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Effect of Routine Screening for Sexual Problems in a Breast Cancer Survivorship Clinic

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INTRODUCTION

Sexual problems are common in women with breast cancer[1] but are inadequately addressed in most settings.[2] Routine screening is one possible mechanism to reduce barriers to care for sexual difficulties and is recommended in the current National Comprehensive Cancer Network (NCCN) survivorship care guidelines.[3] However, brief screening tools for sexual problems in women with cancer are underdeveloped. Previous studies of sexual health screening in cancer survivors are few [4, 5] and focus on patients undergoing active treatment. It is unclear whether screening for sexual problems in the survivorship care setting has any demonstrable influence on clinical care.

In this report we describe outcomes of the preliminary development and implementation of routine screening for sexual problems in a breast cancer survivorship clinic. Our primary aim was to compare rates of documented assessment and intervention for sexual problems before and after implementation of screening.

METHODS

Participants and setting

We sampled 500 adult women who were seen for annual follow-up in the long-term breast cancer survivorship clinic at a comprehensive cancer center. The clinic receives approximately 4,000 visits per year from survivors who are typically at least 5 years post-treatment. Clinicians may refer patients to a separate sexual health clinic at our institution. Prior to the study, clinic staff attended a presentation that outlined common sexual difficulties in breast cancer survivors, services available to address these problems, and

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recommendations for sexual health communication. The study was approved by our local institutional review board with a waiver of informed consent.

Measures

At annual surveillance visits patients complete a two-page review of systems form with questions about current symptoms, changes in medical history, and health maintenance behaviors. The survivorship clinician reviews the form prior to the visit. We added one item to this form to screen for sexual problems. As there are no validated brief screening tools for this population, we engaged a subject matter expert, breast cancer survivorship clinicians, a patient educator, and a volunteer patient representative to develop an item. The item's content was based on clinical consensus, a review of lengthier sexual function questionnaires, and the most frequent presenting complaints among women referred to our sexual health clinic. The item reads: "In the past month or longer, have you been bothered by..." followed by five response choices: "Loss of interest in sex," "Pain or discomfort during sexual activity," "Reduced sexual pleasure or sensation," "Other problems not listed above," and "None of the above/does not apply to me."

We reviewed the clinician's dictated visit note for evidence of assessment (documented identification or acknowledgement of a sexual problem) or intervention (documentation of any clinical advice, referral, or other action taken) for sexual health problems. We also recorded patients' demographic and clinical characteristics and whether patients were new to the survivorship clinic (i.e., just transferred care from the oncologist) or established.

Procedure

Random samples of 250 visits were generated from the two-month period prior to implementation of screening for sexual problems and from the same two months the following year. All records represented unique patients (no duplicate patients). Non-routine visits (e.g., to address acute health problems), records with missing documentation, and male patients were excluded.

Data analysis

We summarized sample characteristics using descriptive statistics. We compared rates of documented assessment and intervention between groups initially using Chi-squared tests and then with multivariate logistic regression models controlling for patient-level variables that differed between groups. Within the post-implementation group, we calculated the frequency of responses endorsed on the screening item.

RESULTS

From 500 records, 31 (6.2%) were excluded, leaving 233 pre-implementation and 236 post-implementation visits for analysis. Baseline patient characteristics were similar between groups (Table 1), with the exception of a larger proportion of established patients and a trend toward more frequent exposure to radiotherapy in the post-implementation group.

Documentation of sexual problems and interventions by the clinician

Clinicians documented sexual problems in 12 (5.2%) records from the pre-implementation group and 18 (7.6%) records from the post-implementation (screened) group ($P = 0.278$). In a multivariate model controlling for patient characteristics that differed between groups, the effect of group on documentation of sexual problems approached statistical significance (Table 2). Clinicians documented *interventions* for sexual problems at very low rates in both groups (6 patients [2.6%] pre-implementation and 7 patients [3.0%] post implementation, $P = .803$).

Patient responses to screening item

In the post-implementation group, 208 patients (88.1%) completed the screening item (i.e., checked any response including “None of the above/does not apply to me”). Post-hoc analyses indicated that patient age, time since diagnosis, and marital status did not predict non-response to the screening item. However, we found that White non-Hispanic survivors were more likely to respond than survivors in other ethnic groups ($P = .003$). Of the 208 respondents, 47 (22.6%) endorsed one or more sexual problems (Table 1). Of the 47 patients who indicated any sexual problem, 11 (23.4%) had corresponding clinical documentation of a sexual problem, whereas only 5 (10.6%) had a documented intervention.

