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SAJ Cancer Science

RESEARCH ARTICLE

ISSN: 2375-6683

Sexual Disorders in Breast Cancer Patients in The Medical Oncology Department of Brazzaville University Hospital

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Citation: Bolenga Liboko Alexis Fortuné, Ngatali CFS, Bintsene Mpika Gickelle, Ndingossoka RJ, Bambi CB, et al. (2022) Sexual Disorders in Breast Cancer Patients in The Medical Oncology Department of Brazzaville University Hospital. SAJ Cancer Sci 8: 101

Abstract

Breast cancer can induce psychological and sexual disturbances in the affected person. These can have an impact on sexual desire and thus affect the foundations of identity, seduction and self-image.

We therefore conducted a descriptive cross-sectional study with prospective data collection to explore this type of alteration over 6 months. The inclusion criteria were: age at least 18 years, WHO Performans status between 0 and 2, written informed consent. The method was the use of the Female Sexual Function Index (FSFI).

Sexual dysfunction was found in 240 out of 312 patients (76.9%). Sexual dysfunction was found to be predominant in patients treated with the combination of surgery and chemotherapy.

Keywords: Breast; Cancer; Sexuality

Introduction

Breast cancer can induce great psychological distress, depressive symptoms and anxiety, which will have an impact on sexual desire and thus affect the foundations of the patient's identity, attractiveness and self-image [1].

Sexuality is a social construct that includes biological, relational and subjective aspects and integrates personal identity with several meanings such as lifestyle adoption, choice of erotic object, types of clothing and manners [2]. Female sexuality is said to be endowed with erotic plasticity as a result of great pressure from socio-cultural norms of beauty [2].

Traditional African societies had an ideal of female beauty, that is, a fatty mass on the hips, buttocks and stomach, as well as an opulent chest [3]. Many African men and women continue to identify with this ideal today because the beauty of a woman in Africa is judged by her looks and behavior [3].

Human sexuality encompasses sexual intercourse as well as eroticism, intimacy and pleasure. Sexuality is experienced and felt through thoughts, actions, desires and fantasies [4]. The influence of breast cancer and its treatments on sexuality is an area that is still little explored; therefore, it is important to investigate the difficulties of the affective and sexual life of patients. This is why we proposed to carry out this study, with the aim of studying the sexual disorders of patients with breast cancer at the university hospital of Brazzaville.

Patients and Methods

This was a descriptive cross-sectional study with prospective data collection, running from 1 March to 31 August 2018, i.e. 6 months. It was conducted in the medical oncology department of the University hospital of Brazzaville. The study population consisted of women with breast cancer followed in hospitalization and outpatient of medical oncology consultation.

To be included in the study, patients should be at least 18 years of age with a WHO performans status between 0 and 2; as well as an informed and written consent.

Patients with impaired consciousness; those at the terminal stage of the disease; patients who did not give informed consent or withdrew consent after initially giving it; patients who were sexually inactive prior to cancer diagnosis; those without a regular sexual partner; patients with a comorbidity associated with cancer; and those with a sexual disorder prior to cancer were excluded from our study.

In addition to the sexuality assessment score, we carried out individual interviews with open-ended questions about aspects of their relationship. We briefly gave them detailed explanations about the study in order to make them fully aware of it and they signed an informed consent, thus giving their agreement to the study.
We used the Female Sexual Function Index (FSFI). Data were collected using a self-administered survey form that was completed by the investigator.

The variables studied were age, marital status, occupation, religion, level of education, duration of the disease, WHO performance status, and treatment received. Sexuality itself was assessed on six multidimensional domains: desire, excitation, lubrication, orgasm, satisfaction, and the FSFI composite score (Table 1).

The diagnosis of sexual dysfunction was evoked from the history, and the diagnostic confirmation and assessment of its severity was made with the Female Sexual Function Index (FSFI), which is the most widely used instrument for the last two decades and consists of 19 questions.

Data entry was done using Epi info7 software. The statistical analysis included a descriptive phase of the study population and the sexual disorders. For the quantitative variables, we calculated the mean and standard deviations, and when these were greater than a quarter of the mean, we calculated the median and its quartiles.

