

Sexual Health During and After Cancer Treatment

Understanding Sexual Desire, Intimacy, Erectile Function, Vaginal Health, Painful Intercourse, Fertility and Recovery After Cancer

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Cancer treatment is designed first and foremost to save life, control disease and improve survival. But surviving cancer is not only about completing chemotherapy, radiation or surgery.

For many patients, another question gradually becomes important:

“What will happen to my sexual life?”

A woman may ask:

“Doctor, since my breast cancer treatment, I have severe vaginal dryness and no sexual desire.”

Another may say:

“Pelvic radiation has made intercourse painful.”

A man treated for prostate cancer may tell me:

“My cancer is controlled, but I no longer get a proper erection.”

Another patient may be most worried about fertility:

“Can I still have children after chemotherapy?”

These are not minor questions.

Sexuality, intimacy, body image, fertility and reproductive planning are important components of quality of life before, during and after cancer treatment. The American Cancer Society, with medical contribution from the American Society of Clinical Oncology, emphasizes that cancer and its treatment can affect the sexual organs, sexual desire, sexual function, intimacy and body image, and that sexual-health concerns should be discussed throughout treatment and survivorship.

My message to patients is therefore:

Cancer treatment should never be stopped or compromised simply to preserve sexual function, but sexual and reproductive health should also not be forgotten once cancer treatment begins.

In many cases, problems can be anticipated, prevented, reduced or treated.



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At **Saira Health Care**, my role in such patients is not to replace the oncologist or treat the cancer itself. My focus is the patient's **sexual and reproductive consequences of cancer and cancer therapy**, with appropriate coordination with the oncology, urology, gynecology and fertility teams.

Cancer Does Not End Sexuality

One of the most harmful assumptions is that a person with cancer should no longer care about sexuality.

Sexual health is much broader than intercourse.

It includes:

sexual desire, physical intimacy, touch, body confidence, erection, vaginal comfort, orgasm, ejaculation, fertility, reproductive planning, contraception and emotional closeness.

Some patients are actively receiving treatment and still value intimacy.

Others may have finished cancer treatment years ago but continue to struggle with sexual side effects.

Even in advanced cancer and palliative care, intimacy may remain meaningful. Contemporary cancer-care guidance therefore treats sexual health as a legitimate component of supportive and survivorship care rather than a luxury.

Why Cancer Treatment Can Affect Sexual Health

Cancer can influence sexuality in several different ways.

Sometimes the cancer directly involves a reproductive or sexual organ.

Sometimes treatment alters nerves, blood vessels or pelvic tissues.

Sometimes treatment reduces estrogen or testosterone.

Sometimes the main causes are fatigue, nausea, pain, depression, anxiety or fear of recurrence.

Cancer treatments may therefore affect:

sexual desire, genital sensation, erections, ejaculation, vaginal lubrication, vaginal elasticity, penetration, orgasm, fertility, body image and relationship confidence.

The exact risk depends upon the type and location of the cancer, treatment used, treatment dose, age, pre-treatment sexual function and other health conditions.



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Sexual Health Should Be Discussed Before Treatment

Whenever possible, sexual and reproductive counselling should begin **before** cancer treatment.

Before surgery, I want the patient to understand whether important nerves, reproductive organs or sexual structures may be affected.

Before pelvic radiation, patients should understand the possibility of long-term tissue changes.

Before chemotherapy, a reproductive-age patient should understand the possible effect on fertility.

Before hormone treatment, sexual and hormonal consequences should be explained.

This gives the patient realistic expectations and, where appropriate, allows fertility-preservation measures to be completed before treatment begins.

The American Cancer Society specifically recommends discussing sexual effects before treatment because this information can help patients prepare and participate in informed treatment decisions.

Sexual Problems Can Occur During or Years After Treatment

Not all sexual side effects appear immediately.

Some occur during treatment and resolve afterward.

Others appear months or even years later.

Radiation scarring is an important example of a delayed effect.

Nerve injury after pelvic surgery may have long-lasting consequences.

Hormone therapy may continue for several years and therefore continue influencing sexual desire and vaginal or erectile function.

Cancer survivorship care should therefore continue to ask about sexual health rather than assuming the issue ends when chemotherapy stops.

How Surgery Can Affect Sexual Health

The effect of surgery depends heavily on the organ involved.

Operations for cancers of the:



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prostate, bladder, rectum, colon, uterus, cervix, vagina, vulva, ovaries, penis, testes or breast

may have particularly noticeable sexual consequences.

Surgery can alter sexual function through tissue removal, scarring, nerve injury, blood-vessel injury, changes in body appearance or changes in urinary and bowel function.

Prostate Cancer Surgery and Sexual Function

Radical prostatectomy can affect erectile function because the nerves involved in erection travel close to the prostate.

When oncologically appropriate, surgeons may use nerve-sparing techniques, but preservation is not possible or successful in every patient.

After prostatectomy, erections may recover gradually over time, but some men develop persistent erectile dysfunction.

Orgasm may still be possible after prostate removal, but ejaculation changes because the prostate and seminal vesicles are no longer contributing seminal fluid. A man may therefore experience a **dry orgasm**, meaning orgasm without the usual ejaculation of semen.

This has important fertility implications because natural ejaculation of semen is no longer possible after complete prostate removal.

Erectile Dysfunction After Cancer Treatment

Erectile dysfunction may result from:

nerve injury, vascular damage, pelvic radiation, hormonal treatment, chronic illness, psychological distress or combinations of these factors.

