

Review

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Review

Sexual Dysfunction Among Melanoma Survivors: A Scoping Review of Current Evidence and Clinical Gaps

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Simple Summary

Melanoma patients often face sexual health problems that significantly impact their quality of life. However, these concerns are rarely addressed in routine medical care. This review explores existing research to assess how common sexual dysfunction is among melanoma patients, what causes it, and how it differs by gender. Over half of patients experience some form of sexual difficulty, often linked to treatment side effects, visible scars, hormonal changes, depression, or anxiety. Women tend to struggle more with body image and fear of cancer recurrence, while men are more affected by hormone-related sexual dysfunction, particularly due to immunotherapy. The review highlights major gaps in clinical recognition and support, emphasizing the need for routine sexual health screening and multidisciplinary care in melanoma survivorship.

Abstract

Sexual health is a fundamental component of quality of life that is frequently compromised in cancer patients. In melanoma care, these issues remain under addressed despite increasing survivorship. This scoping review aimed to map the current literature on sexual health concerns in melanoma patients. Following PRISMA-ScR guidelines, five databases were searched (2010–2025). Ten studies met the inclusion criteria, including cross-sectional, qualitative, and systematic reviews. Sexual dysfunction affected up to 52% of melanoma patients, with higher prevalence in men (68.9%) than women (41.3%). Contributing factors included visible scarring, hormonal imbalances (e.g., testosterone deficiency in 69% of men receiving immunotherapy), body image concerns, anxiety, and depression. Women were more affected by body image and recurrence anxiety, while men experienced higher rates of treatment-induced hypogonadism. Sexual health concerns are highly prevalent yet systematically overlooked in melanoma care. Gaps remain in longitudinal data, cultural considerations, and evidence-based interventions. Routine screening and integrated psychosocial support are critical to improving patient-centered survivorship care.

Keywords: melanoma; sexual dysfunction; body image; quality of life; cancer survivorship; immunotherapy; testosterone deficiency; psycho-oncology; sexual health; patient-centered care; survivorship care; endocrine side effects; body image disturbance; oncology nursing; sexual rehabilitation

1. Introduction

Melanoma is an aggressive form of skin cancer that, despite comprising only a small fraction of skin cancer cases, it accounts for most skin cancer-related deaths [1]. Advances in early detection and novel therapies (including immune checkpoint inhibitors and targeted agents) have dramatically improved survival outcomes in recent years[2]. In fact, the overall 5-years relative survival rate for melanoma now approaches 94% (exceeding 99% for localized disease), with a marked improvement in advanced-stage survival since the mid-2000s [3]. As a result, an expanding population of melanoma into a chronic condition for years [4] . In this context, survivorship issues such as psychological well-being, social reintegration, and sexual health have become increasingly important components of comprehensive melanoma care.

Sexual health is a fundamental aspect of HRQoL that is often adversely affected by cancer and its treatment, yet it remains frequently overlooked in oncology practice [5]. Like other cancers, melanoma can affect sexual functioning through physical, hormonal, and psychological pathways. Surgical excisions may result in disfigurement and body image and self-esteem concerns, while systemic therapies can cause fatigue, neuropathy, and endocrine changes. These factors, alongside emotional distress and fear of recurrence, can significantly reduce sexual desire and satisfaction [5]. Moreover, the advent of immunotherapies and targeted therapies in advanced melanoma, while extending survival, has introduced new chronic side effects that impact sexual health, such as hormonal changes in both men and women can manifest as decreased libido, erectile dysfunction, vaginal dryness, or infertility ^{1,2}. Notably, immune checkpoint inhibitor treatment has been linked to endocrine dysfunctions such as hypophysitis, leading to hypogonadism in a subset of patients ³. Emotional factors are equally significant: patients with melanoma often experience anxiety, depression, and fear of recurrence, which can suppress sexual desire and strain partner relationships [6]. Importantly, these sexual difficulties are not confined to those with late-stage disease- even early-stage melanoma survivors (especially older adults and those with visible treatment scars) have reported challenges in sexual function and satisfaction [7]. Taken together, these issues illustrate that sexual health should be recognized as a relevant domain in the holistic care of melanoma patients [8].

