



## Editorial

## Developing UK Guidance on How Long Men Should Abstain from Receiving Anal Sex before, During and after Interventions for Prostate Cancer

S. Ralph

*Leeds Cancer Centre, Leeds Teaching Hospitals NHS Trust, Leeds, UK*

Received 1 July 2021; accepted 15 July 2021

Prostate cancer has become the most common cancer in England, with 49 029 cases in 2018 [1]. One in eight men will be diagnosed during their lifetime [2]. This translates to a one in four chance of being directly or indirectly affected by prostate cancer for men in same-sex relationships. Although there is no evidence that men who engage in same-sex relationships are at an increased risk of developing prostate cancer, they will be disproportionately affected, by virtue of both partners having a prostate gland.

The sexual side-effects of prostate cancer interventions for gay and bisexual men are broadly the same as those for heterosexual men. However, due to differences in sexual practices they may have some additional concerns, and some sexual side-effects will be more bothersome or challenging to manage. In both quantitative and qualitative studies, gay and bisexual men have reported worse sexual function, ejaculatory function and ejaculatory bother compared with their heterosexual counterparts [3–5]. Erectile dysfunction for men who take the penetrative role during anal sex may require more intensive or invasive forms of treatment, as a penis needs to be more rigid for anal sex than it does for vaginal sex [6]. For men who take the receptive role, the prostate gland has an additional function as the ‘male G-Spot’. Following surgery, it will no longer be there to pleurably stimulate and, following radiotherapy, the sensitivity of the prostate gland as an erogenous zone can be significantly reduced [6,7]. Men who take the receptive role may also experience issues with pelvic pain or rectal irritation following interventions [8]. A systematic review of the relationship between acute and late rectal toxicity after prostate radiotherapy found that late rectal morbidity may be statistically and causally linked to acute rectal toxicity [9]. If men engage in anal sex during

or too soon after radiotherapy, resulting in a worsening of their acute rectal toxicity, they may therefore increase their risk of developing late rectal morbidity, such as chronic rectal bleeding.

To develop UK guidance on how long men should abstain from receiving anal sex before, during and after interventions for prostate cancer, a modified Delphi technique using two question rounds was used to generate consensus opinion from a panel of 15 clinical oncologists and 11 urological surgeons. Panel members were recruited with assistance from The Royal College of Radiologists, The British Association of Urological Surgeons, the British Uro-Oncology Group, The Association of LGBTQ+ Doctors and Dentists, and Prostate Cancer UK. The study received ethical approval from The University of Manchester (UREC 2017-1550-2673).

For pragmatic reasons, the Delphi was limited to two question rounds, without an initial open qualitative round, and a predefined consensus level was not set. Consensus was defined as the median answer given for the interventions listed in Table 1. Although most panel members agreed that men should abstain from receiving anal sex, with an average agreement across interventions of 83%, no clear consensus level could be reached for several of the interventions in relation to how long men should abstain. For example, 73% agreed men should abstain during and immediately after external beam radiotherapy to allow time for radiation proctitis to subside. However, only 27% agreed that men should abstain for 2 months after external beam radiotherapy. Similarly, 91% agreed that men should abstain after a radical prostatectomy to enable the vesicourethral anastomosis time to heal, therefore reducing the risk of leakage at the anastomosis, urinary incontinence and rectal perforation. However, only 45% agreed that men should abstain for 6 weeks after a radical prostatectomy. Despite the low level of consensus

Address for correspondence: Leeds Cancer Centre, Leeds Teaching Hospitals NHS Trust, Beckett Street, Leeds LS9 7TF, UK.

E-mail address: [sean.ralph@nhs.net](mailto:sean.ralph@nhs.net).

<https://doi.org/10.1016/j.clon.2021.07.010>

0936-6555/© 2021 The Royal College of Radiologists. Published by Elsevier Ltd. All rights reserved.

**Table 1**

Summary of how long men should abstain from receiving anal sex, with examples of the clinical rationale provided by panel members

