

Sexual functioning is impaired in patients with rheumatic disease independent of disease activity, therapy or gonadal function

Rheumatic diseases touch all aspects of life and this includes sexuality and reproduction. The reasons for disturbances of sexual function and reproduction are multifactorial and comprise disease related factors as well as therapy. Physical problems, emotional problems and difficulties of partnership arising from disease related stress contribute to a less active and often less enjoyable sex life.¹ Chronic pain, fatigue and the psychological response to chronic disease like depression and low self esteem can reduce sexual interest in patients and thereby reduce the frequency as well as the pleasure of intercourse.

Several studies have addressed sexual functioning in patients with rheumatic diseases compared to healthy controls. One study investigated the influence of arthritis upon sexual satisfaction and activity by interviewing 169 patients with arthritis and 130 controls. Patients differed from controls in their greater loss of sexual satisfaction over time.² In another study, half of the patients with rheumatoid arthritis (RA) lost sexual interest during the course of their disease and 60% were unsatisfied with their sexual quality of life.³ Sexual dysfunctioning is equally experienced by male and female patients. Physical disability, pain, and depression were found related to an impaired sex life in 102 male and 118 female RA patients who were living with a spouse.⁴ By contrast, in the younger age group and in patients with inactive or less active disease, sexual activity and frequency of intercourse was not different from healthy, age-matched controls as in a study of 126 women and 35 men with a history of juvenile chronic arthritis (JCA).⁵

In this issue of *Brazilian Journal of Rheumatology* two articles have addressed sexual function and reproductive health in patients with rheumatic disease: Sexual function and reproductive health in adolescent females with systemic lupus erythematosus⁶ and Reproductive health aspects in men with idiopathic inflammatory myopathy. A multicenter study.⁷ The first study compared sexual function and reproductive health of 52 female patients with JSLE to 52 healthy age matched controls. Reproductive health was examined in detail including

a gynecologic examination and cervicovaginal cytology. Interestingly patients with JSLE were significantly less sexually active, and most important had a much less enjoyable sex life than their healthy peers. However, the reduction of sexual activity was obviously not related to worse genital health in patients, but associated with suffering from a chronic disease, JSLE. Except for a slightly retarded menarche, increased vaginal candidiasis and reduced vaginal lubrication, women with JSLE were otherwise comparable to healthy adolescents in regard to reproductive health. A comparison between patients who complained of reduced quality of their sex life with patients who did not complain revealed no difference in disease activity, disease severity or treatment. Thus it appears that not disease related factors are of major impact on sexual functioning and satisfaction, but the way in which the patient copes with her disease. Impaired sexual functioning was also found in a study of patients with JCA in which JCA was found detrimental to body image.⁸

The present study also makes another important point: a majority of adolescents is sexually active between the age of 15 and 16 years of age. Health professionals should be aware of this and offer counseling to male and female patients including sexuality, birth control and reproduction.

Rheumatic diseases can impair also male fertility by direct involvement of the gonads, by disturbances of the hypophyseal-gonadal hormonal balance and by autoantibodies to testicular cells. Periods of impotence occur in patients with rheumatic disease. Hypoandrogenicity with low levels of testosterone has been found in men with RA, especially in the presence of high disease activity.⁸ Gonadal and sexual dysfunction has been found at an increased rate in men with SLE.⁹ Decreased libido, erectile dysfunction and failure to ejaculate has been reported in 19-35% of men with SLE.¹⁰ Reproductive health has not been studied in male patients with inflammatory myopathies (IIM). Therefore the study published in this issue of *BJR* is of great importance. It investigated in detail testicular morphology and function as well as sexual function in men

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with IIM.⁷ Comparing reproductive health of 25 men with IIM to 25 healthy men studied by the same methods showed significantly impaired sexual activity and fertility in patients. Of concern was the significant increase of testicular atrophy in men with IIM and of abnormal semen morphology. Damage to gonadal tissue did impair fertility in these patients. Long disease duration and older age was associated with erectile dysfunction in patients with IIM whereas disease activity and treatment or hypogonadism did not influence it. Again, the latter finding points to psychological problems arising during a chronic disease course over years.

CONCLUSION

The impact of rheumatic disease on sexual functioning is not routinely addressed by physicians or health professionals, nor is it part of frequently used questionnaires to assess physical function or quality of life. The neglect of this important area prevents adequate counselling and intervention. Therefore the two studies published in this journal are very important contributions for patients and caregivers alike. They increase the knowledge on reproductive health in rheumatic disease and help to improve counselling. This is particularly important in adolescents where adequate information may prevent sexual dysfunction, urogenital disease and unwanted pregnancy. Both studies made a very interesting finding: contrary to what might be expected does sexual functioning not depend on gonadal function, disease activity or treatment, but obviously on psychological factors that have not been measured in the current studies. Both studies point to psychological problems like failing to cope with chronic disease, resulting in depression and low self esteem as possible underlying causes of reduced sexual functioning. It seems that coping with a chronic disease must be achieved first in order to improve the quality of sexual functioning as well. One first step will be to include inquiry about sexuality into the routine care of the patient. A questionnaire on male sexuality has already been developed by the group publishing the present articles.^{6,7} Additional questionnaires for

assessing coping with disease and presence of low self esteem and depression should also be employed when studying sexual functioning. Clarifying the impact of both physical and mental factors on sexuality will help patients to improve quality of life, even when living with a chronic rheumatic disease.

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