Major cancer organizations and guidelines advocate routine assessment of sexual health as part of survivorship planning [9]. In practice, however, discussions about sexuality between patients and providers remain infrequent [10]. Studies across cancer populations have revealed that while most patients experience some degree of treatment-related sexual dysfunction, most are never offered information or support on this topic by their healthcare team [11]. For instance, one survey found that approximately 87% of cancer patients reported an adverse impact of treatment on their sexual life, yet only ~28% had ever been asked about sexual health by clinicians [11]. This disconnects highlights pattern of underreporting and under-recognition of sexual concerns. Patients often hesitate to voice sexual difficulties due to embarrassment from the perception that the topic is “taboo”, whereas providers cite barriers such as limited time, insufficient training, and uncertainty about whose role it is to initiate the conversation [12]. In melanoma care, where attention historically centered on acute treatment outcomes, the integration of sexual health counseling and interventions is only beginning to gain traction [13].

A scoping review is warranted to thoroughly map the current knowledge on sexual issues in melanoma and to identify gaps in practice and research. Unlike in some other malignancies (e.g. breast or genitourinary cancers) where sexual side effects are well documented and management guidelines have evolved; there is a dearth of consolidated evidence regarding sexual function in melanoma patients. Preliminary studies suggested that melanoma survivors may indeed suffer significant sexual dysfunction and related distress, but no standardized approaches for prevention or management have been established. By conducting a scoping review, we aim to elucidate the extent, range, and nature of literature on this topic-spanning qualitative reports of patient experiences, quantitative studies of sexual outcomes, and any described intervention or clinical guidelines. This exploration will help clarify what is known and what is missing, thereby guiding

future research and informing clinicians about best practices for managing sexual issues in melanoma patients.

2. Materials and Methods

This scoping review followed the methodological framework outlined by Arksey and O’Malley⁴ and further refined by Levac et al.⁵, adhering to preferred reporting items for systematic reviews and meta-analysis extension for scoping review (PRISMA-ScR) guidelines⁶. The review protocol was developed a priori to comprehensively map the existing literature on sexual health issues in melanoma patients and identify key concepts, research gaps, and opportunities for future investigation.

2.1. Research Question

This scoping review was guided by following research question: ‘what is the current state of knowledge regarding sexual health issues in melanoma patients, and how are these issues being addressed or managed in the existing literature and clinical practices?’ The question was structured using the population-concept-context (PCC) framework, in which the population included melanoma patients and survivors of all stages; the concept encompassed sexual health issues, dysfunction, and related interventions; and the context referred to oncological care settings and survivorship programs.

2.2. Eligibility Criteria (Table 1)

Table 1. Summary of inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Population: adult patients (≥ 18 years) diagnosis with cutaneous melanoma at any stage, including survivors in remission.	1. Focused solely on other skin cancers without specific melanoma data 2. Addressed general quality of life without specific mention of sexual health components. 3. Non-human studies 4. Editorials, letters to editors, or opinion pieces without original data 5. Duplicate publications of the same datasets.
Concept: studies addressing sexual health, sexual function, sexual dysfunction, body image related to sexuality.	
Context: healthcare settings, survivorship programs, or community-based studies	
Study design: all study designs including quantitative, qualitative, and mixed-methods studies; systematic reviews.	
Language: studies published in English	
Time frame: studies published from September 2010 to September 2025	

2.3. Search Strategy

Systematic research was carried out in five electronic databases: Scopus, Medline ,PubMed, ScienceDirect and Cumulative Index to Nursing and Allied Health Literature (CINAHL), covering the period from 2010 through 2025^{7,8}. The search strategy combined controlled vocabulary (e.g., MeSH terms) and free- text key words related to three core concepts: Melanoma (“melanoma,” “malignant melanoma,” “cutaneous melanoma,” “skin neoplasms”) ; sexual health (“sexual health,” “ sexual function,” “ sexual dysfunction,” “ sexuality,” “body image”; and cancer context (“neoplasms”, “cancer survivors”, “ survivorship”, “oncology”). These terms were adapted for each database and combined using Boolean operators (AND, OR) and truncation symbols where appropriate.

