AOSW 2026
Annual Conference

June 10-12, 2026
Pre-Conferences: June 9, 2026
#AOSW2026
Portland Marriott Downtown Waterfront
Portland, Oregon USA

Optimizing Sexual Recovery of Prostate Cancer Patients and Their Partners: Implementing the International Guidelines for Sexual Health Care After Prostate Cancer Treatment in Oncology Social Work Practice

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Michigan Medicine

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Professor of Social Work
University of Houston-Downtown

Disclosures and Acknowledgements

Daniela Wittmann
- Consultant to Movember

Heather Goltz
- None to disclose

Several slides were generously provided by Dr. Jose Flores of Memorial Sloan Kettering Cancer Center

Several slides were generously provided by the Weiser Center for Prostate Cancer at the University of Michigan

Objectives

- Participants will be able to describe at least three (3) characteristics of an evidence-based theoretical model of sexual recovery after prostate cancer treatment

- Participants will be able to describe and discuss at least three (3) guidelines and related biopsychosocial rehabilitation strategies available for use in clinical and oncology social work practice with prostate cancer patients, partners, and intimate/romantic relationships.

- Participants will describe at least one (1) biopsychosocial rehabilitation strategy that they plan to integrate into their clinical and oncology social work practice within the next 3-6 months.

Agenda

Time	Topic
1:45 – 1:50 pm	Welcome
1:50 – 2:10 pm	Introduction to the International Guidelines for Sexual Health Care after Prostate Cancer Treatment
2:10 – 2:15 pm	The important role of social workers health providers in the context of a multidisciplinary team approach
2:15 – 2:45 pm	Q/A: Discussion
2:45 – 3:15 pm	BREAK
3:15 – 3:30 pm	Sexual dysfunctions after prostate cancer treatment
3:30 – 3:45 pm	The partner and couple perspective
3:45 – 4:10 pm	Q/A: Discussion
4:10 – 4:15 pm	Concluding comments

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GUIDELINES FOR SEXUAL HEALTH CARE FOR PROSTATE CANCER PATIENTS: RECOMMENDATIONS OF AN INTERNATIONAL PANEL

Heather Goltz, PhD, LCSW-S
Professor of Social Work
University of Houston-Downtown

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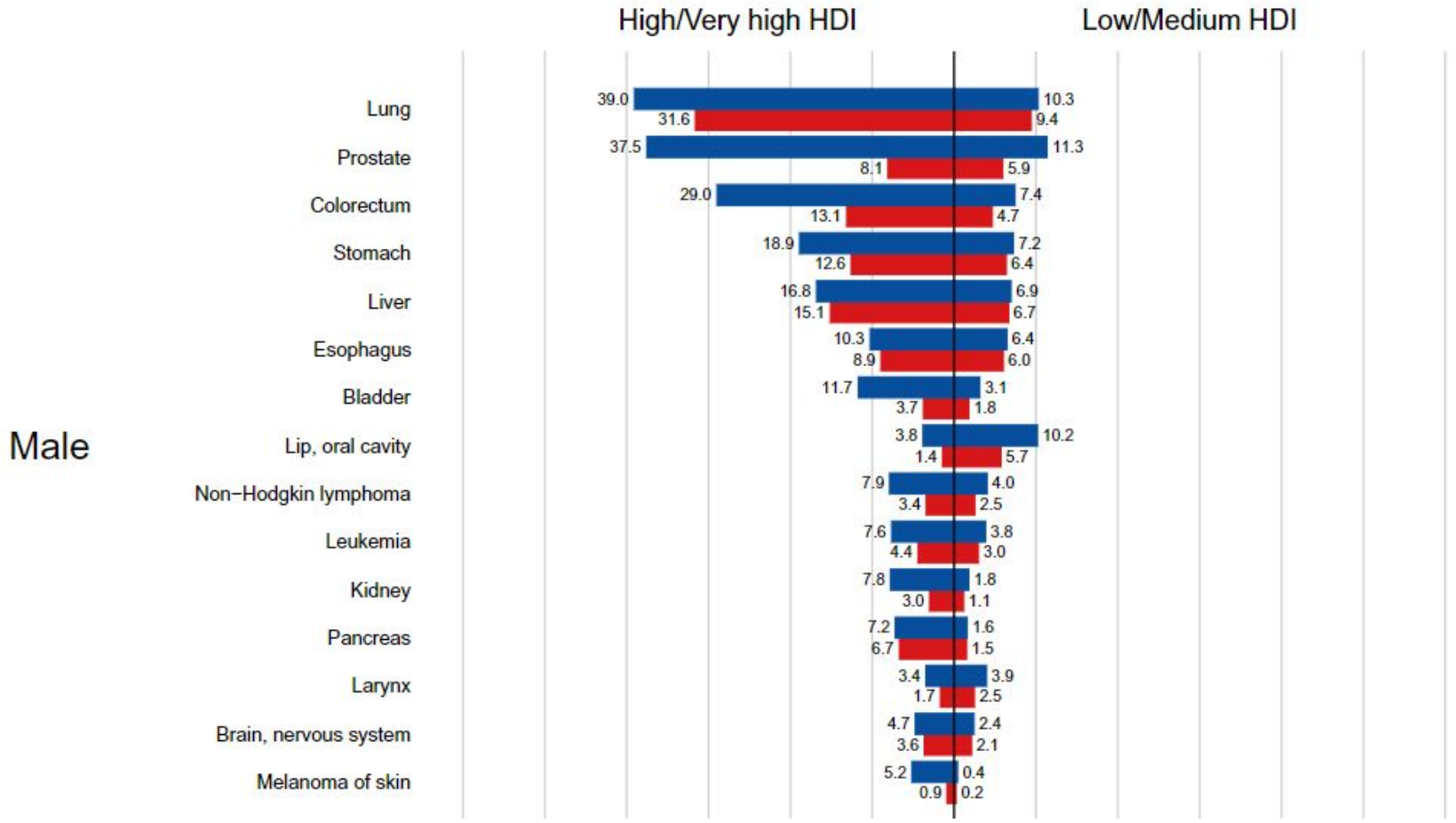
Global Cancer Incidence and Mortality



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.

- The guidelines are a part of a broader True North Movember initiative to provide maximum support for men and their partners in prostate cancer survivorship.

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

Methodology

Systematic Literature Review

- 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).
    - 602 manuscripts were included in the review.
- Evidence and recommendations strengths were aligned with AUA guidelines
- The guidelines were developed by multidisciplinary international experts, patients and partners

External Peer Reviewers

- An international panel of multidisciplinary experts in the psychosexual care of prostate cancer patients was invited to provide peer review
- **26 peer reviewers and 2 patients** provided comments
- Following comment review, the Panel revised the draft as needed

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SOUTH AFRICA
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NIGERIA
Elizabeth Akin-Odanye, PhD

BRAZIL
Sidney Glina, MD

ITALY
Andrea Salonia, M.D., Ph.D.

SINGAPORE
Mark Lin,
Martha Tara Lee, D.H.S.

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CANADA
Gerald Brock, MD
John Oliffe, PhD
Ken Noel, Lived Experience

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Kath Schubach, MSN
Melissa Hadley Barrett, MSN
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UNITED STATES
Maurice Garcia, MD, MAS
Mohit Khera, MD
B. R. Simon Rosser, PhD, MPH, LP
Lawrence Jenkins, MD
William West, Lived Experience

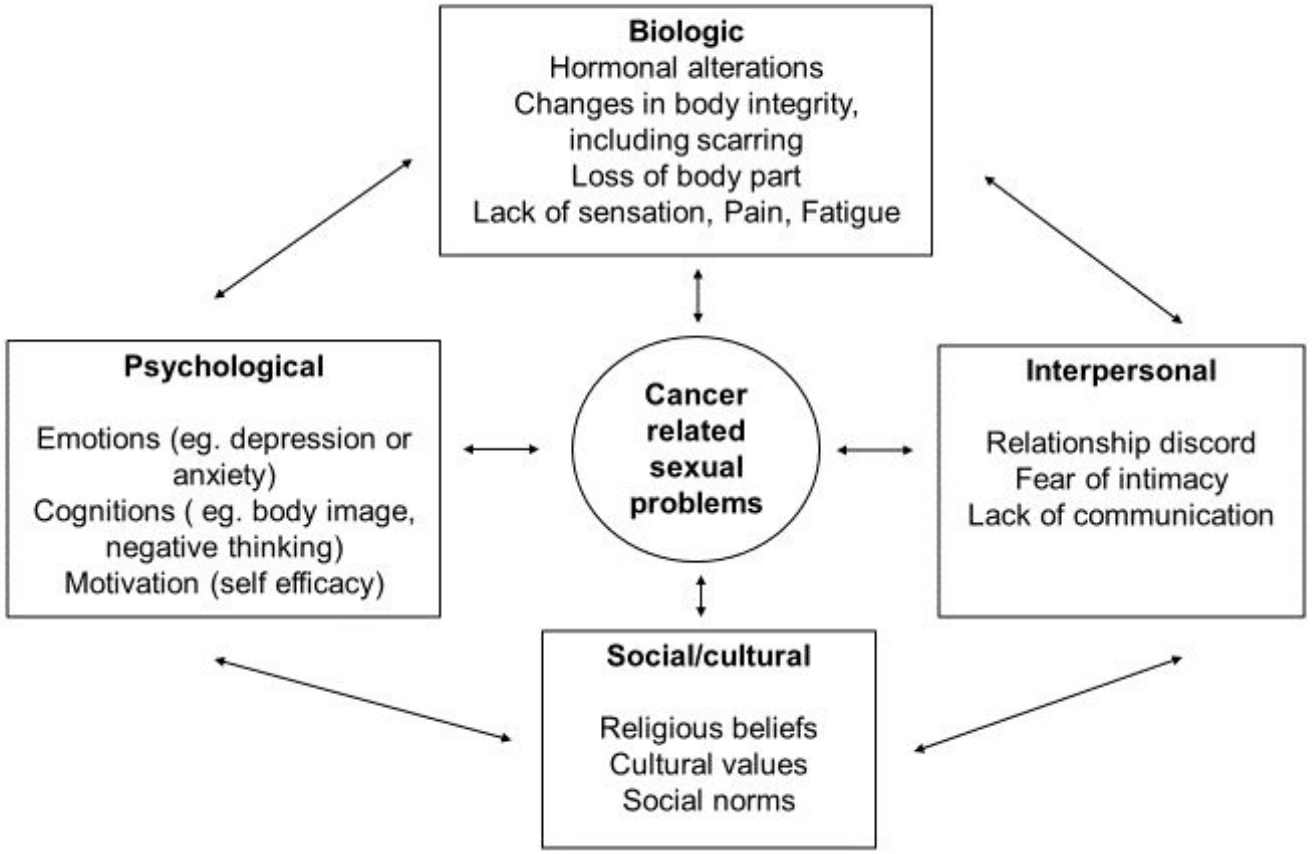
AUSTRIA
Elfriede Greimel, PhD.

Statements

- 47 statements in 9 sections
- We will present a summary of the sections with the range of evidence and recommendation strengths noted at the bottom of the page
- Statements generally focus on clinicians educating the patients and partners

Theoretical Model and Guiding Principles

Theoretical Model



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.

Guiding Principles

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.

Statements 1 - 3

- Clinician-initiated discussions with patients and partners (if partnered and culturally appropriate)
  - Education concerning 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, with emphasis on openness, inclusivity, and tailoring to specific gender and sexual identity needs
  - Education that biopsychosocial treatment for sexual problems can mitigate sexual dysfunctions and lead to the recovery of sexual intimacy
  - Patient and partner education concerning psychological distress and that this distress can be mitigated with appropriate biopsychosocial rehabilitation strategies

(Strong Recommendation; Evidence Strength Grade C)

Example of Statements 1-3

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 context, 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)*

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)*

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)*

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)

Example of Statements 4 - 16

STATEMENT 4: Patients and partners should be counseled that all therapies for prostate cancer have the potential to result in short-term and long-term erectile dysfunction. *(Strong Recommendation; Evidence Strength Grade B)*.

STATEMENT 5: Patients and partners should be counseled that patients treated with radical prostatectomy have different trajectories of sexual function decline and potential recovery compared to patients treated with radiotherapy. *(Moderate Recommendation; Evidence Strength Grade C)*

STATEMENT 6: Patients and partners should be counseled that after prostate cancer therapies, most patients do not return to their pre-treatment erectile function levels. *(Strong Recommendation; Evidence Strength Grade B).*

STATEMENT 7: Patients and partners should be advised that pre-existing erectile dysfunction is associated with a higher risk of post-treatment erectile dysfunction after radical prostatectomy regardless of the surgical technique used and after radiotherapy regardless of the type of radiation employed. *(Strong Recommendation; Evidence Strength Grade B)*

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)

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

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

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)

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)*

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)*

Statements 45 - 47

- Providers and healthcare systems should develop culturally appropriate materials for counseling regarding to the impact of prostate cancer treatment on sexual health
- Insurance coverage for the treatment of sexual dysfunctions secondary to prostate cancer therapies should become universally available in order to recognize the validity of this aspect of prostate cancer care and to reduce disparities in access to care

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THE JOURNAL OF
SEXUAL MEDICINE

ORIGINAL RESEARCH & REVIEWS

ONCOLOGY

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

Check for updates

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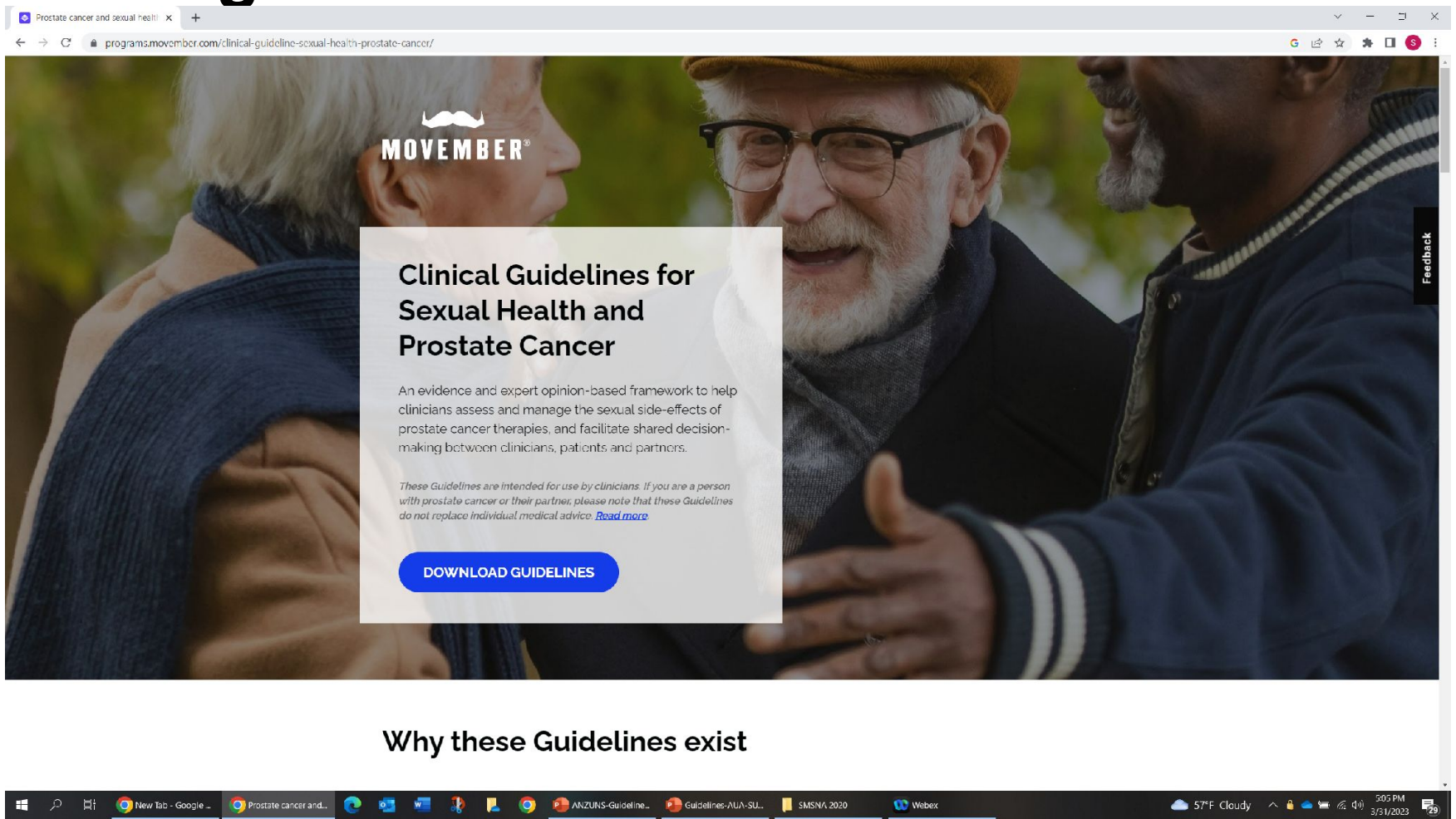
Unabridged Guidelines on Movember Website



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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

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

Fertility Preservation, Prostate Cancer Therapy

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

Patient Version

Patient version is now available on the Movember website

(https://truenorth.movember.com/images/assets/SexualHealthGuidelines-Patient.pdf)

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Australian and New Zealand Urologic Nurses Society (ANZUNS)

International Society for Sexual Medicine (ISSM)

Sexual Medicine Society of North America (SMSNA)

Society of Urologic Nurses and Associates (SUNA)

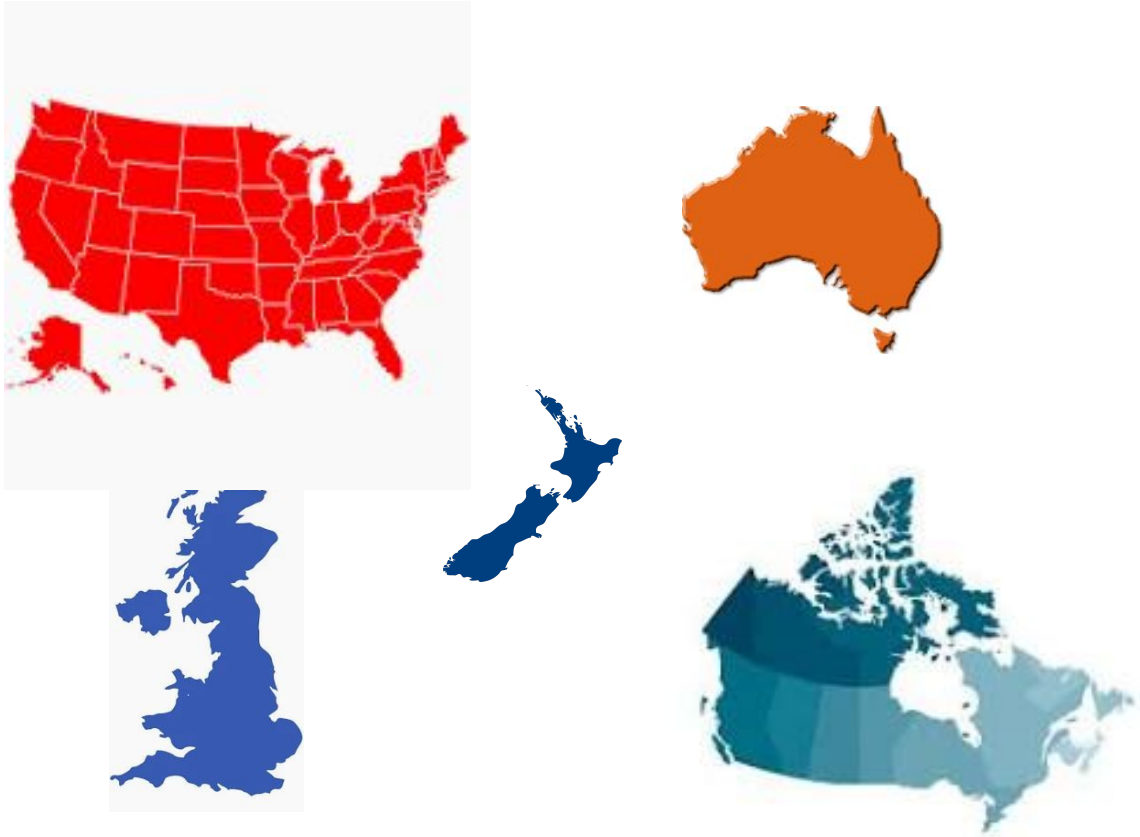
American Psycho-oncology Society (APOS)

