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Sexless marriage phenomenon, prostate cancer, and bioethics

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Abstract

The term sexless marriage refers to the lack of sexual activity or intimacy in a marital union for one year. Prostate cancer treatment can cause this phenomenon, leading to a reality in which the lack of sexual activity affects marriage. The objective of this literature review is to investigate the impact of the disease on the relationship and redefine the role of this partnership with new strategies, so that sexual relations are not restricted to the genitals. The PubMed, SciELO, and Google Scholar databases were consulted, as well as widely circulated websites, using the descriptors prostate cancer, relationship intimacy, partner, sexless marriage, and treatment. The patient's dependence on his partner is noticeable, affecting his self-esteem, whereas she feels responsible for the success of the therapy and bears the anguish imposed by the disease. Welcoming the partner is an opportunity to include a disease with multiple consequences in a current and ethical debate.

Keywords: Sexual behavior. User embracement. Bioethics. Equity. Prostatic neoplasms.

Resumo

Fenômeno *sexless marriage*, câncer de próstata e bioética

O termo *sexless marriage* refere-se à falta de atividade ou intimidade sexual em uma união conjugal por um ano. O tratamento de câncer de próstata pode ocasionar esse fenômeno, acarretando uma realidade na qual a falta de atividade sexual afeta o relacionamento conjugal. O objetivo desta revisão de literatura é investigar o impacto da doença na relação e redefinir o papel dessa parceria com novas estratégias para que a relação sexual não se restrinja ao genital. Consultaram-se as bases PubMed, SciELO e Google Scholar e sites de grande circulação, por meio dos descritores *prostate cancer*, *relationship intimacy*, *partner*, *sexless marriage e treatment*. Nota-se dependência do paciente em relação à parceira, afetando a autoestima dele, enquanto ela se sente responsável pelo sucesso do tratamento e carrega as angústias impostas pela doença. Acolher a parceira é oportunidade de incluir uma doença de múltiplos desdobramentos em um debate atual e ético.

Palavras-chave: Comportamento sexual. Acolhimento. Bioética. Equidade. Neoplasias da próstata.

Resumen

Fenómeno *sexless marriage*, cáncer de próstata y bioética

El término *sexless marriage* se refiere a la falta de actividad o intimidad sexual en una unión conyugal durante un año. El tratamiento del cáncer de próstata puede provocar este fenómeno, llevando a una realidad en la que la falta de actividad sexual afecta la relación conyugal. El objetivo de esta revisión de la literatura es investigar el impacto de la enfermedad en la relación y redefinir el papel de este vínculo con nuevas estrategias para que la relación sexual no se limite a lo genital. Se consultaron las bases de datos PubMed, SciELO y Google Scholar, y sitios web de amplia circulación, mediante los descriptores *prostate cancer*, *relationship intimacy*, *partner*, *sexless marriage* y *treatment*. Se nota la dependencia del paciente con relación a su pareja, lo que afecta su autoestima, mientras ella se siente responsable del éxito del tratamiento y carga con las angustias impuestas por la enfermedad. Acoger a la compañera es una oportunidad para incluir una enfermedad con múltiples repercusiones en un debate actual y ético.

Palabras clave: Conducta sexual. Acogiemento. Bioética. Equidad. Neoplasias de la próstata.

The authors declare no conflict of interest.

Research

Since its inception, bioethics has investigated all the conditions required for the responsible management of human life. Likewise, the perspective that human life is more important than science is formulated. Therefore, this area, due to its importance, ends up assuming a triple function: a) describing and analyzing conflicts; b) proscribing behaviors considered reprehensible and prescribing those considered correct; c) protecting all those involved in an issue and prioritizing when necessary, "the weakest" [1].

These assumptions, especially the last one, are related to the object of this article: the study of the partner's perspective in the phenomenon known as sexless marriage during the partner's prostate cancer treatment. Sexless marriage is a term in the medical literature of the United States that designates a marriage in which sexual intercourse occurs less than ten times a year for a known or unknown reason.

In 1992, the US National Health and Social Life Survey [2] reported that 2% of married respondents between the ages of 18 and 59 had not had sexual intimacy in the past year, and, by comparison, among those aged 65 to 80, 92% had not. Some of the reasons for this include exhaustion, stressful and busy lives, post-operative pelvic surgery, pelvic and genital trauma, inability to achieve orgasm, vaginismus, side effects of medications, drug addiction, pregnancy, acute or chronic diseases, endocrine pathologies, religious principles, transmission of venereal disease, fear of becoming pregnant, fear of having heirs, loss of interest in close relationships, marriage of convenience, and, finally, having cancer [2].

