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Sexual disorders in men with multiple sclerosis: Evaluation and management

Troubles sexuels chez des hommes atteints de sclérose en plaques : évaluation et traitement

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Abstract

Sexual dysfunction (SD) is a common feature of men with multiple sclerosis. SD is often unrecognized as patients and physicians are reluctant to discuss these problems. Rates of symptoms range from 50% to 90% and include erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction and reduced libido. SD can arise at any stage of the disease, even without severe disability. While erectile dysfunction is thought to be related to impairment of the pathways in the spinal cord, fatigue, spasticity, bladder and bowel dysfunction, and pain, contribute to SD. Psychosocial and cultural issues also need evaluating, and include depression, performance anxiety, lowered self-esteem. A comprehensive assessment of all these aspects must be taken into account. Erectile dysfunction can be treated with phosphodiesterase inhibitors and intracavernous injections, with good efficacy. Ejaculatory dysfunction is managed through penile vibratory stimulation and midodrine. Concerning fertility issues, the effects of immunomodulating drugs on semen quality are largely unknown, whereas many immunosuppressive therapies have a negative effect on semen quality that may be definitive. Advanced methods of assisted reproduction may sometimes be the only option for conception. Physicians' awareness of this problem may help to bring about appropriate treatments, and improve the quality of life for these patients.

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Keywords: Multiple sclerosis; Erectile dysfunction; Ejaculation dysfunction; Phosphodiesterase inhibitors; Intracavernous injections; Penile vibratory stimulation; Midodrine

Résumé

La dysfonction sexuelle (DS) est fréquente chez les hommes atteints de sclérose en plaques (SEP). La DS est souvent méconnue parce tant les patients que les médecins hésitent à aborder ces types de problèmes. Des symptômes surviennent dans 50 à 90 % des cas ; parmi eux figurent la dysfonction érectile, la dysfonction éjaculatoire ; la dysfonction orgasmique et une baisse de la libido. La DS peut se manifester à n'importe quel stade de la maladie, sans nécessairement être accompagnée d'infirmités sévères. Alors que la dysfonction érectile (DE) est censée être liée à une lésion spianle, la fatigue, la spasticité et des troubles vésico-sphinctériens sont également en cause dans la DS. En outre, des questions psychosociales et culturelles, dont la dépression, l'anxiété de la performance, et une baisse de l'estime de soi sont à prendre en considération. Une évaluation complète de tous ces aspects est nécessaire. La dysfonction érectile peut être traitée efficacement avec des inhibiteurs de la phosphodiesterase ou des injections intracaverneuses. Le traitement de la dysfonction éjaculatoire comporte la stimulation vibratoire pénienne et la midodrine. En ce qui concerne les questions de fertilité, les effets des immunomodulateurs sur la qualité du sperme sont en majeure partie inconnus, alors que de nombreux traitements avec immunosuppresseurs ont un effet peut-être définitivement négatif sur la qualité du sperme. Des méthodes de procréation assistée représentent parfois la seule option conduisant à la conception. La conscience qu'ont les médecins de ce problème peut contribuer à l'arrivée de traitements appropriés et améliorer la qualité de vie de cette population.

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Mots clés : Sclérose en plaques ; Dysfonction érectile ; Dysfonction éjaculatoire ; Inhibiteurs de la phosphodiéstrase ; Injections intracaverneuses ; Stimulation vibratoire pénienne ; Midodrine

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1. English version

1.1. Introduction

Sexual dysfunction (SD) is a common but often underestimated feature of multiple sclerosis (MS) [1,2]. In men, the reported rates of symptoms range from 50% to 90%, depending on the clinical characteristics of the studied population and on the duration of follow-up [3–5]. In a recent study, up to 86% of men felt that MS had affected their sexual life [6]. SD can arise at any stage of the disease: SD has been reported at an early disease stage, with minimally affected patients [3,7–9]; between 2 to 5 years after diagnosis, 50% of the men report dissatisfaction with their sexual functioning [10].

SD occur significantly more frequently in MS patients than in patients with other chronic diseases or healthy subjects [11]. SD in MS is associated with a marked reduction in the quality of life, and it may compromise fertility [1,4,12]. The nature of SD in MS patients is complex and multifactorial, and a multidisciplinary approach to diagnosis is required [13].