Treatment may include, depending upon the patient:

oral erectile-dysfunction medicines, vacuum-erection devices, penile injection therapy, rehabilitation strategies and, in selected persistent cases, penile prosthesis surgery.

Treatment should be individualized, particularly in patients with cardiovascular disease or those taking medicines such as nitrates.

Androgen Deprivation Therapy and Sexual Function

Hormonal treatment for prostate cancer frequently lowers testosterone.

This can cause:

reduced libido, erectile difficulty, hot flushes, fatigue, changes in muscle mass, weight changes and emotional effects.

The American Cancer Society identifies decreased sexual desire as a common consequence of prostate-cancer hormone therapy and notes that emotional and physical changes may both contribute.

Patients should understand that reduced desire during androgen deprivation is a biological effect of treatment and does not mean that emotional attraction to a partner has disappeared.

Testicular Cancer

Testicular cancer can affect fertility and sexual health both through the cancer itself and through treatment.

Some men already have reduced sperm quality before therapy begins.

Removal of one testicle does not necessarily eliminate testosterone production or fertility if the remaining testicle functions normally.

However, chemotherapy, radiation or additional treatments may reduce sperm production.

This is why sperm preservation should be discussed before treatment in reproductive-age patients whenever feasible.

Breast Cancer and Sexual Health

Breast cancer treatment can influence sexual health through several pathways.

Breast surgery may affect body image and the way a woman experiences breast-related sexual touch.

Chemotherapy may cause temporary or permanent ovarian dysfunction.

Hormone therapies may reduce estrogen activity.

Women may experience:

lower sexual desire, vaginal dryness, painful intercourse, hot flushes, fatigue, altered body confidence and fear related to recurrence.

Cancer-related sexual dysfunction therefore cannot be reduced to one symptom.



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Mastectomy and Body Image

A breast has emotional, cultural and sexual meanings beyond its biological function.

After mastectomy or other breast surgery, a woman may experience:

loss of sensation, altered breast sensation, discomfort, fear about appearance or reduced sexual confidence.

A partner may also be uncertain about touching the treated area.

Open communication and gradual rebuilding of physical confidence can be valuable.

Some women feel comfortable very quickly.

Others need considerably more time.

There is no correct emotional response to breast surgery.

Hormone Therapy for Breast Cancer

Endocrine treatments for hormone-sensitive breast cancer can be lifesaving, but they may significantly influence sexual health.

Treatments that reduce estrogen action can cause symptoms similar to menopause, including:

vaginal dryness, reduced lubrication, painful intercourse, hot flushes and reduced sexual desire.

Aromatase inhibitors, ovarian suppression and other endocrine treatments therefore require proactive attention to vaginal and sexual symptoms.

Patients should **not stop cancer hormone therapy because of sexual side effects without consulting their oncologist.**

Many symptoms can be managed while continuing effective cancer treatment.

Vaginal Dryness in Cancer Survivors

Vaginal dryness can occur after:

chemotherapy, ovarian removal, ovarian suppression, endocrine therapy or pelvic radiation.

Dry tissue produces more friction.



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Friction produces burning and pain.

Repeated pain can then lead to fear, reduced arousal and pelvic-floor muscle tightening.

This creates a cycle in which the original hormonal problem gradually becomes a more complex sexual-pain disorder.

Non-hormonal vaginal moisturizers and lubricants are usually important first-line options.

The American Cancer Society differentiates moisturizers, which are used regularly to maintain moisture, from lubricants, which are mainly used to reduce friction during sexual activity.

Vaginal Estrogen After Breast Cancer

This is an area where individualized medical discussion is essential.

For women with a history of estrogen-dependent breast cancer, non-hormonal measures are generally considered first.

When these measures are inadequate, low-dose vaginal estrogen may sometimes be considered after discussion with the patient's gynecologist and oncologist.

ACOG notes that only small amounts are generally systemically absorbed and that vaginal estrogen may be an option for selected breast-cancer survivors after weighing individual risks and benefits.

A patient should not start estrogen treatment based on internet advice alone.

Her cancer type and current endocrine therapy matter.

Gynecological Cancer Surgery

Treatment for cancers of the uterus, cervix, ovaries, vagina and vulva can affect sexual health in different ways.

Possible consequences include:

anatomical changes, vaginal shortening, scar tissue, ovarian failure, pelvic-floor dysfunction, pain, altered genital sensation and body-image concerns.

Removal of both ovaries before natural menopause causes a sudden fall in estrogen and may produce abrupt menopausal symptoms.

Operations involving the vulva or vagina may change genital anatomy more directly.



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Sexual rehabilitation may therefore need to combine gynecological care with pelvic-floor physiotherapy and psychosexual support.

Hysterectomy and Sexual Function

Hysterectomy itself does not automatically mean the end of sexual function.

Many women retain sexual desire, vaginal sensation and orgasm after hysterectomy.

However, the reason for surgery, whether the ovaries were removed, additional cancer treatment, pelvic scarring and emotional response all influence the outcome.

A patient who experiences sexual difficulty after gynecological cancer surgery deserves assessment rather than being told that it is inevitable.

Vulvar and Vaginal Cancer Treatment

Surgery for vulvar or vaginal cancer can directly alter tissue involved in sexual sensation and penetration.

Depending upon the extent of surgery, patients may develop:

scar-related pain, narrowing, changes in sensitivity, body-image concerns or difficulty with penetration.