In oncology, especially in cases of breast cancer and genitourinary tumors, including prostate cancer, the concept of sexless marriage is well known since the phenomenon causes family suffering, whether due to physical and psychological changes or the disruption of plans and lifestyle, which translates into loss of pleasure and hopelessness [3].

Also, in this context of oncology and female sexuality, erroneous sexual myths exist, such as: 1) genital cancer can be transmitted to another person through sexual intercourse; 2) only young women want to have sexual intercourse; 3) after the appearance of breast or cervical cancer, sexual intercourse can no longer occur; 4) the loss of a breast or uterus decrees the end of a woman's sexual life; 5) the breast is associated with fertility; 6) women with a urinary or fecal stoma are no longer intimate with their partner [4]. All of this makes it difficult for so-called experienced women to exercise their sexuality freely.

For Simone de Beauvoir [5], "one is not born, but rather becomes, a woman" because the form women assume in society is designed by civilization, with the feminine being an intermediate product between the male and the castrated. Currently, due to media exposure, beauty and sexuality are seen as synonymous with youth and are values to be sought at any and every stage of life.

Thus, old age is associated with body degeneration, and women seek to erase the signs of time, aiming for bodies that look increasingly youthful. Thus, for de Beauvoir [6], the older woman loses her place in society, becoming a monster that arouses repulsion and fear.

Serrão [7] notes that, according to the World Health Organization (WHO), sexuality includes the need for contact, tenderness, intimacy, feelings, behaviors, and affections. It is a human need that relates to other aspects of life, going beyond the sexual act itself. It is also a way for people to perceive their identity, as intimacy and closeness give meaning to individuals' lives and establish safe bonds.

Sexuality influences thoughts, eroticism and exchanges, and permeates the mental and physical health of those involved. Hippocratic medicine kept the issue of sexuality away from its concerns until the mid-19th century, as the activity was controlled by religious, moral, political, and legal authorities, so physicians only worked on secondary issues, such as sexually transmitted infections and childbirth. In the 20th century, advances in psychoanalysis and behavioral science were made, followed by the advancement of male and female sexology in the post-World War II period.

Today, in bioethical conflicts related to sexuality, discussions about sexual and obstetric violence, contraception, people living with HIV, the LGBTQIA+ population, and sexual reassignment are open. However, scientific production for older people, especially regarding women, is minimal. According to Foucault [8], in the 20th century, women

were still strongly subject to a "Victorian regime," in which sexuality was repressed, contained, mute, and hypocritical.

Older women suffer from the changes in the sexuality of their new life cycle, as they have long experienced the power relations that prevailed in past decades. In this context, women's behavior has been domesticated under a patriarchal model throughout their lives, in which they have dealt with sexual, social, family, and work inequalities [9].

Prostate cancer survivors and their partners should be informed about the side effects of treatment before it begins and of its post-treatment effects, so the risks and benefits can be weighed. This enables adjustments to control future expectations and provide psychosocial support for the couple [10].

This review focuses on the importance of the partner recognizing her active role of protection when sexual limitations imposed by the treatment appear. Thus, the objective is to investigate the impact of the disease on the marital relationship, especially in the sexual sphere, and to redefine the role of the female partner with new strategies so that sexual relations are not restricted to the genitals.

About prostate cancer

According to the Brazilian National Cancer Institute, prostate cancer is the second most common neoplasm in men, with an estimated 71,000 new cases per year, second only to skin cancer [11]. Prostate cancer has no preventable cause, has an over 95% cure rate when diagnosed early, and is fundamentally a disease of older people, although it can affect younger patients.

In most cases, the partner is also older, facing menopausal problems such as decreased sexual desire, vaginal dryness, dyspareunia, urinary and fecal incontinence, and comorbidities that reduce desire and the sexual act itself. Furthermore, from a Western perspective, older women are stigmatized as being asexual, without desires, feelings, fantasies, or expectations [7].

Prostate cancer is investigated through clinical history, digital rectal examination, prostate-specific antigen (PSA) measurement, and, recently, by performing a magnetic resonance imaging of the prostate. These tests indicate the need for a prostate biopsy to confirm the diagnosis of malignant neoplasia, which, according to clinical, laboratory, and imaging criteria, is classified as localized (early), locally advanced (intermediate), and advanced (metastatic).

