

Sexual Wellbeing During Cancer Care

Understanding Desire, Intimacy, Erections, Vaginal Health, Fertility and Relationships During and After Cancer Treatment

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Introduction

When a person is diagnosed with cancer, sexual health may initially seem unimportant compared with questions about survival, surgery, chemotherapy, radiation or other treatment.

Patients naturally ask:

“Can this cancer be treated?”

“What stage is it?”

“Will I need chemotherapy?”

“What are my chances of recovery?”

But as treatment progresses and the immediate shock begins to settle, another set of questions often appears.

A man may quietly ask:

“Will I still be able to have an erection?”

A woman may say:

“My vagina has become very dry and intercourse hurts.”

A younger patient may ask:

“Will I still be able to have children after treatment?”

Someone who has undergone major surgery may think:



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“Will my partner still find me attractive?”

A patient receiving hormone treatment may say:

“My sexual desire has almost disappeared.”

And sometimes neither partner says anything, even though both are worried.

In my clinical work involving **sexual disorders and infertility**, I consider these questions medically important.

Cancer treatment aims first and foremost to control or cure cancer whenever possible. That priority should never be compromised.

But surviving cancer and living well after cancer are not exactly the same thing.

Quality of life matters.

Relationships matter.

Fertility may matter.

Body confidence matters.

And sexual wellbeing can remain an important part of a patient's identity during treatment and survivorship.

The National Cancer Institute specifically recognises that cancer and its treatment can affect **sexual desire, sexual function, genital organs, body image and intimacy**, and that some effects are temporary while others may be long-term.

The American Cancer Society similarly emphasises that cancer does not make sexuality unimportant; treatment may change the way intimacy is experienced, but many problems can be treated, managed or adapted to.

My message to patients is therefore:

Sexual health is not an embarrassing extra in cancer care. It is part of whole-person care.

Cancer Does Not Automatically Mean the End of Intimacy

Some patients assume:

“I have cancer, therefore sexual life is no longer relevant.”

Others are afraid that sexual activity may make the cancer spread.

Partners may even fear that cancer can be transmitted through sexual contact.



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For almost all cancers, this is not how cancer behaves.

Cancer is **not generally contagious through sexual activity**, and ordinary intimate contact does not cause cancer to spread within the patient's body.

However, there may be periods during treatment when penetrative sex should be modified or temporarily avoided because of:

recent surgery,

low blood counts,

infection risk,

bleeding risk,

mucosal sores,

pelvic radiation effects,

pain,

particular chemotherapy precautions,

or temporary radiation-safety instructions after some forms of brachytherapy.

So the question should not simply be:

“Can cancer patients have sex?”

The more useful question is:

“What is safe and comfortable for this particular patient during this particular phase of treatment?”

Sexual Health Includes Much More Than Intercourse

When I speak about sexual wellbeing, I do not mean only penetration.

Sexual wellbeing can include:

sexual desire,

attraction,

affectionate touch,

erections,

vaginal lubrication,

arousal,



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ejaculation,
orgasm,
fertility,
body confidence,
comfort with one's partner,
and feeling emotionally connected.

A patient may temporarily be unable to have penetrative intercourse but still experience affection, touching, kissing, cuddling and emotional closeness.

This distinction is very important during cancer treatment.

If penetrative intercourse becomes temporarily difficult, intimacy does not have to disappear completely.

Why Cancer Treatment Can Affect Sexuality

Sexual problems during cancer care can develop from several pathways.

Some treatments directly affect reproductive organs, nerves or blood vessels.

Some change hormone levels.

Others cause fatigue, pain, nausea or weakness.

Surgery may change appearance or anatomy.

Cancer itself may create fear and depression.

Treatment may affect body image.

Certain medicines may lower desire or interfere with orgasm.

Therefore, two patients receiving cancer treatment may experience completely different sexual changes.

The NCI notes that sexual outcomes depend on factors such as:

type of cancer,
type of treatment,
treatment dose,
treatment duration,
age,



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general health,

and time elapsed since treatment.

This is why I do not believe in giving every cancer survivor the same “sexual-strength medicine.”

First we need to understand what changed and why.

Cancer Itself Can Reduce Sexual Desire

Not every sexual change is caused directly by cancer medicine.

Imagine what a patient may be experiencing:

fear of death,

uncertainty,

hospital visits,

pain,

nausea,

financial pressure,

disturbed sleep,

weight change,

fatigue,

hair loss,

and concern about family members.

Under those circumstances, lower sexual desire is completely understandable.

The American Cancer Society notes that pain, fatigue, nausea, anxiety, depression and changes in appearance can all reduce sexual interest during cancer treatment.

Therefore, reduced libido during intensive treatment does not necessarily mean a permanent sexual disorder.

Sometimes the body and mind are simply concentrating on survival and recovery.

Fatigue Is One of the Most Underestimated Sexual Side Effects

Cancer-related fatigue is different from ordinary tiredness.



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A patient may feel exhausted even after resting.

If someone is struggling to walk across a room, has undergone chemotherapy that morning and is nauseated, it is unrealistic to expect sexual desire to function exactly as it did before cancer.

Treatment of fatigue, anaemia, sleep problems, pain and other cancer-related symptoms can sometimes improve sexual wellbeing indirectly.

