Rachel Clemments is a 42-year-old mother of two, Sarah, age 12, and Jennifer, age 18. Because of a family history of breast cancer, she has been closely monitored (annual mammograms and clinical breast examination, monthly BSE, a needle aspiration biopsy with negative findings) for 4 years prior to her diagnosis. Mrs. Clemments discovers a lump in her left breast during her monthly BSE. An incisional biopsy reveals invasive lobular carcinoma in the left breast. Mrs. Clemments is debating whether to have reconstructive breast surgery. Her oncologist has recommended a 6-month course of adjuvant chemotherapy, and she is concerned about side effects. One of her greatest concerns is how her illness will affect her ability to support and care for her daughters. She is afraid that recovering from the mastectomy and completing the chemotherapy regimen will limit her ability to keep her part-time job, complete her academic work, and continue to meet the needs of her daughters. Also, this breast cancer diagnosis seems part of the family legacy. She wonders, “When will it happen to Jennifer? To Sarah?”

**ASSESSMENT**

During the history, Laura Nelson, RN, the nurse admitting Mrs. Clemments, learns that her mother, two of her aunts, and one sister had been diagnosed with breast cancer. Her mother and one of the aunts died before age 45. Physical assessment findings include T 98.5°F (37.0°C), BP 110/62, P 65, R 14. Her weight is 120 lb (54 kg); she is 66 inches (168 cm) tall. Modified radical mastectomy is performed; histologic examination shows a 3 cm tumor; axillary node dissection shows that 4 of 16 lymph nodes are positive.

**DIAGNOSES**

- Risk for infection, related to surgical incision
- Ineffective tissue perfusion, related to edema
- Acute pain, related to surgery
- Disturbed body image, related to loss of breast
- Decisional conflict about treatment, related to concerns about risks and benefits
- Interrupted family processes, related to effect of surgery and therapy on family roles and relationships
- Fear, related to disease process/prognosis

**EXPECTED OUTCOMES**

- Remain free of infection.
- Maintain adequate tissue perfusion.
- Experience minimal pain or discomfort during her recovery.
- Maintain a positive body image, regardless of her decision about reconstruction.
- Evaluate the treatment options in relation to personal values and decide on a course of action.
- Together with her daughters, acknowledge the need for a change in family roles during her illness and identify new coping patterns.
- Identify the sources of her fear and demonstrate behaviors that may reduce fears.

**PLANNING AND IMPLEMENTATION**

- Teach her about handwashing and wound care.
- Discuss the postoperative drainage device and its management after she goes home.
- Assess her pain tolerance and administer analgesics as prescribed.
- Teach her to use caution when moving the arm on the operated side, to avoid lifting heavy objects, and to wear gloves when gardening.
- Encourage her to discuss her thoughts and feelings about her body changes.
- Suggest that she talk with a Reach to Recovery volunteer about her thoughts and feelings.

(continued)
The normal female sexual drive can persist well into the eighth and ninth decade. The body maintains the capacity for sexual activity and orgasm long after menopause (see the Meeting Individualized Needs box on page 1595). In a typical sexual event, two physiologic sexual responses occur: vasocongestion and myotonia. Sexual stimulation results in vasocongestion of the blood vessels surrounding the vagina, causing engorgement, increased lubrication, and genital swelling and enlargement. Arousal, or myotonia, increases muscular tension, resulting in voluntary and involuntary muscle contraction.

The sexual response cycle has four phases: excitement, plateau, orgasm, and resolution. These phases always occur in the same sequence; however, the duration of each phase may vary. Sexual arousal typically ends in orgasm, or climax, but sometimes fails to do so. The refractory period, or period in which the sexual organs are incapable of responding to stimulus, does not occur in the female. Multiple orgasms are physically possible in all women.

Although nurses may not do sexual counseling, they should be able to obtain a sexual history without embarrassment, discuss sexual concerns with women, and make appropriate referrals.

**PATHOPHYSIOLOGY**

Disorders of sexual expression may include dyspareunia, inhibited sexual desire, and orgasmic dysfunction.

**Dyspareunia**

The woman with dyspareunia (pain during intercourse) may find it difficult to express her feelings to her partner. This condition is more likely to manifest itself as decreased desire or inhibited orgasm. The causes of dyspareunia range from organic to psychogenic.

Physical conditions, such as imperforate hymen, vaginal scarring, or vaginismus, may cause dyspareunia. Vaginismus is a rare condition in which the vaginal muscles at the introitus contract so tightly that an erect penis cannot be inserted. An