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Omissions in care for sexual health in cardiology and gastroenterology : perspectives of physicians and patients

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**GENERAL DISCUSSION
AND FUTURE
PERSPECTIVES**

The main purpose of this thesis was to evaluate how medical specialists communicate with regards to sexual health and sexual dysfunctions, and to provide evidence for patients' needs regarding care for sexual health in specialized medical practice.

COMMUNICATION

In 1962 Joshua Golden, one of the first sexual investigators, wrote: "The basic problem in managing sexual conflicts has two aspects; those problems which the patient brings, and those which the physician brings. [...] the personal feelings of the doctor influence his ability to communicate with his patients about sexual matters, this involves not only matters of information, but the skill required in communicating effectively with patients about anxiety-laden topics"(1).

Since the late sixties, more and more literature pointed to the impact of sexual abuse and sexual dysfunction on quality of life. The first guidelines were presented in the seventies (2-4).

In spite of all the attention sexual health and sexual function has received in research and the media in the past fifty years, this thesis shows that at this time, in 2014, physicians ways of dealing with sexual dysfunction or care for sexual health did not change much.

While open-mindedness, liberty of speech and straightforwardness have become respected Dutch values, yet taboos exist when it comes to the topics sexual abuse (5), sexual dysfunction and sexuality in the ill and the elderly (6;7). **Chapter 2, chapter 4 and chapter 7** of this thesis indicated that medical specialists still have trouble discussing subjects related to sexuality. Even though they acknowledge their importance, various motives keep them from asking patients about sexual function or about traumatic sexual experiences. One of the main reasons is the perceived inability to deal with these matters once expressed, the same problem that was already pointed out by Joshua Golden in 1962...

SEXUAL HEALTH IN SECOND AND THIRDLINE HEALTHCARE

PART I

Part I of this thesis identified that communication about sexual dysfunction and sexual side effects of medication is not yet routine in the cardiology practice, even though guidelines and reviews have been showing its necessity and purpose.

Care for sexual health, from cardiologists' perspective

One does not need a lot of imagination to picture a fifty year old, decent, male cardiologist sitting behind his desk, trying to convince a sixty year old male patient to use his beta-blocker. The cardiologist tries to stay patient while explaining the importance of the beta-blocker use once again, but a full waiting room awaits him.

Is it surprising this cardiologist does not start about the effects the beta-blocker may have on erectile function? Probably not, because next to the lack of time, the cardiologist is not trained to discuss sexual function or counsel about sexual health. Moreover, the patient did not start about erectile dysfunction, so why would he?

On the other side of the desk, the patient indeed did not take his beta-blocker because it diminishes and weakens his erections. He and his wife still enjoy their sexual relationship and the ability to have good erections makes him feel young and virile. The patient already knows that he needs to take the beta-blocker to reduce his blood pressure and the risk of cardiovascular events, but he feels great at the moment and the benefits of the medication are more on the long term and therefore intangible to him.

This example may be exaggerated but many physicians reading it may recognize the hesitation and natural resistance to start about this sensitive topic which may lead to uncomfortable conversations or takes a lot of time. Everyone that has ever visited a doctor may recognize the feeling that several questions are still unanswered when leaving the doctors' office. In fact, you may have wished the doctor would have given you more reassurance or you may have felt that half of your questions remained unanswered.

With a helicopter view it is obvious to see that the reason for this patients' non-adherence with therapy is the effect of the beta-blocker on the erectile function. The consultation would have taken less time if the cardiologist would routinely ask about sexual function after prescribing a beta-blocker. Or if the patient would have been informed by the cardiologist, a nurse, the apothecary or an information leaflet that erectile dysfunction may occur with beta-blocker use.

It is well known that adherence with antihypertensive therapy is dependent on sufficient information about side effects (8). It was shown that prescribing sildenafil for ED resulted in significant improvements in adherence rates (from 48% to 66%) with antihypertensive therapy (9;10). A better solution would be of course, if the physician would try to reduce the side effects by switching to other agents (**chapter 3**).