This is an important principle:

Sometimes the best treatment for low sexual desire is treatment of the symptom that is exhausting the patient.

Pain Changes Sexual Behaviour

Pain anywhere in the body can interfere with sexual interest.

Genital or pelvic pain can have an even stronger effect.

A patient may begin worrying:

“Will sex hurt?”

Fear then reduces relaxation.

Muscles may tighten.

Arousal may decrease.

Sexual activity becomes stressful instead of pleasurable.

Pain control is therefore part of sexual rehabilitation.

Do not assume that pain is something a cancer patient must accept silently.

Tell the oncology team.

Cancer Surgery and Sexual Function

Surgery affects sexual health differently depending on what part of the body is treated.

Operations involving the:

prostate,

bladder,

rectum,



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penis,

testicles,

uterus,

cervix,

ovaries,

vagina,

vulva,

breasts,

may have particularly direct sexual consequences.

But even surgery far away from the reproductive system can change body image through scars, altered appearance or creation of an ostomy.

The NCI and American Cancer Society both emphasise that cancer surgery can affect sexual function directly through anatomical or nerve changes and indirectly through changes in self-image.

Sexual Function After Prostate Cancer Surgery

Radical prostatectomy can affect erection nerves and permanently changes ejaculation because the prostate and seminal vesicles are removed.

A man may still experience orgasm, but it usually becomes a **dry orgasm**.

Natural conception through intercourse is no longer possible after radical prostatectomy.

Some men recover useful erections gradually, particularly after nerve-sparing surgery, while others require:

PDE5 inhibitor medicines,

vacuum erection devices,

penile injections,

or eventually a penile implant.

These changes should ideally be discussed **before surgery**, not after the patient discovers them unexpectedly.



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Sexual Changes After Bladder or Rectal Cancer Surgery

Pelvic operations can sometimes affect erection nerves, ejaculation pathways, vaginal anatomy or pelvic-floor function.

Some operations also result in a temporary or permanent ostomy.

A patient may then worry:

“How can I be intimate with a stoma?”

The concern is understandable.

But an ostomy does not mean sexual life must end.

Patients may benefit from practical planning, supportive clothing, emptying the pouch beforehand, body-image counselling and gradual reintroduction of intimacy.

The emotional adjustment may be just as important as the physical one.

Breast Surgery and Body Image

Breast surgery can affect sexuality even when genital function itself is unchanged.

A woman may feel:

less attractive,

uncomfortable being seen naked,

uncertain about scars,

distressed after mastectomy,

or disconnected from an area of the body that previously had sexual meaning.

These feelings should not be dismissed.

The NCI recognises that changes in appearance after cancer treatment can significantly affect self-image and intimacy.

Reconstruction may help some women.

Others do not want reconstruction.

There is no single psychologically correct decision.

The important question is what helps the individual patient feel comfortable in her own body.



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Chemotherapy and Sexual Wellbeing

Chemotherapy can influence sexual health directly and indirectly.

In men, some chemotherapy regimens may temporarily reduce testosterone and sexual desire.

In women, chemotherapy may reduce ovarian hormone production and sometimes cause premature ovarian insufficiency or treatment-induced menopause.

That can produce:

hot flushes,

irregular or absent menstruation,

vaginal dryness,

and painful intercourse.

Chemotherapy also commonly causes fatigue, nausea, altered appearance and emotional stress, all of which may reduce sexual interest.

Some effects improve after treatment.

Others may persist.

The degree of recovery depends on the drug regimen, dose, age and individual reproductive health.

Chemotherapy and Erectile Function

Chemotherapy does not automatically cause erectile dysfunction.

The NCI notes that chemotherapy itself usually does not directly eliminate a man's ability to achieve an erection, although hormone changes, fatigue, anxiety and other treatment effects may reduce desire and sexual response.

Therefore, a man who develops ED during chemotherapy deserves proper evaluation rather than assuming:

“Chemotherapy destroyed my erections permanently.”

The cause may be:

fatigue,

low testosterone,

psychological distress,



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medications,
vascular disease,
diabetes,
or a combination.

Radiation Therapy and Sexual Health in Men

Pelvic radiation can affect the blood vessels and nerves required for erection.

This is particularly relevant in cancers involving the:

prostate,
bladder,
rectum,
penis,
or nearby pelvic tissues.

Erectile dysfunction may develop gradually rather than immediately.

Radiation to the prostate can also reduce semen production, resulting in less ejaculate or dry orgasm.

Patients should therefore receive long-term sexual follow-up rather than assuming that normal function immediately after radiation means no later sexual effects will develop.

Radiation Therapy and Sexual Health in Women

Pelvic radiation can cause several changes in female genital tissues.

These may include:

vaginal dryness,
tissue thinning,
reduced elasticity,
shortening or narrowing of the vagina,
vaginal inflammation,
pain during penetration.

This narrowing and loss of elasticity is often called **vaginal stenosis**.



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The NCI specifically recognises vaginal stenosis, atrophy, dryness, burning and painful intercourse as possible consequences of pelvic radiation.

Depending on the cancer type and treatment plan, clinicians may recommend vaginal moisturizers, lubricants, pelvic-floor therapy or vaginal dilator programmes.

