SEXUALITY AND CANCER
# Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>About <em>Sexuality and cancer</em></td>
<td>3</td>
</tr>
<tr>
<td>Talking about sex and your sexual needs</td>
<td>5</td>
</tr>
<tr>
<td>Sexual organs and responses</td>
<td>9</td>
</tr>
<tr>
<td>Effects of cancer on sexuality</td>
<td>16</td>
</tr>
<tr>
<td>Effects of surgery on sexuality</td>
<td>18</td>
</tr>
<tr>
<td>Effects of radiotherapy on sexuality</td>
<td>33</td>
</tr>
<tr>
<td>Effects of chemotherapy on sexuality</td>
<td>39</td>
</tr>
<tr>
<td>Effects of hormonal therapy on sexuality</td>
<td>44</td>
</tr>
<tr>
<td>Infertility</td>
<td>46</td>
</tr>
<tr>
<td>Coping with sexual difficulties</td>
<td>50</td>
</tr>
<tr>
<td>Your feelings</td>
<td>64</td>
</tr>
<tr>
<td>Roles and relationships</td>
<td>67</td>
</tr>
<tr>
<td>Healthy sexuality</td>
<td>69</td>
</tr>
<tr>
<td>Common questions about sexuality and cancer</td>
<td>74</td>
</tr>
<tr>
<td>How we can help you</td>
<td>79</td>
</tr>
<tr>
<td>Other useful organisations</td>
<td>83</td>
</tr>
<tr>
<td>Further resources</td>
<td>89</td>
</tr>
<tr>
<td>Questions you might like to ask your doctor or nurse</td>
<td>93</td>
</tr>
</tbody>
</table>
Sexuality and cancer
About Sexuality and cancer

Cancer and its treatment can have an impact on your sexuality, sex life and relationships. Even if the changes are temporary, there may be many questions that you would like answered to help you understand what’s happening.

This booklet explains the effects that cancer and its treatment can have and also discusses ways of dealing with these effects. Of course, such a small booklet can cover only the most obvious issues. But we hope it will help you understand more about sexuality so that you’re able to talk to your health professionals about issues that relate directly to you and your situation.

This information has been written to be inclusive of all sexual orientations, whether you have a partner, are between partners or have chosen to be single.

We can’t advise you about your individual situation, because this advice can only come from the people looking after you, who are familiar with your full medical history. It’s important that your needs are individually assessed so that you can get the right help and, if necessary, be referred to the best people to help and support you, and your partner if you have one.

Sexuality is the feelings and characteristics that make up your sexual identity. It’s about who you are and how you feel as a man or woman. Sexuality is a very personal matter and means different things to different people.
Sexual attitudes and behaviour vary enormously from person to person, and they’re influenced by our experiences and upbringing, our genetic make-up, our cultural and religious beliefs and by our hormones. Our sexual behaviour can change due to circumstances and it can vary at different times, in different places and in different situations.

When you’re diagnosed with cancer, or when someone close to you is, sexuality and a sex life may be far from your mind. You may worry that you’ll never feel confident or ‘sexy’ again. But cancer need not mean the end of your sex life.

It may be useful when reading this booklet to remember that you’re an individual. When considering sexuality it’s important to focus on your own needs, wishes and desires. You don’t need to worry about what’s considered ‘normal’, as there’s a huge range of different sexual tastes. Your sexuality isn’t fixed – you can change your mind, find new things pleasurable and communicate in new ways. You can aim to feel good about who you are, and how you choose to share that with others.

At the end of this booklet you’ll find some useful addresses and websites (pages see 83–92). There’s also a page to fill in with your questions for your doctor or nurse (see page 93).
Talking about sex and your sexual needs

Our sex lives are usually private and not openly discussed with strangers. Many people find it difficult to talk about very personal and intimate issues. Because of this, you may feel that talking about sex will be embarrassing for you, your partner (if you have one) and any healthcare professionals you talk to. This doesn’t have to be the case. Sex is an important part of most people’s lives. It brings pleasure and closeness, and helps us define who we are. So even if you think it will be embarrassing or difficult, it’s important to try to talk about any sexual problems the cancer or its treatment are causing. There are things that can help with most problems, but you may never find out about them if you keep the issues to yourself.

If you’re lesbian, gay or bisexual you may find it more difficult to discuss your sex life with strangers or healthcare professionals. You may not be comfortable talking about your sexuality because you aren’t ‘out’ to everyone, or you may fear that people you don’t know well will be prejudiced towards you.

Some people feel that because of their religious, cultural or personal beliefs, it’s wrong to discuss their sexual needs with someone else. It’s important to find someone who you feel comfortable talking to and who will respect your beliefs.

If you feel uncomfortable talking to your doctor or nurses, for whatever reason, you could contact one of the organisations listed on pages 83–89 for support and advice. Many of these have confidential helplines.
It can be difficult to find the right words to use, and this can often put people off starting a conversation about sexuality. When talking about sexual areas of our bodies, we sometimes use slang words and unclear expressions. This can sometimes lead to confusion and misunderstanding. The healthcare professionals looking after you will be able to talk to you using the words and expressions you’re used to. They will help you find a common language and make sure you’re both talking about the same things so that you get the right help and support that you need.

Embarrassment can make us feel awkward and stop us saying what we want to. One way to reduce this might be to write down all your questions in advance. You could then show the list to someone who may be able to give you answers. You could use the form on page 93 to do this.

**Support**

It can sometimes be difficult to talk to a partner about sexual problems. You may feel embarrassed and not want to upset them. Your doctor or nurse, or the organisations listed on pages 83–89, can give you support and help with discussing these difficult issues.

Although it can often be difficult to bring up the subject of sexuality when you talk to your doctor or specialist nurse, most healthcare professionals are used to dealing with this subject. They should be able to answer your questions and help you get support, so try not to feel too embarrassed.

Before you see the doctor or nurse, it might help to think about how you could bring up the subject. You could practise a couple of things to say until you feel comfortable saying them.
Healthcare professionals may not think to ask you whether the cancer or its treatment are affecting your sexuality. However, they will be happy to help, and they can refer you for counselling or specialist treatment if they can’t answer your questions.

If you don’t want to talk to anyone face to face, there are many confidential helplines with staff who can help you. Sometimes the anonymity of a helpline can help you to talk about things you find difficult to discuss in person. Sexuality is an important part of many people’s lives and it can be very reassuring to discuss any problems that you have.

Our experienced cancer information specialists can also provide information. They will talk to you confidentially and listen to your concerns. Call us free on 0808 808 00 00, Monday–Friday, 9am–8pm.

**Sex and relationship therapy**

People are sometimes concerned about seeking help from a psychological therapist. They worry that they will be labelled in some way. Asking for help with a sexual problem can be even more difficult because they think they will be thought of as someone who’s ‘obsessed with sex’. It’s important to remember that sex is a normal part of most people’s lives and that asking for help with a sexual problem is no different to asking for help with any other health concern.

Some people think that all sexual problems are physical and that talking about how they’re feeling won’t help. Although many medical conditions can affect our sex lives, this isn’t always the case. Sex therapy can also help you adjust to any physical
changes and help you explore different ways of getting sexual satisfaction.

The therapist will do an assessment of the problem by asking lots of questions and by getting you to explain what’s wrong. If there are any questions you don’t feel comfortable with, you don’t have to answer them. It can sometimes take a couple of sessions of therapy before you feel happy enough to openly talk about your feelings and concerns. Unless you have a physical problem, the therapist is unlikely to ask you to take your clothes off and won’t need to examine your body.

A sex therapist can’t fix all your problems, but will help you, and your partner if you have one, explore the issues and work out ways for you to get what you want. The therapist may suggest some exercises to help you overcome the problem – you don’t have to follow their advice if you don’t want to or if you feel uncomfortable.

Some sex and relationship therapists also have medical or nursing qualifications. If you have a physical problem that’s affecting your sex life, they’ll be able to give you advice about it. If not, they’ll refer you to your GP or specialist.

Like all counselling and therapy, sex and relationship therapy is confidential. The therapist won’t discuss your sessions with anyone else unless they’re concerned that there’s a risk you might harm yourself or someone else.

Your cancer doctor, specialist nurse or GP can refer you to a sex and relationship therapist. You can also find a therapist privately – see the organisations listed on pages 83–89.
Sexual organs and responses

In order to understand any physical changes that occur due to your cancer or its treatment, it may be helpful to be reminded of the sexually sensitive areas of your body and how they respond to stimulation.

Women

A woman’s sex organs are mostly inside her body. This includes the uterus (womb), the cervix (neck of the womb), the fallopian tubes and the ovaries.
Outside a woman’s body are the outer lips of the vagina, also known as the labia majora. When parted, these show the thinner, inner lips – the labia minora. These join at the front to cover the clitoris with a hood. The clitoris is usually sensitive to touch. The head of the clitoris, when not aroused, is about the size of a pea. All together, these form the vulva. Just beneath this, towards the vaginal opening, is the outlet for urine (the urethra). Further back still is the vagina itself. Behind the vagina is an area of skin called the perineum. Beyond that is the anus (opening to the back passage).
Other sexual areas of the female body include the breasts and nipples, which change in hardness and sensitivity when touched. Women also have other sensitive areas on their bodies that respond to direct touch, such as the nape of the neck, the backs of the knees, the buttocks and the inner thighs. The sensitivity of these areas, known as erogenous zones, varies from woman to woman.

**Men**

In a man, the sexual organs are mostly outside the body (see the diagram on the next page). This includes the penis and the testicles (testes or balls). The end of the penis is covered by the foreskin, unless the man has had it removed by circumcision. The ridge on the underside of the head, called the frenulum, is usually the most sensitive part of a man’s penis. At the very top of the penis is a slit that opens to the urethra, which semen and urine pass through to leave the body.

At the base of the penis is a bag formed by wrinkly skin called the scrotum. Inside the scrotum are the testicles. These produce sperm, which are then passed through tubes (known as vas deferens), to mix with other fluids to make semen.

The rest of a man’s sex organs are inside his body (see the diagram on the next page). The prostate gland sits deep in the pelvis and surrounds the first part of urinary tube (urethra), as it leaves the bladder. The prostate gland produces a fluid that mixes with the sperm to form semen. It also helps create the intense sensations a man feels during an orgasm.

The penis, testicles and anus are erogenous zones. A man’s chest and nipples can also be sensitive, and his body may have
other erogenous zones. The sensitivity of these areas will vary from man to man.

**Stages of sexual arousal**

Sexual desire, also known as libido, is the name for interest in sex. Everyone’s desire for sex is different. It can vary between men and women, and according to things such as age, events that happen in your life, your state of mind and changes in your body. For example, many people find their desire for sex reduces
with increasing age or if they are stressed, tired or unhappy. Most women also find their desire changes throughout the menstrual cycle, when they are pregnant or breast-feeding, and after the menopause. Feelings and relationships can also greatly influence the desire for sex in many people.

**Excitement or arousal** is the awakening of sexual feelings, when we feel ‘turned on’ and ready for sex. These feelings can be produced by simply seeing someone we’re attracted to, touching or being touched by a lover, thinking about sex, or having our sexual areas touched. Arousal may or may not lead to orgasm.

**Plateau** is the phase where the body maintains a heightened state of arousal. The body is very sensitive during this phase.

**Orgasm** is the sexual climax – the feelings of intense pleasure that occur as areas of the body go into a series of rhythmic contractions. Some women can feel their uterus contract during orgasm. Men ejaculate semen, unless they have had surgery (vasectomy) that affects the production of sperm.

**Resolution** is the phase that follows sexual arousal and orgasm. This is when the sexual changes in the body go back to normal. Men can’t usually be sexually excited again for a while. However, many women can be aroused to orgasm again straight away. As people get older they tend to lose the ability to become sexually excited repeatedly.
Sexuality and cancer
Emotional effects on desire and sex drive

Desire and sex drive make us act in a certain way when we’re sexually aroused. Desire isn’t fixed – it changes over the years. Many things can reduce sexual desire, including:

• tiredness
• stress
• mood changes (such as anxiety)
• changes in contraception methods
• feeling unhappy about your body
• relationship problems
• traumatic sexual experiences in the past
• excessive drug or alcohol use
• boredom with your sexual routine.