Two reviewers (OA and SA) independently screened all titles and abstract for relevance, and full text were obtained for potentially eligible studies. The same two reviewers then independently assessed full text articles against the inclusion criteria, with any discrepancies resolved by discussion. Data from included studies were extracted in duplicate by OA and SA using a standardized charting form; discrepancies were resolved by consensus.

2.4. Quality Appraisal (JBI)

Each study was evaluated independently by two reviewers using critical appraisal checklists tailored to the Joanna Briggs Institute (JBI) design. Informed by the interpretation of study findings, items were rated YES/NO/UNCLEAR and classified as high (7–10), moderate (4–6), or low (≤ 3). The focus was on combining data from better studies to support the review's findings. Although they were carefully weighed up, studies that were judged to be of low quality provided contextual understanding. Study-level quality scores are displayed in *supplementary materials*.

Following PRISMA-ScR recommendation, the study selection process is summarized in Figure 1. A total of 480 records were retrieved through database searching (Scopus, PubMed midline, ScienceDirect, and CINHALL). After removing 120 duplicates, 360 records remained for title/abstract screening. Of these, 344 were excluded for irrelevance, leaving 16 full-text articles assessed for eligibility. Following full-text evaluation, 10 studies met all inclusion criteria and were included in the final review.

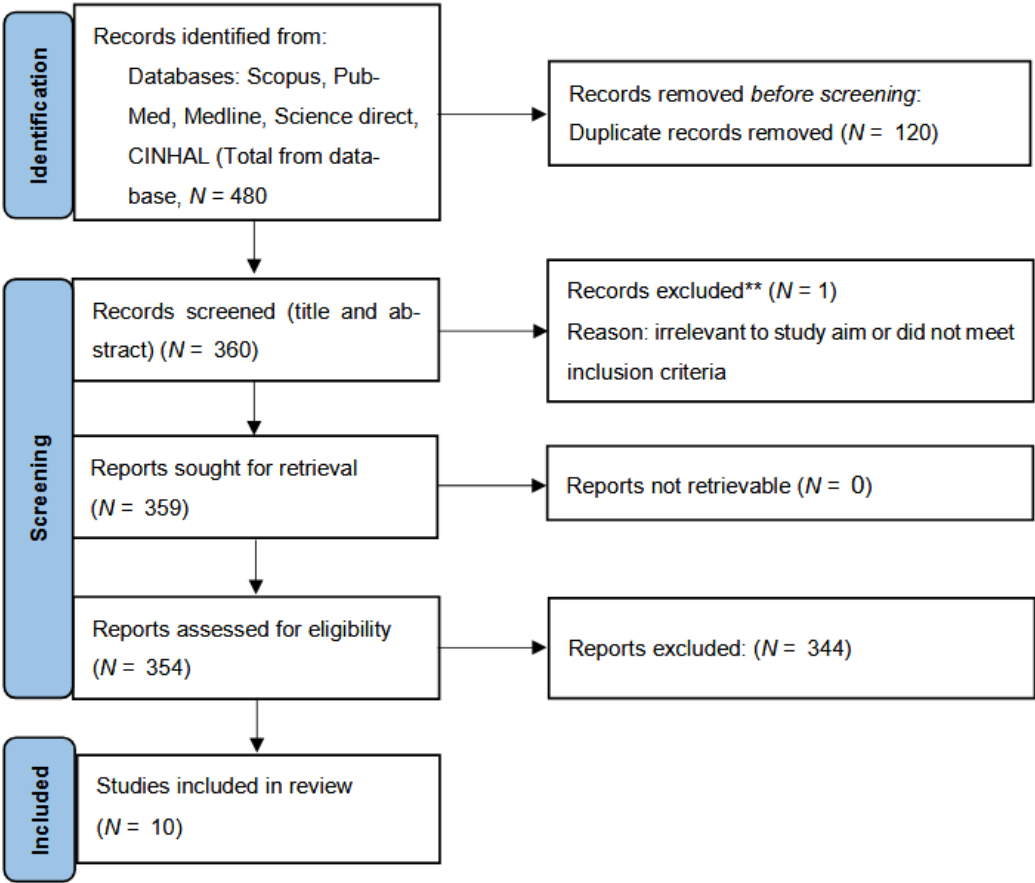


Figure 1. Flow diagram of comprehensive review for retrospective studies with the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) methodology.

2.5. Data Extraction

From the 10 studies that were included in the final literature review, the following data were abstracted and inserted into **Table 2**: author and year of publication, purpose of study, country, sample size, design, and main findings.

Table 2. Studies included in this review.

Author	Purpose	Country	Sample size	Design	Main findings
Muñoz-Barba (2025) [5]	To assess the prevalence of sexual dysfunction (SD) among melanoma patients and identify associated clinical and psychological factors using validated assessment tools	Spain	75 melanoma patients	Cross-sectional study	SD in 52% (69% men, 41% women); linked to depression, anxiety, scars, and QoL
Queirolo (2025)[14]	To systematically review and meta-analyze the effect of sex and gender on adverse events (AEs) in melanoma patients	Italy	Data from 70 independent studies	Systematic review and meta-analysis	Women at higher risk of thyroid and dermatologic AEs; need close monitoring.
