

EDITORIALS

Erectile dysfunction after treatment for colorectal cancer

Is common, but under-recognised and undertreated

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Colorectal cancer is the third most prevalent cancer among men. Fortunately, advances in cancer treatment have improved outcomes and survival. In general, patients treated for colorectal cancer report good quality of life. However, particularly in patients with rectal cancer, quality of life can subsequently be affected by bowel, bladder, and sexual problems.¹ Bowel dysfunction is most common, but sexual function is also often substantially affected. In the linked qualitative study, Dowswell and colleagues assess erectile dysfunction in men after treatment for colorectal cancer (doi:10.1136/bmj.d5824).²

Erectile dysfunction in these patients has not been well described. Given the median age of men with this disease, comorbidities and life stage are likely to be associated. Data suggest, however, that sexual function is uniquely affected, particularly in patients with rectal cancer.³⁻⁷ A recent population based study reported that sexual function in men treated for colon cancer was significantly worse than in the general population,⁸ and more impaired in patients who did not receive chemotherapy. The causes were, however, largely unknown.

Erectile dysfunction is often reported among men who have surgery for rectal cancer (23-62%).³ Associated factors include age, the surgeon's expertise, the type of procedure (low anterior versus abdominoperineal resection), radiation (short versus long course), and time from surgery. Injury or scarring of sympathetic or parasympathetic pelvic nerves by surgery or radiation are causal, but no other factors have yet been identified.

Chemotherapy, particularly newer agents associated with neurotoxicity, may damage autonomic nerves.

Quantitative data on erectile dysfunction after cancer treatment are inadequate. Many studies are retrospective and most do not study patients longitudinally, making it difficult to understand associated temporal trends. Study cohorts typically comprise patients who are heterogeneous in personal characteristics, treatment, tumour stage, and time since treatment, making it difficult to arrive at meaningful conclusions on causes and risk factors. Missing data are common, making it difficult to ascertain the true prevalence of symptoms.

Dowswell and colleagues used qualitative methods, which help to convey the impact of erectile dysfunction in a snapshot of 28

men with erectile dysfunction after treatment for colorectal cancer. Several important aspects emerged: the management of cancer, patients' loss of self esteem or perceived loss of masculinity, and other serious physical and psychological problems. Many patients reported that bowel dysfunction or the presence of a stoma affected their sexual desire. Patients reported difficulty in obtaining reliable information. Many experienced embarrassment or were offended by ageism or dismissive attitudes from healthcare providers. Validation by the care provider, or lack thereof, was an important theme.

Challenges in managing erectile dysfunction include identifying patients, using effective treatments, and managing comorbidities. Although injury to pelvic nerves may explain a proportion of erectile dysfunction in men with rectal cancer, its pathophysiology in colon cancer is not understood. The efficacy of treatments for erectile dysfunction in the general population has not been established in patients with colorectal cancer. Without knowing the causes of erectile dysfunction it is unclear whether standard treatments will help. Also, the best timing of intervention is unknown; there may be an optimal time to initiate treatment, preventing patients from entering a "vicious cycle" in which past experience of erectile dysfunction creates psychological obstacles to sexual activity, and so on. To develop effective interventions it is crucial to understand the potentially unique stressors and confounders associated with colorectal cancer.

Although systems differ, the coordination of care of patients after treatment for cancer is universally challenging. The follow-up of patients is guideline driven, but guidelines on functional problems are lacking. More efficient methods are needed to rapidly triage patients with functional problems such as erectile dysfunction. Quantitative instruments with multiple questions are useful in research settings; however, a clinical screening tool must be focused for use in clinical practice. Dowswell and colleagues' results suggest that patients feel isolated and that even when erectile dysfunction is discussed it is poorly managed. Appropriate referral pathways must be established and their efficacy assessed.

Dowswell and colleagues' study has limitations. A heterogeneous sample provides information on the spectrum of men with erectile dysfunction but fails to deal with several important problems. The prevalence, causes, and treatment options for erectile dysfunction within this cohort may differ from those of others. Erectile dysfunction after treatment for rectal cancer may result from injury to pelvic nerves by surgery or radiation, but the mechanism for erectile dysfunction after colon cancer is unknown and likely to be associated with several factors. Therefore, interventions may differ depending on the type of surgery. In this study the patients' scores on the international index of erectile function were not reported, making it difficult to compare the severity of their dysfunction to that of patients with rectal cancer. These men represent a subset but they probably represent the spectrum of male patients with severe erectile dysfunction after treatment for colorectal cancer. The study would have been richer if the framework sampling included patients successfully treated for erectile dysfunction, so that effective processes or systems could be identified.

The men in the study seemed consistently frustrated in their quest to seek help. Understanding health seeking behaviours that facilitate appropriate treatment could help to develop future referral and management programmes. One factor not studied was the role of the patient's partner. This is probably an important component of sexual rehabilitation for men with colorectal cancer, as it is for men with prostate cancer. Despite the limitations, the study was hypothesis generating and

provided meaningful data. Managing the sequelae of treatment is an important aspect of care in colorectal cancer.

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