Sexuality: A Human Right for People With Cancer

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September 12, 2022 By Don S. Dizon, MD

I once met a woman, years out from her breast cancer diagnosis, who recalled with honesty what it was like to lose her breast, go through chemotherapy and radiation and take endocrine therapy. She didn't have anyone to turn to and discuss what it did to her sexuality and sense of self, what a tough time she was having in her marriage, how her sexuality was changing in ways she couldn't fully understand, how her body was not responding to touch as before. When she brought up these very private issues to her oncologist, she was dumbfounded by the response: "At least you're alive." She never asked again. She and her husband separated and, ultimately, divorced.

Sexuality is not synonymous with sexual activity. It covers intimacy, desire, arousal, orgasm and satisfaction. When it functions normally, we don't think about it, but when something negatively affects who we are sexually and how we experience pleasure, it can be quite distressing. Patients often come to me with a loss of desire, but sitting with someone can help delineate the complexity of the issue, including lack of arousal, pain with penetration or inability to accept one's changed body image.

It is important for clinicians to give voice to these concerns— and for people to feel free to seek help. Just as we address quality of life, we should strive for a better sexual life for all people with cancer. Not every- one wants to be sexually active, but for those who do, we have a responsibility to address it.

While the field of sexual health treatments is young, there are options. For women who have pain with penetration, aqueous lidocaine, a dilute solution, is efficacious. For those with vaginal dryness and atrophy, vaginal moisturizers are a mainstay; but if these are not effective, vaginal estrogen is safe, even for people with hormone-receptor-positive breast cancer.

For men, treatment mainly focuses on PDE5 inhibitors (e.g., Viagra), but male sexuality is more complicated than erectile function. My colleague Anne Katz, RN, and I developed a model of male sexual health after cancer (the Katz-Dizon model) that envisions male sexuality on a scale from anxiety to confidence—influenced by health, medications and treatment- related side effects but also by society's and one's own view of sexuality growing up and the views of intimate partners.

We have a long way to go. Much of the work on sexuality after cancer emphasizes the heterosexual experience; the issues, evaluation and the treatments for sexual and gender minoritized people remain unexplored. We need to be aware of our own implicit biases when it comes to care of the whole patient.

Our efforts to prolong the survival of people with cancer need to address the issue of what that life can—and will—look like. To avoid conversations around sexuality after cancer robs people of the opportunity to fully participate in a domain that defines us as human beings.

Sexuality does not have to be another part of one's life "lost" to cancer. That was true of the woman whose marriage fell apart due to cancer. The reason she came to see me after years was that she had started a new relationship. Helping her rediscover her sexuality and sensuality helped bring that part of her life back.

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