European Association of Urology Nurses (EAUN)

Oncology Nursing Society (ONS)

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 underway in Australia, UK, USA, Canada, New Zealand



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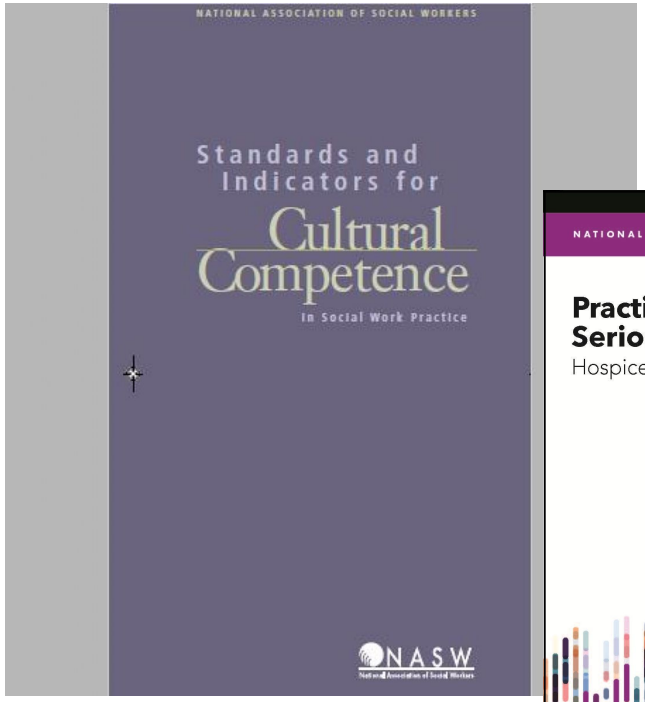
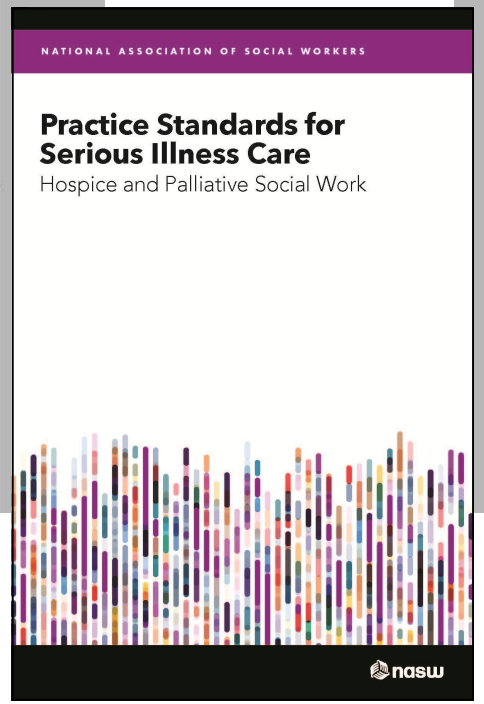
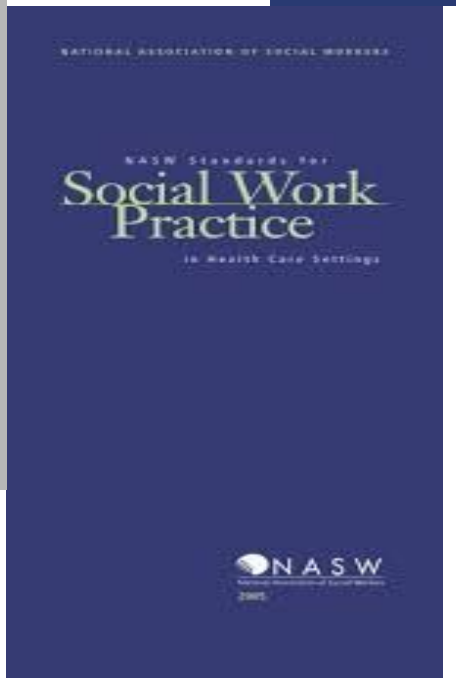
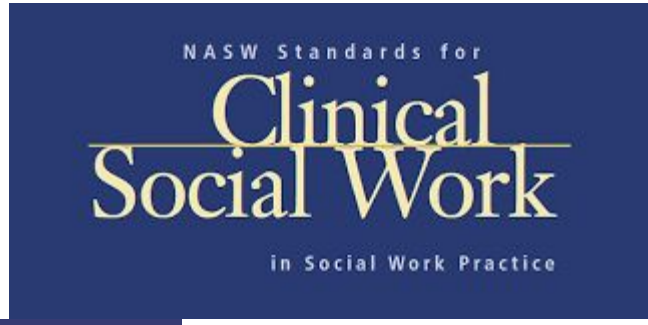
Role of OSWs in the IDT









Role of OSWs in the IDT

The scope of practice in oncology social work, as identified in the **AOSW Standards of Practice**, includes:

- **Services to cancer survivors, families and caregivers** through clinical practice providing comprehensive psychosocial services and programs through all phases of the cancer experience
- **Services to institutions and agencies** to increase their knowledge of the psychosocial, social, cultural and spiritual factors that impact coping with cancer and its effects, and to insure provision of quality psychosocial programs and care
- **Services to the community** through education, consultation, research and volunteering to utilize, promote or strengthen the community services, programs and resources available to meet the needs of cancer survivors
- **Services to the profession** to support the appropriate orientation, supervision and evaluation of clinical social workers in oncology; participate in and promote student training and professional education in oncology social work; and advance knowledge through clinical and other research

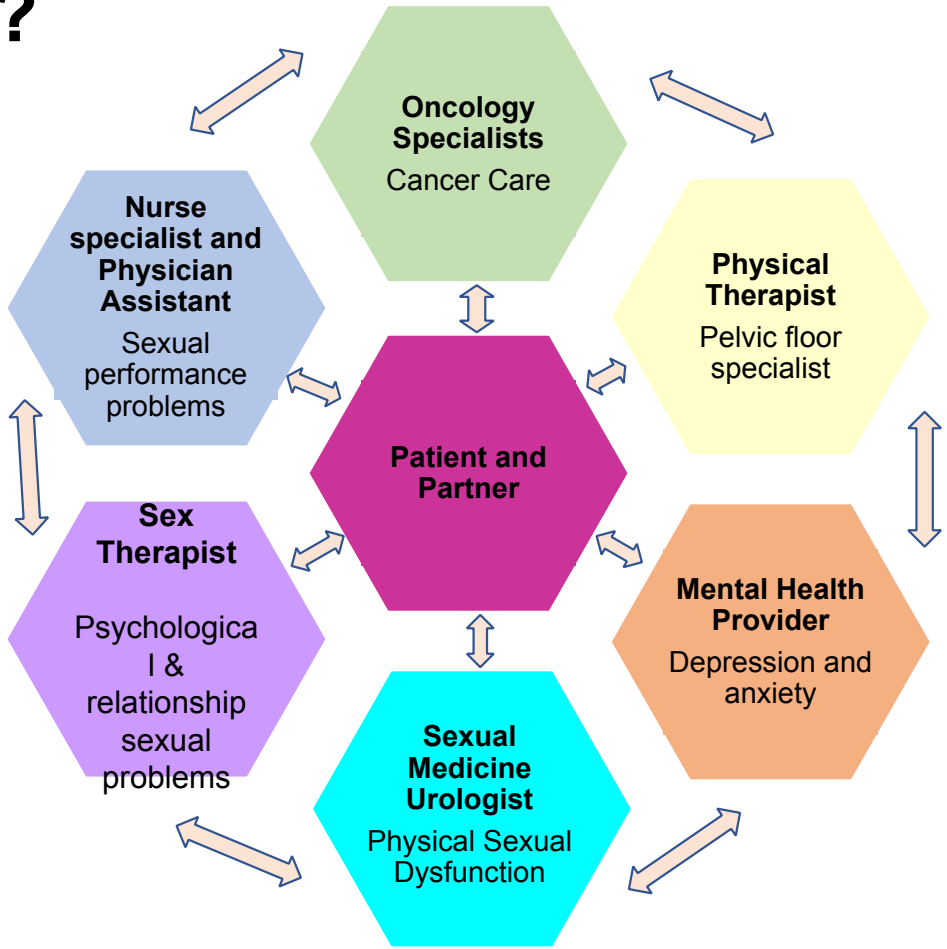
Role of OSWs in the IDT

- Educator
- Advocate
- Broker/Negotiator
- Facilitator
- Systems/Strengths specialist
- Clinician

What Can Oncology Social Workers Do?

PLISSIT Model

- Permission
- -Ask permission to discuss?
- Limited Information
- - Educate patient about the impact of treatment on sexuality
- Specific Suggestions
  - Sexual aids education and emotional support
- Intensive Therapy
  - Refer to individual, sex therapy or couples therapy



Pillai & Ashline, Sex and Rel Ther, 2014, Wittmann et al., J Sex Ther, 2015, Supp Care Ca, 2015, J Sex Med, 2022

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Instructions

Scan the QR code with your device to access the brief survey.

This survey gathers insights to improve sexual health guidelines and resources in prostate cancer care through the ISSM and Movember partnership.

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SEXUAL DYSFUNCTION AFTER PROSTATE CANCER TREATMENT

Daniela Wittmann, PhD, LMSW
Associate Professor of Urology Emerita
Michigan Medicine

The Price of Prostate Cancer Treatment

Treatment	Long-term effect
Surgery (radical prostatectomy, open, laparoscopic, robot assisted)	• Urinary dysfunction (incontinence or irritability, urethral stricture) • ***Sexual dysfunction (ED, loss of ejaculation, changed orgasm, penile shortening)***
Radiation (external beam or brachy therapy)	• Urinary dysfunction (incontinence, irritability, hematuria, urethral stricture) • ***Sexual dysfunction (progressive ED, decrease in semen volume), anal irritation and loss of elasticity*** • Bowel dysfunction (urgency, frequency, fecal incontinence, irritability and pain)
Hormone (androgen deprivation)	• ***Sexual dysfunction (loss of libido, ED, genital shrinkage, diminished orgasm)*** • Other symptoms (hot flashes, bone density loss, emotional volatility, hair loss, gynecomastia, metabolic syndrome)

Male sexual dysfunctions after prostate cancer treatment

- Erectile dysfunction (ED)
- Penile length alterations
- Urinary incontinence
- Low libido/sex drive
- Low testosterone
- Sexual incontinence
- Delayed orgasm
- Painful orgasm
- Penile curvature

ERECTILE DYSFUNCTION (ED)

- Most frequently reported and studied sexual dysfunction after prostate cancer treatment

- Most inadequately explained to patients prior to treatment

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Patient Preoperative Expectations of Urinary, Bowel, Hormonal and Sexual Functioning Do Not Match Actual Outcomes 1 Year After Radical Prostatectomy

Daniela Wittmann,* Chang He, Michael Coelho, Brent Hollenbeck, James E. Montie and David P. Wood, Jr.†

- Only 32% patients thought that erections would be worse after surgery
- 11% patients thought that erections would be better after surgery

Education

Preparing Patients and Partners for Recovery From the Side Effects of Prostate Cancer Surgery: A Group Approach

Kellie Paich, Rodney Dunn, Ted Skolarus, James Montie, Brent Hollenbeck, Ganesh Palapattu, David Wood Jr., Staci Mitchell, Victor Hola, Kim Erickson, Jennifer Shifferd, and Daniela Wittmann

- 73% patients thought that erections would be worse after surgery
- 84% patients thought the ability to be sexually active after prostatectomy would be different
- 4% patients thought erections would be better after surgery

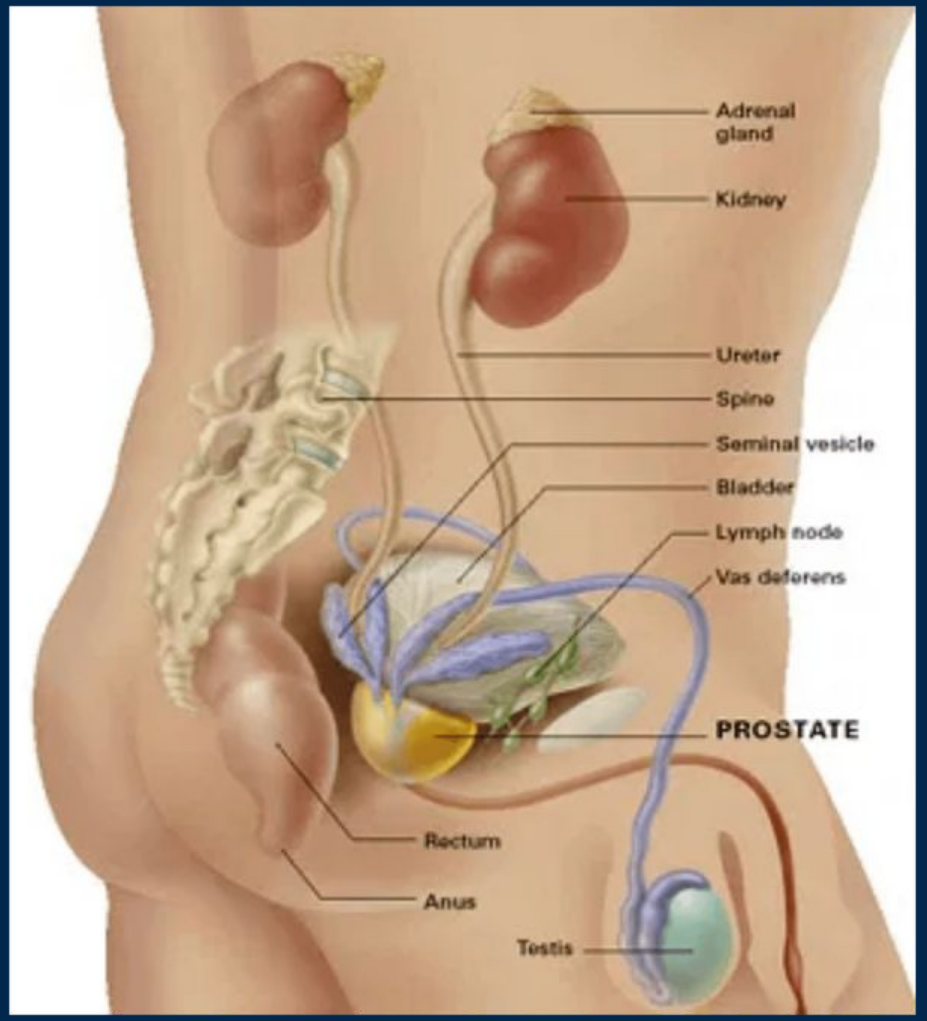
Prostate Anatomy

The Prostate Gland

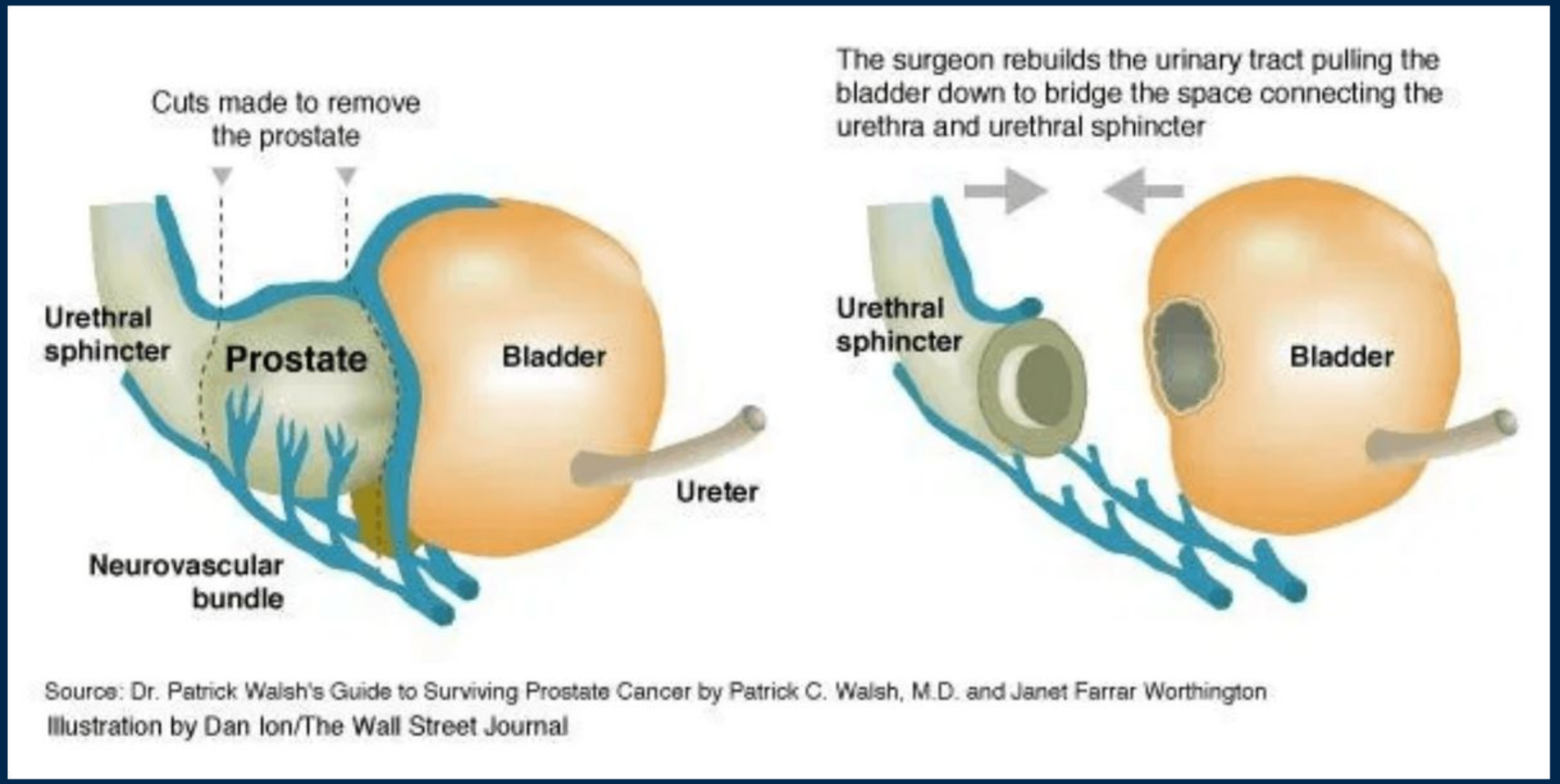
- Male reproductive gland located below the bladder and in front of the rectum
- Surrounds the urethra — the tube that empties urine from the bladder
- Produces fluid that liquefies semen

Seminal Vesicles

- Located behind the prostate on the right and left
- Store seminal fluid



Pelvic Anatomy: Prostate and Surrounding Structures



Source: Dr. Patrick Walsh's Guide to Surviving Prostate Cancer by Patrick C. Walsh, M.D. and Janet Farrar Worthington
Illustration by Dan Ion/The Wall Street Journal

Recovery of Urinary Control and Erectile Function after Prostatectomy

Urinary Control

- Can take up to **6 months** to recover (often sooner)
- Recovery timeline varies by individual
- Pelvic floor PT significantly accelerates recovery

Erectile Function

- Can take up to **2 years** to recover
- Highly individual

What Influences the Fate or Erectile Function and Bladder Control?

