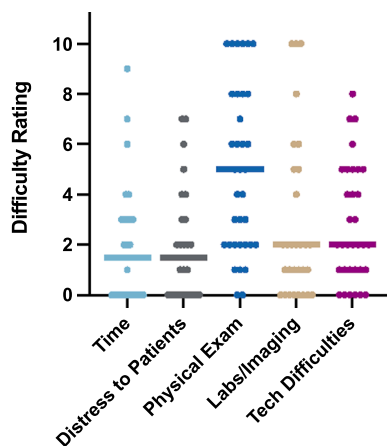


Fig. 2. Barriers to using telemedicine for RRSO consults. Rated on a scale of 0–10, 10 being the largest barrier. Individual dots represent each respondents ranking. Bar represents median ranking. N = 26 for time, N = 26 for distress, N = 35 for physical exam, N = 30 for labs, N = 33 for tech difficulties.

spent less time discussing sexual function over telehealth than in-person, while 85% of providers reported spending the same time in each modality. Average time spent discussing sexual function during RRSO consults in person was 6.8 min (SEM = 0.5, N = 59), while time spent via telehealth (amongst users) was 6.3 min (SEM = 0.55, N = 40). A paired *t*-test amongst those using telehealth showed that sexual function discussions were 9% (35 s) longer in-person than over telehealth (p = 0.02). No difference between male and female providers was noted in their time discussing sexual health, whether consults were in person (p = 0.61) or virtual (p = 0.30). Age of the provider did not correlate with time spent discussing sexual health in either modality (in person: R² = 0.03; telehealth: R² = 0.02). In ranking comfort and importance of discussing post-RRSO sexual function on a scale of 0–10, with 10 being the highest, physicians both felt very comfortable discussing sexual function (median 10, range 2–10) and deemed it very important (median 7, range 1–10) (Supplemental Fig. 1). Some physicians felt that they have increased how often they discuss sexual function due to “[providers] own awareness that it was an important issue”. One physician noted in the virtual space women have more freedom, “if their husbands are in the room, they are less likely to ask about [sexual function]”. Many interviewees also expressed that sexual function is becoming more acceptable to talk about. Two interviewees remarked that during their training many of the gynecologic oncology attendings were male, and that “[sexual function] never came up and now it comes up a lot”.

The range of topics related to sexual function varied widely across responders. Physicians reported commonly discussing menopausal symptoms (84% of responders) and vaginal dryness (80%), however less than 5% discussed reduced sexual satisfaction and orgasm difficulty. A variety of other topics discussed are listed in Table 3. One physician

Table 3
Topics discussed on sexual function.

Topics	Rates of Discussion % (count of physician discussing)
Menopausal Symptoms	21% (58)
Vaginal dryness	20% (55)
Reduced Libido	15% (41)
Dyspareunia	13% (36)
General reduction in sexual function	11% (32)
Impact on relationship	7.8% (22)
Body image issues	5.7% (16)
Reduced sexual satisfaction	3.6% (10)
Orgasm difficulty	2.5% (7)

reported "I'm very honest in that I tell [the patient] I wish our data was better on sexual function. Do we have detailed data on what happens to orgasm with the GYN procedures that we do? I wish we did, but we don't".

Challenges to discussing sexual function over telehealth were also assessed. Many physicians (40%) felt there were no challenges, however concerns expressed included lack of external cues to start the conversation (30%), confirming the patient is in a safe place (9%), lack of time (10%), and confirming the patient is in a private place (26%). No respondents reported that sexual health should be handled by another medical specialist besides themselves.

4. Discussion

4.1. Uptake of telemedicine

Most physicians transitioned many of their RRSO consults to telehealth (85.7%) during the COVID-19 pandemic. Survey data and interviewees both suggest that this change was relatively seamless for this type of visit. Enthusiasm for telemedicine echoes other data around the uptake of telehealth during this time period (Demeke et al., 2021; Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location [Internet], 2021). There was a 63-fold increase in telemedicine visits in 2020 compared to 2019 for Medicare Fee-for-service patients (Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location [Internet], 2021). This increase reflects improved infrastructure; one study reported that twice as many health centers became capable of using telemedicine during the COVID-19 pandemic (Demeke et al., 2021). Patient interest has also driven uptake of telemedicine. A patient survey found that those patients who both lived in rural counties and had difficulty attending appointments were 100% interested in the transition to telehealth for gynecologic surveillance appointments (Gynecologic oncology patients are ready for telemedicine in routine care, 2021).

