SEXUAL MEDICINE REVIEWS REVIEW

Sexual Activity Recommendations in High-Risk Pregnancies: What is the Evidence?

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ABSTRACT

Background: While sexual activity in normal, healthy pregnant women is safe, concern regarding elements of the sexual act have led to restrictions in pregnancies experiencing complications that are frequently insufficiently addressed in clinical practice.

Aim: To comprehensively review the literature for evidence that supports or refutes specific sexual activity restrictions in high-risk pregnancy conditions.

Methods: A search of PubMed, MEDLINE, Ovid, UpToDate, Google Scholar, and Google for relevant publications related to any aspect of sexual activity affecting high-risk pregnancies complicated by history of preterm delivery, shortened cervix, presence of cerclage, pre-mature rupture of membranes, placenta abruption, placenta previa, multiple gestation, or history of classical cesarean section was performed.

Outcomes: The scientific evidence on the pathophysiology of sexual activity and specific high-risk pregnancies, and their interaction.

Results: Despite expert opinion restricting sexual acts or intercourse, there are minimal published data that specifically address sexual activity in high-risk pregnancies.

Conclusions: Clinicians need to engage in conversations regarding specific sexual activity for patients experiencing complications in pregnancy. Recommendations for or against restricting sexual activity should be based on evidence-based guidelines. Significant advances in this area of obstetrics are necessary to make validated recommendations. **MacPhedran S. Sexual Activity Recommendations in High-Risk Pregnancies: What is the Evidence? Sex Med Rev 2018;XX:XXX-XXX.**

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Key Words: Sexual Activity; Coitus; Prostaglandins; Orgasm; Preterm Birth; High Risk; Pregnancy

INTRODUCTION

The majority of patients desire information from their clinician regarding the safety of sexual activity during pregnancy but fail to receive adequate counseling. Depending on the study, anywhere from 15−30% of patients may receive limited counseling regarding sexual activity during the antepartum period.[1,2] Most of the information women obtain is therefore through friends, family, or the Internet.[1−4] If women do receive information from their obstetric provider, most feel the advice is insufficient. There are many reasons why this is the case including lack of provider knowledge, lack of data, and lack of comfort in discussing. Providers are not given much guidance as the expert opinions of those writing obstetric textbooks, clinical management guidelines, and other common resources have minimal specific recommendations or do not comment on sexual activity.[5−7]

When the clinician initiates sexual activity recommendations during pregnancy, it is almost always regarding pregnancies experiencing complications.[2] Pregnancies complicated by a high-risk diagnosis are almost exclusively counseled to restrict sexual activity or abstain completely. However, the restriction is most commonly "pelvic rest," which is not defined in terms of what specific sexual acts are to be avoided or are permissible. In particular, pelvic rest does not address whether orgasm needs to be limited in pregnancy. This vague restriction on all sexual activity leaves patients confused and disappointed.

Expectant couples seek intimacy but concerns of harming the pregnancy can affect the sexual and physical well-being of the relationship. There is a gradual decline in intercourse and other sexual habits as gestation progresses. While patient and partner

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fear and patient physical discomfort are major reasons for the decrease, approximately 50−75% of couples are still having intercourse in the last trimester of pregnancy and 30% in the last month.[1,8−10] Whether the couple or the provider place restrictions on sexual activity, patients are still engaging in or want to engage in sexual activities with their partners or alone. Even if couples abstain from coitus, patients participate in oral sex (30%), manual stimulation (20−40%), and other stimulation (30% of the time) in the last 2 months of pregnancy.[1,9]

Sexual activity in pregnancy is a topic insufficiently addressed in clinical practice and in the literature. Many studies evaluating sexual activity during pregnancy were performed decades ago. Further, many of these studies have limitations and study design shortcomings such as small sample size, retrospective data, incomplete sexual histories, and recall bias and typically only included healthy, uncomplicated pregnancies. In addition, the results are inconsistent among the published research. There is even less scientific evidence to provide substantiated recommendations in high-risk pregnancies. Many of the restrictive recommendations that obstetricians provide are based on conjecture of hypothetical pathophysiologic processes or perpetuation of previous mentor's comments and are not based on clinical guidelines or data. Further, as less than 15−30% of providers inquire about sexuality in pregnancy, it is unlikely that the expert opinion cited in the literature is based on significant patient data.[1,2]

