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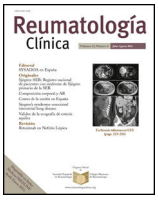

Editorial

# 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.

## References


1. WHO. Sexual health document series. Geneva: World Health Organisation; 2006.
2. Elst P, Sybesma T, van der Stadt RJ, Prins AP, Muller WH, den Butter A. Sexual problems in rheumatoid arthritis and ankylosing spondylitis. Arthritis Rheum. 1984;27:217–20.
3. Abdel-Nasser AM, Ali EI. Determinants of sexual disability and dissatisfaction in female patients with rheumatoid arthritis. Clin Rheumatol. 2006;25:822–30.
4. Josefsson KA, Gard G. Women's experiences of sexual health when living with rheumatoid arthritis – an explorative qualitative study. BMC Musculoskelet Disord. 2010;11:1–8.
5. Helland Y, Kjeken I, Steen E, Kvien TK, Hauge MI, Dagfinrud H. Rheumatic diseases and sexuality: disease impact and self-management strategies. Arthritis Care Res. 2011;63:743–50.
6. Xibillé-Friedmann D, Alvarez-Fuentes M, Flores-Flores G, Gudiño-Quiroz J, Cruz-Valdez A. Percepción de la sexualidad en pacientes con enfermedades reumáticas: estudio piloto de casos y controles. Reumatol Clin. 2005;1:20–4.
7. Van Berlo WTM, van de Wiel HB, Taal E, Rasker JJ, Weijmar Schultz WC, van Rijswijk MH. Sexual functioning of people with rheumatoid arthritis: a multicenter study. Clin Rheumatol. 2007;26:30–8.
8. Isik H, Isik M, Aynioglu O, Karcaaltincaba D, Sahbaz A, Beyazcicek T, et al. Are the women with Sjögren's Syndrome satisfied with their sexual activity? Rev Bras Reumatol. 2017;57:210–6.
9. Maddali Bongi S, del Rosso A, Orlandi M, Matucci-Cerinic M. Gynaecological symptoms and sexual disability in women with primary Sjögren and sicca syndrome. Clin Exp Rheumatol. 2013;31:683–90.
10. Priori R, Minniti A, Derme M, Antonazzo B, Brancatisano F, Ghirini S, et al. Quality of sexual life in women with primary Sjögren syndrome. J Rheumatol. 2015;42:1427–31.
11. García Morales M, Callejas Rubio JL, Peralta-Ramirez MI, Henares Romero LJ, Ríos Fernández R, Camps García MT, et al. Impaired sexual function in women with systemic lupus erythematosus: a cross-sectional study. Lupus. 2013;22:987–95.
12. Yin R, Xu B, Li L, Fu T, Zhang L, Zhang Q, et al. The impact of systemic lupus erythematosus on women's sexual functioning. A systematic review and meta-analysis. Medicine (Baltimore). 2017;96:1–4.
13. Levis B, Burri A, Hudson M, Baron M, Thombs BD, Canadian Scleroderma Research Group (CSRG). Sexual activity and impairment in women with systemic sclerosis compared to women from a general population sample. PLoS ONE. 2012;7:1–8, e52129.
14. Levis B, Hudson M, Knafo R, Baron M, Nielson WR, Hill M, et al. Rates and correlates of sexual activity and impairment among women with systemic sclerosis. Arthritis Care Res (Hoboken). 2012;64:340–50.
15. Pirilidar T, Müezzinoglu T, Pirildar S. Sexual function in ankylosing spondylitis a study of 65 men. J Urol. 2004;171:1598–600.
16. Healey EL, Haywood KI, Jordan KP, Garratt AM, Ryan S, Packham JC. Ankylosing spondylitis and its impact on sexual relationships. Rheumatology. 2009;48:1378–81.
17. Kurizky PS, Henrique da Mota LM. Sexual dysfunction in patients with psoriasis and psoriatic arthritis – a systematic review. Rev Bras Reumatol. 2012;52:938–48.
18. Currey HLF. Osteoarthrosis of the hip joint and sexual activity. Ann Rheum Dis. 1970;29:488–93.
