

ADVANCES IN IBD

Current Developments in the Treatment of Inflammatory Bowel Disease

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Inflammatory Bowel Disease and Sexual Dysfunction



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G&H What challenges do patients with inflammatory bowel disease face regarding sexuality?

BC Inflammatory bowel disease (IBD) is a chronic illness, and sexual dysfunction is a well-recognized complication of chronic illness. In addition, IBD is diagnosed in most patients between the ages of 15 and 40 years, which is a time when body image, formation of intimate relationships, exploration of sexual activity, and emotional security are particularly important, so patients are very vulnerable to the impact of their disease on their sexuality. IBD can result in increased bowel frequency, abdominal pain, incontinence, perianal fistulas, abscesses, or skin tags, which can potentially lead to embarrassment, decreased confidence, and decreased desire. In addition, treatment of the disease with corticosteroids or surgery can result in mood changes, decreased body image, scars, and a possible temporary or permanent stoma. Patients also have systemic symptoms. One in 3 patients experiences chronic pain, and almost half of patients experience persistent fatigue, which can affect sexual drive and performance. In addition, 20% of patients have concomitant arthritis, which can lead to reduced sexual pleasure. Patients are also more prone to depression and anxiety, which can decrease sexual desire. Finally, chronic diseases such as IBD can cause relationship stress, decreased body image, and concerns of incontinence, and fear about communicating about IBD may result in anxiety and delay in establishing relationships with potential sexual partners.

The challenges are physiologic and psychosocial, and there is a lot of overlap. Physiologic factors, such as fatigue, joint pain, abdominal pain, and dyspareunia, are more easily addressed by the gastroenterologist. Female

patients with IBD also are at increased risk for vaginal infections and poor lubrication, which can increase dyspareunia. Erectile dysfunction and decreased sexual function are increased in men with active IBD compared with men who do not have IBD or whose IBD is in remission.

From the psychosocial view, depressed mood and anxiety, common in patients with IBD, impair sexual function, with depression, in particular, being the greatest independent risk factor for sexual dysfunction regardless of disease status. Patients with IBD, particularly women and those who have had any type of operation, are very prone to poor body image, with the rate of decreased body image in patients with a stoma reported to be as high as 100%.

G&H Do the challenges differ between patients who have Crohn's disease and those who have ulcerative colitis?

BC Patients with Crohn's disease are more likely to have perianal and fistulizing disease and to require a permanent stoma as part of their treatment, whereas patients with ulcerative colitis are more likely to have surgery with pouch formation, but these differences do not seem to translate into a significant difference between the 2 groups in terms of sexual dysfunction. The approach to assessment and management should be the same.

G&H In what way does sexual dysfunction differ between men and women with IBD? Which sex is the most challenged?

BC Women with IBD are more significantly affected than are men with IBD. Almost all studies have found higher

rates of sexual dysfunction independent of disease activity in women with IBD compared with rates of sexual dysfunction in the general population. Findings are more variable in relation to men with IBD. Some studies suggest that the rate of sexual dysfunction in men with IBD is no higher than the rate of sexual dysfunction in the general population except in those with more severe or frequent disease activity. Study focus has been more robust for men because the primary outcome—erectile dysfunction—is objective and easier to assess, whereas sexual dysfunction in women is more complicated, and outcomes are more subjective and difficult to assess, with a resulting focus on dyspareunia, lubrication problems, and vaginal infections.

G&H Does pharmacotherapy for IBD or its sequelae have an impact on sexual responsiveness or function?

BC The effects of medication on IBD and sexual function have not been extensively studied. In one study, most patients reported that they did not feel that their medications affected their libido or frequency of sexual activity, but, at the same time, nearly 10% of patients in the study were frequently omitting medications because of a perceived negative effect on their sexual activity.

Corticosteroids are the biggest concern regarding sexual function. We know that the effects of corticosteroid use contribute to poor body image, and in one study, corticosteroid use was found to be an independent risk factor for decreased sexual function in women. Adverse effects of corticosteroid therapy include mood changes, acne, weight gain, stretch marks, and hirsutism, which all can affect a patient's body image. Corticosteroid use can also increase the risk of oral and vaginal *Candida* infections, which impact sexual function. In addition, corticosteroid use can increase the risk of diabetes, which is a known risk factor for sexual dysfunction. Methotrexate also has been associated with impotence in a few rare reports, and antidepressant use is significantly associated with sexual dysfunction.

G&H What is the impact of proctectomy on sexual function in patients with IBD?

BC Proctectomy can have 2 results. It can result in an ostomy or a pouch. Research on sexual function and ostomies is, surprisingly, very limited, with most papers being published in the early to mid-1980s before pouches were performed in patients with ulcerative colitis as standard of care. However, we do know that one of the greatest concerns for patients with IBD is the effect of a stoma on intimacy and sexuality. Unique challenges that patients with stomas face include unpleasant odor, appliance-related issues that make sex less desirable, and greater impact on body image following surgery.