There are many reasons a pregnancy may be considered high-risk but not all high-risk pregnancy diagnoses carry the same concerns with sexual activity. The sexual activity restrictions most providers would give for a pregnancy complicated by the presence of a placenta previa would likely differ from the restrictions for a pregnancy complicated by twin gestation.[6,11,12] The unfortunate truth is that the data are limited in both of these diagnoses and most other high-risk conditions.

In addition to the paucity of data surrounding sexual activity in high-risk pregnancies, there is even less information regarding safety of specific sexual acts in complicated pregnancies. The implications that a specific aspect of sexual activity leads to complications in pregnancy are based on pathophysiologic theory or extrapolated from non-sexual acts. Intercourse with or without orgasm compared to non-penetrative activities with or without orgasm may have different effects during pregnancy. The degree of uterine contractions from endogenous oxytocin release, exogenous or endogenous prostaglandin (PG) effects, or direct trauma by these processes can vary between different sexual acts and from woman to woman.[13−19] Additionally, in many instances more than 1 of these processes occurs with the specific sexual activity, making it difficult to ascertain which process would be the main detrimental culprit (Figure 1).

In this article, a comprehensive review of the literature and summary of the available data regarding recommendations for "sex, coitus, intercourse" or specific sexual acts in various obstetric complications was performed. The high-risk pregnancy diagnoses reviewed here are not exhaustive but are focused on common conditions in which a clinician may be concerned that continued sexual activity is unsafe for the pregnancy and may cause undue risk including: history of pre-term birth (PTB), shortened cervix, presence of cerclage, pre-mature rupture of membranes, placenta abruption, placenta previa, multiple gestation, and history of classical cesarean section. For high-risk pregnancy diagnoses for which no evidence is available to support a recommendation, a discussion is provided of the scientific evidence that may support the recommendation for or against sexual activity in general or specific sexual acts. Finally, specific recommendations are provided in each category of high-risk diagnosis and the level of evidence to support the recommendation.

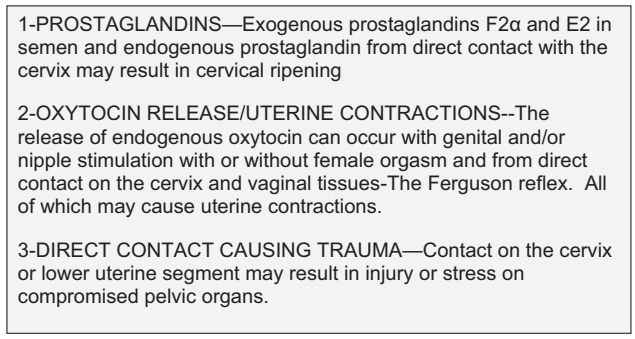

Figure 1. Proposed pathophysiologic mechanisms.

METHODS

Search Strategy

A literature search of PubMed, MEDLINE, Ovid, UpToDate, Cochrane Library, Google Scholar, and Google was performed with no restrictions on publication date. Any publication related to the high-risk pregnancy categories and sexual activity, coitus, orgasm, intercourse, semen, or pelvic rest was included. The specific high-risk pregnancy diagnoses included in the review were the result of a consensus among the maternal-fetal medicine faculty at the institution. The search was limited to those publications in the English language. Additional articles were identified from the relevant references obtained in the literature search. Duplicate articles were removed. The abstracts and full texts were then reviewed. For topics that no articles could be found, searches were performed on hypothetical mechanisms of action using any related terminology.

Study Selection

Any articles that addressed sexual activity regarding pregnancy complications were included. The studies included were observational studies, cohort studies, randomized controlled trials, meta-analysis, reviews, and case reports. Also included were studies in which sexual activity and the association with pregnancy complications was the primary, secondary, or tertiary analytic outcome.

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