Conclusion Sexual dysfunction in gynecological neoplasms has been reported to be as high as 90% in this preliminary analysis; receiving brachytherapy did not significantly modify the prevalence before or after its application. It is important to identify the psychosocial factors in each patient's context to intervene in a timely manner and that each of the women with an oncologic pathology is evaluated in a comprehensive manner.

Results Of 341 identified records, 10 studies on 89 patients were included: 1 prospective study, 6 retrospective studies, and 3 case reports. All studies were very low quality with an overall serious risk of bias. The primary tumour was located in the cervix (n=42), uterus (n=22), vulva (n=11), vagina (n=3), ovary (n=3), Gartner duct (n=1) or synchronous tumours (n=3). For 4 patients the primary tumour was not reported. Bony resections included the pubic (n=11) and pelvic bone (n=9), hemipelvectomy (n=7), sacrectomy (n=2) and the transverse process of L5 (n=1). Margins were negative in 69 patients and were not reported for 6 patients. 14 patients had positive margins (R1: n=6; R2: n=3; ‘positive’: n=5). 30-day mortality was 1.1% (1/89). 3 studies reported on improved QoL after surgery, of which only one used a validated QoL questionnaire. Most frequently reported complications were infectious.

Conclusion Despite the sparsity of published studies, QoL seems to be improved after PE with neurovascular or bony resections in a highly selected patient group. There is a need for collecting QoL outcomes in a validated and uniform manner.