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## Sexuality and Intimacy

Michael L. Krychman, MDCM

April 18, 2009

### ELIZABETH CORKERY:

Welcome to the “Sexuality and Intimacy” workshop. My name is Elizabeth Corkery, and I have been living with advanced breast cancer since June of 2005. This is actually my first time volunteering with Living Beyond Breast Cancer. They've been a wonderful resource for me the past few years.

I just want to tell you a couple of things before I introduce our speaker. This session is being audio-recorded. So if you have a question, please let me bring around the microphone ... so everyone can hear you. Also, the doctor has mentioned [that] if you want to write down any questions [rather than asking them] ... out loud, he will read the questions and address them [without announcing your name]. I have provided some paper for you to write ... down [any questions you'd prefer to ask in that manner].

Dr. Michael L. Krychman is medical director of the Sexual Medicine Center at Hoag Hospital, and executive director of the Southern California Center for Sexual Health and Survivorship Medicine, both located in Newport Beach, California. He is presently associate clinical attending [physician] at the University of Southern California and the University of California, Irvine. He is the former co-director of the Sexual Medicine and Rehabilitation program at Memorial Sloan-Kettering Cancer Center, and was an associate clinical attending faculty member at Cornell Weill Medical Center in New York City.

Dr. Krychman holds licenses from three states — California, Pennsylvania and New York — and is a board-certified OB/GYN [obstetrician/gynecologist]. He is a clinical sexologist and AASECT [American Association of Sexuality Educators, Counselors and Therapists] certified sexual counselor with a master's [degree] in public health and human sexuality. Fluent in French and English, Dr. Krychman obtained his doctorate in medicine and master's [degree] in

surgery from McGill University School of Medicine in Montreal, where he was named a Great Distinction Medical Scholar.

Dr. Krychman's clinical interests include sexual pain disorders, loss of libido, chronic medical illness as well as breast cancer sexuality. He has a special interest in survivorship medicine, which focuses on reduction of recurrence, risk reduction and optimizing general health while maximizing quality of life. He is a well-known speaker who is featured locally, nationally and internationally.

Dr. Krychman is on the editorial board of the *Journal of Sexual Medicine*, *Current Sexual Health Reports* and is an associate editor for *Sexuality for the Female Patient*. He co-authored chapters in two textbooks, *Cancer, Sexuality and Sexual Expression in Female Sexual Dysfunction, First Edition*, and *Reconstructive Surgery and Rehabilitation in Principles and Practice of Gynecologic Oncology, Fourth Edition*. He is the scientific co-chairman for the 2009 ISSWSH [International Society for the Study of Women's Sexual Health] annual educational meeting. He has published countless articles in peer-review journals and has been featured in many magazines.

Dr. Krychman has published three books, *100 Questions and Answers for Women Living With Cancer: A Practical Guide for Cancer Survivorship*, *100 Questions and Answers on Cervical Cancer*, and most recently *100 Questions and Answers About [Women's] Sexual Wellness and Vitality*. He has been featured in *The New York Times* and *U.S. News & World Report*, *The Wall Street Journal*, *Health* magazine, *Marie Claire*, *Coast*, *Cosmopolitan* magazine and many others.

Please welcome Dr. Krychman. [Applause]

### MICHAEL L. KRYCHMAN, MDCM:

I was listening to that [introduction] and wondering who they were talking about. Wow.

Before I ... start, we have about an hour and a half, and I just want to let everybody know that this is really going to be very fun. Whenever you put sex in the topic you're going to learn little

things, probably laugh, maybe get a little embarrassed — a little bit. ... My [opinion is] that [sex is] a very important topic. ... [My approach is that in order to discuss sex], sometimes we have to *not* be so serious all the time when we're talking about it.

I think it's really important for you to get an understanding of ... my perspective [in order] to understand where I came from, [and] where I am right now. I did my training in Montreal. Then I did my OB/GYN residency in California. Then I got the bug to be back on the East Coast. I was actually living in Philadelphia, so I have to say it's very nice to be home again. I lived in Philadelphia for about six years, and then I got recruited to Memorial Sloan-Kettering Cancer Center to do their Sexual [Medicine] program.

[That role] ... morphed into an opportunity, where it was really about survivorship medicine and ... living with disease. I was back on the East Coast for a variety of personal reasons and [was] really, really interested in the development of understanding of what we do as healthcare providers, [as well as] what we do with patients. Whether it's a prescription, whether it's radiation-chemo — what have you — it certainly has far-reaching effects. When the patient goes home, [the treatment plan and the treatment itself] affects ... relationships. It affects ... friends [and] family, [not just the patient]. As healthcare providers, I think we have lost sight of that.

When I was at Sloan-Kettering, I had a wonderful opportunity to work alongside a lot of researchers. Then I felt that I needed to have a change. I was blessed with the birth of my 3-year-old twins. Unfortunately, a three-hour commute was not very conducive to being an active participant in my children's lives. So we made the switch to be on the West Coast, to be closer to family and friends.

As everybody sees, I am wearing both leis today. I have ... been touched by breast cancer,



both personally and professionally. Both my grandmothers had metastatic breast cancer, and they lived for a very, very, very long time with the disease. They taught me much more than how to be a good grandson and eat everything on my plate. They really gave me a lot of courage and understanding in terms of really appreciating what cancer has become. It's no longer the "C-word" that is mentioned in whispers in the back hallway.

I think it is very, very important to understand that cancer, no matter what stage you are at, is really a chronic medical disease. It is like high blood pressure. It is like diabetes. My goal is, and my mission [when I] speak to both patients and healthcare providers, is [this]: to encourage people to understand that just as when [a healthcare provider] diagnose[s] a diabetic and a hypertensive and [asks that person to make] ... lifestyle [changes] ... [for the sake of disease management, the healthcare provider should also] ... be very, very concerned about the impact [on] ... [that individual's] relationships. [That concern about relationship impact should carry over to cancer treatment as well.] I'll tell you some stories, some interesting things, and we'll have some fun there.

I think this is a better title for my talk. I think it's really important to understand that no matter what your personal experience is with breast cancer, I would say sexual healthcare is really about providing you the ingredients. Every woman will make her specific recipe. We'll talk about some of the things we can offer you as healthcare providers, [as well as] things you can seek out. Because there's a lot of misinformation, and there's a lot of interest in terms of maintaining active sex lives.

What is the ideal paradigm? Well, it's a mission between sexual medicine, oncology and the patient. Very often women will come to me and ... say, "I feel like pieces of a puzzle. I go to the medical oncologist for this, and I go to the gynecologist for that, and I go to the radiation specialist for this ... And they're pieces of a puzzle. "My colon is addressed by the GI guy." They say, "Does anybody talk to each other? Does the colon [doctor] know what's going on in my arm, and does this [medicine or treatment] go with that [one]?" [The treatment] feels very, very disjointed.

That's why I formulated this concept of survivorship medicine. What I do at my center is I give women survivorship care plans, which means I have people come from all over the world — I just recently had some international people come to California and spend some time, and ... really

formulate a plan. [The plan included] everything down to the nitty-gritty, [such as] nutrition, diet, vitamin D — a whole variety of different things. They can take this plan and go back and really get organized. I always say my best analogy is that I am — you have a medical oncologist and a surgical oncologist, and they might be the captains of the ship. You're the passenger. Think of me as a cruise director. Everybody has to get along [in order] to have a good cruise — so, very, very important.

Really, our mission at my center is to enhance the lives of patients and their partners; and assess and treat physical, psychological, medical, surgical issues of intimacy. We understand that it's very complicated. That's the bottom line. It's an array of veins, arteries, nerves, hormones, but [that is] not where [it] stops. Women are not ruled by their hormones. There's stress. There's anxiety. There are children. There's the stock market. Everything certainly impacts your emotions, your feelings, your interests and your level of sexual interest. The WHO [World Health Organization] actually put it well. They said that sexual health is actually a right. Somatic, emotional, intellectual and social aspects of well-being that are positively enriching are very, very important.

There's actually a good reason to be sitting here, not only this esoteric discussion of "it's nice to have sex and feel loved and be intimate," but there's new data emerging that women ... who are intimate and have good relationships — both with partners and with friends — tend to have decreased disease, decreased recurrence rates, decreased need for medication. Those that are in poor relationships tend to have poor overall health. So, again, there's a link between relationship health and overall health. We now understand that if you're feeling good emotionally, it certainly impacts how you feel physically. So we're now understanding that. So, again, this [notion of a link between sex and health] became very popular. Most men will remember there was an article that [said] if a man has sex three times a week, his rate of prostate cancer decreases exponentially. I'm also here to tell you that some of the emerging evidence supports the [notion] that women who engage in active intimate lives tend to have lower rates as well — not of prostate cancer, but of breast cancer or progression of disease. So [this subject is] very, very important.

... There are a lot of studies. But it's actually quite interesting, because women tend to release — and we'll talk about some of the hormones —

they tend to release oxytocin, they tend to release a lot of different hormones when they are orgasmic or when they are sexually active. These [hormones] are thought to decrease the proliferation of breast cells. ...