DISCUSSION

Although the NCCN recommends screening for sexual problems through self-report in the survivorship care setting,[3] we found scant evidence to support this practice. Our findings are in accord with those of other studies that have critiqued the effectiveness of routine screening to address psychosocial needs in cancer survivors.[6–9] We also found an unexpectedly high rate of noncompletion for the screening item, particularly among ethnic minority women, suggesting a need to refine such items for acceptability.

Our study has several limitations, chief among them the retrospective study design and the single-institution setting. Random assignment to screening was not feasible in our setting. Despite our efforts to ensure content validity and face validity, the screening item was not subjected to further psychometric evaluation. Finally, patients were long-term survivors and may have addressed sexual concerns earlier in their care.

Whereas numerous studies have described the nature and frequency of sexual health concerns among breast cancer survivors, our data are among the first to determine how screening of an entire clinic population affects documented care for these concerns. Screening strategies should be further developed and tested in conjunction with robust mechanisms to improve provider communication and access to care. However, our findings indicate that screening through self-report alone is insufficient to affect care specific to sexual problems.

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Table 1
Sample Characteristics by Time Period (Pre- versus Post-implementation of Sexual Health Screening)

Characteristic	Pre-Implementation (n = 233)		Post-Implementation (n = 236)		P
	n	%	n	%	
Age at diagnosis					0.259
Mean (SD)	53.1 (10.6)		54.2 (9.6)		
Min - Max	25.8 – 82.0		27.5 – 76.9		
Age at visit					0.311
Mean (SD)	63.6 (10.4)		64.5 (9.4)		
Min - Max	37.7 – 89.3		38.1 – 86.3		
Time since diagnosis, years					0.902
Mean (SD)	10.5 (5.9)		10.3 (5.8)		
Min - Max	0.8 – 36.3		0.3 – 30.2		
Race/ethnicity					0.844
White	179	76.8	174	73.7	
Hispanic (any race)	23	9.9	28	11.9	
African American	22	9.4	24	10.2	
Asian	8	3.4	10	4.2	
Other	1	0.4	0	0.0	
Marital status					0.995
Married	154	66.1	154	65.3	
Single	24	10.3	24	10.2	
Divorced/separated	25	10.7	27	11.4	
Widowed	30	12.9	31	13.1	
Recurrence history					0.569
Primary only	216	92.7	215	91.1	
Recurrent/metastatic	5	2.1	9	3.8	
Second primary breast tumor	12	5.2	12	5.1	
Surgery type					0.426
Excisional biopsy	5	2.1	3	1.3	
Segmental mastectomy	111	47.6	119	50.4	

Characteristic	Pre-Implementation (n = 233)		Post-Implementation (n = 236)		P
	n	%	n	%	
Total mastectomy (unilateral)	77	33.0	69	29.2	0.805
Total mastectomy (bilateral)	40	17.2	42	17.8	
Other	0	0.0	3	1.3	
Chemotherapy exposure					0.107
No	130	55.8	129	54.7	
Yes	103	44.2	107	45.3	
Radiotherapy exposure					0.691
No	110	47.2	94	39.8	
Yes	123	52.8	142	60.2	
SERM exposure					0.424
No	135	57.9	141	59.7	
Yes	98	42.1	95	40.3	
AI exposure					<0.001
No	161	69.1	171	72.5	
Yes	72	30.9	65	27.5	
New or established patient					n=208
New	62	26.6	15	6.4	
Established	171	73.4	221	93.6	
Endorsement of sexual problems					n=208
Loss of interest in sex	--	--	31	14.9	
Pain or discomfort	--	--	23	11.1	
Reduced pleasure or sensation	--	--	13	6.3	0.5
Other problems	--	--	1	0.5	
Not applicable/Does not apply	--	--	161	77.4	

Table 2

Logistic Regression Predicting Clinician Documentation of Sexual Problems

Characteristic	OR	95% CI	P
Time: Post-implementation (ref: pre-implementation)	1.92	0.85 – 4.35	0.118
Established patient (ref: new)	0.40	0.16 – 1.00	0.050
Received radiotherapy (ref: no radiotherapy)	1.09	0.51 – 2.34	0.819