

MINIREVIEW

SEXUAL DYSFUNCTION IN PATIENTS WITH PSORIASIS

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ABSTRACT

Psoriasis is a chronic inflammatory disease that affects the patients' quality of life. In psoriatic patients, the quality of life is generally low due to multiple co-morbidities, treatments, stigma and misperceptions about this condition. Sexual dysfunction, in both women and men, is a comorbidity that may impact the quality of life of these patients, in addition to those listed above. Because the recognition of sexual dysfunction by the patient can be difficult and considered shameful, it is necessary for the family doctor to intervene to improve the sexual health of these patients.

Keywords: psoriasis, sexual dysfunction, comorbidities.

RÉSUMÉ

Le dysfonctionnement sexuel chez les patients atteints de psoriasis

Le psoriasis est une maladie inflammatoire chronique qui affecte la vie des patients. La qualité de vie est généralement réduite en raison de multiples comorbidités, traitements, stigmatisation et fausses perceptions de cette maladie. La dysfonction sexuelle chez les femmes et les hommes est un changement dans la qualité de vie de ces patients en plus de ceux énumérés ci-dessus. Parce que la reconnaissance du dysfonctionnement sexuel par le patient peut être considérée comme difficile et honteuse, il est nécessaire que le médecin de famille intervienne pour améliorer la santé sexuelle de ces patients.

Mots-clés: psoriasis, dysfonctionnement sexuel, comorbidités.

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INTRODUCTION

Psoriasis is a chronic, inflammatory, disfiguring disease, with an estimated prevalence between 1% and 8.5% globally^{1,2}. Psoriasis is a chronic disease that affects patients' quality of life more than other chronic diseases, mainly due to skin damage.

World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social well-being related to sexuality; it is not just the absence of illness, dysfunction or infirmity³. For sexual health to be achieved and maintained, the sexual rights of all individuals must be respected, protected and fulfilled³.

One-fourth of patients with psoriasis have sexually-affected lives after the onset of psoriasis, regardless of gender. Sexual dysfunction is one of the causal factors in reducing the quality of life in patients with psoriasis, along with low self-esteem, anxiety, depression and suicidal ideation. Sexual dysfunction in psoriasis is influenced by factors such as the severity of psoriasis, psoriasis body area, associated physical and/or psychic comorbidities⁴. 40.8% of patients with psoriasis have sexual dysfunction⁵. Several dermatological conditions, in addition to psoriasis, may affect sexual function, including: lichen simplex, chronic eczema, vitiligo and chronic urticaria⁶. Some studies have reported both erectile dysfunction and impotence due to drugs used in psoriasis, such as methotrexate⁷.

In family doctor's practice, sexual dysfunction in patients with psoriasis is too little approached. From this point of view, it is necessary to make the family doctor aware of the risk of sexual dysfunction in these patients. Patients often feel uncomfortable about addressing this issue, and it is primarily necessary for the family doctor's initiative to initiate patient discussion on the subject. The subsequent approach depends on each patient and their needs, on the severity of psoriasis, the areas of the body affected by psoriasis, the associated comorbidities and the treatments followed.

SEXUAL DYSFUNCTION IN MEN

Erectile dysfunction is defined as persistence of the inability to achieve or maintain an erection during sexual intercourse⁸. Psoriasis affects self-confidence, due to the unattractive and embarrassing impression, especially in the case of exacerbation of psoriasis. Rejection due to psoriasis is encountered by 44.7% of men⁹.

The main cause of erectile dysfunction is considered to be atherosclerosis, but other factors such as psychosocial factors or lifestyle contribute to this dysfunction. Hormonal disorders also play an important role, especially in patients with psoriasis, which

is characterized by low levels of total testosterone and increased levels of estradiol¹⁰. Erectile dysfunction is also influenced by the presence of chronic diseases and by aging.