In this study, providers endorsed the use of telemedicine and noted several benefits of this approach. They noted better wait times for patients which could greatly improve patient satisfaction. A previous study showed that most patients spend about 38 min waiting to see their doctors, with satisfaction scores declining dramatically after 10 min (Bleustein et al., 2014). Additionally, providers felt telemedicine was safe and effective for talking about sexual function. This is consistent with research during the pandemic that showed a 1.3 fold increase in men reaching out over telemedicine to discuss sexual medicine compared to office visits (Rabinowitz et al., 2021).

While the uptake of telemedicine was common, the most notable difference was due to geographical location. There was reduced uptake in telemedicine from providers in the Southeast and Southwest compared to the West. In some states, telehealth appointments can only be offered if they meet the same "standard of care" as an in-person setting (OCCUPATIONS CODE CHAPTER 111, 2021) or if the patient is already established (50-state survey). Reimbursement rates for telemedicine also vary in private-payer practices (Kwong, 2021) and depend on state based parity laws (The 2021 Florida Statutes, 2021; Michigan Legislature). Such nuances potentially explain the geographical differences, and physicians interviewed noted how maintaining these parity laws would be integral to continuing telemedicine.

4.2. Sexual functioning is frequently discussed, but we still need to improve topic diversity

This study found that providers almost universally discuss sexual function during RRSO consults, which is an improvement from historical data in gynecologic oncology (Andersen, 1993; Stead et al., 2003). This is consistent with a prior study by Tucker et al in which 91% of 388 physicians surveyed discussed sexuality preoperatively before RRSO (Tucker et al., 2016). They reported higher rates of discussion were

associated with physicians who self-reported as female, had higher levels of training regarding discussing sexual function, and time in practice when comparing gynecologic oncologists over juniors and fellows (Tucker et al., 2016). While our survey did not note such associations, which may be due to an improvement in discussing sexual function since the Tucker study in 2016 with the increased emphasis on the importance of sexual function more recently as outlined by the WHO's Healthy (Healthy People 2020, 2020) Report, however it may be due to the limited survey size (Tucker et al., 2016; Healthy People 2020, 2020).

In this study, the amount of time discussing sexual health was on average 35 s shorter during telehealth appointments and was related to a difference in time spent by 15% of physicians surveyed. While this may not represent a clinically significant amount of time, it may suggest that without the physical exam or non-verbal cues from patients, physicians are less prompted to continue talking about sexual function. This research and prior literature argue that more time should be spent discussing certain topics such as orgasm difficulty, body image and impact on relationships as Ivanov et al found that patients reported the cause of sexual inactivity was due to poor body image (48%), vaginal dryness (46%), and lack of desire (63%) (Ivanov et al., 2016). Retrospective surveys from RRSO patients wish they had known more about the impact of surgery on their sex life (59.2% of respondents) and availability of sex counseling (57.1%), very few patients reported needing more information on how the surgery would impact their breast cancer (17.3%) and ovarian cancer (13.3%) risks (Campfield Bonadies et al., 2011). Interview data suggested the limitations in data around sexual function after gynecologic oncology surgery limits counseling preoperatively. This underscores the need for better prospective data on patient outcomes and how with this data physicians may feel better equipped discuss these topics.

Respondents were similar to the overall demographic base in the Society of Gynecologic Oncology, however data from this study represent a minor portion of practicing gynecologic oncologists in the United States. The low response rate of 6% is a major limitation that has been noted in research dependent on email surveys, especially amongst physicians (Thoma, 2011), as it introduces a risk of non-response bias and limits the validity of the findings. We aimed to limit non-response bias by not stating our hypothesis in the survey documents and reporting all non-responders in the analysis. This study is also limited by the self-reported and retrospective nature of the data. Physicians were not required to report verified numbers, such as the time spent in counseling, and thus data represent their own estimates. Additionally, this survey assessed only physician use of and attitudes towards telehealth, and therefore this study cannot comment on patient perspectives.

Overall, this study found that virtual visits are well accepted and offer equivalent counseling for RRSO consults. We found providers must take additional attention when discussing sexual function, particularly in which topics they choose to cover. Physicians endorsed continuing telehealth usage as long as state regulations continued to fund virtual and in-person consults equivalently.

Author Contributions

Authors of this publication include **Dr. Elisabeth Diver**, who supervised all research design and methods and assisted in manuscript writing both in creation and editing, **Dr. Allison Kurian** and **Dr. Catherine Benedict** contributed with survey design and manuscript review and editing, **Dr. Samantha Wagner** participated in interview analysis and annotation, and **Alana O'Mara** aided in study design and execution, conducting interviews, analyzing data, manuscript writing and editing, as well as visualization creation.

Declaration of Competing Interest

The authors declare that they have no known competing financial

interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.gore.2022.101036>.

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