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Review article

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

Pedro Henrique Tavares Queiroz de Almeida[a,b], *Clarissa de Castro Ferreira*[c,*], *Patricia Shu Kurizky*[b], *Luciana Feitosa Muniz*[d], *Licia Maria Henrique da Mota*[b]

[a] *Universidade Federal de São Carlos, São Carlos, SP, Brazil*
[b] *Universidade de Brasília, Brasília, DF, Brazil*
[c] *Hospital Regional de Ceilândia, Ceilândia, DF, Brazil*
[d] *Hospital Universitário de Brasília, Universidade de Brasília, Brasília, DF, Brazil*

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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.

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

Palavras-chave:
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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),

☆ Work idealized and developed in the Rheumatology Service, Hospital Universitário de Brasília, Brasília, DF, Brazil.

* *Corresponding author.*
E-mail: ferreira.clarissa@gmail.com (C.d.C. Ferreira).

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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.

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 study[5] 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