Desire for sex is greatly affected by your state of mind. If you’re depressed, anxious or afraid about your cancer, its treatment or your relationship, you may find it more difficult to be sexually aroused.

Physical effects on sexual response

For the phases of sexual arousal to occur, certain systems in the body need to be working normally.

Physical arousal, plateau and orgasm will only happen if the body has a good blood supply, if the nerves to the pelvic area are working well and if the balance of hormones in the body is right.
Effects of cancer on sexuality

In the following sections we describe some of the possible effects that cancer and its treatment can have on sexuality. In later sections (starting on page 50), we suggest some ways of overcoming these problems.

It’s very difficult to accurately predict how cancer and its treatment will affect you. For many people, the changes in their sexuality will be temporary. However, some people may need to adapt to permanent changes and develop new ways of giving and receiving sexual pleasure. Having cancer doesn’t mean your sexuality will be destroyed. With support and clear communication, you will often still be able to enjoy a fulfilling sex life.

There are four main ways that cancer or its treatment can affect your sexuality. It can affect your:

- physical ability to give and receive sexual pleasure
- thoughts and feelings about your body (body image)
- emotions – such as fear, sadness, anger and joy
- roles and relationships.

The links between these four areas are important. If there’s a problem in one of them, it may have an impact on another.

When someone becomes ill, it can affect their ability to feel good about themselves sexually, or their physical ability to give and receive sexual pleasure. If this has happened to you or your partner, it might be helpful to understand that some changes will only be temporary. Even if the changes are
long-lasting or permanent, you can find ways to adapt sexual techniques that are no longer possible or discover new ones.

You can learn to feel good about yourself sexually despite the cancer and the possible side effects of the treatments.

**Tiredness**

Many people with cancer say that they feel ‘washed out’ and almost completely without energy for many months or even years. This may be to do with the cancer itself, or sometimes the treatment. This tiredness can make people lose interest in sex during and after cancer treatment.

You may find it helpful to read our booklet *Coping with fatigue*.

**Mismatch in sex drive**

In many relationships, one partner is more interested in sex than the other. Cancer can exaggerate this. If one partner has a change in their level of desire, this can be upsetting when there’s the added complication of cancer.
Effects of surgery on sexuality

Any type of surgery can affect your sexuality and sex life, even if it doesn’t involve your sex organs. However, cancer surgery that directly affects the genitals and other sexual and reproductive areas of the body may cause quite noticeable changes. Your surgeon and specialist nurse will talk to you about the surgery and how it might affect you.

Effects of surgery on women

Hysterectomy
This is the removal of the uterus (womb) and cervix. There are different types of hysterectomy, which affect sexual function in different ways. With a radical (Wertheim’s) hysterectomy, once the womb is removed the surgeon stitches up the top end of the vagina. This makes it approximately a third shorter than it was before. Sometimes one or both ovaries are also removed. A simple hysterectomy is unlikely to affect the length of the vagina.

Having a slightly shorter vagina is usually no problem at all. Early on however, while you’re still healing, you may prefer not to have penetrative sex or to be very gentle, controlling the depth of penetration. Try different positions to find out which are most comfortable.

A hysterectomy may affect a woman’s experience of orgasm. This happens because once the womb is removed there are no longer any uterine contractions, and because some of the nerves leading to the clitoris can be affected by the surgery. Most women find that they are still able to have an orgasm, but the sensation may be different from before the operation.
Effects of surgery on sexuality

Some surgeons specialise in doing surgery that is less likely to damage the nerves. This is known as **nerve-sparing surgery**.

Unfortunately, women who have a hysterectomy will be unable to get pregnant. This can be very difficult to cope with. The feelings and emotions you may have are discussed on pages 46–47.

Other methods of having a baby may still be possible. See pages 47–49 for more information.

**Trachelectomy**
For some women with very early cancer of the cervix, it may be possible to have a radical trachelectomy rather than a hysterectomy. In this type of surgery, the cervix, the tissues next to the cervix and the upper part of the vagina are removed. The rest of the womb is left in place, so it may still be possible to get pregnant.

After a trachelectomy the vagina will be slightly shorter than before. This is not normally a problem for most women, but if you find penetration uncomfortable, try different positions where you can control the depth of penetration.

**Oophorectomy**
This is the name of the operation where an ovary is removed. The ovaries produce most of the oestrogen in the body. If both ovaries are removed (a bilateral oophorectomy), you’ll go into a menopause and may have menopausal symptoms such as a dry vagina (see page 52) and a lowered sex drive (see page 50).

Removing both the ovaries is sometimes known as a surgical menopause. It’s likely that you’ll notice menopausal symptoms occurring more quickly than the gradual onset that occurs with a natural menopause. For many women, HRT (hormone
replacement therapy) can return the body’s systems to nearly normal. You may find it helpful to talk all this through with your doctor or specialist nurse.

**Radical cystectomy**
A cystectomy is removal of the bladder. During a radical cystectomy, the surgeon may also remove the womb, the ovaries, part of the vagina, the tube that drains urine from the bladder (urethra) and the fallopian tubes. The surgeon will explain this to you before the operation.

This operation may include a reconstruction of the vagina, which often means that the vagina will be shorter than before. This can make penetrative sex painful or difficult, and can also affect the ability of some women to have an orgasm.

If the urethra is removed, the end where it opens outside the body is often also removed. This can affect the blood supply to the clitoris, making it less responsive to arousal. The end of the urethra doesn’t always have to be removed, and your surgeon can advise you about this. Because the womb is removed during this operation, you’ll be unable to get pregnant, which can be very difficult to cope with.

Removing the ovaries will cause an early menopause and menopausal symptoms in women who haven’t already reached their natural menopause. There’s more information about this in the oophorectomy section on page 19.

When the bladder is removed, a ‘new’ bladder can often be made using part of your bowel. If it’s not possible to reconstruct the bladder, an opening is made in the wall of the abdomen (a stoma) so that urine can drain into a bag. Stomas are discussed in more detail on page 29.
Mastectomy and lumpectomy
Mastectomy is the removal of a breast. This operation creates a body change that can affect sexual arousal in many ways – particularly if you were previously aroused by having your breasts touched. Some women say the operation affects their image of themselves and makes them feel less womanly. Some women may find that they need a lot of time to talk through the feelings and emotions that a mastectomy can cause.

A lumpectomy removes just the breast cancer and an area of surrounding tissue – not the whole breast. It can still affect the way a woman feels about her body and may affect the sensations in the breast.

Abdomino-perineal resection
An abdomino-perineal (AP) resection is one of several different operations used to remove tumours of the rectum. During the operation, the anus, rectum and part of the lower end of the large bowel (sigmoid colon) are removed, and a stoma is formed so that bowel motions can drain into a bag. Stomas are discussed in more detail on page 29. Sometimes an AP resection may also involve the removal of the womb, ovaries and part of the vaginal wall.

After an AP resection, some women find that penetrative sex can be uncomfortable in some positions. This is because the rectum normally cushions the vagina and because you may have an altered vaginal shape. Trying different positions can help. It’s not recommended that stomas should be used for penetrative sex, but in some situations this may be possible. Your doctor or specialist nurse can discuss this with you further.

If your ovaries have been removed, you may experience menopausal symptoms that make sex difficult, such as a dry
vagina (see page 52) or lowered sex drive (see page 50). HRT may be possible for some women.

An AP resection will mean that women who previously had anal sex will no longer be able to, which can be difficult to accept. It may be possible to keep the rectum, although this will depend on the individual situation and can increase the risk of the cancer coming back. You may want to discuss this issue with your surgeon before surgery.

**Vulvectomy**
A vulvectomy is where part or all of the vulva (see page 10) is removed. This is a rare operation that’s sometimes necessary for women who have cancer (or melanoma) of the vulva. Removing the vulva will affect sexual sensations, especially if the clitoris has been removed.

**Pelvic exenteration**
This is a major and rare operation that’s sometimes used to treat advanced pelvic cancers. During the operation, all the structures in the pelvis are removed. This can include the womb, cervix, ovaries, vagina, bladder and rectum. If the rectum and bladder are removed, two stomas may be formed. Stomas are discussed in more detail on page 29. A ‘new’ vagina may also be reconstructed, which may be shorter and narrower than before.

A pelvic exenteration can change the way that women have sex, alter their sensations and cause problems with body image. The operation varies from woman to woman, and the effects it has on sexuality will also vary. Your surgeon and specialist nurse will advise you about the extent of the operation needed and how it may affect you sexually.
Effects of surgery on men

Prostatectomy
A radical prostatectomy is the removal of the prostate gland (see pages 11–12). Many men who have a prostatectomy will have difficulty getting or keeping an erection (erectile dysfunction – ED) after the surgery. This is due to damage to the nerves that control an erection. This can be permanent and starts immediately after the surgery.

Long-term ED is more likely to occur in older men and in those who had difficulty getting an erection before the surgery. There are ways of dealing with ED, and these are discussed on pages 54–57. Some surgeons specialise in surgery that is less likely to damage the nerves and can reduce the risk of problems. This is known as nerve-sparing surgery. Another type of surgery for prostate cancer is called robotic surgery, which uses a special machine, called a da Vinci machine, to help with the operation. ED seems to be less common with this type of surgery, but it’s currently only available at a few centres in the UK.

After a prostatectomy no semen will be produced, and any sperm produced by the testicles are simply reabsorbed back into the body rather than being ejaculated. In men who can still have and maintain erections, it’s still possible to have an orgasm, but there will be no ejaculation. This is called a dry ejaculation or dry orgasm.

These changes will mean that it’s impossible to father a child using normal methods. It may still be possible to have children if you stored sperm before the operation (see page 49), or using a method called testicular sperm extraction (TESA), where a small sample of testicular tissue is removed to look for sperm.
If you’re infertile after a prostatectomy and wanted to have a child, this can be very upsetting. Some of the feelings and emotions that you may have are discussed on pages 46–47. Other methods of having a baby may still be possible – see page 49 for more information.

After a prostatectomy, some men may find that they leak small amounts of urine (incontinence). This is often temporary and can usually be managed very well with advice from a specialist nurse or continence adviser. Incontinence can cause embarrassment if you’re sexually active, especially if you have to wear pads or need a catheter (tube to drain urine). Urinary problems are discussed in more detail on pages 58–59.

**Cystectomy**
A cystectomy is the removal of the bladder. During a radical cystectomy, the surgeon will also remove the prostate gland. It’s very common for men to have nerve damage after this type of operation, which may make it impossible for them to get an erection. Sometimes the ability to get an erection returns with time. Nerve-sparing surgery may be possible, which can reduce the risk of erection problems. Because the prostate is also removed, men who have had a radical resection will also have dry ejaculations (see page 24).

When the bladder is removed, a ‘new’ bladder can often be made using part of your bowel. If it’s not possible to reconstruct the bladder, an opening is made in the wall of the abdomen (a stoma) so that urine can drain into a bag. Stomas are discussed in more detail on page 29.

**Abdomino-perineal resection**
An abdomino-perineal (AP) resection is one of several different operations used to remove tumours of the rectum. During the
operation, the anus, rectum and part of the lower end of the large bowel (the sigmoid colon) are removed, and a stoma is formed (see page 29). It can affect the nerves that control erections and ejaculation. Modern surgical procedures try not to damage the nerves in this part of the body but, even so, many men will have erection problems.

An AP resection will mean that men who previously had anal sex will no longer be able to. This can be very difficult to accept for some men. It may be possible to keep the rectum, although this will depend on the individual situation and can increase the risk of the cancer coming back. You may want to discuss this issue with your surgeon before surgery. It is not recommended that a stoma should be used for penetrative sex, although in some situations this may be possible. Your doctor or specialist nurse can discuss this with you further.

**Orchidectomy**

An orchidectomy is an operation where a testicle is removed:

**Removal of one testicle** In men with testicular cancer, usually only one testicle is removed. This won’t cause infertility and doesn’t usually affect sexual performance. Sometimes, however, men who develop testicular cancers may have testicles that aren’t working properly and are only producing fairly small amounts of male hormone (testosterone). In this situation, removing one testicle may mean that the other one can’t produce enough testosterone. This can cause problems such as a loss of interest in sex (reduced libido) or difficulty getting or keeping an erection (erectile dysfunction – ED). Low levels of testosterone may also make orgasms less intense.

