B U L L E T I N O N T H E



Rheumatic Diseases

FOR EVIDENCE-BASED MANAGEMENT OF RHEUMATIC DISEASES

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SUMMARY POINTS

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Sex and Arthritis

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Sex is a normal part of the everyday lives of most people. However, people with rheumatic diseases are reticent about discussing their sex lives with their physicians, and their physicians usually have not learned to ask or answer these intimate questions (1-4).

Rheumatic diseases may significantly affect a person's sex life, as can the confounding effects of medications frequently used to treat these chronic illnesses. Loss of self-esteem, depression, and perception of self by others may also contribute to sexual dysfunction (5-9). The role of partners of the afflicted has received little attention as well (9).

Rheumatic Diseases and Sexual Dysfunction

Literature regarding sexual dysfunction of people with rheumatic diseases is scant. Indeed, the best discussion of this that came to our attention was from a *Penthouse* publication (10). A recent review noted that only 10 studies adequately assessed sexual function in rheumatic disease patients. Even these few studies were limited by not having definitions, indices, or validated methods for evaluating sexual difficulties in people with rheumatic disease (11).

Nevertheless, there is consensus that arthritis can interfere with sexual functioning.

Osteoarthritis

Characterized by joint pain, tenderness, and limitation of movement, osteoarthritis (OA) can have a negative impact on a person's sex life, particularly when the hip joint is involved. Degenerative hip disease makes intercourse more diffi-

cult and potentially painful. Published surveys have suggested that two thirds of patients with hip OA have sexual difficulties. Pain and stiffness are more important than libido, and 25% report some marital tension as a consequence. The majority of patients with hip OA experienced improved sexual performance after total hip replacement (12).

Rheumatoid Arthritis

The inflammation and fatigue associated with rheumatoid arthritis (RA) can have profound effects on a person's sexuality. About 50% of patients with RA experience loss of sexual interest, and 60% are unsatisfied with their sexual quality-of-life. Eighty-five percent of women and 69% of men with RA report that increased disease activity with joint swelling is a major limiting factor for initiating sexual activity (6).

Flexion contractures and deformities can limit touching. It may be difficult to move in such a way during intercourse that sexual arousal can be achieved. This is especially true for women with hip motion limitation. The traditional "missionary" position was chosen as the most satisfying but also as the most painful (5,6). Orgasmic intensity does not seem to be affected; however the length of foreplay is significantly shorter because patients wish to reach orgasm quickly because prolonged sexual activity causes too much pain and/or fatigue.

Patients with juvenile rheumatoid arthritis (as do those with adult RA) rate disease activity as the most important factor limiting sexual interest and activity (13).

Sjögren's Syndrome

Underdiagnosed by primary care physicians and rheumatologists, primary Sjögren's syndrome is associated with atrophic vaginitis, decreased cervical mucous secretions, and gingivitis. In addition, secondary Sjögren's syndrome is associated with RA and systemic lupus erythematosus (SLE). The prevalence of painful intercourse is high in this group, and kissing can be difficult or unpleasant (16,17). In one study, however, fertility, parity,

and sexual activity did not differ from that seen in healthy controls (18).

Systemic Lupus Erythematosus

This systemic inflammatory disease with its myriad manifestations can have a variety of sexually related affects. Discoid or cutaneous rashes can be disfiguring and can decrease self-image, as can changes in appearance from long-term glucocorticoid therapy. People with SLE frequently experience fatigue, anemia, and inflammation and are also prone to infections.

Studies show that women with SLE have a high abstention rate; low frequency of masturbation, genital petting, and intercourse; diminished vaginal lubrication; poor general sexual adjustment; poor ability to adjust to psychosocial stresses; and more depression (11,19). Greater vaginal discomfort or pain during intercourse and difficulty with penetration due to vaginal tightness were also found. Sex drive, motivation, subjective arousal, orgasmic attainment, and satisfaction were not found to be worse compared with controls (19).

One report suggested an increased prevalence of impotence in men with SLE (20).

