Low Back Pain and Sexuality

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✔ Kronik bel ağrılı hastalarde sexüel disfonksiyon önemli bir problemdir. Klinik tecrübelerimiz ve literatürden edindiğimiz bilgilere göre bunun 3 temel sebebi vardır. Normal sinir sistemi fonksiyonunu engelleyen primer organik patoloji; ağrıyı gidermek için kullanılan ilaçların yan etkileri ve kronik ağrıdan kaynaklanan psikolojik faktörler. Bu yazıda bel ağrılı hastada sexüel disfonksiyona yol açan faktörler ve bunlara karşı alınabilecek önlemler literatür ışığında gözden geçirilmiştir.

Anahtar Kelimeler: Bel ağrısı, seksüel disfonksiyon.

✔ Sexual dysfunction in the patient with chronic low back pain is a frequently misunderstood and neglected aspect of this disease classification. Clinical experience and a review of the literature defines three causative factors: primary organic pathology interrupting normal nervous system function; side effects of medication prescribed for the condition, and psychological factors relating to anxiety over performance and fear of pain during sexual activity. The purpose of this article is to discuss the factors regarding sexual dysfunction in patients with chronic back pain.

Key words: Low back pain, sexual dysfunction.

Low back pain is one of the most common and unpredictable conditions. It affects people of all ages, races, socioeconomic classes and both sexes. There are a wide variety of infectious, neoplastic, metabolic and traumatic causes of back pain. However, in many patients a definite cause cannot be identified[1]. In addition, patients who present with low back discomfort may suffer from psychological problems. Many clinicians consider chronic low back pain to be a psychophysiological disorder and indicate that back pain may be associated with depression, neuroticism and a lifestyle of invalidism and manipulative doctor/patient relationships. Emotional factors related to sexuality can intensify muscle tension and increase low back pain. Sexual dysfunction is defined as the inability to achieve and maintain full erection or to perform an enjoyable satisfactory coitus when these had previosly occurred[2]. Although there is rapidly growing body of knowledge about the diagnosis and treatment of chronic low back pain, there have been only a few papers relating to sexual dysfunction in this group[3,4].

A group of men with chronic low back pain syndrome resulting from industrial accidents was studied by Laban[3], Sixty-three percent were found to have erectile dysfunction even though organically they showed no more neurological problems than the 37% whose sexual functioning was normal. In another study of 153 male patients with low back pain syndrome, it was revealed that 69.3% reported sporadic to complete erectile dysfunction[4]. While low back pain appears to be frequently associated with reduced sexual performance, physicians do not agree on whether physical injuries, such as herniated discs, or remediations such as spinal fusion, can actually cause physically based erectile dys-

function in males. Flynn and Price[5] emphatically stated that sexual dysfunction following lumbar surgery is not organic and that it responds to time and psychotherapy. They concluded that sexual complications from surgery have been highly exaggerated based on a study of 4500 cases performed by 20 surgeons worldwide where only 20 cases of erectile dysfunction occurred. Low back syndromes can cause sexual dysfunction having both organic and functional origins. In the case of the chronic pain patient, the patient's physical disability, having failed to respond fully to surgical or medical management, frequently causes disruptive and complex reactions within the patient and his family. Specific disruptions due to the chronic disability are the negative impact on self concept and sexual activity[6].