Reconstructive surgery and later sexual rehabilitation may be appropriate in some patients.

Colorectal and Anal Cancer

Treatment of rectal, anal and other pelvic cancers can also affect sexuality.

Pelvic surgery may damage nerves involved in erection, ejaculation or genital function.

Radiation can affect vaginal tissues or erectile function.

An ostomy can also change body image and practical aspects of intimacy.

Sexual rehabilitation is therefore relevant even when the cancer did not begin in a reproductive organ.

Living With an Ostomy and Intimacy



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A colostomy or ileostomy can initially make a person feel less sexually attractive or fearful of leakage during intimacy.

Practical adaptations, good stoma care and communication with the partner can help.

A person with an ostomy remains capable of intimacy and sexual pleasure.

The challenge is often rebuilding confidence and learning how the changed body functions.

How Chemotherapy Affects Sexual Health

Chemotherapy influences sexuality in several ways.

Some effects are indirect:

fatigue, nausea, vomiting, mouth ulcers, pain, hair loss and reduced physical confidence can all lower sexual interest.

Other effects are hormonal.

In women, certain chemotherapy regimens can interfere with ovarian function, producing temporary or permanent ovarian insufficiency and symptoms such as missed periods, hot flushes and vaginal dryness.

In men, some chemotherapy may temporarily lower testosterone and libido.

The impact depends upon the drugs, doses and individual patient.

Chemotherapy and Fertility Are Not the Same as Sexual Function

A patient may have normal sexual desire and erection but reduced fertility.

Another may have reduced libido while remaining fertile.

Another may lose ovarian function and experience both fertility and sexual consequences.

These are separate questions.

Sexual function asks:

Can the person experience desire, arousal, comfortable sexual activity and orgasm?

Fertility asks:

Can the person biologically conceive or produce a pregnancy?



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Cancer care should address both.

Sexual Activity During Chemotherapy

Many patients can remain sexually active during chemotherapy, but this should be confirmed with the oncology team because circumstances differ.

There may be periods when sexual intercourse should temporarily be avoided because:

white blood cells are very low and infection risk is increased, platelets are very low and bleeding risk is increased, genital or oral tissues are sore, surgery is healing, or another treatment-specific restriction is present.

The NCI specifically notes that some patients may need temporary abstinence when infection or bleeding risk is high.

Chemotherapy in Body Fluids

Some anticancer drugs or their metabolites may remain temporarily in body fluids.

Depending upon the treatment, oncology teams may advise condoms or other barrier protection during vaginal, anal or oral sexual activity for a specified period after treatment.

There is **no single universal number of days** that applies to every chemotherapy drug.

Patients should follow instructions for their specific regimen.

Infection Risk During Cancer Treatment

Chemotherapy and other cancer treatments can lower neutrophils—the white blood cells that help fight infection.

During periods of significant neutropenia, infection risk is increased.

This matters for sexual activity when there are:

genital sores, mucosal injury, active infection or practices likely to cause tissue trauma.

Patients should ask the oncology team whether blood counts require temporary precautions.

Bleeding Risk and Sexual Activity



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Some treatments lower platelet counts.

When platelets are very low, relatively minor trauma may cause bleeding.

NCI specifically recommends discussing whether activities including sexual intercourse need to be limited during significant thrombocytopenia.

This is another reason advice should be individualized to the current blood count rather than generalized.

Radiation Therapy and Sexual Function

Radiation effects depend primarily on the area being treated.

Radiation far from reproductive structures may have little direct effect on genital function, although fatigue, body-image changes and general illness can still reduce desire.

Pelvic radiation can have much more direct consequences.

Pelvic Radiation in Women

Radiation for cancers involving the:

cervix, uterus, vagina, vulva, bladder, rectum, anus or other pelvic structures can damage the vaginal lining and supporting tissues.

During treatment, tissues may become inflamed and sore.

Later, healing can produce fibrosis and scarring.

Possible long-term effects include:

vaginal dryness, reduced elasticity, vaginal shortening, narrowing and painful penetration.

Pelvic radiation can also damage the ovaries and cause premature menopause.

Vaginal Stenosis After Radiation

Vaginal stenosis means that the vagina becomes shorter, narrower or less elastic because of scarring.

This can make:



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sexual penetration painful, gynecological examination difficult and cancer follow-up examinations more uncomfortable.

American Cancer Society guidance recognizes vaginal dilators as an important strategy for helping maintain vaginal flexibility after pelvic radiation in appropriate patients.

A dilator should be introduced according to the radiation or gynecologic oncology team's recommendations rather than during active tissue injury without guidance.

Vaginal Dilators Are a Medical Rehabilitation Tool

Patients sometimes associate vaginal dilators only with sexual activity.

Their role after pelvic radiation is broader.

Keeping the vagina adequately open may also make future pelvic examinations easier, which is important for cancer surveillance.

Active research in 2026 continues to study ways of improving adherence to dilator therapy after pelvic radiation, demonstrating that vaginal rehabilitation remains an important survivorship issue.

Pelvic-Floor Physiotherapy After Cancer Treatment

Pelvic-floor physiotherapy may help selected cancer survivors who experience:

pelvic pain, muscle guarding, painful penetration, scar-related dysfunction, bowel or bladder difficulties.

Interest in pelvic prehabilitation and rehabilitation around pelvic radiotherapy is increasing, with active clinical research examining whether pelvic physical therapy can reduce pain and improve sexual outcomes.