Return of urinary Control Depends On:

Pre-operative urinary function

Extent of cancer and extent of surgery

Participation in pelvic floor physical therapy

Erectile Function Depends On:

Age at time of surgery

Whether nerve-sparing surgery was possible

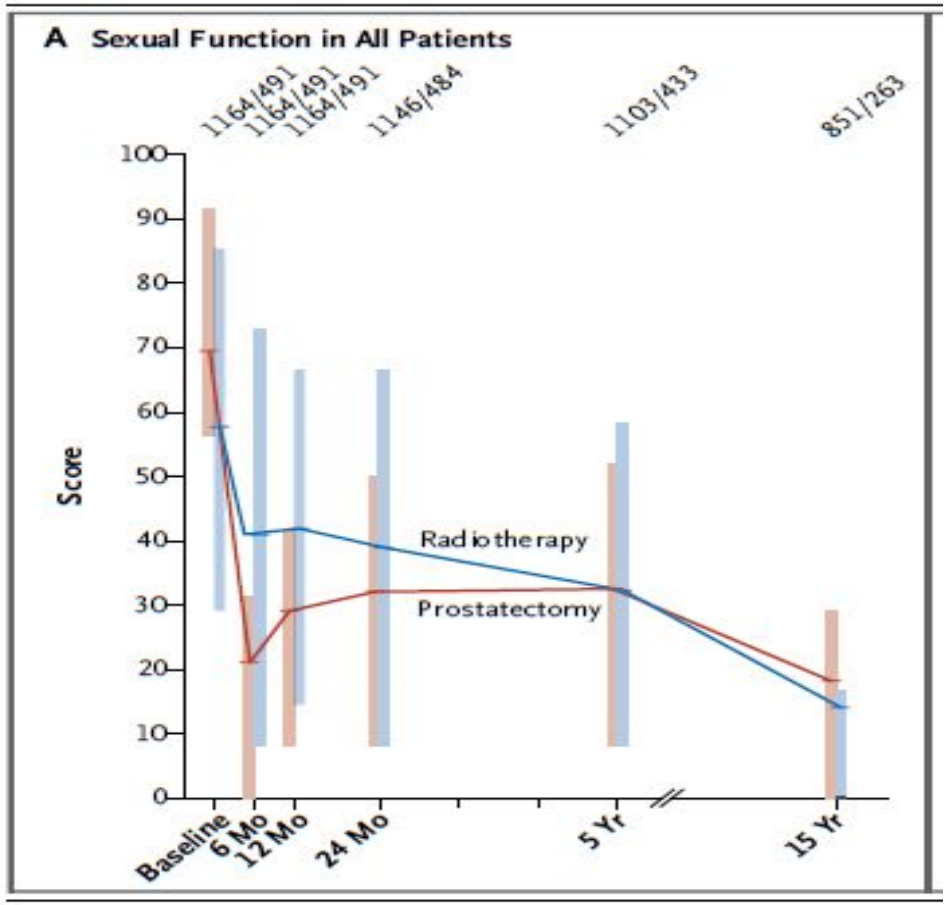
Quality of erections before surgery

Participation in penile rehabilitation program

Trajectory of Erectile Function After Radiation & Hormonal Therapy

- After radiation, decline of erectile function is gradual and noticeable within a year of treatment
- As hormonal therapy is administered, erectile function declines within 2-3 weeks and may or may not return if the therapy is intermittent

15- YEAR ERECTILE FUNCTION FOLLOW-UP AFTER RP AND RT



ED at 2 years
79% prostatectomy patients
61% radiation patients

ED after 15 years
87% surgically treated
93% treated with radiation

ED in general population
50% general population, mean age 73

Resnick et al., NEJM, 2013
Litwin et al., J Urol, 1999

GENERAL HEALTH AND ERECTILE FUNCTION

Optimizing your **general health before surgery** significantly improves erectile function recovery outcomes.

Medical Conditions

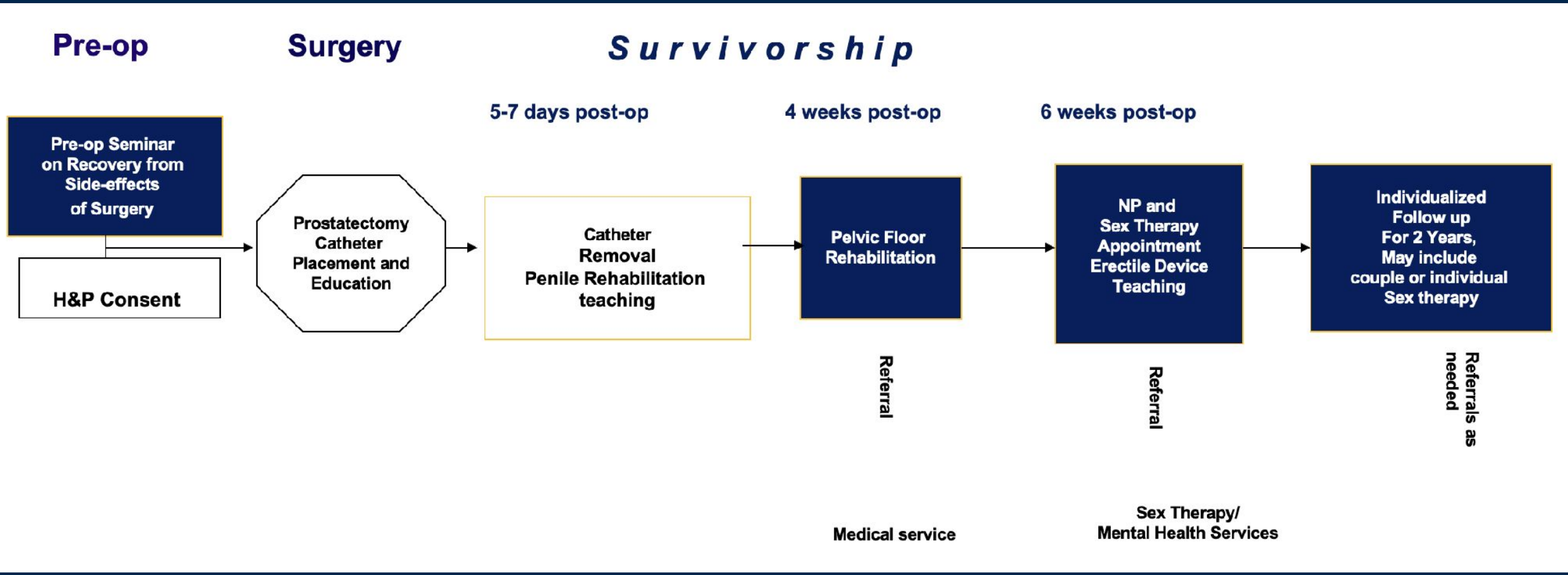
- Diabetes
- High blood pressure (hypertension)
- Cardiovascular disease

Lifestyle & Psychological Factors

- Smoking and excessive alcohol use
- Certain medications (sedatives, tranquilizers, antihypertensives)
- Stress, depression, anxiety, and fatigue
  Exercise and plant-based food consumption vs inactivity and red meat consumption

Carto et al., Urology, 2022

U of M PROSTATE CANCER SURVIVORSHIP CARE



Wittmann et al., Urology, 2021

PENILE REHABILITATION

(Protecting Corporal Tissues and Patient Activation - not validated through research)

PDE-5 Inhibitor

Sildenafil or Tadalafil — low dose every other day for 3 months to promote penile oxygenation.

Prelude Device

Soft vacuum therapy used **daily** to promote blood flow and prevent penile shrinkage.

Vacuum Erection Device

Used **every other day** to draw blood into the penis and maintain tissue health.

Sexual Stimulation

Daily stimulation/masturbation promotes blood flow and nerve recovery.

Aids to Erectile Function: Overview

PDE-5 Inhibitors

Oral medications (Viagra, Cialis)

Vacuum Devices

Prelude (soft) and VED (erection device)

Injection Therapy

Medication injected directly into the penile shaft

Penile Implants

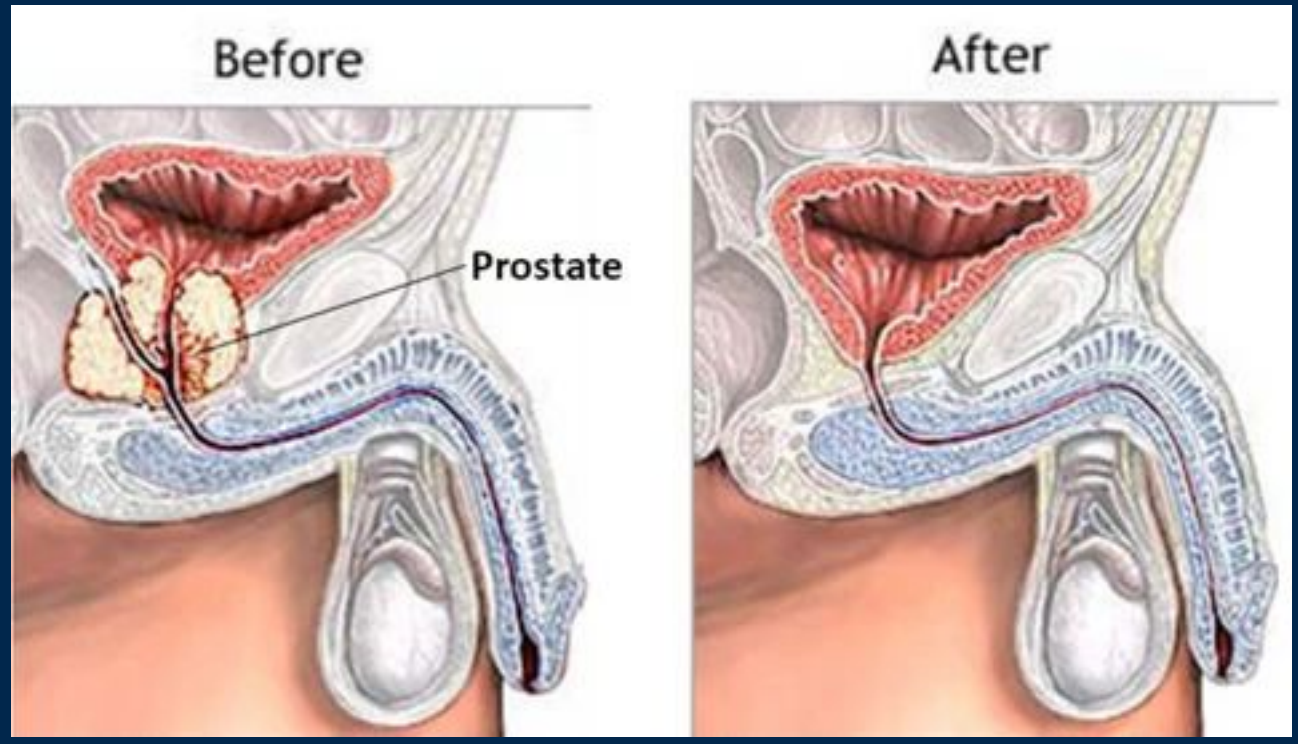
Surgical option when other treatments have failed

PENILE SHRINKAGE

A decrease in blood flow to the penis may cause atrophy (shrinking) of the cells in the penis.

Structural changes in the pelvis can occur when the prostate is removed.

Some people do not notice a change in size, but one in five may have a 15% decrease in measurements.



PENILE LENGTH RECOVERY

Treatment

- Penile traction device
- Vacuum erection device

Mulhall et al. Clinical Care Pathways in andrology. Erectile dysfunction: Evaluation. 2014. Parekh A, et al. Reduced penile size and treatment regret in men with recurrent prostate cancer after surgery, radiotherapy plus androgen deprivation, or radiotherapy alone. Urology. 2013 Jan;81(1):130-4. Yu Ko WF, et al. Penile length shortening after radical prostatectomy: men's responses. Eur J Oncol Nurs. 2010 Apr;14(2):160-5

LOW SEX DRIVE

Definition: It is described as a decreased interest in sexual activity.

Prevalence: 54% among prostate cancer survivors.

Causes:
- Low testosterone level
- High prolactin level
- Hypothyroidism level
- Antidepressant medications (SSRI)
- Psychological causes

Treatment: Based on the leading causes

Mulhall et al. Clinical Care Pathways in andrology. Erectile dysfunction: Evaluation. 2014. Joseph D et al. Perceptions of prostate cancer patients undergoing definitive radiotherapy on the impact of prostate cancer and radiation therapy on male sexuality ecancer 18 1726. Heyne S et al. Frequency of Sexual Problems and Related Psychosocial Characteristics in Cancer Patients—Findings From an Epidemiological Multicenter Study in Germany. Front Psychol. 2021; 12

TESTOSTERONE AND PROSTATE CANCER

Symptoms of low testosterone include:

- Fatigue
- Possibly feeling down or emotionally labile
- Low sexual desire
- Erectile dysfunction

TESTOSTERONE AND PROSTATE CANCER

Assessment

- Review of pre-prostate cancer treatment testosterone level

- Testosterone supplementation prescribed when cancer is considered stable (1-2 years after treatment)

AMERICAN UROLOGICAL ASSOCIATION
Evaluation and Management of Testosterone Deficiency

(Published in 2018, reviewed and validity confirmed in 2024)

Guideline Statement 17

- Clinicians should inform patients of the absence of evidence linking testosterone therapy to the development of prostate cancer. (Strong Recommendation; Evidence Level: Grade B)

- Supplementation should be offered only to hypogonadal men

Mulhall JP, Trost LW, Brannigan RE et al: Evaluation and management oftestosterone deficiency: AUA guideline. J Urol 2018; **200:** 423.

SEXUAL INCONTINENCE

Definition: Urine leaks during foreplay (arousal incontinence) or at the moment of the orgasm (climacturia)

- Prevalence = 16-90% after Radical prostatectomy

Treatment

- Empty bladder before sexual activity
- The use of a tension loop during sexual activity (50% reported rare or occasional leak)
- Use condom – not effective with a flaccid penis

- **Psychological approach** - normalize

- Pelvic floor therapy

- Surgical procedure including slings and artificial urinary sphincter

Mulhall et al. Clinical Care Pathways in andrology. Erectile dysfunction: Evaluation. 2014 International Journal of Impotence Research volume 33, pages 259–270 (2021) BJU Int. 2013 Mar;111(3):500-4

DELAYED ORGASM (ANORGASMIA)

- **Definition:** as the persistent difficulty, delay in, or absence of attaining orgasm after sufficient sexual stimulation, which causes personal distress.
- Delayed orgasm and anorgasmia are associated with significant sexual dissatisfaction
- **Prevalence**: 63% of men reported orgasm problems after prostate cancer surgery – weaker, painful

Causes:

- SSRI antidepressants
- Low testosterone level (< 300 ng/dL)
- Penile sensation loss (Diabetes, Post chemotherapy due to peripheral neuropathy)
- Hyperstimulation (anxiety)
- Psychological causes (Common cause, conflict relationship for example)

Treatment: Based on the leading causes

Mulhall et al. Clinical Care Pathways in andrology. Erectile dysfunction: Evaluation. 2014. Hendren S et al. Prevalence of Male and Female Sexual Dysfunction Is High Following Surgery for Rectal Cancer. Ann Surg. 2005 Aug; 242(2): 212–223.

PAINFUL ORGASM (DYSORGASMIA)

- **Definition:** Pain at the moment of the orgasm, may be associated with chronic pelvic pain syndrome
- **Prevalence:** up to 18% post prostate cancer surgery- Pain in the penis, scrotum and perineum

Causes: It may be related to spasms of the bladder neck, and/or pelvic floor muscles

It may diminish with time and stimulation

Treatment:

- Alpha-blockers (alfuzosin)
- Pelvic floor therapy (nerve entrapment)

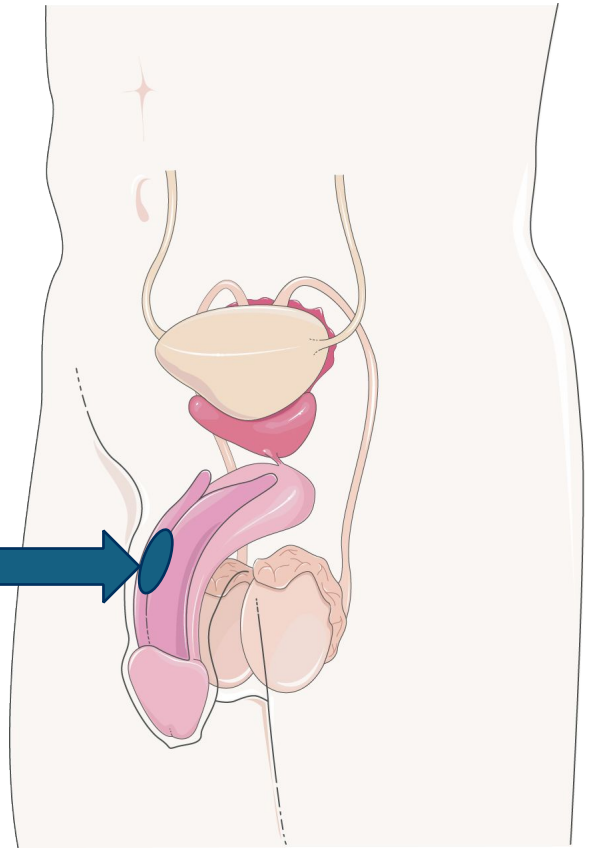
Mulhall et al. Clinical Care Pathways in andrology. Erectile dysfunction: Evaluation. 2014. Dickstein DR, et al. Sexual health and treatment-related sexual dysfunction in sexual and gender minorities with prostate cancer. Nat Rev Urol. 2023 Jun;20(6):332-355

