



*Hosts*

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**Francine Foss MD**

Professor of Medical Oncology

***Sexuality, Intimacy, Menopause,  
and Cancer Survivorship***

**Guest Expert:**

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**Yale Cancer Center Answers**

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Welcome to Yale Cancer Center Answers with Dr. Francine Foss and Dr. Lynn Wilson. Dr. Foss is a Professor of Medical Oncology and Dermatology, specializing in the treatment of lymphomas. Dr. Wilson is a Professor of Therapeutic Radiology and an expert in the use of radiation to treat lung cancers and cutaneous lymphomas. If you would like to join the conversation, you can contact the doctors directly. The address is [canceranswers@yale.edu](mailto:canceranswers@yale.edu) and the phone number is 1-888-234-4YCC. This week, Lynn welcomes Dr. Elena Ratner. Dr. Ratner is Assistant Professor of Gynecology, Obstetrics, and Reproductive Sciences at Yale School of Medicine and she joins us this evening for a conversation about sexuality, intimacy, menopause, and cancer survivorship. Here is Lynn Wilson.

Wilson Tell us about how you first got interested in this field and a little bit about your background and training, what are the details that led up to the current expertise that you have?

Ratner My training actually did not provide me with a lot of expertise coming into this field. As a gynecologic oncologist we all complete a four year residency in obstetrics and gynecology, during which we certainly get exposure and training on sexuality and menopause. I came to this in my professional life because of a specific patient. This one particular patient I met when I was actually in part of my training and then when I graduated and started my own practice she followed me into my practice. This is a young patient, young woman in her 30s, she was 38 at the time, and she was diagnosed with cervical cancer a long time before that, 8 years before, she had radiation and chemotherapy and was cured from her disease, so from that standpoint she was a great-great success. So, we saw this patient very infrequently every 3 to 6 months and every time we would document in the chart how the cancer was gone, and how this was such a great medical success. And yet every time that I would see her when I had my own practice, I knew that she was miserable, that her social life was very-very poor. She was in the midst of her second divorce, she was a single mom and when I approached her about this bad social situation, it really came out that all of this was because of the diagnosis of cervical cancer and the treatment of cervical cancer and even though the cancer was cured, she forever was affected by it and she was not able to be intimate with anybody. She was not able to be sexually active with anybody and that was so imperative to her functioning and her quality of life, even though she was survivor, the success of this treatment was not real because her life was nevertheless devastated by the disease.

Wilson Did she have physical problems and psychological problems related to her cancer and the treatment?

Ratner She absolutely did. When all this came out, initially I was very pleased that I was able to bring all this out and then I thought that I could easily fix things, I could easily give a cream or give her some sort of prescription that can relieve her of her physical symptoms and that is when I realized that her problems were so much more in depth than just physical things I could see and I could easily fix. But more than half of her problems were actually psychologic way back to how she could be diagnosed with cervical cancer, and how she was treated, and how she was afraid that the cancer was going to come back. She was afraid that she was going to die. She was afraid that her

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kids will be left without their mom. So her issues were so much beyond the physical issues that I could see and I could fix easily, and that is why when we provide sexuality and intimacy care, it cannot be just physical or just psychologic. It really has to be this multidisciplinary approach between a physical and medical provider and a counselor, psychologic provider.

Wilson Tell us a little bit, Dr. Ratner, about the different types of cancers that you help patients manage, the cancers that you treat, and which ones seem to have the greatest effect on women and their sexuality?

Ratner Female sexuality dysfunction, in the general population, in woman without cancer is actually very-very common. There was a very good study that we always quote that says as many as 43% of all women have some sort of a sexual dysfunction and that could range from pain during intercourse to low desire for sex, but that number, that percentage, is much-much higher in patients with cancer. The literature says that women with breast cancer and women with gynecologic cancer are the most affected and men with prostate cancer. The numbers of women affected are as high as 80% to 90% in breast cancer and similarly 80% to 90% in women with gynecologic cancers such as uterine cancer or cervical cancer or ovarian cancer. So, that is predominantly the population of women that we see, mostly women with breast cancer and women with gynecologic cancers. We have recently expanded this service to the rest of the Cancer Center and now we are seeing a lot of women who receive chemotherapy or radiation as young adults or adolescents and that is a different group of women who are affected differently, but nevertheless very much affected.

Wilson Are there certain types of treatments that are most responsible for these types of issues and if so, describe what those negative affects can be physically for a patient?