Treatment should be provided by professionals experienced in oncology and pelvic rehabilitation.

Radiation and Sexual Function in Men

Pelvic radiation can affect erectile function by damaging blood vessels, nerves and surrounding tissues.

Erectile difficulties may develop gradually rather than immediately.

Radiation for prostate, bladder, rectal and anal cancers may therefore have long-term sexual consequences.



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Patients should report these problems early because rehabilitation and erectile-dysfunction treatment may be helpful.

Internal or Systemic Radiation Precautions

Most external-beam radiation does **not** make the patient radioactive.

Certain internal or systemic radioactive treatments are different.

Depending upon the isotope and treatment, temporary restrictions regarding close physical contact or sexual intimacy may be necessary.

Patients should follow the specific radiation-safety instructions given by their nuclear-medicine or radiation-oncology team.

Targeted Therapy and Immunotherapy

Targeted drugs and immunotherapy have transformed cancer care.

Their sexual effects are often less predictable than the classical effects of pelvic surgery or hormonal therapy.

Sexual function can nevertheless be influenced indirectly through:

fatigue, skin changes, endocrine abnormalities, pain, diarrhea, neuropathy or other treatment effects.

Immune checkpoint inhibitors can sometimes affect endocrine glands such as the thyroid, pituitary or adrenal glands, which can secondarily influence energy, hormonal function and sexuality.

Any new sexual symptom occurring with these treatments should therefore be discussed with the oncology team rather than automatically attributed to stress.

Stem-Cell Transplantation and Sexual Health

Patients undergoing hematopoietic stem-cell transplantation may experience sexual changes related to:

chemotherapy, radiation, hormonal loss, fatigue, prolonged illness and graft-versus-host disease.

Genital graft-versus-host disease can produce inflammation, dryness, scarring or pain.



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Such symptoms need specialist assessment because ordinary vaginal moisturizers alone may not be sufficient.

Sexual Desire During Cancer Treatment

Temporary loss of libido is extremely common.

Reasons include:

fatigue, pain, nausea, hormonal change, fear, depression, medications, altered appearance and concern about survival.

For many patients, sexual desire improves as health improves, but persistent loss of desire should not automatically be dismissed.

Cancer survivors can benefit from sexual-health evaluation, psychological care and treatment of contributing physical symptoms.

Cancer Treatment and Orgasm in Women

Cancer treatment does not automatically eliminate the ability to experience orgasm.

However, orgasm may become:

more difficult, less intense, painful or psychologically difficult.

Reasons may include hormonal change, pelvic surgery, vulvovaginal pain, reduced genital sensation, pelvic-floor dysfunction, antidepressant medication or fear.

Treatment therefore begins by identifying the dominant cause.

Ejaculation and Orgasm in Men

Ejaculation and orgasm are related but are not identical.

Cancer surgery can sometimes eliminate or alter ejaculation even when orgasm remains possible.

For example, prostate surgery commonly results in orgasm without semen.

Other operations or treatments may affect nerves or ducts involved in ejaculation.

The American Cancer Society notes that nerve damage, inability to produce semen or obstruction of the ejaculatory pathway can all produce ejaculatory changes.

Patients should therefore not assume that absence of semen always means absence of orgasm.

Painful Ejaculation After Cancer Treatment

Pelvic radiation, urethral irritation, prostate treatment, surgical scarring or pelvic-floor muscle dysfunction can occasionally make ejaculation painful.

Pain should be investigated rather than accepted as inevitable.

The source may be:

inflammatory, structural, neurological or muscular.

Cancer and Body Image

Sexual health involves how a person sees their own body.

Cancer treatment may leave:

mastectomy scars, abdominal scars, genital scars, ostomies, hair loss, weight changes, lymphedema or changes in muscle mass.

Patients may feel that their partner will no longer find them attractive.

These fears can reduce intimacy even when genital sexual function remains physically intact.

Body-image support should therefore be considered part of cancer sexual rehabilitation.

Fear of Cancer Recurrence During Sex

Some survivors worry:

“Can sex make the cancer return?”

Ordinary consensual sexual activity does not cause cancer recurrence.

Others worry that cancer can be transmitted to their partner.

Cancer itself is not ordinarily a sexually transmitted disease.

Specific infections associated with certain cancers—such as HPV or hepatitis—are separate issues and may require appropriate sexual-health counselling.



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Intimacy Does Not Have to Mean Penetrative Intercourse

During active treatment, penetrative intercourse may sometimes be difficult or medically inappropriate.

Intimacy can still include:

holding, kissing, massage, affectionate touch and other mutually comfortable sexual or non-sexual closeness.

The American Cancer Society encourages couples to recognize that sexual intimacy is broader than intercourse and to adapt sexual activity according to comfort and medical circumstances.

Communication With the Partner

Cancer can change the sexual experience for both members of a couple.

A partner may worry:

“Will touching hurt?”

“Will I cause infection?”

“Does my partner still want me?”

The patient may think:

“My partner no longer finds me attractive.”

Silence can magnify these concerns.

Open, calm communication often reduces fear and allows couples to discover new ways of being intimate.

Cancer and Mental Health

Anxiety, depression and fear of recurrence can significantly affect:

sexual desire, arousal, erection, orgasm and relationship intimacy.

Sexual-health treatment therefore sometimes requires a psychosexual therapist, psychologist or counsellor familiar with oncology.

The goal is not to suggest that the sexual problem is imaginary.

Cancer produces genuine biological changes, but psychological and relationship consequences can amplify them.