Training is needed to make the cardiologist more comfortable with raising the subject of

sexual health and to make them familiar with treatment and referral options (**chapter 2 and chapter 4**).

Sexual healthcare in cardiology, from cardiac patients' perspective

The male patient

Chapter 5 made apparent that ED was prevalent among the vast majority of male cardiac patients, compared to those without a cardiac diagnose. Of those with ED, most were bothered by it and half would have liked to discuss possible treatment options with the cardiologist.

ED has been shown to be a very common problem among men with cardiovascular disease. Next to the fact that it might be a result of insecurity about the cardiac condition or induced by the antihypertensive agents used. It is therefore impossible for cardiologists to avoid paying attention to male sexual healthcare.

On the other side, patients need to be educated and helped to lose prejudices which keep them from asking questions about sexual health. It should feel natural for cardiologists and their male patients to discuss ED, since it can significantly impact patients' and their partners' quality of life, reduce their adherence with therapy and cause relational problems, while ED easily can be reduced or resolved.

The female patient

Most of the women studied in **chapter 6** of this thesis, were 60 years or older and therefore postmenopausal. The low response rate for the study was already an indication for the reservations women in this age category have towards sexuality.

The survey results however, showed a prevalence of FSD almost as high as ED in the male cohort. But the women clearly appointed less importance to sexual function compared to men in the same age category. Most women with sexual dysfunction were not interested in treatment for SD.

This may be explained by the fact that aging (postmenopausal) women devalue their expectations regarding sex, or do not attach great importance to the sexual side effects of their medication (11).

Another explanation may be the lack of knowledge about female sexual function.

For men, treatment for ED was found in the form of PDE-5 inhibitors. The discovery and release of Viagra in 1998 has led to a steady cash flow for pharmaceutical companies. Advertisement for the different erection potentiating agents is abundantly present in all

kinds of media. This may surely have diminished the embarrassment for men to talk about ED. And, because knowledge about ED has been spread for promotional purposes, most men now know there is hope for improvement of erectile function, which may be good reason to wish to speak to the doctor about it.

On the other hand, the search for female-desire drugs has been a fixation of the pharmaceutical industry for more than a decade as well, largely because the popularity of PDE-5 inhibitors have shown that gigantic sums of money can be made with a quick chemical solution to sexual dysfunction.

Viagra and its competitors deal with the 'simple' mechanism of ED, which is the most troubling difficulty for men. But the psychological complexity of hyposexual desire disorder, the most common cause for FSD, has as yet defeated industry giants.

It is also important to note that Viagra isn't entirely without influence on the mental state of desire. The mechanics of the body and the mysteries of the mind are intertwined. When a man has an erection, his sensitized nerves and enhanced feelings of power have a positive feedback on his drive (12). Research has shown, that women are less cognizant of genital arousal, and probably for this reason, Viagra-like substances haven't done enough to raise women's ratings of desire in past experiments. For women, agents need to be added to more directly target the brain (13). The desire pill for women (Lybrido®), which has recently been in the news, combines PDE5-inhibitors with testosterone and showed an increase in desire and in rates of orgasm in preliminary trials (14;15). However, the Food and Drugs Administration (FDA) has to approve of larger randomized trials, before this medication has a change to reach the market. If that happens, providing a quick and easy solution for women to improve their sexual function, they may start wishing for more sexual healthcare in the cardiology practice as well.