Ratner It is really an unfortunate combination. Different treatments have different side effects and different ways that they can affect sexuality and intimacy. Surgery for breast cancer is very well known to greatly affect a woman's self-image. There is lot of literature that describes how women really feel very differently after mastectomy and how they kind of lose their femininity and their sense of self, and they find kind of a different image that is new to them. Gynecologic surgery is also difficult, we take out cervixes, and uteruses, and we change the whole anatomy of the woman's pelvis. There is a lot of literature how certain kind of hysterectomies shorten the vagina, and of course taking out the ovaries during the hysterectomy puts women into menopause and that in itself, whether it is issues of fertility or of early menopause, or even menopause that is on time but yet surgical and abrupt, is very-very difficult for people. Radiation carries its own bad side effects in terms of sexuality and intimacy. There is a lot of literature about whole pelvic radiation and radiation, something called intracavitary radiation, especially for patients with cervical cancer and there is a lot of literature that that in itself changes how the vagina feels. The vagina becomes shorter, it is not lubricated. Patients have a lot of pain during intercourse. Chemotherapy has a great number of different ways it affects sexuality and intimacy. Different chemotherapy agents produce different side effect, some bring the woman into the menopausal state. It is much-much

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more difficult for women if they are younger when they receive chemotherapy because the results other than the side effects are much more pronounced and then other chemotherapies, again, they change a women's desire to have intercourse. They change their libido and going back to what we talked about before, it does not matter what the treatment is, there is a huge psychologic component that plays a role in all these three different treatment modalities.

- Wilson Is there anything we can do to try to prevent some of these negative effects? Being aware of them upfront before treatment starts? Have you found that is helpful for you in making things better for patients knowing what might happen, counseling them upfront, doing things therapeutically, very rapidly during treatment or right afterwards, what your thoughts about that?
- Ratner I think that is exactly right, what you just said. So much relief is just acknowledgement. There is a great amount of literature and one in particular that talks about how women expect to be told that this could happen and that they get much-much better if you prepare them and tell them this is the treatment and this is what might happen and when it does happen it is normal. It is not you, it is treatment and it is not permanent, some of it will get better, but whatever does not get better, we can help and we can improve on. I think the most important thing is the communication between the provider and the patient. I cannot tell you how many women came to me and said, you know, if only I could have talked about this in the beginning, then when it happened, I would not feel that this is me. If I knew that this is normal. If I knew that this is something that was expected, that would have been much easier, I would have been prepared for it. It would not have scared me. I think the most important thing is to be able to communicate and to be able to leave this door open and to say, you know, those are the things that other women report. This might happen to you. If it does not, great; but if it does, it is normal, and I am here whenever you want to talk about it.
- Wilson Have you found that since there are physicians such as yourself with special expertise and interest in this subject and since the patients know that and you are talking to them upfront about these things, is your sense that there are a lot of patients out there that would like to talk about this, have these problems but maybe with other physicians they are afraid to bring it up, afraid to talk about it, embarrassed, those sorts of things?
- Ratner I think you are absolutely correct. There is a huge barrier and I think the barrier is not just on the provider's side, I think the barrier is both on the patient's side and on the provider's side, and there is a lot of literature that talks about that. There is also a lot of literature that talks about how to address it. Therefore, for physicians who do not feel comfortable there are very easy models that can be used in order to be able to ask the patient, ask the woman about these issues. But I think the most important thing is not the models, and the most important thing is not the time that it takes. I think the most important thing is to care about this and to just ask in a routine exam, you know, this is now completely part of my practice, I ask about it like I ask about smoking and I ask about alcohol use, I ask about this, and I do not push it, and I ask and I leave it open, and I say, I am here,

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and if at any point you would like to discuss it, then I am here for you, and I close it. It is not forced, but nevertheless I have not yet had one patient who has not taken me up on the offer.

Wilson I see.

Ratner Some at that time, some later.

Wilson Why is it that there are not more people such as yourself who have this interest and expertise to help their patients in this way, because obviously, knowing your work and knowing who you are, it makes perfect sense to me, but I know that there are places that do not have physicians who have an interest in this area, and probably do not put the conscientious effort to bring these issues up with their patients. Why do you think that is?

Ratner The interesting thing is that for me this interest and this passion came as a surprise. For me, it happened because there was a need and because, exactly as you said, there really was nobody in the community who was addressing these issues with cancer survivors and I felt that was paramount in their quality of life. I think it is a difficult subject. I think physicians, and again, there are barriers on both sides, and I think frequently physicians do not push it. I think the patients, especially cancer patients, feel so grateful to be alive and to be cured or to be in remission, that very frequently, I cannot tell you how many times, I have patients that say this is something they have wanted to bring up for years, but did not want to sound ungrateful. This seems so small in comparison to what they have been through, and yet it is not small, it is their life, it is their quality of life, it is their family. These women are young. They have a whole life in front of them.

Foss We are going to take a short break for a medical minute. Please stay tuned to learn more information about sexuality, intimacy, menopause, and cancer survivorship with Dr. Elena Ratner.