Systemic Sclerosis

Raynaud's phenomenon, tight skin, and digital ulcers will diminish tactile sensation, which may lead to ineffective sexual stimulation. Besides the fingers, Raynaud's phenomenon can also affect the tongue, nipples, and penis (diminishing erections). Skin tightening and thickening can alter selfimage, leading to concern about attractiveness. Low self-esteem and social isolation were found to be common in people with systemic sclerosis. Deformities, interstitial lung disease, poor nutrition, and muscle atrophy decrease libido, stamina, and endurance. Internal organ involvement, especially cardiopulmonary disease, may impair sexual performance because of decreased exercise tolerance.

The major sexual problem in male patients is erectile failure. In many cases it is an early manifestation of the disease. It is likely that impotence results from microvascular disease, infiltration of penile structures with connective tissue components, and/or neurogenic dysfunction. In addition, men may experience premature ejaculation (16,21).

Fibromyalgia

People with fibromyalgia have a high prevalence of sexual dysfunction. Some researchers have linked sexual abuse to cause the syndrome in some individuals, and others have correlated sexual dysfunction with complaints of irritable bladder, vulvodynia, and vaginismus. Tension headaches and myofascial tender points decrease pleasure (22).

Antirheumatic Therapies and Sexual Dysfunction

Medications frequently used to treat rheumatic diseases may affect sexual function. Glucocorticoids are commonly used in many rheumatic diseases and in high doses are associated with side effects that can have a strong impact on sexuality. They not only alter the physical appearance of the patient by causing the characteristic buffalo hump, moon facies, and thin extremities, but also may have psychological manifestations such as decreased libido, depression, mania, and even psychosis (14). Immunosuppressants have been noted to cause oral and genital ulcers, skin rashes, anemia, and particularly hair loss - which may have a significantly detrimental effect on self-image. Immunosuppressive medications, particularly cyclophosphamide, promote amenorrhea and infertility.

Agents such as tricyclic antidepressants and selective serotonin reuptake inhibitors, used to manage fibromyalgia syndrome, decrease libido.

Patient Concerns

Arthritis affects individuals' sexuality differently, however certain generalizations emerge.

In our society, sexuality includes adoption of expected gender roles. In our society definitions of masculinity traditionally identify the male as robust and strong. Arthritis alters one's capacity for display of such strength. It may also remove the patient from gainful employment. The corresponding role for a woman in our society traditionally identifies her as wife, homemaker, attentive mother, and increasingly, an income provider. Again, arthritis may interfere with her capacity to meet these demands. The patient's self-esteem has been lowered because of the fear of not meeting expectations both of self and the presumed views of others.

Whatever the type or localization of the arthritic condition, sex drive is commonly reduced. Pain, the fear of pain, and fatigue may quell libido. Even in those people with drive and competence sufficient to initiate or accept sexual intercourse, the extent and method of sexual expression is likely to be limited by arthritis.

Partner Concerns

People with arthritis frequently have reduced libido, so sexual frustration is not as much an issue as it is for the partner. Partners fear causing pain or distress when they attempt sexual intercourse in the manner and frequency of their natural inclination. Spontaneity is replaced by expediency. This leads to curtailment of the duration and variety of foreplay and afterplay, and to adoption of the most direct and rapid techniques for producing orgasm. Diminished satisfaction in lovemaking may result.

Recommendations for Your Patients

The sexual problems of your patients can invariably be ameliorated. By counseling, treatment, assistance, and prevention it is possible to assist in some way (Table 2). The PLISSIT (permission, limited information, specific strategies, intensive therapy) model is useful in defining appropriate levels of intervention (8).

Permission

Permission means incorporation of inquiry about sexuality into the routine care of the patient and offering the patient permission to identify concerns and problems. Permission may also be given to discuss sexuality openly with one's partner, to normalize sexual activities other than intercourse, and to reassess the sexual attitudes that function as a barrier to the broad expression of sexuality. Some of the greatest benefits that wise counseling can provide are the removal of fear of unknown and the widening of sexual experience between partners (23).

Limited Information

Limited information may be given to the patient to help him or her understand the possible changes that may occur as a result of the disease or treatment. Whenever possible, sex counseling should include both partners and should be prefaced by an explanation of the natural history of the particular form of arthritis in question. Thus, patients may able to make appropriate adjustments or understand the changes without superimposing the added impact of performance anxiety, fear, and communication difficulties into the sexual interaction. Understanding the medical background of any sexual dysfunction can be immensely helpful to the preservation of a satisfactory marital relationship (24).