Leven (2025) [15]	To examine sex-specific survival in advanced metastatic melanoma and to evaluate the impact of sex on clinical outcomes following first-line treatments with PD-1–based immune checkpoint inhibition (ICI) or BRAF/MEK-directed targeted therapy (TT)	Germany	2032 patients (1274 males, 758 females)	Prospective multicenter study using the ADOREG registry	No major sex differences in survival; slight male advantage with PD-1.
Carli (2024) [16]	To explore the psychosocial impact of advanced melanoma, focusing on the relationship with the body, the relational/social sphere, coping strategies, and overall quality of life.	Italy	22 advanced melanoma (III-IV) .	Qualitative (narrative)	Body image disruption, social isolation, resilience, need for psychosocial support
Heyne (2023) [17]	To assess sexual satisfaction in long-term cancer survivors (5- and 10-years post-diagnosis) and examine the physical and psychosocial factors influencing it.	Germany	924 cancer survivors	Survey (longitudinal)	~50% reduced sexual satisfaction; fatigue, pain, and depression strongest predictors
Cosci (2023) [18]	To explore sex-specific differences in cutaneous melanoma, with a focus on hormonal influences and male reproductive health	Italy	N/A (Review)	Narrative review	Men at higher incidence and mortality; ICIs may impair fertility; sperm banking advised.
Vogel (2021) [19]	To describe sex differences in cancer-specific psychosocial quality of life among long-term melanoma survivors	USA	724 long term survivors	Cross-sectional	Women reported more appearance concerns & fear of recurrences.
Peters (2021)[20]	To assess the prevalence of testosterone deficiency in men undergoing immunotherapy for malignant melanoma and to	USA	49 males on immunotherapy	Retrospective cohort	69% had low testosterone; often untreated; risk increased

	evaluate the management of this condition.				with ipilimumab, obesity.
Sampogna (2019) [21]	To compare quality QoL between patients with melanoma and NMSC	Italy	65 melanom as 368 NMSC patients	Cross-sectional	Melanoma →higher emotional distress; NMSC →more physical burden
Graça Pereira (2017) [22]	To analyze the impact of body image and social support on psychological morbidities.	Portugal	106 patients with skin cancer	Cross-sectional	Body image & social support mediated QoL, stress, & psychological morbidity.

AE, adverse effects; ICI, immune checkpoint inhibitor; NMSC, non-melanomatous skin cancer; PD-1, programmed death protein-1; QoL, quality of life; SD, sexual dysfunction; TT, targeted therapy.

