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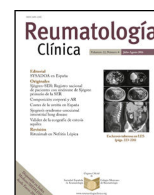

Editorial

Sexuality and rheumatic diseases[☆]

Sexualidad y enfermedades reumáticas

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The World Health Organization defines sexual health as a state of physical, emotional, mental and social well-being. Sexuality is described as an essential part of the individual, and integral part of the human being.[1]

One of the aspects that can influence the quality of life of patients with rheumatic diseases is sexuality. The prevalence of sexual problems in rheumatic diseases can range between 36% and 70%, and increases with the duration of the disease.[2–5] There are a number of causes. Physical or emotional problems, hormonal changes, certain treatments and difficulties in the relationships of the patients with their partners, can contribute to a less active and often less satisfactory sex life.[6] In phases of high activity, there can be a decrease in sexual desire because of chronic pain, fatigue and stiffness. On the other hand, changes in body image due to deformities can lead to a loss of self-esteem and a decline in sexual satisfaction. Pain during sexual relations, erectile dysfunction and difficulty in adopting certain positions are physical questions also related to sexuality that may lead to a loss of interest and in a decrease in the frequency of sexual relations.[5,7]

Specific sexual problems have been reported in different rheumatic diseases, such as rheumatoid arthritis (RA),[2,7] Sjögren's syndrome,[8–10] systemic lupus erythematosus,[11,12] scleroderma,[13,14] ankylosing spondylitis,[2,15,16] psoriatic arthropathy[17] and osteoarthritis of the hip,[18,19] among others.

Sexual problems in RA patients have been related to disease duration, loss of mobility and joint pain.[7] Erectile dysfunction in men is correlated with the activity or severity of the disease, pain and fatigue. In woman, we can add depression, which affects sexual desire, arousal, orgasm and sexual satisfaction.[3,4] In patients with juvenile idiopathic arthritis, sexual dysfunction has been related to changes in body image.[20] In women with Sjögren's syndrome, vaginal dryness and vaginitis can produce dyspareunia in 40–50% of the patients.[21,22] Dyspareunia can also develop in scleroderma, in RA and in systemic lupus erythematosus. In scleroderma, Raynaud's phenomenon can affect the tongue and nipples; sclerosis of the fingers and digital ulcers can interfere both in the sense of touch and in sexual stimulation. In men with systemic sclerosis, erectile dysfunction is produced by a reduced blood pressure in the penis due to the involvement of small vessels.[23] Cases of been reported of decreased libido, erectile dysfunction, premature ejaculation and difficulty in achieving orgasm in men with systemic lupus erythematosus.[24] In woman, sexual dysfunction has been associated with depression and a poorer body image.[12] In psoriatic arthropathy, functional deterioration, decreased self-esteem, anxiety disorders, lesions in genital regions and certain treatments can affect sexuality.[17] A number of authors have indicated that high levels of proinflammatory cytokines, such as tumor necrosis factor alpha and interleukin 1, which participate in the pathogenesis of psoriasis, are related to the depression that affects patients with psoriatic arthropathy. In men with erectile dysfunction, this condition has been related to arteriosclerosis.[25] The sexual relationships of patients with ankylosing spondylitis are affected by different causes. Substantial impact is associated with physical function, pain, high disease activity, anxiety and depression, and unemployment.[16] There are cases in which cauda equina syndrome has been linked to impotence.[26]

Limitations to sexual activity are common in patients with osteoarthritis of the hip. In a study carried out in 121 patients, 67% of those who completed a questionnaire reported experiencing sexual problems. It was more frequent among women and was related to pain and stiffness.[18] Another of the aspects recorded was the lack of communication between physicians and patients. In a more recent retrospective study, 89% of the patients who had undergone hip arthroplasty mentioned that arthritis of the hip joint had limited their sex life before surgery.[19] According to the data of a systematic review, quality of life related to sexuality after total hip replacement improved, but the magnitude of the effect varies greatly (0–77%).[27]

The lack of communication and comprehension of the disease on the part of patients' partners or, on occasion, too much attention on the part of the latter for fear of causing physical harm, can be another aspect that complicates sexual relationships.[23,28]

In the care of rheumatic patients, there is a lack of communication with respect to sexuality. There are barriers on the part of patients, either due to insecurity about mentioning the problem, because of the consideration that sexuality is not a disease, due to fear of a possible negative attitude on the part of the physician, or because of a belief that nothing can be done about sexual problems.[29]

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The subject of sexuality is not usually taken up between physicians and patients[30] and reference to it does not appear in questionnaires utilized to assess health-related quality of life.[31,32]

The evaluation of sexual problems requires valid and reliable tools, that must be easy to put into practice.[33] In this respect, a group of French rheumatologists drew up a questionnaire with 10 simple items on sexual health in RA patients, which was validated in a population in France.[34]

There is very little information in our field about the prevalence of sexual dysfunctions in rheumatic diseases. The identification of the causes that can provoke them is a challenge, given the large number of factors that can be involved. A first step would be the utilization of self-administered, reliable and validated questionnaires to detect these problems. Thus, in the Research Unit of the Spanish Society of Rheumatology (SER), we have proposed a project to adapt and validate the "Qualisex" questionnaire developed in France for use in Spanish patients with RA. This questionnaire will provide us with a tool that will enable us to assess this important aspect of the quality of life of our patients both in clinical practice and in research. We will be able to utilize it in observational studies and in clinical trials to evaluate the efficacy of certain interventions or even new treatments. It could also be of interest to employ it in other rheumatic diseases.

Rheumatic diseases should not be an impediment to maintaining satisfactory sexual relationships. Sexual activity should be planned ahead in accordance with desire and physical condition. Communication with the one's partner concerning feelings, desires, games and sexual needs is essential. It is necessary to recognize the importance of acts of affection, of caresses and of any physical contact.

In terms of practical advice, it is best to avoid cold temperatures while taking a shower or having a warm bath, or the utilization of an electric blanket to maintain a pleasant temperature. It is advisable to be rested and relaxed, to take medication for the pain 30 min before having sexual relations and to employ an intimate lubricating gel to ease discomfort during intercourse. Smoking and alcohol should be avoided. We recommend sexual positions that are more effective for the avoidance of pain[2,35,36] and to remember the importance of confiding in health professionals.

The most attractive part of the body is the mind, and attitude is everything.

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