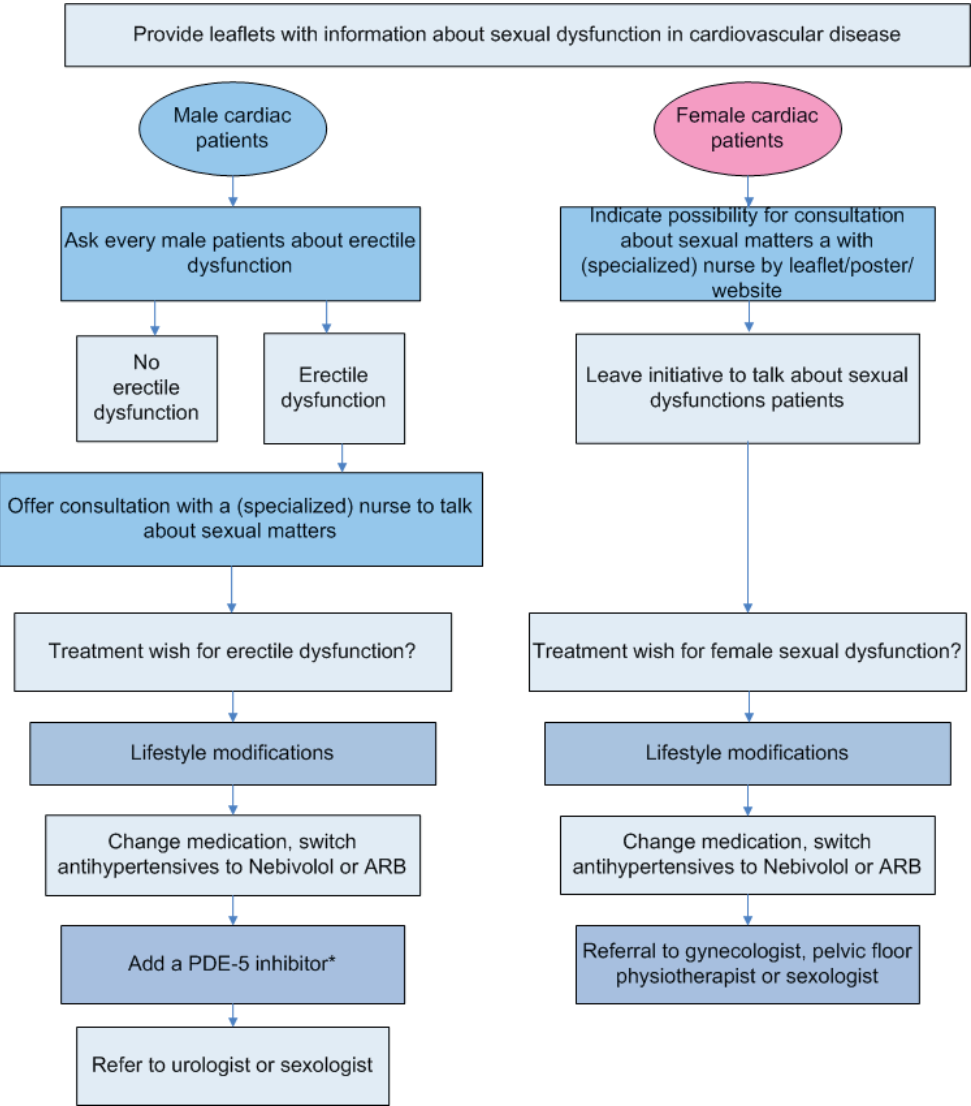
Until then, the recommendation for female sexual healthcare in the cardiology practice as can be inferred from this thesis is as follows: women with cardiovascular disease appreciate the availability of information and options for sexual healthcare. However, the initiative to start about sexual health in cardiology should be left with the female patients themselves (see **chapter 6**).

The other recommendations for improvements of sexual healthcare in cardiology as can be deduced from the data in **part I** were summarized and presented in Figure 1.

Future studies are mandatory to assess the effects of these adjustments on patients' satisfaction with the provided care and to assess improvements in quality of life.

Figure 1. Proposed adjustments for the cardiology practice to improve sexual healthcare for patients

with cardiovascular disease



and/or severe valvular disease), sexual activity should be deferred until the patient is stabilized and optimally managed(16).

*PDE-5 inhibitors are contraindicated in combination with use of organic nitrates

PART II

Care for sexual abuse in gastroenterology, from gastroenterologists' perspective

In recent years, the scientific community has been paying attention to the relation between lifetime sexual abuse to gastrointestinal complaints. The prevalence of sexual abuse is higher in patients with gastrointestinal symptoms (17-20).