3. Results

The systematic search identified 10 studies that met the inclusion criteria for this scoping review on sexual health issues in melanoma patients. The included studies represented diverse geographical locations, with research conducted in Spain, Italy, Germany, Portugal and the United States, and. The study designs varied considerably, encompassing cross sectional studies, systematic reviews, qualitative research, prospective cohort studies, and narrative reviews. The sample sizes ranged from 22 participants in qualitative studies to large-scale analyses involving over 2,000 patients.

3.1. Study Characteristics and Populations

Most studies (n=7) [5,15,17,19–22] employed quantitative methodologies, while one utilized qualitative [16] approach and two were review studies [14,18]. Study populations predominantly consisted of adult melanoma patients across various disease stages, with some studies specifically focusing on advanced melanoma patients [16], or long-term survivors [17,19]. Sample demographics varied, with several studies reporting female predominance in their cohorts, particularly among survivorship studies [17,19].

3.2. Prevalence of Sexual Dysfunction in Melanoma Patients

Sexual dysfunction emerged as a significant concern among melanoma patients, with prevalence rates varying across studies. The most comprehensive assessment was conducted by Munoz-barba (2025), who reported an overall sexual dysfunction prevalence of 52% among 75 melanoma patients in Spain [5]. Notably, 29.3% of participants reported a direct negative impact of melanoma on their sexual function, with decrease sexual desire being the most frequently reported issue.

In a broader cancer survivorship context, Heyne (2023) found that nearly half of long-term cancer survivors, including melanoma patients, reported reduced sexual satisfaction compared to their pre-diagnosis level [17]]. This finding was consistent across both 5-years and 10-years survivor cohorts, indicating the persistent nature of sexual health challenges following melanoma treatment.

Table 3 summarized key prevalence estimates. Several melanoma cohorts also identified psychosocial correlates: for example, mood disturbance (anxiety/depression) and poorer quality of life were consistently linked to sexual dysfunction. One Italian cross-sectional study noted that nearly 30% of melanoma patients explicitly attributed sexual difficulties to their cancer, primarily reduced desire (54.5% of affected patients) and postoperative discomfort.

Table 3. summarized key prevalence estimates.

Study	Measure	Sample (n)	Overall SD (%)	Male SD (%)	Female SD (%)
Munoz-Barba (2023) [5]	FSFI/IIEF criteria	75	52.0%	68.9%	41.3%
Hyene (2023) [17]	Self-rated satisfaction loss	924 survivors	~50% (reduced satisfaction)	—	—
Vogel (2021) [19]	Melanoma specific QoL survey	724 survivors	N/A (gender comparison)	—	—

Abbreviations: FSFI, Female Sexual Function Index; IIEF, International Index of Erectile Function; N/A, not available; QoL, quality of life; SD, sexual dysfunction, abnormal sexual function; **, reported prevalence of sexual dysfunction or reduced sexual satisfaction in melanoma patients; male/female SD (percentage) are among those studies providing sex-stratified rates.

3.3. Gender-Specific Differences in Sexual Health Outcomes

Gender disparities were evident throughout literature. Munoz-barba (2025) demonstrated that 68.9% of men and 41.3% of women experienced sexual dysfunction [5]. Multiple studies identified important gender differences in sexual health experiences among melanoma patients. Women were more likely than men to report changes in appearance and fear of recurrences or developing a second melanoma. However, they also demonstrated a greater likelihood of reporting positive impacts from their melanoma experiences [19]. Queirolo (2025) conducted a systematic review and meta-analysis demonstrating that women had significantly higher risks of thyroid-related adverse events and dermatological complication with targeted therapy, which could indirectly impact sexual health through body image concerns and hormonal disruptions [14].

Men showed distinct patterns of sexual health impairment. The narrative review by Cosci (2023) highlighted that men generally have higher melanoma incidence, progression rates, and mortality compared to women [18]. Furthermore, this review emphasized that immune checkpoint inhibitors may adversely affect male fertility and testicular function, leading to recommendations for sperm cryopreserved in men undergoing such therapies.