Sexual dysfunction in patients with chronic back pain can be basically divided into three categories according to etiology: neurological, pharmacological and psychological. Sexual dysfunction may result from actual damage to the nervous system, causing erectile dysfunction specifically. Shafer and Rosenblum[7] believe that disc disorders at the tenth thoracic to the first lumbar vertebrae will more than likely result in erectile dysfunction, but admit that the neurologic control of erection is so complicated that sexual dysfunction can occur as a result of injury at any level of the spinal cord from the cervical to the lumbar region. They concluded that the connection between herniated discs and erectile dysfunction might be found more commonly if the matter were thoroughly investigated. Golden[8] stated that anly lesion interfering with transmission of nerve impulses can cause dysfunction upon attempted intercourse, but in low back patients the nerve roots that transmit genital stimulation impulses are most commonly involved. Excessive scar formation from surgical procedures can interfere with nerve function and there is also the possibility of iatrogenic complications, especially with multiple surgeries. In the back pain patient with positive neurological findings of the sciatic nerve distruption; weakness of the dorsiflexors or plantarflexors of the foot or symptoms of neurogenic bladder associated with back pain, a complete sexual history should be elicited to ascertain the effects of any compressive syndroms on sexual function. Reassurance along these lines will help prevent a temporary disorder from becoming permanent for lack of treatment. Unfortunately, drug therapy is a major component in the management of chronic low back pain. Since the chronic pain syndrome is characterized by anxiety, depression and neuroticism[9], use of the major tranquilizers, such as the phenothiazines, along with the tricyclic anti-depressants is becoming well recognized[10]. More common is the use of the centrally acting skeletal muscle relaxants to control muscle spasm in the low back. A decrease in libido and impotence are not uncommon adverse reactions for any-one of the three classifications of drugs[11]. Most often, patients are unaware of the possibility of these side effects. Inhibition on the part of the physician or the patient to discuss sexual matters as they relate to current treatment can result in unnecessary anxiety over a condition that could be easily controlled or reversed. Ideally, use of prescription drugs in this group of patients should be judicious, following a complete medical and psychological evaluation including drug history and sexual history. The patient may be informed of potential adverse reactions if appropriate. Some of the psychological compo-

nents of the chronic pain syndrome have been noted above. Anxiety and depression have a known adverse effect on sexual functioning[12]. But, in addition to the anxiety associated with his condition, the chronic pain patient has another anxiety. If he or she is sexually active, there is a constant fear of the sudden exacerbation of pain or muscle spasm while in the act of intercourse. Awkward sexual postures necessitated by poor body mechanics or sudden movements involving hyperextension of the spine can cause severe pain and spasm resulting in loss of interest, loss of erection or loss of self-esteem. The effect of pain on one's capacity for satisfaction in sexual expression is decidedly negative and may lead to disinterest and avoidance of any sexual encounter.

This kind of performance anxiety requires knowledgeable, supportive therapy. To be of assistance, the health professional must have a thorough knowledge of the patient's medical condition and be able to answer questions about positioning in general and make helpful suggestions to the patient with low back pain. For example, positions that allow for lumbar spine extension are typically the most uncomfortable for this group of patients. Hyperextension, and rapid or twisting movements of the back tend to cause muscle spasm. For females with back pain, the supine position is usually easiest. For males, the inferior or more passive position helps decrease back pain. Theoretically, for patients with back pain the "spoon" or side position is most comfortable position for intercourse. This should be done only in the back-to-front position, as face-to-face positioning can cause hyperextension of the spine.

Other specific recommendations for the management of pain include local applications of heat,hot tubs, or moist packs to decrease muscle spasm. Paradoxically, ice wrapped in a towel or cooling aerosol sprays may also provide comfort. Use of a firm mattress or bedboard and support for the affected areas in the small of the back and legs with pillows should be stressed. Pillows should support the contour of the spine and legs, avoiding bony prominences. Judicial use of medication including relaxants, salicylates and sedatives may help relieve pain and muscle spasms. A program of extension exercises may be instituted, including diaphragmatic breathing, lifting the head and shoulders from the bed, and flattening the lumbar spine by contraction of the abdominal and gluteal muscles. The low back patients should be taught correct posture and proper body mechanics, especially when lifting heavy objects. If increased gravitational stress on the spinal column is secondary to obesity, health professionals should encourage a program of weight reduction and regular exercise compatible with age and physique.

Solving sexual problems of patients having chronic back pain can be the first step in encouraging the acceptance of a positive self-concept. If the patient is able to gain or regain his capacity to function sexually, he will have taken a giant step in reestablishing a positive self-concept.

Sexuality is a vital human characteristic. As outlined in this paper, the back patient is subject to neurological, pharmacological and psychological factors that could adversely affect sexual functioning. Recognition of the needs of the back patient in this area by sensitive professionals would be a new area and positive approach in the treatment of a major health problem.

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