All of these categories have treatment, which can be curative or palliative, exclusive or combined: radical prostatectomy, pelvic radiotherapy, cryotherapy, brachytherapy, drug-based hormone deprivation, bilateral orchiectomy, immunotherapy, use of radiopharmaceuticals, watchful waiting, or active surveillance. The latter two modalities consist of monitoring the case without treatment. Urologists, radiologists, radiotherapists, oncologists, nuclear medicine physicians, palliative and family physicians, pathologists, anesthesiologists, psychiatrists, geriatricians, psychologists, sexologists, physical therapists, and nurses conduct the whole therapy.

In early and intermediate cases, the most commonly used treatment is radical prostatectomy. This is a technique for removing the tumor, intending to preserve the vascular-nervous bundle in which the erectile nerves are inserted, which are directly responsible for the penile erection mechanism. Despite the current efforts to perform robotic surgery, the literature reports that there is still a high rate of total or partial erectile dysfunction immediately after the procedure. However, there is some recovery of erectile function between 6 and 12 months after surgery.

Even though the prostate and its coverings are worked very closely to avoid nerve damage, erectile dysfunction occurs in up to 63% of men who undergo the robotic prostate extraction process, according to data from Basourakos and collaborators [12]. This rate varies according to diagnostic criteria, the extent of the disease, patient anatomy, surgeon experience, pre-procedure erectile function, and patient comorbidities/medications.

Other serious complications of surgical treatment are urinary incontinence, urethral stenosis, urinary fistulas, shortening of the penis, loss of penile sensitivity and temperature of the glans, climacteric syndrome, anejaculation, and penile tortuosity. However, it is essential to note that these complications can be treated, even if only partially or temporarily.

Also, in the curative line, radiotherapy, a procedure that consists of irradiating tumor cells to kill them, applied for a period of six months to two years, can result in erectile dysfunction in the medium and long term.

In advanced cases, with hormonal blockade of testosterone, there is a loss of sexual desire and, ultimately, of the excitatory mechanism and penile rigidity due to hypogonadism with low testosterone levels. Other adverse effects are weight gain, changes in libido and behavior, gynecomastia, and the distribution of fat with a feminine pattern throughout the body. It also discourages the female partner, with serious consequences of hopelessness regarding what life offers [13].

In this disruptive context, the question of the female, male, or multiple partners arises, depending on the family and sexual arrangements and scope. As a basis, we can start from the data presented by Worthington [14], showing that in the United States alone, more than 3 million men have survived prostate cancer and, consequently, suffer the effects of treatment. Added to this is the estimate that 73% of these men between the ages of 65 and 80 are married or have partners [14].

With the expectation of a cure for prostate cancer, patients with erectile dysfunction or urinary incontinence need to rely much more on the support and understanding of their female partners. Ferreira [15] reveals that third parties bring 60% of men who go to their first prostate evaluation appointment and that the main incentive to take and monitor the results is women (daughters, sisters, wives, and partners). In the sexist anecdotal symbolism of the "prostate exam," this fear of being invaded begins with the digital rectal exam and prostate biopsy, continues with the communication of the bad news of the prostate cancer diagnosis, and persists in the choices and consequences of treatment, a true oncological journey.

Today, some questionnaires aim to investigate the sexual side of women and could be explored in this subject. The best known is the Female Sexual Function Index (FSFI), an instrument for use in field research that assesses the strength of each domain of sexual response (desire, arousal, lubrication, orgasm, satisfaction, and pain) and converts the subjectivity of conjugal intimacy into objective, quantifiable and analyzable data, with validation in Brazil [16].

The unveiling of the discussion on women's sexual pleasure sees their sexual satisfaction, relating it, therefore, to the principles of bioethics of autonomy and justice. Sexuality, according to the World Health Organization, is one of the arms of quality of life, which makes it fundamental to human existence in several domains [7]. In *Estudo da vida sexual do brasileiro*, Abdo [17] states that the participating women consider sex important/very important for sexual harmony and that they feel comfortable talking about sex without restrictions.

