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Review article

How the rheumatologist can guide the patient with rheumatoid arthritis on sexual function[☆]



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ABSTRACT

Sexuality, an integral part of human life and quality of life, is one of those factors responsible for individual welfare. Sexual dysfunction can be defined as a change in any component of sexual activity, which may cause frustration, pain and decreased sexual intercourse. Although it is known that chronic diseases, such as rheumatoid arthritis (RA), influence the quality of sexual life, sexual dysfunction is still underdiagnosed, due to two reasons: (i) patients fail to report the complaint because of shame or frustration and (ii) this subject is rarely called into question by doctors. Rheumatologists are increasingly willing to discuss areas which are not directly related to drug treatment of joint diseases, such as quality of life, fatigue, and education of patients; however, sexuality is rarely addressed. The aim of this review is to present some useful concepts to Rheumatologists for orientation of their patients with RA with respect to sexual function/dysfunction, some considerations concerning the role of these professionals in order to instruct the patient, general notions about sexual function, including practical concepts about the more appropriate sexual positions for patients with RA, and a multidisciplinary approach to sexual dysfunction.

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Como o reumatologista pode orientar o paciente com artrite reumatoide sobre função sexual

RESUMO

A sexualidade, parte integrante da vida humana e da qualidade de vida, é uma das responsáveis pelo bem-estar individual. A disfunção sexual pode ser definida como alteração em algum componente da atividade sexual e pode acarretar frustração, dor e diminuição dos intercursos sexuais. Embora se saiba que doenças crônicas, como a artrite reumatoide (AR),

Palavras-chave:

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influenciam a qualidade da vida sexual, a disfunção sexual ainda é pouco diagnosticada, o que se deve a dois motivos: tanto os pacientes deixam de relatar a queixa por vergonha ou frustração quanto os médicos pouco questionam seus pacientes a esse respeito. Os reumatologistas estão cada vez mais dispostos a discutir domínios que não estão diretamente relacionados com o tratamento medicamentoso das doenças articulares, como qualidade de vida, fadiga e educação dos pacientes. A sexualidade, no entanto, é muito pouco abordada. O objetivo desta revisão é apresentar alguns conceitos úteis ao reumatologista para orientação do paciente com AR quanto à função/disfunção sexual, considerações relativas ao papel desse profissional no sentido de instruir o paciente, noções gerais sobre função sexual, incluindo conceitos práticos sobre posições sexuais mais adequadas para portadores de AR, e abordagem multidisciplinar da disfunção sexual.

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Introduction

Sexuality, an integral part of human life and quality of life, is one of those factors responsible for individual welfare. Sexuality not only refers to the sexual act itself, but to the entire spectrum ranging from self-image and the valorization of self, to the relationship with the partner.¹

Sexual dysfunction can cause frustration, pain and decreased sexual intercourse.² Although it is known that chronic diseases can influence the quality of sexual life, sexual dysfunction is still underdiagnosed, due to two reasons: (i) patients fail to report the complaint because of shame or frustration and (ii) this subject is rarely called into question by doctors.^{3,4}

Our group has studied the prevalence of sexual dysfunction in women with diagnoses of various rheumatic diseases, including systemic lupus erythematosus (SLE), rheumatoid arthritis (RA), systemic sclerosis (SSc), antiphospholipid syndrome (APS), fibromyalgia, psoriasis and psoriatic arthritis.^{5,6}

We have observed that one of the components that may hinder an approach of the subject with the patient and consequently a suitable treatment is the lack of guidance on sexual function by the physician. Sexual function is a neglected area of quality of life in patients with rheumatic diseases.¹

The apparent lack of interest of the doctor in relation to sexual function of his/her patients could be explained by factors such as constraints in consultation time, uneasiness when discussing sexuality (both by the physician and the patient), uncertainties about physician role and relative competence on issues of sexuality of his/her patients.^{1,4,7,8}