3.4. Hormonal Effects

Peters (2021) focused specifically on male melanoma patients undergoing immunotherapy and identified testosterone deficiency in 69% of participants [20]. This hormonal disruption was frequently associated with fatigue and sexual dysfunction, yet few patients received appropriate testosterone replacement therapy, highlighting significant gaps in clinical recognition and management. Hypophysitis with subsequent hypopituitarism occurred primarily with ipilimumab treatment, with obesity and participation in clinical trials increasing the risk of testosterone deficiency.

Figure 2. Hormonal pathway of sexual dysfunction in male melanoma patients receiving immunotherapy. Ipilimumab treatment induces Hypophysitis (Pituitary inflammation), leading to decreased testosterone production and subsequent erectile dysfunction. This pathway affects approximately 69% of men undergoing immunotherapy.

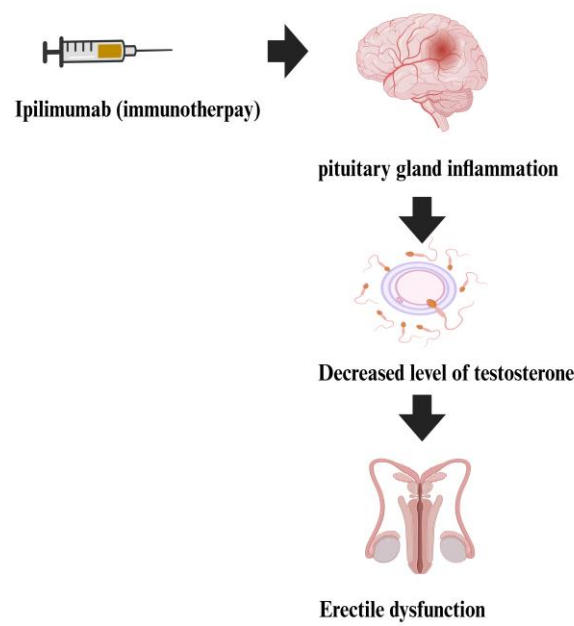


Figure 2. hormonal pathway of sexual dysfunction in male melanoma patients receiving immunotherapy.

Heyne (2023) demonstrated that physical symptom burden had a stronger impact on sexual satisfaction than psychosocial factors among cancer survivors [17]. Factors independently associated with higher sexual satisfaction included female gender, absences of hormone therapy, lower comorbidity burden, reduced fatigue, and better emotional and social functioning.

3.5. *Body Image and Psychosocial*

Body image concerns emerged as a central theme affecting sexual health in melanoma patients. Carli (2024) conducted qualitative study with 22 interviewed advanced melanoma patients and identified significant negative impacts on body image, including feelings of estrangement from their bodies, concerns about visible scars, and fear of body exposure [16]. These findings were supported by patients experiencing isolation and reduced social support during treatment, despite having access to medical and family support systems.

Craca Pereira (2017) provided empirical evidence for the mediating role of body image in the relationship between illness perceptions and quality of life among 106 patients with skin tumor [22]. Their analysis demonstrated that body image concerns the mediated relationship between illness perceptions, family stress, psychological morbidity, and overall quality of life. Additionally, social support was found to mediate the relationship between family stress, psychological morbidity, and quality of life, underscoring the interconnected nature of psychosocial factors in sexual health outcomes.

As previously noted in the gender differences sections, Vogel (2021) found that female were more likely than males to report changes in appearance [19], reinforcing the particular vulnerability of women to body image-related sexual health concerns in melanoma survivorship. An example is a lady with advanced cutaneous melanoma lesion located in the posterior auricular region which would result in visible disfigurement and scarring that contribute to body image disturbances and related sexual health concerns postoperatively.

3.6. *Treatment-Related Issues*

Several studies identified specific treatment-related factors contributing to sexual dysfunction in melanoma patients. Peters (2021) found that hypophysitis and hypopituitarism occurred primarily

with ipilimumab treatment, with obesity and participation in clinical trials increasing the risk of testosterone deficiency [20]. The high prevalence of unrecognized and untreated testosterone deficiency highlighted significant gaps in clinical care.

