

## **Mellen Center Approaches – Sexual Dysfunction in MS**

**Framework:** Sexual dysfunction is a common symptom of MS. However, it is an underappreciated condition that often goes unreported by both the patient and clinician. Sexual dysfunction can affect a person's mood, relationships, daily functioning, and quality of life. At the Mellen Center our approach is to assess for sexual dysfunction symptoms in patients, identify factors contributing to the problem, and treat from a multidisciplinary perspective.

### **Q: What are common sexual dysfunction problems in MS?**

A: Common problems related to sexual functioning in this population include decreases in genital sensation, decreases in libido and vaginal lubrication, erectile dysfunction, and difficulties with orgasm.

### **Q: What are the gender differences in sexual dysfunction in adults with MS?**

A: In terms of gender differences, the most prevalent problems for men include erectile dysfunction, loss of sexual confidence, orgasmic dysfunction, and genital numbness. For women, the most common presentations include orgasmic dysfunction, loss of libido, inadequate vaginal lubrication, and genital numbness.

### **Q: How prevalent is sexual dysfunction in adults with MS?**

A: Though research in this area is still fairly limited, studies indicate prevalence rates of 40 to 80% in women and from 50 to 90% in men. A survey of MS patients (n=5868) found that 67.2% of participants endorsed sexual dysfunction symptoms that were present *always* or *almost always* in the previous six months. Moreover, a clinical sample from the Mellen Center revealed that 60% of patients endorsed some form of sexual dysfunction (n=105).

### **Q: What causes sexual dysfunction in adults with MS?**

A: In the general population, sexual dysfunction is usually evaluated according to different aspects of the sexual response cycle (i.e., disorders of libido, arousal, and orgasm). Though the etiology of sexual dysfunction in MS patients is still not entirely understood, a common conceptualization is that the nature of sexual changes in this disease can be attributed to primary, secondary, or tertiary causes.

Primary causes of sexual dysfunction in MS include those due to physiological impairment associated with lesions in the cortex and spinal cord which can lead to numbness or paresthesias that directly affect the genitals; loss of libido; decreased vaginal lubrication in women; and difficulty initiating or maintaining an erection in men. Certain medications can also have an impact on primary causes. Secondary causes are likely associated with non-sexual physical changes, such as fatigue, spasticity, pain, and bladder and bowel dysfunction. Tertiary causes

refer to psychosocial variables that can interfere with sexual performance or satisfaction, including changes in social roles, depression, demoralization, and interpersonal difficulties.

**Q: Why is it important to assess for and treat sexual dysfunction?**

A: Despite the high frequency of sexual dysfunction in individuals diagnosed with MS, it is an often overlooked and not addressed by healthcare providers. Patients also tend to underreport this problem. In addition, research in this area is limited. Sexual dysfunction affects young and older adults and it can have a significant impact on an individual's relationships and quality of life.

**Q: How do we assess for sexual dysfunction in patients with MS?**

A: A clinician can screen for sexual dysfunction symptoms as part of routine review of systems when inquiring about bladder and bowel function. It is always helpful to conduct a review of current medications and potential side effects that may impair sexual functioning.

Another option would be to utilize the Multiple Sclerosis Intimacy and Sexuality Questionnaire 19 (MSISQ-19), a 19-item self-report measure that addresses the three dimensions of sexual dysfunction (i.e., primary, secondary, and tertiary causes). The questionnaire, using a 5-point Likert scale ranging in order of frequency of experience (1 never, 2 almost never, 3 occasionally, 4 almost always, and 5 always), assesses the level in which MS symptoms have interfered with the individual's sexual functioning in the previous 6 months. It is the only scale specifically designed and validated for an MS population. One of the advantages of the MSISQ-19 is that it only takes about 2 minutes to complete and can be done prior to the visit. If the screening is positive for sexual dysfunction symptoms, the practitioner can then follow up and inquire whether the patient would like help with these symptoms.

**Q: What are barriers for providers to assess sexual dysfunction?**

A: A study conducted by Griswald (2003) surveyed a group of MS specialty health-care professionals and found that the primary reason for not assessing for sexual dysfunction is limited time with patients (44%). Other barriers included having the issue be "outside of my role" (15.3%), patient discomfort (12.5%), lack of professional training or comfort (6.9%), other priorities (5.6%), limited medical coverage so they cannot afford treatment (2.8%), too intrusive for patients (2.8%).

Adequate training in healthcare provider and practice in assessment will increase providers comfort levels. Patients typically rely on the clinician to discuss issues in sexual functioning and many are grateful when the topic is addressed. (Foley, 2006)

Other barriers may include available resources and scope of practice. Having a list of physician and health psychology referrals that specialize in sexual dysfunction can be helpful in these cases. In addition, providing educational materials have been shown to be beneficial in some cases (Christopherson et al., 2006).

**Q: How do we treat sexual dysfunction in the context of MS?**

A: Treatment will depend on the nature of the symptoms and whether they are classified as primary, secondary, or tertiary, or likely a combination of these. Approaching treatment from a multidisciplinary model can be helpful, which can include neurologists, urologists, nurse practitioners, and health psychologists. Specific recommendations can be found on the table below.