19. Lavernia CJ, Villa JM. High rates of interest in sex in patients with hip arthritis. Clin Orthop Relat Res. 2016;474:293–9.
20. Packham JC, Hall MA. Long-term follow-up of 246 adults with juvenile idiopathic arthritis: education and employment. Rheumatology (Oxf). 2002;41:1440–3.
21. Skopouli FN, Papanikolaou S, Malamou-Mitsi V, Papanikolaou N, Moutsopoulos HM. Obstetric and gynaecological profile in patients with primary Sjögren syndrome. Ann Rheum Dis. 1994;53:569–73.
22. Van Nimwegen JF, Arends S, van Zuiden GS, Vissink A, Frans GM, Kroese FGM, et al. The impact of primary Sjögren's syndrome on female sexual function. Rheumatology. 2015;54:1286–93.
23. Ostensen M. New insights into sexual functioning and fertility in rheumatic diseases. Best Pract Res Clin Rheumatol. 2004;18:219–32.
24. Ostensen M. Sexual and reproductive health in rheumatic disease. Nat Rev Rheumatol. 2017;13:485–93.
25. Cabete J, Torres T, Vilarinho T, Ferrreira A, Selores M. Erectile dysfunction in psoriasis patients. Eur J Dermatol. 2014;24:482–6.
26. Liu CC, Lin YC, Lo CP, Chang TP. Cauda equina syndrome and dural ectasia: rare manifestations in chronic ankylosing spondylitis. Br J Radiol. 2011;84:e123–5.
27. Harmsen RT, Haanstra TM, Sierevelt IN, Jansma EP, Nolte PA, Nicolai MP, et al. Does total hip replacement affect sexual quality of life? BMC Musculoskelet Disord. 2016;17:198.
28. Hill J, Bird H, Thorpe R. Effects of rheumatoid arthritis on sexual activity and relationships. Rheumatology. 2003;42:280–6.
29. Helland Y, Dagfinrud H, Haugen MI, Kjeken I, Zangi H. Patients perspectives on information and communication about sexual and relational issues in rheumatology health care. Musculoskelet Care. 2017;15:131–9.
30. Helland Y, Garratt A, Kjeken I, Kvien TK, Dagfinrud H. Current practice and barriers to the management of sexual issues in rheumatology: results of a survey of health professionals. Scand J Rheumatol. 2013;42:20–6.
31. Gossec L, Paternotte S, Aanerud GJ, Balanescu A, Boumpas DT, Carmona L, et al. Finalization and validation of the rheumatoid arthritis impact of disease score, a patient-derived composite measure of impact of rheumatoid arthritis: a EULAR initiative. Ann Rheum Dis. 2011;70:935–42.
32. Esteve-Vives J, Batlle-Gualda E, Reig A. Spanish version of the Health Assessment Questionnaire (HAQ): reliability, validity and transcultural equivalency Grupo para la Adaptación del HAQ a la Población Española. J Rheumatol. 1993;20:2116–22.
33. Sierra JC, Vallejo-Medina P, Santos-Iglesias P, Lameiras M. Validación del Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ) en población española. Aten Primaria. 2012;44:516–26.
34. Gossec L, Solano C, Paternotte S, Beauvais C, Guadin P, von Krause G, et al. Elaboration and validation of a questionnaire (Qualisex) to assess the impact of rheumatoid arthritis on sexuality with patient involvement. Clin Exp Rheumatol. 2012;30:505–13.
35. Charbonnier C, Chagué S, Ponzoni M, Bernardoni M, Hoffmeyer P, Christofilopoulos P. Sexual activity after total hip arthroplasty: a motion capture study. J Arthroplasty. 2014;29:640–7.
36. Almeida PH, Castro Ferreira Cd, Kurizky PS, Muniz LF, Mota LM. How the rheumatologist can guide the patient with rheumatoid arthritis on sexual function. Rev Bras Reumatol. 2015;55:458–63.