

relation to the number of people who experience treatment-related late effects months or years after cancer treatment is completed.

Sexual well-being is identified as a core element of quality of life for people affected by cancer, particularly those receiving treatment for malignancies involving the pelvic organs. Yet clinicians continue to experience significant difficulties talking to patients about the sexual consequences of cancer and its treatment. This paper presents selected data from two studies that explored the organisational, health professional and patient characteristics that act as barriers or enablers to the discussion of sexual concerns in the clinic.

Material & Methods: These two studies used participant observation of radiotherapy follow-up clinics and one surgical urology clinic plus interviews with health professionals, patients and partners to explore the context and content of discussions about male and female sexual morbidity after treatment. Participating patients were women treated for gynaecological or ano-rectal malignancy and men treated for prostate cancer.

Results: In the women's study consultations (n = 69) were led by medical staff and focused largely on disease surveillance, specific aspects of toxicity monitoring and managing active symptoms. Vaginal toxicity was discussed less frequently (42%) than bowel (81%) or bladder (70%) toxicity and sexual issues were discussed in only 25% of consultations. In the men's study (n = 60) content was also set by medical staff and disease and toxicity monitoring dominated discussions, yet men's sexual concerns were addressed in 53% of consultations.

In the urology clinic there was a proactive approach to the pharmacological management of erectile dysfunction that was considered a routine part of urological practice but this was not mirrored in the radiotherapy clinic. In both studies the broader aspects of male and female sexual expression that can be altered by cancer treatment such as desire, orgasm, sexual satisfaction or relationship impact were rarely discussed. Furthermore, partners were not actively involved in the consultation process even when present.

Health professionals felt inhibited discussing sexual concerns with couples, older patients, patients from an ethnic minority background, those with later stage disease, co-morbidities or a number of active problems. Service factors also adversely affected capacity to address the sexual recovery of patients and their partners. This was particularly the case with regard to time constraints, clinician's lack of knowledge regarding the availability of specialist resources and a lack of clear referral pathways both within and beyond the cancer centre.

Conclusions: If prompt and accurate identification of treatment related sexual concerns are to lead to appropriate clinical intervention or further referral these findings suggest change needs to take place at both an individual practitioner and service design level. Questions remain regarding the most appropriate time and context to raise sexual concerns within the constraints of conventional medical follow-up. These findings are important for the development of supportive care and cancer survivorship services and for the training of health professionals engaged in post-treatment toxicity assessment, patient information and support.

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INVITED

Therapeutic approaches for sexual dysfunction in men treated for prostate cancer

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Prostate cancer (PCa) affects the lives of thousands of men across Europe and the USA, and is the most frequent non-skin male malignancy in Western countries. PCa incidence is greatly increasing because of the worldwide trend for increased longevity in the general population, and the routine prostate-specific antigen tests. Both external-beam radiotherapy (EBRT) and brachytherapy (BT) can be offered as curative options. Although it is commonly believed that the incidence of erectile dysfunction (ED) after radiotherapy is lower than after surgery, percentages reported in the literature vary from 6 to 84% after EBRT to 0–51% after BT. Ejaculation problems and a decrease in libido occur also frequently.

The etiology of ED after radiotherapy for PCa is multi-factorial. Vascular, neurogenic and psychogenic factors are equally important. The most likely mechanism is a damage of the vasculature of the neurovascular bundles and fibrosis of the penile bodies. The time elapsed between radiation therapy and evaluation of erectile function has to be considered; it takes at least 18–24 months before ED rates reach a maximum.

Before the introduction of oral drugs to treat ED, the only therapeutic modality for post-radiation ED was the use of intracavernosal injections that were effective in most of the patients. Two studies have investigated the use of PDE5 inhibitors for treatment of post-radiation ED. In the first study, 45% of the patients after sildenafil and 8% after placebo reported improved erections (p < 0.001). Successful intercourse was reported in 55% of the patients after sildenafil versus 18% after placebo (p < 0.001). In the second study, 67% of the patients after tadalafil and 20% after placebo reported

improvement of erectile function with tadalafil (p < 0.0001). Successful intercourse was reported by 48% of patients after tadalafil versus 9% after placebo (p < 0.0001). Side effects for both studies were mild or moderate. Sexual dysfunction after radiotherapy for PCa has been often underestimated. Patients should be offered sexual counseling, and informed about effective oral drugs to treat ED.

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INVITED

Education and training staff: how to develop and integrate oncosexology?

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Cancer and its treatment have extensive influence on sexuality and intimacy and as such seriously impair the quality of life of patient and partner. In good cancer care 1. the topic of sexuality and intimacy is effectively addressed; 2. problems in these areas are taken seriously and handled well by the various oncology professionals, and 3. when necessary, patient or couple are referred to a sexology professional with enough relevant oncosexological expertise.

These three fields require an adapted set of knowledge. The first two fields require also a set of attitude and skills, that most oncology professionals do not have at their disposal. At the same time many professionals believe that they should possess such skills and attitude. This situation can constitute a major obstacle for changing the tradition of professional silence when intimacy and sexuality are at stake in the cancer population.

Oncology can learn from physical rehabilitation, where we developed extensive experience in the training the various professionals in matters of sexuality. Knowledge is a small part of what is needed. The majority of time is spent on training skills. This starts with 'talking sex' in role-playing and then with ones own patients. Attitude turns out to follow automatically during that training process.

An important part of change is developing the group-competence of discussing sexual topics in a professional way within the multidisciplinary team or unit.

Connected to this process the oncology group/unit should connect with sexology professionals who develop the necessary knowledge, skills and attitude to deal with cancer patients.

References

Gianotten WL, Bender J, Post M, Höing M. Training in sexology for medical and paramedical professionals. A model for the rehabilitation setting. *Sexual and Relationship Therapy* 2006;21:303–317.

Scientific Symposium (Thu, 24 Sep, 09:00–11:00) Monitoring and management of adverse drug events

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INVITED

Management of adverse drug events

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Systemic cancer therapy is associated with multiple risks for the patient. Most cancer patients under systemic treatment experience adverse drug events such as constipation/diarrhea, nausea/vomiting, fatigue, myelosuppression, skin reactions, anorexia, and mucositis. These adverse events are usually predictable by available clinical data and can often be prevented or ameliorated.

Nevertheless, the minimisation of toxic effects of anticancer therapy is a challenging task. During the last two decades, several new drugs have become available for supportive care, e.g. 5-HT₃ and neurokinin-1 receptor antagonists for the prevention of nausea and vomiting, or palifermin which reduces the incidence and severity of mucositis. In addition, evidence-based clinical practice guidelines have been developed and implemented, particularly for antiemetic prophylaxis and therapy. Several studies have shown a positive effect of these guidelines on both clinical and economic outcomes. Current research particularly aims at developing measures against other treatment-associated symptoms, e.g. the fatigue syndrome. As a consequence, adverse drug reactions are increasingly 'manageable' leading to a higher quality of life for the patient.

However, special efforts have to be undertaken in order to ensure that an individual patient benefits from this development. In terms of cancer many disciplines contribute to the care process. Thus, cross-profession and cross-sector cooperation is crucial in order to improve information flow and to exploit the specific knowledge of each profession.