Sexual health in heart failure patients: Break the silence

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Abstract

Background: Patients with HF may report a decrease in sexual performance, a loss of sexual pleasure or satisfaction, a decrease of sexual interest, and a decrease in the frequency of sex.1–4 For a lot of HF patients, sexual health is important, with 52% of the men and 38% of the women with HF reporting that sex was important and sexual health was impacting their quality of life.

Purpose: Discussion, advice and counseling about sexual health and dysfunction are needed to decrease worries of HF patients and partners, avoid skipping medication because of fear for side effects, or prevent inappropriate use of potency enhancing drugs or herbs and improve quality of life.

Conclusions: Sexual counseling is an area of importance for HF patients; therefore, physicians, nurses, and other healthcare professionals must take an active role in providing sexual counseling in practice. Cardiac patients who receive sexual counseling has been shown to improve patient knowledge, better sexual desire and satisfaction, fewer fears about sexual activity, being more likely to engage in sexual activity, and better confidence in the ability to engage in sexual activity.

Clinical implications: Psychological and physiological consequences of heart failure affect sexual health of patients. Sexual health is an important quality-of-life concern for patients and their partners, and healthcare providers help them by sexual counseling of both partners.

Keywords: Heart failure, sexual health, sexual dysfunction, and counseling.

Introduction

Heart Failure (HF) can be defined as an abnormality of the cardiac structure or function, leading to inability of the heart to pump sufficient blood to the requirements of the metabolizing tissues of the body. This failure will lead to retention of sodium and water in order to compensate for this loss, causing symptoms such as breathlessness, orthopnoea, paroxysmal nocturnal dyspnoea, dry hacking cough, reduced exercise tolerance and fatigue [1].

According to the DSM-IV, sexual dysfunction (SD) is characterized by a disturbance in the sexual response cycle or pain related with sexual intercourse. Sexual dysfunction is listed as sexual desire disorder, female sexual arousal dysfunction, male erectile dysfunction (ED), female and male orgasm dysfunction, premature ejaculation and sexual pain (vaginismus and dyspareunia). Sexual disorders are often co morbid, and multiple dysfunctions harm other phases of the sexual cycle [2].

Sexual activity is an important determinant of quality of life (QOL) and sexual problems are common in heart failure patients. Sexual dysfunction can affect QOL in heart failure patients, by decreasing libido, decreasing intercourse and sexual dissatisfaction [3].

A study was conducted on 100 Heart failure patients, 52% of men and 38% of women with heart failure reported that sex was important part of their life and that sexual problems reduced their health related quality of life3, mental health, and relationship satisfaction found in a sample of 100 HF patients, that 75% of men and 60% of women were never asked about sexual health, intimacy or sexual problems by health care providers, indicating that treatment options are rarely discussed or initiated in clinical practice and sexual health is the most untouched phenomena [4].

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A study conducted by among 77 stable ambulatory HF patients showed that more than half of HF patients experienced a marked decrease or total cessation of sexual activity due to their illness and more than one-third perceived a marked decrease or total absence of sexual pleasure, interest, and constant problems or being unable to perform or engage in sexual activity [5]. In addition, 43.1% of patients experienced an important overall need for sexual counseling concerning sexual activity, with information on relationships (69.2%), symptoms (58.5%), and relaxation (49.2%) being the most desired topics during visit [6].

Heart failure patients and their partners have expressed a wish to receive information about resuming sexual activity after a confirmed diagnosis of HF. However, when these topics were addressed, patients experience barriers, such as the perception that individual or health care providers do not appear experienced enough to understand the patient's problems, or because feelings of shyness and embarrassment prevent them from initiating discussions or they might judge them [7].

Heart failure (HF) has an impact on physical function affecting daily life of the patient and his/her partner. Patients with HF may report a decrease in sexual performance, a loss of sexual pleasure or satisfaction, a decrease of sexual interest, and a decrease in the frequency of sex. Sexuality and a satisfying sexually active life is an important component of quality of life [8].

Sexual counseling is important for both heart failure patients and their partners. Psychological concerns are prevalent among HF patients and their partners as well. Resuming sexual activity, about possible dangers and what to do in case symptoms occurs, is a common concern. HF patients frequently request information on how and when to return sexual activity. Partners have considerable concerns, often more so than patients therefore, the inclusion of partners while sexual counseling is crucial [9]. sexual counseling must be an integral part of HF management and treatment.

Prevalence of sexual dysfunction in heart failure patients

Approximately 60% to 87% of patients with advanced HF report sexual problems [10]. These issues embrace a marked decrease in sexual interest and activity, and twenty five percent of patients with HF report that they have totally stopped sexual activity altogether [11]. Sexual problems include absence of interest in or fear for having sex, orgasmic difficulties, or erectile dysfunction (ED) in men.