The sexual response cycle consists of the following phases: (1) Desire: characterized by fantasies about sexual activity and desire for sexual activity. (2) Excitation: subjective feeling of sexual pleasure and accompanying physiological changes; in man, characterized by penile tumescence and erection, while in the woman pelvic vascular congestion, lubrication, vaginal expansion, and swelling of the external genitalia are observed. (3) Orgasm: climax of sexual pleasure, with release of sexual tension and rhythmic contraction of perineal muscles and reproductive organs. In man, it is characterized by the sensation of ejaculatory inevitability, followed by ejaculation, while in the woman contractions of the lower third of vaginal wall occur. (4) Resolution: feeling of relaxation and general well-being.^{9–11}

Sexual dysfunction is directly linked to the improper functioning of one of the phases that compose the sexual cycle. According to the diagnostic criteria of DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, fourth edition), sexual dysfunctions are characterized by disturbances in sexual desire and by psychophysiological changes that characterize the sexual response cycle, causing marked distress and interpersonal difficulties.¹²

RA can influence sexual function in several aspects.¹³ The reasons for disturbances in sexual functioning are multifactorial and include aspects related to the disease itself and also to the treatment.

In a study conducted by our group (unpublished data), in which 68 women diagnosed with early RA (less than a year of symptoms at diagnosis time) were evaluated, we found a high frequency of sexual dysfunction (79.6% of patients with active sexual life), a figure higher than in most previous studies of patients with established RA.^{1,4,13–15}

In a second study⁵ evaluating 163 patients with diagnoses of various rheumatic diseases, including 24 patients with established RA, we found sexual dysfunction in 18.4% of all evaluated patients and in 8.3% of RA patients. It is important to mention that 24.2% of all patients and 17% of RA patients had no sexual activity during the study period.

Abdel-Nasser et al. showed in their study that over 60% of female patients with RA had difficulty in sexual performance (i.e., sexual disability) and a decrease in sex drive. This inability was related, among other factors, to disease activity, pain and disability, as assessed by HAQ.⁷

Pain, morning stiffness, joint swelling and fatigue can lead to a decreased sexual interest, as well as hindering the sexual act. In addition, low self-esteem and a negative body image, which commonly affect patients with RA, are relevant psychological factors.^{1,4,7,9}

The perception of a negative body image, decreased joint mobility and muscle strength, morning stiffness and poor performance in daily physical activities also contribute to the deterioration of sexual health in patients with RA. Drugs used in their treatment may also lead to sexual dysfunction.¹⁶ Among synthetic disease-modifying anti-rheumatic drugs (DMARDs), there are reports of sexual dysfunction with the use of methotrexate (MTX). Although this drug is generally well tolerated, there are reports of decreased libido, impotence and development of gynecomastia in men after the start of its

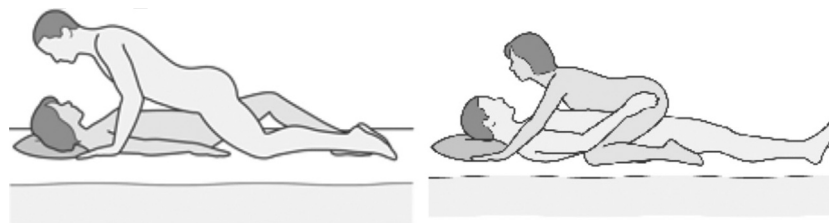


Fig. 1 – On the left, this position prevents the woman performing hip abduction and knee and spine flexion, and allow resting her upper limbs, since the partner performs hip abduction and holds his weight during sexual activity. On the right, a variation of this position, that can be adopted if the man presents RA.