Specific Strategies

Specific strategies might include suggestions about a variety of positions for intercourse and a variety of a ways of achieving orgasm. Patients may benefit from advice about the use of analgesics or heat preceding sexual activity or the use of physical support to minimize pain and discomfort.

Advice regarding preparation for sex is important. The principle of muscle relaxation before activity applies to almost all activities of daily living, including sex. Application of moist heat for periods of 10 to 15 minutes before any activity can reduce the gelling that impedes motion. Range of motion exercises can help limber muscles (13,23). Muscle relaxants in small doses do not appear to affect sexual function and may be taken an hour beforehand. The cooperation of the spouse needs to be obtained, because he or she must wait through the partner's preparation.

Analgesic drugs are frequently of the greatest help in allowing less restricted sex. With the exception of narcotics that

can depress sexual desire, analgesics can be used safely. Intra-articular injection of glucocorticoids, especially into joints used during sexual activity, can be effective. Symptomatic treatment of dryness in Sjögren's syndrome with vaginal lubrication is recommended (25). Because estrogen deficiency may worsen the vaginal dryness in postmenopausal women, local or systemic estrogen replacement may also be helpful (29). [Author: No reference 29 included]

Surgery might be considered when joints are immobile. This removes the mechanical interference with sexual performance. The indication for total hip replacement has broadened and some orthopedic surgeons consider arthritis in a young married woman a sufficient indication for surgery. However, people with artificial hips should avoid marked abduction of the hips because dislocation of prosthesis can occur. After surgery, the patient must be advised to avoid intercourse for six to eight weeks because it takes approximately that long for the internal capsule to heal. Side-lying positions and posterior approach positions are contraindicated, as are any positions that increase hip flexion. The recommended position is with the patient supine and legs in abduction (16,23,24).

Kegel exercises are recommended. The exercises develop the pelvic musculature. Gentle intromission, perhaps with the aid of a lubricant, followed by simultaneous rhythmic pelvic contractions may be sufficient to produce orgasm.

Counseling should also include information about changes in position that might make sexual activity possible without further therapeutic alterations. Physicians should familiarize themselves with positional variations to counsel more effectively; if neither the patient's nor the physician's reticence can be overcome, reference to manuals can achieve the desired result.

When medication has proved insufficient and surgery is not contemplated, postural alternatives may be satisfactory. Physicians should familiarize themselves with positional variations to counsel more effectively; if neither the patients nor the physician's reticence can be overcome, reference to manuals can achieve the desired result.

Impotence may develop in men with arthritis. Most often this is psychogenic and is related to pain, general symptoms, motion limitation, and patient anxiety related to sexual performance. Abstinence from sexual activity is known to increase the risk of sexual dysfunction. Sildenafil is approved for erectile dysfunction of both organic and psychogenic etiologies and there are no contraindications that would prevent the use of this medication in people with arthritis.

Intensive Therapy

Intensive therapy is the domain of trained sex therapists. A couple's sexual problems might stem much more from marital discord than from any problems created by arthritis. Under these circumstances the clinician will want to refer to other physicians, psychologists, sex therapists, or counselors skilled in marital relationships and sexual disturbances. At the same time, physicians should avoid the reflexive reaction of referring a patient to a sex therapist as soon as a sexual concern is uncovered.

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TABLE 1

Recommendations for Your Patients

GENERAL

- Discuss sexuality openly with the partner
- · Explore different sexual positions
- Explore alternate methods of sexual expression if needed
- Use heat or physical activity before sex for maximal muscle relaxation
- Use physical support to minimize pain and discomfort
- Use pain medication and muscle relaxants just before sex

Specific Symptoms

Vaginal dryness

- · Estrogen replacement therapy
- Estrogen cream
- Vaginal lubricants

Impotence

- Sildenafil
- Sex therapist Immobility of hip joints
- · Change in position
- Alternate methods of sexual expression (masturbatory and orogenital techniques)
 Surgery (total hip replacement)

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Help For Your Patients

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