HF patients reported (75%) considerably more often erectile dysfunction. Erectile dysfunction is the persistent inability to achieve and/or maintain a penile erection sufficient for satisfactory sexual performance. Patients with heart failure may experience ED for reasons similar to the general population, and the etiology may be polyfactoral but there are social, psychological, physiological and drug-related consequences specific to heart failure that may account for the high incidence of ED. A relationship was found between age and erectile severity. Altered penal vasculature, reduced penile circulation, reduced androgen, reduced smooth myocytes, reduced nitric oxide production are involved in severe erectile dysfunction in the elder patients with HF.

Although in most studies more male patients report sexual issues, also women with heart disease are known to have more frequent sexual problems compared with women in the general population [12]. Women may experience other types of sexual dysfunction than men, including decline in sexual interest or need, decline inarousal, orgasmic disorder, or painful intercourse. In a very general population, 27% offemales(age 50–59) reported lack of interest in sexual activity, and 23% of females were not able to have an orgasm [13]. In a HF population, 80% of the female HF patients reported reduced lubrication and 76% reported frequent unsuccessful intercourse.

However, some sexual problems already present prior to the onset of HF, but such issues also can develop during different phases in the HF course. In a previous study, 27% of the patients not having any sexual problems at 1 month after discharge developed sexual problems over time. In 70% of the patients who had difficulties at 1 month after discharge, the sexual problems remained as before. At the same time, 30% of the patients, who reported sexual problems at 1 month after discharge, did not report difficulties in sexual activity at follow-up.

Factors contributing to sexual problems in heart failure patients

Heart disease and its management especially pharmacological, change the way blood circulates throughout the body and may reduce the quantity of blood supplied by the heart to distant areas and tissues of the body, including the reproductive organ. Reduced blood flow can lead to erectile dysfunction in males and sexual arousal difficulties in females. Symptoms of heart disease such as chest pain, shortness of breath, dyspnea and fatigue may additionally interfere with sexual performance and enjoyment of sexual activities in HF patients [14].

The ability of HF patients to engage in sexual activity depends on New York Heart Association (NYHA) functional classification of their affliction, being stabilized, and receiving optimal medical management. Pharmacological management such as Beta Blockers, diuretics, and cardiac glycosides, frequently used in the treatment of HF, are associated with sexual dysfunction, as well as common co morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), hypertension, obesity, and depression play a considerable role in developing sexual problems.

HF specific factors that are related to sexual problems are HF symptoms such as dyspnea; fatigue, cough, and activity

intolerance [15]. In addition to, emotional and psychological concerns in HF patients may result in anxiety and fear regarding sexual activity. When engaging in sexual activity, symptoms including chest pain, palpitations, shortness of breath, and fatigue are frequently reported. This creates a need for patients to receive information, sexual counseling concerning sexual functioning and a safe return to being sexually active.

How to assess sexual concerns/problems

During a general clinic or office visit or rehabilitation an open discussion regarding the patient and partner's sexual concerns can help to determine the direction of treatment and counseling specific to the problem. It is very important to assess the sexual intimacy before beginning sexual counseling. When conducting a sexual assessment, it is essential to consider the needs and concerns of HF patient and their partners. It is particularly important as a dyad. Partners may exhibit higher level of concern than the patient. Moreover, the need for support and information might vary between the patient and partner, perhaps necessitating different approaches to address sexual concerns.

Assessment should be a part of routine practice and it must be provided to all HF patients and their partners, regardless of age (many older adults are sexually active in their 80's, including older women), gender, marital status, or sexual preference (heterosexual or same sex relationship)[16].

Assessment include reviewing existing sexual problems, provide information on concerns, and support safe return to sexual activity after a cardiac event or procedure. It is very important to know the severity of the HF (NYHA Classification) and perceptions (thoughts, beliefs and misconceptions) about the disease of both partners. Describe the heart specific causes and adverse effect of cardio medication and other co morbid illness such as diabetes renal dysfunction, thyroid disease or prostatic disease may contribute to the sexual dysfunction. Patients with more extensive stages of HF, other serious comorbidites or sexual dysfunction related to required medication, sexual activity may not be possible, they require comprehensive assessment and /or referral to specialist such as urologist, psychologist and /or sex therapist.

Patient with compensated HF and fall in to mild or NYHA class I or II,sexual activity is generally reasonable. Patients with advanced HF having NYHA class III or IV it is not advisable to engage in sexual activity, until the condition becomes stabilized or clinically they return to a lower classification (i.e. class I or II) and optimal medical treatment is achieved.

The HF patient ability to achieve three to five metabolic equivalents (METs) during exercise testing without significant symptoms or marked ECG changes and the 6-minute walk test are useful to determine tolerance for exercise and for sexual activity [17].

Thus, it is essential to view the capacity for sexual activity as something that may change over time, depending on the patient's medical condition and psychological state of mind. This is crucial to discuss with patients and partners, to both understand the disease process and in relationship to sexual activity. Further diagnostic evaluation of cardiac function by the cardiologist, advanced practice nurse, or primary care provider may be indicated prior to giving clearance for sexual activity.

Practical approach and specific consideration

A proper attention to environmental considerations by the health provider, such as a quiet setting that allows for privacy and ensuring confidentiality are essential in discussing intimate topics.

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