... The data support that women who have sexual complaints tend to be more depressed, more anxious. They have more time off from work, more relationship problems. ... If you treat the [relationship] issues, all those [other] issues tend to resolve, [which] improve[s] quality of life. Again, quality of life is an essential parameter when you're talking about sexual function.

The NCI [National Cancer Institute] estimates that about 40- to 100-percent of cancer survivors experience some form of sexual complaint. If you look at the breast cancer literature, about 50- to 90-percent of all breast cancer survivors have some form of sexual complaint. So it's not just for the select few. It's very, very common. This [notion that a breast cancer patient has to tolerate sexual problems] ... is really a thing of the past.

Patients want to talk about sexual activity, but [often] don't [talk about it]. Why don't they? Eighty-five percent of adults would like to discuss sexual functioning with their physician or healthcare provider, but most [people] believe they don't have time, [or] they're [too] embarrassed [to bring it up]. Most people actually think there's nothing that can be done. You'd be surprised. Most patients that I see ... [tell me], "Thank God that there's someone like you. I've been searching and searching and my doctor said, 'You should just be thankful you're alive,'" or, "There's nothing I can do for you." So, again, there is a lot of myth and myster[y] surrounding sexual function, both on the patient's side ... and on the healthcare provider's side. Because they feel like it's like a Pandora's Box. They're going to open up this box and they're not going to know how to address those functions.

What about discussions? We see that we were doing really badly before. We're only talking about 13 percent [of providers] were talking about it and then only 5 percent thereafter, so, again, not doing well. We still have this Victorian conservative era. We can talk about all the other intimate issues that are going on when you give chemotherapy and radiation. But when it comes to sexual function and relationships, we have somehow lost our ability to communicate effectively. ...



[Here] are some data. . . . Every five years there's an international consensus conference on sexual health and sexual medicine. This year, I [was invited to] present at this conference. I'll be presenting all the data on breast cancer intimacy. Unfortunately, for me, it's in Paris this summer. [Laughter] So I will have to make the sacrifice and go. But, again, it is a very common problem, whether it's desire, arousal, orgasm, pain. Actually, pain and lowered interest are the biggest complaints. Women will have pain, and they will avoid having sexual contact for a variety of different reasons. . . .

Why is it important? Twenty-five percent of new cases present [symptoms] before menopause. We're getting better at diagnosing metastatic disease. People are living longer and healthier lives in spite of having metastatic disease. But the most important facet here is [that] 20 years from the diagnosis, about 30-percent [of people] report that sexual problems were attributed to having breast cancer. So, again, the origin of complaints really comes from the original diagnosis. [That's why this issue is] so very important, that it's not just an acute issue. It can be long-[term]. It can certainly affect people [for a] very, very long [time].

It's actually very interesting, because after the dust settles and after the acute crisis, I think quality-of-life concerns become very, very important. What's going to happen with my children? What's going to happen with my relationship? These actually move very much to the forefront in terms of concern, in terms of treatment-effects. How is this going to add quality to my life? . . . As the number of survivors increase, they're a very strong voice. [As a group, survivors are] really demanding improved research in terms of breast cancer intimacy, how it affects patients. We'll kind of go over it a little bit more in detail.

These are some things that patients have told me. "Yes, I'm thankful to be alive, but I'm dead down there." These are actual words. "Breast cancer treatment contributed to the deterioration of my excellent marriage. They never told me I would feel like this." So, again, during treatment, very often you are not told of the ramifications. It always reminds me of those commercials on TV, where you're talking about these medications, and then the person goes into this high-speed talk about all the potential side effects, and you're kind of overwhelmed.

The whole concept of sexual function really kind of ties into a whole variety of different things:

. . . . fertility preservation in the newly diagnosed [or other issues]. Right now in my center I'm dealing with a young lady who has metastatic disease, and she wants to preserve her eggs. She's married. She wants to . . . fertilize the eggs . . . and then bank the embryos. . . . She found me, luckily. Her [other] doctors are really trying to urge her not to do anything, because they don't know what her survivorship will be. Rather than urge her to [follow that advice], I have taken the position that I need to provide her with all the appropriate options and give her information. So she's in the process of doing that right now. [She] certainly understands the implications — that she might have embryos frozen and might have [to use] a surrogate [rather than go through the pregnancy herself]. But she doesn't know how long she might live to see these children. That's okay, and that's okay with me. But I think it's not okay . . . to [deny her] . . . the appropriate information [and the chance to decide for herself].

I think it's important to understand that everyone's experience of sexual function is not the same. I do a lot of work in what's called cross-cultural sexuality. Asian, African American, special populations all experience cancer differently, and different cultural issues are very, very important. Very often, healthcare providers are not sensitive to cultural needs. It's important to understand that everybody experiences sex and intimacy very, very differently.

As we said earlier, dryness and pain are the biggest issues, [as are] changes in self-esteem. Very often people feel compelled to be very, very aggressive in terms of surgery — prophylactic surgeries, removal of the other breast, removal of ovaries — without being properly informed of the ramifications and the long-term effects. When I was at Sloan-Kettering, we did a lot of research on risk-reducing BSO [bilateral salpingo oophorectomy], removal of the ovaries, especially in women who've had metastatic disease. . . . We found that there's a huge amount of impact. The risk-reduction is minimal compared to the great effects [BSO has] on the heart, cardiovascular [system], and on sexual function and on quality of life. Patients tend to have great concern. Even the concept of removing the other breast: There's still this concept that even if you remove the other breast, we would intuitively think women's anxiety about the cancer coming back, especially in the other breast, would decrease. For some reason, it doesn't. There's still some underlying anxiety. . . .

I think the biggest controversy that exists now is about topical estrogen, whether it's a tablet or a cream. We'll talk about those for treatment of local vaginal effects. I think that's the biggest controversy. I'll try to address those, because I think that's really poorly understood.

What [does it mean to be] sexually healthy while surviving cancer? Hormones are important, and they affect a whole variety of things: whether it's the blood vessels, whether it's muscles, whether it's the veins, arteries and nerves. But I will tell you, I take a very temperate approach. I think women are not ruled by their hormones. I have just as many women in my center who have not one speck of estrogen or testosterone [in their bodies], and they're having the best sex life ever. The reverse is true: a lot of women who have a lot of estrogen and testosterone, and their relationships are poor. So, again, think twice about the things that you've been told. [Consider whether some of it is] misinformation, because [treatment effects are] not necessarily true across the board for every single woman.

Sexual function is really just the tip of the iceberg. I think it's really important to understand that there are a lot of medical illnesses that certainly can be attributed to the development of chronic medical disease. I recently had a young lady who came in and said her orgasms were not as good as they were before, and they weren't as intense. Unfortunately, we did a further workup, and we found out that she had the beginning stage of MS [multiple sclerosis]. So, again, sexual function is not this esoteric issue of just being close to your partner and having a good time. There are a variety of [physical] things [that contribute to a healthy sex life].

. . . . Men come in, and they say they have erectile difficulties. Before they go into the room, their blood pressure is measured, their cholesterol is measured, because certainly they're not stressed out. *It has to be* a medical issue. [Laughter] Now, what did we do to women [in the past]? Women would come in and say, "I have low desire." I have a collection of old history medical books, and if you look through those, about 40 years ago, do you know the number-one prescription . . . for a woman who . . . had low desire was? She was told to go home, have a glass of wine and a warm bath. On top of that, usually a male doctor would say, "Okay, dear," or "sweetie" or "honey," . . . "Go home, because you're just anxious and upset." So, again, we've over-medicalized men, because men



certainly have feelings, too, and we've under-medicalized women. We don't even understand.

... Breast cancer patients will come in [to my office] and say, "I have pain during intercourse," or, "I really have no interest," or, "My orgasmic response has this." The doctors will say, "She's just depressed, she's anxious, she's nervous." ... [No.] She has real medical issues that can be addressed and treated. But they're swept under the table and just put into this "You're depressed; you're hysterical" kind of crockpot-diagnosis, where the [healthcare provider is] really not addressing the underlying medical issues.

I see this all the time. I see patients [who may have been living with cancer for a few years] ... and I go through their medication and say ... "Well, what's this medication?" She says, "I don't know. They gave it to me because I was feeling a little moody;" or, "I was low," "I wasn't feeling good. This was five years ago." It's an antidepressant. I say, "Do you know this is an antidepressant?" She [answers], "No." And I [respond], "Well, how do you feel?" She said, "I feel great." She doesn't even know why she's on the medication. They would just instantly give her the medication. So very often you have to kind of dig deep. Very often a lot of other things can [be contributing to sexual issues]. ... It's not all in your head. That's the bottom line. Patients have been told that it's all in their heads.

So, we'll go through some of the complaints — whether it's what we do as surgeons or radiation and chemo — and then we give you all these medications to keep [the] ... disease static. What that means is — and I say it again because I've lived through it and I treat patients — you can live. My late grandmother, she lived with metastatic breast cancer for 25 years. She was on medication, and it kept the disease stable.

**WOMAN:**

[Off microphone] Where were her mets?