These should be individualized by the treating cancer and gynaecological team.

Vaginal Dilators After Pelvic Radiation

Some women receiving pelvic radiation are advised to use vaginal dilators after treatment.

The goal is generally to help maintain vaginal flexibility and reduce adhesions or narrowing.

This should be explained carefully.

A vaginal dilator is not intended as a punishment or forced sexual activity.

Patients should receive clear guidance regarding:

when to start,

how often to use it,

lubrication,

how much discomfort is acceptable,

and when to stop and seek medical advice.

A pelvic-health physiotherapist or appropriately trained clinician can be extremely helpful.

Hormone Therapy Can Have Major Sexual Effects

Hormone therapies are essential treatments for several cancers, but they can significantly affect sexuality.

For example, **androgen-deprivation therapy** for prostate cancer suppresses testosterone activity.

This can reduce:

sexual desire,

spontaneous erections,



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sexual thoughts,

and erectile response.

Some patients also experience fatigue and body-composition changes.

In breast cancer, endocrine treatments that reduce estrogen activity can contribute to:

vaginal dryness,

painful intercourse,

menopausal symptoms,

and reduced sexual desire.

These effects do not mean that the treatment is inappropriate.

They mean that quality-of-life side effects should be actively managed.

Sexual Desire During Androgen-Deprivation Therapy

A man taking hormonal treatment for prostate cancer may ask:

“Why doesn't sildenafil completely solve my problem?”

The answer may be that the problem is not only penile blood flow.

If testosterone is profoundly suppressed, sexual desire itself may be markedly reduced.

An erection tablet can assist blood flow.

It cannot automatically restore sexual interest in someone whose hormonal environment has deliberately been altered as part of cancer treatment.

This is why sexual rehabilitation must be based upon the actual mechanism.

Never Start Testosterone Without Oncology Approval

A cancer patient with low desire or fatigue should never purchase testosterone injections or “testosterone boosters” without proper specialist assessment.

This is particularly important in prostate cancer and other hormone-sensitive conditions.

Hormone supplementation may be inappropriate or dangerous depending upon the tumour biology and current cancer status.

Sexual-health treatment must never compromise cancer control.



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Targeted Therapy and Immunotherapy

Targeted drugs and immunotherapies have transformed cancer treatment.

Their effects on sexuality vary considerably between medicines.

Some can alter hormone production or indirectly affect sexual function through:

fatigue,

skin changes,

pain,

endocrine effects,

gastrointestinal symptoms,

or emotional stress.

The American Cancer Society notes that some immunotherapies and targeted treatments may affect reproductive or hormonal health and that research is still developing for many agents.

Patients should ask specifically about the exact medicine they are receiving rather than assuming every new cancer treatment has the same sexual side effects.

Medicines Used During Cancer Care Can Also Affect Sexual Function

The cancer treatment itself may not be the only medication influencing sexuality.

Some patients take:

opioids for pain,

antidepressants,

anti-nausea medicines,

sedatives,

antihypertensive medicines,

or other supportive treatments.

Certain medicines can reduce libido or make orgasm more difficult.

NCI specifically notes that opioids and some antidepressants may contribute to sexual problems during cancer care.



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Do not stop such medicines by yourself.

Instead, tell the treating clinician about sexual side effects.

Sometimes an alternative exists.

Sexual Health in Men During Cancer Care

Men may experience one or more of the following:

reduced desire,

difficulty obtaining an erection,

difficulty maintaining an erection,

reduced ejaculation,

dry orgasm,

painful ejaculation,

weaker orgasm,

loss of fertility,

body-image concerns,

performance anxiety.

These problems should be separated rather than all being described simply as:

“sexual weakness.”

A man with normal libido but poor erections requires a different approach from a man who has no sexual desire because of hormonal treatment.

A man with dry orgasm after prostatectomy requires explanation, not an unnecessary medicine intended to increase semen.

Erectile Dysfunction During and After Cancer Treatment

ED can develop after:

prostate surgery,

pelvic radiation,

pelvic nerve injury,

hormonal treatment,



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vascular damage,
psychological stress,
or another medical condition.

Treatment may include, depending upon the patient:

PDE5 inhibitors such as sildenafil or tadalafil,
vacuum erection devices,
penile injections,
penile rehabilitation,
counselling,
penile implants in selected cases.

Cancer patients should not buy unidentified “sexual strength” products.

The oncology and sexual-health teams should review the patient's cardiovascular status and medications before treatment is selected.

Ejaculation and Orgasm Can Change Without Eliminating Pleasure

Cancer treatment may change the amount or direction of semen.

A man may experience:

reduced ejaculate,
dry orgasm,
retrograde ejaculation,
painful ejaculation,
weaker orgasm.

The American Cancer Society explains that several cancer treatments can affect ejaculation while orgasm may still remain possible.

This is important psychologically.

A man should not assume:

“No semen means no orgasm.”

or:

“No semen means I have lost all sexual function.”



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Ejaculation, orgasm, fertility and erection are related but distinct biological processes.

Sexual Health in Women During Cancer Care

Women may experience:

reduced desire,

reduced arousal,

vaginal dryness,

painful intercourse,

shortened or narrowed vagina,

genital sensitivity changes,

reduced orgasm,

treatment-induced menopause,

body-image changes,

fertility loss.