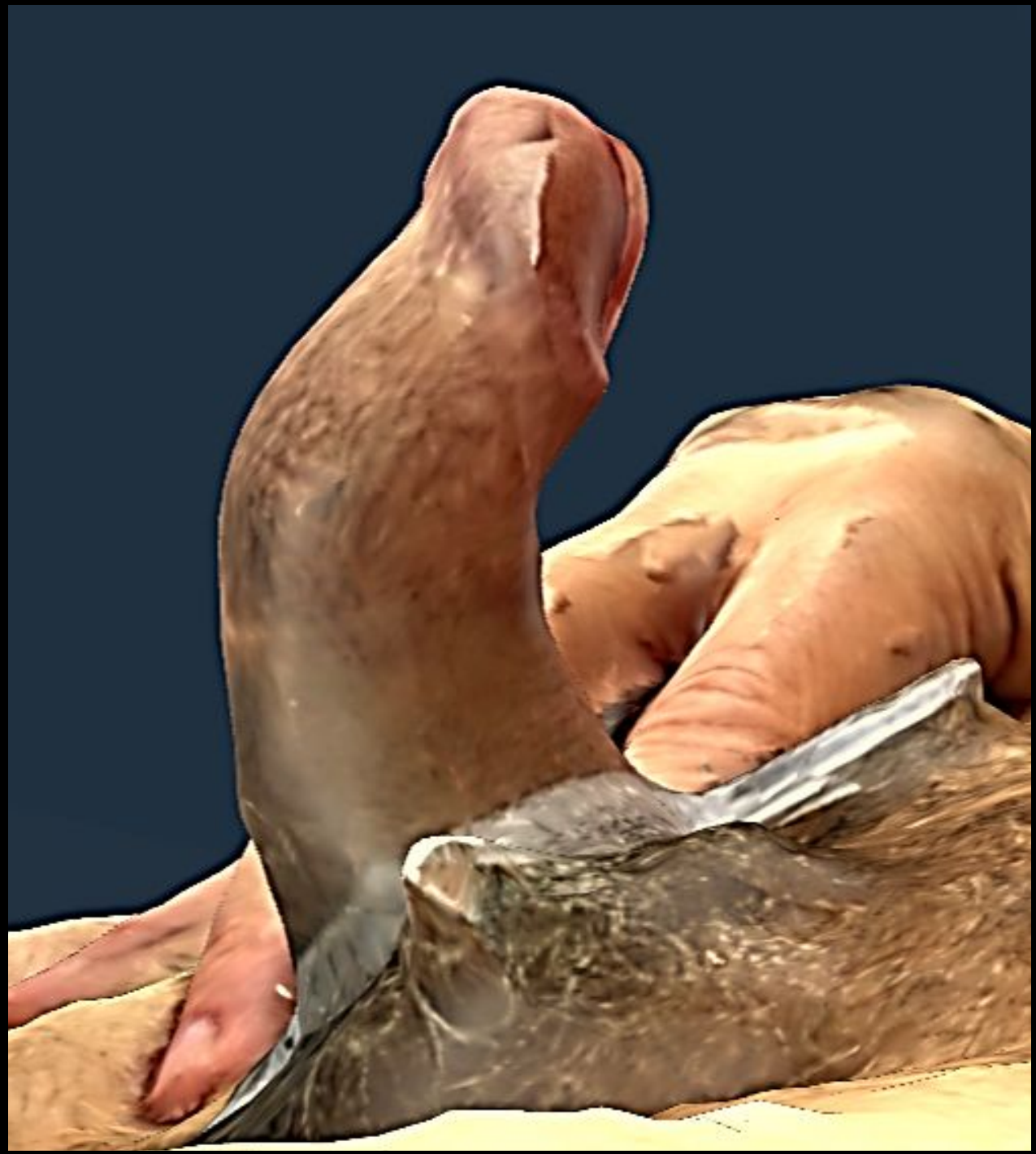
PEYRONIE'S DISEASE

- Most common symptom is penile curvature
- A plaque forms when the tissues are healing and the penis curves around it
- Painful erections
- Loss of length in the penis, loss of girth in the shaft
- Indentations or hourglass shape
- Other kind of deformities, palpable lumps, difficulties with the hardness of the erections or penile instability

PEYRONIE'S DISEASE

Plaque





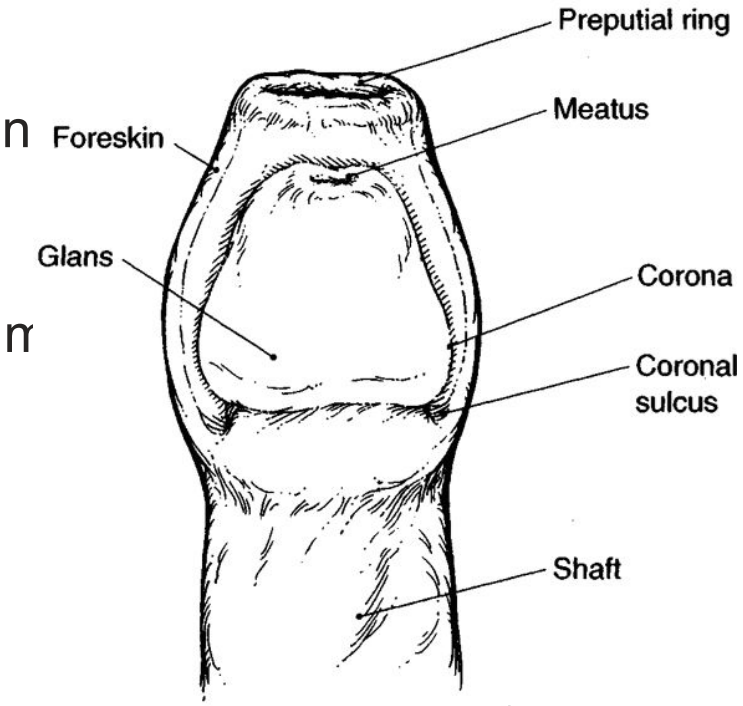
IMPACT ON ERECTIONS AND ON PARTNERS

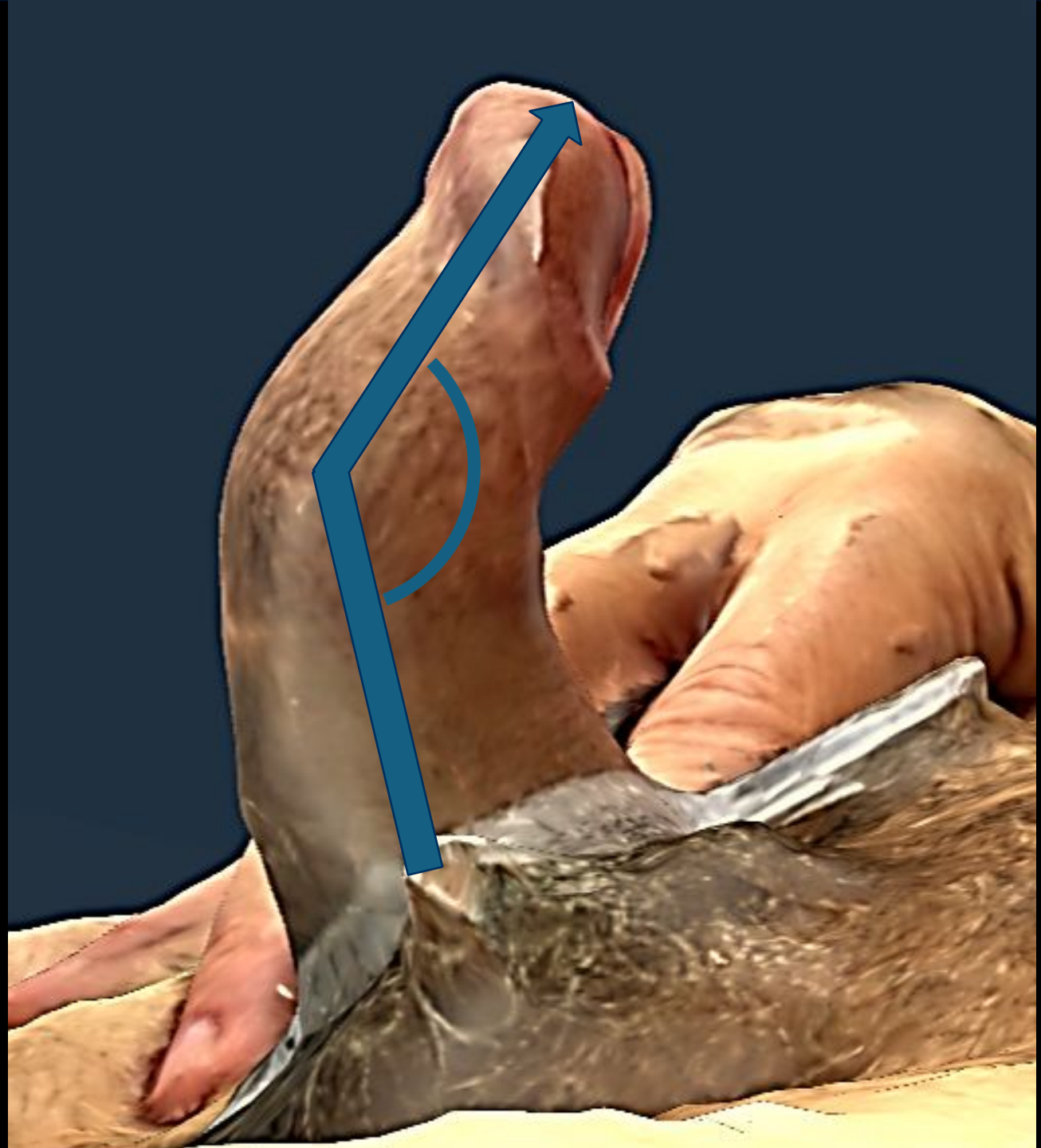
- Painful erections or a burning sensation during the sexual activity.
- The pain can range from mild to intense enough to make intercourse difficult or impossible.
- Partner may experience pain with penetration, depending on degree of curvature.
- This is reported during the acute phase and usually lasts for weeks or months. However, it will improve until it disappears for most patients when the plaque and Peyronie’s disease are stable.

CURVATURE ASSESSMENT

During this test:

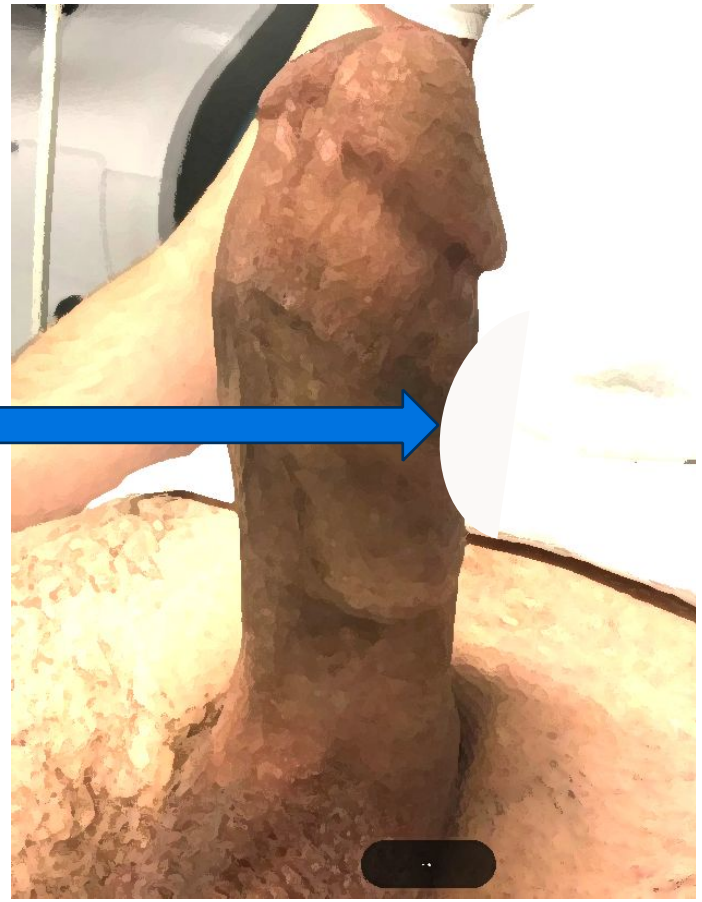
- Penile injection to achieve the most rigid erection
- Different measurements are assessed, including
  - Number of curvatures, location (base, mid-shaft, distal), orientation (dorsal, ventral or lateral), degrees
  - Distance of the point of maximum curve and the coronal sulcus
  - Penile size and girth at different points (base, point of the maximum curve and distal)
  - Penile stability
  - And the presence of other deformities
- Also, a penile Doppler ultrasound is performed to evaluate the hemodynamic parameters and the presence of calcifications of the plaque





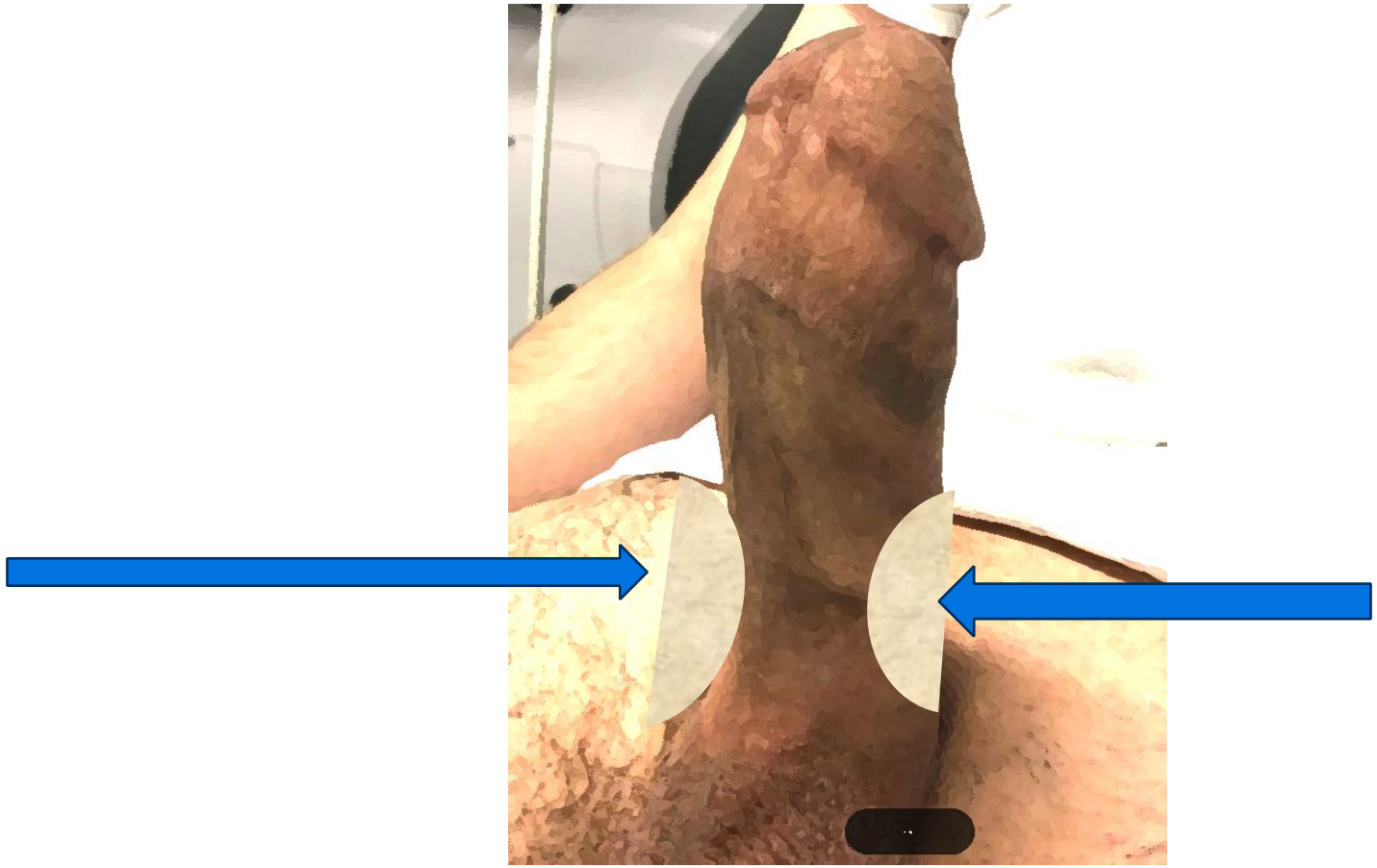
OTHER DEFORMITIES

Indentations



OTHER DEFORMITIES

Hourglass Shape



NON-SURGICAL and SURGICAL TREATMENTS

Oral Medications

Tadalafil
5 mg daily

Intralesional Injection

ILX cycles
(up to 8 injections)

PTD or VED

PTD (Restorex: 30-60 minutes daily for 6 months, Straight out)

VED (Slowly erection, maintained for 1 minute, and then release it, repeat 5 times, twice/d for 6 months)

Surgery
(stable phase, 12 months)

Penile Plication +/- External Tunical Grafting

Penile prosthesis

TREATMENT SUCCESS

- Expectations must be managed.
- The success of the treatment is considered if the curvature is reduced by more than 10 degrees or more than 20% compared to the baseline curvature.
- There is a chance of residual curvature; if the curvature is less than 30 degrees, this is considered functional for sexual activity.
- Other deformities or instability could not be improved with these treatments.

TAKE HOME MESSAGES

- Men experience a number of sexual dysfunctions after prostate cancer treatment; ED is only one of them
- These dysfunctions cause significant distress
- Preparing patients for these side-effects is important
- Rehabilitation is critical to restoring men's confidence in their bodies

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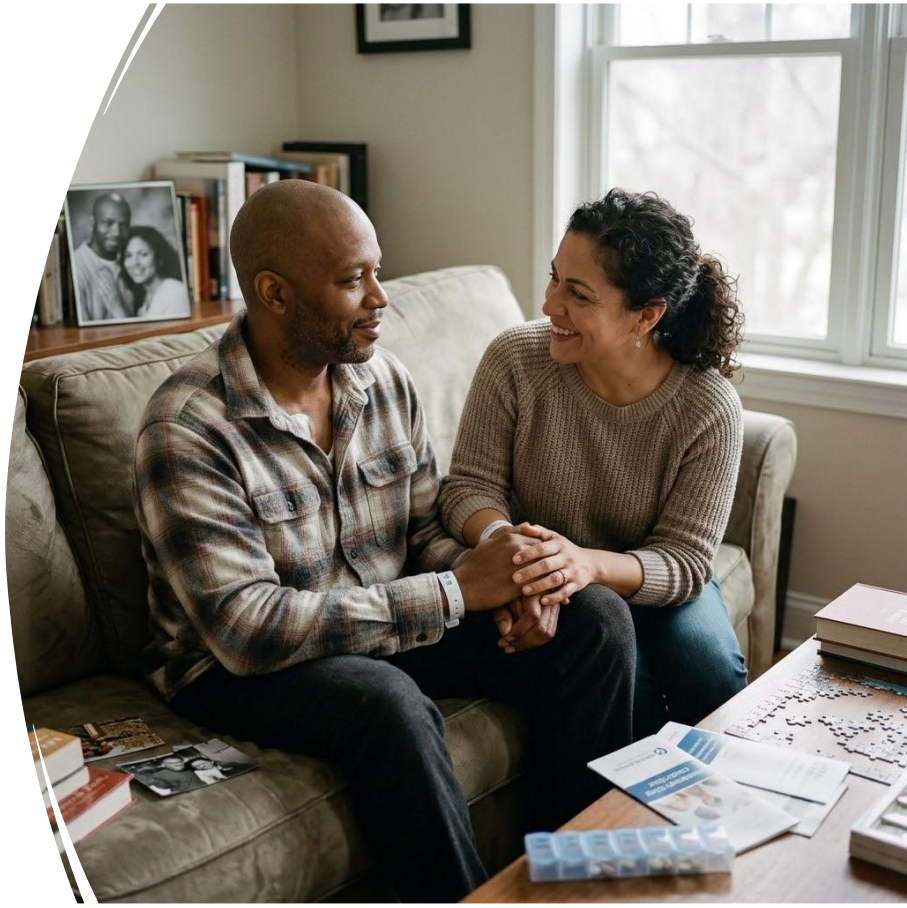
The Partner and Couple Perspective

Daniela Wittmann, PhD, LMSW
Associate Professor of Urology Emerita
Michigan Medicine



Guiding Principle # 5

- Including the partner in sexual health counseling, if both partners agree, is preferable when men are partnered.

Why is Including the Partner Important?

- Both patients and partners experience a loss of sexual function, familiar sexual interaction, body image and perhaps status in a social environment leads to a mourning process
- *'Disenfranchised grief'* was identified as reluctance of patients and partners to ask for help with sexual problems from clinicians who saved their lives
- Both patients and partners are affected by the fact that there is no return to baseline sexual function for most patients, but rehabilitation and recovery of sexual intimacy is possible

Pillai & Ashline, Sex and Rel Ther, 2014, Wittmann et al., J Sex Ther, 2015, EurUrol, 2015, Supp Care Ca, 2015, J Sex Med, 2022

Patients and Partners Have Shared and Unique Grief Foci

Men and Partners May Grieve Different Aspects of Their Sex Lives

Men and partners share grief about

- The loss of spontaneity
- Familiar sexual interactions

Men singularly grieve

- Loss/change of body image – see erections daily throughout their lives
- Threat to masculinity
- Confidence about satisfying the partner
- The pleasure of ejaculation

Partners singularly grieve

- Penetration
- The man's confidence during sex, sometimes his leadership
- The way in which the man's erection is interpreted as a sign that the patient finds the partner attractive

"I'm not a man any more!"

"She's going to leave me!"