**MICHAEL L. KRYCHMAN, MDCM:**

What? They were all over.

**WOMAN:**

[Inaudible]

**MICHAEL L. KRYCHMAN, MDCM:**

Yes. Every person is different. ...

**WOMAN:**

... Was this recently she died?

**MICHAEL L. KRYCHMAN, MDCM:**

Yeah. Yeah.

So, I think it's really important to understand that

metastatic, depending on your disease, it's a chronic disease. The concept of cure, or eradication —

[Speaking simultaneously]

**WOMAN:**

[Off microphone] It's not a chronic disease. ... This disease is about telling you you're going to die in two years.

[Editor's Note: At LBBC, we hear a variety of opinions on the use of the word "chronic" to describe metastatic breast cancer. Some women embrace the word, while others, like the woman speaking, feel the word does not respectfully represent their experience. Many factors impact the length of life after a diagnosis of metastatic breast cancer, including the location of the metastasis, how the cancer responded to previous treatments, the therapies available for the specific type of breast cancer, and many other variables. It is challenging to speak generally about length of life, because behind every statistic there are many exceptions. Your healthcare team is the best place to start to understand your prognosis, and you may need second, third or even fourth opinions to learn about all your options. LBBC has tools to help you jump-start your conversation. Visit the Advanced Breast Cancer section of our Web site (<http://www.lbbc.org/advanced-breast-cancer.asp>) or order a free copy of our guide, *Understanding Treatment Options for Advanced Breast Cancer*, at <http://www.kintera.org/site/apps/ka/ec/product.asp?c=afLFJOOyHsE&b=1198725&ten=9dIEJLPgG9LGLHnFbJITNtH7LGKQMoEaLOJ0PEG&ProductID=61343I>. Let us know how you feel about the word "chronic" to describe metastatic breast cancer at [information@lbbc.org](mailto:information@lbbc.org).]

**MICHAEL L. KRYCHMAN, MDCM:**

You can certainly live a very long time with advanced metastatic disease, depending on —

[Speaking simultaneously]

... the disease you have and the extent of your metastatic disease, you can. There are people that live who have been diagnosed with metastatic disease who are alive greater than two years. There are people in this room that are —

[Speaking simultaneously]

**WOMAN:**

[Off microphone] — tell us two years. [Inaudible] ... that it's not a chronic disease. Nobody dies of a chronic disease in two years.

**SECOND WOMAN:**

[Off microphone] [Inaudible] ... and they're always out of date. ... one gynecologist told me ... metastatic breast cancer is fatal, but the way that the doctors treat it, [it] is as though it's a chronic illness.

[Speaking simultaneously]

**WOMAN:**

[Off microphone] As though, as though, not that it is.

[Speaking simultaneously]

**MICHAEL L. KRYCHMAN, MDCM:**

Yeah.

**WOMAN:**

[Off microphone] [Inaudible] ... it is fatal, but it gets treated as if it were a chronic illness.

**MICHAEL L. KRYCHMAN, MDCM:**

It's the same as HIV.

**WOMAN:**

[Off microphone] No. People [can] live for 24-plus years with AIDS. Nobody except your grandmother here is living that long with metastatic disease.

[Editor's Note: Like other diseases, HIV/AIDS has a variable prognosis depending on the subtype of disease and the ability to access life-lengthening treatments. With HIV/AIDS, people can live as little as nine months or as long as 20 years. The same is true for metastatic breast cancer—the length of life varies by the location and size of the cancer and the access to effective treatments, among other things. The age at diagnosis is another factor that affects survival, but diagnosis at a younger or older age does not always equal shorter survival. Each diagnosis of metastatic breast cancer is unique, and you should speak with your doctors about your individual case.]

**MICHAEL L. KRYCHMAN, MDCM:**

Okay. Well, let's open it up. Okay. That's fine.

**SECOND WOMAN:**

[Off microphone] How many people do you know? I know somebody [inaudible] ... 30 years.

**THIRD WOMAN:**

[Off microphone] I'm nine years [since diagnosis with metastatic breast cancer].

**MICHAEL L. KRYCHMAN, MDCM:**

What?

**THIRD WOMAN:**

[Off microphone] I'm nine years.



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**WOMAN:**

[Off microphone] Yeah?

**MICHAEL L. KRYCHMAN, MDCM:**

Okay.

**WOMAN:**

[Off microphone] That's not 24 years.

**THIRD WOMAN:**

[Off microphone] It's a long time.

**WOMAN:**

[Off microphone] Yes, it is.

[Speaking simultaneously]

**MICHAEL L. KRYCHMAN, MDCM:**

And I want to ask you. Did they say — ...

**WOMAN:**

[Off microphone] The maximum that anybody would give me was [one year].

**MICHAEL L. KRYCHMAN, MDCM:**

There you go. Every woman is different, and every woman's experience of cancer is different. I accept the challenge, but I understand the semantics. It's treated as if it's a chronic disease. I would beg — if I asked you, do you feel — and I would ask most women in this room — do you feel that when disease is static, meaning you can have an advanced disease and it's not progressing ... [and] you could live, as this woman is saying right here, she's living for nine years [with metastatic disease]. So she's living with advanced disease. I would bet that she is not the outlier. There are many women — do you — maybe I'm wrong. Maybe I'm wrong and — ...

**WOMAN:**

... I mean, sure, you find people that do live a long time with metastatic disease. But the realities are — I mean, the ASCO [American Society of Clinical Oncology] conference last September, they put out that the median for metastatic breast cancer since the mid-1980s has been three years and remains three years. [Read the abstract: [http://www.asco.org/ASCOv2/Meetings/Abstracts?&vmview=abst\\_detail\\_view&confID=58&abstractID=40160](http://www.asco.org/ASCOv2/Meetings/Abstracts?&vmview=abst_detail_view&confID=58&abstractID=40160)] We're losing a lot of people very young. I run a support group. I [started with] 28 women [with] ... metastatic breast cancer. ... A lot of them are gone, even within a year of their diagnosis. So the reality is: True, you do find some that are living a long time. But you're also finding a lot that are dying really quickly. And with this disease longevity, unfortunately, is not good.

**MICHAEL L. KRYCHMAN, MDCM:**

If you look back, let's say five years ago — and, first of all, the median is 50-percent of people will live [more than three years]. So 50-percent, it's like is the glass — 50-percent will live less than three years, and 50 percent will live more than three years.

**WOMAN:**

[Off microphone] Right.

**MICHAEL L. KRYCHMAN, MDCM:**

And if you look at the trend in terms of the medial survival, it's increasing. It's not decreasing or staying the same.

**WOMAN:**

[Off microphone] But there are still 40,000 who are dying every year. That hasn't changed.

**WOMAN:**

Excuse me. I have a request. I know that what you're speaking about is an important conversation, and yet we came here to talk about sexuality and survivorship. I'm really looking forward to what you have to say.

**MICHAEL L. KRYCHMAN, MDCM:**

I appreciate that.

**WOMAN:**

So my request is that we continue the conversation. [Applause] Thank you.

**MICHAEL L. KRYCHMAN, MDCM:**

Great. Thank you. Okay. So, on that note, we'll talk a little bit about some of the things that happen ... when you have surgery. Again, the concept of total mastectomy versus lumpectomy: does it ... influence sexual function? The answer is actually, no. So depending on what surgery you have, it really doesn't affect ... sexual function.

Where it does differ is that people who have conservative surgery tend to have more breast caressing. The breasts are really an area of eroticism. Some women actually say that if you have scars, [the area] tends to have heightened sensitivity, and there might be guilt or shame associated with this as well. It's really about understanding ... what is going on in terms of sexual function. So, again, this is a normal response. ... If you look at the long studies, people who have had conservative surgery or radical surgery: coital frequency, ease of orgasm, overall sexual satisfaction is really the same.

What about other surgeries, like cosmetic surgeries? Cosmetic surgery is not always satisfactory. There's this issue about the nipples —

to replace the nipples, not replace the nipples. And how does [that decision] relate to self-esteem? Removal of the ovaries certainly can affect sexual function. ... If you remove both breasts, again, [that] certainly affects sexual function. So, the breast cancer issues relating to surgery are the extent [of surgery], the reconstruction [of the breast(s)]. There might be some psychological issues relating to the missing pleasure from caressing or absent erotic areas. Don't underestimate nipples, because they're very important to a woman's sense of femininity. Lymphedema — and I was looking at one of these booths, and I think that's wonderful, instead of lymphedema, LymphedIVAs [<http://lymphedivas.com>]. The armbands — I think those are wonderful.

We also would like to think that [every] partner [is] supportive when [you are] undergoing treatment. [But that's] not always necessarily so. We'll talk a little bit about partners and their reaction[s].

What about chemotherapy? Again, some of the acute issues — whether it's nausea or vomiting — those clearly can affect sexual functioning. But I think we underestimate the issues of hair [in both visible and private areas]: eyelashes, eyebrows. A variety of different products now are actually available to help in terms of sense of recovery and self-esteem. So, again, very, very important that even in the acute treatment, if you're undergoing chemotherapy, it can certainly affect [issues that trace back to self-esteem, and, in turn sexuality].