Arthritis Information: Sex and Arthritis; reproduced with permission from Arthritis Research UK.

administration. After a few weeks of discontinuation or of dose reduction of this medication, the patient improves.¹⁷ Impotence has been reported with the use of hydroxychloroquine and sulfasalazine.¹⁶

Corticosteroids can have side effects with great impact on sexual function, with change in body image, as well as leading to depression and psychosis. Medications used to treat comorbid conditions such as fibromyalgia can also influence sexual function in RA patients. Tricyclic antidepressants and serotonin reuptake inhibitors may lead to a decrease of libido and hamper in reaching orgasm.¹⁸

Role of the rheumatologist in the orientation of the patient with rheumatoid arthritis on sexual function

Panush et al. describe a strategy to approach and offer guidance on sexual function, called by these authors as PLIS-SIT (permission, limited information, specific strategies and intensive therapy).¹⁹ Permission consists in questioning the patient about his/her sexual dysfunction, taking the liberty and showing openness to dialogue. The doctor must show the patient that his/her sexual problems can be mitigated. Furthermore, it is essential that the doctor encourages the dialogue with the patient's partner, due to his/her need to be aware of the difficulties of the couple.^{19,20}

The second step is to search and provide information about sexual dysfunction. At this stage, one should establish the cause of the problem – lack of libido, pain, fatigue, vaginal dryness, anxiety, fear of not having a good performance or not satisfying the partner are possible causes.¹⁹

The third phase is to develop specific strategies for each problem. Low sexual desire can be circumvented by replacing medications, psychotherapy and stress reduction. Transdermal testosterone may be used in women with low levels of this hormone or in those undergoing surgical menopause.²¹ As to vaginal dryness, lubricating oils or intravaginal estrogen creams may be used.¹⁹ With regard to pain and fatigue, the practice of different sexual positions, resting before intercourse and the use of muscle relaxants or painkillers are recommended.^{19,20} The use of supports in the joints helps in maintaining the sexual positions; on the other hand, heat in the form of compresses takes effect reducing joint stiffness. It is recommended, though, to take a warm bath before intercourse, to achieve muscular relaxation.

Hip arthroplasty can help in cases of joint immobility. The indications for this surgery are increasing. Lafosse et al. applied a questionnaire to 135 post-hip arthroplasty patients, and the vast majority reported improved sexual life, especially women, because this surgery allowed a greater variety of sexual positions.²²

Men with arthritis may develop impotence, usually of psychogenic origin. In such cases, phosphodiesterase inhibitors may be used, with a level of evidence A in cases of organic, psychogenic and pharmacological erectile dysfunction.¹⁸

As a fourth step, the patient would be referred to the sex therapist, in case of failure of other strategies. In some situations, the couple's sexual dysfunction is not only a function of arthritis.¹⁹

Table 1 summarizes recommendations on sexual dysfunction discussed above.

Guidance as to changes in the positions taken during sexual activity is based on principles of joint protection and energy conservation. The concept involves patient education on proper joint alignment and movement, based on biomechanics principles, besides adopting strategies of division and organization of the daily routine to prevent fatigue, reduce pain and maintain an optimal level of functionality throughout the day.²³

As with most activities of daily living, sexual activities are developed through personal experiences that define and change the way these relations occur between partners.²⁰ Thus, the guidance should be individualized, provided timely and using an appropriate and accessible language, to enable the relationship of the concepts illustrated by the healthcare professional with examples from everyday life of the patient, facilitating the understanding and the incorporation of the guidelines into his/her routine.²⁴

The positions that can be adopted by patients and partners involve reducing hip and knee amplitude of motion, changes in position (decubitus), and use of furniture, pillows and other support in order to minimize the effort required for postural maintenance.²⁵ Changes in the positions already taken by the patient can facilitate the process of adaptation and incorporation of the physician's instructions (Fig. 1).

Among the proposed changes, the combination of changes in position and reduced joint range of motion are alternatives for most patients suffering joint pain in both upper and lower limbs (Fig. 2).

The lateral decubitus position allows the patient to reduce the effort required to support the body during sexual activity.