*Medical  
Minute*

*It is estimated that nearly 200,000 men in the US will be diagnosed with prostate cancer this year and one in six American men will develop prostate cancer in the course of his lifetime. Fortunately, major advances in the detection and treatment of prostate cancer have dramatically decreased the number of men who die from the disease. Screening for prostate cancer can be performed quickly and easily in a physician's office using two simple tests, a physical exam and a blood test. With screening, early detection and a healthy lifestyle prostate cancer can be defeated. Clinical trials are currently underway at federally designated comprehensive cancer centers like the one at Yale to test innovative new treatments for prostate cancer. The Da Vinci Robotic Surgical System is an option available for patients at Yale that uses three dimensional imaging to enable the surgeon to perform a prostatectomy without the need for a large incision. This has*

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*been a Medical Minute, and more information is available at [yalecancercenter.org](http://yalecancercenter.org). You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.*

- Wilson Welcome back to Yale Cancer Center Answers. This is Dr. Lynn Wilson and I am joined by my guest this evening Dr. Elena Ratner, and we are discussing sexuality, intimacy, menopause, and cancer survivorship.
- Wilson Dr. Ratner, when a patient undergoes cancer treatment and has effects of the treatment that are impacting on her sexuality, what are some of the interventions or treatments that you consider for this patient? I know that may be a complicated answer, but give us some scenarios and some of the treatments you might recommend to try to counteract some of the effects of the cancer treatment.
- Ratner A lot of the treatments for sexuality and intimacy dysfunction, and I do not even like calling it that because it is really not a dysfunction, it is all about your personal life and how this affects you in your life, but the service we provide, the clinic that we offer is a combination of a menopause provider, Mary Jane Minkin, who is one of the menopause gurus and the psychology group under Dwain Fehon. So, the treatment we provide is absolutely patient individualized and patient directed. We also take care of women who do not have cancer, and for those women, the treatment is much easier and many times there are hormonal treatments, whether it is estrogen treatment or testosterone treatment that we use, and that has certainly helped women's libidos and I am not going to bore you with many different studies, but for women with cancer, especially for women with breast cancer or uterine cancer, the choices are more limited and again every patient is different and every patient who I meet, I sit down with her, and I discuss the risks, benefits, and then we make a decision that is right for her. We do not have a protocol. Everything is individualized for the specific woman. But for women with those cancers, the estrogens are much more difficult. So, we use a combination of herbal medications. I have recently become a big fan of acupuncture. We have a special exercise program that we offer, there is special reflexology that we do to improve sexuality. So what we offer is again a patient individualized plan, if she is able to safely use hormones, whether those are hormones that we use vaginally or hormones that we use orally or through a patch, then great, but if we feel that those choices are not what she wants or I am not comfortable with, then we provide a combination of other alternative medicine and all of our patients, or most of them, the ones that require it, are seen by a counselor, and these counselors are special counselors who deal with issues of sexuality and intimacy both in cancer patients and in patients without cancer, and then those counselors continue to see these women separately from us, and we take care of the women this way together.
- Wilson When we know that a patient is going to be receiving pelvic radiation, a young woman who is premenopausal for example, are there any surgical procedures that can be used to move the ovaries out of the field, for example, to try to be preventative when we know that we may get into trouble with a certain treatment?
- Ratner Absolutely, there is something called ovarian transposition. It is used in exactly the kind of

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woman that you described, women with cervical cancer, or women with anal cancer, where we would have to radiate their pelvis and the ovaries would be in the field. I do this procedure routinely and what we do is we take the ovaries out of the field of the radiation and bring them up higher and keep them away from the harm of radiation.

Wilson Can they stay in that location or do you typically move them back again after radiation is over?

Ratner No, usually they get very happy and very comfortable where they are and I even have women who we were then able to collect eggs, somebody whose ovaries have moved almost all the way by the lung and we are able to collect her eggs, so she was able to have children through that.

Wilson Have you seen a more substantial percentage of the population of patients you care for that are older in age, now that we are doing a bit better with the success of the cancer?

Ratner I certainly have a much higher proportion of older woman recently because exactly, I think women live longer and cancers get diagnosed longer, and cancers get cured much more now and women live into their 70s, 80s, and 90s. I have one patient right now who I am taking care of who is 100, and she comes to me and gets estrogen, she is happy and has a wonderful quality of life. At the same time, I also have a large number of younger patients, patients with cervical cancer. I think the screening has gotten better, so I think more people are now getting diagnosed with earlier stage cervical cancer and breast cancer and there is a higher cure rate because they get diagnosed at an earlier stage.

Wilson What are some of the worries and concerns that these patients have going into the treatment program?