We shouldn't underestimate acute menopause: hot flashes, vaginal dryness, irritability, a variety of different things. There [are] ... methods to treat those, to make life a little more comfortable: whether it's a Chillow — a cooling pillow — or rhythmic breathing or a variety of other, different approaches, [such as] acupuncture. It's not all about hormones. So there are a whole variety of treatments ... that you can [access] to counteract the effects [of cancer treatment].

Radiation, again, lymphedema — I've had patients who their biggest issue was the lymphedema. They can't even put their arm around their partner without experiencing some pain, range of motion.

Partner reactions [to cancer treatment are not always helpful]: Men will come in and say, "I can't touch her. She's radioactive," [reacting to] a lot of myths.

... We're getting a lot better in terms of treating breast cancer. ... If you think back, we



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used to take off the skin all the way down to the bone, [and] then we took off the breast. Now we're leaving the muscle [intact]. Very often . . . we're doing a lumpectomy. Again, what did we used to do? Radiate the whole entire field. Then we got focus. Now we're doing what's called MammoSite, putting radiation in even at the time of surgery — getting better, less aggressive in terms of treatment side effects. We're understanding that we don't have to be super aggressive to get the same effects in terms of response. So, again, these are all coming from quality-of-life issues: We understand that survival is the same if we do a mastectomy all the way down to the bone, or if we do a lumpectomy, or if we do whole-field versus focal radiation, again depending on your stage and grade.

What about hormones? I say that the aromatase inhibitors, the Femara, Aromasin, are actually really contributing to a lot of sexual complaints. These are very, very good [medicines] because they keep disease static. But they also cause problems with bones, with vaginal dryness, with pain. They can also certainly affect your lipids so, again, a [discussion about the] risk-benefit balance [should occur with your healthcare provider]. You need to know that once you're taking something, there could be side effects. There are certainly things you can do to empower yourself, [and] to decrease the burden of disease as well. Tamoxifen, raloxifene: also medications that have been used [that] certainly don't have conclusive effects on sexual functioning, but certainly can cause problems with clotting, with abnormal vaginal bleeding. Certainly, again, risk-benefit balance is quite important for patients.

What about the psychological changes that happen? I think that it's really important to understand that there's a whole variety of changes that go on with your psyche: loss of sensation, loss of womanhood, feeling a little bit older, missing parts. This is where your balance is. You have relationships.

Then what I call information control: Every person's need for information is different, unique. Some people are spending hours and hours searching the Internet for more and more information, and other people maybe go to a conference or two a year, and some people rely [only] on their doctor [for information]. So, again, everybody's experience, information [level] and need for information is very, very different. No one mold is right and no one mold will fit for each [individual] woman.

I think it's really important — and that's the way I practice — to really understand that paradigm that doctors are used to: A leads to B leads to C leads to D. When you deal with quality-of-life issues, you need to understand that it's not so linear. Every woman's experience is very, very different. I will be bold enough to say that everyone's disease is different. You can have two women who are ER/PR [estrogen receptor/progesterone receptor] positive, at the same stage and the same grade, but they behave differently. . . . It's not an exact science. [A doctor] might be [treating according to] what is the majority, what is the expected, and it's not [the right treatment for this case]. We're always surprised.

Unfortunately, I always think doctors want a cookbook. They want a quick recipe that . . . is going to work for everybody, and they don't have to have lateral thinking. But unfortunately, with cancer, it doesn't work that way. . . . Every person's experience and everybody's interpretation is different — just like everybody's genetics are different, and genetics certainly influence it. . . . Why, if we give two people the same chemo, will one have [a] 50-percent reduction in [her] tumor and [another] person will only have 25-percent [reduction]? . . . So it's very, very different.

I think everybody goes through this process at a different place . . . taking on a very different experience in terms of understanding what their own personal definition is, how they will live in their own survivorship. Survivorship medicine, whether you're in it for six months, six years or 20 years, you are still living with disease. The concept of survivorship medicine, as people used to say — you are dying with disease. So you have cancer, and you're *dying from it*. My concept and the new trend is [to change that perspective, and say] you have metastatic disease and you are *living with it*. Okay? And no matter — we could all walk out tomorrow and get hit by a bus, whatever. You're living with your disease, and you're trying to empower yourself to make good choices for as long as you will be living with your disease.

Let's not forget about men, [and] the implications of relationships. . . . We like to think that men are supportive all the time. [Laughter] It's not always the case. I was fortunate enough to be involved with the singer Carly Simon and she, as you know, has [had] breast cancer, so [she wrote in the song "Scar," in 2000]:

A big man will love you  
Even more when you're hurting.  
And a really big man  
Loves a really good scar.

Sometimes [an illness is] the impetus for a bad marriage to deteriorate. The crisis of cancer can pull people apart or pull them together. I became a counselor because I found that being a doctor was not enough. I really needed to address some of the psychological concerns with the patient as well.

I have breast cancer patients who come home and say, "I have breast cancer. I'm going to go green." In about ten minutes, the microwave is removed from the house; all the detergents, all the canned food, all the processed food — it's gone. And she plants a garden. She's going to be green and be very proactive and empowered in her health. The husband comes home, and he's a meat-and-potatoes kind of guy. So you can see how that kind of dynamic certainly can influence the whole concept of cancer, and how it impacts the relationship. "You don't understand me because I want to be empowered," [she says]. "Where's my steak?" [he replies, along with] a variety of different things. So it's not always a positive pulling together of couples. Sometimes it pulls couples apart, and it's important to understand that.

I put this slide in to [illustrate] . . . that every woman's experience with cancer is very different. Everybody's culture is different. Everybody's age is different. Everybody's reaction is different. Because everybody is really different. We can't apply all the same rules to every person. Every person's individualized experience will be different, because [as] I will show you, I have women who have breast cancer, and many of them have had advanced metastatic breast cancer — and I published a paper — [and] they chose to be on testosterone, because testosterone will help their desire. And they said, "Give me two years of black-and-white versus four years of gray. It's my decision." So, again, we'll talk about individualized choices.

Let's not forget that some of us in the audience are single. Okay? So it's important that 50-plus [percent] of marriages end in divorce, and some of those end at the same time of a diagnosis. So, again, rejection, disclosure — a whole variety of different things — STDs [sexually transmitted diseases], safe-sex education. . . . Not everybody is involved in a heterosexual, monogamous relationship, [and that's] very important to



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understand as well. So everyone's experience is very different. We try to individualize care.

I think this sums up metastatic disease: "The first time I had cancer, I had the fear of the unknown. When it came back, I had the fear of the known." A patient told me that. I think that was quite important to understand. When we look at the data on metastatic breast [cancer] and sexuality, we see that younger women and those who have a distant recurrence — meaning that if you've had disease and then you've been free for about ten years and then you have it come back — are [at] the greatest risk [for sexual difficulties]. But, again, people cope with the disease. They maintain their level of sexual functioning. It's so very important, even in the face of metastatic disease. We don't really know what separates those who function well from those who have deterioration, and future investigational research is ongoing.

These are kind of the issues. Do you have any concerns about sexual function? This is what healthcare providers should be doing, and somehow you should bring up the topic if it's important to you. What we do is a [medical] history [of] physical [issues]. We do lab tests. We rule out chronic disease. I would say that in the acute crisis of cancer care, very often chronic medical disease is ignored. Ten to 15 percent of the patients who come to see me have underlying thyroid dysfunction, underlying hypertension that was not addressed. Everyone was [so focused] on the breast issues that they forgot there is a whole person attached to the breast, and there [are] a variety of other medical illnesses that ... can contribute to th[at woman's] overall, general health.

Treatment follow-up, and this is kind of what we do: I think the most important thing is the new norm. [We should focus on] what is the new normative behavior, rather than on treatment. Because treatment implies the possibility of complete recovery, which may not even be possible. So I think the new norm is really understanding where you are and where you want to be, given the situation. I think that's what we focus on when we're going [through] treatment. We talked about the treatment issues, and we'll go over these, give you some actual issues.

Chronic disease, like hypertension, diabetes, thyroid dysfunction: In the acute crisis of cancer care, very often they're neglected. I said ten to 15 percent of women who come to see me with [the] complaint, "I have pain or dryness" ... end up

having chronic disease. I would say that — how many women who have breast cancer have a cardiologist? How many in the room have a cardiologist? I would say that any woman who's had radiation and has gotten chemotherapy should probably have a cardiologist. Why? Everyone will say, "You know what? They were really concerned about my heart before they gave me chemo. They gave me a MUGA [Multiple-Gated Acquisition Scan]. They [had] me on a treadmill. Then after [the cancer diagnosis], they [weren't] really worried." But you're getting radiation directly to the heart, to the field. You're getting chemotherapeutics that affect the heart. At least go for one visit — very important.