"His penis is too short!"

"I don't want to have to initiate!"

"When he penetrates after he uses the pump, it does not feel the same, I can no longer have orgasms with penetration"

Patient-Reported Outcomes Measurement Information System
Dynamic Tools to Measure Health Outcomes From the Patient Perspective

PROMIS Sexual Function and Satisfaction

Manual

- Sexual Interest
- Satisfaction with Sex Life
- Vaginal lubrication
- Vaginal discomfort
- Erectile dysfunction
- Anal discomfort
- Use of sexual aids
- Sexual activity

STATEMENT 19: Patients and partners should be counseled that an assessment of the partner's sexual function can help plan treatment designed to support couples' recovery of sexual intimacy. (Clinical Principle)

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Major themes:

- Female partner sexual health and losses in the context of aging and PCa
- PCa-related sexual dysfunction as a couple's disease and recovery as a dyadic process
- Survival vs sex
- Expanding the sexual repertoire
- Coping: being proactive vs avoidant about physical intimacy
- Coping: coming to terms with changes in sexual function
- Difficulty communicating about sex
- Lack of physician-led sexual health counseling and support
- Benefit of peer interactions and proactive
- Information seeking in addressing unmet sexual health needs

ONCOLOGY

Unmet Sexual Health Needs of Patients and Female Partners Following Diagnosis and Treatment for Prostate Cancer

Randall Li, MD,[a] Daniela Wittmann, PhD, MSW,[b] Christian J. Nelson, PhD,[c] Carolyn A. Salter, MD,[d] John P. Mulhall, MD,[e] Nataliya Byrne, BA,[a] Tatiana Sanchez Nolasco, MPH,[a] Marina Ness, MPH,[f] Natasha Gupta, MD,[a] Caroline Cassidy, BA,[c] Theodore Crisostomo-Wynne, MD,[d] and Stacy Loeb, MD, MSc, PhD[a]

J Sex Med 2022;

Understanding the sexual health perceptions, concerns, and needs of female partners of prostate cancer survivors

Natasha Gupta, MD[1,2,3,*], Laura Zebib, MPH[4], Daniela Wittmann, PhD[4], Christian J. Nelson, PhD[5], Carolyn A. Salter, MD[6], John P. Mulhall, MD, MSc, FECSM, FACS, FRCSI[7], Nataliya Byrne, BA[1,2,3], Tatiana Sanchez Nolasco, MPH[1,2,3], Stacy Loeb, MD, MSc, PhD (hon)[1,2,3]

- Qualitative study of posts to the Inspire Us TOO Prostate Cancer Online Support and Discussion Community
- 6,193 posts were identified, 661 posts from women
  - 66 (10%) of randomly selected posts from women were analyzed
  - 66 of randomly selected posts from male patients were analyzed

(JSM 2022, 2023)

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Development of a Questionnaire about the Sexual Quality of Life for Female Partners of Prostate Cancer Patients (Loeb et al., Eur Urol Oncol, 2025)

DOMAINS

DISTRESS
LOSS OF CONNECTION
DISCOMFORT WITH SEXUAL COMMUNICATIONS
FRUSTRATION WITH SEXUAL COUNSELING BY PROVIDERS
EXPANSION OF SEXUAL REPERTOIRE
NON-PENETRATIVE ACTIVITY

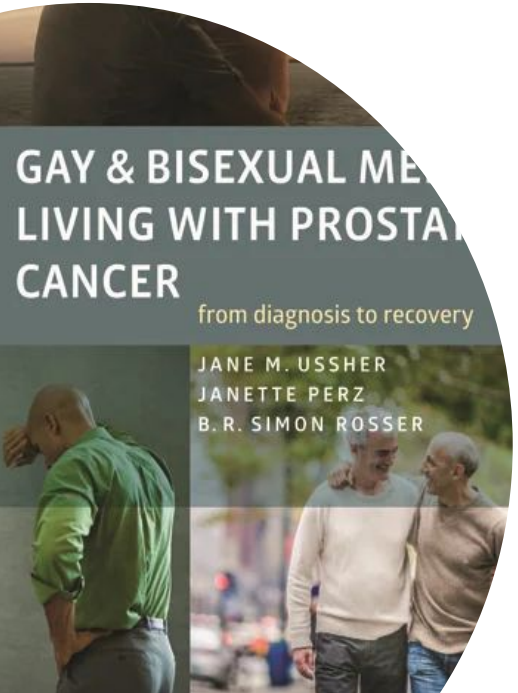
200 Female partners of men with prostate cancer

Statistical Analysis with Mann Whitney U Test Comparing Median SCIPPP-F Scores:

- No significant differences based on marital status, relationship length, or menopausal status
- Trend toward lower (better) SCIPPP-F scores among non-white partners (p=0.07)

Diversity

- **Unique needs of diverse cultural, ethnic, racial groups**
  - In some cultures, sexual dysfunction takes away from the man's role as the head of the family and marginalizes the partner (Bamidele et al., Psychooncology, 2019)



- **Unique needs of gay and bisexual men**
  - Need firmer erections for anal penetration and ejaculate is meaningful to gay and bisexual men's erotic play (Ussher et al., 2016)

J Sex Med. 2022 March ; 19(3): 529–540. doi:10.1016/j.jsxm.2021.12.012.

Creation and Psychometric Validation of the Sexual Minorities and Prostate Cancer Scale (SMACS) in Sexual Minority Patients-The Restore-2 Study

Elizabeth J. Polter, MPH[1], Nidhi Kohli, PhD[2], B.R. Simon Rosser, PhD, MPH[1], Kristine M.C. Talley, PhD, RN[5], Christopher W. Wheldon, PhD[3], Chris J. Hoefer, BS[1], Morgan Wright, MPH[1], Ryan Haggart, MD[4], Darry Mitteldorf, MSW, MPA[6], Gudrun Kilian, BA[1], Badrinath R. Konety, MD, MBA[7], Michael W. Ross, MD, PhD[8], William West, PhD[9]

Created with 401 Gay and Bisexual Men

- Validated with EPIC in this population

Assesses 7 domains:

- Problem Count (PC)
- Sexual satisfaction (SS)
- Sexual confidence (SC)
- Frequency of sexual problems (FSP)
- Urinary incontinence in sex (UI)
- Problematic receptive anal sex (PRS)
- Role in Sex Assessment (RIS)

After Cancer Treatment, Patients Cope with Losses in All Domains of Sexual Function

- Desire
- Arousal
- Orgasm
- Pain with sexual activity

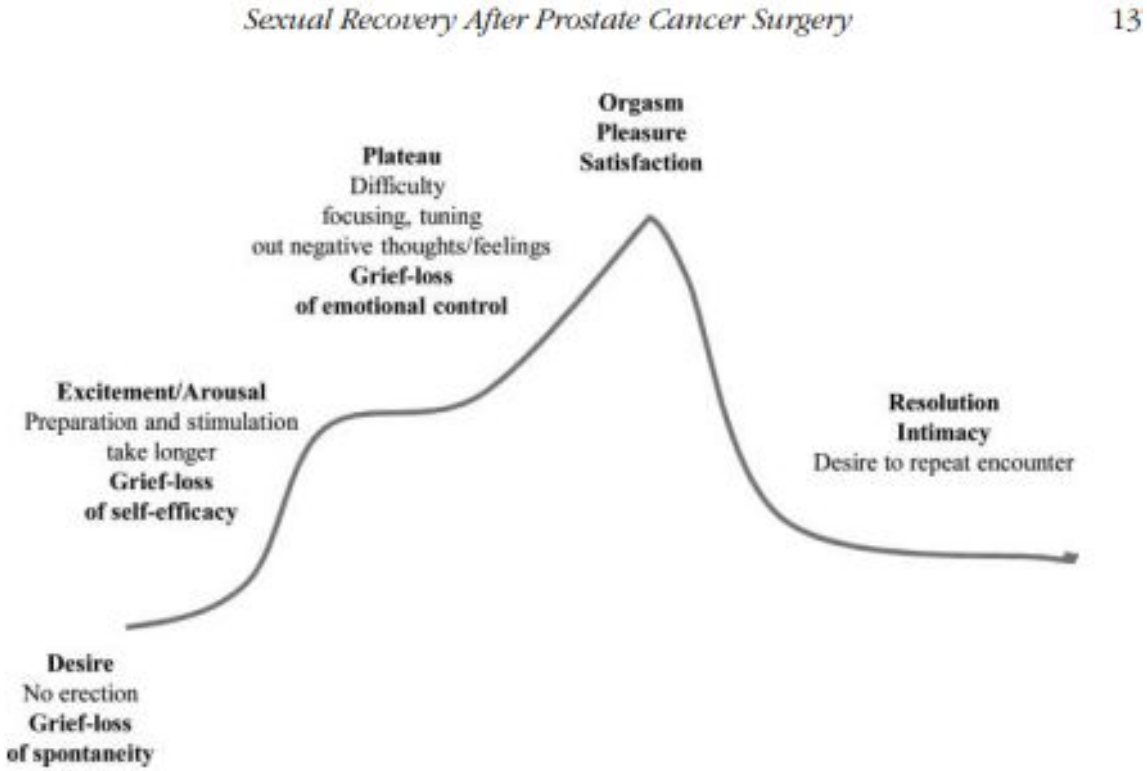


FIGURE 1. Grief as a part of a sexual encounter.

(Wittmann et al., J Sex Mar Ther, 2011)

It is Up to the Clinician to Bring up Sexual Concerns

Counseling Patients and Partners about the Impact of Prostate Cancer on the Biopsychosocial Aspects of Sexuality

Guidelines Statement 1: A clinician-initiated discussion should be conducted with the patient and the partner (if partnered and culturally appropriate), about realistic expectations of the impact of PCT on the patient's sexual function, the partner's experience and the couple's sexual relationship. The clinician should promote openness and inclusivity, consider cultural context, and tailor counseling to the specific needs of patients who are heterosexual, gay, bisexual, identify as men who have sex with men, transgender women ad gender non-conforming individuals. (Strong Recommendation; Evidence Strength Grade C)

Factors Contributing to a More or Less Successful Couples' Sexual Recovery (from a study of 20 couples with prostate cancer)

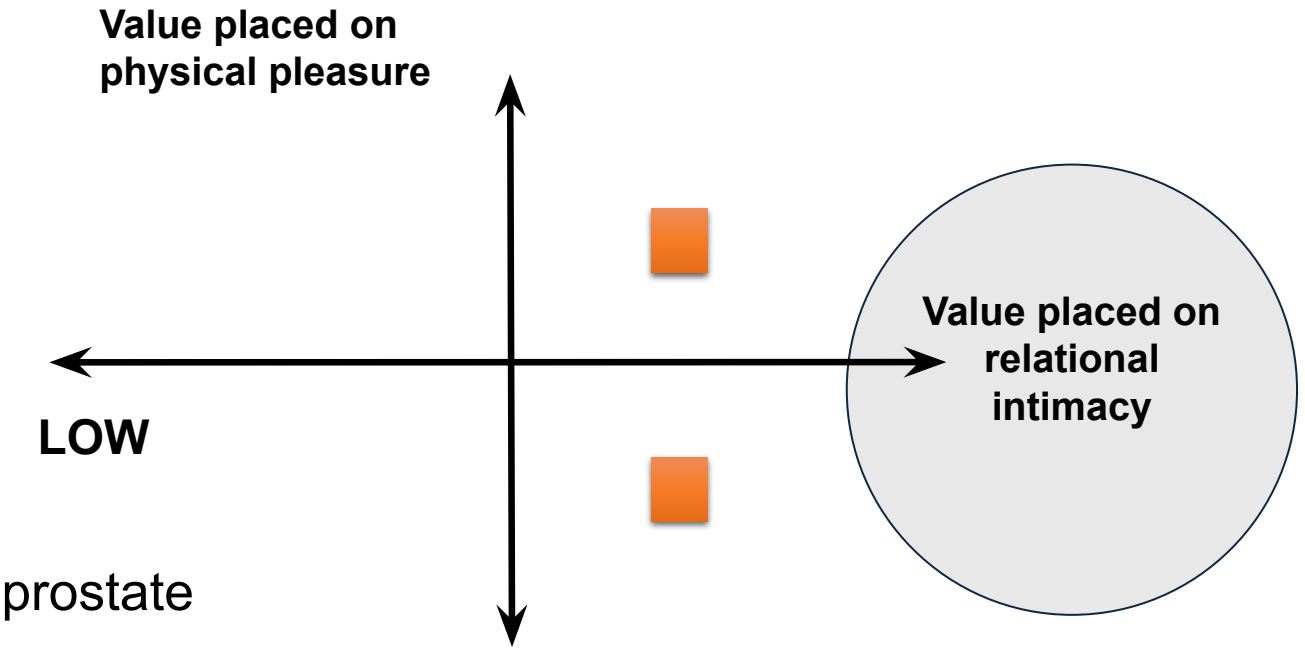
- **Post-surgery positive coping:** *shared* normal grief and mourning, ongoing sexual activity, acceptance of sexual losses, use of sexual aids, partner's positive interest in sex *regardless of menopause*

- **Post-surgery self-defeating coping:** inability to share the grieve sexual losses, no or infrequent sexual activity, relationship problems, stressors, inflexible sexuality, partner's low or no interest sex *regardless of menopause*

(Wittmann et al., J Sex Med, 2015)

Sexual Values as the Key to Maintaining Satisfying Sex After Prostate Cancer Treatment: The Physical Pleasure–Relational Intimacy Model of Sexual Motivation

Andrea M. Beck · John W. Robinson · Linda E. Carlson



- Qualitative study with 17 men with prostate cancer
- Reported factors that enabled couples to retain their sexual relationship were *acceptance, flexibility and persistence*

Arch Sex Beh, 2013

Sexual Script Flexibility after Prostate Cancer

- 61 men with prostate cancer
- Cross-sectional study

Table 3. Correlations among measures of interest.

	1	2	3
1. Sexual Satisfaction	1.00	.37**	−.69**
2. Sexual Script Flexibility	–	1.00	−.15
3. Sexual Functioning	–	–	1.00

Spearman correlations were calculated for correlations involving sexual satisfaction; a Pearson correlation was calculated between sexual functioning and sexual script flexibility.
**$p < .01$.

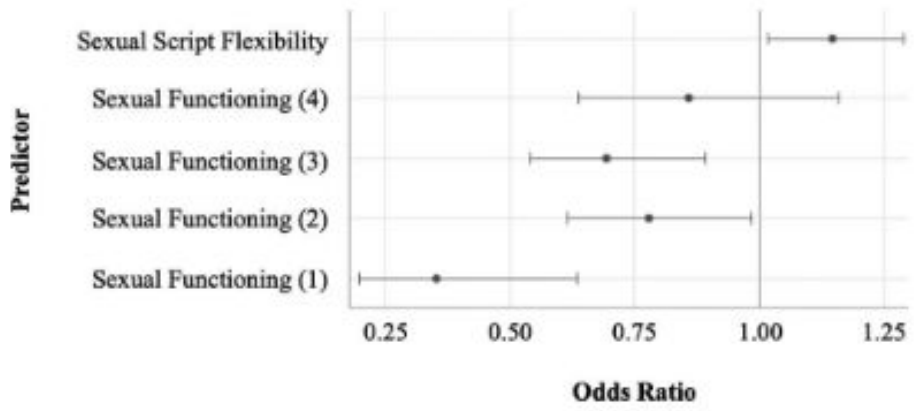


Figure 2. Odds ratios.

(McInnis et al., J Psychosoc Onc, 2023)

Key Interventions that Help Couples Recover Sexual Intimacy after Cancer

- Pre-treatment education – realistic expectations
- Normalization of emotional reactions
- Work on sexual communication
- Sexual aids use education and early re-engagement in sexual activity
- Re-eroticization of the body
- Sensate focus exercises to reduce anxiety,
- Encouragement of flexibility to expand sexual repertoire
- Neuroplasticity: explore alternative erotic sensations (neck, ears, wrists, nipples, stomach, anus)
- Individualization of treatment, based on inclusivity
- Timely referral to relevant subspecialties

(Pillai & Ashline, Sex and Rel Ther, 2014, Wittmann et al., J Sex Ther, 2015, Supp Care Ca, 2015, J Sex Med, 2022)

Take Home Messages

- Prostate cancer has a significant negative impact on patients' sexual function; both patients and partners are affected
- Clinicians must be the ones to ask about sexual concerns; a multidisciplinary team does the work of rehabilitation
- Assessment and potential referral of the partner's sexual function and concerns optimizes sexual outcomes for patients and partners
- **Social workers have an important role in educating and supporting patients and partners on their journey to sexual recovery after prostate cancer treatment**

Case Discussion

- A is a 57 yo man who was treated with prostatectomy for intermediate risk prostate cancer. He is healthy otherwise.
- As a part of his care, he is seen by a nurse who will teach him about penile rehabilitation
- His wife is invited into the clinic room. She comes in and says:
  - “I will absolutely not be part of this. Sex has always been about him, and this is just more of the same. Forget it, I’m leaving.” She leaves the room.
- What would you do?

Case Discussion

- The patient was instructed by the nurse on penile rehabilitation and ED treatments on his own.
- A referral was made to a sex therapist who met with the wife
  - Apparently, the wife felt that through the years, her husband who was inexperienced when he married her, never figured out how to pleasure her. She was unwilling to instruct him. Sex ended when he had an orgasm, and she was left unsatisfied. She had never had an orgasm with her husband.
- The therapist met with the husband who agreed with his wife's assessment.
  - He was uncertain about what to do. He accepted her approach through the years and felt ashamed and inadequate. He never pursued any education about sexual health and women's sexual function/satisfaction.

- How would you proceed from here?

Case Discussion

- The couple were seen together and their approach to sex was presented to them:
  - She indulged in magical thinking
  - He indulged in lack of curiosity about his wife's sexual functioning and preferred guilt to education
- The patient was provided with sex education and materials to learn about female anatomy and sexual function.
- The patient's wife had to work through distrust of the therapist when she was faced with the interpretation of her approach.
- In the process of treatment, the patient's wife spoke about the way that diabetes affects her sexual function – important information for the patient and for the relationship
- The couple worked on other issues that had built distrust and lack of communication.
- 18 months later, the therapist found out that the couple were having regular, satisfying sex by accident!

Resources

- International Society for Sexual Medicine – Movember Partnership
- Home - ISSM | Movember
  - Expert videos
  - Webinar series
  - Workshops – stipends available
  - Toolkit

- Full version of guidelines – Movember website
- https://truenorth.movember.com/clinical-guideline-sexual-health-prostate-cancer/

- Patient version of guidelines – Movember website
- https://truenorth.movember.com/images/assets/SexualHealthGuidelines-Patient.pdf

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Portland, Oregon USA

Thank You!

dwittman@med.umich.edu

goltzh@uhd.edu

Instructions

Scan the QR code with your device to access the brief survey.

This survey gathers insights to improve sexual health guidelines and resources in prostate cancer care through the ISSM and Movember partnership.

THE JOURNAL OF
SEXUAL MEDICINE

ORIGINAL RESEARCH & REVIEWS

ONCOLOGY

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

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ABSTRACT

Background: Patients with prostate cancer suffer significant sexual dysfunction after treatment which negatively affects them and their partners psychologically, and strain their relationships.

Received March 23, 2022. Accepted August 29, 2022.

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https://doi.org/10.1016/j.jsxm.2022.08.197

Aim: We convened an international panel with the aim of developing guidelines that will inform clinicians, patients and partners about the impact of prostate cancer therapies (PCT) on patients' and partners' sexual health, their relationships, and about biopsychosocial rehabilitation in prostate cancer (PC) survivorship.