Sexual problems in MS can stem from primary, secondary, or tertiary sources. Primary SD stems from physiologic impairments directly due to demyelinating lesions in the spinal cord and/or brain. Symptoms may include numbness or sensory paresthesias in the genitals, and erectile and ejaculatory dysfunctions. Secondary SD refers to non-sexual physical changes, which nevertheless affect the sexual response, such as fatigue, spasticity, bladder and bowel dysfunction, and pain. Tertiary SD refers to psychosocial and cultural issues that interfere with sexual satisfaction or performance, such as role changes that stem from MS, low self-esteem and demoralization, and interpersonal or communication difficulties [14]. Organic and nonorganic factors may coexist so that a detailed evaluation is often required to uncover all the causes for SD [2].

1.2. Symptoms

1.2.1. Primary SD

Erectile dysfunction (ED, 50%–85%), ejaculatory dysfunction (50%), orgasmic dysfunction (50%) and reduced libido (39%) are reported in most studies [5,11,14–20]. More specific information can be found in the study by Redelman in 2009, using questionnaire in 68 men, where at least 50% of respondents had difficulties with (in decreasing frequency) frequency of intercourse, sexual performance, masturbation erections and orgasms, intercourse erections and orgasms and retarded ejaculation. Around 70% had difficulties with masturbatory erections and orgasms and around 20% always had the difficulty [6].

ED is the most commonly reported sexual problem. ED is thought to be related to impairment of the pathways in the spinal cord with involvement of the somatic sacral spinal segments (reflexogenic erection) [2,15,21], though the pons might be involved as well [20]. Markedly reduced serum testosterone levels and impaired hypothalamic–pituitary–thyroid axis function have been found in MS men, which may play a significant role in the high frequency of ED that

occurs in MS [22]. However, men with ED may still experience nocturnal penile tumescence and erections on morning waking, but this does not indicate that their problem is psychiatric, as was perhaps formerly thought [17,18,23,24].

Ejaculatory dysfunction may take different forms, including premature ejaculation (up to 60%), retrograde ejaculation, anejaculation (up to 33%) and delayed ejaculation (up to 50%) [4,6,11,15,24–26]. ED and ejaculatory dysfunctions are often related to one another, as ejaculation was lost in all impotent men and in one-third of those with ED [26]. As the sympathetic centre for ejaculation is located at thoracolumbar spinal segments, a spinal cord involvement is also possible [21].

1.2.2. Secondary and tertiary SD

The prevalence of secondary and tertiary SD is harder to estimate [27]. Neurogenic bladder symptoms [15,28], pyramidal signs in the lower limbs [15], age at onset of symptoms [21] are frequently associated with SD, with fatigue being probably the most inconvenient condition [11,24,29]. The correlation between disability and SD is still controversial: while several studies found a significant relation between MS-induced levels of disability and SD [3,12], others did not [30]. However, the risk of developing SD and the extent or number of SD-associated symptoms increase significantly as a function of time [5]. Significant associations were also observed between SD and depression or anxiety [3,21], low educational level, physical disorders and cognitive symptoms [21]. (For a complete review on these associations, please see the following recent papers [2,8,13,27,31,32]).

In addition to MS-related symptoms, many symptomatic treatments currently used in the clinical practice — antispastics, anticonvulsivants, antidepressants — may have the potential to cause ED and ejaculatory dysfunction, or decreased libido [27,31]. In particular, delayed ejaculation and absent or delayed orgasm are common side effects of selective serotonin reuptake inhibitors, while sexual desire (libido) and arousal difficulties are also frequently reported [33]. Intrathecal baclofen also compromises erection and ejaculation, with a dose-dependent effect [34].

1.3. Assessment of SD in MS

While SD represents some of the most distressing features of MS, they are often unrecognized, as patients and physicians are reluctant to discuss these problems [11,35,36]. However, the emergence of effective treatment strategies for SD provides compelling justification to overcome this reluctance. It is noteworthy to stress that patients appreciate the discussion of their sexual problems. They indicate that they are helped by receiving information on possible alterations in their sexual function and on the different treatment options available for their sexual problems [19]. Hence, it is extremely important that neurologists and specialists in physical medicine and rehabilitation be fully aware of the entity and the complexity of SD. Their team, including nurses and health care providers, should be sufficiently trained to discuss, evaluate and manage those problems [13].

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