The lady in the audience gave you statistics about how many women die [every] year [from breast cancer]. Anybody have any idea how many women die every year from cardiovascular disease? A woman dies every minute of every day of cardiovascular issues. Women who are taking Aromasin, aromatase inhibitors, do you know your lipid level? I think you have to understand that there [are] a variety of implications. So how many people know about their vitamin D levels? I would hope a lot of you do. If you don't, you should — again, [that information is] linked to disease.

We talked about [multiple] medications, polypharmacy. Very often at the time of diagnosis you get all these things, and you're refilling them, and then you don't really know [everything you need to know]. "Should I be on this? Should I not be on it? Do I need this antidepressant? Do I not? Oh, I might as well take it." It certainly has implications. So assessing what you're on and how they interact [is] very, very important. SSRIs [or selective] serotonin reuptake inhibitors, the antidepressants, the Prozac's, those kinds of medications certainly can affect sexual function and they have side effects as well.

What about the other medications? Almost every medication certainly can have an effect, but there [are] a variety of different [side effects]. All these medications that are listed here certainly have effects on sexual function. So, again, understanding what you're on, what you need to be on, modifying that if you can, and really understanding that, for some women, all it takes is removal of ... one of the drugs [to alleviate sexual function issues]. Maybe they don't need to be on the SSRI, or they can be on something else. Or [maybe] they can get another medication to counteract the [side] effect. ...

What about behavior, stress, time- and pain-management, physical therapy? I think lymphedema programs are very important. Many women don't have access to these [programs]. In some ways, that's why the Internet is very, very good. Alternative [practices that are used to enhance] sexual expression [are] very important — yoga, mindfulness. Mindfulness was addressed in a variety of different venues. The first study was Dr. [Lori] Brotto out of UBC [University of British Columbia] ... [<http://www.empowher.com/media/video/video-dr-brotto-how-do-you-use-mindfulness-treat-womens-sexual-arousal-disorders>].

What about structured sexual tasks? This is like guided imagery, exploring Tantra, sexual devices, accessories. Most women don't know that there is lingerie specifically made for women who have breast cancer, for scars. It's [Nottiwear.com; Editor's Note: as of November 2009, the Web site was inactive] ... out of Canada. ... They have specific lingerie that you can get. Nordstrom's [[http://about.nordstrom.com/promos/prosthesis\\_program.asp](http://about.nordstrom.com/promos/prosthesis_program.asp)] — they make specialized bras. Some women find that ... the breasts may be asymmetrical because of surgery or deformity, [and because of that], they're self-conscious. It affects their every [clothing] choice. They kind of get up in the morning and the look in their closet and [say], "What am I going to feel good in? I don't feel good in anything because I feel lopsided." ... There are a lot of resources available for help.

What about medical treatment? We're not doing very well in terms of female sexual health. Premarin Vaginal Cream is the only medication available that is FDA-approved for the treatment of moderate to severe painful intercourse. It recently got approved. [Editor's Note: in November 2008, FDA approved Synthetic Conjugated Estrogens A Vaginal Cream for painful intercourse, also called dyspareunia.] Again, [use of estrogen creams comes with a] "black box" warning [for] women who have estrogen-receptor positive tumors ...

What about hormones? I live in California [where there is a] big resurgence [in the practice] of putting women who have breast cancer on hormones. So, again, everybody's experience is different. I'm certainly not here to advocate hormones. I do not prescribe hormones. I do not recommend hormones for women who have breast cancer. But, again, everybody's choice is individualized. [The] whole concept of this movement of bio-identical hormones — Suzanne



Somers, sexy again, she had breast cancer. She's on bio-identical hormones. It was heralded as the cure-all, and [that cure-all notion is] absolutely a farce. Not necessarily so. A lot of controversy. But there's also a lot of data [that says] ... some women, [after] go[ing] on hormones, feel better; and their disease does not progress. I'm not saying it's the norm. I'm not saying it's recommended. It is very limited data. ... The emerging data, when I presented at ASCO, is [that] it's not systemic levels. It's not what estrogen is going around in your body. It's actually what's going on intracellularly, what's going on in the breast. So it's a balance between estrogen, progesterone, what receptors are being activated or not. ...

What about other things, other medications that are not hormones? A lot of women are very anxious about hormones because estrogen and progesterone — there are a variety of things to counteract vaginal dryness: non-hormonal moisturizers. We moisturize our skin. There are vaginal moisturizers like Replens, vitamin E. There are lubricants. But, again, you have to be very selective, because not all lubricants are created equal[ly]. Some have bactericides, spermicides, colors, flavors. Those are irritants — so you have to be very careful. You want something that's very, very — what I call pure. ... We'll give you some suggestions. Other medications that are not hormones: We'll talk about Wellbutrin. We'll talk about Viagra, Cialis. Those tend to help with arousal, and it helps for women who are on SSRIs, or the antidepressant medications. They need to be on it, but they can't get an orgasm. You can take these medications, and they can help.

I put this slide in to remind everybody that risk is a personal decision. So risk is very, very personal. This young lady, she's tried to sue the city for several million dollars because they were jackhammering out[side] of her door. She said that she was worried about the effects the sound of jackhammers [would have] on her unborn child. Here she is, outside smoking. What that shows is that everyone's risk-tolerance is very different. It's an individualized choice. Some people will drive 100 miles an hour on [Interstate] 95. Trust me. I just drove it. [Laughter] And some people will go slowly. Some people will wear seatbelts. Some will not. Everybody's risk is individualized. That is how medicine should be practiced. You have to separate your personal belief from your professional responsibility. You have to weigh the pros and the cons and help patients, empower them to make

active decisions about what is the best decision for them, given where they are in their disease.

Yes.

#### WOMAN:

[Off microphone] ... There are certain doctors who ... [will] do one-medicine-satisfies-all. And when you say, "Hey, I'm different. Why can't we look at" this, this, this and this; they sort of get offended. Because you're suggesting, "I need individual care." How do you go about telling the doctor, "Hey, I'm a unique individual here. This is the treatment that I think I need," without offending [him or her].

#### MICHAEL L. KRYCHMAN, MDCM:

I have a unique philosophy that a good doctor is never afraid of a second opinion. I think arrogance and ignorance are a bad combination when you're a healthcare provider. I learned that very early on in my career. I think it's a challenge, as the patient. I think it's a huge challenge, because you're right. You can't put a circular peg into a square hole. I think it's very, very important to understand that everybody should be treated [as an individual]. And unfortunately with constraints of healthcare you might not have the opportunity to seek an alternative opinion.

But I think that you need to find a doctor who will listen. I think there are ways to do it. I [try to be] ... a doctor who does listen: patients will come to me with a second opinion, and ... I will send them an article. I'll say "there's more than one way to skin a cat, for lack of a better expression." But I think it's really important to listen. Sometimes it's a challenge.

I would say sometimes it's easier to approach the allied healthcare providers. What I mean is the nurse, the nurse practitioner. I always say that nurses do 90 percent of the care and get 10 percent of the credit. Doctors do 10 percent of the care and get 90 percent of the credit. ... Not to put down what doctors do, but very often there's this whole concept of [a] God complex. And that's paternalism. Paternalis[ts] in medicine [are] a dying breed. Paternalism in medicine is, "I'm the good doctor, and you do what I say." Classic story is [when] the doctor says, "You should lose weight. You should lose weight," and he's huge. Then he leaves the room, goes downstairs and lights a cigarette. It happens.

So, the paternalism-concept is really fading. This whole concept of individualized care is really emerging. And it's a challenge ... because you have

to understand, on the flip-side, doctors have a lot of constraints. [Those] ... constraints [come from] ... healthcare providers for reimbursement, [from] time, from insurance companies — a whole variety of different things. But [those constraints] should not affect the [doctor's] voice. If you look at the data, the average doctor — any idea how long a patient speaks before the average doctor will interrupt? About ten seconds. That's what they studied. I think it's really important to — I know it's a challenge, but you really have to seek out healthcare providers who will listen.

What about low-dose vaginal estrogen, minimally-absorbed local vaginal estrogen? This is the biggest controversy, I think. No matter when I give a talk, I always talk about local estrogen. Do I do it? Do I not do it? I will say yes, I do it. I prescribe it to women. But everything in life [is a] risk-benefit [analysis]. There's no such thing as a free lunch. I monitor estradiol levels. I tend to strongly, strongly encourage alternatives first: Replens, vitamin E, lubricants. If that doesn't work, then we go to minimally-absorbed local estrogen. The most important thing to remember is our medical oncologists and surgeons tend to say, "Okay, we've got to measure your estradiol level, and if it's undetectable, then we're good. We're very happy." I guarantee you if I measured your estradiol levels, some of you, even on Aromasin — if you're on tamoxifen, forget it. Your estradiol levels are huge. But if you're on Aromasin or Femara or any of those medications, you still have estradiol and you still have estrone. You still have estrogen.

There are no studies to show that a slight bump up — whether from ten to 12 or ten to 17 or ten to 20 — there's no study to show that [estrogen-based vaginal creams are] related to disease progression or recurrence rate. There are no studies. Just because there are no studies doesn't mean it's not ... linked. ... There are case control studies that show women who have breast cancer, who are put on local estrogen — creams or rings — ... if you look at them, you don't have ... rapid progression of disease. You don't have metastatic disease when you didn't have it before.