Methods: The guidelines panel included international expert researchers and clinicians, and a guideline methodologist. A systematic review of the literature, using the Ovid MEDLINE, Scopus, CINAHL, PsychINFO, LGBT Life, and Embase databases was conducted (1995−2022) according to the Cochrane Handbook for Systematic Reviews of Interventions. Study selection was based on Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Each statement was assigned an evidence strength (A-C) and a recommendation level (strong, moderate, conditional) based on benefit/risk assessment, according to the nomenclature of the American Urological Association (AUA). Data synthesis included meta-analyses of studies deemed of sufficient quality (3), using A Measurement Tool to Assess Systematic Reviews (AMSTAR).

Outcomes: Guidelines for sexual health care for patients with prostate cancer were developed, based on available evidence and the expertise of the international panel.

Results: The guidelines account for patients' cultural, ethnic, and racial diversity. They attend to the unique needs of individuals with diverse sexual orientations and gender identities. The guidelines are based on literature review, a theoretical model of sexual recovery after PCT, and 6 principles that promote clinician-initiated discussion of realistic expectations of sexual outcomes and mitigation of sexual side-effects through biopsychosocial rehabilitation. Forty-seven statements address the psychosexual, relationship, and functional domains in addition to statements on lifestyle modification, assessment, provider education, and systemic challenges to providing sexual health care in PC survivorship.

Clinical Implications: The guidelines provide clinicians with a comprehensive approach to sexual health care for patients with prostate cancer.

Strengths & Limitations: The strength of the study is the comprehensive evaluation of existing evidence on sexual dysfunction and rehabilitation in prostate cancer that can, along with available expert knowledge, best undergird clinical practice. Limitation is the variation in the evidence supporting interventions and the lack of research on issues facing patients with prostate cancer in low and middle-income countries.

Conclusion: The guidelines document the distressing sexual sequelae of PCT, provide evidence-based recommendations for sexual rehabilitation and outline areas for future research. **Wittmann D, Mehta A, McCaughan E, et al. Guidelines for Sexual Health Care for Prostate Cancer Patients: Recommendations of an International Panel. J Sex Med 2022;19:1655−1669.**

Key Words: Prostate cancer; Sexual rehabilitation; Biopsychosocial; International

INTRODUCTION

Sexual dysfunction is the most commonly reported health-related quality of life outcome following therapies for prostate cancer, affecting men, partners, and their relationships. Sexual health care should therefore be central to prostate cancer survivorship care.

National origin, ethnicity, and race affect perspectives on gender roles, sexual orientation, relationships, health beliefs, disparities in access to healthcare, and uptake of healthcare offered. Help-seeking may be impeded by men's culture-driven discomfort about discussing sexual side-effects of treatment − a topic considered embarrassing and intensely private.[1]

These guidelines were created, based on a biopsychosocial model of sexuality[2] (Figure 1) and 6 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) As a part of a new sexual paradigm in survivorship, grief and mourning have been shown to play an important role in couples' recovery of sexual intimacy, despite sexual dysfunction.[3] (4) Men rarely return to baseline sexual function after prostate cancer therapy. (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 support men and their partners who desire to recover sexual intimacy after prostate cancer therapy.

METHODS

The guidelines were developed by an international expert panel and a guideline methodologist (MF). A systematic literature review, designed to reflect the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[4] (Figure 2), using the Ovid MEDLINE, Scopus, CINAHL, PsychINFO, LGBT Life, and Embase databases (search dates January 1, 1995 through April 30, 2022) was conducted to identify peer-reviewed publications relevant to the impact of PCT, assessment of PCT consequences for sexuality, and treatments for sexual sequelae of PCT. The review

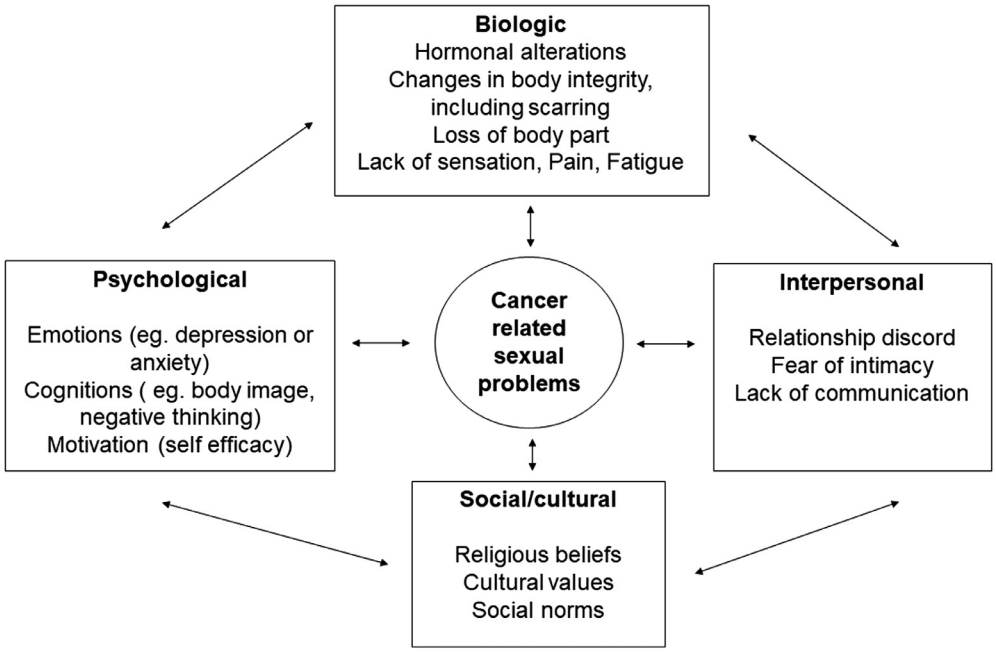

Figure 1. A biopsychosocial model of the impact or cancer on sexuality. Bober and Varella, Journal of Clinical Oncology, 2012, adapted, with permission.

yielded an evidence base of 610 articles after application of inclusion/exclusion criteria which were used to create the guidelines statements. Three articles met criteria for meta-analysis. Evidence assessments and recommendations followed the nomenclature of the AUA. If sufficient evidence existed, then the body of evidence for a statement was assigned a strength rating of A (high certainty), B (moderate certainty), or C (low certainty). Evidence-based statements of Strong, Moderate, or Conditional Recommendation were developed based on benefits and risks/burdens to men and their partners (Table 1).[5] Additional information is provided as Clinical Principles and Expert Opinion when insufficient evidence existed. For detailed information on methodology, evidence evaluation procedures, the nomenclature system, and the body of evidence strength for each statement, please see the unabridged guideline at http://movember.com/sexualhealthguideline.

The Expert Panel

The initial leadership team, DW, EM, JM, discussed and agreed that there was not a comprehensive summary of research and clinical experience that would assist clinicians caring for men with prostate cancer in their approach to treating sexual dysfunction in prostate cancer survivorship. Since this is a worldwide problem and the extant research had been conducted in Japan, Australia, Europe, and North America, the team invited an international, multidisciplinary team of clinician scientists with deep knowledge of the topic of sexual dysfunction, faced by prostate cancer patients and their partners, to collaborate on developing guidelines for care that would address all aspects of sexuality — sexual function, the patient's and partner's psychological response to it, and its impact on their relationship. Clinicians with relevant experience from low and middle-income countries were also invited, as were patients and partners whose insights were considered invaluable. The panel's goal is for the guidelines to provide clinicians, caring for prostate cancer patients, with a way to conceptualize the impact of prostate cancer therapies on all aspects of sexuality, and become aware of treatments available to help men and partners recover sexual intimacy after prostate cancer therapies.

Guidelines Statements

Counseling Patients and Partners about the Impact of PCT on the Biopsychosocial Aspects of Sexuality

1. **A clinician-initiated discussion should be conducted with the patient and the partner (if partnered and culturally appropriate), about realistic expectations of the impact of PCT 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 context, and tailor counseling to the specific needs of patients who are heterosexual, gay, bisexual (GBM), identify as men who have sex with men (MSM), transgender women, and gender non-conforming individuals. (Strong Recommendation; Evidence Strength Grade C)**
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)**
3. **Patients and partners should be advised that psychological distress, including grief and mourning about sexual losses, resulting from the sexual side-effects of PCT, can be experienced after PCT, and that distress can be mitigated with appropriate biop-**

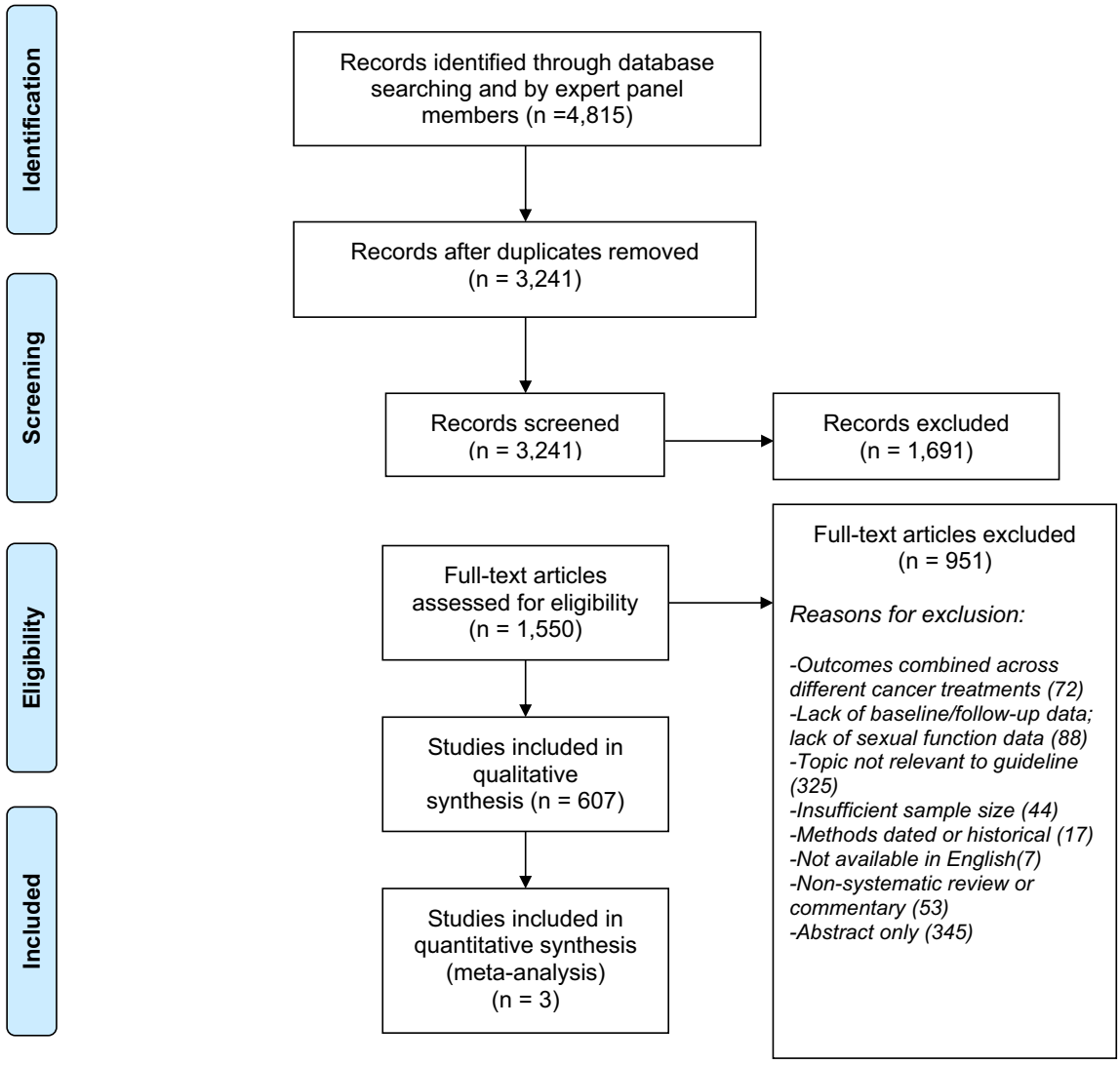

Figure 2. Preferred reporting items for systematic reviews and meta-analyses (PRISMA).

sychosocial rehabilitation strategies. (Moderate Recommendation; Evidence Strength Grade C)

PCT-related sexual dysfunction is ubiquitous in survivorship.[6–12] Approximately 81–93% of patients report that PCT negatively affects their sex lives, with 20–58% of men reporting cessation of sexual activity with their partner.[13] Men's body image, sense of masculinity, overall health status, and relationships also are negatively affected.[14–16,17,18,19,20] The impact of sexual dysfunction can be conceptualized in terms of patient, partner, and couple loss of spontaneous sexual activity, sexual identity, feelings of masculinity, and of relationship intimacy.[21,22] It is critical to provide psychoeducation on strategies to successfully integrate loss via the process of grief and mourning. Realistic expectations for recovery are a cornerstone of patient and partner counseling.[23,24,25] Including the partner is desirable: both members of the couple are affected by the patient's sexual dysfunction.[19,26]

In the United States, an estimated 97,845 -123,006 gay and bisexual prostate cancer survivors lack appropriate healthcare for treatment-related sexual dysfunctions.[27] A worldwide estimate is difficult, given that same-sex sexual behaviors are stigmatized and criminalized in almost 80 countries across the globe, but an estimated 6–20% of men have sex with men in Asia, Latin America and Eastern Europe.[28,29] Sexual recovery of transgender women and gender non-conforming patients with a prostate should be supported during survivorship. Stigma, discrimination, and lack of knowledge by healthcare providers can discourage these patients from seeking care.[30,31]

Counseling Patients on the Impact of Individual Prostate Cancer Therapies on Sexual Function

4. **Patients and partners should be counseled that all PCTs may result in the patient's short-term and long-term erectile dysfunction (ED). (Strong Recommendation; Evidence Strength Grade B)**
5. **Patients and partners should be counseled that patients treated with radical prostatectomy have different trajectories of sexual function decline and potential recovery compared to patients**

Table 1. Nomenclature linking statement type to level of certainty, magnitude of benefit or risk/burden, and body of evidence strength — AUA.

	Evidence strength A (High certainty)	Evidence strength B (Moderate certainty)	Evidence strength C (Low certainty)
Strong Recommendation (Net benefit or harm substantial)	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is substantial Applies to most patients in most circumstances and future research is unlikely to change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is substantial Applies to most patients in most circumstances but better evidence could change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) appears substantial Applies to most patients in most circumstances but better evidence is likely to change confidence (rarely used to support a Strong Recommendation)
Moderate Recommendation (Net benefit or harm moderate)	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is moderate Applies to most patients in most circumstances and future research is unlikely to change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) is moderate Applies to most patients in most circumstances but better evidence could change confidence	Benefits > Risks/Burdens (or vice versa) Net benefit (or net harm) appears moderate Applies to most patients in most circumstances but better evidence is likely to change confidence
Conditional Recommendation (No apparent net benefit or harm)	Benefits = Risks/Burdens Best action depends on individual patient circumstances Future research unlikely to change confidence	Benefits = Risks/Burdens Best action appears to depend on individual patient circumstances Better evidence could change confidence	Balance between Benefits & Risks/Burdens unclear Alternative strategies may be equally reasonable Better evidence likely to change confidence
Clinical Principle	A statement about a component of clinical care that is widely agreed upon by urologists or other clinicians for which there may or may not be evidence in the medical literature		
Expert Opinion	A statement, achieved by consensus of the Panel, that is based on members' clinical training, experience, knowledge, and judgment for which there is no evidence		

This table is present in all the guidelines of the American Urological Association and is reproduced here with permission.

treated with radiotherapy. (Moderate Recommendation; Evidence Strength Grade C)

6. **Patients and partners should be counseled that after PCT, most patients do not return to their pre-treatment erectile function levels. (Strong Recommendation; Evidence Strength Grade B)**
7. **Patients and partners should be advised that pre-existing ED is associated with a higher risk of post-treatment ED after radical prostatectomy, regardless of the surgical technique used, and after radiotherapy, regardless of the type of radiation employed. (Strong Recommendation; Evidence Strength Grade B)**
8. **Patients and partners should be informed there is no clear evidence supporting the advantage of either robotic, laparoscopic, or open radical prostatectomy in terms of post-operative erectile function outcomes. (Moderate Recommendation; Evidence Strength Grade C)**
9. **Patients and partners should be counseled that both prostatectomy and radiation therapy may be associated with orgasmic pain, decreased sexual desire, anodyspareunia during anal intercourse, and changes in ejaculatory function. Prostatectomy results in immediate and complete loss of ejaculate volume, while radiation therapy is associated with a more gradual decline and variable reduction in ejaculate volume. (Moderate Recommendation; Evidence Strength Grade C).**
10. **Patients and partners should be counseled that sexual arousal incontinence and climacturia may occur after radical prostatectomy with the potential to recover with recovery of urinary control. (Strong Recommendation; Evidence Strength Grade C)**
11. **Patients and partners should be counseled that penile length and girth/volume loss may occur after radical prostatectomy. (Moderate Recommendation, Evidence Strength Grade C)**
12. **Patients and partners should be informed that radical prostatectomy may be associated with an increased risk of the development of penile curvature (Peyronie's disease; PD). (Conditional Recommendation, Evidence Strength Grade C)**
13. **Patients and partners should be counseled regarding the diverse impacts of androgen deprivation therapy (ADT) (as a primary or as an adjuvant ADT) on sexual desire, erectile function, penile girth and length, ejaculatory function, orgasmic function, and couples' intimacy. (Strong Recommendation; Evidence Strength Grade C)**
14. **Patients and partners should be counseled that patients treated with combined ADT and radiotherapy are at risk for the cumulative sexual side effects associated with both ADT and radiotherapy. (Strong Recommendation; Evidence Strength Grade C)**
15. **Prior to undergoing PCT, clinicians should routinely ask prostate cancer patients (regardless of age) and their partners if future fertility is desired. (Moderate Recommendation; Evidence Strength Grade C)**
16. **Patients interested in future fertility should be counseled that PCT may negatively affect their fertility potential. These patients could consider pre-treatment sperm banking and**

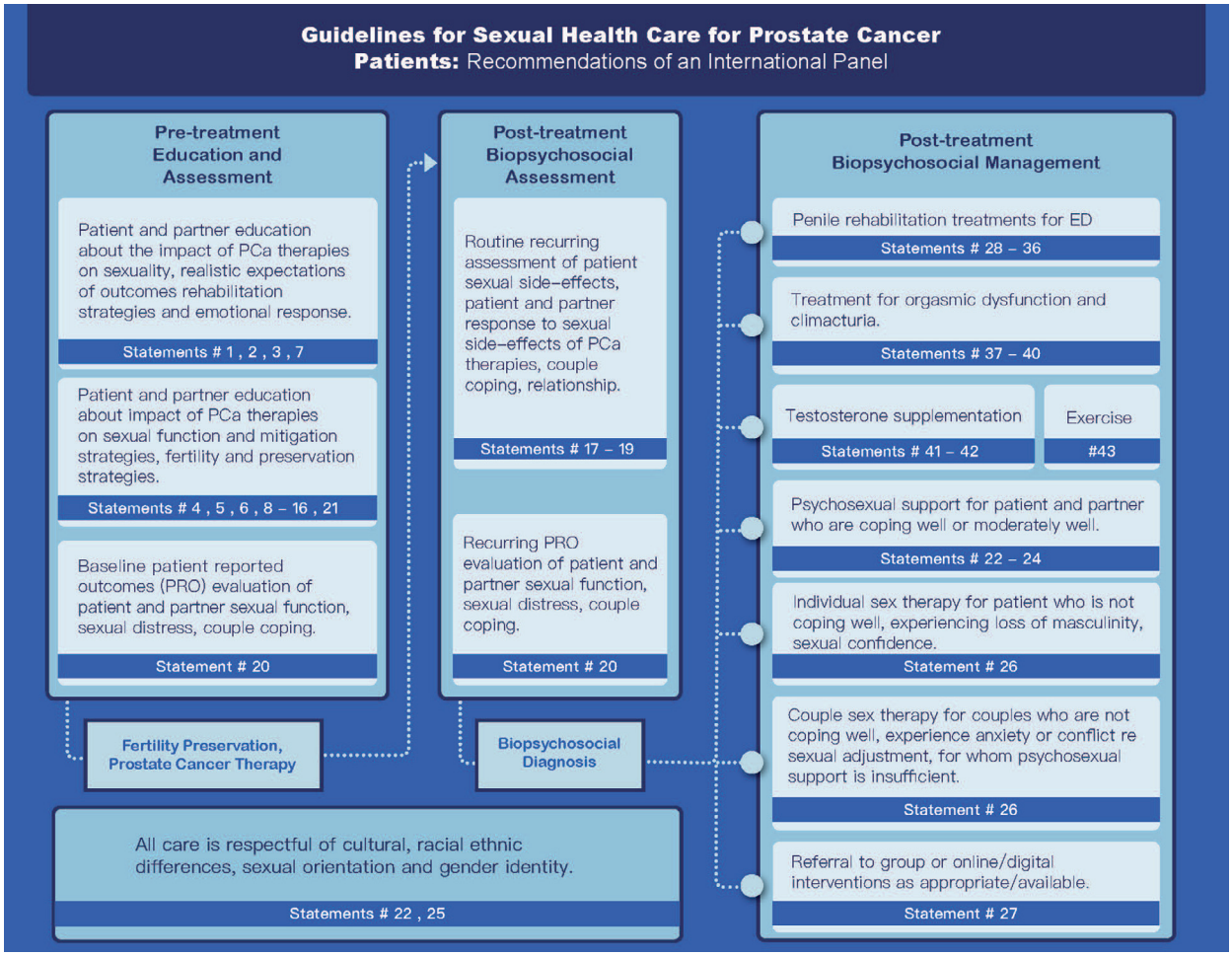

Figure 3. Guidelines for sexual health care for patients with prostate cancer.

referral to a reproductive specialist as availability of assisted reproductive techniques and financial and cultural considerations allow. (Moderate Recommendation; Evidence Strength Grade C)

Although patients may initially find it difficult to appreciate the way in which their sexuality will be affected, patients are more likely to develop realistic expectations and navigate the early recovery of sexual intimacy if they are prepared for the sexual side-effects of PCT.[32]

All PCTs can result in ED. Most men do not return to their pre-treatment erectile function levels after PCT, although better sexual function before intervention correlates with better sexual function recovery. This relationship is present regardless of surgery or radiation type or technique, and is evident across different measures of sexual function. (For a detailed discussion and supporting literature, see the full guideline http://movember.com/sexualhealthguideline.)