Intervention	Abstain (yes)	Consensus* (median)	Consensus level	Mean	Examples of clinical rationale provided by panel members
Before a PSA test	-	1 week	58% (15/26)	1.6 weeks	'Increases in PSA after external compression of the prostate are usually mild and with a half-life of 2.2 days a week should allow a chance for near normal levels to return.' 'Prostate massage is known to increase PSA levels. To ensure a more accurate PSA measurement, any form of prostate massage, including anal sex, should be avoided before a PSA test.'
After a transrectal biopsy	91% (10/11)	2 weeks	55% (6/11)	1.5 weeks	'Needle punctures of the rectum should heal before the trauma of intercourse.' 'The clinical rationale for delay after transrectal ultrasound is to allow the rectal epithelium to heal reducing the risk of infection.'
After a transperineal biopsy	73% (8/11)	1 week	60% (6/10)	1.2 weeks	'The rectum has been perforated by transrectal ultrasound-guided prostate biopsies, which is not the case with transperineal prostate biopsies. Consequently, the chance of bacterial translocation about transperineal prostate biopsies is much less.' 'After transperineal biopsy the delay is to allow skin wounds to heal and bruising to settle to reduce painful intercourse.'
After a radical prostatectomy	91% (10/11)	6 weeks	45% (5/11)	4.8 weeks	'The rectal wall may be thinned by a radical prostatectomy. Allowing time for healing and oedema to settle after surgery is the basis for my answer.' 'Complete healing must occur. Disruption of anastomosis is a major risk. Healing is vital. Also, urinary continence the major complication could be exacerbated.'
After the insertion of fiducial markers	60% (9/15)	1 week 2 weeks	40% (4/10) 40% (4/10)	1.6 weeks	'Allow a week to ensure no issues with infection; should have early fibrotic reaction around the markers by that stage. Also depends on route of insertion; if transperineal, risk much less.' 'Fiducials need to embed in the prostatic tissue in a consistent manner prior to radiotherapy planning. They may be displaced by anal intercourse. Loss of markers may make subsequent image-guided radiotherapy difficult/impossible. Ultimately the image-guided radiotherapy and intensity-modulated radiotherapy contribute to reduced toxicity for external beam radiotherapy so it is worth this investment of time on the part of the patient.'
During external beam radiotherapy	73% (11/15)	N/A	73% (11/15)	N/A	N/A
After external beam radiotherapy	73% (11/15)	2 months	27% (4/15)	1.9 months	'Any post-radiotherapy trauma should be avoided. Typical time to recovery post-radiotherapy is 6 weeks, so this seems reasonable.' 'The rectum often develops a degree of proctitis (even if subclinical) during radiotherapy, meaning the rectal wall will become more prone to damage, some of which may be long term. Thus, I think anal intercourse is probably best-avoided during and immediately after radiotherapy.'
After high-dose rate brachytherapy	100% (5/5)	2 months	60% (3/5)	1.6 months	'To decrease anorectal symptoms.' 'To allow prostate and rectal inflammation to settle.'
After permanent seed brachytherapy (iodine-125)	100% (4/4)	1 month 2 months	50% (2/4) 50% (2/4)	1.5 months	'Radiation exposure to partner and to allow local prostate and rectal inflammation to settle.' 'Radiation protection and trauma issues.'

PSA, prostate-specific antigen.

\* Consensus was defined as the median timeframe given by panel members for each intervention. When a panel member answered that men should not abstain their numerical answer was transferred into the statistical software as 0 weeks or months for the purpose of calculating the consensus level for that intervention. When a panel member answered they were unsure if men should abstain, their data were not included in calculating the consensus level for that intervention, as no numerical answer could be implied.

reached for some of the interventions, the mean time-frames for how long men should abstain do not differ greatly from the median.

Panel members failed to reach consensus for how long men should abstain after the insertion of fiducial markers and iodine-125 permanent seed brachytherapy. Given the similarities between the insertion of fiducial markers and a prostate biopsy it seems sensible to mirror the advice produced for prostate biopsies, depending on what route the fiducial markers are inserted. Following additional consultation with brachytherapy medical physics experts, it was recommended that men should abstain for 6 months after iodine-125 permanent seed brachytherapy as a radiation protection measure to minimise radiation exposure to a partner's penis during anal sex. Medical physicists can also produce individualised risk assessments, which may reduce the period of time an individual patient is advised to abstain in comparison with the generic guidance of 6 months (the process followed to produce the generic guidance can be found in [Appendix A](#)).

Men should therefore abstain from receiving anal sex before, during and after interventions for prostate cancer to avoid receiving a false-positive prostate-specific antigen (PSA) test; minimise the risk of post-intervention complications; manage their side-effects appropriately; and to minimise radiation exposure to sexual partners.

In this study, panel members were also asked about their clinical practice in relation to patient communication. Despite most panel members agreeing that men should abstain from receiving anal sex before, during and after interventions for prostate cancer, only 39% said they ask men with prostate cancer about their sexual orientation. Furthermore, only 13% said they ask about anal sex if they are aware their patient is gay or bisexual. Similarly, in a recent survey of UK oncologists, 5% said they ask about a patient's sexual orientation as part of their consultation and just 8% felt confident in their knowledge of the specific healthcare needs of LGBTQ+ patients [10].

Despite initiatives such as the NHS Rainbow Badge Project [11], which aims to make healthcare environments more inclusive of the needs of LGBTQ+ patients, these statistics show that cancer services are not quite as far down the equality and diversity yellow brick road as they should be. To prevent these initiatives from becoming an equality and diversity box ticking exercise, it is incumbent upon individual health professionals to take responsibility for making their own clinical practice more inclusive.