The relationship between melanoma diagnosis and emotional well-being significantly influenced sexual health outcomes. Sampogna (2019) compared quality of life melanoma and non-melanoma skin cancer patients and found that melanoma patients reported significantly more emotional distress, particularly feelings of depression [21]. While non-melanoma skin cancer patients experienced higher symptoms scores indicating greater physical burden, melanoma patients demonstrated greater psychological and emotional quality of life impairment.

4. Discussion

4.1. Research Gaps and Methodological Considerations

The reviewed studies revealed significant gaps in current research on sexual health in melanoma patients. Most studies were cross-sectional in design, limiting understanding of temporal relationships and changes in sexual function over time. Additionally, several studies included mixed cancer populations or focused on general quality of life measures without specific sexual health assessments, making it difficult to isolate melanoma-specific sexual health issues.

The geographics distribution of research was limited, with most studies conducted in European countries and the United States, potentially limiting generalizability to other populations. Furthermore, intervention studies addressing sexual health issues in melanoma patients were notably absent from the literature, indicating a significant gap in evidence-based management strategies. The findings of this scoping review are consistent with the broader consensus in psycho-oncology literature regarding cancer and sexual health. In contrast to melanoma highly visible skin changes, many other cancers also result in internal or concealable alterations. For example, breast cancer treatments often cause physiological and body image changes (like mastectomy, chemotherapy-induced menopause, or hair loss), but these can usually be hidden under clothing or by prosthesis. In psycho-oncology studies of breast cancer, sexual problems are linked not only to physical effects (e.g. vaginal dryness or hormonal changes) but also to body-image distress and relational strain [23]. Similarly, genitourinary caners (e.g. prostate cancer) typically disrupt sexual function through internal mechanisms (nerve damage, hypogonadism, hormonal therapy) rather than through visible disfigurement. In men with prostate cancer, for instance, treatment like radical prostatectomy often lead to erectile dysfunction and a threatened sense of masculinity- “feeling as if they had lost a bit of their manhood” – even though no external changes are apparent [24]. What sets melanoma apart is the external, visible scarring and pigmentation on exposed skin, which can exacerbate body image concerns and stigma. Carli (2024). note that “due to its visibility and scaring outcomes, melanoma often results in impaired body image”[16]. Munoz-barba (2025). also found that melanoma survivors’ sexual dysfunction was strongly associated with location of visible scar postoperatively [5]. Pereira. emphasize that body image disturbances are central to melanoma patients’ quality of life, arguing that psychological care should explicitly target these visible changes [22]. In short, while sexual health issues in other cancers often stem from internal or surgically concealed changes and their hormonal/relational sequelae [23,24], melanoma adds the extra burden of conspicuous skin scars and pigment changes that heighten the stigma and body-image distress [5,16]. These differences underscore why melanoma patients may experience unique challenges in sexuality and self-esteem that merit tailored psychological support [16,22]. Clinical implications: given that more than half of melanoma patients report some sexual dysfunction [5], oncologists and dermatologists should incorporate routine sexual-health screening into care. A multidisciplinary team (including mental-health and endocrine specialists [5]) can then address the full spectrum of issues-from hormonal side effects to the psychological impact of visible differences) may help mitigate the stigma and distress unique to melanoma survivors [16,22]. Likewise, awareness that female patients often worry about appearance (and that men on immunotherapy may develop hypogonadism) can guide gender-sensitive support strategies. Overall, these findings echo broader

psycho-oncology evidence that cancer care must go beyond survival to improve patients quality of life [22,23]. Regarding the role and recommendations for improving sexuality care for patients, our previous work provides detailed methods, including structured notes, role-play workshops, and a proactive approach to breaking the silence.^{9,10}

4.2. Limitation of Current Evidence

Although recent studies have generated valuable insights that may inform clinical guidelines, several methodological shortcomings must be acknowledged. Most investigations to date employ cross sectional designs, which preclude the establishment of casual relationships between risk factors and sexual dysfunction. Furthermore, the predominant reliance on self-reported questionnaires introduces subjectivity, with findings vulnerable to recall bias and social desirability effects—particularly salient given the stigma surrounding sexual health. These methodological constraints limit both the internal validity and generalizability of current evidence.

