



Update on . . . Gynecologic Cancer

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The focus of this column is to describe published research studies of interest to professional oncology nurses. This issue highlights two studies on gynecologic cancer.



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Women's Sexual Health Should Be Post-Pelvic Radiation Priority

White, Faithfull, and Allan (2013) conducted a focused ethnographic study from the United Kingdom (U.K.) discussing factors influencing the clinical assessment and interventions of long-term sequela of radiotherapy (RT) for women with pelvic malignancies. Pelvic RT causes physical side effects as well as psychosocial responses that negatively impact the sexual health of women and their partners. The authors illustrated the lack of research and thorough clinical assessment available to manage patients long term. The rationale for the study was the existence of a significant population of two million cancer survivors in the U.K. (MacMillan Cancer Support, 2008). Epidemiologic data suggest that few clinical supports are in place for cancer survivors and, therefore, post-treatment quality-of-life (QOL) alterations are not addressed. Clinicians are known to focus on assessment and management of acute treatment-related side effects and are unaware of and reluctant to manage chronic, late, or long-term side effects. QOL and RT studies indicate that women receiving pelvic RT experience significant disruption to sexual well-being. Accurate data in this population do not exist because of minimal prevalence data about the sexual function of the general U.K. adult population.

White et al. (2013) contended that research has adopted an essentialist perspective in the study of sexual dysfunction, which has resulted in a neglect of psychological, relational, and social components of male and female long-term, treatment-related sexual side effects. Biologic determinism is identified as the first perspective to emerge in defining sexuality; however, the need to include Foucault's (1990a, 1990b)

theory of social construction, which accounts for the psychosocial effect of the anatomic and physiologic changes, is considered essential and is used as part of the framework of White et al.'s (2013) study.

The purpose of the study was to explore factors that influence clinical assessment and management of RT-induced sexual dysfunction and to illustrate the deficiencies of the multiprofessional team (e.g., physicians, nurses, radiotherapists, social workers) in providing quality time for discussion and to craft appropriate interventions during routine oncology follow-up. In addition, the article provided findings of biomedical (i.e., functional), socially constructed, and subjective elements of women's altered sexual lives following cancer treatment.

The study was conducted during a five-month period of participant observation of RT follow-up consultations (N = 69) from two National Health Service cancer centers and 49 in-depth participant interviews (24 women, 5 partners, 20 health professionals). The first theme that emerged was the culture of the clinic shaped by the biomedical model. Two subthemes evolved within that theme: fear of recurrence and limits of the biomedical gaze (only the physical examination, not any leading psychosocial questions posed by the team to assess sexual health). The second theme focused on the construction of female sexuality post-treatment, in which female sexuality was understood by clinicians and women through biologic and anatomic realities created by pelvic RT and sexual impact.

The study's findings explored factors that adversely affect delivery of sexual rehabilitation from a social, organizational, and patient and partner perspective following cancer. Clinicians practicing in inflexible, resource-limited systems with significant time constraints

are challenged to go beyond the pure physical assessment and needs of cancer survivors. The knowledge provided in the study is pivotal and extends beyond the clinical diagnosis of women with pelvic cancer. Sexual rehabilitation must be at the forefront of professional oncology nursing practice for all patient populations affected by acute and chronic sexual compromise related to cancer diagnosis and treatment. In addition, issues related to gender equity in this domain must be prioritized and pursued.

Foucault, M. (1990a). *The history of sexuality: An introduction* (vol. 1). London, England: Penguin Books.

Foucault, M. (1990b). *The care of the self: The history of sexuality*. London, England: Penguin Books.

Macmillan Cancer Support. (2008). *It's no life: Living with the long term effects of cancer*. London, England: Author.

White, I.D., Faithfull, S., & Allan, H. (2013). The re-construction of women's sexual lives after pelvic radiotherapy: A critique of social constructionist and biomedical perspectives on the study of female sexuality after cancer treatment. *Social Science and Medicine*, 76, 188–196. doi:10.1016/j.socscimed.2012.10.025

Lactation May Reduce Risk of Ovarian Cancer

Ovarian cancer is the seventh most common cause of cancer mortality among women, accounting for 4% of female cancers (Ferlay et al., 2010). Ovarian cancer usually is diagnosed in advanced stages. The overall five-year survival rate is about 45%, and possible causes have been linked to the turnover of surface ovarian epithelium during ovulation and increased proliferation of ovarian epithelium from elevated gonadotropin concentrations (Siegel, Naishadham, & Jemal, 2012). Two protective risk factors for ovarian cancer are oral contraceptive use and higher parity, which may reduce ovarian cancer risk by decreasing gonadotropin concentrations and suppressing ovulation (Milne et al., 2010). Breastfeeding delays ovulation and inhibits the release of reproductive hormones implicated in ovarian cancer (McNeilly, 2001).