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## **Why don't we mention "impact on intimacy" when we ask patients to give consent for treatment of oral cancer?**

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Dear Sir,

Approximately 1/3 of patients have reported reduced sexual interest or enjoyment following major head and neck cancer therapy. Relative to the older patient cohort, a higher number of younger patients have reported intimacy issues strong enough to cause concern.<sup>(1)</sup> Ironically, as oncogenic variants of the human papillomavirus become more common, the cohort becomes younger and thus are more likely to be significantly affected.<sup>(2)</sup>

Consider the effects of therapy and management; poor patient prognosis and physical disfigurement increase the burden of psychological distress within relationships<sup>(3)</sup> and reduce physical and emotional intimacy. Coupled with the side effects of respective treatment modalities (e.g. xerostomia, restricted lingual motility, loss of control of oral musculature), acts of physical intimacy can be made more complicated, unpleasant or impossible. In addition, mental health has also been shown to significantly associated with intimacy issues,<sup>(4)</sup> and can negatively impact quality of life.

The consent process for head and neck cancer therapy focuses mainly on the somatic aspects of treatment, but discussions regarding the effect on intimate behaviour rarely manifest in our experience. Therefore, the consent we provide to our patients is not fully informed consent.

In the past, the Bolam test was the accepted standard, whereby a responsible body of oral and maxillofacial surgeons would provide the same degree of information and the patient would only be informed of intimacy issues if they enquired specifically. We have recently progressed to an era of Montgomery consent which considers the material risks "*in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk*".<sup>(5)</sup> In this context, if a reasonably thinking patient with capacity considers the loss of intimacy (emotional and/or physical) as a price too great to pay at the expense of their cancer therapy, they are within their human right to refuse treatment. Although this may be of detriment to the patient, as eluded to above, there is a cohort of patients that would consider the reduced sexual interest or enjoyment as "*significant enough to cause concern*".<sup>(1)</sup> It is a decision that we as clinicians have no right to make for patients, and therefore we must provide all available information regarding possible behavioural changes when consenting patients, thus allowing fully informed decisions to be made. If it affects their relationships, quality of life, mental and emotional health, only the patient can assess the significance of reduced intimacy on their future decision to follow through with therapy.

Currently, no reliable predictor exists on how treatment will affect patient intimacy, and though it is not the sole factor involved, it certainly has an influence. We must therefore aim to educate all our patients, regardless - "*If this is not the responsibility of healthcare professionals, whose responsibility is it?*"<sup>(2)</sup>

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