Symptom	Treatment
<i>Treatment of Primary Causes</i>	
Orgasmic dysfunction Premature/delayed ejaculation	<ul style="list-style-type: none"> <li>Assess current medications that could be contributing (e.g., antipsychotics, SSRIs, and TCAs).</li> <li>Gain an understanding of the different factors that could be contributing (i.e. other secondary or tertiary symptoms)</li> <li>Focus is on appropriate contributing symptom management</li> </ul>
Decreased vaginal lubrication	<ul style="list-style-type: none"> <li>Incorporate water-soluble lubricants prior to and during sexual activity and/or lubricants that contain menthol or other vasoactive agents as these can sometimes improve sensation (e.g., K-Y Jelly, Replens, or Astroglide)</li> </ul>
Decreased libido	<ul style="list-style-type: none"> <li>Cognitive Behavioral Therapy (CBT) to address unhelpful beliefs about sexual functioning/sexuality</li> <li>Couples therapy/Counseling</li> <li>Consider reducing/changing SSRIs and other medications that could be contributing</li> <li>Consider use of Flibastin for female patients</li> <li>Body mapping exercises</li> </ul>
Decreased genital sensation and paresthesias	<ul style="list-style-type: none"> <li>Genital sensation can be improved with more vigorous genital stimulation and the use of vibrators</li> <li>Adequate management of paresthesias</li> <li>Cognitive Behavioral Therapy (CBT)</li> <li>Couples therapy/Counseling</li> </ul>
Erectile dysfunction	<ul style="list-style-type: none"> <li>Use of PDE-5 (phosphodiesterase-type-5) inhibitors*</li> <li>Injectable medications for ED in MS such as prostaglandin**</li> </ul>

	<ul style="list-style-type: none"> <li>• Consider reducing/changing SSRIs and other medications that could be contributing</li> <li>• Consider adding Wellbutrin to antidepressant regimen</li> <li>• Use of a vacuum assistive device (cannot be used for longer than 30 minutes)</li> <li>• Cognitive Behavioral Therapy (CBT) to address unhelpful beliefs about sexual functioning/sexuality</li> </ul>
<b><i>Treatment of Secondary Causes</i></b>	
Fatigue	<ul style="list-style-type: none"> <li>• Energy conservation strategies such as planning sexual activity during a time of the day when MS fatigue is at its lowest; taking naps; using ambulation aids</li> <li>• Pharmacologic treatment of fatigue as outlined in the Mellen Center Approach on management of fatigue.</li> </ul>
Bladder and Bowel Symptoms	<ul style="list-style-type: none"> <li>• Behavioral strategies include restricting fluid intake before sexual activity, self-catheterization just before sexual activity, planned bowel movements twice a day and before sexual activity, use of condoms for concerns of urinary leakage in men</li> <li>• Pharmacological interventions include the use of anticholinergic medications (may decrease vaginal lubrication which can be alleviated with the use of a water-soluble lubricant)</li> </ul>
Spasticity	<ul style="list-style-type: none"> <li>• Active symptomatic management</li> <li>• Physical therapy focusing on range of motion exercises</li> <li>• Take antispasticity medication 30 minutes prior to sexual activity</li> <li>• Explore alternative sexual positions to minimize discomfort or pain from spasticity</li> </ul>
Cognitive changes	<ul style="list-style-type: none"> <li>• To improve attention and concentration needed for successful sexual activity, the goal is to minimize nonsexual stimuli and maximize sensual and sexual stimuli</li> </ul>

	<ul style="list-style-type: none"> <li>• Cognitive rehabilitation may be recommended</li> </ul>
<b><i>Treatment of Tertiary Causes</i></b>	
Body image	<ul style="list-style-type: none"> <li>• Cognitive Behavioral Therapy (CBT)</li> <li>• Couples counseling or sex therapy</li> </ul>
Role reversal	<ul style="list-style-type: none"> <li>• If sexual partner is the primary caregiver, it may be helpful to incorporate other family members to perform caregiving duties for the patient to reduce “role conflict”</li> <li>• Individual or couples counseling</li> </ul>
Depression	<ul style="list-style-type: none"> <li>• Cognitive Behavioral Therapy (CBT)</li> <li>• Consider SNRIs such as venlafaxine, desvenlafaxine, or duloxetine as opposed to SSRIs, such as fluoxetine, paroxetine, sertraline, or citalopram, which may result in more sexual side effects</li> <li>• Consider adding Wellbutrin to antidepressant regimen as this medication has a lower profile of sexual dysfunction as a side effect</li> </ul>

\* Sildenafil (Viagra) is the only medication evaluated in clinical trials in men with MS

\*\*Contraindicated when patient is on nitrate-based cardiac medications, as they can lower blood pressure excessively.

\*\*It is recommended to refer the patient to a specialist in this area.

Note: *All patients should be evaluated by their physician to be sure they are healthy enough for sexual activity.*

## Resources:

National MS Society – Intimacy and Sexuality in MS.

<http://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/Brochure-Intimacy-and-Sexuality.pdf>

## References:

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Foley FW & Iverson J. Sexuality. In: *Multiple sclerosis: A Guide for Families*. 3<sup>rd</sup> ed. New York, NY. Demos Medical Publishing; 2006.

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Griswald G, Foley FW, Zemon V, LaRocca NG, Halper J. MS health professionals' comfort, training, and practice patterns regarding sexual dysfunction. *Int J Mult Scler Care*. 2003; 5(2):3-10.