In the couple's minds, there is the expectation of curing cancer without the damage caused by the treatment, such as erectile dysfunction and urinary incontinence, which would be the "trifecta"—curing the patient, maintaining erectile function, and maintaining urinary function [18]. In fact, the surgeon does not explain the complications to the couple in the period before the surgery, generating dissatisfaction and regret later.

Erectile dysfunction treatment is done using erectogenic drugs, applying prostaglandin injections into the penis, and implanting a penile prosthesis. However, these treatments partially impair the pleasure of sexual intercourse achieved over years or decades, characterizing a "bionic or artificial" sexuality, according to the patients [19].

From then on, the wife or partner becomes the companion of the disease and the illness, no longer the sexual object. Changes in sexuality after cancer are associated with self-punishment, rejection, sadness, anger, lack of sexual desire, and communication [20].

Method

This integrative literature review covered the period from 2000 to 2023 and was conducted through searches in PubMed, SciELO, the Google Scholar research platform, and widely circulated websites. The descriptors used in the search were prostate cancer, relationship intimacy, partner, sexless marriage, and treatment.

Full texts in Portuguese, Spanish, or English with a focus on investigating the sexless marriage

phenomenon in the context of prostate cancer and marital relationships were included. The exclusion criteria were as follows: presenting little or no relevant information related to the topic or not providing additional support to the other selected data. Among the 100 chosen studies, 34 met the inclusion criteria, one of which was from Central America. No Brazilian studies were selected.

Results and discussion

Guercio and Mehta [21] raise the debate on the female partner's perception and satisfaction after radical prostatectomy. When it comes to the operated patient, it is noted that the female partner's support improves sexual function and the couple's satisfaction. They also note the lack of a female figure in studies on prostate cancer and that erectile dysfunction can cause frustration, anxiety, and depression, culminating in separation.

Boehmer and Babayan [22] address the same topic based on a case study. The authors investigated the female partner's sexual satisfaction in 21 cases in which prostate cancer had been diagnosed but before the start of treatment. Of these 21 cases, 13 female partners were interviewed separately in semi-structured interviews with their partners about the threats of erectile dysfunction.

The women answered questions about erectile dysfunction, emphasizing the other dimensions of the relationship, and also demonstrated concern for their partner's health. This shows that they understand the intrinsic relationship built between male identity and sexual potency since, *according to the hegemonic model of masculinity, men were raised since childhood* (...) *to be the agent or the "penetrator"* [23].

Along the same lines, Palácios and collaborators [24] cover a slightly larger group of patients undergoing surgery, radiotherapy, and hormone use—and their respective partners—totaling 253 men and 174 women. The partners reported high levels of anxiety, given the treatment and the consequent changes in the relationship, and half of them reported difficulties in dealing with this new model of coping with sexuality. Regarding urinary incontinence, 61.1% claim to have no difficulty dealing with the situation but point out that the care the patient requires, such as changing diapers, has influenced their romantic relationship.

Palácios and collaborators [25] advocate that female partners do not want to put pressure on their husband's sexuality, in the sense that they will have difficulty dealing with the sexual side effects of cancer treatment. Physicians are also not helpful in this regard, as they ask a few questions about the couple's sex life in the anamnesis. The authors propose that sexologists and psychologists guide the conduct specialized in sexology.

Moving on to a longitudinal dimension of the problem, the study by Ramsey and collaborators [26] stands out, investigating the effects of treatment on the relationship and daily life of patients six months after surgery and twelve months after it. The research highlights that, of the 88 couples who took part in the study six months after the procedure, 12% indicated that the impacts of treatment were very negative on their sexual relationship. By the 12th month, this percentage had risen to 29%, which shows that the impacts worsen over time.

Concerning men who have sex with men (MSM), studies such as that by Martin-Tuite and Shindel [27] and Manne and collaborators [28] show that many MSM who deal with the after-effects of prostate cancer have developed strategies to continue their sexual practices, such as increasing closeness, having a greater appreciation for life, and recognizing positive qualities and good healthy lifestyle practices. Thus, they shift the focus away from the phallus, which can be a learning opportunity for other men in the same situation.

As for the LGBTQIA+ population, there are transgender women, known as "women with prostates," because gender reassignment surgery does not involve the removal of the prostate. While the risk of prostate cancer is low, trans women should be aware of 1) the physician's lack of knowledge about the fact that a patient registered as a woman has a prostate; 2) their PSA levels may be altered due to the use of female hormones, such as estrogen; and 3) prostate cancer symptoms may be absent or confused with the symptoms of reconstructive surgery [29]. This population is likely to increase, and their partners will also suffer from the sexless marriage phenomenon.