Initially after the operation, sexual positions that apply pressure to the area should be avoided. Some men say that orgasms
feel different, and the normal contractions of the testicular sac (scrotum) at orgasm may feel uncomfortable. The amount of fluid ejaculated is usually less than before.

**Removal of both testicles** If both testicles are removed, for example as a treatment for prostate cancer, you will be infertile and you may be unable to have an erection due to a lack of testosterone. See page 46 for more information about infertility.

Hormone replacement therapy (HRT) can be used to replace some of the testosterone, which can help to improve libido and the ability to get erections. HRT can be given as tablets, injections, or patches and gels that are applied to the skin. You may find it helpful to talk all this through with your doctor or specialist nurse.

**Testicle replacement**
It’s common for a false testicle (prosthesis) to be inserted into the scrotum. This gives the appearance and feel of a normal testicle. However, although it looks normal, men may still feel differently about their body. Some men describe feeling less masculine, and need time to talk through this change.

**Retroperitoneal lymph node dissection**
Some men who have had testicular cancer will have an operation to remove the lymph nodes in the lower abdomen. This is done if the nodes are still enlarged after radiotherapy or chemotherapy. The operation, called a retroperitoneal lymph node dissection, can affect the nerves that control ejaculation of semen. This can cause the semen and sperm to flow back into the bladder (a retrograde ejaculation). Having retrograde ejaculations is harmless, although orgasms will feel different and you will no longer be able to father children. Before the
operation it may be possible to store sperm samples so that you can still father a child. Some men will recover their ability to ejaculate normally over the next few years and regain their fertility.

**Sperm storage is discussed in our leaflet Cancer treatment and fertility – information for men.**

A retroperitoneal lymph node dissection doesn’t stop a man getting an erection and having an orgasm, although the intensity of an orgasm may be weaker.

**Penectomy and penile reconstruction**

Surgery to remove the penis is called a penectomy, which may be partial (where part of the penis is removed) or total (where the whole penis is removed). The surgeon will try to remove as little of the penis as possible and may be able to reconstruct it if necessary, although the penis is likely to be smaller than before and may have scars.

Penile surgery can have a significant impact on a man’s body image and self-confidence.

After surgery, most men are able to have a fulfilling sex life. Unless you’ve had all of your penis removed, you should still be able to have erections and orgasms. If your whole penis has been removed, you will no longer be able to have penetrative sex or receive oral sex, so you’ll need to experiment to find new ways to have sex. The areas around your scrotum and testicles will still be sensitive and you may still be able to have orgasms. If you’ve had a penile reconstruction, you may be able to get an erection, but this will depend on the type of reconstructive surgery you’ve had.

Your surgeon or specialist nurse will discuss the surgery with you and answer any questions you have.
Effects of surgery on both men and women

Stoma
Sometimes surgery is used to create an opening in the abdominal wall (a stoma), due to bowel or bladder cancer, or advanced cervical or ovarian cancer. A stoma will allow for waste from the body (either urine or bowel motions) to drain into a bag that’s fixed over the stoma. In this situation there’s a high chance of permanent damage to the blood supply and the nerves in the genital area. This may cause men to have problems in getting and maintaining an erection. It’s not clear how this type of operation affects arousal and orgasm in women.

A stoma can make some sexual positions uncomfortable. It can also affect your self-confidence and the way you feel about your body (body image) – see pages 61–63. You should reassure your partner that sex will not harm the stoma.

Make sure that the bag fits well and doesn’t leak. It’s a good idea to empty the bag before sex, although this can sometimes affect spontaneity. Some foods can cause the bag to fill quickly, so avoid eating or drinking anything that usually causes you problems. You may also be able to plug the stoma or do a stoma washout so that a bag isn’t needed for a short time.

Stoma nurses can give advice and help with all the effects on sexuality that a stoma may cause. Information is also available from the Ileostomy and Internal Pouch Support Group or the Sexual Advice Association (see pages 85 and 87). It is not recommended that a stoma should be used for penetrative sex, although in some situations this may be possible. Your doctor or specialist nurse can discuss this with you further.
Laryngectomy
A laryngectomy is the removal of the voice box (larynx), which can change the way a person talks and breathes. Communication between couples is very important. Although it’s usually possible to speak after a laryngectomy using an aid or oesophageal speech, it can sometimes be difficult or distracting during sex. Oesophageal speech is a way of speaking that can be taught to people who have had their voice box removed.

It may help to discuss what you’d both like before starting sex, and to develop ways of signalling messages to each other.

Facial surgery
Surgery for head and neck cancers can sometimes leave scars and may be disfiguring. This can change the way a person feels about themselves and may cause low self-esteem. Surgery that involves the jaw or tongue may alter the way a person speaks, which can affect the way they communicate. Surgery may also affect the way a person kisses or gives oral sex. However, newer surgical techniques and advances in plastic surgery aim to minimise any lasting problems.

There are a number of organisations, such as Let’s Face It and Changing Faces, that can give advice and help to people trying to cope with a facial disfigurement. See pages 83 and 85 for details.

Limb amputation
Very occasionally, when treating some types of cancer such as primary bone cancer, it’s necessary to amputate the affected arm or leg. Advances in surgical techniques have meant that amputation is rarely needed as it’s often possible to remove just the affected part of the bone.
Effects of surgery on sexuality

If amputation is necessary, the limb will often be replaced with an artificial arm or leg (a prosthesis). Some people are happy to have sex wearing their prosthesis, which can help with positioning and movement. However, some people find that the straps used to secure the prosthesis are uncomfortable and get in the way. You can try different sexual positions, and pillows can be used to help with positioning and balance.

Some people have problems with pain that appears to come from the part of the body that has been amputated. This is known as phantom pain. Any type of pain can be distracting during sex and may reduce sexual desire. If you have problems with pain, your doctor can often prescribe effective painkillers.

**Removal of lymph nodes**
If lymph nodes have been removed as part of your treatment, this can cause swelling in a nearby area of the body. For example, when lymph nodes are removed from under the arm as part of treatment for breast cancer, the affected arm may swell. If lymph nodes are removed from the groin, this may cause swelling of the legs and pubic area. The swelling is called lymphoedema.

Lymphoedema can affect the way that you feel about your body and may make it difficult to use the affected part of the body. You may need to find sexual positions that don’t put weight on the area affected by lymphoedema.

Ways of reducing lymphoedema are described in our booklet *Understanding lymphoedema*.
Sexuality and cancer
Effects of radiotherapy on sexuality

Radiotherapy treats cancer by using high-energy rays (radiation) that destroy the cancer cells, while doing as little harm as possible to normal cells. It can either be given as external radiotherapy from outside the body using x-rays, or from within the body as internal radiotherapy.

Radiotherapy can cause side effects, such as fatigue (tiredness that doesn’t go away with rest) that can last for several weeks or months. In this situation sex may be one of the last things on your mind, or you just may be too tired to actually have sex.

Radiotherapy can also cause a skin reaction. The skin can be very sensitive in the groin, perineum and anal areas (see pages 9–12), and, in women, the vulva. If a skin reaction does occur, it can make sex difficult and painful.

Radiotherapy to the pelvic area can also cause other side effects, such as diarrhoea and nausea (feeling sick). Some people also get inflammation of the bladder (cystitis) or rectum (see pages 9–12), which can cause pain and bleeding. Some women may also have vaginal bleeding. These side effects can either make sex difficult or affect your desire to have sex. Most of these side effects are temporary, but very rarely they can be permanent. See pages 50–63 for ways to cope with some of these side effects.

A possible long-term side effect of radiotherapy is damage to the tiny blood vessels close to the surface of the skin. This will cause red spidery marks on the skin and is called
Sexuality and cancer

telangiectasia. These blood vessels can be delicate and are more likely to bleed. Telangiectasia may affect how you feel about the way you look, or make sexual contact difficult if the skin is fragile.

**Effects of radiotherapy on women**

In women, radiotherapy can affect sexual function when it’s given to the pelvic area for cancers of the anus, rectum, bladder, vagina, vulva, cervix and womb (endometrium). Women who receive radiotherapy as part of their treatment for leukaemia (total body irradiation) or lymphoma may also experience vaginal changes. After high-dose treatment with a stem cell or bone marrow transplant, some women may develop graft versus host disease (GVHD). This can cause the vaginal tissues to be affected, resulting in sexual difficulties.

**Pregnancy and radiotherapy**

Radiotherapy can cause damage to an unborn child. So if you haven’t yet had your menopause, you may be asked by the staff in the radiotherapy department to have a pregnancy test before you start your radiotherapy. You will need to use effective contraception throughout your radiotherapy treatment. You can discuss this with your doctor or specialist nurse.

If you’re already pregnant when your cancer is diagnosed and before your radiotherapy starts, it’s very important to discuss with your doctor the pros and cons of continuing with your pregnancy. It’s sometimes possible to delay starting radiotherapy until after the baby is born. This depends on the type of cancer you have, the extent of the disease, and how advanced your pregnancy is. It’s important to be fully aware of all the risks and alternatives before making any decisions.
As well as talking to your doctor about your pregnancy, you can also talk to our cancer information specialists on 0808 808 00 00.

**Hormonal changes**
Radiation to the pelvic area for cancer of the anus, rectum, bladder, endometrium, cervix, vagina or vulva, or for leukaemia or lymphoma, can affect the ovaries and reduce the production of female hormones. This is usually permanent but occasionally may be temporary for some women. The production of hormones gradually decreases over about three months. This will cause symptoms of the menopause, such as hot flushes, vaginal dryness and mood swings.

Until it’s confirmed that you have experienced the menopause (as a result of treatment), you may be advised to continue using contraception to avoid pregnancy.

Your doctor may be able to give you hormone replacement therapy (HRT), which can help reduce the impact of these changes. If you’ve had breast cancer or a hormone-sensitive gynaecological cancer, you may be advised not to take HRT. Some complementary therapies can help reduce menopausal symptoms. It may be helpful to discuss this with your doctor or specialist nurse, and we can send you a booklet about cancer and complementary therapies.

A woman who has already had her menopause will have far fewer hormonal changes than a woman whose ovaries were still working before the radiotherapy treatment.

**We can send you a fact sheet about coping with menopausal symptoms.**
Effects on the vagina
The vagina can be affected by radiotherapy to the pelvic area. It becomes sore and tender in the early stages and for a few weeks afterwards. Over time, this irritation may leave scarring. This makes the vagina narrower and less flexible (see page 53), and also reduces the production of lubrication that’s normally associated with sexual arousal. This loss of lubrication can lead to pain caused by friction and irritation of the tissues during sex.

You may find it helpful to read our booklet Pelvic radiotherapy in women: possible late effects.

Effects of radiotherapy on men
In men, radiotherapy may affect sexual function when it’s given to the pelvic area for cancers of the prostate, anus, rectum and bladder.

Erectile dysfunction (ED)
Radiotherapy to the pelvic area can reduce a man’s ability to have an erection. Up to 70% of men (7 in 10) have problems getting or keeping an erection after radiotherapy for prostate cancer. In affected men, their erections aren’t as strong as they were before the treatment, and this gradually gets worse over a year or two.

ED occurs because the blood vessels that supply blood to the penis become scarred and are unable to let enough blood through to fill the penis. Some men may get an erection but then lose it. Other men are unable to have an erection at all. Treatment with drugs such as those listed on pages 55–56 can help some men to get and maintain an erection after having radiotherapy.
Effects of radiotherapy on sexuality

Treatments that can help you overcome ED are discussed on pages 55–57. It’s thought that using these treatments soon after radiotherapy may help to prevent erectile difficulties in some men.

**Urinary problems**
Some men who have internal radiotherapy (brachytherapy) for prostate cancer develop problems passing urine. They may need a tube into the bladder to drain urine (a catheter), or they may have leakage of urine (incontinence). Often these problems are temporary, but they may be permanent for some men.