That's not saying that [local estrogen is] safe. So I'm not coming up here and saying everybody run out and [get] on local estrogen, because I don't want to send that message. The message ... is that your care should be individualized, and [that] everybody's entitled to make their own decision based upon their disease: what their disease is, what medications they're on, what has worked and [what



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has] not worked. If you look here on bullet three, surgical oncologists, medical oncologists, gynecologists and patients will often disagree. You have to get everybody on board, and everybody has to be on the same team, otherwise you're going to have chaos. So it makes no sense if I say, "Well, maybe you should be on estrogen," and she's half-naked, grabbing her clothes and running out the door because she doesn't want to be on estrogen. It's futile. Or if the medical oncologist she absolutely loves, [the one who] is God to her . . . says, "Absolutely not." It's not going to be a good, comprehensive team.

Again, you have to know what your risk-tolerance is. This Kendall study, it was 2006, increased estradiol levels in breast cancer patients, they were on Vagifem. [Read the abstract: [http://annonc.oxfordjournals.org/cgi/content/abstract/mdj127v1.maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=aromatase&searchid=1138611594679\\_199&FIRSTINDEXT=0&sortspec=date&journalcode=annonc](http://annonc.oxfordjournals.org/cgi/content/abstract/mdj127v1.maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=aromatase&searchid=1138611594679_199&FIRSTINDEXT=0&sortspec=date&journalcode=annonc)] This was 25 micrograms of Vagifem. There's a new Vagifem coming out, 10 micrograms. Premarin Vaginal Cream — all the studies were on 2 grams. Now Premarin cream is .5 [grams]. So, again, you have to tailor it. Some women do very well on Vagifem. It's supposed to be twice a week. Some women do well once. I have breast cancer patients on Vagifem once every ten days, and they're using Replens or vitamin E. . . .

. . . Replens is a vaginal moisturizer. Inside the vagina, the difference between — there was one study. It was by Roux, one study between Replens and local estrogen. The difference in those is that Replens took much longer to get that same effect. Estrogen is really quicker. But Replens takes longer. It's every two to three days. It's non-hormonal. There are some women who are sensitive to the components. But it works very well. It's over the counter, it works very well, and it helps the ridges, folds, elasticity, pliability, stretchability of the vagina.

### **WOMAN:**

And are there any non-vibrator . . . mechanisms that help with that?

### **MICHAEL L. KRYCHMAN, MDCM:**

Yeah. We're going to get there.

### **WOMAN:**

Okay.

### **MICHAEL L. KRYCHMAN, MDCM:**

Yes, I'm sorry.

### **WOMAN:**

[Off microphone] Do you need to use the Replens regularly, every two or three days, to make

### **MICHAEL L. KRYCHMAN, MDCM:**

Yes.

[Speaking simultaneously]

### **WOMAN:**

[Off microphone] — cumulative effect?

### **MICHAEL L. KRYCHMAN, MDCM:**

Yes, yes. You can't just — think of — I'll give you the analogy. My mom gave me this analogy. She said, "You know, moisturizer — [imagine] you're invited to the Academy Awards. You have wrinkles under your eye, and you want to look good. You've got to use a moisturizer on a regular basis for it to look better." So a . . . vaginal moisturizer is like that. Let's say the day of the Awards you wake up, and you have a blemish. You use a concealer, or you use cover-up. That's a lubricant. So the day of the event, use a lubricant. It's made for that activity. It's made for friction, the viscosity is made for the day of the event. The moisturizer is not. So using a moisturizer the day of the Academy Awards is not going to really have a long-term effect on the wrinkles.

### **WOMAN:**

And one more question. The Faslodex, if you're on Faslodex, does that act the same as the aromatase inhibitors or —

### **MICHAEL L. KRYCHMAN, MDCM:**

Yes.

### **WOMAN:**

Okay.

### **MICHAEL L. KRYCHMAN, MDCM:**

So, we were talking about risk. Again, I think putting risk in perspective is very, very important. I think that we have lost sight of that. . . . A lot of women are very, very concerned about minimally absorbed local estrogen. But we know that the hazard-risk for . . . alcohol, smoking, obesity is certainly high. . . . There's data to support . . . that vigorous physical activity is actually very good for breast cancer patients. So, again, putting risk in perspective for an individual person is very, very important.

What about testosterone? Testosterone was used by the Mayo Clinic in breast cancer patients

and . . . it had no effect on mood, vitality, sexual functioning. My study, a case series of three who had metastatic disease, all three were given the opportunity to go on testosterone. [<http://www3.interscience.wiley.com/journal/II8496272/abstract?CRETRY=1&SRETRY=0>] They were informed, and they consented. They knew that taking this medication could potentially increase disease, meaning cause disease to progress, increase recurrence elsewhere, and ultimately accelerate their demise. And they all said, "No problem. I want to be on it. I need to have sexual functioning return," and they all did better.

There's, again, no such thing as a free lunch for androgens. I have a lot of women in my center who have breast cancer — whether it is metastatic or not — on androgens. They're followed very, very closely, and they are aware of their risk. And they've made their own decision. I have to separate my personal belief from my professional responsibility [to offer information to women and let them decide for themselves]. I personally might think that androgens are not a good thing for breast cancer patients. But after I give them all the information, they say, "You know what? I want to try this. I need this. My relationship is really important for me. My desire is important. It works in some people. It doesn't work in others. Let me try it, and I understand where I am and what it could do." I have to stand by them, because I know these women are driven, and they will get their therapy elsewhere. It might not necessarily be safer. It might actually be more dangerous when they're going to other healthcare providers or doing it themselves. . . .

What about the Viagra, Cialis, Levitra, the PDE5 inhibitors? There are a lot of studies to show that they don't help women. So these are the Viagra, [or] Cialis — "the weekendender." Viagra has gotten a lot of effect and, again, women have been affected by it [for] a variety of different reasons. . . . Now [that] we have a better understanding for SSRIs, the anti-depressant medication, Cialis certainly helps. So if you are on an SSRI [such as] Prozac, and you can't have an orgasm, [there are two options]. If you cannot get off the medication or change [antidepressants after consulting with your healthcare provider], you can take Cialis and have orgasmic response.

I think it's important — I tend to [prescribe] Cialis [in my practice]. Cialis is the weekendender. Women need spontaneity. I call it the lawnmower effect. The man goes, takes Viagra, mows the lawn



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for an hour, comes back and says, "I'm ready." And she says, "You've got to be kidding me." [But] Cialis, it's the weekend. You can take it in the morning, and it's good for the whole weekend.

This is a new medication, flibanserin, stage III clinical trials. I am one site of five in North America that is a registry for low libido, and it's the first registry that allows women who have breast cancer to be in the study. So we're learning about low libido. This will go to the FDA shortly and hopefully gain approval, so stay tuned. This is something for low interest, low desire that is not a hormone, that might be on the horizon for breast cancer patients. And we might be doing some studies in that so, again, very, very interesting and exciting time.

Wellbutrin, another medication that I use quite often: Wellbutrin is originally an anti-depressant, but works very well on desire. We've used it in breast cancer patients. So women that have low libido and might feel a little blue, depressed, Wellbutrin might be a good choice. So it's a centrally acting one which not only helps mood but it increases arousal, orgasm and desire. We use it quite often in sexual medicine for breast cancer patients. So there are certainly things that can be done.

I put a few slides in about the nutraceuticals. ... We're spending billions and billions of dollars [on] ... over-the-counter [medicines and supplements]. I would advise most people if they're taking vitamins or herbs or supplements or black cohosh or taking a variety of different things from their local market to look at this website. It's on Sloan-Kettering's site, <http://www.mskcc.org/mskcc/html/11570.cfm>. If you go on [www.mskcc.org](http://www.mskcc.org) you can type in "about herbs." [That search will produce] ... everything you always wanted to know but were afraid to ask about vitamins, about herbs, about compilations, about the good, the bad, the ugly, how it interferes [with other medicines]. Where's the data? There's a whole section for healthcare providers. There's a whole section for consumers. [This link is a] very, very good choice. And there [is] a lot of [information] about sexual enhancers.

Variety: You're bombarded with a lot of things, whether it's Passion Rx or libido or yohimbe ... I would caution everybody to be very careful because there's no magic silver bullet, and some of these can be detrimental. They're not FDA-regulated and, again, not a lot of good data.

Zestra is feminine arousal fluid. It's a topical

... [and has been] shown to be very helpful in sexual enhancement. So if you are having issues with arousal or orgasm, [Zestra] can certainly be applied directly to the clitoral tissue, or the mons [pubis], or the outside of the vagina. Again, you have to be very careful. It's not always very helpful. This is, again, a nutraceutical, over-the-counter. [But] a lot of patients have said they found it helpful.