Treatment should therefore be individualized according to the main complaint.

A woman whose major problem is vaginal dryness requires different care from one whose major issue is body-image distress after mastectomy.

Vaginal Dryness During Cancer Treatment

Vaginal dryness is particularly common when ovarian estrogen production falls or estrogen action is deliberately blocked.

Dry tissue creates friction.

Friction causes pain.

Pain creates fear.

Fear reduces arousal.

This can become a self-reinforcing cycle.

Management may involve:

non-hormonal lubricants,

vaginal moisturizers,



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pelvic-floor treatment,

and in selected patients local hormonal therapies.

However, women with hormone-sensitive cancers such as certain breast cancers require individualized discussion with oncology and gynaecology before hormonal products are used.

Do not assume that because a vaginal treatment is applied locally it is automatically appropriate for every cancer survivor.

Painful Sex Should Not Be Accepted as the Price of Cancer Survival

Patients sometimes think:

“I survived cancer. I should not complain about sex hurting.”

I disagree.

Survival and quality of life are not competing ideas.

Persistent pain deserves evaluation.

Possible causes may include:

vaginal dryness,

radiation changes,

surgical scar tissue,

pelvic-floor dysfunction,

infection,

treatment-induced menopause,

vaginal stenosis.

Appropriate care may substantially improve comfort.

Cancer, Fertility and Sexuality Are Related but Different

A cancer patient can have completely normal sexual desire but impaired fertility.

Another may remain fertile but experience severe erectile dysfunction.

A woman may lose ovarian function but still remain sexually active.

A man may have no ejaculation after prostate surgery but still experience orgasm.



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This distinction is particularly important in my practice because my work includes both **sexual disorders and infertility**.

Fertility should not be assessed only from sexual performance.

Sexual function should not be assessed only from fertility.

Fertility Preservation Should Be Discussed Before Cancer Treatment Whenever Possible

This is one of the most important recent advances in cancer care.

The **2025 ASCO Fertility Preservation Guideline Update** states that clinicians should discuss the possibility of treatment-related infertility **as early as possible before cancer treatment begins** and should refer patients who are interested in fertility preservation—or uncertain about it—to reproductive specialists.

For men, established approaches may include:

sperm cryopreservation,

and in selected circumstances surgical sperm retrieval.

For women, established approaches can include:

embryo cryopreservation,

oocyte freezing,

ovarian-tissue cryopreservation,

and certain fertility-preserving surgical approaches depending on the cancer.

The correct choice depends upon:

cancer type,

urgency of treatment,

age,

reproductive status,

and personal preferences.

Do Not Wait Until Cancer Treatment Is Finished to Ask About Fertility

This is a message I consider especially important for younger patients.



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Some treatments can permanently damage eggs or sperm.

Once that damage has occurred, preservation options may become much more limited.

The 2025 ASCO guideline therefore specifically recommends addressing fertility risk **before treatment whenever possible.**

A patient does not need to be married or planning a child immediately for this conversation to matter.

The question is about future reproductive choice.

Sperm Banking

For many post-pubertal male patients, sperm cryopreservation before cancer treatment is an established fertility-preservation option.

The American Cancer Society similarly advises men interested in future biological parenthood to discuss sperm preservation with their cancer team before treatment begins.

Even when time is limited, fertility referral may sometimes be possible without significantly delaying cancer therapy.

Ask rather than assume there is no time.

Fertility Preservation in Women

Women may have several potential options depending upon age, cancer diagnosis and how quickly treatment must begin.

These can include:

freezing eggs,

freezing embryos,

ovarian-tissue cryopreservation,

selected ovarian transposition or fertility-sparing surgery.

ASCO's 2025 update recognises ovarian-tissue cryopreservation as an established fertility-preservation approach and emphasises multidisciplinary access to reproductive specialists.

No single option is appropriate for every patient.



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Treatment-Induced Menopause

Some cancer therapies can cause ovarian function to stop temporarily or permanently.

A younger woman may suddenly develop:

hot flushes,

vaginal dryness,

loss of menstruation,

sexual discomfort,

reduced fertility.

This can be emotionally difficult because menopause arrives abruptly rather than gradually.

Sexual rehabilitation, fertility counselling and menopause management may all become relevant.

Is Sex Safe During Chemotherapy?

For many patients, sexual activity is possible during chemotherapy if they feel physically well enough.

But there are important exceptions.

If blood platelet levels are very low, penetrative sex may increase bleeding risk.

If neutrophils or other immune cells are very low, infection risk may become more important.

Some patients receiving intensive chemotherapy or stem-cell transplantation may temporarily be advised to avoid close physical contact or penetrative activity.

Therefore, ask your oncology team whether there are specific restrictions during your regimen.

Do not rely on advice given to another cancer patient because the treatment may be completely different.

Chemotherapy Can Be Present in Body Fluids

Small quantities of some chemotherapy or anti-cancer medicines may temporarily be present in:



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semen,
vaginal fluid,
or other body fluids.

For this reason, cancer teams may advise using **condoms or dental dams** during treatment and for a specified period afterward.

The exact duration depends upon the medicine.