Chapter 7 of this thesis however, indicated that inquiring about sexual abuse is not yet routine in the Dutch Gastroenterology practice.

Training and a standard question(naire) to improve care

Our data pointed to the importance of training for residents and gastroenterologist to obtain the necessary knowledge about sexual abuse and its effects on gastrointestinal symptoms. Furthermore, a standard question about sexual abuse before performing endoscopy (**chapter 8**) would be a simple, but effective improvement of care.

Research indicated that, even if sexual abused women do not confirm the abuse in the first instance, physicians' routinely asked questions about it may evoke the idea that discussion about it is possible (21). Beforehand of asking about abuse it is important for the physician to explain that gastrointestinal symptoms can be related to experiences of sexual abuse in the past. This may help the patient to relate his or her history and once the sexual abuse is entrusted to the physician, it is much easier to place the patients' sickness behavior and health-problems in the right context.

Clinical guidelines for care around colonoscopy in patients with a sexual trauma should become available to enable gastroenterologists to offer patient centered care and diminish distress for these patients as much as possible during trans anal procedures. In that respect questions about earlier traumatic abuse may save time, frustration, money and energy, instead of causing extra diagnostic procedures, unnecessary operations, doctor-shopping and greater health costs (22).

Special treatment needs for patients with a sexual abuse history

Next to the treatment of the physical components of the complaints of these patients, the gastroenterologist should be aware that referral to a mental health consultant is often desirable for patients with sexual abuse experience. Childhood sexual abuse can lead to a wide range of psychiatric illnesses, as posttraumatic stress disorder (PTSS), anxiety disorders, dissociative disorders, substances abuse, conversion and somatization disorders, (borderline) personality disorders and psychosis (23;24). Other psychiatric

consequences are suicidal thoughts, auto mutilation, emotional instability, aggression, delinquent behavior, negative self-image, feelings of guilt and despair, sexual dysfunction (as seen in **chapter 8**), anxiety attacks, sleeping disorders, distrust, relational problems and loneliness (25;26).

Most victims of abuse react neutral or relieved to questions about sexual abuse, only in a minority it was described to increase the complaints (23). The fear that many healthcare providers have, that asking about abuse would lead to more disturbances, is not grounded (27). Inquiry into abuse is important for both men and women (see the subheading 'gender' on page 172) and in every age category, not in the least in the elderly. For even decades after the sexual abuse, it can still hugely impact mental en physical health of its victims. Many elderly patients may have early experiences which may be partly dealt with or were successfully repressed. In later age posttraumatic complaints can exaggerate and even start after decennia in which the patients thought the trauma was processed (27). In Table 1 factors suggesting a history of abuse are displayed (28).

It may be difficult to address the psychological difficulties patients have, coping with chronic pain and illness because that can be intimidating for the non-psychiatric physician. But the physician need to emphasize that improvement in psychological distress can increase tolerance of pain and provide better adjustment to medical illness.

Several forms of psychotherapy are proven to be helpful (29), but because of shame or inability to deal with the generated emotions, the patient may be reluctant to see a mental health consultant. In this situation the physician must accept the patient's wishes' continue in care and suggest that the topic can always be discussed another time. In any case it is important the gastroenterologist maintains continuity in care, referral to a mental health professional should always exist next to treatment of the physical complaints (28). The mental health consultant can identify psychological co-morbid conditions, confirm sexual abuse history and decide on psychopharmacologic treatment. If needed, the mental health consultant can either personally initiate or implement referral for psychological treatment along with medical care.