Domain	Score	Coefficient	Minimum score	Maximum score
Desire	1 - 5	0,6	1,2	6
Excitation	0 - 5	0,3	0	6
Lubrication	0 - 5	0,3	0	6
Orgasm	0 - 5	0,4	0	6
Satisfaction	0 (OR 1) - 5	0,4	0,8	6
Pain	0 - 5	0,4	0	6
Total score			2	36

Table 1: FSFI composite score

Results

The socio-demographic characteristics of the cancer patients are shown in Table 2.

The prevalence of sexual disorders in women with breast cancer was 76.9% (Table 3).

Table 4 shows the distribution of physical and psychological causes of the disorders found in the women.

The sexual disorders found were decreased libido in 53.8% of the women; decreased sexual arousal in 56.4%; insufficient lubrication in 59.0%; difficulties in reaching orgasm in 66.7%; dyspareunia in 28.2%.

Forty-three point six percent (43.6%) of the patients did not feel satisfied with their sexuality.

Decreased desire, sexual satisfaction, decreased arousal, pain on penetration, insufficient lubrication, and difficulty reaching orgasm are represented in Table 5.

Variables	n	%
Age [1] (in years)		
[18-24]	14	4,5
[25-34]	68	21,8
[35-44]	87	27,9
[45-65]	143	45,8
Marital status		
Single	66	21,1
In couple	86	27,6
Married	160	51,3
Level of education		
Primary	69	22,1
Secondary	168	53,8
University	75	24,1
Religion		
Catholic	142	45,5
Revival church	67	21,5
Protestant	41	13,1
Muslim	27	8,7
Other [2]	35	11,2
Profession		
Paid professional activity	84	26,92
No paid activity	228	73,08
Total	312	100,0

(1) :median 41,5 years [q1= 18 q3= 65]

(2): atheist, animist, Jehova's witness, brahmanist

Table 2: Distribution of women according to socio-demographic characteristics

	n	%
Normal	72	23,1
Disorder	240	76,9
Total	312	100,0

Table 3: Prevalence of sexual disorders among women with breast cancer

Causes	n	%
Secondary sexuality	133	55,4
Not my age	28	11,7
Decreased self-esteem	22	9,2
Asthenia	19	7,9
Physical pain	18	7,5
Spouse's refusal	15	6,2
Fear of contaminating	5	2,1
Total	240	100,0

Table 4: Distribution of physical and psychological causes of disorders found in women

Type of treatment	Orgasm	Lubrication	Pain	Excitement	Satisfaction	Desire	Total
Chemo-surgery	64	51	63	45	89	85	397
Non-specific	63	66	54	89	58	64	394
Surgery	42	42	50	38	37	66	275
Chemotherapy	38	39	40	37	32	16	202
Chemo-radiotherapy	28	34	32	30	23	9	156
Surgery-radiotherapy	5	8	1	1	1	-	16
Total	240	240	240	240	240	240	1440

Orgasm: reaching orgasm **Lubrification:** insufficient lubrification of the vagina
Pain: pain on penetration **Excitation**: decreased excitation
Satisfaction: decreased arousal **Desire**: decreased desire

Table 5: Distribution of women according to treatment received and sexual disorders

Discussion

The cross-sectional nature of this study was beneficial in terms of speed and ease of data collection and ensured optimal quality in the acquisition of results, as the collection of information was contemporaneous with the event to be studied, which in our case is sexual dysfunction in women with breast cancer.

The length of the period was defined by the need to obtain a statistically significant sample.

Our study allowed for self-selection bias, as participation in the study was voluntary. Some women were very reluctant when the work was explained to them, while others withdrew their consent after giving it beforehand. Our sample size did not represent all women with breast cancer followed in the medical oncology department during our study.

Sociodemographic Characteristics

Our study described a profile of women aged 35-65 years (73.7%), with a median age of 41 years, in couples (78.9), with a secondary level of education (53.8), not working (73.1) and of Catholic religion (45.5%).

This profile was similar to that of Ellouz et al in 2017 in Tunisia [5], and Errihani et al in 2008 in Morocco [6]. The only difference with the work of Ellouz and Errihani was the religious affiliation, as their patients were all Muslims.