Psoriasis is associated with numerous comorbidities, such as dyslipidemia, obesity, metabolic syndrome, diabetes, hypertension, depression and a sedentary lifestyle. Hence, the question arises as to the extent to which erectile dysfunction is affected by the skin involvement in psoriasis and/or associated comorbidities, which themselves can lead to erectile dysfunction. On the other hand, erectile dysfunction is a cardiovascular risk marker, as compared to the cardiovascular risk exposure of a moderately smoker¹¹. Cardiovascular events may occur 3-5 years after the diagnosis of erectile dysfunction, the early diagnosis being important for the patient's cardiovascular approach^{12,13}.

As an independent risk factor, psoriasis in combination with arthritis (psoriatic arthritis) exposes the patient to a much greater risk of developing erectile dysfunction due to inflammation that sustains endothelial dysfunction, with vascular function being affected.

Besides the presence of arthritis, the severity of psoriasis is another factor that generally determines the degree of erectile dysfunction. However, one study showed the presence of erectile dysfunction in 46.6% of patients with severe psoriasis and 56% in mild psoriasis¹⁴.

There is a two-way relationship between psoriasis and periodontitis, where systemic inflammation produced by psoriasis can increase the severity of periodontitis, the outbreak of infection acting as a triggering factor in psoriasis (periodontal disease causes vascular endothelial infection, local growth of white cells, tissue growth factors and endotoxins, favoring atherosclerosis and erectile dysfunction)¹⁵.

SEXUAL DYSFUNCTION IN WOMEN

Due to the stigma that occurs in psoriasis, women have problems with sexual dysfunction, too. Still, the causal mechanism is not fully known and the assessment of the degree of sexual dysfunction in women is difficult to achieve.

Kurizky, in a study published in 2013, found the presence of sexual dysfunction in 68% of the 150 women with psoriasis who participated in the study¹⁶. Meeuwis et al found the sexual dysfunction present in 48.7% of 102 women with psoriasis¹⁷.

The Woman's Sexual Index Questionnaire evaluates: pain, desire, satisfaction, lubrication, excitement and orgasm; the most affected in patients with psoriasis is sexual desire while lubrication and pain are less common in patients with psoriasis^{16,18}.