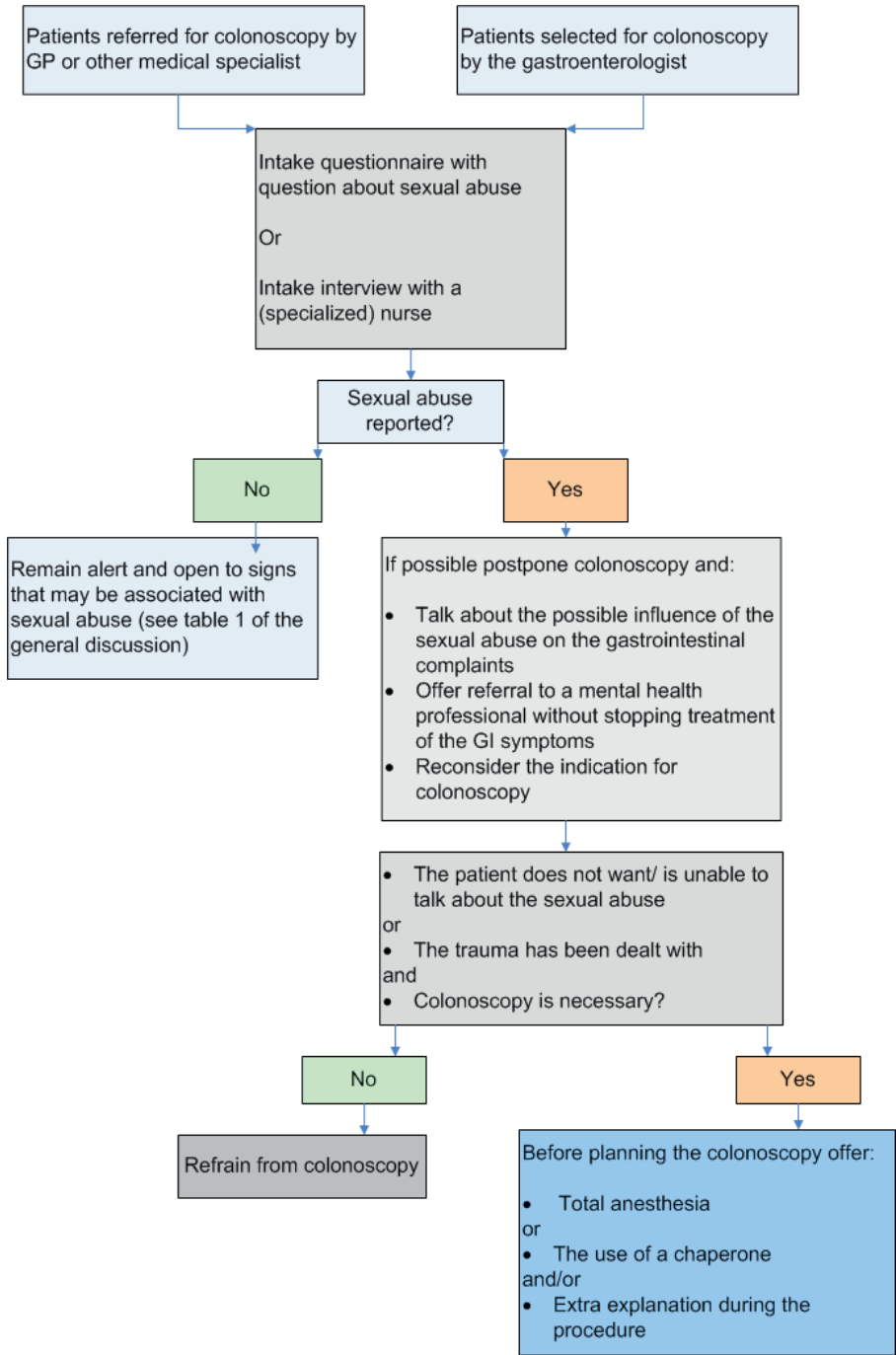
From the results described in **chapter 7 and 8**, several effective and easy applicable recommendations for adjustments in care for patients with sexual trauma in gastroenterology could be deduced. These recommendations are presented in the form of a flow charts (Figure 2, page 170). Future implementation studies should be conducted to evaluate whether these options are effective and if they improve treatment and outcomes of patients with a sexual abuse history in the gastroenterology practice.