**Ejaculation problems**
In men who can still have and maintain erections, it’s very common to have dry ejaculations. When this happens, little or no semen is ejaculated at orgasm. This is not harmful but can worry you if you don’t expect it.

Some men feel a sharp pain as they ejaculate if they have recently had radiotherapy treatment. This is caused by radiation irritating the urethra (see pages 11–12). This problem usually disappears within a few weeks after the treatment has ended.

*We can send you a booklet about pelvic radiotherapy in men.*
Infertility

For both men and women, radiotherapy to the pelvic area will cause infertility (the inability to have children). In women the ovaries will stop making eggs, and in men the production of sperm will stop. These changes can’t be reversed and infertility will be permanent. If you wanted to have children, this can be very difficult to cope with.

Radiotherapy given to other parts of the body may also affect the sexual organs, and could also cause infertility.

See pages 47–49, where we discuss the options for dealing with infertility. We also have leaflets about cancer treatment and fertility in men and women that we can send you.

We talk about the feelings and emotions you may have about infertility on pages 46–47.

It’s important that you discuss the risk of infertility fully with your doctor or specialist nurse before you start treatment. If you have a partner they will probably want to join you for this discussion. Then you can both be aware of all the facts and have a chance to talk over your feelings and the options for the future.

You might find it useful to read our booklet Understanding radiotherapy.
Effects of chemotherapy on sexuality

Chemotherapy uses anti-cancer (cytotoxic) drugs to destroy cancer cells. Some of the side effects of chemotherapy – such as feeling sick, weakness, depression, tiredness and a lack of energy – can reduce your sex drive. However, many of these side effects can be reduced or stopped with medicines.

You might find it useful to read our booklet *Understanding chemotherapy*.

Once chemotherapy is over, your sex drive will usually come back in time. However, if the chemotherapy has made your hair fall out, if you’ve lost weight, or if you have a central line or PICC line, you may not feel very ‘sexy’. Some of the tablets given to prevent sickness can also cause a low sex drive. Once you stop taking these tablets, your sex drive should return.

Some chemotherapy drugs can affect the nerves in your hands and feet. This is called peripheral neuropathy. It can cause tingling or numbness, or a sensation of pins and needles and pain. If your hands are uncomfortable or numb, you may find some sexual contact or positions difficult. Peripheral neuropathy is usually temporary, but may be permanent.
**Effects of chemotherapy on women**

In women, chemotherapy can reduce the amount of hormones produced by the ovaries. You may notice changes to your periods, which can sometimes stop altogether. Despite this change, it’s important to talk to your doctor or specialist nurse about contraception, because it’s still possible to become pregnant, even with irregular menstrual cycles.

**You should use a reliable barrier method of contraception all through your treatment and for up to a year afterwards.**

**Tiredness**

Tiredness and the change in hormone levels may cause a lower sex drive, and reduce arousal during sex. Some of the medicines mentioned on pages 52–53 can help to increase sex drive and improve arousal. You can discuss this with your healthcare team.

**Symptoms of early menopause**

Because chemotherapy can reduce the amount of hormones produced by the ovaries, it can cause the symptoms of an early menopause, including hot flushes, irritability, sleep disturbances and vaginal dryness. Vaginal thrush (see page 54) is common in women having chemotherapy, especially if you’re taking steroids or powerful antibiotics to prevent infection. Your doctor can prescribe treatment for this.

**Pregnancy and chemotherapy**

If you’re pregnant before your cancer is diagnosed and your chemotherapy starts, it’s very important to discuss with your doctor the pros and cons of continuing with your pregnancy. It’s sometimes possible to delay starting chemotherapy until
Effects of chemotherapy on sexuality

after the baby is born. It depends on the type of cancer you have, the extent of the cancer, how advanced your pregnancy is and the particular type of chemotherapy you’ll be having.

You should talk to your doctor or nurse about your pregnancy and be sure that you’re fully aware of all the risks and alternatives before making any decisions. You can also talk to our cancer information nurse specialists on freephone 0808 808 00 00.

**Effects of chemotherapy on men**

Some men find that their sex drive falls while they’re having chemotherapy, due to tiredness and sometimes nausea. It will usually return to normal soon after the treatment is finished. Some types of chemotherapy reduce the amount of male hormone (testosterone) that’s produced, but this also usually goes back to normal in time.

A few chemotherapy drugs can damage the nerves (neurotoxicity), which may affect a man’s ability to get and keep an erection. Your doctor or nurse can tell you how likely this is to happen to you, based on the chemotherapy drugs you’re having. However, chemotherapy is unlikely to have any permanent effect.

**Contraception during chemotherapy**

Although chemotherapy can reduce fertility, it’s quite possible for a woman having chemotherapy to become pregnant during the treatment. Female partners of a man having chemotherapy can also become pregnant.

A new pregnancy should be avoided during chemotherapy (for both men and women), as there’s a risk that the drugs could harm the developing baby. For this reason, your doctor
and nurses will advise you to use a reliable method of contraception throughout your treatment and for up to a year afterwards. It’s usually best to use a barrier method of contraception (such as condoms or the cap), because the side effects of chemotherapy, such as sickness and diarrhoea, can make the contraceptive pill less effective.

**Infertility**

Unfortunately some chemotherapy treatments may cause infertility (the inability to have children) in both women and men. In women, the ovaries may stop making eggs. In men, chemotherapy may reduce the number of sperm produced or affect the sperm’s ability to reach and fertilise a woman’s egg during sex. In both men and women, infertility will depend on the drugs that are being used and may be temporary or permanent.

It’s important to discuss the risk of infertility fully with your doctor before you start treatment. If you have a partner they will probably want to join you for this discussion. Then you can both be aware of all the facts and have a chance to talk over your feelings and the options for the future.

We talk about the feelings and emotions you may have about infertility on pages 46–47.

**See pages 47–49 for options for dealing with infertility. We also have leaflets about cancer treatment and fertility in men and women that we can send you.**
Sexuality and cancer


**Effects of hormonal therapy on sexuality**

Some cancers are influenced by hormones naturally produced within the body, so treatment is given to change the hormone levels. Some hormonal therapy drugs are given as tablets, and some by injection.

**Effects of hormonal therapy on women**

Tamoxifen and anastrozole (Arimidex®) are commonly used hormonal therapy drugs, often given as part of the treatment for breast cancer. They can make some women have symptoms similar to those of the menopause. These can include vaginal soreness, dryness or discharge, shrinking of the vagina, and a reduced sex drive (see page 52–53). However, some women have very few side effects, or none at all.

There are many other hormonal therapies, and these often cause side effects that may affect your sex drive, such as tiredness or vaginal dryness.

A drug called goserelin (Zoladex®) is sometimes given to women who have not yet had their menopause. Zoladex® reduces the production of sex hormones by the ovaries, so periods stop and women have menopausal symptoms while they are taking this drug. Zoladex® can cause a reduction in sex drive. Usually Zoladex® is taken for two years and, once the drug is stopped, your sex drive will gradually return to normal. The other side effects will also disappear.
Hormonal therapy can affect a woman’s fertility. Periods may become irregular or stop completely. The effects are usually temporary and normal fertility will come back in the months after the therapy is stopped. However, some hormonal therapy treatments bring on a permanent menopause. Fertility is discussed in more detail on pages 46–49.

**Effects of hormonal therapy on men**

In men with prostate cancer, it can be helpful to lower testosterone levels. This may be done by giving tablets or injections, or by removing the testicles. We can send you a booklet about prostate cancer, which has more details about this.

These treatments may reduce your sex drive, and if and when you do feel like sex, you may not be able to get or keep an erection. You may also notice that you produce less semen, need to shave less often and have less muscle strength. These side effects will often disappear once treatment is finished.

Some men having hormonal therapy treatments may develop breast swelling and tenderness. A man whose testicles have been removed may feel less masculine. However, neither the operation nor hormonal therapy will make you feminine, as some men fear. If you feel it would help you, sometimes false testicles can be used to give the appearance and feel of normal testicles.

Hormonal therapy will affect a man’s fertility by reducing sex drive and making it difficult to get an erection. These effects usually disappear once the treatment has finished. If your testicles are removed you will be infertile. Fertility is discussed on pages 46–49.

**We have fact sheets on the commonly used hormonal therapy drugs.**
Infertility

Many people are devastated when they discover that the surgery, radiotherapy or chemotherapy treatment they need for their cancer will mean they can no longer have children. Infertility is very hard to come to terms with, especially if you were planning to have children in the future, or to have more children to complete your family. The sense of loss can be very painful and distressing. Sometimes it can feel as though you have actually lost a part of yourself. You may feel less feminine or less masculine because you can’t have children. Body changes, such as the menopause or inability to have an erection, may damage your self-confidence even more.

People’s reactions to the risk of infertility vary. Some people may come to terms with it quickly and feel that dealing with the cancer is more important. Others may seem to accept the news calmly when they start treatment, and find that the impact doesn’t hit them until the treatment is over and they are sorting out their lives again. There’s no right or wrong way to react.

Who can help?

You may want to discuss the risks and all your options with your nurse or doctor before you start treatment.

You may also need an opportunity to talk to a trained counsellor about any strong emotions that become too much for you. See pages 83–89 for details of helpful organisations.

If you have a partner, they will also need special consideration in any discussions about fertility and future plans. You may both need to speak to a professional counsellor or therapist.
specialising in fertility problems. They can hopefully help you come to terms with your situation.

Your doctor or specialist nurse may be able to refer you to a specialist, or you can be put in touch with one directly by contacting the organisations on pages 83–89. You can also call our cancer information specialists on 0808 808 00 00. They can discuss with you any problems you may have, and they can also help you find a counsellor who can offer you help and advice. All calls to our support line are made in confidence.

Possible ways of preserving fertility

It can sometimes be difficult to predict whether your fertility will be affected by cancer treatment, or whether it will return to normal when treatment is over. There are a number of things you may be advised to consider that can help you to get pregnant or father a child if cancer or its treatment have affected your ability to do this naturally. These need to be started before your treatment, so it’s important that you discuss the risk of infertility fully with your doctor or specialist nurse before you start. If you have a partner they will probably want to join you for this discussion. Then you can both be aware of all the facts and have a chance to talk over your feelings and the options for the future.

Possible ways of preserving a woman’s fertility

It may be possible to collect and store some of your eggs for later use. Collecting eggs takes about 3–4 weeks and involves stimulating your ovaries with hormones to produce more eggs than normal. The eggs are collected and then fertilised with sperm (from your partner if you have one, or from a donor), to form embryos. The embryos are then frozen. Because this process takes a number of weeks, it may not be suitable if
you have to start treatment straight away. Once your cancer treatment is finished and you’re ready to start thinking about having children, one or two embryos can be thawed and placed in your womb.

There’s a risk with some cancers – such as breast, ovarian and womb cancer – that the hormones used to stimulate the ovaries may also stimulate the cancer to grow. Any risks of fertility treatment will be discussed with you.

It’s possible to store unfertilised eggs, however if the eggs are not fertilised before they’re stored, the chance of a successful pregnancy will be low.

Before treatment it may be possible to remove small pieces of ovarian tissue that contain some eggs. These tissue samples are frozen and can be put back into the body at a later date. This way of preserving fertility is still at a very early stage of development and only a few pregnancies have been achieved using this method. Only a few hospitals in the UK are able to store samples. Your doctor or specialist nurse can discuss this with you.

Young women and teenage girls who have started their periods should be aware of any infertility risks of their treatment so that, if possible, they can store embryos, eggs or ovarian tissue.

You may be charged a fee to store your embryos or eggs, and also for any fertility treatment that you decide to have.

If you’ve had your womb removed (hysterectomy) or had radiotherapy directly to the womb, you will not be able to get pregnant. Some women may consider adoption or surrogacy, which is when another woman carries a baby
for you. Some women choose not to have fertility treatment, adoption or surrogacy and go on to enjoy life without children. Everyone is different.