Ask your oncology pharmacist, doctor or nurse:

“How long do we need barrier protection after each treatment?”

There is no universal number that applies to every chemotherapy regimen.

Contraception During Cancer Treatment

Infertility risk does not automatically mean pregnancy is impossible.

A patient may have reduced fertility and still become pregnant or cause a pregnancy.

Many cancer medicines and radiation treatments can harm a developing fetus.

Therefore, appropriate contraception may be necessary during therapy and for a defined period afterward.

Ask the treating team which contraceptive method is appropriate.

This is particularly important because hormonal contraception may not be appropriate in every cancer.

Sexual Activity After Surgery

After cancer surgery, the patient should allow the surgical site to heal.

How long that takes depends upon the operation.

Someone recovering from a minor procedure and someone recovering from major pelvic surgery do not have the same timeline.

Ask:

“When is penetration safe?”

“Are there positions I should avoid?”

“How much lifting or pressure is safe?”



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“Is there a risk of wound disruption?”

Do not use an arbitrary number of days found online.

Follow the surgical team's advice.

Radiation Does Not Always Make a Patient Radioactive

Patients sometimes worry that external-beam radiation makes physical intimacy dangerous to their partner.

It generally does not.

External radiation comes from a machine outside the body and does not make the patient radioactive afterward.

Certain forms of **internal radiation or brachytherapy** are different and may involve temporary precautions.

The radiation-oncology team should provide exact instructions.

Cancer Cannot Usually Be Passed to a Partner Through Sex

This deserves repeating because some couples remain frightened.

Cancer itself is not generally transmitted between partners through sexual activity.

A partner cannot “catch” prostate cancer, breast cancer, colon cancer or most other cancers by having sex with someone who has cancer.

Certain infections associated with cancer risk, such as HPV or hepatitis viruses, are a separate issue.

But the malignant cancer cells themselves are not normally sexually contagious.

Body Image Can Change Even When Sexual Function Is Physically Normal

A patient may technically be capable of sexual activity but not feel comfortable being seen naked.

Cancer can leave:

scars,

loss of a breast,

an ostomy,



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hair loss,
weight change,
swelling,
removal of reproductive organs,
genital changes.

These physical changes may alter how someone sees themselves.

The NCI recognises that body-image changes after cancer can cause worries about attractiveness, sexual performance and intimacy.

Psychological recovery therefore deserves attention alongside physical rehabilitation.

An Ostomy Does Not Mean Sexual Life Is Over

Patients with colostomy or ileostomy may feel embarrassed about:

appearance,
odour,
leakage,
whether a partner will react negatively.

Practical preparation can help.

Emptying the pouch before intimacy and using comfortable supportive coverings may improve confidence.

But equally important is communication.

A caring partner may be far less disturbed by the stoma than the patient fears.

Hair Loss and Changes in Appearance Can Affect Sexual Confidence

A person may say:

“I no longer look like myself.”

That feeling can strongly affect intimacy.

The partner can help by offering reassurance without dismissing the patient's emotions.

Instead of saying:

“It doesn't matter,”



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a more supportive response might be:

“I understand that the change is difficult. I am still attracted to you, and we can take things at your pace.”

That acknowledges both the distress and the relationship.

Talking With Your Partner About Cancer and Sex

Cancer can create silence between partners.

The patient may think:

“My partner probably doesn't want me anymore.”

The partner may think:

“I should not initiate sex because the patient is ill.”

Both remain silent.

A simple conversation can help:

“Cancer treatment has changed the way I feel physically and sexually. I still want closeness with you, but I may need us to approach intimacy differently for a while.”

A partner can respond:

“Tell me what feels comfortable. We do not have to prove anything.”

This removes performance pressure.

Do Not Make Penetration the Only Definition of Intimacy

During cancer care, there may be times when intercourse is:

uncomfortable,

unsafe,

exhausting,

or simply unwanted.

Intimacy can still include:

holding hands,

hugging,

kissing,



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cuddling,

affectionate massage,

non-painful sexual touch,

emotional closeness.

The American Cancer Society specifically recognises that closeness and intimacy can remain meaningful even when cancer temporarily changes sexual activity.

Sexual Rehabilitation Should Begin With Realistic Goals

The goal should not always be:

“Make my sex life exactly the way it was before cancer.”

Sometimes that is possible.

Sometimes it is not.

A prostate-cancer survivor with dry orgasm cannot recreate ejaculation after the prostate and seminal vesicles have been removed.

A woman after pelvic radiation may need a different approach to penetration.

A patient with an ostomy may need practical adaptation.

Sexual rehabilitation often means learning how intimacy can remain satisfying **within the body the patient has now.**

That is adaptation, not defeat.

Pelvic-Floor Physiotherapy

Pelvic-floor rehabilitation can be helpful for selected cancer patients experiencing:

pelvic pain,

vaginal tightness,

urinary symptoms,

pain during intercourse,

pelvic-floor overactivity,

pelvic-floor weakness.

This can be especially relevant after:



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pelvic surgery,
pelvic radiation,
gynaecological cancer treatment,
prostate treatment.

Treatment should be provided by a clinician trained in pelvic health and coordinated with the oncology team when necessary.