Bringing the debate closer to Latin America, the text by Berríos and Rivero Vergne [30], from Puerto Rico, presents the perspective of ten partners of prostate cancer survivors, referring to the perception of women as "guardians of health. As their partners' primary caregivers, women actively participate in the treatment process, caring for everything from pain to personal hygiene [30]. Thus, the patient's need for their female partner increases significantly, which affects their self-esteem, and the partner feels responsible for the success of the treatment, also bearing, as a consequence, the anguish of the disease.

Bioethical perspective

The social role of women has historically been constructed from a predominantly sexist male perspective so that they have been relegated to a place of care. Added to this prejudiced context are data collected by the Brazilian Society of Mastology, which indicate that 70% of female patients dealing with breast cancer are abandoned by their partners when they reach a high degree of physical and emotional weakness [3].

These facts reveal that women provide care but receive no care in return. Therefore, the exercise of conjugality is one of the ways of experiencing sexuality, with in-depth knowledge of one's own body and that of one's female partner. With this, one can define conjugal existence, its characteristics, and its limits uniquely [3].

It is necessary to alleviate the patient's suffering, but above all, to include the wife in the care, who remains by her husband's side, since she is structurally placed in the role of caregiver. Thus, prostate cancer is considered by specialized literature in the United States as a relationship illness because the female partner is part of the recovery from malignant neoplasia, mitigating the side effects of the treatment. In addition, wives report more emotional suffering upon diagnosis of prostate cancer than their husbands [31].

Therefore, considering the established principles of bioethics (beneficence, non-maleficence, justice, and autonomy), achieving a comprehensive ethical-humanistic and fair perception of the prostate cancer patient and, above all, establishing his relationship with his partner is necessary.

Brazilian men, immersed in the Latin American culture of virility and phallocentrism, make interest in the sexual pleasures, desires, and knowledge of their partner a very remote prospect. Thus, the scheme is constructed: erection = male = virile = successful man = desired by women = admired by all men = woe to those who fail, as Kaplan and Sapetti [32] argue.

Bioethics supports the relationship between the physician, patient, and others involved, *always valuing a democratic and deliberative relationship. It counts on the participation of the professional and all those involved in this link to choose the best alternative for intervention* [33]. The principle of autonomy, which concerns the patient's right to self-government and the need to involve the female partner since she is also profoundly affected by these choices, stands out.

An alternative is also applied to initial cases of prostate cancer that occur mainly in Nordic countries, in which the choice is made not to undergo treatment. This involves the application of the watchful waiting method, a high-level observation, i.e., no invasive treatment is performed, as indicated in the initial phase of the disease, as it is known that prostate cancer, in most cases, does not result in the death of the patient [34].

In active surveillance, several annual exams are performed, and at any time when the disease parameters worsen, the patient may undergo invasive treatment. Therefore, instinctively, not treating the patient may mean preserving sexual health and male body image.

The principle of beneficence, intrinsically related to that of non-maleficence, also touches on the subject of this review because it aims to cure cancer with an unpredictable course. The principle of justice also deals with the concept of equity, aiming to build egalitarian relationships, even in relationships and situations of inequality, seeking balance between peers.

At first glance, the principle of justice may seem strictly linked to providing and accessing health care. However, on closer inspection, it reaches the critical point of the issue, as it goes beyond the patient since the female partner

also suffers the consequences of the treatment. She should also aim for her well-being and happiness, living a more pleasurable dyadic relationship with shared gains.

Final considerations

While the selected studies demonstrate that the topic has been addressed in research abroad, the discussion is still shallow in Brazil. Welcoming the female partner is an opportunity to include a disease with multiple consequences in a current and ethical debate, bringing as subsidies the bioethical principles of autonomy, justice, non-maleficence, and beneficence for the operated patient and his wife.

It is understood that the man who has lost part of his sexuality, who does not have full erectile function, and whose penetration function is reasonable, to a certain extent, is seen as being in a protection network. On the other hand, science still does not acknowledge this patient's wife. Thus, this research is justified by investigating the impact of the disease on the marital relationship and, above all, on the sexual sphere, redefining the role of the partner with new strategies not to keep sexual relations restricted to the genitals.