Ratner For patients with cancer, there are so many different components of what they worry about that I certainly did not understand until I became involved in this program. I think women worry about normal things that we all worry about. They worry about their children, and their work and their life and then they worry about the cancer and whether it will come back, whether they would live and whether they will need more treatment, and I think as part of that it is very important that in that worry they still remember and we still remember that they are normal women. They have husbands and partners and want to be loved and want to love and want to have intercourse and want to have a normal life and I think that sometimes gets forgotten in the midst, both by us and by the patient.

Wilson Do you find that there are some patients that maybe, when you open that door for them at an initial visit or in the beginning or when you are discussing their diagnosis, you open the door on these subjects but they do not say very much. Are there some patients who maybe after treatment is over or maybe it just takes a matter of time for them to feel comfortable with you after several visits or after their treatment is over. Have you seen some patients then open up and become much more expressive about their concerns?

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- Ratner Absolutely, and that is why I now routinely use this technique of just opening the door the first time and I do not use models, I do not use questions. I just ask about it and then leave it open because a great number of women will come back to me later, even when they know me a little bit better or when they kind of pass the surgery and pass the worst of the chemotherapy and a lot of the initial treatment, they kind of take a breath in and they say, “okay, I made it through this, it is time for me to get back to my normal life.” As I have mentioned, I have not had even one patient, any of my gynecologic oncology patients, none of them have not come back to ask something or to share something and many times they do not want the intervention, they do not want to the treatment, they just want to tell me about it and they want to hear me say I am here, I care, it is normal, even if they get better or if it does not, I am here for you and we we’re going to find a way to make it better for you.
- Wilson Can you describe for our listeners what a treatment induced menopause experience may be like for a woman? What sort of changes might she expect if we are doing surgery and removing the ovaries or we are doing radiotherapy or certain chemotherapies? What sort of changes might she expect?
- Ratner The menopause that these women would go through is much more severe than the menopause that a woman would go through naturally in her early 50s, usually. When woman go through menopause naturally they have time for their hormones to start declining. Some go into something called perimenopause and then they go into menopause. In women whose menopause is brought on by surgery or radiation or chemotherapy, it is abrupt, they come in the morning, they are totally fine and then six hours later, let’s say, they have no hormones or little hormones left. And again, for these women it is so much more difficult, they are not just dealing with now this new menopause, they are dealing with this menopause within the whole paradigm of their new diagnosis and the new treatment. What women experience are severe hot flashes. There is very good literature that talks about breast cancer patients who experience severe hot flashes as part of treatment with tamoxifen or Arimidex and the same thing happens with the patients who go into surgical menopause. Women have difficulty sleeping and difficulty concentrating. We are actually starting a very good study now where we are looking at recognition for women who are undergoing menopause and there is no question that we will correlate it to decreased cognition and decreased memory and decreased ability to think clearly. Joint pain is also very-very common, it is actually one of the most common complaints of menopause, and then sex drive; sex drive, lack or complete loss of sex drive, accompanied by mood changes and irritability. And again these symptoms are not gradual, they come out of nowhere and they are usually quite severe.
- Wilson Then of course, we have, as we discussed, the psychological component on top of all this. So it can be a difficult situation, obviously.
- Ratner Absolutely.
- Wilson Are there any ways to more objectively asses a level of sexual dysfunction? I know you speak to the patient and she complains about a variety of things, but are there formal assessments, are there

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scales to try to grade this severity and does that help you as their physician come up with a management scheme?

Ratner Absolutely, and the care of the patient sometimes requires an extensive evaluation like that, sometimes it does not. In my practice we do extensive questionnaires with a very strict assessment of again, dysfunction, and I hate using that word, so that we can know the improvement with interventions but yes, there are a multitude of different questionnaires, different scales that are used and we use a very specific set that is actually now all electronic, and very easy to use.

Wilson Are there diagnostic tests, laboratory tests, those sorts of things that you integrate into your program?

Ratner No, I do not. There certainly are, you can certainly measure hormonal levels and so forth, but we do not because we feel that again, everything comes down to the woman, to the patient and about how she feels. So, I do not quite care what the levels are. If she does not feel like the levels are high enough, then they are not high enough.

Wilson Right and you can tell obviously.

Ratner Right.

Wilson Is there any new research or clinical trials that you are excited about?

Ratner There is a new National Society of Sexuality and Intimacy Committee that just formed maybe 6 to 12 months ago that we are very much a part of together with the University of Chicago and Memorial Sloan-Kettering Hospital, and we are just now in the process of building this committee and starting trials. Here at Yale we are about to start a very big trial about needs assessment, about really trying to assess how many women have this problem and how do we reach out to them and how do we teach the providers to ask and to open themselves and to allow the patient to speak.

*Dr. Elena Ratner is Assistant Professor of Gynecology and Obstetrics and Reproductive Sciences at Yale School of Medicine. If you have questions or you would like to add your comments, visit [yalecancercenter.org](http://yalecancercenter.org), where you can also get the podcast and find written transcripts of past programs. You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.*