Psychological and Sex-Therapy Support

Cancer can generate:

fear,
depression,
body-image distress,
performance anxiety,
relationship tension,
trauma associated with medical procedures.

Even when the physical sexual problem is being treated, psychological effects may remain.

The NCI and American Cancer Society both recommend discussing persistent sexual concerns with the care team and considering counselling or specialist sexual-health support.

Professional sex therapy may be particularly useful when there is:

performance anxiety,
avoidance,
difficulty adjusting to body changes,
communication problems,
persistent fear of pain,
or relationship strain.

Seeking therapy does not mean the sexual problem is imaginary.

It means cancer has affected both body and mind.



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When Mental-Health Support Becomes Especially Important

Seek additional psychological help when cancer-related sexual difficulties are accompanied by:

persistent sadness,
severe anxiety,
hopelessness,
relationship breakdown,
social withdrawal,
loss of interest in most activities,
significant body-image distress,
inability to discuss intimacy with a partner.

Psychological care is not a luxury in oncology.

A recent Indian randomized study found that adding structured psychological intervention to standard cancer treatment improved stress, coping and quality-of-life outcomes compared with treatment as usual alone.

The Unani Perspective on Cancer-Related Sexual Wellbeing

As a physician trained in the **Unani system of medicine**, I believe one of its valuable principles is that a patient should be viewed as a whole person rather than as an isolated organ or laboratory result.

Classical Unani medicine considers:

Mizaj, or temperament,
sleep,
diet,
physical activity,
emotional state,
digestive health,
general vitality,



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reproductive and sexual wellbeing.

Cancer and intensive treatment can disturb many of these areas simultaneously.

A patient may have poor sleep.

Appetite may decrease.

Fatigue may increase.

Mood may deteriorate.

Sexual desire may fall.

General physical strength may decline.

This is why supportive whole-person care has understandable value.

What Is the Appropriate Role of Unani Medicine in Cancer Care?

This requires very careful distinction.

Unani medicine should **not replace evidence-based cancer-directed treatment**.

A patient with a malignant tumour who needs:

surgery,

chemotherapy,

radiotherapy,

immunotherapy,

targeted therapy,

or hormone treatment

should not discontinue that therapy because someone promises that a herbal treatment can cure the cancer.

India's Central Council for Research in Unani Medicine itself describes Unani interventions in cancer as **adjuvant to conventional treatment for specific supportive purposes**, including quality-of-life and treatment-support goals.

This is how I believe Unani care should be approached responsibly.

How Unani Care May Support Sexual Wellbeing During Cancer Treatment



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At **Saira Health Care**, if a patient receiving cancer treatment seeks help for sexual-health concerns, my first responsibility is to understand the oncology plan.

I want to know:

What cancer does the patient have?

Which treatment is being used?

Is the cancer hormone sensitive?

Has there been pelvic surgery?

Is chemotherapy ongoing?

Is radiation ongoing?

What medicines is the patient taking?

Are blood counts low?

Is there fertility risk?

Only then can supportive care be considered safely.

When appropriate and agreed with the oncology team, individualized Unani-oriented supportive care may focus on areas such as:

general wellbeing,

sleep,

nutrition,

fatigue,

digestive health,

emotional balance,

and selected sexual-health symptoms.

This does **not** mean using Unani medicine as the treatment for cancer itself.

Unani Treatment Should Never Interfere With Oncology

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

Cancer drugs often have narrow therapeutic requirements.

A herbal medicine may change:

absorption,



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metabolism,
liver enzymes,
drug transport proteins,
bleeding risk,
or other pharmacological pathways.

The National Cancer Institute specifically warns that herbs and dietary supplements can alter the way anticancer medicines are metabolised and may reduce their effectiveness or increase toxicity.

Therefore, before I recommend any Unani formulation to a patient receiving active cancer treatment, the complete medication list must be reviewed.

The oncologist should know what the patient is taking.

“Natural” Does Not Mean Safe During Cancer Treatment

Patients sometimes believe:

“Chemotherapy is strong medicine, but herbs are natural, so they cannot interfere.”

That is not correct.

The NCI and NCCIH both warn that herbal medicines and supplements can interact with cancer treatment.

For example, known herb–drug interactions can change the concentration of chemotherapy or targeted medicines in the body.

Cancer treatment is precisely the situation where undisclosed supplement use can become particularly risky.

Always tell:

oncologist,
pharmacist,
surgeon,
radiation oncologist,
and Unani physician
about every medicine and supplement you are using.



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Antioxidant Supplements During Chemotherapy Are Not Automatically Beneficial

Another common assumption is:

“Antioxidants protect healthy cells, so taking large doses during chemotherapy must be helpful.”

The science is not that simple.

Some chemotherapy and radiation treatments work partly through oxidative mechanisms.

The NCI notes that some studies have raised concerns that antioxidant supplements taken during treatment may reduce treatment effectiveness or be associated with worse cancer outcomes.

Therefore, do not add high-dose antioxidant supplements during chemotherapy or radiotherapy without oncology approval.

Unani Supportive Care Is Not the Same as an Unregulated “Cancer Cure”

This distinction is essential.

A registered Unani physician working cooperatively with an oncology team is very different from an unknown product seller who says:

“Stop chemotherapy and take this herbal cancer cure.”

