



OUTER-COURSE VS. INTER-COURSE

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Editor's note: Even though the sample size for this study is small, Us TOO felt the study questions and outcomes measured were informational for the Us TOO network of survivors and their partners, and might serve to open lines of discussion about any post-treatment issues encountered, and identify potential approaches for solutions.

This paper is based on the study I did for my PhD. I am also the wife of a prostate cancer survivor. The study population consisted of 13 prostate cancer survivors and their partners. The short form of the Sexual Health Inventory for Men (SHIM) was filled out by both partners as well as the sexual bother scale. Separate interviews were tape recorded. The study group consisted equally of Canadians and Americans; the men aged 58 to 83; married from 13 to 55 years.

- 8 men had a nerve sparing radical prostatectomy
- 3 men had external beam radiation and in 2 cases androgen deprivation
- 1 man had proton beam radiation
- 1 man had brachytherapy (radioactive seed implants)

Prior to cancer treatment 100% of my study group were sexually active irrespective of their age.

- 83% had sex once or twice per week
- 17% had sex two to four times per week (aged mid to late 70)
- 72% described their sexual practices as innovative

An earlier study done in 2003 examined the erectile function in aging men and found that 62% of men between the ages of 65 and 75 were impotent. My study group was sexually more active than the norm so what happened to their sexual practices after treatment for prostate cancer?

- 80% continued to have sex, with or without penetration, once to twice per week but 77% needed aid or some form of assistive stimulation,
- 20% in their eighties maintained intimacy but no longer felt the need for orgasmic sex.

The type of aids my participants use were felatio, mutual masturbation, external pumps, inter-cavernosal shots and one successfully used Viagra®, which requires an intact nerve supply to the penis to be effective. Two cases, 18 months after surgery, resumed normal intercourse. In this study, the effects of radiation appeared to continue destroying nerve tissue in the treatment area for longer than reported.

Disappointing was the fact that even though 100% of the study group were sexually active at the time of diagnosis only one of the 13 treating physicians asked about pre-treatment sexual relations and practices. When approached one other physician dealt with and discussed this subject. The majority of the group felt unprepared to deal with the after effects of the treatment.

All of the male and female participants, when asked if they could only have one thing, sexual intercourse or intimacy chose intimacy (hugging, kissing, holding hands, cuddling, caressing while naked, bonding and sharing intimate experiences).

- None of the participants felt that intimacy only occurred during “penetrative intercourse.”
- Eleven of the women said they were willing to settle for not having penetrative sex but wanted intimacy, the most important part of their relationship.
- Three of the men were not concerned about penetrative sex or erectile function.
- Ten of the men were concerned with erectile function and penetrative sex.

The question arose as to why eleven women weren't concerned about the lack of penetrative sex whereas 10 men were concerned?

This led me to start to address the issue of sexuality. After treatment, which of these—orgasm or penetration—was more important to both partners? Some of the answers dealing with the link between sexuality and penetrative sex required an in depth literature review.

- According a 2004 nationwide study of female sexuality, 70% of women never experience vaginal orgasms.
- Could this be why 11 of the women weren't concerned about penetration?

If 62% of men over the age of 75 are impotent and women don't need penetration for orgasms what is the problem? Could the solution be to have orgasms without penetration? Did the men and women know that men could achieve an orgasm without an erection? How many men and their partners in my group knew that 70% of women do not experience vaginal orgasms and that clitoral orgasms are stronger?

- 100% of men and 83% of the women knew that there was such a thing as clitoral orgasm but only about 10%-15%, were aware that it is actually stronger.
- 36% of men and 45% of women did not know that most women do not have vaginal orgasm.
- Orgasm without erection was not a widely known fact amongst this study group.

It became obvious that the importance of educating patients about the necessity of achieving sexual satisfaction without penetrative intercourse could not be over emphasized; ‘Outer-course versus intercourse’ so named by one of the study participants. Although the couples in this study were in concurrence assessing the severity of the Erectile Dysfunction, they were not that accurate in assessing the amount of “bother” this caused their partners.

- 46% of the women in the study believed that their male partners had less concern about penetration than the man actually had.
- 46% of the men in the study group believed that their partners had more concerns about the loss of penetrative sex than the women actually had.

My group felt that good information is essential to make good decisions. 85% of the group felt that both partners should have input into treatment decisions as the outcome affected both of them. They felt their treating physician provided poor information and especially concerning:

- Pre-treatment sexual activity
- The woman's role
- The women's sexuality which includes either clitoral orgasm or vaginal orgasm or both
- Orgasm without erection

Post treatment risks of impotence were not fully discussed. The risk of incontinence, which involved 20% of the group, was fully discussed.

The group had several recommendations:

- A take home video educating patients about the total picture of diagnosis, treatment, after effects and solutions should be developed.
- Both partners should visit the treating physician
- All couples should be asked to complete a form describing their current sexual activity and hand it to the treating physician

- Educate patients and their partners:
 - Sexual enjoyment should not be sacrificed for either partner
 - Satisfactory orgasm can occur without penetration or erection
 - Each couple must develop solutions that are acceptable to both partners
 - There are many alternatives such as mutual masturbation, oral sex (felatio), sex toys and dildos
 - even penile implants, pumps and shots for those who feel that penetrative intercourse is essential
- Most important is to maintain intimacy, kissing, hugging, holding hands, stroking etc.

Based on my study and literature reviews there are many things that the treating physicians can do to help their patients better prepare for prostate cancer treatment:

- Almost 60% of Canadian patients want enough information to allow them to make their own treatment decisions (2004 study)
- Consider your patients current sexual habits and practices when recommending and selecting treatment
- Thoroughly inform your patient of all the after effects of all the treatments and discuss alternative solutions other than medical/chemical ones.
- Many men were given Viagra that didn't work due to treatment compromised nerve supply and this left them feeling discouraged and hopeless.

About Us TOO International

Us TOO International is a grassroots, 501-c-3 non-profit prostate cancer education and support network of 325 chapter support groups worldwide, providing men and their families with FREE information, materials and peer-to-peer support so they can make better decisions on detection, treatment options and coping with ongoing survivorship.

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