Other sexual dysfunctions that may occur after PCT, especially radical prostatectomy, include orgasmic dysfunction, sexual incontinence, anodyspareunia in men who have receptive anal sex, penile length and girth loss, and penile curvature.[33,34] Although the prevalence of these dysfunctions varies widely, patients can experience significant bother, leading to avoidance of sexual relations and a decrease in quality of life.

Androgen deprivation therapy (ADT) has additional adverse impacts on sexual desire: many men significantly decrease sexual activity or stop altogether. Depression, anxiety, and emotional lability are commonly reported. Anatomic changes in response to ADT include loss of penile length and testicular size, gynecomastia, loss of body hair, and weight gain, which can substantially impact men's sexual body image and self-confidence.[35]

Assessment of Sexual Dysfunction and Sexual Distress

17. **Clinicians should offer screening and assessment prior to PCT and regularly throughout follow-up, tailored to cultural context, sexual orientation, and gender identity. (Clinical Principle)**
18. **In both pre and post PCT assessments, clinicians should pay attention to the presence of ED, low sexual satisfaction, low desire, orgasmic dysfunction [including altered orgasmic sensation, lack**

of orgasm (anorgasmia), painful orgasm (dysorgasmia) and orgasm-associated urinary incontinence (climacturia)], sexual arousal incontinence, changes in penile shape, girth, length or size, anodyspareunia, curvature, couples' sexual concerns and avoidance or cessation of sexual activity, and couples' sexual concerns. (Moderate Recommendation; Evidence Strength C)

19. **Patients and partners should be counseled that an assessment of the partner's sexual function can help plan treatment designed to support couples' recovery of sexual intimacy. (Clinical Principle)**
20. **Clinicians should use validated Patient Reported Outcome (PRO) measures whenever appropriate and whenever possible to assess patients' sexual function and possibly partners' sexual function, as well as sexual distress, based on a clinical assessment of the patients' and partners' goal for sexual recovery. (Clinical Principle)**

Given the significant sexual difficulties throughout survivorship, a biopsychosocial sexual health assessment is critical. Oncology clinicians can screen for concerns; specialists trained in sexual health can provide a full biopsychosocial sexual health assessment. Validated measures that assess sexual function, relationship quality, couple coping, and sexual communication exist. However, a validated measure to assess sexual relationships is yet to be developed.[36–38]

Assessment of the impact of PCT on sexuality should be grounded in culture-specific beliefs and values,[39,40] as health literacy and spirituality also affect the understanding of and give meaning to PCT, sexual side-effects, and rehabilitation.[41–44] The assessment of partners' sexual function can be valuable as post-menopausal female partners may experience vaginal dryness and low desire.[45]

Available PRO measures were normed in high income countries and may not be responsive to cultural, ethnic or racial priorities. These measures include the International Index of Erectile Function (IIEF),[46,47] the Erectile Function Domain (EFD) of the IIEF, the Sexual Health Inventory for Men (SHIM),[48] Patient-Reported Outcomes Measure Information System (PROMIS),[49] the Erectile Dysfunction Inventory for Treatment and Satisfaction (EDITS),[50] the Self-Esteem and Relationship (SEAR) Questionnaire,[51] the Expanded Prostate Cancer Index Composite (EPIC),[52] the Sexual Distress Scale in Men with Prostate Cancer (SDS),[53] Peyronie's Disease Questionnaire (PDQ)[54] and the Female Sexual Function Index (FSFI).[55] These measures are fully described in the unabridged guideline http://movember.com/sexualhealthguideline.

Lifestyle Modification

21. **Lifestyle modification should be recommended to patients to optimize their overall health and sexual health, including avoiding smoking, engaging in physical activity, weight loss, increasing consumption of healthful plant-based foods, and reducing consumption of red and processed meat. (Clinical Principle)**

Diets high in fruit, vegetables, whole grains, and fish are associated with a lower risk of ED; red and processed meat and refined grains are associated with more ED.[56–58] Physical activity is associated with a lower risk of ED; obesity, smoking, and alcohol consumption have been associated with a higher prevalence of ED.[59]

Psychosocial Treatment

22. **Clinicians should provide education, individualized sexual rehabilitation, and psychosexual support to patients and partners across the entire survivorship continuum, tailored to: PCT type, partnership status, cultural, ethnic, and racial context, sexual orientation, and gender identity. (Strong Recommendation; Evidence Strength Grade C)**
23. **Clinicians should normalize grief as a typical reaction to sexual losses and encourage patients and partners to whom sexual recovery is important to pursue sexual intimacy despite sexual losses. (Strong Recommendation; Evidence Strength Grade C)**
24. **Clinicians should include the partner, if both the patient and partner agree, and provide support for couples coping with the sexual side-effects of PCT both directly and through referral for psychosexual treatment. (Strong Recommendation, Evidence Strength Grade C)**
25. **Clinicians should support GBM, MSM, transgender women, and gender non-conforming patients and their partners with information relevant to their sexual experience, and guide them towards meaningful support resources. (Expert Opinion)**
26. **Clinicians should refer patients, partners, and couples for whom education and support are insufficient for specialty psychosexual treatment. (Clinical Principle)**
27. **Clinicians should make patients and partners aware of group interventions and digital health/telemedicine methodologies that can increase access to sexual health support in prostate cancer survivorship. (Moderate Recommendation, Evidence Strength Grade C)**

Pre-treatment education about PCT-related sexual dysfunction and sexual recovery, addressed through education in a biopsychosocial framework, can lead to better adjustment outcomes.[32,60] Describing grief and mourning as a normal reaction to sexual losses and important aspects of coping can help patients and partner begin to re-establish sexual activity after prostate cancer treatment.[61–63]

Counseling for the use of erectile aids is supported by the most robust evidence. Couples also benefit when they are encouraged to communicate, expand sexual repertoire to non-penetrative sexual activities, and support each other during the recovery process.

Currently no evidence-based psychosocial interventions are designed for GBM and MSM although some interventions have relevant content.[62,64] These patients' unique needs must be considered when planning treatment. The prostate has sexual sensitivity; its surgical removal represents a loss of a sexual organ.[65] Radiation leads to loss of prostate sensitivity and its role in orgasm.[66] Other losses may include an erection firm enough for anal penetration, timing of resumption of anal penetration, the loss or diminution of ejaculate as an aspect of erotic play, and the resumption of sexual activity when the usual sexual roles ("top"

or "bottom") are no longer available.[65,67] Tailored pre-treatment and post PCT counseling is needed in survivorship.

Insufficient information is available to make specific recommendations that respond to cultural, ethnic, and racial differences. Groups from different cultures vary in perceptions of sexual dysfunction-related bother, impact on mental health, and interpersonal relationships after PCT.[68–70]

Supporting men who are single or widowed who wish to have a relationship is equally important so that they can work towards the goal of having a successful sexually intimate relationship while using erectile aids.

It is uncertain what kind of sexual distress transgender women and gender non-conforming patients experience after PCT. Support for sexual recovery can be planned, based on the acknowledgement of their unique sexual concerns related to identity, history of hormonal and surgical treatment, and sexual goals in survivorship.[71]

Support groups can provide an outlet for sharing experiences about sexual recovery. Sexual orientation, gender identity, culture, race and ethnicity may dictate the kind of group support that will be acceptable.[72] Although rarely utilized by heterosexual couples, men in same sex relationships sometimes open up their relationship to other lovers to maximize eroticism and sexual satisfaction.[73,74] GBM, MSM, and transgender women may rely on non-traditional supports, having experienced rejection from families.[75] Patients and partners with pre-existing sexual or relationship problems, and those not coping well with the sexual changes after PCT, should be offered sex therapy referral. Online support resources, such as malecare.org, can be a particularly valuable asset in countries with few clinical resources.[76]

Clinical environments will make patients feel included and respected if they are decorated with images reflective of the diversity of cultures, ethnicities, races, sexual orientations, and gender identities. Handouts can be similarly composed. Intake forms that give an opportunity to specify one's gender, sexual orientation, culture, ethnicity, and racial identity can assure the patient of the likelihood that his individuality will be respected.

Treatment of Sexual Dysfunctions

28. **Clinicians should consider nerve-sparing surgical treatment options, when available and oncologically safe, irrespective of baseline ED. (Moderate Recommendation; Evidence Strength Grade C)**
29. **Clinicians should 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. (Clinical Principle)**
30. **Clinicians should counsel patients that use of phosphodiesterase type 5 inhibitors (PDE5i) for penile rehabilitation in the early post-prostatectomy period (up to 45 days post-surgery) does not improve rates of unassisted and PDE5i-assisted erectile function recovery at 12 months compared to placebo. (Strong Recommendation; Evidence Strength Grade C)**
31. **Clinicians should advise patients there is limited evidence to determine the benefit of non-PDE5i approaches for penile rehabilitation in order to promote recovery of erectile function. (Moderate Recommendation, Evidence Strength Grade C)**
32. **Patients and partners should be counseled that there is insufficient evidence to definitively support penile rehabilitation with PDE5 inhibitors for the prevention of penile volume loss. (Conditional Recommendation, Evidence Strength Grade C)**
33. **Clinicians should counsel patients that there is insufficient evidence to fully determine the benefit of PDE5i use after radiation therapy as a strategy for penile rehabilitation. (Conditional Recommendation, Evidence Strength C)**
34. **Clinicians should support patients' use of pro-erectile aids, as well as non-penetrative sexual activity, if they wish to continue to engage in sexual activity. (Strong Recommendation; Evidence Strength Grade C)**
35. **Clinicians should discuss all available erectile function treatment options with patients following all PCT modalities, including PDE5i, intraurethral suppositories, intracavernosal injections (ICI), vacuum erection devices (VED), penile traction therapy, and penile implants. Clinicians should tailor recommendations based on patient preference, efficacy, and phase of erectile function recovery. This discussion should address benefits, risks, and contraindications associated with each option, as well as patient and partner goals. (Clinical Principle)**
36. **Clinicians should inform patients with persistent ED after completion of PCT about the potential benefits and risks of penile implant surgery. (Moderate Recommendation; Evidence Strength Grade C)**
37. **If identified, altered orgasmic sensation, difficulty reaching orgasm, or anorgasmia can be managed using a biopsychosocial approach. (Expert Opinion)**
38. **Persistent, bothersome dysorgasmia may be treated using alpha-adrenergic blockers. (Moderate Recommendation, Evidence Strength Grade C)**
39. **Patients and partners should be counseled regarding management strategies for bothersome sexual incontinence (including sexual arousal incontinence and climacturia), including psychological reframing. (Clinical Principle)**
40. **Patients should be counseled that there are insufficient data regarding the efficacy of pelvic-floor rehabilitation, penile tension loop, a male sling operation, or placement of an artificial urinary sphincter for the management of sexual incontinence (including sexual arousal incontinence and climacturia). (Conditional Recommendation, Evidence Strength C)**
41. **Clinicians may discuss the risk and benefits of testosterone therapy to improve low sexual desire in hypogonadal men following PCT. (Moderate Recommendation, Evidence Strength Grade C)**
42. **Clinicians should counsel patients that there are inadequate data to quantify the risks vs benefits regarding testosterone therapy to treat low sexual desire in men with treated, or active, non-metastatic prostate cancer. (Conditional Recommendation, Evidence Strength C)**

Erectile dysfunction is the most pervasive and widely-studied effect of PCT. Studies that compared erectile function recovery among men who had nerve-sparing vs non-nerve sparing

procedures generally reported higher erectile function recovery rates with nerve-sparing techniques[77]; however, when data are aggregated across studies, pre-PCT erectile function, rather than surgical technique, is a stronger predictor of post-PCT erectile function. For citations, see the unabridged guideline http://true-north.movember.com/SexualHealthGuideline. It is reasonable to consider that the same functional anatomic approach can also be applied to radiation treatment. Vessel-sparing radiation has been described as 1 technique designed to preserve sexual function while maintaining high levels of cure.[78]

Penile rehabilitation following prostate cancer is intended to minimize the negative impact of PCT on sexual function and to engage patients in sexual recovery. It may include a combination of pharmacological and non-pharmacological strategies aimed at preserving penile length, erectile function and the quality of the corpora cavernosa; PDE5i's are most commonly employed, but have not been proven to restore erectile function.[79,80] Similarly, data from vacuum erection devices only report outcomes while the device is in use and do not include results after a washout period.[81] Preliminary data from a single RCT evaluating second generation penile traction therapy suggest possible benefits in preserving erectile function and penile length when used in the early post-operative period following prostatectomy. However, external validation is warranted.[82] It is also notable that penile rehabilitation is not synonymous with, and does not ensure, restoration of cavernous nerve activity.

Strategies for treatment of ED include PDE5i's, ICI, intraurethral suppository, vacuum erection devices, and penile implants. Approach to treatment should be tailored. Patients should be thoroughly counseled about the efficacy, risks, and expected outcomes with the use of any of these approaches in the context of their individual needs and expectations. Consultation with a sexual medicine or sexual health expert can also address other sexual dysfunctions such as orgasmic dysfunction, sexual incontinence, and low libido.

Orgasm is the brain's perception and interpretation of the various striated and smooth muscle (accessory glands) contractions and sensory neuronal stimulation in the pelvic region and other erogenous zones. Prostate cancer treatments can remove or radiate the prostate and surrounding bladder neck, seminal vesicles, and vas deferens which may result in altered orgasmic sensation or orgasmic threshold.[83,84] Psychological and physiological variants such as depression, altered erectile function, and reduced testosterone with ADT can further reduce the chance of reaching and enjoying orgasm or may even cause dysorgasmia. Pelvic floor therapy has been described as helpful for chronic pelvic pain (CPP) management and for post radical prostatectomy incontinence training.[85,86] Treatments for dysorgasmia may include pelvic floor therapy for general pelvic floor hypertonus but no direct literature exists.

There is a limited number of studies examining the efficacy of surgical intervention for climacturia. In a series of 46 men with climacturia and stress urinary incontinence following radical prostatectomy 100% had resolution of their climacturia after transobdurator sling placement, while 84% had resolution of stress urinary incontinence.[87,88] Improvement in climacturia and SUI have also been described in small series of men undergoing mini-Jupette graft after radical prostatectomy, with >90% of patients noting significant or complete resolution of climacturia.[89,90]

The specific role for testosterone therapy in men with treated, active, and metastatic prostate cancer is unclear. Several small series have been reported of men with treated or non-metastatic prostate cancer who received testosterone for symptomatic hypogonadism and have shown minimal or no increased risk for prostate cancer progression in these settings.[91–94] However, all studies evaluating the safety of testosterone in these settings have been non-randomized and include small cohorts with relatively short follow-up.

Lifestyle Modification Strategies

43. **Clinicians should inform patients and partners about the importance and benefits of exercise for sexual health and as a component of medical management related to ADT. (Moderate Recommendation; Evidence Strength Grade C)**

Randomized clinical trials have shown the benefit of exercise on many aspects of wellbeing that support sexual health, such as body composition, fatigue/energy level, quality of life, physical function, social functioning, psychological distress, urinary problems, cognitive decline.[95]

A Summary of Guidelines Statement

Figure 3 is an at-a-glance summary of the guidelines. Guidelines statements are organized to suggest a pathway for a systematic approach to providing sexual health care to patients with prostate cancer and their partners.

Clinician Education and Training

44. **Clinicians should undergo sexual health education in interprofessional groups using case-based/reflective learning approaches, adopting a biopsychosocial lens, and incorporating attention to ethnic and racial diversity and to sexual minorities. (Strong Recommendation; Evidence Streng th Grade C)**

The most common barriers identified by clinicians to discussing sexuality are "lack of training" (38%) and "difficult issue to discuss" (27%).[96] Studies have documented gaps in provider education either in general sexual health care or in prostate cancer.[97–99] The Sexual Health & Rehabilitation e-Training program (SHARE-T) focuses on teaching participants how to do a sexual health assessment and treatment. It has produced good outcomes specific to sexual health training in prostate cancer using a web-based design.[100] The American Society for Clinical Oncology (ASCO) recently published a position paper that calls

for more competency-based training for providing care to sexual and gender minorities.[101] Competency in assessing sexual problems after PCTs should be a requirement of professional organizations administering accreditation for clinicians caring for patients with prostate cancer.

Healthcare Programs and Systems

45. **Providers and healthcare systems should develop culturally appropriate materials for counseling patients and their partners regarding the impact of PCT on sexual health. (Moderate Recommendation; Evidence Strength Grade C)**
46. **Patient education programs about sexual recovery after PCT should be tailored to reflect local cultural influences, based on resources available in that region, conceptualization of sexual recovery, and of the priorities in that region. (Expert Opinion)**
47. **All insurance providers should cover the treatment of sexual dysfunctions secondary to PCT in order to validate this clinically important aspect of prostate cancer care and to reduce disparities in access to care. (Clinical Principle)**

Prostate cancer is prevalent among people in every corner of the world. The definition of sexuality varies with cultural, ethnic, and racial conceptualizations. To adequately define the needs of the population being cared for, providers must have cultural, racial, and ethnic awareness and clinician training.[102,103] Cultural sensitivity is often lacking in prostate cancer educational materials.[104] Patients and partners should be consulted when developing educational materials.