The second approach can be dangerous.

NCCIH clearly states that no complementary health approach has been demonstrated to cure cancer or put cancer into remission, and using unproven products instead of effective treatment can cause serious harm.

At Saira Health Care, cancer-directed treatment should remain under oncology.

Saira Health Care's Approach to Sexual Wellbeing During Cancer Care

At Saira Health Care, my focus is **sexual disorders and infertility**.

When a cancer patient presents with an intimate-health concern, I prefer to identify the exact issue.

Is it:

low desire?



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erectile dysfunction?

dry orgasm?

painful ejaculation?

vaginal dryness?

painful penetration?

loss of fertility?

treatment-induced menopause?

body-image distress?

performance anxiety?

relationship strain?

These are different problems.

The treatment plan should therefore be individualized.

My Role and the Role of the Oncology Team

I consider collaboration extremely important.

The oncologist's role is to diagnose, stage and treat cancer.

Depending on the problem, additional specialists may include:

urologists,

gynaecologists,

reproductive endocrinologists,

fertility specialists,

pelvic-health physiotherapists,

psychologists,

psychiatrists,

psychosexual therapists.

My role within Saira Health Care is to evaluate sexual and reproductive concerns within my focused area of practice, provide appropriately selected supportive Unani care where safe, and refer or collaborate when the patient's cancer treatment or sexual complication requires another specialist.



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This is responsible integrative medicine.

Questions Every Cancer Patient Should Consider Asking Before Treatment

If possible, ask your oncology team:

Will this treatment affect my sexual function?

Could it affect erections or ejaculation?

Could it cause vaginal dryness or painful intercourse?

Could it trigger early menopause?

Could it affect orgasm?

Will it affect my fertility?

Should I preserve sperm, eggs, embryos or reproductive tissue before treatment?

Do we need contraception?

Do we need condoms or dental dams during treatment?

When will sexual activity be safe after surgery?

Are any herbal medicines or supplements unsafe with my treatment?

These questions are appropriate.

Cancer care should make space for them.

Frequently Asked Questions

Can I have sex while receiving cancer treatment?

Often yes, but the answer depends on treatment, blood counts, surgical recovery, infection risk and the medicines being used.

Your oncology team should give individualized advice.

Can my partner catch cancer from me during sex?

Generally, no.

Cancer itself is not normally contagious through sex.



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Can chemotherapy be present in semen or vaginal fluid?

Small amounts of some chemotherapy drugs may temporarily appear in body fluids.

Your cancer team may recommend condoms or dental dams during treatment and for a defined period afterward.

If chemotherapy may make me infertile, do I still need contraception?

Yes, if you or your partner could potentially become pregnant.

Reduced fertility does not necessarily mean zero fertility, and anticancer treatments can harm a developing fetus.

Should fertility preservation be discussed before cancer treatment?

Yes, whenever treatment poses a fertility risk and future biological parenthood may matter.

The 2025 ASCO guideline strongly recommends discussing reproductive risk early and referring interested or uncertain patients to fertility specialists.

Can a man freeze sperm before chemotherapy?

Yes.

Sperm cryopreservation is an established fertility-preservation option for many post-pubertal male patients and should ideally be discussed before treatment begins.

Can women preserve eggs before cancer treatment?

For appropriate patients, oocyte or embryo cryopreservation may be possible.

Ovarian-tissue cryopreservation and selected fertility-preserving procedures are other options depending on the clinical situation.

Can chemotherapy cause low sexual desire?

Yes.

Fatigue, nausea, psychological stress and hormone changes may all contribute.



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In men, some treatments lower testosterone; in women, some chemotherapy can reduce estrogen or cause treatment-induced ovarian failure.

Can cancer treatment cause erectile dysfunction?

Yes.

Pelvic surgery, radiation, hormonal treatment and other factors can contribute to ED.

Treatment options may include medicines, vacuum devices, injections or other specialist therapies depending upon the cause.

Can cancer treatment cause painful sex in women?

Yes.

Vaginal dryness, low estrogen, scar tissue, pelvic radiation and vaginal stenosis can all contribute.

Is vaginal dryness treatable?

Often, yes.

Non-hormonal lubricants and moisturizers may help.

Some patients may be candidates for local hormonal or other therapies, but women with hormone-sensitive cancers require individualized specialist discussion.

Can prostate-cancer treatment cause dry orgasm?

Yes.

Prostate surgery and some other prostate treatments may permanently reduce or eliminate semen ejaculation, although orgasm may still be possible.

Can hormone therapy for prostate cancer reduce libido?

Yes.

Androgen-deprivation therapy lowers testosterone activity and can markedly reduce sexual desire and erectile function.



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Can I take a sexual-enhancement herbal medicine during chemotherapy?

Not without oncology review.

Herbal products can interact with anticancer drugs and may change treatment effectiveness or toxicity.

Can Unani medicine cure cancer?

Current scientific evidence does not support using Unani medicine as a replacement for established cancer-directed therapy.

CCRUM materials describe Unani approaches as **adjuvant** to conventional treatment for supportive purposes, and complementary-care authorities warn against substituting unproven treatment for effective oncology care.

Can Unani medicine help cancer patients at all?