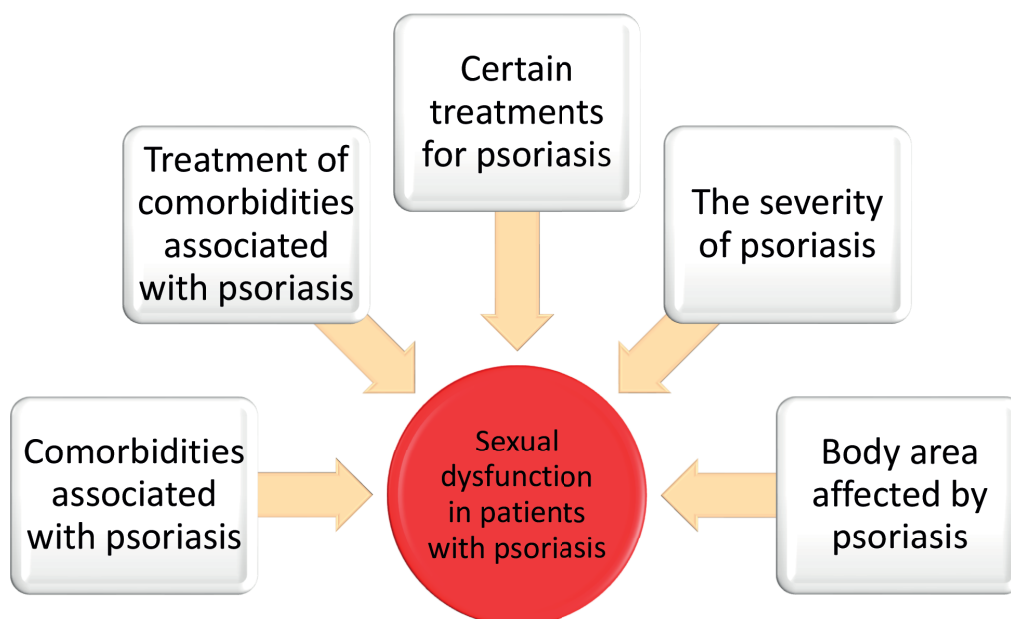


Figure 1. Possible influences on sexual dysfunction in patients with psoriasis

The topography of cutaneous lesions (especially the genital area, abdomen, thighs and back) plays an important role in sexual dysfunction. A prevalence of psoriasis at the genital level of 35%-42% was shown¹⁹. The presence of genital lesions in psoriasis generally does not interfere with sexual function, women experience a feeling of lack of attractiveness that causes them to have sexual dysfunction more frequent. Another factor to consider is the severity of psoriasis, with sexual dysfunction being more common in people with severe psoriasis compared to moderate and mild psoriasis²⁰.

Because psoriasis may be accompanied by pruritus, bleeding, desquamation, and joint damage, they may be considered as elements that are contributing negatively (depending on the severity of each individual) to sexual dysfunction.

Depression and anxiety are already seen as an important part of psoriatic disease. The psychological connection between psoriasis and sexual dysfunction is represented by depression. Increases in TNF- α and IL-1 in psoriasis may be associated with depression, depression and anxiety being proved to have a higher frequency in patients with psoriasis compared to the general population^{21,22}. It can be considered a chain response, psoriasis predisposing to depression and depression contributes to sexual dysfunction.

PERSPECTIVES AND DISCUSSION

Although there are not many studies regarding this issue, the treatment of psoriasis (both topical and

systemic) can influence sexual dysfunction in both sexes.

Some topical therapies may exhibit irritation and toxicity when used for genital psoriasis, topical corticosteroids (low potency), and calcitriol may give less atrophy or irritation in the genital area than high potency corticosteroids²³.

Sexual dysfunction and erectile dysfunction have been associated with the administration of methotrexate and etretinate/acitretin²⁴. Methotrexate is commonly used in the treatment of psoriasis. Decreased libido, infertility and impaired spermatogenesis have been mentioned as very rare adverse effects, in addition cases of erectile dysfunction and gynecomastia have been detected²⁵. In association with depression, treatment with isotretinoin, acitretin and etretinate has induced in some cases erectile dysfunction, which can be reversible^{26,27}. Also, especially in women, the possibility of vulvovaginal candidiasis due to medication should be considered, which may be an important factor in female sexual dysfunction.

Cyclosporine appears not to be associated with sexual dysfunction. Biological anti-TNF, ustekinumab and anti-IL-17A therapies improve sexual life in patients with psoriasis, most likely due to good treatment results, with the possibility of psoriasis remission^{28,29}.

Because psoriasis has many comorbidities, their treatment (non-steroidal anti-inflammatory drugs, antidepressants, H1 antagonists, muscle relaxants, proton pump inhibitors, anxiolytics and some anti-hypertensives) may affect the sexual function^{5,30,31}.

Al-Mazeedi et al in 2006 reported that sexual dysfunction was present in 38.9% of patients with severe psoriasis included in the study and 29.7% of patients with moderate psoriasis, while 30.8% of those with mild psoriasis had sexual dysfunction²⁰. This study is in contradiction with many other studies that have shown that the higher the severity of psoriasis, the lower sexual dysfunction is present.

Patients who have lesions in the genital area have a lower score in terms of quality of life than the rest of patients with psoriasis, as shown by Meeuwis et al¹⁷.

Gupta et al found in the group of patients with psoriasis and sexual dysfunction compared with patients with psoriasis without sexual dysfunction the following: decreased sexual activity after triggering psoriasis at 40.8%, presence of joint pain at 77%, significant presence of depression and higher tendency to consume alcohol⁵.

