Limited evidence exists on the use of contraceptive methods among breast cancer survivors. Lambertini and colleagues' report on the use of contraception among premenopausal women with early-stage breast cancer who participated in the multicenter Cancer Toxicity (CANTO) cohort study, finding that at the time of diagnosis, 54.2% of patients reported contraceptive use, with most women choosing hormonal methods. After diagnosis and during follow-up, the use of contraception decreased significantly to approximately 40% (38.9% at year 1 and 41.2% at year 2), and most patients reported using reversible mechanical methods.

These findings highlight several unmet needs among breast cancer survivors. Patients diagnosed with breast cancer face a myriad of survivorship issues throughout their lifespan. Among these are reproductive health concerns, which are encountered by an increasing number of younger breast cancer survivors and include issues surrounding fertility, pregnancy, and contraception. A particular gap in care is the limited access to evidence-based gynecological care, including contraceptive counseling for those not desiring pregnancy. A previous study reported that many pregnancies among breast cancer survivors were unintended and occurred in women not planning to conceive. There are many reasons for this pattern, including the lack of adequate contraceptive counseling, the use of ineffective contraceptive methods, and the mistaken belief that cancer treatments may induce permanent infertility.

All women, including breast cancer survivors, need to have full access to reproductive health choices, which includes education about contraception and access to the full spectrum of gynecological services with knowledgeable health care professionals. Of note, in the Lambertini et al study, having a consultation with a gynecologist in the previous year was associated with a higher likelihood of contraceptive use. A more structured and coordinated system that links oncologists, gynecologists, and primary care clinicians is essential to providing long-term follow-up care to the increasing number of breast cancer survivors. In addition, patient and clinician education regarding preferred contraceptive methods, including raising awareness about the option of using a long-acting reversible nonhormonal copper intrauterine device as well as improving knowledge about the limited efficacy of gonadotropin-releasing hormone agonist therapy for preventing pregnancy, are needed.

In addition to access to specialty care, the extent of symptom burden due to various breast cancer therapies was also associated with the likelihood of contraceptive use. In the Lambertini et al study, factors such as patient-reported sexual function and the presence of physiological leukorrhea were typically lower among those who did not report contraceptive use after receipt of breast cancer treatment. These findings are consistent with those of another study that reported similar sexual concerns among survivors, including low desire, arousal issues, lack of appropriate lubrication, difficulty in achieving orgasm, and pain with penetrative sexual activity. Treatment-induced menopause, which produces a rapid decrease in hormone levels, can be affected by chemotherapy and gonadotropin-releasing hormone agonists in premenopausal women, resulting in substantial symptom burden. Thus, personalized symptom management should be an integral component of supporting women's reproductive and sexual health choices as part of comprehensive cancer survivorship care.

As we envision a more inclusive health care model for the future, these survivorship concerns will also need to be addressed among diverse populations with breast cancer. As stated by the
authors, the CANTO study did not collect information on sexual orientation, and the sexual function score on the breast cancer-specific module of the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire was used as a surrogate to define patients as sexually active. We know that people of all genders and sexualities who are diagnosed with cancer have additional unmet needs, and efforts to address the sexual health concerns of minoritized populations are urgently needed, including the concerns of those who identify as nonbinary.

Cancer-related sexual and reproductive concerns need to be approached using a coordinated and comprehensive biopsychosocial model that addresses biological, psychological, interpersonal, and sociocultural factors. These items would ideally be able to be personalized and delivered via close partnerships between cancer survivors and multidisciplinary teams using an integrated approach. Such coordinated efforts often require access to specialists in women's health, pelvic floor rehabilitation, and psychosocial oncology working closely with oncologists and primary care clinicians.

All individuals diagnosed with cancer need to have the opportunity to make the most informed decisions about reproductive and sexual health before, during, and after cancer treatment. How we effectively implement such coordinated efforts remains to be determined yet undoubtedly requires close partnerships between diverse members of health care specialties and patients. There are many opportunities for improving the care of breast cancer survivors, including supporting bodily autonomy and facilitating informed health care choices about fertility, pregnancy, and contraception.