4.3. Directions for Future Research

To strengthen the evidence base, future studies should adopt longitudinal designs to clarify temporal associations and better delineate causal pathways. In addition, interventional research is critically needed to address the paucity of evidence regarding effective management strategies. Such trials should evaluate the impact of targeted psychosocial, pharmacologic, and rehabilitative interventions on sexual health outcomes. Importantly, standardized assessments of sexual function should be incorporated routinely into melanoma clinical trials, particularly those involving immunotherapies, where endocrine toxicities may impair sexual functions. Collectively, these strategies will advance a more robust and clinically actionable understanding of sexual dysfunction in melanoma populations.

5. Conclusions

This scoping review provides a comprehensive synthesis of the existing literature on sexual health issues in melanoma patients. The compilation of existing research shows that sexual health has been continuously underrepresented in melanoma research and practice, despite the fact that quality of life, psychological wellbeing, and coping mechanisms have all gotten a lot of attention. Intimate relationship issues, diminished self-esteem, and changes in body image are common complaints from patients. There is a significant gap in holistic patient care because these issues are rarely addressed in clinical interactions, despite their significant influence on wellbeing. Our knowledge of how melanoma and its treatments impact sexual functioning over time is further limited by the dearth of intervention studies, the literature's lack of cultural diversity, and the absence of longitudinal data. Increased clinical awareness, systematic screening for sexual health needs, and the creation of patient-centered, evidence-based interventions are all necessary to close these gaps. Future studies ought to give special attention to cross-cultural viewpoints, incorporate patient and partner voices, and assess the efficacy of educational and supportive initiatives aimed at enhancing sexual wellbeing. It is not only possible, but also essential, to incorporate sexual health into standard melanoma care in order to guarantee thorough, considerate, and genuinely patient-centered cancer care. We recommend that future clinical guidelines integrate standardized sexual health assessments into routine melanoma care pathways and that clinicians receive targeted training on initiating conversations about sexuality with patients.

Supplementary Materials: The critical appraisal table as Table S1.

Author Contributions: Conceptualization, P.T. and O.A.; methodology, P.T. and O.A.; software, O.A.; validation, A.A. and O.A.; formal analysis, O.A.; investigation, O.A.; resources, P.T. and K.J.; data curation, O.A.; writing—original draft preparation, O.A.; writing—review and editing, O.A.; P.T. and L.S.; supervision, P.T. and K.J.; project administration, P.T. All authors have read and agreed to the published version of the manuscript.

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Abbreviations

The following abbreviations are used in this manuscript:

ADOREG – Arbeit gemeinschaft Dermatologist Oncology Registry
AEs – adverse events
BRAF – Rapidly Accelerated Fibrosarcoma B-type
DLQI – Dermatology Life Quality Index
EORTC QLQ-C30 – European Organization for Research and Treatment of Cancer Quality of life Questionnaire - Core 30
FSFI – Female Sexual Function Index
GAD-7 – general anxiety disorder - 7 items
HADS – The Hospital Anxiety and Depression Scale
HRQoL – health-related quality of life
ICI – immune checkpoint inhibition
IIEF – International Index of Erectile Function
JBI – Joanna Briggs Institute
MeSH terms – Medical Subject Headings terms
MEK – Mitogen-Activated Protein Kinase
N/A – Not Available
NMSC – non-melanoma skin cancers
NRS – Numeric Rating Scale
PCC – population-concept-context
PD-1 – programmed cell death protein 1
PHQ-9 – Patient Health Questionnaire - 9 items
PRISMA – Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PRISMA-ScR – Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping review
QoL – quality of life
SD – sexual dysfunction
TT – targeted therapy

Notes

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