Prevalence of Sexual Disorders

We found 76.9% sexual dysfunction in our study population. Data from the literature are consistent with our result.

Male et al in 2016 in Canada [7] stated that women with breast cancer had more sexual dysfunction compared to healthy women.

This result also appeared to be consistent with that obtained in a Tunisian study by Ellouz et al in 2017 [5] who reported 75% sexual dysfunction in women with breast cancer.
However, Leila et al in 2016 in southern Tunisia [8] reported sexual dysfunction in 53.2% of women in remission from breast cancer. This difference could be explained by the use of the European Organization for Research and Treatment of Cancer (EORT) quality of life scales. However, the scale used in this study does not explore all the areas of sexuality.

Zaied et al in 2013 in Monastir, Tunisia [9] reported 18% sexual dysfunction in women with breast cancer, this difference could be explained by the fact that the alteration of sexuality in our study population, where 95.9% of the women were followed up for a period ranging from 2 months to 3 years, was more severe than that observed in Zaied's study, where 96% of the women were followed up for up to 10 years [9]. Indeed, sexual dysfunction is usually observed just after the diagnosis of breast cancer and after treatment [10].

Sexual Dysfunction

The improvement of the life prognosis of cancer patients is the result of the use of several therapeutic means, all of which can alter the quality of life and sexuality of patients, in the short or long term. These treatments include surgery, chemotherapy, radiotherapy, hormone therapy and, more recently, targeted therapies [9]. Sexual dysfunction is one of the complications of treatment [11].

Almost 58.8% of women reported no sexual activity in the last 4 weeks following the survey. Chronic diseases in general and cancer in particular affect self-esteem, which may be responsible for the avoidance of sexual intercourse [12].

In interviews with our patients, the main complaints expressed by them included low self-esteem (35.5%), physical asthenia (27.5%), and they most often stated that sexuality was secondary (29.4%). These reasons could be at the origin of the disgust of the sexual act, thus of the absence of sexual intercourse for more than half of the patients in our study.

A decrease in libido was noted in 53.8% of women with breast cancer, a decrease in sexual arousal in 56.4%, insufficient lubrication in 59.0%, difficulty in reaching orgasm in 66.7% and dyspareunia in 28.2%. Thus, 43.6% of our patients did not feel satisfied with their sexuality. These observations were similar to those of other studies by Zaied et al [9], Ouabhi et al in 2017 in Morocco [13], Alacacioglu et al [14], Shandiz et al [15], Castelo et al [16], Ellouz et al [5] who reported a decrease in libido, a decrease in arousal, vaginal lubrication, dyspareunia, difficulty in reaching orgasm, dissatisfaction with sexual life in general in respectively 56%, 60%, 53%, 59%, 43%, 39%.

Our results could be explained by some of our observations, such as the fact that some patients complained about pain in their scars, or that their bodies had changed (lowered self-esteem). Some said that sexuality was secondary, so they had to concentrate on their disease, while older women reported that sexuality was not for them anymore; this reflects the negative effects of cancer treatments, and the psychological consequences of the diagnosis, of the breast surgery (symbolic organ of femininity and sexuality).

Treatments Received

The most common therapeutic mean administered to patients, who recorded the highest number of sexual disorders, were the combination of surgery and chemotherapy (42.2%), followed by chemotherapy (16.7%), and surgery (16.7%). This could be explained by the fact that surgery, chemotherapy and the combination of surgery and chemotherapy are responsible of physical (pain, aesthetic

damage, dysfunction) and psychological (asthenia, rejection by the spouse, lowered self-esteem, secondary sexuality) sequelae that were identified during the interviews with the patients during the survey.

Conclusion

Breast cancer represents a major public health issue both in developed countries and in low-income countries, as it is the case in Congo for example, where it represents 30.1% of hospitalizations in 2013 in women (Brazzaville). Sexual dysfunction is common among Brazzaville women with breast cancer. The prevalence seems to be higher after the diagnosis of the disease and during treatment. They may be iatrogenic or psychological in origin and depend on the dynamics of the couple's relationship. Awareness training on the importance of addressing sexuality among breast cancer patients should be considered, as well as the sharing in groups among them, given the lack of communication between clinicians and patients regarding sexuality issues.

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