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Sexual Health in Advanced Cancer

Sexuality remains important for some patients even when cancer cannot be cured.

For one person intimacy may mean intercourse.

For another, holding a partner may be more important.

Palliative-care teams can address sexual-health and relationship concerns just as they address pain, nausea and sleep. The American Cancer Society specifically recognizes sexuality as relevant during palliative and end-of-life care.

Fertility Is a Major Part of Cancer Sexual and Reproductive Health

For younger patients in particular, fertility should be discussed as early as possible.

Cancer treatment can affect:

egg supply, ovarian function, sperm production, ejaculation, reproductive organs and ability to carry a pregnancy.

The risk depends upon the cancer and treatment.

Importantly, fertility preservation should ideally be discussed **before cancer-directed treatment begins whenever medically feasible.**

The Important 2025 ASCO Fertility Preservation Update

The American Society of Clinical Oncology issued a major updated fertility-preservation guideline in 2025.

The guideline recommends evaluating and counselling people with cancer about reproductive risks at diagnosis **and during survivorship.**

Patients who are interested in fertility preservation—or are uncertain about future parenthood—should be referred promptly to reproductive specialists.

This is an important development.

Fertility should not be discussed only once, on the day of diagnosis.

Reproductive goals can change after treatment.

Fertility Preservation for Men



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The 2025 ASCO guideline recommends **sperm cryopreservation** before cancer-directed treatment when appropriate.

If a man cannot provide a semen sample, surgical sperm retrieval such as testicular sperm extraction may sometimes be considered.

The guideline also advises that sperm collected very shortly after cancer therapy has begun may have increased genetic damage risk, emphasizing why fertility preservation is best completed beforehand whenever possible.

NCI likewise identifies sperm banking and surgical sperm retrieval among fertility-preservation options.

Fertility Preservation for Women

Established approaches may include:

egg freezing, embryo freezing, ovarian-tissue cryopreservation, ovarian transposition in selected radiation cases and fertility-sparing cancer surgery when oncologically appropriate.

The 2025 ASCO update also recognizes in-vitro maturation of oocytes as an emerging fertility-preservation option for selected patients.

NCI similarly describes embryo, egg and ovarian-tissue cryopreservation among current fertility-preservation approaches.

Ovarian Suppression Is Not a Replacement for Egg or Embryo Preservation

Gonadotropin-releasing hormone agonists may sometimes be used as an adjunct during chemotherapy, particularly in selected breast-cancer patients.

However, current ASCO guidance states that ovarian suppression should **not replace established fertility-preservation methods** such as egg, embryo or ovarian-tissue cryopreservation when these are feasible.

Fertility Assessment After Cancer Treatment

The 2025 ASCO update specifically expanded fertility discussions into survivorship.

Patients who did not preserve fertility before treatment may still benefit from post-treatment fertility assessment.

Depending upon the patient, this may involve:



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semen analysis, ovarian-reserve evaluation, menstrual history, reproductive endocrinology consultation or discussion of assisted reproductive options.

Pregnancy After Cancer

There is no single universal waiting period after cancer treatment before pregnancy.

Timing depends upon:

cancer type, recurrence risk, treatment received, duration of endocrine therapy, fertility status and the health of the patient.

Patients should therefore discuss pregnancy planning with both their oncology and reproductive teams.

Stopping endocrine cancer therapy to attempt pregnancy should never be done without oncology supervision.

Contraception During Cancer Treatment

Cancer therapy may reduce fertility without eliminating it.

A woman may still ovulate.

A man may still produce sperm.

Several cancer treatments may harm an embryo or fetus.

Effective contraception may therefore be necessary during and for a treatment-specific interval after therapy.

The exact method should be chosen with the oncology and reproductive-health teams because hormone-sensitive cancers may influence contraceptive choice.

Sexual Rehabilitation After Cancer

Rehabilitation should begin with identifying the particular problem.

For one patient, the main problem is erectile dysfunction.

For another, vaginal dryness.

For another, pelvic-floor tightening.

For another, fear of intercourse.

For another, infertility.



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For another, loss of genital sensation.

These are different problems and should not receive the same treatment.

Managing Vaginal Dryness

Depending upon cancer type and treatment, management may include:

regular non-hormonal vaginal moisturizers, lubricant during sexual activity, careful treatment of vulvar irritation and management of associated pelvic-floor dysfunction.

When symptoms persist, additional options may be discussed with the oncology and gynecology teams.

In women with hormone-sensitive cancer, hormonal treatment requires individualized decision-making.

Painful Intercourse After Cancer

Dyspareunia may arise from:

dryness, radiation fibrosis, surgical scars, vaginal narrowing, pelvic-floor dysfunction, genital graft-versus-host disease, menopause or fear-related muscular guarding.

A careful examination is important because simply prescribing more lubricant will not correct severe vaginal stenosis or pelvic-floor myalgia.

Pelvic-Floor Rehabilitation

A cancer survivor with pelvic pain or sexual dysfunction may benefit from a pelvic-health physiotherapist, especially after:

pelvic surgery, pelvic radiation, genital scarring or prolonged painful intercourse.

Treatment can include:

muscle relaxation, coordination, scar work, desensitization, mobility exercises and appropriately selected strengthening.

Current cancer survivorship resources include pelvic exercises among options for reducing pain and improving bladder, bowel and sexual function.

Vaginal Dilator Therapy



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Dilators may be particularly helpful after pelvic radiation where there is concern about vaginal narrowing.