Guenther et al followed the frequency of sexual dysfunction according to the sex of the patient. After direct correction with the PASI score, the presence of sexual dysfunction in the female sex was revealed by 27.1% compared to the male with 20.8%²².

Although several authors associate sexual dysfunction in psoriasis with depression, sexual dysfunction due to depression has been reported to be about sex drive, while sexual dysfunction due to psoriasis has been associated with orgasm disorder, meaning that sexual dysfunction in psoriasis may not be related of depression¹⁸.

Sexual dysfunction in patients with psoriasis is complex, with components such as sexual intercourse involving psychological factors, and components such as erection and orgasm related to psychological and physical factors³².

The complexity of sexual dysfunction is evidenced by the low quality of life in most patients with psoriasis. The vicious circle is highlighted by the limitation of physical effort, mainly due to pruritus, irritation and pain, resulting in sexual dysfunction. Another component of the vicious circle is psoriatic arthritis that can lead to sexual dysfunction, due both to psoriatic lesions and also to joint pain^{20,33}. The fear of isolation and rejection, that many patients with psoriasis have, can also lead to sexual dysfunction, especially because of the patient's desire to hide the lesions³⁴.

Russo et al showed that 26% of patients with psoriasis face family tension due to the disease, but also with various workplace difficulties in 40% of the cases³⁵. Family tension leads to sexual dysfunction among partners.

Several studies have followed the sexual dysfunction in patients with psoriasis. These studies over

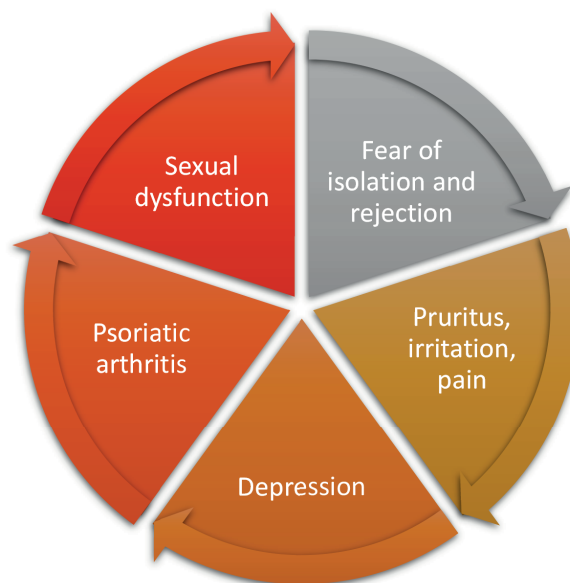


Figure 2. The vicious circle of sexual dysfunction in patients with psoriasis

time have found the prevalence of sexual dysfunction in psoriasis ranging from 22.6% to 71.3%^{4,36}.

Because family medicine pursues chronic patients, course of treatment, and has a general overview of the general state of the patient over time, it should primarily look at the occurrence of sexual dysfunction in these patients. Patients may be reluctant to discuss sexual dysfunction, but the same problem can be experienced by family doctors, who often have difficulty in directly addressing the sexual intercourse during the consultation^{37,38}. Family doctors can face difficulties in addressing sexual concerns due to lack of time, fear of offending the patient and to little knowledge on some sexual aspect³⁹.

Aschka et al found that only 12% of the patients studied had medical consultations for sexual problems, most of them prefer that the doctor to be the initiator of the discussion about sexuality⁴⁰.

CONCLUSIONS

Psoriasis affects the quality of life of patients on the physical, mental and sexual level. Sexual dysfunction among patients with psoriasis is common in both men and women. The causes of psoriasis-related sexual dysfunction are multiple, and more studies are needed to accurately determine the relationship between psoriasis and sexual dysfunction. It is obvious and necessary to address the patient in terms of sexual health. The evaluation and management of sexual dysfunction should start in the family doctor's office, and it is necessary to establish the limitations and involvement of the family doctor.

Compliance with Ethics Requirements:

„The authors declare no conflict of interest regarding this article“

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