Table 1. Factors associated with a history of abuse

Psychological issues
Difficulties in establishing trust
Difficulties perceiving a sense of control over the illness and life events
Feelings of helplessness and dependency
Feelings of vulnerability, shame and guilt
Gastrointestinal and other medical disorders
Chronic pain (including functional abdominal pain syndrome)
Severe constipation (slow transit constipation, and pelvic floor dyssynergia)
Chronic pelvic pain
Narcotic bowel syndrome
Eating disorders (bulimia nervosa, anorexia nervosa, rumination)
Unexplained vomiting
Morbid obesity
Multiple functional GI and functional somatic conditions
Psychiatric disorders
Somatoform disorders (somatization, conversion, hypochondriasis, pain)
Dissociation disorders including multiple-personality disorder
Personality disorders (borderline personality disorder, histrionic personality disorder)
Eating disorders (bulimia nervosa, anorexia nervosa, rumination)
Anxiety disorders (post-traumatic stress disorder, obsessive-compulsive disorder)
Severe depression and panic disorder
Illness-related behaviors
Disability disproportionate to the clinical data
Attempts to validate disease and denial that psychological factors may play a role
Placement of responsibility for healthcare with physician
Avoidance of health-promoting behaviors
Marked anxiety and difficulties with procedures (rectal or vaginal examination, endoscopy)
Borderline behaviors (intense attachments, ‘splitting’ difficulty in dealing with uncertainties, demanding behaviour)
Unwanted outcomes
Multiple diagnostic procedures, treatments and surgeries
Substance abuse (alcohol, medications, illegal drugs)
Disability and litigation seeking
Frequent and excessive use of medical care services

Source: Drossman et al. *Ann Intern Med.* 1995;123(10):782-794.

Figure 2. Proposal for the improvement of care for patients with sexual abuse in the gastroenterology practice



Health care for sexual abuse in gastroenterology, from patients' perspective

The patient-physician relation can be significantly improved if openness about sensitive topics such as sexual abuse can be created (30;31). Results of **chapter 8** showed that most patients with a history of sexual abuse would appreciate the gastroenterologists asking about it. Gender was not of influence. In both male and female patients the prevalence of sexual abuse was significant. As was already explained these figures were likely an underestimation due to the demarked question used for the identification of sexual abuse, by means of which mild to moderate abuse forms such as fondling or exposure to exhibitionists were implicitly excluded. In addition, we presumably missed many patients from non-Western countries, due to cultural and linguistic barriers.

The association of abuse and gastrointestinal disease

Chapter 8 showed that abdominal pain was related to a history of sexual abuse and with more distress during colonoscopy. This was a finding we expected, while multiple studies have indicated the association between gastrointestinal illnesses, pain and sexual abuse (32-34). Furthermore, epidemiological studies have suggested a link between a history of abuse and a diagnosis of more severe irritable bowel syndrome (IBS) (18;28;32). And, patients with a history of abuse have more severe illness and poorer health outcomes (32).

Several possible mechanisms have been suggested to explain these associations (35):

A history of sexual abuse may have a sensitizing peripheral effect that contributes to heightened visceral sensitivity (peripheral disordered visceral function);

Sexual abuse may have a centrally mediated effect on modulation of the conscious perception of visceral signals and/or altered affective or behavioral responses to afferent visceral signals, thus leading to more severe symptoms and adverse clinical outcome.

One study looked at the effect of a history of abuse on visceral, rectal sensation in patients with IBS. It was examined whether reduced pain thresholds in patients with IBS were related to psychological factors and/or prior history of sexual abuse. They found that higher pain sensitivity in IBS patients correlated with psychological factors (that is, anxiety and somatization). However, sexual abuse was not found to be associated with lower pain thresholds (36). Support for a possible central modulating role of sexual abuse on affective and behavioral responses came from studies using brain imaging techniques. These studies have shown morphological (decreased hippocampal mass)(37;38) and functional (reduced activation of anterior cingulate cortex)(39) abnormalities in subjects with sexual abuse history. Using PET and fMRI it was shown that a history of abuse modulates the anterior cingulate cortex activation, a region involved in the motivational and affective reactions to painful stimulation (40-42). These alterations in cingulate cortex activity were

associated with pain reports and correlated with psychosocial distress (43).

