

Sexual Inactivity among Hemodialysis Patients: The Patients' Perspective

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An emphasis on patient-centered care is becoming one of the dominant themes of health care reform worldwide. This emphasis involves active participation by patients (and their family/caregivers) in determining the type and standard of care that is best suited to maximize the individuals' quality of life. In this model, the goal of the health care provider is to develop collaborative structures of care that engage patients in decisions and empower them to make informed choices about their care. This goal requires that health care providers listen carefully to patients and strive to understand the patients' perspective on their illness, symptoms, life concerns, and treatment. Too often, health care providers focus on objective, easily assessed outcomes and organize therapeutic regimens around these measures. However, what problems and issues do patients want addressed? What are their concerns?

The work by Mor *et al.* (1) in this issue of *CJASN* examines sexual functioning in women on hemodialysis (median age=64 years) using a reasonable modification of the well validated Female Sexual Function Index (FSFI). This study is important, because few previous studies have critically examined the problem of the perception of the sexual functioning of women with ESRD. Mor *et al.* (1) note a low level of sexual activity among these patients (on all assessments, 81% of women reported that they were not sexually active), which has been well documented in prior studies (2). Importantly, however, Mor *et al.* (1) also look at the reasons for sexual inactivity and patient satisfaction with their current level of sexual functioning. The main reasons cited by patients for lack of sexual activity in this study were lack of a partner (39%) and lack of interest (43%). Actual sexual difficulties were cited by only 2% of women.

The recent meta-analysis by Strippoli *et al.* (2) suggests that 84% of women on dialysis have sexual dysfunction. Sexual dysfunction in this study was defined as a score on the FSFI of ≥ 18 . This instrument assesses sexual dysfunction by evaluating six domains of sexual functioning in 4 weeks before completion of the questionnaire: (1) desire, (2) arousal, (3) lubrication, (4) orgasm, (5) global satisfaction, and (6) pain. However, what if the patient is not engaging in sexual activity? Does lack of sexual activity define sexual dysfunction? A variety of factors can contribute to lack of sexual activity. For example, age is an important determinant of sexual activity (3). Of general medical patients, 60% of

women ages 65–74 years and 85% of women ages 75–85 years report not having sexual activity in the preceding 12 months (3). The presence of a potential sexual partner has also been noted to be strongly associated with sexual activity for women with ESRD in the meta-analysis by Strippoli *et al.* (2). Similarly, for men with ESRD, the absence of a sexual partner is also associated with sexual dysfunction (4).

However, are women on dialysis dissatisfied with their level of sexual activity (5,6)? A previous study by Steele *et al.* (6) observed that only one half of patients on peritoneal dialysis not having intercourse desired to be sexually active. In the Dialysis Outcomes Practice Patterns Study, only 38% of patients with ESRD report that their sex lives are impacted by their ESRD disease, despite the low frequency of intercourse noted in patients with ESRD (5). Additionally, an important study by Toorians *et al.* (7) of 261 patients ages 20–60 years (including patients on hemodialysis and peritoneal dialysis and patients who received transplants) concluded that the high incidence of sexual dysfunction in patients on dialysis is more related to loss of sexual interest than mechanical or physiologic problems (7). The study of Mor *et al.* (1) extends these observations and helps us better understand women's perception of sexual inactivity. On 64% of assessments, women reported being moderately to very satisfied with their sexual lives, whereas only 19% of women reported being moderately to very dissatisfied with their sexual lives (1). Thus, the lack of sexual activity did not seem to be a major source of concern for patients and obligates the health care provider to rethink his/her approach to the sexual inactivity of the patient with ESRD. Does the patient perceive this inactivity as a problem, and does the physician need to develop treatment strategies to address it?

What about men with ESRD? A recent meta-analysis observed that 83% of men maintained on dialysis have erectile dysfunction of varying degrees (4). However, as with women on dialysis, men's interest in sexual activity may be substantially reduced. Toorians *et al.* (7) attributed decreased sexual desire (libido) for men, like women, to be the main cause of sexual difficulties (7). Furthermore, the treatment of erectile dysfunction in men has proven to be challenging; problems include a lack of interest in treatment programs and a poor response to various therapeutic regimens, in large part because of lack of interest in targeted therapies (8,9).

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One of the strengths of the work by Mor *et al.* (1) is that it underscores the point that the sexual inactivity of patients with ESRD needs to be seen in the context of the patient's overall medical problems, burden of the treatment regimen, and life situation; sexual problems, as with other areas of difficulty for the patient with ESRD, cannot be seen in isolation. Thus, as we formulate an approach to help the patient on dialysis adjust to the sexual realities of ESRD, we must put the problem of sexual dysfunction (or lack of sexual activity) in context. We must inquire about the sexual activity of the patient and the patient's perception of this activity. Is he or she interested in having more sexual activity? Is he or she satisfied with the current level of sexual activity? If he or she is not satisfied, how important is it for the individual patient? Are there specific areas of sexual difficulty that need attention? Is a potential partner readily available? What is the nature of the relationship with such a partner? We must remember that marital discord, of varying degrees, is commonly noted in patients with ESRD (10).

A major challenge for nephrologists is both assessing and addressing the multiple areas of difficulty presented by patients with ESRD. Sexual difficulties are one of a multitude of problem areas presented by patients with ESRD. These difficulties span the breadth of a comprehensive review of systems from physical complaints to cognitive difficulties to psychosocial and/or interpersonal problems. Thus, understanding the importance of each of these problematic domains for the individual patient is critically important. As emphasized in the work by Mor *et al.* (1), sexual inactivity may be noted, but it may not be perceived as a problem area by the patient.

In developing treatment strategies for patients with ESRD, health care providers too often focus attention on preselected areas that use standardized assessment tools. These tools often do not fully explore the patients' perceptions of their symptoms, issues, and problems, and they do not address the impact of these symptoms on the overall quality of life of the patient (11). The work by Mor *et al.* (1) emphasizes for us that it is critically important not just to document (with a validated tool) an area of patient dysfunction, but that we need to understand the importance of it for the patient. We then need to develop a hierarchy of problem areas for each patient that needs to be addressed.

Disclosures

None.

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See related article, "Sexual Function, Activity, and Satisfaction among Women Receiving Maintenance Hemodialysis," on pages 128–134.