It may have an appropriately selected **supportive role**, particularly within a coordinated integrative-care plan addressing general wellbeing, nutrition, sleep, digestive health and certain quality-of-life concerns.

Evidence for specific Unani interventions in cancer and cancer-related sexual dysfunction remains limited, so treatment claims should remain realistic and individualised.

Should I tell my oncologist about Unani medicines?

Yes.

Always.

The oncologist and pharmacist should know about all herbal medicines, supplements, vitamins and traditional formulations you are using because interactions with cancer treatment are possible.

When to Seek Specialist Sexual-Health Help

Ask for additional support if you experience:

persistent erectile dysfunction,

complete loss of sexual desire that is distressing,



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severe vaginal dryness,
recurrent painful intercourse,
vaginal narrowing after radiation,
painful ejaculation,
persistent orgasm difficulty,
significant body-image distress,
relationship conflict,
fertility concerns,
anxiety about intimacy after treatment.

Patients should not wait until the problem has existed for years.

Early counselling and rehabilitation may make adjustment easier.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

My professional qualifications and training include:

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

My focused clinical work involves sexual disorders, reproductive health and infertility.

These areas frequently overlap with oncology because cancer and cancer treatment can affect:

fertility,
erection,
ejaculation,
libido,



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vaginal health,
sexual pain,
hormone function,
and intimate relationships.

At Saira Health Care, my aim is to provide patients with a professional and confidential environment in which these concerns can be discussed without shame.

My Message to Cancer Patients

If you are undergoing cancer treatment and your sexual life has changed, please do not think:

“I should be grateful to be alive, so I have no right to discuss this.”

You can be grateful for treatment and still want help with:

pain,
erections,
vaginal dryness,
fertility,
sexual desire,
or intimacy.

These feelings can exist together.

Likewise, do not compare your recovery with another cancer patient.

Two people can have the same cancer and completely different sexual side effects.

Ask your own treatment team.

My Message to Partners

Cancer affects couples as well as individuals.

Your partner may be afraid you no longer find them attractive.

They may be embarrassed about scars.

They may worry about erectile dysfunction.

They may feel unattractive after losing hair or a breast.



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They may be frightened that sex will hurt.

Do not assume silence means lack of interest.

Ask:

“What feels comfortable for you?”

rather than:

“Why don't you want sex anymore?”

Intimacy during cancer care may need patience and adaptation.

That does not make it less meaningful.

Final Words From Dr. Nizamuddin Qasmi

Cancer treatment must always prioritise the control of cancer.

But medicine should also remember the person who is being treated.

That person may be:

a husband,

a wife,

a partner,

a young adult hoping for children,

a cancer survivor adjusting to a changed body,

or someone who simply wants to feel close to the person they love.

Sexual wellbeing deserves a place in cancer care.

Modern oncology gives us powerful treatments for cancer.

Modern sexual medicine gives us ways to address erections, vaginal health, pelvic-floor function, sexual pain, hormone-related symptoms and intimacy concerns.

Modern reproductive medicine allows many patients to discuss fertility preservation before potentially gonadotoxic treatment.

Psychological and psychosexual care can help with body image, anxiety and relationship adjustment.

And the Unani system can contribute a carefully individualized whole-person perspective addressing lifestyle, sleep, nutrition, general wellbeing and selected



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supportive needs **when used in coordination with oncology and never in place of cancer treatment.**

That distinction is central to my approach at **Saira Health Care.**

I do not believe responsible traditional medicine should ask a cancer patient to choose between Unani care and oncology.

Cancer-directed treatment belongs with the oncology team.

Supportive sexual and reproductive care should work around that treatment safely.

So if cancer has changed your sexual health, please ask for help.

Do not assume the problem is too embarrassing.

Do not purchase unknown sexual medicines.

Do not hide supplements from your oncologist.

Do not delay fertility-preservation discussion when treatment may threaten fertility.

And do not believe that cancer automatically removes your right to intimacy.

Cancer treatment may change sexuality, but with appropriate medical care, communication, rehabilitation and support, many patients can preserve or rebuild a meaningful and satisfying intimate life.

Important Medical Disclaimer

This article is intended for general patient education and health awareness and does not replace individualized oncology, surgical, urological, gynaecological, reproductive or sexual-health assessment.

Cancer treatment should be directed by an appropriately qualified oncology team.

Sexual activity may need to be modified or temporarily avoided after surgery, during periods of severe thrombocytopenia or neutropenia, during certain intensive treatments or when the oncology team advises specific precautions.

Use appropriate contraception when recommended because cancer treatment may harm a developing fetus even when fertility is reduced.

Patients receiving chemotherapy or other systemic anticancer treatment should follow their oncology team's instructions regarding condoms, dental dams and the duration of barrier precautions.

Fertility preservation should ideally be discussed before cancer-directed treatment whenever the treatment may threaten reproductive function.



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Unani medicines, herbal products, supplements and high-dose vitamins should not be started during cancer treatment without review by the oncology team because clinically important interactions are possible.

Unani medicine may be considered for carefully selected supportive purposes but should **not replace surgery, chemotherapy, radiotherapy, immunotherapy, targeted therapy, endocrine therapy or another medically indicated cancer treatment.**