The aim is gradual maintenance or restoration of tissue flexibility.

Dilators should not be used forcefully.

Active bleeding, infection, severe radiation injury or significant pain should prompt clinical reassessment.

Erectile Rehabilitation

For men, sexual rehabilitation may include:

optimization of cardiovascular and metabolic health, appropriate erectile-dysfunction medication, vacuum devices, injection treatment and psychosexual support.

Persistent erection problems following prostate or pelvic cancer treatment should be evaluated rather than dismissed as unavoidable ageing.

Sexual Counselling

Cancer changes sexual identity as well as physical function.

Sex therapy can help patients and couples adapt to:

new sensations, altered anatomy, changed erections or ejaculation, painful penetration, fear, reduced confidence and communication problems.

This can be particularly valuable when medical treatment has improved physical function but avoidance and anxiety remain.

A Unani Perspective on Sexual Health After Cancer Treatment

As a physician trained in Unani medicine, I approach sexual and reproductive recovery within the context of the patient's complete health.

Traditional Unani medicine gives importance to:

Mizaj or constitutional state, nutrition, sleep, physical activity, digestion, elimination, psychological wellbeing and reproductive function.

This broad whole-person perspective can be valuable in cancer survivorship because sexual difficulties frequently coexist with:



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fatigue, disturbed sleep, poor appetite, digestive problems, emotional stress, reduced physical strength and reproductive concerns.

However, cancer requires a particularly careful distinction between **supportive care** and **anticancer treatment**.

Unani Medicine Does Not Replace Oncology

I want to state this very clearly.

Unani treatment should never be used as a substitute for medically indicated cancer surgery, chemotherapy, radiation therapy, immunotherapy, targeted therapy or hormonal treatment.

There is no reliable evidence that an Unani sexual or herbal formulation can replace established cancer treatment.

The National Cancer Institute similarly states that no special diet, vitamin, supplement or herb has been proven to cure cancer or reliably prevent recurrence, and some supplements can interfere with anticancer treatment.

Responsible integrative medicine begins by protecting effective cancer treatment.

Herbal Medicines Can Interact With Cancer Drugs

This point deserves special attention because many cancer patients assume:

“Herbal means harmless.”

That is not correct.

Herbal and nutritional products can alter enzymes and transport systems used to metabolize cancer medicines.

NCI documents clinically important or potentially important interactions involving substances such as St John's wort, grapefruit products, green-tea extracts and certain anticancer medicines.

For this reason, I do **not** recommend that a patient receiving chemotherapy, targeted therapy or endocrine cancer treatment begin Unani or herbal medicines without reviewing the complete product and medicine list with the oncology team.

Antioxidant Supplements Require Caution During Cancer Treatment

High-dose antioxidant supplementation is another area where patients need caution.

Some cancer treatments work partly through oxidative cellular injury.

NCI reviews evidence suggesting potential adverse outcomes with certain antioxidant supplement use during chemotherapy or radiation in some settings.

Ordinary nutritious food and pharmacological high-dose supplements are not the same thing.

Any concentrated supplement during active treatment should therefore be discussed with the oncologist.

How Unani Care May Be Used Responsibly

Within these safety limits, Unani principles may have a supportive role in selected cancer survivors.

I may consider the patient's:

nutrition, digestive health, sleep, physical recovery, general wellbeing, sexual confidence and reproductive concerns.

But any oral Unani medicine during active oncology treatment requires careful review for possible interactions.

In some patients, the safest integrative contribution may be **non-drug supportive care**, lifestyle guidance and sexual-health counselling rather than herbal medication.

This is especially important during active chemotherapy and targeted therapy.

My Specialised Approach at Saira Health Care

At **Saira Health Care**, a patient who has cancer or has completed cancer treatment is not treated as though the cancer diagnosis belongs to us.

The oncologist remains responsible for oncological treatment and cancer surveillance.

My focused role in **Sexual Disorders & Infertility** is to address problems such as:

sexual desire changes, erection problems, ejaculation changes, painful intercourse, vaginal dryness, pelvic-floor dysfunction, reproductive planning, infertility concerns and relationship-related sexual difficulties.

I first want to know:

What cancer was treated?

Which surgery was performed?



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Was pelvic radiation given?

Which chemotherapy or targeted medicines were used?

Is endocrine therapy still continuing?

Were the ovaries or testes affected?

Was fertility preservation performed?

Only after understanding those facts can a responsible sexual or reproductive plan be developed.

Why the Cancer Treatment Record Matters

Two patients may both say:

“I had cancer treatment.”

But one had thyroid surgery.

Another had pelvic chemoradiation.

Their expected sexual consequences are completely different.

For this reason, cancer survivors should ideally keep records of:

diagnosis, surgery, chemotherapy agents, radiation field and dose where available, hormonal therapy and current medication.

This information can be extremely useful when later sexual or fertility problems are evaluated.

Contribution of Saira Health Care

The contribution of **Saira Health Care** in sexual disorders and infertility is particularly relevant to survivorship because sexual and reproductive concerns frequently fall between medical specialties.

An oncology consultation naturally focuses on cancer control.

A routine follow-up visit may focus on recurrence surveillance.

Yet the patient may silently be struggling with:

loss of erection, painful penetration, inability to ejaculate, infertility, reduced libido or fear of intimacy.

Our objective is to help bring these concerns into proper clinical discussion.