The average age for men to be diagnosed with prostate cancer in the UK is 65–69 years [12]. The average gay or bisexual man with prostate cancer will therefore have lived at a time when their sexual orientation was criminalised and classified as a mental illness. They will have lived through the HIV/AIDS crisis of the 1980s, which attached further stigma and shame to their sexual orientation and sexual practices. Many of these patients will also have had negative experiences with healthcare services because of their sexual orientation. Older gay and bisexual men are therefore unlikely to be forthcoming about their sexual orientation for fear of actual or perceived discrimination

from health professionals [13], who should therefore take responsibility for initiating these conversations.

A previous editorial for *Clinical Oncology* contains useful 'practice pointers' on how to approach conversations about sexual orientation and sexual practices with patients [14]. To help facilitate disclosure within the prostate cancer setting, a question about sexual orientation should be added to forms such as the Sexual Health Inventory for Men (SHIM), which patients can complete before their consultation. When discussing sex with patients, overly clinical language can make conversations feel awkward, and asking someone directly if they have anal sex may also feel too blunt. It can therefore be helpful to incorporate language into the consultation that patients would use themselves to describe their sexual practices. In relation to anal sex, a 'top' is someone who takes the penetrative role, a 'bottom' the receptive role, and someone who is 'versatile' enjoys both. This terminology is universally used within the gay and bisexual community, particularly across Western societies. Following a question about sexual orientation in which a patient discloses that they are gay or bisexual, health professionals could then ask, 'In relation to your sex life, are any of the following, words you would use to describe what you enjoy: top, bottom or versatile?'

Cancer services pride themselves on providing person-centred holistic care. However, services sometimes fall short of that standard by failing to recognise the relevance of sexual orientation to a patient's treatment and care. If health professionals are to fulfil this most basic of tenets, they must endeavour to make their clinical practice more inclusive. Cancer charities, such as Prostate Cancer UK, have taken a leading role in addressing the specific needs and concerns of gay and bisexual men with prostate cancer through the development of targeted information and support resources [15,16]. The charity has also played an instrumental role in the setting up and continued support of Out with Prostate Cancer and LGBT Walnut, the UK's only prostate cancer support groups for gay and bisexual men and trans women. Although there is a lot of excellent work being done within the National Health Service to reduce health inequalities for LGBTQ+ patients, the organisation and the health professionals who work within it still have far to go to catch up with the positive examples being set by national cancer charities.

The guidance on consent from the General Medical Council, and supporting case law, advises that health professionals should not rely on assumptions about what information a patient might want or need, or the significance they might attach to different outcomes [17]. Gay and bisexual men with prostate cancer have been described in the literature as 'invisible diversity' [18], 'hidden populations' [19] and 'a truly invisible species' [20]. To make the invisible visible, cancer services must move away from a heteronormative model of care, in which patients are assumed to be heterosexual unless they self-disclose otherwise. It is the responsibility of health professionals to initiate conversations about sexual orientation and sexual practices, to ensure patients undergoing treatment for prostate cancer receive tailored information, empowering

them to make informed treatment decisions and manage their side-effects appropriately.

## Conflicts of Interest

S. Ralph reports that financial support was provided by the National Institute for Health Research. S. Ralph is Co-founder of Out with Prostate Cancer, the UK's first prostate cancer support group for gay and bisexual men and trans women, established in 2013.

## Funding

S. Ralph, Masters in Clinical Research Studentship (MRES-2015-03-018-201), was funded by Health Education England (HEE)/National Institute for Health Research (NIHR) for this research project. The views expressed in this publication are those of the author(s) and not necessarily those of the NIHR, HEE, National Health Service or the UK Department of Health and Social Care.

## Acknowledgements

The author would like to thank P. Bownes, Head of Brachytherapy and Gamma Knife Physics at St James's University Hospital, Leeds, for producing the generic guidance on iodine-125 permanent seed brachytherapy contained in [Appendix A](#).

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.clon.2021.07.010>.