New thing in the market — I'm not sure if you've seen it: KY Intense. It's [a] non-hormonal, non-drug gel, which is topically applied, [and] can be used [by] cancer patients. [The company that makes KY is] ... making claims that it enhances sexual experience, improves arousal, lubrication, [and is] not associated with genital irritation, adverse reactions. ... Every woman is different. Some women will find this very pleasurable, very enjoyable where their latency — meaning time to orgasm — and intensity of orgasm has changed. [Latency and intensity of orgasms] can [change] as women get older, [and changes can occur if women have had] multiple therapies and [are] on medications. A lot of women find this [product] very, very helpful.

What about lubricants? We talked about lubricants. They all vary with lubricity. ... Some women like the slippery, the slick, [while] some people like the gel or the thick — the KY or the Astraglide.

I think it's important to remember about the warming flavors, bactericides, spermicides. Be very careful. Read labels. If you really want to be overwhelmed, go to the [pharmacy] and look at the lubricant counter — whole, million choices. Very often what a patient gets when they go to the doctor [is the suggestion to] use a lubricant. ... Not all lubricants are the same. I tend to recommend paraben-free lubricants. So Astraglide, KY — they all have parabens. Parabens tend to be irritating for a lot of women. So, again, different things for different women. Slippery Stuff is also a very, very good brand. It's without glycerin. A lot of women who've had cancer therapies tend to be very sensitive to glycerin, and glycerin can promote yeast infections. So if you are prone to yeast infections, glycerin-free products might be helpful for you.

Other factors that have been shown to be helpful for sexual activity: [physical activity]; ... social support; having a healthy, well-balanced diet — [those are all] very, very important. I always say that I try to empower women. If women can

think of me when they go to the grocery store and they say, "Oh, that crazy Dr. Krychman, and I'm going to have broccoli because he told me [that would help]." ... I think I've done my job. If I write a prescription for calcium — do you know that if a doctor writes a prescription he has about a 15- to 20-percent chance that the patient's going to take it? The first drop-off is getting it into the car, so about 20 percent of patients don't even make it from the office into the car. Then you've got to get it from the car into the pharmacy. Then you've got to get it from the pharmacy back to your house, and then you've got to take it. So it's much better to [suggest] lifestyle changes than to write a prescription. Nutrition [is] very, very helpful. ... You have to be educated and empowered to know what you can choose, [and] what you can't. If you choose the fortified [orange juice] that has vitamin D, [that's] a good choice. So, again, making good choices, empowering you to try your best to live [healthfully].

Again, we talked about moisturizers — things like Replens, even vitamin E — simple, easy, cheap. Take a vitamin E tablet, pierce it, squeeze the vitamin E oil out, put it on your finger, put it in the vagina. It's very, very helpful. I've had women that don't like the Replens, but they tend to use ... EVOO, extra-virgin olive oil. You can use that. I just told her, "It's not really romantic to have the big bottle next to your nightstand." [Laughter] "Just get one of those little fancy bottles at Big Lots or something and just put it in there." ... Also FeminEase, Moist Again, [there are] a whole variety of different things, so read some labels. Replens is the most popular one, usually available online or from grocery stores.

What about a vibrator — [a] self-stimulator? Very often, I tell women that there's a normal process as women age. Arousal tends to decrease, so it takes longer. Women want to slow down sex as they get older. It takes longer to become aroused, lubricated, and it just takes longer in terms of foreplay. What happens in terms of men? Men want to hurry up sex, because as a man gets older he tends to lose his erection. So he's hurrying it up and she's slowing it down. So very often there's a mismatch in terms of timing. I think it's really important to understand self-stimulators. All sexual accessories, certainly can ... have a place, depending on who you are and what relationship you're in.

... We do a lot of what I call bibliotherapy or education. There is a whole variety of books out



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there, whether it's on cancer survivorship, hot flashes or understanding about the different types of orgasm. I had one woman who came in, she had breast cancer and she had bilateral mastectomies. [She] said she couldn't have an orgasm because the only way she was able to get an orgasm was from breast stimulation. [That] happens [with other women as well]. So we gave her information and she embarked on a journey of self-understanding to learn that there were clitoral orgasms and vaginal orgasms. Now she's very happy. So it's about education and learning; learning the new normal together as a couple, [and acknowledging] what is going to change.

I will tell you this: Even if cancer did not invade your life, your life would be different, because you get older, things change. Everything changes, including sex. So I think it's really important to understand that. ... Things certainly change.

I became a counselor because I think it's very important to understand ... [that] communication [is] very important. I think open and honest dialogue, ... [inaudible] active, non-judgmental listening [are important]. I always say men don't want a traffic cop, but they want instructions — even if they don't ask for them. So, you know, the proverbial man driving around in circles because he ... really wants direction, but he doesn't want to ask for it. So I think it's really important [to respond to the fact that men want information but may not ask for it].

I think that when we are in relationships, the most important thing to say to each other is, "What do you mean by that?" Because we think we can read minds. I always say that men are notoriously clueless. I always tell this story of a couple [who] came in, and [their disagreement was about] ... the water bottle on the plane. I'm going to see how many of you have experienced this: A couple, husband and wife, [are] on the plane. The wife is asleep. [The] stewardess walks by and says, "Would you like water?" He says, "Sure, I'll take water." She [walks away]. Wife wakes up and says, "Where's my water?" [Laughter] Now, the reverse happens. The husband's sleeping, snoring. The cart comes by. The stewardess says, "Would you like water?" She says, "Sure, I'll take water, and I'll take one for my husband, because maybe when he wakes up, he'll want one." [It's a] different kind of thinking.

Men and women are hardwired differently in how they think and how they approach

communication. So the wife might say, "Take out the garbage," and he's thinking, "Okay. I can take it out at halftime." She really means, "Take out the garbage now." So when I [counsel] couples, I say, "[Verbalize what you're thinking, which is]: 'What do you mean by that?'" Because [if you don't find that out], you're not [going to communicate] ... clear[ly]. ...

So, non-verbal communication: laughter, listening — very important. ... I wrote about this in my third book — the "escalator of sex." [This is] where a woman knows how sex is going to proceed and intimacy is going to proceed right from when he walks home with the flowers. It's [when sex has become] a typical thing. So sometimes novelty is very important, [because sex can] become boring, routine, predictable, pre-planned. [It's] very, very important to know that it's not always so routine, so focus on alternatives.

The wheel of pleasure: Really, it's focusing on pleasure, not performance. It doesn't always have to ... be [about] an orgasm. It's like a fine dining experience. A man walks into the restaurant and says, "Where's dessert?" A woman walks into a restaurant and says, "The table's very pretty. The waiter is nice. The food is good, the table set, lovely. The first course was wonderful, second course was good. And, you know what? I don't really want dessert tonight." So, again, a different experience. [It's about] focusing on pleasure, togetherness and intimacy rather than on performance and orgasm. [Making the experience a priority is] is very, very crucial.

Novel activities: Why is vacation sex very good? Bring vacation home. Do things novel. I always tell people: Dance in the living room; ride a roller coaster. There is some basis to this. If you do new activities, even with partners who've been 20 years together, you release adrenaline, oxytocin. They're the love hormones, [and they] tend to increase bonding and togetherness.

Mindfulness is really about much more [than] stopping and smelling the roses [on occasion]. It's really about being in the here and now [in most moments of your life]. The concept is when you're washing the dishes, actually wash the dishes — be present. How many of us drive somewhere and don't really know how we go there? It's really much more to stop and smell the roses. It's been shown to be very, very effective in a variety of healthcare issues: chronic pain, IBS [irritable bowel syndrome], fibromyalgia. The list goes on and on. There are new studies [to] show that if you are very attentive

to everything, you tend to have increased sexual function — new studies out of Vancouver with Dr. Brotto, very, very good.

We have a great acupuncture program. So if you believe in acupuncture as I do, acupuncture and libido, a wonderful program. Acupuncture and hot flashes: women are doing really well on this. So, again, finding people who are trained that understand [specific therapies] can be helpful.

I always say there's a balance, and I tried not to put all the negative aspects of pain, fatigue, changes and what have you. Some women say that cancer was a positive experience — better communication, increased understanding, careful contact, more intense feelings. So, again, cancer certainly has positive effects.

These are quotes from patients, [what] they have told me: The don't sweat the small stuff; new zest for life; they stop and smell the roses; they don't put off what they were going to do tomorrow, they do [it] today; they focus on today; there's less worry about the future. So, again, these are quotes from patients that have said that.

Understand that it's not always about sex. There is the healing power of touch. Men deprived of touch become aggressive. Women deprived of touch and connection become depressed. And those are clinical studies, very, very important.

There are a lot of good resources for sexuality. These are some of them. It involves a whole team, whether it's your internist, oncologist, fertility specialist, gynecologist, a whole variety of healthcare providers that really have to work in unison. Unfortunately, very often it's the patient who's helping the communication along. Hopefully with electronic medical records gaining forefront it will be a little bit easier and better for patients as well.

These are some of the books that I have written. [100 Questions and Answers for Women] *Living With Cancer* is really a practical guide to female cancer survivorship. It's for every type of cancer. It goes through general health, mind-body-spirit. It goes through sexual health, well-being. The other book focuses primarily on wellness. I'm very excited to let you guys know I'm writing a book with some colleagues on breast cancer, intimacy, sexuality and relationships, with Sandy Finestone. ... So we're very, very excited to be embarking on this project.