Most countries lack insurance coverage for erectile aids for the management of PCT-related ED or for psychosexual counseling.[105,106] Out of pocket cost for PDE-5 inhibitors can vary between pharmacies by as much as 38000%.[107] High cost and lack of coverage for medications, devices, and psychosexual counseling creates disparity, compromising patients' ability to recover post-PCT sexual intimacy.

Future Directions

There is a growing body of evidence to validate that the concept that sexual health support is critical to the wellbeing of patients with prostate cancer and their partners, however most research has been conducted in Europe and in English-speaking countries where research resources are more available and attitudes towards prostate cancer and sexuality are relatively similar. Funding sources should be identified to promote research in low and middle-income countries on cultural, ethnic and racial groups' attitudes towards sexuality, sexual practices and preferences for support. Similarly, funding sources should be identified to promote research on sexual and gender minorities, such as men who have sex with men, trans women and gender non-conforming patients.

The most significant gap in the treatment of physiologic sexual dysfunction is the lack of evidence demonstrating convincingly that penile rehabilitation protocols improve the recovery of erectile function. Animal models have not translated well into human recovery. At this time, the value of penile rehabilitation is largely psychological because it engages men and their partners in sexual recovery early. More research is needed to advance this area of survivorship care.

Treatment for erectile dysfunction following prostate cancer treatment is supported by well-established evidence. The major gap in care is the uncertainty about the acceptability of erectile dysfunction treatments in cultural and ethnic groups, given the stigma associated with sexual dysfunction. Locally based research can answer questions about the acceptability of sexual aids.

Psychosocial support for the use of pro-erectile treatments is now evidence-based but is not implemented in the majority of prostate cancer treatment settings. Attentiveness to partners' needs and interventions for couples are just emerging. Interventions tailored to sexual orientation and gender identity remain undeveloped. More research into the needs and preferences of these populations is needed so that relevant interventions can be developed and tested.

Lack of clinician competence to provide sexual health care is an ongoing barrier. Education to address patients' and partners' sexual health concerns and rehabilitation must become an integrated part of multidisciplinary professional training for clinicians who care for prostate cancer patients.

Addressing perceived cost will be key moving forward, as healthcare institutions claim cost is the primary barrier to patients' obtaining sexual aids and to embedding a fully trained specialist in psychosexual care in oncology treatment programs. Moreover, culturally appropriate methods for providing integrated sexual health care should be investigated.

Finally: advocacy directed at providers, institutions, and governments is needed to secure funding for research to answer questions about the psychosexual needs and resources relevant to patients and partners in low and middle-income countries. Evidence-based clinical care in prostate cancer survivorship can only grow if it becomes a societal priority. Given the considerable prevalence of prostate cancer globally, support of men and partners' efforts to recover sexual intimacy after prostate cancer treatment represents a metric of quality of prostate cancer care.

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Conflict of Interest: Daniela Wittmann is routinely supported by the Department of Urology of the University of Michigan to attend annual meetings of the American Urological Association and the Sexual Medicine Society of North America, is a past Member of the Board of Directors of the Sexual Medicine Society of North America, and is an associate editor of the *Journal of Sexual Medicine*.

Sharon L. Bober reports receiving honoraria from UpToDate and Johns Hopkins University and being chair for the Scientific Network on Female Sexual Health and Cancer.

Stacy Loeb is supported by Department of Defense Idea Development Award W81XWH2010380.

Ted A. Skolarus reports UpToDate royalties for authorship on a prostate cancer survivorship topic; he also reports grants from the National Cancer Institute (R37CA222885 and R01CA242559).

Bridget F. Koontz is a consultant for Rythera Therapeutics; reports research funding from Janssen Scientific Affairs, Merck Pharmaceuticals, and Blue Earth Diagnostics; receives royalties from Demos Publishing; is a symposium steering committee member for the American Society of Clinical Oncology; is a committee member for the American Association of Physicists in Medicine, the National Cancer Institute, and NRG; and is on advisory boards for Bayer, Blue Earth Diagnostics, and Myovant. L.

Michael Glodé reports grants or contracts from the National Institutes of Health and the State of Colorado; consultancy for Janssen, Exelixis, Bayer, and Seattle Genetics; participation on boards for Janssen and Exelixis; multiple patents (none related to the topic of this article); committee membership for Movember; and stock or stock options in Aurora Oncology.

John P. Mulhall is an Editor in Chief of the Journal of Sexual Medicine; advisor to Vault Health and reports stock or stock options in Vault Health, has received payment for expert testimony, and has received support for attending meetings and/or travel from Memorial Sloan Kettering.

Laurel L. Northouse reports personal stock in Microsoft and Stryker and consulting fees for the Dyadic Interventions for people with Advanced cancer and their Informal Caregivers study.

Kellie Paich is an employee of Movember.

Christian J. Nelson reports a grant from the National Institutes of Health (R01 CA190636).

Craig E. Pollack reports stock ownership in Gilead Pharmaceuticals and is working on a temporary assignment at the Department of Housing and Urban Development (HUD); this report does not represent the views of HUD.

Nelson Bennett is a speker for Endo Pharmaceutical Company and Coloplast, he has a training grant from Coloplast.

Michael Kirby is a speaker for the following pharmaceutical companies — Lilly, Astra Zeneca, Glaxo-Smith-Kline.

Run Wang is a speaker for Boston Scientific, Teleflex and Coloplast.

Arthur Burnett receives research grant support from: Endo Pharmaceutical, Boston Scientific, and the National Institutes of Health. He is a consultant and advisor to Boston Scientific, Coloplast, Reflexonic, Astellas, Novartis, Futura Medical, Comphya SA, and Myriad Genetics; he is a patent holder for MHN Biotech; he is a member of the following Boards: Urology Care Foundation, The American Urological Association PAC, and Mentoring Mae teens in the Hood. He is a member of the editorial boards of Urology Practice, Andrology, Canadian Journal of Urology, International Urology and Nephrology, Urology Time; he is on the board of UroMissionsWorks Inc (Non-profit).

Ashley Duby is the owner of Midwest Premier Business Solutions, LLC and is contracted with Movember to provide assistance with project management.

The other authors made no disclosures.

Funding: This work was supported and funded by Movember.

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MOVEMBER®

GUIDELINES FOR SEXUAL HEALTH CARE FOR PROSTATE CANCER PATIENTS

This guideline has been adapted for prostate cancer patients and their partners, families and support networks from Wittmann et al., Guidelines for Sexual Health Care for Prostate Cancer Patients: Recommendations of an International Panel. J Sex Med. 2022; 19(11)1655-1669.

INTRODUCTION

Patients frequently report sexual problems after treatment for prostate cancer. It is important to try to preserve sexual function and address these issues as part of the ongoing care for patients with prostate cancer and their partners. These guidelines have been created through the collaboration of experts in sexual health, including clinicians, researchers, and prostate cancer survivors and their partners. They carefully review the existing research on sexual dysfunction and recovery and provide a framework for the care of individuals and their partners.

Sexual dysfunction can have a complex impact. Its effects can vary for patients and their partners depending on factors such as:

- Age
- Race
- Sexual orientation
- Gender identity
- Personal relationships
- Existing medical conditions
- Treatment methods
- Cultural context

These guidelines aim to recognize, appreciate, and address the diverse experiences of all patients, taking into account their individual circumstances.

HOW WERE THESE GUIDELINES MADE

The guidelines are based on 602 articles published from 1995 to 2022. The approach to evaluate these articles was systematic: we reviewed all the relevant information available. To make sure the guidelines were accurate, we evaluate each statement using a strict evaluation system, following the same process used by the American Urological Association.

GUIDING PRINCIPLES

1. Healthcare providers should regularly and openly discuss sexual health concerns with prostate cancer survivors to address their needs effectively.
2. Sexuality is a personal experience that involves sexual function and pleasure. It impacts both the partner and the couple. Social and cultural factors also influence sexual practices and beliefs. Sexual recovery should consider all these aspects of sexuality.
3. Finding new ways to express sexual intimacy despite sexual dysfunction is a multi-step journey. Recognizing and grieving changes is a central part of the coping process.
4. Research shows that most patients do not fully regain their pre-treatment level of sexual function after prostate cancer treatment, but they can still experience pleasure.
5. In cases where the patient is in a relationship, involving the partn, er in all stages of pre- and post-treatment evaluation and counseling is best. Couples working together as a team tend to have better sexual recovery outcomes.
6. It is important to have a diverse team of healthcare providers with expertise in various fields to give comprehensive sexual healthcare for patients and their partners after prostate cancer treatment. This team can include professionals from primary care, urology, radiation oncology, medical oncology, sexual health, gynecology, physical therapy, nursing, social work, psychiatry, and psychology.

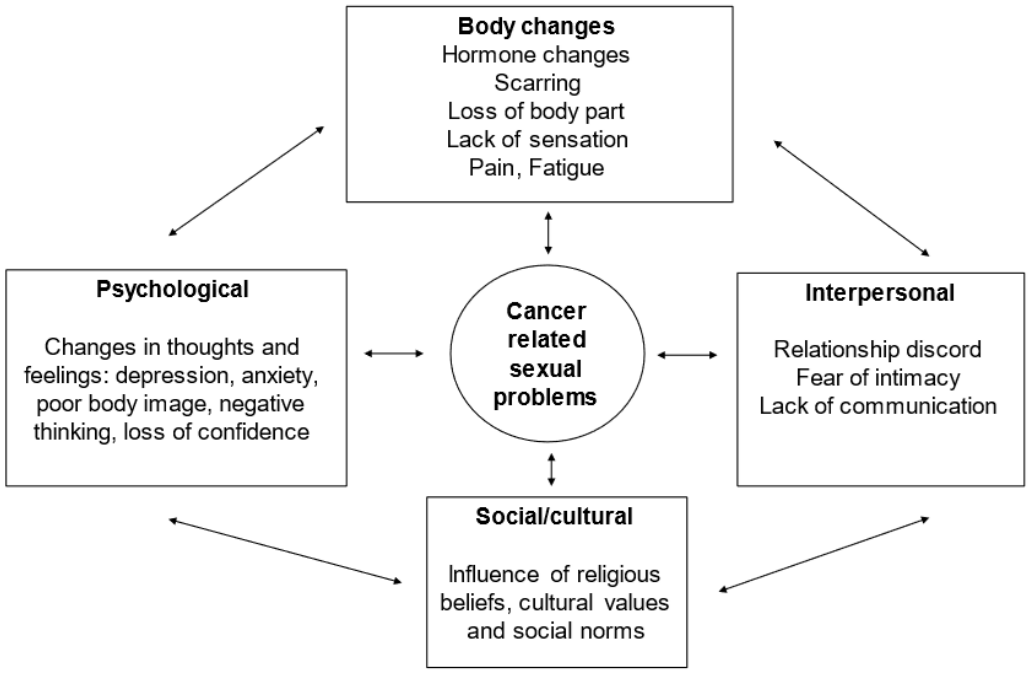

Figure 1. The Impact of Cancer on Sexuality (adapted from an article by Bober and Varella, Cancer, 2012).

GUIDELINES SECTIONS

These guidelines are divided into six main sections covering recommendations for pre-treatment education/counselling, early post-treatment assessment, and initiation of bio-psychosocial sexual health treatment.

Section 1	Counseling Patients and Partners about the Impact of Prostate Cancer Therapies on the Biopsychosocial Aspects of Sexuality
Section 2	Counseling Patients and Partners about the Specific Impact of Individual Prostate Cancer Therapies on Sexual Function
Section 3	Assessment of Sexual Function and Sexual Distress
Section 4	Psychosocial Treatment
Section 5	Medical Treatment
Section 6	Lifestyle Modification Strategies

1. HOW SHOULD CLINICIANS COUNSEL PATIENTS AND PARTNERS ABOUT THE SEXUAL IMPACT OF PROSTATE CANCER TREATMENT?

Clinicians should take the lead in discussing sexual health to normalise conversations about sexual concerns, sexual dysfunction, and intimacy during clinical visits. It is important for clinicians to proactively raise the topic of sexual health regularly and consistently throughout the entire journey of prostate cancer treatment, rather than waiting for the patient and

partner to start the conversation. These recommendations aim to overcome the stigma of discussing sexual health concerns and make sexual healthcare a core part of prostate cancer care.

Clinicians should adopt an inclusive approach and ensure that counseling is tailored to the patient's cultural background, ethnicity, race, sexual orientation, and gender identity.

Clinicians should provide patients and their partners with realistic expectations regarding the impact of prostate cancer treatment on sexual function and their sexual relationship. They should also inform them about available rehabilitation strategies to help them return to sexual activity.

Clinicians should address the emotional distress that patients and their partners may feel as a result of these sexual changes. This includes acknowledging feelings of grief and mourning. A sex therapist or counselor can give support to help you cope with these challenges.

2. WHAT SHOULD PATIENTS AND PARTNERS KNOW ABOUT THE IMPACT OF INDIVIDUAL PROSTATE CANCER THERAPIES ON SEXUAL FUNCTION?

These guidelines recommend telling patients about sexual side-effects that may happen from prostate cancer treatment:

- Problems with erections (erectile dysfunction, or ED) is a common side-effect after all treatments. The outcome differs depending on which treatment you get. After surgery, ED is immediate, and recovery is possible based on the patient's baseline erectile function. After radiation, ED tends to happen gradually. Hormonal therapy can cause ongoing erectile dysfunction for as long as the therapy is continued. Patients should be aware that there may be a loss of penile length, girth, and volume following treatment.
- After surgery, the patient will no longer ejaculate. After radiation and hormonal therapy, there may be a decrease in how much ejaculate comes out with orgasm.
- Changes in orgasm may happen. It may take longer to reach orgasm and it can be less intense, very rarely painful after surgery or radiation. These changes can improve over time with stimulation. Hormonal therapy may lead to loss of orgasm.
- Patients should be informed about the possibility of penis curving, known as Peyronie's Disease.
- After surgery, patients may be unable to father a child (infertile). We are not sure how radiation and hormone therapy impact sperm health, so providers should discuss saving and freezing your sperm to use after treatment.

It is important for healthcare providers to discuss these potential sexual side-effects with patients to ensure they have a full understanding of what to expect and can make informed decisions about their treatment and sexual healthcare.

3. WHY IS IT IMPORTANT TO ASSESS SEXUAL FUNCTION AND SEXUAL DISTRESS IN PATIENTS AND PARTNERS?

Patients should be screened and assessed for sexual function, concerns, and distress before treatment and throughout the survivorship phase. This helps healthcare providers understand the impact of treatment on sexual health and to identify any issues come up.

The partner should also be assessed for sexual function, concerns and distress. This helps healthcare providers to have a full understanding of the couple’s sexual health.

By assessing both the patient and their partner, healthcare providers can gather valuable information that helps them plan personalised rehabilitation strategies and address any sexual concerns or distress effectively.

4. COUNSELING PATIENTS AND PARTNERS ABOUT THE IMPORTANCE OF PSYCHOSOCIAL TREATMENT

Psychosocial treatment provides education to patients and their partners about the expected sexual side-effects of treatment, rehabilitation strategies, and the emotional impact of these side-effects on both the individual and the couple. Emotional distress the patient or their partner feel is a normal response and should be validated.

People with different sexual orientations and gender identities, such as gay and bisexual men, transgender women, and those who do not identify as male or female, may have unique needs that require tailored treatment approaches. For instance,

counseling for gay and bisexual men should address topics like the importance of a firmer erection for anal penetration or the significance of ejaculate.

Psychosocial treatment should also consider the cultural, ethnic, and racial values and preferences of patients and partners so they feel understood and respected. Incorporating these tailored approaches can increase the couple's engagement in rehabilitation.

Patients and partners should be encouraged to seek support from support groups and online support programs whenever possible. Patients who identify as gay, bisexual, have sex with men, are transgender, or are non-binary may have non-traditional support systems, and this should be considered when discussing available support resources.

Patients and couples may benefit from referral to a sex therapist who specialises in addressing the mental health and relationship aspects of their experiences, especially when:

- distress related to sexual losses does not resolve.
- there are pre-existing sexual and relationship difficulties.

5. COUNSELING PATIENTS AND PARTNERS ABOUT BIOMEDICAL TREATMENT

Patients and their partners should be informed about the available treatments for erectile dysfunction. Treatments can be tailored to their specific stage of recovery or decline, as well as their personal preferences. Treatment options include:

- Pills: Medications that can help improve erectile function.
- Injections: Medications injected directly into the penis to make an erection.
- Suppositories: Medications that are inserted into the opening at the end of the penis to create an erection.
- Vacuum pumps: Devices that create a vacuum around the penis to help get or keep an erection.
- Penile implants: Surgical implants that can provide a rigid erection when desired.

Patients should get advice on techniques to minimize urine leakage if they are leaking when turned on or during climax/orgasm. However, it is important to reassure most patients that this issue will usually get better on its own, over time.

Psychological strategies can help patients accept this stage of sexual recovery as normal and without health risk.

A vacuum decide or penile lengthening devices recommended by a urologist can help patients who have penile shortening after prostatectomy. It is best to start using these devices soon after surgery, within several weeks rather than waiting for months.

Patients with penis curving should discuss medical and surgical treatment options with their healthcare providers.

Low desire, orgasmic problems, and unresolved feelings about sexual changes are best addressed through sex therapy. Patients may find it helpful to seek the assistance of a sex therapist who can provide guidance and support in managing these challenges.

6. WHAT KINDS OF LIFESTYLE CHANGES CAN HELP?

Patients and their partners should be advised that certain lifestyle factors can have a positive impact on erectile function. They should get the following information:

- Quitting smoking: Stopping smoking can improve erectile function. Patients should be encouraged to quit smoking and offered support and resources to help them in the process.
- Moderate alcohol consumption: Consuming alcohol in moderation is associated with better erectile function. Patients should be advised to limit their alcohol intake to moderate levels. This means having two drinks or less per day.
- Plant-based or heart-healthy diet: Following a plant-based or heart-healthy diet can contribute to improved erectile function. Patients should be encouraged to incorporate more fruits, vegetables, whole grains, and lean proteins into their diet while minimizing the consumption of processed foods, meat, saturated fats, and added sugars.
- Regular exercise: Engaging in regular physical activity is associated with better erectile function. Patients should be encouraged to incorporate exercise into their routine, aiming for at least 150 minutes of moderate-intensity aerobic activity or 75 minutes of vigorous-intensity aerobic activity per week, along with strength training exercises.

By adopting these healthy lifestyle practices, patients may improve their overall erectile function and enhance their overall well-being. It is important to provide guidance and support to help patients and their partners make sustainable lifestyle changes.

SHARING THESE GUIDELINES WITH YOUR HEALTHCARE PROVIDER

Prostate cancer treatments can cause sexual changes that impact not only the patient but also their partners and the overall relationship. Using comprehensive rehabilitation strategies that address the various aspects of sexuality and associated distress can help maintain or restore sexual intimacy.

We encourage you to actively engage with your healthcare providers by sharing these guidelines. By discussing the guidelines during appointments, you can ensure that your healthcare team is aware of your specific needs and concerns regarding sexual health. This collaborative approach facilitates open communication and enables healthcare providers to tailor the treatment and support to meet the unique requirements of each individual and couple.

Sharing the guidelines with healthcare providers can increase open discussions and guiding the development of personalized rehabilitation strategies. It empowers patients and partners to actively participate in their care, promoting a patient-centered approach to sexual healthcare and supporting their journey towards maintaining or recovering sexual intimacy.

RELATED RESOURCES

True North Sex and Intimacy Guide
truenorth.movember.com/sex-after-prostate-cancer

Patient Sexual Health Guidelines
truenorth.movember.com/images/assets/SexualHealthGuidelines-Patient.pdf

Clinician Sexual Health Guidelines
truenorth.movember.com/clinical-guideline-sexual-health-prostate-cancer/

truenorth.movember.com/sex-after-prostate-cancer