## References

- [1] Prostate Cancer UK. *Prostate cancer now most commonly diagnosed cancer in England* 2020. Available at: <https://prostatecanceruk.org/about-us/news-and-views/2020/1/prostate-cancer-now-most-commonly-diagnosed-cancer-in-england>. [Accessed 24 June 2021].
- [2] Prostate Cancer UK. *About prostate cancer: facts and figures* 2019. Available at: <https://prostatecanceruk.org/prostate-information/about-prostate-cancer>. [Accessed 24 June 2021].
- [3] Wassersug RJ, Lyons A, Duncan D, Dowsett GW, Pitts M. Diagnostic and outcome differences between heterosexual and nonheterosexual men treated for prostate cancer. *Urology* 2013;82:565–571. <https://doi.org/10.1016/j.urology.2013.04.022>.
- [4] Lee TK, Handy AB, Kwan W, Oliffe JL, Brotto LA, Wassersug RJ, et al. Impact of prostate cancer treatment on the sexual quality of life. *J Sex. Med* 2015;12:2378–2386. <https://doi.org/10.1111/jsm.13030>.
- [5] Hart TL, Coon DW, Kowalkowski MA, Zhang K, Hersom JI, Goltz HH, et al. Changes in sexual roles and quality of life for gay men after prostate cancer: challenges for sexual health providers. *J Sex. Med* 2014;11:2308–2317. <https://doi.org/10.1111/jsm.12598>.
- [6] Rosser BRS, Merengwa E, Capistrant BD, Lantaffi A, Kilian G, Kohil N, et al. Prostate cancer in gay, bisexual, and other men who have sex with men: a review. *LGBT Health* 2016;3:32–41. <https://doi.org/10.1089/lgbt.2015.0092>.
- [7] Ussher JM, Perz J, Rose D, Dowsett GW, Chambers S, Williams S, et al. Threat of sexual disqualification: the consequences of erectile dysfunction and other sexual changes for gay and bisexual men with prostate cancer. *Arch Sex. Behav* 2017;46:2043–2057. <https://dx.doi.org/10.1007%2Fs10508-016-0728-0>.
- [8] Rosser BRS, Kohil N, Polter EJ, Leshner L, Capistrant BD, Konety BR, et al. The sexual functioning of gay and bisexual men following prostate cancer treatment: results from the Restore study. *Arch Sex. Behav* 2020;49:1589–1600. <https://doi.org/10.1007/s10508-018-1360-y>.
- [9] Peach MS, Showalter TN, Ohri N. Systematic review of the relationship between acute and late gastrointestinal toxicity after radiotherapy for prostate cancer. *Prostate Cancer* 2015;624736. <https://dx.doi.org/10.1155%2F2015%2F624736>.
- [10] Berner AM, Hughes DJ, Tharmalingam H, Baker T, Heyworth B, Banerjee S, et al. An evaluation of self-perceived knowledge, attitudes and behaviours of UK oncologists about LGBTQ+ patients with cancer. *ESMO Open* 2020;5:e000906. <https://doi.org/10.1136/esmoopen-2020-000906>.
- [11] Stonewall. NHS. *Rainbow badges* 2021. Available at: <https://www.stonewall.org.uk/about-us/news/nhs-rainbow-badges-%E2%80%93-play-your-part-promoting-lgbt-inclusion-health-care>. [Accessed 24 June 2021].
- [12] Prostate Cancer UK. *Are you at risk?* 2019. Available at: <https://prostatecanceruk.org/prostate-information/are-you-at-risk>. [Accessed 24 June 2021].
- [13] Hoyt MA, Frost DM, Cohn E, Millar BM, Diefenbach A, Revenson TA. Gay men's experiences with prostate cancer: implications for future research. *J Health Psychol* 2017;3:298–310. <https://doi.org/10.1177%2F1359105317711491>.
- [14] Berner AM, Webster R, Hughes DJ, Tharmalingam H, Saunders DJ. Education to improve cancer care for LGBTQ+ patients in the UK. *Clin Oncol* 2020;33(4):270–273. <https://doi.org/10.1016/j.clon.2020.12.012>.
- [15] Prostate Cancer UK and Stonewall. *Exploring the needs of gay and bisexual men with prostate cancer* 2013. Available at: <https://www.patientlibrary.net/cgi-bin/download/file/122053>. [Accessed 24 June 2021].
- [16] Prostate Cancer UK. *Prostate cancer tests and treatment: a guide for gay and bisexual men* 2018. Available at: <https://shop.prostatecanceruk.org/our-publications/all-publications/prostate-cancer-tests-and-treatment-guide-for-gay-and-bisexual-men>. [Accessed 24 May 2021].
- [17] Chan SW, Tulloch E, Cooper ES, Smith A, Wojcik W. Montgomery and informed consent: where are we now? *BMJ* 2017;357:j2224. <https://doi.org/10.1136/bmj.j2224>.
- [18] Blank TO. Gay men and prostate cancer: invisible diversity. *J Clin Oncol* 2005;23:2593–2596. <https://doi.org/10.1200/jco.2005.00.968>.
- [19] Filiault SM, Drummond MJN, Smith JA. Gay men and prostate cancer: voicing the concerns of a hidden population. *J Men's Health* 2008;5:327–332. <https://doi.org/10.1016/j.jomh.2008.08.005>.
- [20] Perlman G, Drescher J. Introduction: what gay men (and those near and dear to them) need to know about prostate cancer. *J Gay Lesbian Psychother* 2005;9:1–7. [https://doi.org/10.1300/J236v09n01\\_01](https://doi.org/10.1300/J236v09n01_01).