**We have a leaflet about fertility and cancer treatment for women, which discuss the options for dealing with infertility.**

**Possible ways of preserving a man’s fertility**
If you haven’t completed your family before you need to start treatment, you may be able to save (bank) some of your sperm for later use. If this is possible, you’ll be asked to produce several sperm samples over a few weeks. These will then be frozen and stored so that they can be used later to try to fertilise an egg and make your partner pregnant. The pregnancy should then carry on as normal. You may be charged a fee to store your sperm, and also for any fertility treatment.

Young men and boys should also be aware of any infertility risks of their treatment so that, if possible, their sperm can be stored for later years.

If you’re permanently infertile after treatment and don’t have any sperm stored, you and your partner may want to think about using donated sperm. This can be a difficult decision, and you and your partner will be offered counselling and information about the implications.

**We have a booklet about fertility and cancer treatment for men, which discuss the options for dealing with infertility.**
Coping with sexual difficulties

If you don’t feel like sex

It’s important to let your partner know if you don’t feel interested in sex. It can help to explain how you feel, so that they don’t feel rejected. You can also suggest what you would be happy with, such as ‘I don’t want to have sex but I’d love to have a cuddle’.

If your partner is feeling frustrated it may be helpful for them to reduce the frustration through masturbation, either with you or alone.

If you have fatigue (continual tiredness that isn’t relieved by rest) and don’t have much energy, it might help to have sex in different ways. Less energetic positions, where your weight is well supported, can reduce strain. You may also prefer quicker sexual contact rather than longer sessions. These are things you can talk about together.

If the tension is building between you, you may find it helpful to get support from a counsellor or sex and relationship therapist (see pages 7–8) who specialises in offering help in these circumstances. See pages 83–89 for organisations that can help.

Pain during penetrative sex

Pain during penetrative sex can occur after pelvic surgery or radiotherapy to the area. It may also occur if you’re taking medicines that reduce the production of natural lubrication.
Pain can reduce sexual feelings and desire. Often, an experience of pain can lead to a fear of pain, which can in turn lead to tension. Tension can be distracting and stop you from achieving arousal, prevent lubrication and cause further pain.

There are many reasons for pain during sex. It’s important to let your partner know what’s painful so that you can explore other positions or ways of having sex. Often, the cause can be treated simply. If you have pain during sex, tell your doctor or nurse. They can examine you to find out why and suggest possible solutions.

If you have pain or are worried about pain, it may helpful if you:
• have sex after taking painkillers that have had a chance to work
• learn some relaxation techniques to use before having sex
• take control of the depth and speed of penetration
• try to ensure you and/or your partner are close to orgasm before penetration
• try different types of sexual contact, perhaps without penetration, that you don’t find painful
• use pillows and cushions to help you feel more comfortable and supported
• have sex side by side, to reduce body weight on a sore area.

We have a booklet called Controlling cancer pain that might help.
Vaginal problems

Surgery, chemotherapy, hormonal therapy, or radiotherapy to the pelvic area, may cause vaginal changes. These changes can include dryness, narrowing, shortening, ulcers and infection, and they may lead to pain during penetrative sex.

Vaginal dryness

This can be helped by a number of creams and gels that can be put directly into the vagina:

Replens MD® is a non-hormonal cream available from most chemists. It’s applied 2–3 times a week and works for about three days at a time. The cream binds to the vaginal wall and the water held within it reduces dryness and boosts the blood flow in the vagina.

Ovestin® and Ortho-gynest® are available on prescription from your doctor. They contain very small amounts of oestrogen and can be used as a cream or as a tablet that’s inserted into the vagina (pessary). The effect in the vagina is short-lasting. This product may not be appropriate for women who have a hormone-dependent cancer such as breast or endometrial cancer. It’s important to check with your specialist whether this would be a helpful product for you.

Vagifem®, also available on prescription, is a pessary that contains a small amount of oestrogen. It’s usually used daily for two weeks. A small research study has shown that Vagifem® can increase the amount of oestrogen circulating in the body. Because of this risk, Vagifem® may not be recommended for women who are taking aromatase inhibitors, such as anastrozole (Arimidex®), exemestane (Aromasin®), or letrozole (Femara®). Your specialist or
breast care nurse can give you further advice and information about this.

**Estring®** is a vaginal ring that’s worn for three months at a time. It slowly releases a small amount of oestrogen and may help to reduce vaginal dryness.

**Water-based lubricants** such as Senselle®, Astroglide®, Sylk®, Vielle® or the range produced by Durex® can help to increase moisture levels, making sex easier. They can be bought at a chemist or some supermarkets. Some women prefer to buy lubricants online or to use glycerine, which is cheap and not embarrassing to buy due to its many uses. Other women prefer to use organic, natural lubricants, such as Yes® or V Gel, which are available to buy online.

**Vaginal narrowing**
This may happen after radiotherapy to the pelvis and sometimes after surgery. After your treatment you’ll usually be advised to use vaginal dilators. These are plastic tubes of varying sizes that can be inserted by yourself or as part of joint sexual touch. The dilators prevent the two side-walls of the vagina sticking together, and are used with lubricants. They’re available from your doctor or specialist nurse at the hospital. An alternative way to prevent vaginal narrowing is to have regular penetrative sex or to use a dildo, vibrator or your or your partner’s lubricated fingers.

**Vaginal shortening**
After some types of pelvic surgery the vagina may be slightly shorter than before. While you’re still healing, you may prefer not to have penetrative sex or to be very gentle, controlling the depth of penetration. Try different positions to find out which ones are most comfortable for you.
**Vaginal ulceration**
Radiotherapy can also cause some areas of the vagina to become sore (vaginal ulcers), and these may bleed slightly. These can take weeks, or sometimes months, to heal. If you have any unusual bleeding after sex, you should tell your doctor and ask for an examination.

**Vaginal infection**
Some women find that they’re prone to getting vaginal thrush infections while having radiotherapy or chemotherapy. This is because there are changes in the acidity in the vaginal area, which allow the normal organisms in the vagina to overgrow. You may have thrush if you notice a creamy-white discharge, or an itchiness in the vaginal area that gets worse if you scratch. This is easily treated with medicines that can be bought from your chemist. If you’ve had sexual contact, your partner may also need to have treatment.

If you’re not affected by any of these vaginal side effects, then penetrative sex is perfectly safe during radiotherapy and chemotherapy. You should use effective contraception if there’s any risk that you could become pregnant. Your doctor or nurse can advise you on the best method for your situation.

**Loss of erection**
Many men have erection difficulties after cancer surgery or radiotherapy to the pelvic area, but the treatment may not be the only factor. Studies have found that men commonly have sexual problems after operations that have nothing to do with their genital area. Therefore your cancer operation may not be the cause of all your sexual difficulties. There may be psychological factors involved that you aren’t consciously aware of.
Some men find that they can have full erections with time. Even if they can’t, a half-erect penis can still be effective for having sex. The positioning for this may be better with the partner on top guiding the penis inside.

If you’ve had an operation that’s damaged the nerves that control erections, this need not be the end of your sex life. You don’t need to have a hard penis to give your partner pleasure. You may find it helpful to increase your range of sexual activity to include oral sex, mutual touching, increased masturbation or the use of sexual toys, such as a dildo or vibrator, to increase your pleasure and that of your partner.

**Medicines, injections, pumps and implants**

If you have problems getting or maintaining an erection, there are many options that can help you. Remember that these will give you a hard penis, but won’t necessarily increase your feelings of arousal. It’s worth trying different methods as some may work better than others.

**Sildenafil (Viagra®)** can help to produce an erection by increasing and sustaining the blood supply in the penis. It’s usually taken an hour before having sex, and then an erection will occur following direct sexual stimulation. Viagra should be prescribed by your GP. However, it may not be recommended for you if you have heart problems and/or are taking certain drugs, such as nitrates. It can cause side effects for some people, including heartburn, headaches, dizziness and visual changes. Another possible side effect is that occasionally the erection lasts for more than a couple of hours and there’s a danger of damage to the tissues of the penis.
Vardenafil (Levitra®) tablets are similar to Viagra®. They normally work within 25–60 minutes. The most common side effects are headaches and flushing of the face.

Tadalafil (Cialis®) tablets can also be used to help produce an erection. They can be taken up to 36 hours before having sex. Cialis® works by increasing the effects of one of the chemicals produced in the body during sexual arousal. It shouldn’t be taken by people who are taking certain heart medicines.

An injection of a drug such as alprostadil (Caverject®, Viridal®) or papaverine directly into the penis, using a small needle, causes an erection. The drug restricts blood flow and traps blood in the penis, causing an instant erection. Some experimentation is often needed at first to get the dose right. One of the possible side effects is that if too much of the drug is given, the erection stays for too long and there’s a danger of damaging the tissues of the penis. Some men who use these injections say that the head of the penis isn’t as hard as the shaft. The injections are prescribed by your GP. Usually this method is recommended to be only used once a week, which may not be enough for some men or their partners.

Pellets of alprostadil (MUSE®) can be inserted into the penis. The pellet melts into the surrounding area and, after some rubbing to distribute it into the nearby tissues, produces an erection. Some men find that the pellet is initially uncomfortable.

Vacuum pumps (sometimes called vacuum constriction devices) can also be used to produce an erection. The pump is a simple device with a hollow tube that you put your penis into. Pumps are either operated by hand or battery, and draw blood into the penis by creating a vacuum in the tube. Once the penis is full of blood, a rubber ring is placed around the base to keep
the erection. The vacuum is released and the pump removed. The erection can be maintained for about 30 minutes. Once you’ve finished having sex the ring is taken off and the blood flows normally again.

The advantage of vacuum pumps is that they don’t involve inserting anything into the penis, but it does take a couple of weeks or so to get used to using one. They’re particularly helpful for people who aren’t able to use other methods of getting an erection. Your penis may feel slightly colder than usual because the blood is not moving around. The ring should only be worn for half an hour at a time. The pump can be used as many times as you want, providing you allow half an hour between each use so that the blood can flow properly. The pumps are available on the NHS or can be bought online.

**Penile implants** are sometimes used after all other methods have been tried. There are two main types, which have to be inserted during an operation. The first type uses semi-rigid rods that keep the penis fairly rigid all the time, but allow it to be bent down when an erection isn’t needed. The second type involves a hydraulic device that, when activated, causes an erection. Your doctor can discuss penile implants with you.

If you think any of these options might be useful to you, your doctor or nurse can give more information or you can contact the organisations on pages 83–89.
Urinary problems

Urinary leaking (incontinence) or difficulty passing urine are occasional problems for both women and men after some cancer treatments. You may have to wear incontinence pads or have a urinary catheter, which may lead to feelings of embarrassment. You may feel unclean or unattractive and avoid intimate contact altogether.

Coping with incontinence

Although it may seem too embarrassing, it’s a good idea to discuss the incontinence with your sexual partner. Be honest with them – tell them that a little urine may leak during sex. You may want to let them know that urine is sterile and it won’t cause an infection for them. It can also help to have towels and tissues handy in case there’s any leakage. Maintaining good personal hygiene will help you feel more confident.

It’s a good idea to avoid drinking too many fluids for about an hour or so before you have sex, and to pass urine beforehand so that your bladder is as empty as possible. It’s sometimes possible to make sure that your bladder is empty by putting in a catheter, and your nurse or a continence adviser can discuss this with you. You may also want to have a shower or bath before having sex, which you can do alone or with your partner.

Some women find that penetrative sex makes the incontinence worse. If this happens you can explore other ways of getting sexual pleasure, such as foreplay, massaging and oral sex. Trying different sexual positions may also help.

After prostate surgery, some men find they lose a small amount of urine at the point of orgasm/climax. This is known as climacturia. If this loss of urine is distressing to you or your
partner, you may wish to wear a condom to contain the loss. Pelvic floor exercises may help you to increase urinary control, and a technique called bulbo-urethral massage can reduce the urine likely to be expelled in this way. Your specialist nurse or urology team can give you further information.

Your doctor or specialist nurse can give you advice on different ways of coping with incontinence. They can also refer you to a continence adviser for further support.

**If you have a catheter**
Sex is still possible if you have a urinary catheter in place. Your nurse or a continence adviser can discuss this with you. In some situations it may be possible to remove the catheter during sex, and the nurse or adviser can show you how to do this.