References

1. Conselho Regional de Medicina do Estado do Rio de Janeiro. Bioética e medicina. Rio de Janeiro: CREMERJ; 2006. p. 9.
2. Laumann EO, Gagnon JH, Michael RT, Michaels S. National health and social life survey, 1992: [United States] [Internet]. Ann Arbor: Inter-university Consortium for Political and Social Research; 1992 [acesso 12 jan 2024]. DOI: 10.3886/ICPSR06647.v2
3. Macieira RC, Maluf MF. Sexualidade e câncer. In: Kovacs MJ, Franco MHP, Carvalho VA, editores. Temas em psico-oncologia. São Paulo: Summus; 2008. p. 303-15.
4. Katz A, Agrawal LS, Sirohi B. Sexuality after cancer as an unmet need: addressing disparities, achieving equality. Am Soc Clin Oncol Educ Book [Internet]. 2022 [acesso 23 jan 2024];42:1-7. DOI: 10.1200/EDBK_100032
5. Beauvoir S. O segundo sexo. Rio de Janeiro: Nova Fronteira; 1980.
6. Beauvoir S. A velhice. Rio de Janeiro: Nova Fronteira; 1990.
7. Serrão C. A sexualidade na terceira idade: olhar, mudar e agir. Revista Transdisciplinar de Gerontologia [internet]. 2007 [acesso 23 jan 2024];1(1):70-2. Disponível: https://bit.ly/4dFLgjz
8. Foucault M. História da sexualidade I: a vontade de saber. Rio de Janeiro: Graal; 1977.
9. Lucena DS, Gonçalves GO, Barbosa Neto JH, Silva, PMC. A sexualidade na senilidade de mulheres: uma revisão integrativa da literatura. In: Anais 6° Congresso Internacional de envelhecimento humano [Internet]. Campina Grande: Realize; 2019 [acesso 5 jan 2024]. Disponível: https://bit.ly/3XojyBW
10. Albaugh JA, Lapin BR Petkewicz J, Tenfelde S Life after prostate cancer treatment: a mixed methods study of the experiences of men with sexual dysfunction and their partners. BMC Urol [Internet]. 2017 [acesso 11 jan 2024];17(1):45. DOI: 10.1186/s12894-017-0231-5
11. Instituto Nacional de Câncer. Neoplasia maligna da próstata (taxas ajustadas) [Internet].2022 [acesso 10 dez 2022]. Disponível: https://tny.im/V9AXS
12. Basourakos PS, Kowalczyk K, Moschovas MC, Dudley V, Hung AJ, Shoag JE *et al*. Robot-assisted radical prostatectomy maneuvers to attenuate erectile dysfunction: technical description and video compilation. J Endourol [Internet]. 2021 [acesso 10 dez 2022];35(11):1601-9. DOI: 10.1089/end.2021.0081
13. Novan L, Morag A. Advanced prostate cancer patients' relationships with their spouses following hormonal therapy. Eur J Oncol Nurs [Internet]. 2003 [acesso 11 jan 2024];7(2):73-80. DOI: 10.1016/s1462-3889(03)00022-x
14. Worthington JF. Sexual health after prostate cancer: patients and partners. Prostate Cancer Foundation [Internet]; 2020 [acesso 13 dez 2022]. Disponível: https://tny.im/X9UH8