In summary, the fact that sexual abuse leads to more illness behavior and abdominal pain is not only caused by psychological factors and coping strategies but as well by stress-induced changes in the hippocampus and cortex.

Gender

In chapter 8 it was found that sexual abuse was more prevalent among female than male patients. This is in concordance with the literature, sexual abuse has always been more prevalent in women, however childhood sexual abuse of boys have come to the surface more often in the past years, for example in the catholic church (44).

In our sample, no differences were seen between male and female sexual abuse victims regarding the distress scores and physical complaints. This may indicate that men and women respond to sexual abuse in a similar fashion, however, gender differences regarding this response has never been studied. Virtually all research studying the effects of sexual abuse were conducted among female patients, leaving the effects of sexual abuse on men a significant understudied subject. To be able to further adjust patient-centered healthcare for sexual abuse victims in the gastroenterology practice, studies exploring the effects of abuse in men needs to be conducted.

While currently all evidence about the impact of sexual abuse in gastrointestinal disease was collected in female patients, it is comprehensible that gastroenterologists paid more attention to sexual abuse in women than in men (**chapter 7**).

ROLE FOR THE GENERAL PRACTITIONER IN CARE FOR SEXUAL FUNCTION AND SEXUAL ABUSE

The results found in both parts of this thesis can be extrapolated to other medical workers. Especially the general practitioner is important in this context.

In the Netherlands, the general practitioner (GP) can play a crucial role in sexual healthcare. The GP is the gatekeeper and manager of patient's health and receives all correspondence from patient consultations with the medical specialist. Furthermore, the GP often provides the patients with (repeated) prescriptions for medication prescribed by a medical specialist. Ideally, patients have a good relationship with their GP, he or she could be easier to approach than the medical specialist. Patients and GP should be familiar with one another.

If this, rather old fashioned situation, is the case the GP would be a much better place for patients to talk about and receive treatment for sexual dysfunction, to ask questions regarding sexual health or to talk about abuse experiences.

Older studies among GP's and their patients, however, showed that even in this type of general practice, patients find it difficult to talk about sex and sexual abuse experiences (45-47). And, GP's do not usually tend to ask about sexual dysfunction or a possible story of abuse (48;49).

In the modern form of Dutch general practices, patients do not 'have' their own GP anymore. Patients visit a healthcare center in which several GP's work together and mostly are not available during every day of the week. In this situation, the lack of continuity in care from the 'personal' GP may be another barrier for patients to bring up the topics sex and/or sexual abuse. Research should be conducted to identify if this new form of general practice changed the attention for sexual health and whether this is an extra barrier for patients to reveal abuse experiences.

Lastly, it needs to be noted that in recent years several sexual assault centers where opened in the US and in Europe to provide multidisciplinary care for men and women who experienced sexual abuse, for example rape. These centers enable provision of medical, forensic and physiological support and follow-up care (50). Since 2012 sexual assault centers were opened in Utrecht and in Nijmegen. Both GP's and medical specialists should be aware of the availability of these centres for the referral of patients reporting recent or ongoing sexual abuse. In addition, while sexual abuse regrettably is such a common social problem, availability of only two centres for sexual assault victims is rather scarce. Centers should be initiated in every large city in the Netherlands.

Final remarks

It seems strange that in this modern western society where freedom is everything and taboos seem to have disappeared, discussing sexual matters with a physician still seems to be difficult.

Sex is, next to the origin of human life, an important component for quality of life. Problems in sexual health, such as sexual dysfunction or sexual victimization, highly affect people's lives and their relationships. It therefor deserves much more attention in medical healthcare.

With the use of internet, patients have become better informed and more demanding. A different type of health care -patient centered health care- is becoming the standard. To adequately provide this patient centered healthcare, sexual health has to be given the necessary attention. And attention for sexual abuse has to be incorporated in (specialized) medical healthcare. We may still have a long way to go, but the results of this thesis may be a next step toward this transition.

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