Most research looking at sexual function following pouch surgery has found that this operation is associated with good outcomes. It is difficult to assess what this means, though, because prior to pouch surgery, most patients are quite ill, so their sexual functions preoperatively are not optimal. Most studies, however, have found that between a quarter and half of patients report improved sexual function and improved rates of sexual satisfaction following pouch surgery. In long-term follow-up, up to 90% of patients report being satisfied with their sexual health following the operation. Complications can occur, though, such that, in these same reports, between a quarter and a third of patients report worse sexual function following surgery. In particular, increased incidence of dyspareunia postoperatively is consistent and common across most studies. As for concern regarding increased incidence of erectile dysfunction following surgery, most studies have shown this concern to be unfounded, with rates of erectile dysfunction reported to be between 2% and 4% following surgery.

G&H Aside from recent papers about fertility in women with IBD, why has so little been published about sexual health in the IBD literature?

BC I think that so little has been published about IBD and sexual function because the topic is a challenging area of study. Fertility studies have very clear-cut objectives, outcomes, and endpoints, whereas sexual function is quite subjective, particularly in women. Validated tools for measuring sexual dysfunction are needed as is standardization of methodology. Many of the available published studies have been done in different populations, often have no control group, and are retrospective, which makes drawing conclusions or making any generalizations from the existing research difficult. To date, no studies on treatment for sexual function in IBD have been published. Funding for research in this area is challenged because it is an area in which psychologic interventions are the focus rather than pharmacologic interventions.

G&H In relation to the psychosocial issues, what is the gastroenterologist's role in diagnosing and managing sexual dysfunction in IBD?

BC Medical treatment for IBD is improving every day, but the goal of the gastroenterologist is not just control of the active disease but improvement of the quality of life of the patient. We know that decreased sexual function affects a patient's quality of life, and that stress can create a sense of helplessness. If this helplessness and otherwise poor psychologic adjustment to IBD are left untreated, they can translate into depression, low self-esteem, and/or social withdrawal. Therefore, it is very important, from

a gastroenterologist's point of view, to not just lock in IBD as a gastrointestinal problem, but see and address the bigger picture.

From a patient's perspective, a recent study found that two-thirds of women and almost half of men with IBD wanted information about the impact of IBD on intimacy and sexuality, and they reported that this information should be given during delivery of the diagnosis. Further, patients felt that this information should be delivered by the IBD specialist. Therefore, it is important that gastroenterologists who diagnose and manage IBD create a supportive environment and a relationship with their patients that facilitates discussion about quality-of-life issues, such as sexuality. Gastroenterologists should not wait for the patient to bring up the topic because studies have shown that patients are very reluctant to bring up the subject of sexual dysfunction; they are embarrassed by it and feel that physicians will be embarrassed as well and not know how to help them. So, it is very important for a gastroenterologist, once he or she has developed a relationship with the patient, to address questions regarding sexual health.

G&H How would the gastroenterologist counsel the patient or collaborate with a mental health counselor?

BC The first step is to identify the issue and determine the problem. From a counseling point of view, it is important to let the patient know that he or she is not alone and to emphasize that the problem is not something he or she has to endure as an aspect of IBD but can be managed. The patients should be screened for risk factors, which include depression, previous surgery, relationship stress, abdominal pain, and incontinence. Each symptom should be individually treated. Inquiry about antidepressant use is also important as is weaning the patient from corticosteroid therapy. Suggest smoking cessation if the patient smokes cigarettes, as this may improve lubrication or erectile dysfunction issues.

If mobility is an issue, discuss pain relief options and use of pillows for modification of sexual position. Note that, with dyspareunia, the missionary position can instigate penetration pain during sexual intercourse, so consider discussing modification of positions in this situation. Another option for the patient is sexual pharmacology, which may be better managed by a sexual health specialist. Simply treating erectile dysfunction in men and lubrication issues in women can be very helpful.

A mental health worker might be involved in treating depression in a patient with IBD, evaluating antidepressant use, and adjusting medication if the patient happens to be taking a selective serotonin reuptake inhibitor or serotonin-norepinephrine reuptake inhibitor, which are associated with a lot of sexual adverse effects. Bupropion or mirtazapine, both of which have a lower rate for sexual adverse effects, may be given instead. The mental health practitioner also would evaluate partnership stress in relation to sexual function; therefore, it is important that the mental health worker communicate any of his or her findings to the gastroenterologist. Basically, the gastroenterologist should be astute about symptoms and address each particular symptom in each individual patient to get him or her back on track.

Dr Christensen has no relevant conflicts of interest to disclose.

Suggested Reading

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