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Where appropriate, care may involve coordination with:

oncologists, urologists, gynecologists, reproductive-medicine specialists, pelvic-floor physiotherapists and psychosexual professionals.

Cancer Treatment Should Never Be Stopped for a Sexual Remedy

This is one of the most important principles in this article.

If a medicine such as:

tamoxifen, an aromatase inhibitor, ovarian suppression or androgen deprivation

is causing difficult sexual side effects, the patient should discuss these effects with the oncology team.

Do not stop anticancer therapy independently.

The correct objective is:

manage the side effect while preserving effective cancer treatment whenever possible.

When Should a Cancer Survivor Seek Sexual-Health Evaluation?

Assessment is particularly useful when there is persistent:

loss of sexual desire that causes distress, erectile dysfunction, painful intercourse, vaginal dryness, inability to tolerate penetration, vaginal narrowing, painful ejaculation, genital numbness or pain, loss of orgasm, infertility concerns or relationship difficulty related to sexual changes.

Patients do not need to wait until sexual function has been absent for years.

Early intervention can sometimes prevent secondary problems such as pelvic-floor guarding and fear of intimacy.

When Sexual Symptoms May Need Urgent Oncology Review

Most sexual problems are not emergencies.

However, prompt medical review is appropriate for:

new unexplained genital bleeding, severe pelvic pain, new genital mass, persistent ulceration, significant urinary bleeding, fever during cancer treatment, severe genital



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infection, sudden severe testicular pain, heavy bleeding during thrombocytopenia or a new symptom raising concern for treatment complication or cancer recurrence.

New pain in a cancer survivor should never automatically be assumed to be “just a sexual problem.”

Frequently Asked Questions

Can I have sex while receiving cancer treatment?

Many patients can, but not everyone should at every stage of treatment.

Low white blood-cell counts, low platelets, recent surgery, active infection, genital sores or treatment-specific precautions may require temporary changes. Ask the oncology team about your particular regimen.

Can cancer spread to my partner through sex?

Cancer itself is generally not sexually contagious. Certain infections associated with cancer risk, such as HPV, are separate infectious conditions.

Can chemotherapy be present in semen or vaginal secretions?

Some chemotherapy drugs or metabolites may temporarily be present in body fluids, so barrier protection may be recommended during and shortly after treatment. The required duration depends on the specific drug.

Can cancer treatment cause low libido?

Yes.

Hormonal changes, fatigue, pain, depression, anxiety and treatment side effects can all reduce sexual desire.

Can cancer treatment cause erectile dysfunction?

Yes.

Pelvic surgery, radiation and hormonal treatment are among the important causes.

Will erections always return after prostate surgery?

Recovery differs considerably among patients. Age, baseline erectile function, nerve preservation and other health factors influence recovery. Persistent ED can often still be treated.

Can a man orgasm after prostate removal?



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Many men can still experience orgasm, although ejaculation is usually absent after radical prostatectomy.

Why has my vagina become dry after breast-cancer treatment?

Chemotherapy-induced ovarian failure and hormone-blocking treatment can lower estrogen activity, contributing to vaginal dryness and painful intercourse.

Can breast-cancer survivors use vaginal estrogen?

Some may be able to after non-hormonal treatments prove inadequate, but this requires individualized discussion with the oncologist and gynecologist, particularly in estrogen-sensitive disease.

What is vaginal stenosis?

It is narrowing, shortening or reduced elasticity of the vagina, often caused by pelvic radiation-related scarring. It may make intercourse and pelvic examinations difficult.

Can vaginal dilators help?

They are commonly used after pelvic radiation to help maintain vaginal patency and elasticity. They should be used according to the oncology or pelvic-rehabilitation team's instructions.

Can pelvic-floor physiotherapy help cancer survivors?

It may help selected patients with pelvic pain, scar-related dysfunction, pelvic-floor overactivity or painful intercourse. Pelvic rehabilitation is increasingly incorporated into cancer survivorship care.

Can chemotherapy make me permanently infertile?

Some chemotherapy regimens can damage eggs or sperm permanently, while others have temporary or limited effects. Risk depends on the drugs, doses, age and baseline fertility.

Should fertility be discussed before cancer treatment?

Yes, whenever treatment may impair reproductive potential and the clinical situation allows it.

The 2025 ASCO guideline recommends counselling at diagnosis and continuing fertility discussion during survivorship.

What fertility options exist for men?

Sperm cryopreservation is a standard approach, and sperm retrieval may sometimes be possible when a semen sample cannot be produced.



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What fertility options exist for women?

Options may include egg freezing, embryo freezing, ovarian-tissue cryopreservation, ovarian transposition and fertility-sparing surgery in selected patients.

Can pregnancy occur during cancer treatment?

Potentially yes if fertility remains.

Because many treatments can harm an embryo or fetus, appropriate contraception is often necessary.

When can I try for pregnancy after cancer?

There is no one answer for all cancers.

The timing should be determined by the oncology and reproductive teams according to cancer type, recurrence considerations and treatment history.

Can Unani medicine restore sexual health after cancer?

Unani principles may have a supportive role in individualized survivorship care, especially regarding general wellbeing, nutrition, sleep, digestion and broader sexual-health concerns.

However, there is currently insufficient evidence to claim that a specific Unani medicine can reliably reverse cancer-treatment-related erectile dysfunction, vaginal stenosis, ovarian failure or nerve injury.

Can I take Unani or herbal medicines while receiving chemotherapy?

Only after the complete formulation has been reviewed with the oncology team.