Table 1 – Recommendations on sexual function/dysfunction to the patient with a diagnosis of rheumatoid arthritis.

General guidelines	Discussion of problems with the partner, explore new sexual positions, use of painkillers and muscle relaxants before intercourse. Use of heat to relieve pain and joint stiffness (compresses, warm bath)
Vaginal dryness	Use of lubricants, vaginal estrogen creams
Erectile dysfunction	Use of sildenafil, sex therapy
Lack of libido	Evaluate possible exchange of medications, techniques for stress reduction, testosterone replacement in specific cases



Fig. 2 – Lateral decubitus position; reduction in hip and knee range of motion, as well as low back spine alignment. Arthritis Information: Sex and Arthritis; reproduced with permission from Arthritis Research UK.



Fig. 3 – The patient has constraints to hip and knee mobility. In addition to the comfort provided by the reduced amplitude of movement, this position allows reducing the effort required for postural maintenance. Arthritis Information: Sex and Arthritis; reproduced with permission from Arthritis Research UK.

In addition, the alignment of the spine, hip and knee joints can be maintained with the aid of pillows and cushions, decreasing the pain.

Although in some cases the patient may need to use his/her upper limbs, some positions (Fig. 3) allow resting these structures, preventing them from being used to support body weight. These positions may be suggested to patients that present constraints and joint deformities in their lower limbs.

In addition to changes in positions, environmental modifications allow carrying out the activity in a more similar way to the usual for the patient, favoring the performance of sexual activity without major changes. The goal of these changes is to promote the transfer of weight bearing for other surfaces; thus, the patient saves energy, enjoying moments of rest during sexual activity with the use of brackets and supports that can be obtained with the furniture itself, and with pillows and cushions. Fig. 4 shows examples of simple changes that can be adopted by patients in various stages of the disease.

It is important that the medical staff also advise the patient about other ways of expressing their sexuality, as touching,

caressing, kissing and with the use of a not penetrative sex, that may also be part of the sexual activity of the patient. Furthermore, interventions that aim to improve these activities contribute to a better relationship between patients and their partners, favoring the empowerment with respect to the disease process and, consequently, quality of life.²⁶

Multidisciplinary approach to sexual dysfunction

Due to the multiplicity and complexity of forms of sexuality expression, the approach of patients with sexual dysfunction involves broad aspects and hard-to-approach themes, whose handling requires the formation of bonds and an environment enabling the understanding of aspects beyond physical complaints, for instance, emotional and social factors.^{2,14,27}



Fig. 4 – In both situations, the patient leans on the bed or furniture, avoiding weight bearing on the upper limbs and the completion of sexual activity with reduced mobility of hip and knees. Arthritis Information: Sex and Arthritis; reproduced with permission from Arthritis Research UK.

Thus, patient care delivered by a multidisciplinary team allows the development of actions at different levels of complexity in health care. These actions should address the different contexts of the activities performed by patients in their daily lives, including the expression of their sexuality.^{25,26,28}

In this perspective, the psychologist acts favoring the management of emotional problems related to the illness process and the implications of these issues on the affective and sexual relationship with the patient.^{27,29} Interventions to control pain and increase mobility and muscle strength, providing improved physical capacity for the patient, are held by the physical therapist,²⁹ and this process is monitored by a physical education professional,³⁰ in order to promote a reduction of objective symptoms related to RA, such as fatigue, pain and joint movement restrictions. Guidelines on the organization of the routine and protection of joints during activities of daily living, as well as the indication of assisted technology to modify objects and environments, are demands met by occupational therapists.^{27,31}

Conclusions

The knowledge of the impact that RA promotes in sexuality by the rheumatologist and other health professionals is of great importance, since it facilitates the physician-patient discussion about the influence of the disease in several domains of patient's quality of life, besides allowing the optimization of the treatment of RA, here encompassing the attention to the patient's sexual difficulties.

Conflict of interest

The authors declare no conflict of interest.

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