Women can tape the catheter out of the way on their leg or hip. It’s worth experimenting with different sexual positions to find ways that are more comfortable for you and that don’t put pressure on the catheter.

Men can fold the catheter back along the penis using surgical tape and cover it with a condom to keep it in place. Extra lubrication may be needed. To avoid the catheter getting blocked with semen, you may need to flush out the bladder after sex. Your nurse or a continence adviser can discuss this with you.

**Bowel problems**

Loose bowel motions (diarrhoea) and needing to open the bowels with very little or no warning (faecal incontinence) can sometimes be a side effect of cancer treatment, especially pelvic radiotherapy. These effects may be temporary but can
sometimes be permanent. Having problems with your bowels can have a huge impact on your life. It may make you feel less interested in sex but can also make you feel embarrassed and affect your confidence. You may feel unclean or unattractive and avoid intimate contact.

You can discuss any bowel problems with your doctor or specialist nurse, or with a dietitian. They may be able to reduce the side effects using a combination of medicines, dietary changes and exercises, and can help you cope with how the problems are making you feel. Other things you can do that may help include:

- being aware of which foods trigger the diarrhoea or make it worse, and avoiding them for several hours before you have sex
- emptying your bowels just before you have sex
- maintaining good personal hygiene, which will help boost your confidence
- burning scented candles, which may help if you are concerned about smells
- letting your partner know that you may have to rush to the toilet, and making sure that you can get there quickly and easily
- having tissues and towels handy during sex
- using an anal plug (available from the Bladder and Bowel Foundation – see page 83).
Changes in body image

Body image is the mental picture we have of our own appearance. This image is drawn from what our body actually looks like, and also from how we think we look. Throughout our lives, our body image is constantly changing. Our body image can be altered whether or not a cancer or its treatment causes changes to our appearance.

Changes in body image can cause feelings of distress that go far beyond the physical effects of a cancer and its treatment. When there’s been a change in body image that’s sudden and dramatic, you may feel abnormal. You may also have feelings of shame, embarrassment, inferiority and anger. When the change is a visible one, these feelings can be reinforced by the reactions of other people.

Some people adapt well to body changes caused by cancer and its treatment over time. However, others can become anxious, less confident or depressed. They can withdraw from relationships and from social activities they enjoy.

The effect on a person is not always related to the size, severity or visibility of the change. For example, a small, hidden scar can still affect a person’s mood, confidence and sexuality.

**We have a booklet about the effects of cancer and its treatment on body image.**
Hiding changes
If the change can be hidden under clothes, for example a colostomy or mastectomy, a fairly common reaction is to pretend that everything is normal. You might hide the change, avoid looking at it, and conceal it from others. However, avoidance can lead to increasing feelings of anxiety about the thought of someone finding out.

Changes such as having a stoma or having a breast removed are likely to cause a significant change in the way you feel about your body. If this is true for you, you could try having sex partly dressed or in your underwear, rather than completely naked. Changing the lighting level during sex can also help to build your confidence about how your body looks. It may help to lie on your side to prevent pressure on scars or stomas. Facing away from your partner, not towards, may also help.

Talking about your feelings around body image
It’s important to tell someone your fears, rather than hiding them and letting them grow into something bigger. The more you’re able to face the things you’ve been avoiding, the better. It might be important to spend some time thinking through your worst fears, and planning a way of managing them to help build your confidence.

If you’re the partner of someone who has changes in their real or perceived body image, it may also take you time to adjust to and accept the changes. You may need to talk through your own fears with someone.
Your feelings

The feelings we have can be very powerful influences on our sexuality and our sexual behaviour. If you’re feeling depressed or anxious, or afraid about your cancer, its treatment or your relationship, you’re unlikely to be aroused by thoughts of sex.

Being diagnosed with cancer usually causes many strong emotions that may make you less interested in sex. Fear, anxiety, pain, anger, envy and jealousy are common blocks to arousal. People who’ve had a change in their body due to illness or surgery often have a fear of rejection.

Normal, everyday feelings are intensified, which can be exhausting and may lead to a loss of interest in sex. However, some people feel an increase in sexual arousal – everybody’s different. Some people say that they feel guilty for worrying about their sex life when they should just be grateful for being alive. Feelings can sometimes be overwhelming and may be intensified by the worry that your emotions will also affect the people around you.

*We can send you our booklet* The emotional effects of cancer, which discusses the effects cancer may have on all areas of your life.

Ways of releasing feelings

Sexual self-esteem is often directly related to overall feelings of wellbeing. If you feel unsure about yourself and lack confidence as a result of the cancer, you may also lack confidence sexually. It can help to talk about and express these difficult feelings.
You could share your feelings with someone who will listen and not judge you or tell you what to do – perhaps a close friend or family member. If you have feelings that are hard to discuss, you could always talk to our cancer information specialists on 0808 808 00 00.

Sexual contact can be a good outlet for some people. Anger may subside in a healthy way after intercourse. Sexual contact can also distract people from feelings that are bothering them.

You may find it best to talk directly with your partner if you have one. Share your rage, anger and other feelings. Many couples use such times to start being more honest with one another, perhaps after many years of avoiding sensitive issues. Keeping old feelings hidden won’t help you or your relationship to heal. By talking openly you may find that you can overcome the problems in communication that are common in matters of sex and cancer.
Sexuality and cancer
Roles and relationships

Whenever someone has an illness that’s affecting their loving, romantic or sexual life, it’s helpful to think about what their relationship was like before. A relationship that was difficult before cancer is diagnosed probably won’t be any better afterwards. However, some couples come to a new understanding and love for one another as a result of coping with a shared challenge such as cancer.

Change in role

Cancer, or its treatment, can temporarily change a person’s role in their family. During treatment or after surgery, you may not have the physical energy to do all the things around the house that you did before.

 Relatives and neighbours may get involved in lending a hand, and sometimes this can leave you with a sense of not being needed, or not having control over your life. You may feel that you’ve lost your place. For some people, leading an independent life or fulfilling their role as a mum, dad or breadwinner has been part of their sexual self-esteem, so they find a change in role difficult to deal with.

Changed plans

Future plans may also have to be changed as a result of cancer and its treatments. Couples may have made all kinds of plans, spoken or unspoken, to enrich their relationship or sex life. Some look forward to their children leaving home so that they have more time, money and privacy for their relationship. They may feel that having cancer at this stage...
of life cheats them of this opportunity. It’s very normal to grieve for this kind of loss.

**If you’re single**

If you want to start a new relationship, it may be difficult to decide what to tell a new partner about your cancer, and also when to tell them.

There’s no simple answer that will work well for everyone. To help you decide, it may be useful to consider how safe you feel in the new relationship, and whether you feel you can trust your new partner with very personal information. This is particularly relevant if you have a body change that you conceal and are anxious about revealing. With time, you’ll probably feel stronger and more able to discuss your cancer and its effects.

Before making a strong commitment to a new partner, you should make time to discuss your cancer, especially if it could affect the length of your life or has affected your fertility. Lasting relationships are based on honesty, and keeping your cancer from your new partner may affect your future together. A loving partner should accept you as you are, and if they don’t then they’re probably not the right partner for you.

If you think that you need some help, you can find support from friends and others who love you. There are organisations that offer support listed on pages 83–89.

**Friends**

You may find that your relationships with friends change. Some friends may not be able to deal with your cancer and you may find that you lose touch with them. Sometimes this
can feel like a rejection, which can lower your self-esteem. It’s important to focus on the friends who are able to support and listen to you. You can also contact some of the support organisations listed on pages 83–89.

Healthy sexuality

Nearly all of the sexual problems people have because of cancer are variable and can be temporary. For example, loss of control, loss of part of your body, grieving and anger can all be healed, or resolved to an extent, given the opportunity and time. Support from people around you can be very helpful. Cancer need not mean the end of your sex life, whether you’re heterosexual, gay, bisexual or transgender, and whether you’re in a relationship or single.

Communication and information

Communication is essential for healthy sexuality in a relationship. You can use this booklet to find out more about possible side effects of cancer and its treatment, so that you can prepare yourself for changes. You, and your partner if you have one, can consider how to manage this aspect of your life. You might want to gather more information or resources to help you feel in control of maintaining good sexual self-esteem while having treatment.

Changes

Being open to change encourages healthy sexuality. You may need to develop a whole new style of openness and flexibility.
It might be, for example, that you have always taken the lead in sex and this may have to change now. It could be that your favourite sexual positions are no longer comfortable, even just for a time. You may have seen sex as being entirely about intercourse. But if penetrative sex is impossible for some reason you may want to start exploring other ways to have and give sexual pleasure.

**Acknowledging needs**

Acknowledging your own needs and those of your partner is essential for healthy sexuality within couples. Remember that it’s not just the person with cancer who will be affected. It can be more upsetting to watch someone you care for undergoing surgery and other treatments than to go through it all yourself.

**Partners**

Sometimes it’s the partner of the person with cancer who has a problem about sex.

Your partner may feel afraid to touch you for fear of hurting you. Some people incorrectly believe they might catch the cancer through sexual contact. Your partner may lose desire as a direct result of the changes brought about in you. They may also feel rejected if they don’t realise that your reduced sexual desire is due to the cancer or its emotional effects.

**Changed sex drive**

It’s also important to acknowledge that your partner’s sex drive may not be reduced. Sometimes it can even increase, if intimate touch helps to reassure them in times of stress. It may be important to talk through with your partner other
ways they can meet their sexual needs, such as masturbation. This can help to reduce any frustration resulting from reduced sexual contact. This may not be what you would ideally want, but it can be a useful way for both of you to meet your needs.

**Emotional intimacy may increase through greater communication, even when sex is not possible.**

**Starting again**

Starting again and relearning about sensual bodily pleasures may be important for anyone who has had a break in sexual contact. When rebuilding intimacy, you may need to start very slowly and gently. Try caressing without a goal of orgasm or penetration. Remember that there are many loving and erotic activities other than intercourse.

Early on, and perhaps even during treatment, you can keep love alive by cuddling and holding one another. Learning to massage one another can be supportive.

A person with cancer doesn’t have to give up sexual contact completely. However, some people may find that they don’t miss sexual contact and that not having sex isn’t a problem for them.

A healthy sexual self-esteem is about being true to ourselves. We’re free to make choices about how we express our feelings, and to decide which sexual behaviour suits us and how, or if, we then share ourselves with others.

**Possible changes**

When you’ve been through an experience of cancer, you may never be the same again. Your view of your life, your relationships, your job and your family may all change.
Managing all this change can be difficult to deal with, but you can use this challenge to build your relationships.

Many people say they:
• become more honest with their partner
• stop putting off things that they want to do, sexually or otherwise
• start to be more realistic about life in general
• take up new interests that they’d been putting off for years.

Getting help
The idea of getting back to normal may mean a whole rethink of your sex life. This might not be easy. If you find that things aren’t going well, look for help sooner rather than later.

If you’ve had problems for a while, remember that sex therapists and counsellors are used to helping couples who have let matters drift, slowly getting worse, so that by the time they get help the relationship may have serious problems.

A good place to start is at your GP surgery. There might be a counsellor in the practice. If not, they will know how you can contact one. There are some useful addresses on pages 83–89. The College of Sexual and Relationship Therapists (see page 84) has a list of nationwide counsellors and therapists who can offer advice and support.

Books and DVDs on sexual issues are available from shops and the internet — often they aren’t on display in shops, so you may need to ask directly. Your local library may also have some useful books that you can borrow.
Common questions about sexuality and cancer

Can sexual activity cause cancer?

Not in the strictest sense of the word. In practical terms, the development of some types of cancer may be influenced by a virus that’s commonly passed from one person to another during sex.

Cancers of the cervix, vulva, anus, penis and some mouth cancers are more likely to occur in people who have the human papilloma virus (HPV), which is transmitted through sexual contact. However, HPV is very common and most people who have it don’t develop cancer as a result.

There are many factors other than the virus that can increase the risk of developing cancer, such as:

• whether or not you smoke
• your age
• your diet
• the genes you inherit from your parents
• your general health.