Some herbs and supplements can change anticancer drug metabolism or effectiveness.

Can I stop my hormone cancer treatment because it is affecting sex?

Not without speaking with your oncologist.

Sexual side effects deserve treatment, but cancer-control therapy should not be stopped independently.

A Message From Dr. Nizamuddin Qasmi

When a cancer survivor tells me:

“Doctor, my cancer treatment saved my life, but my sexual life has disappeared,”

I take that concern seriously.



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Being grateful for successful cancer treatment does not mean a patient loses the right to ask about sexuality.

A woman can be grateful that her breast cancer is controlled and still be distressed by painful intercourse.

A man can be grateful after prostate-cancer surgery and still be deeply affected by erectile dysfunction.

A young survivor can be cancer-free and still worry about whether he or she will ever have children.

These feelings are not selfish.

They are part of survivorship.

The correct approach is also not to promise that one sexual tonic will undo the effects of major cancer treatment.

Cancer-related sexual problems can arise from:

nerves, hormones, blood vessels, scar tissue, pelvic muscles, reproductive-organ damage or psychological consequences.

These mechanisms require different treatments.

My role is therefore to understand what has changed and help guide the patient toward appropriate rehabilitation.

Current Medical Understanding

Modern cancer care increasingly recognizes three important principles.

First, sexual health belongs in oncology and survivorship care.

Patients should be given opportunities to discuss sexuality before, during and after cancer treatment.

Second, fertility preservation should be discussed early and revisited later.

The 2025 ASCO guideline formally recommends evaluating reproductive risks both at cancer diagnosis and during survivorship.

Third, sexual rehabilitation should be individualized.

Vaginal moisturizers, lubricants, carefully selected hormonal options, pelvic-floor physiotherapy, dilators, erectile-dysfunction treatment, fertility care and psychosexual counselling all have roles in selected patients.



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The future of cancer survivorship is therefore not simply longer survival.

It is **better quality of survival**.

Conclusion

Sexual Health During and After Cancer Treatment is an important part of comprehensive cancer survivorship.

Cancer and its treatment can affect sexual function through:

surgery, chemotherapy, radiation, hormone therapy, nerve injury, vascular injury, hormonal loss, fatigue, pain, altered anatomy, body-image changes and psychological distress.

Women may experience:

reduced desire, vaginal dryness, painful intercourse, premature menopause, vaginal narrowing, pelvic-floor dysfunction and fertility problems.

Men may experience:

reduced libido, erectile dysfunction, altered ejaculation, painful ejaculation, changes in orgasm, low testosterone and impaired fertility.

Many of these problems are treatable or manageable.

Modern sexual rehabilitation may involve:

lubricants and moisturizers, pelvic-floor physiotherapy, vaginal dilators, carefully individualized vaginal hormonal treatment, erectile-dysfunction therapies, psychological or sex therapy and reproductive-medicine support.

Fertility should be discussed early. The major **2025 ASCO fertility-preservation update** recommends reproductive counselling at diagnosis and again during cancer survivorship, with established fertility-preservation methods offered whenever appropriate.

From an Unani perspective, whole-person care—including nutrition, sleep, digestion, physical recovery, emotional wellbeing and reproductive health—can have value as part of survivorship support.

However, Unani or herbal treatment must never replace cancer therapy or surveillance.

Herbal products must also be used cautiously because some can interfere with anticancer medicines.



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At **Saira Health Care**, my approach is therefore deliberately integrative but oncology-led:

protect the cancer treatment, understand the sexual problem, preserve fertility whenever possible, rehabilitate sexual function, address emotional and relationship consequences, and use Unani supportive care only when it is medically compatible with the patient's cancer treatment.

Cancer treatment may change sexual function.

It does not mean sexual health no longer matters.

And survivorship should mean more than being alive.

Wherever medically possible, it should also mean helping patients return to a life that is physically comfortable, emotionally meaningful and sexually fulfilling.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH) — UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders, sexual rehabilitation, reproductive-health concerns and infertility.

In cancer survivors, his role is focused specifically on **sexual and reproductive consequences of cancer and its treatment**, while cancer therapy, cancer surveillance and decisions about chemotherapy, radiation, immunotherapy, targeted therapy and endocrine therapy remain under the treating oncology team.

His clinical approach emphasizes responsible integration of sexual medicine, reproductive-health assessment and Unani supportive principles while coordinating with appropriate oncology, urology, gynecology, fertility and rehabilitation specialists.



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Medical Disclaimer

This article is intended for health education and general public awareness. It does not provide cancer diagnosis or treatment and does not replace the advice of a medical oncologist, radiation oncologist, surgical oncologist, urologist, gynecologist or other appropriately qualified healthcare professional.

Patients should never stop, delay or modify chemotherapy, radiation therapy, immunotherapy, targeted therapy, endocrine treatment or other cancer therapy because of sexual side effects without consulting the treating oncology team.

Any vitamin, herbal medicine, Unani formulation or nutritional supplement being considered during active cancer treatment should be disclosed to the oncologist or oncology pharmacist because clinically important drug interactions may occur.

Patients receiving cancer therapy should ask their cancer team about contraception, condom use, pregnancy timing, sexual activity during periods of low blood counts and fertility preservation.

New unexplained bleeding, severe genital or pelvic pain, fever during cancer treatment, persistent genital ulceration, significant urinary bleeding, rapidly worsening symptoms or concerns about cancer recurrence require prompt medical assessment.



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