15. Ferreira U. Câncer de próstata: tire suas dúvidas: 99 respostas e um alerta. São Paulo: Âmbito; 2006.
16. Thiel RRC, Dambros M, Palma PCR, Thiel M, Riccetto CLZ, Ramos M de F. Tradução para português, adaptação cultural e validação do Female Sexual Function Index. Rev Bras Ginecol Obstet [Internet]. 2008 [acesso 15 jan 2023];30(10):504-10. DOI: 10.1590/S0100-72032008001000005
17. Abdo CHN. Estudo da vida sexual brasileira. São Paulo: Bregantini; 2004. p. 202.
18. Bianco FJ Jr, Scardino PT, Eastham JA. Radical prostatectomy: Long-term cancer control and recovery of sexual and urinary function ("trifecta"). Urology [Internet]. 2005 [acesso 10 dez 2022];66(5):83-94. DOI: 10.1016/j.urology.2005.06.116
19. Wespes E, Amar E, Hatzichristou D, Hatzimouratidis k, Montorsi F, Pryor J, Vardi Y. EAU Guidelines on erectile dysfunction: an update. Eur Urol [Internet]. 2006 [acesso 10 dez 2022];49(5):806-815. DOI: 10.1016/j.eururo.2006.01.028
20. Hawkins Y, Ussher J, Gilbert E, Perz J, Sandoval M, Sundquist K. Changes in sexuality and intimacy after the diagnosis and treatment of cancer. Cancer Nursing [Internet]. 2009 [acesso 10 dez 2022];32(4):271-280. DOI: 10.1097/NCC.0b013e31819b5a93
21. Guercio C, Mehta A. Predictors of patient and partner satisfaction following radical prostatectomy. Sex Med Rev [Internet]. 2018 [acesso 11 dez 2022]; 6(2):295-301. DOI: 10.1016/j.sxmr.2017.08.005
22. Boehmer U, Babayan RK. Facing erectile dysfunction due to prostate cancer treatment: perspectives of men and their partners. Cancer Invest [Internet]. 2004 [acesso 11 dez 2022];22(6):840-8. DOI: 10.1081/cnv-200039641
23. DaMatta R. Tem pente aí? In: Caldas D, organizador. Homens: comportamento, sexualidade e mudança. São Paulo: Editora Senac; 1997. p. 39.
24. Palacios LAG, Krouwel EM, den Oudsten BL, den Ouden MEM, Kloens GJ, van Duijn G *et al*. Suitable sexual health care according to men with prostate cancer and their partners. Support Care Cancer [Internet]. 2018 [acesso 11 jan 2024];26(12):4169-76. DOI: 10.1007/s00520-018-4290-2
25. Palacios LAG, Den Ouden MEM, Den Oudsten BL, Putter H, Pelger RC, Elzevier HW. Treatment-related sexual side effects from the perspective of partners of men with prostate cancer. J Sex Marital Ther [Internet]. 2019 [acesso 11 jan 2024];45(5):440-51. DOI: 10.1080/0092623X.2018.1549636
26. Ramsey SD, Zeliadt SB, Bloygh DK, Moinpour CM, Hall IJ, Smith JL *et al*. Impact of prostate cancer on sexual relationships: a longitudinal perspective on intimate partners' experiences. J Sex Med. [Internet]. 2013 [acesso 27 dez 2022];10(12):3135-43. DOI: 10.1111/jsm.12295
27. Martin-Tuite P, Shindel AW. Prostate cancer and sexual consequences among men who have sex with men. Int J Import Res [Internet]. 2021 [acesso 28 dez 2022];33(4):473-9. DOI: 10.1038/s41443-020-00392-6
28. Manne SL, Kashy DA, Kissane D, Zaider T, Heckman CJ, Penedo FJ, Myers S. Relationship intimacy processes during treatment for couple-focused interventions for prostate cancer patients and their spouses. J Psychosoc Oncol Res Pract [Internet]. 2019 [acesso 20 dez 2022];1(2):e7. DOI: 10.1097/OR9.0000000000000007
29. Prostate Cancer Foundation of Australia. Understanding prostate cancer for LGBTQIA+ people. St Leonards: Prostate Cancer Foundation of Australia; 2020.
30. Berríos R, Rivero Vergne A. El cáncer prostático en la experiencia de pareja: la mujer como guardiana de la salud. Interam J Psychol [Internet]. 2015[acesso 20 dez 2022];49(3):387-98. Disponível: https://tny.im/8rrXK
31. Crowe H, Costello AJ. Prostate cancer perspectives on quality of life and impact of treatment on patients and their partners. Urol Nurs [Internet]. 2003 [acesso 23 dez 2022];23(4):279-85. Disponível: https://pubmed.ncbi.nlm.nih.gov/14552074
32. Kaplan M, Sapetti A. La sexualidad masculina. Buenos Aires: Galerna; 1986.
33. Campos NF, Costa LB. Discussões sobre bioética, direito penal e pacientes testemunhas de Jeová. Rev. bioét (Impr.) [Internet]. 2022 [acesso 20 nov 2023];30(2):337-45. p. 338. DOI: 10.1590/1983-80422022302529PT
34. Bill-Axelson A, Holmberg L, Garmo H, Rider JR, Taari K, Busch C *et al*. Radical prostatectomy or watchful waiting in early prostate cancer. N Engl J Med [Internet]. 2014 [acesso 20 nov 2023];6;370(10):932-42. DOI: 10.1056/NEJMoa1311593

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