Remember, sex is really a function of a variety of different issues. It's not only about hormones. A whole variety of issues make you who you are and who you want to be.



Treatment is very — it's not linear. It can't be linear. Every woman is different. [Inaudible] ... A variety of ... [treatments may] work [when used together]: ... pain management, medical evaluation, alternative medicine, structure[d] task[s] or treatment[s], or medications. I know it's a challenge [finding the right combination for you], and everybody faces that.

I always put this slide in. I say, "Why do good people get cancer and suffer?" I could stand up here as a healthcare provider and say, "[The reasons are] oncogenes, proteins, risk factors." But as a healthcare provider and as a cancer survivor myself, I can tell you that it is your relationships with others that will help you through this very difficult time. I think it's really essential to understand that, that it might be the kind words of your doctor, your nurse. It might be your partner, your friend or even a stranger who will help you through a very, very difficult time when you're dealing with this crisis.

I [am] excited to mention [that] I was recently interviewed on Oprah Radio, talking about cancer and sexuality. They kind of blindsided me and the opened me up to the audience, and then we had [people] call in. There were some patients who had breast cancer. So if you are interested in listening to that, it's on Oprah Radio [[http://www.oprah.com/media/20090316\\_oradio\\_lb](http://www.oprah.com/media/20090316_oradio_lb)]. ...

We'll stop in a few minutes, just open it up and give you [all a chance to ask] some questions. I thank you very much. I know it's been a long day. These are [the people] I run for in my own personal journey for cancer survivorship. I thank you very much for your kind attention. We have some time for questions or concerns. Thank you. [Applause]

**ELIZABETH CORKERY:**

Thank you. You want to raise your hand if you have a question? And I'll bring the microphone out.

**WOMAN:**

I'm wondering if pH is the key to having a healthy vagina.

**MICHAEL L. KRYCHMAN, MDCM:**

Vaginal pH?

**WOMAN:**

Yeah.

**MICHAEL L. KRYCHMAN, MDCM:**

I think you make a good point. Vaginal pH is very, very important. Usually if you have atrophic changes, the vaginal pH increases. So every woman's vagina has good and bad bacteria. It's a balance between that. It's kind of a fight ... even on a good day you have a lot of bacteria. The vaginal pH certainly changes when you have atrophic changes. So you need restoration of the vaginal pH. Estrogen certainly does that. Replens can certainly do that as well. ... that's an objective measurement. So when you go to the gynecologist, you should say, "What's my vaginal pH?" And after they take a step back, and they give you the deer-in-headlights look, you should say, "Well, am I atrophic or not? What's my pH?" Then it's a good measure, because then you know if you're using the right qualities, [and] you can restore that to normal.

**WOMAN:**

The information that you gave about the local estrogen replacement, is that true across the board also for metastatic breast cancer? Or have the studies been done just for —

**MICHAEL L. KRYCHMAN, MDCM:**

There is no data. There's only old data on breast cancer. They didn't study metastatic breast cancer patients. There is no data on metastatic breast cancer and local estrogen. The only study is by Dew, et al. It's a cohort study where they used estrogen cream. Most doctors are a little apprehensive for two years. I have to tell you that a lot of the oncologists that I worked with at Sloan-Kettering, when you had metastatic disease, they weren't worried about local estrogen. They were more liberal, actually, to prescribe local estrogen, minimally absorbed local estrogen in women who had metastatic disease than that didn't. I don't know necessarily their rationale behind it. That was just the trend. It was very individualized.

I think everybody has to make their own decision. Again, I would advocate using non-hormonal things first. But some women need a touch of local [estrogen]. And my first thing is [to] know what your estrogen [and] estrone level[s] are.

**WOMAN:**

Actually, I had a couple of questions. When you talked about the vitamin D, do you test your patients before you prescribe the D, or do —

**MICHAEL L. KRYCHMAN, MDCM:**

Yeah.

**WOMAN:**

— [do] you have a recommended dosage? ... I've had people say to me, "You should be taking vitamin D," but nobody every says, "Oh, this is what your D level [is]" —

**MICHAEL L. KRYCHMAN, MDCM:**

I measure vitamin D in every woman who comes into my office.

**WOMAN:**

Okay.

**MICHAEL L. KRYCHMAN, MDCM:**

Because there's emerging data to support the fact that there's a subset of women who have vitamin D deficiency, [and] who are more at risk for developing breast cancer. Those that have breast cancer and have lowered vitamin D levels are more likely to [experience a] recur[rence of breast cancer]. The concept is every woman should know her vitamin D level. Then you'd be surprised how many people are low. I was shocked. I was completely shocked. You can certainly get [vitamin D] from your diet. There are a variety of different [units vitamin D comes in]. But usually it's 1,000 [International Units]. And then I remeasure [the vitamin D level in the women] to make sure that it's going up.

**WOMAN:**

Then my other question was the pH thing. That was interesting. Is there one thing that you recommend, be it the Replens or the vitamin E or — I thought the olive oil was interesting. I've never heard that one before.

**MICHAEL L. KRYCHMAN, MDCM:**

The Replens is the only one that's been studied to show that it will restore the vaginal pH. So when you said everything is based on vaginal pH, I agree to some extent. But you can use — I have a lady who was allergic to the Replens, so she couldn't use that. Vitamin E, and —

**WOMAN:**

The Replens for me seems to be an irritant, actually.

**MICHAEL L. KRYCHMAN, MDCM:**

Yeah. And it's not inexpensive. So I would try vitamin E.

**WOMAN:**

Okay.



**MICHAEL L. KRYCHMAN, MDCM:**

I tend not to [advise use of] the vitamin E oil, like in a bottle, in a dropper. I tend to tell them to buy the little tablets.

**WOMAN:**

You can get suppositories, too. They're hard to find. You have get them online.

**MICHAEL L. KRYCHMAN, MDCM:**

But I think you might be — as I said, women who've had chemotherapy [and] menopausal women [have] very, very sensitive . . . vaginal tissues. So you might be sensitive to some of the components of the Replens.

**WOMAN:**

All right. Thank you.

**MICHAEL L. KRYCHMAN, MDCM:**

And there's a whole variety. I would just make sure you, read the labels and read what's in there. Glycerin, parabens, the polyglycols, those are the things that can be offensive to some women. And there is paraben and glycerin-free Astraglide, which is also very, very good — it's in most drugstores. Yes.

**WOMAN:**

[Off microphone] [inaudible] . . . is [testing for low vitamin D levels] standard, the doctors are always testing it, you just have to ask them?

**MICHAEL L. KRYCHMAN, MDCM:**

No.

**WOMAN:**

You have to ask them to test it?

**MICHAEL L. KRYCHMAN, MDCM:**

I have to tell you that it's just emerging data, and most doctors don't know about it. It's emerging. There's been some talk about it. It's a trend, and it takes a while for standards to come out. But we're seeing a greater trend of women being tested for vitamin D.

**WOMAN:**

I know you're supposed to have [vitamin] D3, I think it is, right? So are there —

**MICHAEL L. KRYCHMAN, MDCM:**

So about 1,000 [IUs] —

**WOMAN:**

— different tests or —

**MICHAEL L. KRYCHMAN, MDCM:**

We just order it from the lab in vitamin D, and they'll measure your — it's 25-hydroxyl or something like that.

**WOMAN:**

Okay.

**MICHAEL L. KRYCHMAN, MDCM:**

I would just recommend that. If anybody here wants the resource on the vitamin D, just give the people from the conference your e-mail and I can send you the PDF file on that. The reasoning is, I have one lady in my center who's very into vitamin D. She's a very big proponent of it and [she has a deficiency in] her whole family. It's a genetic issue, that [she and her relatives] don't process [vitamin D] at the receptor level. So she has low D, her sister has low D, her mom has low D, and that's why the concept is that it might be linked to the development — she has breast cancer — it might be linked to the development of breast cancer in some families. And it's really a genetic vitamin D deficiency. Those that have breast cancer and have low vitamin D might have [a higher risk of recurrence]. They haven't done any studies that I know of [with] women who have metastatic disease [to find out if] it halt[s] progression or not. That's the limited data.

**ELIZABETH CORKERY:**

I'm going to take one more question, and then we have to wrap it up. But there will still be opportunity tomorrow morning to ask questions at the panel. Thank you. . . .

**WOMAN:**

Thank you. Can I just mention something about the [vitamin] D3?

**MICHAEL L. KRYCHMAN, MDCM:**

Sure.

**WOMAN:**

Larry Norton recommends a [vitamin] D3 level of over 40 when you're tested for it. He suggests 10,000 IUs a week of D3.

**ELIZABETH CORKERY:**

Thank you, Dr. Krychman, and thank you, everyone, for coming. [Applause] Please fill out your evaluation forms in your bags, and you can either hand it to me if you want to fill it out before you leave or to any Living Beyond Breast Cancer employee. Thank you.

[END OF TRANSCRIPT]