

Bladder Cancer: A Focus on Sexuality

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Background: A bladder cancer diagnosis and the effects of treatment can have a significant impact on a patient's physical, emotional, and psychological well-being. Because healthcare providers tend to focus on these aspects of care, a patient's concerns with changes regarding sexual health are often overlooked.

Objectives: The purpose of this article is to provide oncology nurses with an overview of causes of and treatment for sexual dysfunction as it relates to patients with bladder cancer.

Methods: Data were extracted using key words and phrases such as *bladder cancer, cystoscopy, cystectomy, pelvic exenteration, and sexual dysfunction.*

Findings: Oncology nurses are ideal healthcare providers to assess the sexual health concerns of patients with bladder cancer. Oncology nurses can be valuable resources for patients by giving them permission to discuss sexual health, educating them and their partners about potential implications of treatment on sexuality, reviewing treatment options, and facilitating referrals to other providers who specialize in treating sexual dysfunction.

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Bladder cancer is the sixth most common cancer diagnosed in the United States (American Cancer Society, 2015a). Risk factors include cigarette smoking, exposures (e.g., aniline dye, cyclophosphamide, textiles, pelvic radiation), chronic cystitis, and genetic mutations (Baney, 2009). Signs and symptoms of bladder cancer include painless hematuria; irritative urinary symptoms including frequency, urgency, and dysuria; and, in advanced stage, pain from metastatic disease. Screening guidelines for bladder cancer do not exist because evidence is inadequate to determine whether screening for bladder cancer has an impact on mortality (National Cancer Institute, 2013).

Treatment varies widely among the stages of bladder cancer. Treatment of nonmuscle invasive bladder cancer (NMIBC) (stage CIS-T1) may include one or more transurethral resections of the bladder tumor (TURBT), instillation of intravesical therapy, and a strict follow-up schedule with evaluation for recurrence using local cystoscopy. Patients with muscle invasive bladder cancer (MIBC) (stages T2–T4a) may undergo neoadjuvant systemic chemotherapy, cystectomy, adjuvant chemotherapy or trimodal therapy with TURBT, chemotherapy, and radiation therapy.

Many patients with bladder cancer receive treatment that may temporarily or permanently cause some degree of sexual

dysfunction. For example, during a cystectomy, men may have a prostatectomy and women may undergo a hysterectomy; prostatectomies and hysterectomies have well-studied negative impacts on sexual functioning (Bober & Varela, 2012). Sexual dysfunction has been studied and reported in cancer literature but remains one of the least-addressed aspects of cancer care. Unlike other treatment-related side effects, sexual dysfunction is less likely to resolve with time (Schover, 2005). Throughout the literature, an emphasis is placed on the relationship between cancer treatment and the impact of treatment on sexual function, and many studies limit the scope of sexuality to fertility, contraception, menopause, erectile function, or the capacity for intercourse (Hordern, 2008). The terms *intimacy* and *sexuality* often are used interchangeably when discussing sexual health and sometimes used as blanket terms to describe connectivity between behavior, activity, partnership, function, and attitude (Lindau, Laumann, Levinson, & Waite, 2003). The World Health Organization (2006) offers a patient-centered definition of sexuality. Intimacy infrequently is defined as a separate entity to sexuality but has been described as the sharing and closeness between partners, encompassing touch and intimate communication (Hordern, 2008).