Genitourinary and Sexual Health Care for Women with Cancer: Overlooked Quality of Life Indicators

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Introduction

Genitourinary health and sexual well-being are critical aspects of quality of life and overall health, especially for patients with malignancy who face the negative physical and emotional consequences of cancer and cancer treatment. However, evidence suggests that physicians rarely address these concerns in clinical practice. As cancer survivorship continues to improve with advancements in detection and treatment, the need for supportive gynecologic and sexual health care for women with cancer is greater than ever. The purpose of this study was to characterize the prevalence of oncologist-reported counseling for genitourinary syndromes (GUS) or sexual health concerns (SHC) in women with cancer being cared for at an urban academic safety net hospital and to identify potential gaps in care for this patient population.

Methods

A retrospective study of 514 women receiving cancer treatment or follow-up cancer care from January 24, 2022, to March 31, 2022, was performed. Inclusion criteria consisted of female patients aged 18 or older with a prior or current cancer diagnosis. Demographics and clinical data were abstracted from patient charts to investigate factors associated with screening for GUS or SHC. Charts were further reviewed to determine whether the oncologist initiated a treatment or referral process for patients endorsing GUS or SHC. Statistical analyses were conducted using R statistical software version 4.0.2. Demographic variables were compared between groups using Wilcoxon rank sum tests for continuous variables and Fisher exact tests for categorical variables.

Tables and Figures

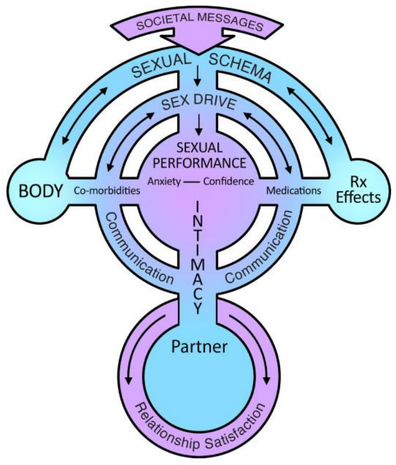


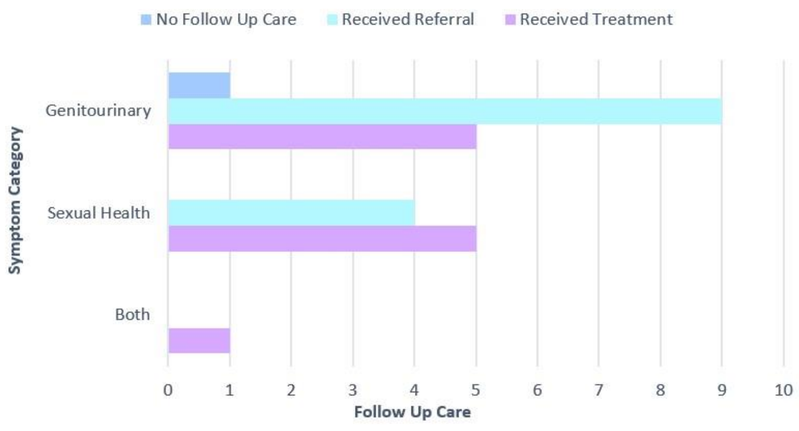
Figure 1: **Model of sexual health for cancer survivors.**

Source: *Seminars in Oncology Nursing*, vol. 36, Falk SJ, Dizon DS., Sexual Health Issues in Cancer Survivors.

Table 1: **Genitourinary syndrome (GUS) and sexual health concern (SHC) evaluation by cancer status.**

		GUS or SHC Counseling		
	n (%)	Yes	No	P-values
Total (n)	514	68	446	
Cancer Stage (49 N/A)				
Stage 0	39 (8.4)	5 (7.8)	34 (8.5)	.54
Stage 1	138 (29.7)	22 (34.4)	116 (28.9)	
Stage 2	108 (23.2)	14 (21.9)	94 (23.4)	
Stage 3	98 (21.1)	16 (25.0)	82 (20.4)	
Stage 4	82 (17.6)	7 (10.9)	75 (18.7)	
Cancer Type				
Breast Cancer	207 (40.3)	15 (22.1)	192 (43.0)	.001
Cervical Cancer	43 (8.4)	16 (23.5)	27 (6.1)	<.001
Colorectal Cancer	39 (7.6)	2 (2.9)	37 (8.3)	.144
Ovarian Cancer	32 (6.2)	10 (14.7)	22 (4.9)	.005
Vulvar Cancer	19 (3.7)	7 (10.3)	12 (2.7)	.007
Uterine Cancer	53 (10.3)	16 (23.5)	37 (8.3)	.001
Other Cancer	154 (30.0)	7 (10.3)	147 (33.0)	<.001
Disease Status				
Alive with Disease	275 (53.5)	16 (23.5)	259 (58.1)	<.001
Alive without Disease	239 (46.5)	52 (76.5)	187 (41.9)	
Treatment Status				
On Active Treatment	266 (51.8)	21 (30.9)	245 (54.9)	<.001
Not on Treatment	248 (48.2)	47 (69.1)	201 (45.1)	
Treatment Type				
Surgical	371 (72.2)	52 (76.5)	319 (71.5)	0.468
Chemotherapy	319 (62.1)	39 (57.4)	280 (62.8)	0.422
Radiation	250 (48.6)	32 (47.1)	218 (48.9)	0.796
Hormonal	127 (24.7)	12 (17.6)	115 (25.8)	0.175
Targeted	168 (32.7)	9 (13.2)	159 (35.7)	<.001
Immunotherapy	69 (13.4)	4 (5.9)	65 (14.6)	0.055
Palliative	83 (16.1)	8 (11.8)	75 (16.8)	0.377
No Treatment	19 (3.7)	1 (1.5)	18 (4.0)	0.492

Figure 2: **Follow up care by symptom category.**



Results

A total of 68 of 514 (13.2%) subjects were asked about GUS or SHC by their oncologist. Of the patients that had these discussions, 25 (36.8%) endorsed GUS or SHC. The majority (96.0%) of patients who reported GUS or SHC received treatment or referral for further care. Roughly one-third of gynecologic cancer survivors (37.2% of cervical cancer, 31.3% of ovarian cancer, 36.8% of vulvar cancer, and 30.2% of uterine cancer) discussed GUS or SHC with their oncologist. In contrast, only 7.2% of breast, 5.1% of colorectal, and 4.5% of other cancer survivors had documented discussions of GUS or SHC. Documented conversations about these topics were more common in patients without evidence of disease (21.8% vs. 5.8%, $p < .001$). Patients who were not on active treatment were more likely to have documented discussions than those on active treatment (19.0% vs. 7.9%, $p < .001$). Patients on targeted therapy were significantly less likely to have documented GUS or SHC conversations with their oncologist (35.7% vs. 13.2%, $p < .001$). There were no other significant differences by treatment type, race, ethnicity, need for translator, insurance status, or BMI with regards to counseling for GUS or SHC.

Conclusions

Women with gynecologic cancers were more likely to have documented GUS or SHC counseling by their oncologist than women with other cancers. Patients without evidence of disease and not receiving treatment were also more likely to have documented discussions surrounding these issues. Although only 13.2% of patients had documented GUS or SHC conversations, most of those patients were able to achieve follow-up care, illustrating a large gap in care and revealing an opportunity to address a significant quality of life issue for these patients.