These factors can influence whether or not an infection with a virus will affect the development of a cancer. However, some people still see sex as ‘bad’ or ‘sinful’ and on some unconscious level worry that their cancer may be punishment for some past ‘sin’. If you feel worried or guilty about your cancer having been
given to you as a punishment, it can help to talk this through with a religious or spiritual adviser, a counsellor or one of our cancer information specialists on 0808 808 00 00.

Can I catch cancer from my partner?

No. If your partner has cancer, you can’t catch it from any sexual activity. You can’t catch cancer by having sex.

Could having sex make my cancer worse?

No. In fact, sex and all the love and caring that goes with it can be helpful to people who have cancer. Many people feel depressed, unlovable, guilty or afraid when they have cancer or are having treatment. Affection and acceptance from a partner can make a big difference. Sex doesn’t make the cancer more likely to come back or spread.

How can I overcome tiredness?

Be flexible about the time of day you have sex. Try having sex in the morning when you feel refreshed after a night’s sleep rather than last thing at night. Experiment with less demanding sexual positions. You can agree with your partner that sex need not always be a long session.

How soon can I have sex after having surgery?

This will vary greatly according to the sort of operation you had and how quickly you are healing. Your surgeon or specialist nurse can give you more information.
Can chemotherapy drugs be present in sexual fluids?

It isn’t known whether chemotherapy drugs can be present in semen or vaginal fluids. Therefore it’s safest either to avoid sex or to use some other form of barrier contraception, such as a condom, during and for about 48 hours after chemotherapy. Using barrier contraception removes any potential risks and avoids the stinging sensation that some partners experience.

When can I start trying to get pregnant?

It’s essential to avoid becoming pregnant while you or your partner are having chemotherapy treatment. This reduces the risk that the chemicals could be absorbed and harm the developing baby. Many doctors recommend not becoming pregnant or fathering a child for up to a year after treatment, as this is the time when the cancer is most likely to come back.

Which sexual positions should I use after having cancer?

This will depend a lot on which part of the body is affected by the disease. If it’s the pelvic area, it will take some gentle and patient experimenting to discover which sexual positions now suit you and your partner. This can also be true after a mastectomy, when some people say that they don’t want their partner’s weight resting on them. Having sex side by side, or swapping who’s on top, may be better. Most couples find that with loving communication they can sort out what suits them best. The things you find most enjoyable will change with time, so be prepared to change what you do.
What can I do if I’m embarrassed about my scars but still want to have sex?

It’s a good idea to talk things through with your partner. Most people find their partner is much less concerned by their scars than they imagine and love them as a person and not just because of the way they look. Once the subject has been discussed openly, most people feel more relaxed about the changes in their body.

Why not try having sex in semi-darkness, by candlelight for example, to avoid being seen so clearly? Some women also say that they find having sex with their bra on after a mastectomy makes them feel sexier. This holds the false breast (prosthesis), if there is one, and helps to hide scars. Crop tops or an all-in-one body suit with gusset poppers can also be comfortable without you having to be completely hidden. Men may also find it helpful to wear clothing during sex if they are bothered by their scars.
How we can help you

Cancer is the toughest fight most of us will ever face. But you don’t have to go through it alone. The Macmillan team is with you every step of the way.

Get in touch

Macmillan Cancer Support
89 Albert Embankment,
London SE1 7UQ
Questions about cancer?
Call free on 0808 808 00 00
(Mon–Fri, 9am–8pm)
www.macmillan.org.uk
Hard of hearing?
Use textphone
0808 808 0121 or Text Relay.
Non-English speaker?
Interpreters are available.

Clear, reliable information about cancer
We can help you by phone, email, via our website and publications or in person. And our information is free to everyone affected by cancer.

Macmillan Support Line
Our free, confidential phone line is open Monday–Friday, 9am–8pm. Our cancer support specialists provide clinical, financial, emotional and practical information and support to anyone affected by cancer. Call us on 0808 808 00 00 or email us via our website, macmillan.org.uk/talktous

Information centres
Our information and support centres are based in hospitals, libraries and mobile centres, and offer you the opportunity to speak with someone face-to-face. Find your nearest one at macmillan.org.uk/informationcentres
**Publications**
We provide expert, up-to-date information about different types of cancer, tests and treatments, and information about living with and after cancer. We can send you free information in a variety of formats, including booklets, leaflets, fact sheets and audio CDs. We can also provide our information in Braille and large print.

You can find all of our information, along with several videos, online at macmillan.org.uk/cancerinformation

**Need out-of-hours support?**
You can find a lot of information on our website, macmillan.org.uk
For medical attention out of hours, please contact your GP for their out-of-hours service.

**Someone to talk to**
When you or someone you know has cancer, it can be difficult to talk about how you’re feeling. You can call our cancer support specialists to talk about how you feel and what’s worrying you.

We can also help you find support in your local area, so you can speak face-to-face with people who understand what you’re going through.
Professional help

Our Macmillan nurses, doctors and other healthcare and social care professionals offer expert treatment and care. They help individuals and families deal with cancer from diagnosis onwards, until they no longer need this help.

You can ask your GP, hospital consultant, district nurse or hospital ward sister if there are any Macmillan professionals available in your area, or call us on 0808 808 00 00.

Support for each other

No one knows more about the impact cancer has on a person’s life than those who have been affected by it themselves. That’s why we help to bring people with cancer and carers together in their communities and online.

Support groups
You can find out about support groups in your area by calling us or by visiting macmillan.org.uk/selfhelpandsupport

Online community
You can also share your experiences, ask questions, get and give support to others in our online community at macmillan.org.uk/community
Financial and work-related support

Having cancer can bring extra costs such as hospital parking, travel fares and higher heating bills. Some people may have to stop working.

If you’ve been affected in this way, we can help. Call the Macmillan Support Line and one of our cancer support specialists will tell you about the benefits and other financial help you may be entitled to.

We can also give you information about your rights at work as an employee, and help you find further support.

Macmillan Grants
Money worries are the last thing you need when you have cancer. A Macmillan Grant is a one-off payment for people with cancer, to cover a variety of practical needs including heating bills, extra clothing, or a much needed break.

Find out more about the financial and work-related support we can offer at macmillan.org.uk/financialsupport

Learning about cancer
You may find it useful to learn more about cancer and how to manage the impact it can have on your life.

You can do this online on our Learn Zone – macmillan.org.uk/learnzone – which offers a variety of e-learning courses and workshops. There’s also a section dedicated to supporting people with cancer – ideal for people who want to learn more about what their relative or friend is going through.
Other useful organisations

Bladder and Bowel Foundation
SATRA Innovation Park, Rockingham Road, Kettering NN16 9JH
Helpline 0845 345 0165
Tel 01536 533255
Email info@bladderandbowelfoundation.org
www.bladderandbowelfoundation.org
UK-wide advocacy charity that provides help, information and advice for all types of bladder- and bowel-related problems.

Breast Cancer Care
5–13 Great Suffolk Street, London SE1 0NS
Free helpline 0808 800 6000 (Mon–Fri, 9am–5pm, Sat, 9am–2pm)
Textphone 0808 800 6001
Email info@breastcancercare.org.uk
www.breastcancercare.org.uk
Provides information, practical assistance and emotional support. Breast care nurses run the helpline and email service. Offers a peer support service where you can talk to a trained supporter who has experience of breast cancer.

British Association for Counselling and Psychotherapy (BACP)
BACP House, 15 St John’s Business Park, Lutterworth LE17 4HB
Tel 01455 883300
Email bacp@bacp.co.uk
www.bacp.co.uk
Aims to promote awareness and availability of counselling, and to signpost people to appropriate services. The website has a database where you can search for a qualified counsellor.

Changing Faces
The Squire Centre, 33–37 University Street, London WC1E 6JN
Tel 0845 4500 275
Email info@changingfaces.org.uk
www.changingfaces.org.uk
Provides support and
information for people who have any sort of disfigurement, and their families, with the aim of building effective coping strategies and self-confidence. Publishes a wide range of self-help booklets and DVDs.

The College of Sexual and Relationship Therapists (COSRT)
PO Box 13686, London SW20 9ZH
Tel 020 8543 2707
Email info@cosrt.org.uk
www.cosrt.org.uk
A national specialist charity for sex and relationship therapy. Has a list of qualified practitioners and clinics providing sex or relationship therapy in the UK. Send a stamped addressed envelope for details, or visit the website.

Colostomy Association
2 London Court, East Street, Reading RG1 4QL
Helpline 0800 328 4257
Tel 0118 939 1537
Email cass@colostomyassociation.org.uk
www.colostomyassociation.org.uk
Provides support and advice for colostomates, their families and their carers. Provides a 24-hour email and telephone helpline, and visits for those who need them. Publishes comprehensive advisory literature and a quarterly magazine.

FPA (formerly the Family Planning Association)
50 Featherstone Street, London EC1Y 8QU
Helpline 0845 122 8690
(England, Scotland and Wales) 0845 122 8687
(Northern Ireland)
Email general@fpa.org.uk
www.fpa.org.uk
The leading voluntary organisation combining sexual health and family planning. Aims to promote sexual health and family planning through information, research and education.

GaysCan
Tel 020 8368 9027
(Mon–Sat, 10am–7pm)
Email gayscan@blothlom.org.uk
Other useful organisations

A UK helpline via phone and email. Gives information and support to gay men living with cancer and their partners, families and friends.

**Ileostomy and Internal Pouch Support Group**
Peverill House,
1–5 Mill Road, Ballyclare,
Co. Antrim BT39 9DR
**Tel** 0800 0184 724
**Email** info@iasupport.org
**www.the-ia.org.uk**
Produces several factsheets to help those with an ileostomy, and also some for medical advisers treating patients with stomas.

**Infertility Network UK**
Charter House,
43 St Leonard’s Road,
Bexhill-on-Sea TN40 1JA
**Tel** 0800 008 7464
**Email** admin@infertilitynetworkuk.com
**www.infertilitynetworkuk.com**
A national charity that provides information, support, telephone counselling and helpful contacts for people with fertility difficulties.

**The Institute of Psychosexual Medicine**
12 Chandos Street, Cavendish Square, London W1G 9DR
**Tel** 020 7580 0631
**Email** admin@ipm.org.uk
**www.ipm.org.uk**
Has a comprehensive list of doctors throughout the country who are trained in psychosexual medicine.

**Jo’s Trust**
16 Lincoln’s Inn Fields,
London WC2A 3ED
**Helpline** 0808 802 8000
**Email** info@jostrust.org.uk
**www.jostrust.org.uk**
Provides information and support for women affected by cervical cancer and their families.

**Let’s Face It**
72 Victoria Avenue,
Westgate-on-Sea CT8 8BH
**Tel** 01843 833724
**Email** chrisletsfaceit@aol.com
**www.lets-face-it.org.uk**
An international network for people with facial disfigurement. Links together patients, their families, friends and professionals for self-help,
information and mutual support.

**London Lesbian and Gay Switchboard**
PO Box 7324, London N1 9QS
**Helpline** 020 7837 7324
(Mon–Sun, 10am–11pm)
**Email** admin@llgs.org.uk
**www.llgs.org.uk**
The helpline gives advice, information and referrals to the lesbian, gay, bisexual and transgender (LGBT) community, their families and their friends.

**Outsiders Club/Sex and Disability Helpline**
BCM Box Lovely, London WC1N 3XX
**Helpline** 07074 993 527
**Tel** 020 7354 8291
**Email** sexdis@outsiders.org.uk
**www.outsiders.org.uk**
A UK-wide community of people who feel socially isolated because of physical disabilities. Helps people gain confidence, make new friends and find partners. Outsiders runs the Sex and Disability Helpline, for professionals and disabled people with sexual problems. Produces leaflets covering all aspects of sex for people who are disabled.

**Ovacome**
PO Box 6294, London W1A 7WJ
**Tel** 020 7299 6654
**Email** ovacome@ovacome.org.uk
**www.ovacome.org.uk**
A national support group for everyone involved with ovarian cancer, including patients, families, friends, carers and healthcare professionals.

**The Prostate Cancer Charity**
1st Floor, Cambridge House, 100 Cambridge Grove, London W6 0LE
**Helpline** 0800 074 8383
(Mon–Fri, 10am–4pm, Weds, 7–9pm)
**Tel** 020 8222 7622
**Email** from the website
**www.prostate-cancer.org.uk**
Provides information and support for prostate cancer patients and their families, and funds scientific research into prostate cancer. Runs a telephone helpline with
experienced nurses for anyone concerned about prostate cancer. Can arrange contact with other men and their families who are willing to talk about their experiences. Provides a range of literature, sent free of charge within the UK.

**Relate**  
Premier House, Carolina Court, Lakeside, Doncaster DN4 5RA  
**Tel** 0300 100 1234  
**www.relate.org.uk**  
Offers advice, relationship counselling, sex therapy, workshops, mediation, consultations and support – face-to-face, by phone and through the website.

**The Sexual Advice Association**  
(formerly the Sexual Dysfunction Association)  
Suite 301, Emblem House, London Bridge Hospital, 27 Tooley Street, London SE1 2PR  
**Helpline** 020 7486 7262  
(Mon, Weds, Fri, 9am–5pm)  
**Email** info@sexualadviceassociation.co.uk  
**www.sda.uk.net**  
A charity that aims to improve people’s sexual health and wellbeing, and to raise awareness of how sexual conditions affect the general population.

**Urostomy Association**  
4 Demontfort Way, Uttoxeter ST14 8XY  
**Tel** 01889 563191  
**Email** secretary.ua@classmail.co.uk  
**www.uurostomyassociation.org.uk**  
Aims to assist people who are about to have, or have had, surgery resulting in the diversion or removal of the bladder. Provides information, help and advice on appliances, work situations and relationship problems.
General cancer and support organisations

Cancer Black Care
79 Acton Lane,
London NW10 8UT
Tel 020 8961 4151
(Mon–Fri, 9.30am–4.30pm)
Email info@cancerblackcare.org
www.cancerblackcare.org
Offers a range of information and support for people with cancer from ethnic communities, their friends, carers and families. Welcomes people from different ethnic groups including African, Asian, Turkish and African-Caribbean communities.

Irish Cancer Society
43–45 Northumberland Road,
Dublin 4, Ireland
Cancer helpline
1800 200 700 (Mon–Thurs, 9am–7pm, Fri 9am–5pm)
Email helpline@irishcancer.ie
www.cancer.ie
Operates Ireland’s only freephone cancer helpline, which is staffed by qualified nurses trained in cancer care.

Maggie’s Cancer Caring Centres
8 Newton Place,
Glasgow G3 7PR
Tel 0131 537 2456
Email enquiries@maggiescentres.org
www.maggiescentres.org
Located throughout the country, Maggie’s Centres offer free, comprehensive support for anyone affected by cancer. You can access information, benefits advice, and emotional or psychological support.

Tak Tent Cancer Support – Scotland
Flat 5, 30 Shelley Court,
Gartnavel Complex,
Glasgow G12 0YN
Tel 0141 211 0122
Email taktent4u@gmail.com
www.taktent.org
Offers information and support for cancer patients, their families and friends, and to health professionals. Runs a network of support groups across Scotland, meeting monthly in the evening. Also provides counselling and complementary therapies.
Further resources

Related Macmillan information

You may want to order some of the booklets and leaflets mentioned in this booklet. These include:

- Cancer and complementary therapies
- Cancer treatment and fertility – information for men
- Cancer treatment and fertility – information for women
- Controlling cancer pain
- Coping with body changes
- Coping with fatigue
- Pelvic radiotherapy in men: possible late effects
- Pelvic radiotherapy in women: possible late effects
- The emotional effects of cancer
Sexuality and cancer

- Understanding advanced (metastatic) prostate cancer
- Understanding breast cancer
- Understanding breast reconstruction
- Understanding cancer of the ovary
- Understanding cancer of the vulva
- Understanding cervical cancer
- Understanding chemotherapy
- Understanding early (localised) prostate cancer
- Understanding early (superficial) bladder cancer
- Understanding invasive and advanced bladder cancer
- Understanding locally advanced prostate cancer
- Understanding lymphoedema
- Understanding radiotherapy
- Understanding rectal cancer
- Understanding secondary breast cancer
- Understanding testicular cancer
- Understanding womb (endometrial) cancer

To order, visit be.macmillan.org.uk

To order the fact sheets mentioned in this booklet, call 0808 808 00 00. This information is also available online.

Audio titles

Our high-quality audio materials, based on our variety of booklets, include information about cancer types, different treatments and about living with cancer. To order, visit be.macmillan.org.uk

To order your free CD, visit be.macmillan.org.uk or call 0808 808 00 00.

Useful websites

A lot of information about cancer is available in the internet. Some websites are excellent; others have misleading or out-of-date information. The sites listed below are considered by
nurses and doctors to contain accurate information and are regularly updated.

**Macmillan Cancer Support**
[www.macmillan.org.uk](http://www.macmillan.org.uk)

Find out more about living with the practical, emotional and financial, emotional and financial effects of cancer. Our website contains expert, accurate up-to-date information on cancer and its treatments, including:

- our 100+ booklets, 350+ fact sheets, videos featuring real-life stories from people affected by cancer, and information from medical professionals
- how Macmillan can help, the services we offer and where to get support
- how to contact our cancer support specialists, including an email form for sending your questions
- local support groups search, links to other cancer organisations and a directory of information materials
- a huge online community of people affected by cancer sharing their experiences, advice and support

**www.cancer.org**
(American Cancer Society)
Nationwide community-based voluntary health organisation dedicated to eliminating cancer as a major health problem. It aims to do this through research, education, advocacy and service.

**www.cancerhelp.org.uk**
(Cancer Research UK)
Contains patient information on all types of cancer and has a cancer research clinical trials database.

**www.healthtalkonline.org**
and
**www.youthhealthtalk.org**
(site for teens and young adults)
Both websites contain information about some cancers and have video and audio clips of people talking about their experiences of cancer and its treatments.
www.macmillan.org.uk/CancerVoices  
(Macmillan Cancer Voices)  
Macmillan Cancer Voices is a UK-wide network that enables people who have or have had cancer, and those close to them such as family and carers, to speak out about their experience of cancer.

www.cancer.gov  
(National Cancer Institute – National Institute of Health – USA)  
Gives comprehensive information on cancer and treatments.

www.nhs.uk  
(NHS Choices)  
NHS Choices is the online ‘front door’ to the NHS. It’s the country’s biggest health website and gives all the information you need to make choices about your health.

www.nhsdirect.nhs.uk  
(NHS Direct Online)  
NHS health information site for England – covers all aspects of health, illness and treatments.

www.nhs24.com  
(NHS 24 in Scotland)  
Health information site for Scotland.

www.nhsdirect.wales.nhs.uk  
(NHS Direct Wales)  
Provides health information for Wales.

www.n-i.nhs.uk  
(Health and Social Care in Northern Ireland)  
The official gateway to health and social care services in Northern Ireland.

www.patient.co.uk  
(Patient UK)  
Provides good-quality information about health and disease. Includes evidence-based information leaflets on a wide range of medical and health topics. Also reviews and links to many health- and illness-related websites.
Questions you might like to ask your doctor or nurse

You can fill this in before you see the doctor or nurse, and then use it to remind yourself of the questions you want to ask and the answers you receive.

1. ____________________________
   Answer ____________________________

2. ____________________________
   Answer ____________________________

3. ____________________________
   Answer ____________________________

4. ____________________________
   Answer ____________________________

5. ____________________________
   Answer ____________________________

6. ____________________________
   Answer ____________________________
Notes
Disclaimer

We make every effort to ensure that the information we provide is accurate, but it should not be relied upon to reflect the current state of medical research, which is constantly changing. If you are concerned about your health, you should consult a doctor. Macmillan cannot accept liability for any loss or damage resulting from any inaccuracy in this information or third-party information, such as information on websites to which we link. We feature real-life stories in all of our articles. Some photographs are of models.

Thanks

This booklet has been written, revised and edited by Macmillan Cancer Support’s Cancer Information Development team. It has been approved by our medical editor, Dr Terry Priestman, Consultant Clinical Oncologist.

With thanks to: June Allen, Clinical Nurse Specialist for Gynaecological Oncology; Dr Jim Barber, Consultant in Clinical Oncology; Dr Peter Blake, Consultant Clinical Oncologist; Phillipa Lloyd, Gynaecological Oncology Clinical Nurse Specialist; Sue Ronaldson, Psychosexual Therapist; Bruce Turner, Uro-oncology Nurse Practitioner; Dr Isabel White, Macmillan Clinical Research Fellow in Cancer Rehabilitation; and the people affected by cancer who reviewed this edition.

Sources


Royal College of Physicians, Royal College of Radiologists and Royal College of Obstetricians and Gynaecologists. The Effects of Cancer Treatment on Reproductive Functions: Guidance on Management. 2007.

Can you do something to help?

We hope this booklet has been useful to you. It’s just one of our many publications that are available free to anyone affected by cancer. They’re produced by our cancer information specialists who, along with our nurses, benefits advisers, campaigners and volunteers, are part of the Macmillan team. When people are facing the toughest fight of their lives, we’re there to support them every step of the way.

We want to make sure no one has to go through cancer alone, so we need more people to help us. When the time is right for you, here are some ways in which you can become a part of our team.

Share your cancer experience
Support people living with cancer by telling your story, online, in the media or face-to-face.

Campaign for change
We need your help to make sure everyone gets the right support. Take an action, big or small, for better cancer care.

Help someone in your community
A lift to an appointment. Help with the shopping. Or just a cup of tea and a chat. Could you lend a hand?

Raise money
Whatever you like doing, you can raise money to help. Take part in one of our events or create your own.

Give money
Big or small, every penny helps. To make a regular or one-off donation – see over.

Call us to find out more
0300 1000 200
macmillan.org.uk/getinvolved
Please fill in your personal details

Mr/Mrs/Miss/Other
Name
Surname
Address

Postcode
Phone
Email

Please accept my gift of £
(Please delete as appropriate)
I enclose a cheque / postal order / Charity Voucher made payable to Macmillan Cancer Support

OR debit my:
Visa / MasterCard / CAF Charity Card / Switch / Maestro

Card number

Valid from

Issue no

Signature
Date / /

Don’t let the taxman keep your money

Do you pay tax? If so, your gift will be worth almost a third more to us – at no extra cost to you. All you have to do is write your name below, and the tax office will give 25p for every pound you give.

☐ I am a UK taxpayer and I would like Macmillan Cancer Support to treat all donations I have made for the six years prior to this year and all donations I make in future as Gift Aid donations, until I notify you otherwise.

I understand that I must pay an amount of Income Tax and/or Capital Gains Tax for each tax year (6 April one year to 5 April the next) that is at least equal to the amount of tax that Macmillan will reclaim on my gifts for that tax year.

Macmillan Cancer Support and our trading companies would like to hold your details in order to contact you about our fundraising, campaigning and services for people affected by cancer. If you would prefer us not to use your details in this way please tick this box. ☐

In order to carry out our work we may need to pass your details to agents or partners who act on our behalf.

If you’d rather donate online, go to macmillan.org.uk/donate

Please cut out this form and return it in an envelope (no stamp required) to: Supporter Donations, Macmillan Cancer Support, FREEPOST LON15851, 89 Albert Embankment, London SE1 7UQ
Cancer is the toughest fight most of us will ever face. If you or a loved one has been diagnosed, you need a team of people in your corner, supporting you every step of the way. That’s who we are.

We are the nurses and therapists helping you through treatment. The experts on the end of the phone. The advisers telling you which benefits you’re entitled to. The volunteers giving you a hand with the everyday things. The campaigners improving cancer care. The community supporting you online, any time. The fundraisers who make it all possible.

You don’t have to face cancer alone. We can give you the strength to get through it. We are Macmillan Cancer Support.

Questions about living with cancer?
Call free on 0808 808 00 00 (Mon–Fri, 9am–8pm)
Alternatively, visit macmillan.org.uk

Hard of hearing? Use textphone 0808 808 0121, or Text Relay.
Non-English speaker? Interpreters available.

Registered charity in England and Wales (261017), Scotland (SC039907) and the Isle of Man (604).