

Let's talk about sex

(title of a song from 1991 by 'Salt 'n Pepa')

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Sexual dysfunction in general is associated with cardiovascular disease and cardiovascular risk factors. This has been well documented in the literature for many years now and therefore should be well known among cardiologists [1, 2]. The vascular cause of erectile dysfunction (ED) is endothelial dysfunction. ED may present several years before the symptomatic onset of coronary artery disease and may even be a marker for coronary artery disease [3]. It was also shown that satisfaction with sexual life is associated with a reduced risk of symptomatic coronary heart disease [4]. Yet the question 'How's your sex life?' often remains unasked in the outpatient clinic, and patients are often reluctant or too embarrassed to talk about sexual problems.

Nicolair and colleagues performed a survey among Dutch cardiologists and residents in cardiology to assess our knowledge about the negative and positive effects of cardiovascular drugs on sexual function [5]. They demonstrated that we as (future) cardiologists know little about these effects of 'our' cardiac medication. The negative side effects of beta-blockers are generally well known. But, and we must admit that we were not aware of this either, third-generation beta-blockers appear to have a positive effect on sexual function [6]. It has been suggested in several smaller studies that sexual dysfunction could improve during treatment with angiotensin II blockers in hypertensive and diabetic patients [7, 8]. However the investigators of the ONTARGET/TRANSCEND trial, who studied nearly 1550 male patients treated with telmisartan, ramipril or both or placebo, did not find a significant improvement in erectile function in the patients on trial medication. Their study results reaffirmed, however, that erectile dysfunction is a predictor of

cardiovascular death, myocardial infarction, hospitalisation for heart failure and stroke [9, 10].

The authors of the Dutch survey found that 41.9 % of the respondents indicated a need for training to increase their knowledge on sexual function in the patient with cardiovascular disease, so they would be better able to inform their patients [5]. It would be interesting to know the number of residents within this group of respondents. If most of the respondents who indicated the need for training were residents, this could implicate that sexual function is an underexposed subject in cardiology training. When we look at the educational program of Dutch cardiology residents, the textbook and Guidelines of the European Society of Cardiology (ESC) are mandatory literature. The textbook contains a whole chapter on erectile dysfunction although only little information is given about (side) effects of cardiovascular drugs on sexual function. And, as the chapter title says, it only mentions erectile dysfunction, and contains no information on sexual (dys)function in women [3]. In several of the ESC Guidelines one can find some information on sexual function and cardiovascular disease. From this information we also learn that to inquire about sexual function should be a part of the general vascular anamnesis [11]. Only recently, on 29 July 2013, a consensus document on sexual counselling for individuals with cardiovascular disease was published by the American Heart Association and the ESC Council on Cardiovascular Nursing and Allied Professions [12]. This document was published in both the European Heart Journal and Circulation and provides a very practical and useful overview on sexual counselling for patients with various kinds of cardiovascular disease and their partners. Besides the information in the ESC Textbook and Guidelines, sexual function is not a routine part of our national educational program, as this national program can simply not cover all cardiovascular topics and self-education is an essential part of the general cardiology training.

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Most studies about sexual dysfunction in cardiovascular disease concern male patients. This applies both for studies about sexual function while having a cardiac disease and about (side) effects of cardiovascular medication on sexual function. As is also mentioned by the authors of the Dutch survey, this is simply because erectile dysfunction, in contrast to vaginal dryness, is more easy to evaluate in validated questionnaires. In a recently published small study, 17 women who had suffered a myocardial infarction (MI) during the last 24 months were interviewed about their sex lives [13]. Often heard boundaries for these women to resume sexual activity after MI were fear of having another heart attack during sexual activity, and low desire which can also be attributed to symptoms of depression that started after the infarction. Most women in this small study indicated a need for information and a time-line as a guide for resuming physical activity including sexual activity. It appeared to be very much appreciated by the patients if their doctors addressed the subject of resuming sexual activity after MI. Of course this may be difficult to do during the first visit to the outpatient clinic after hospital admission, which is also often the first contact between patient and doctor, as the doctor in the outpatient clinic is often not the doctor who treated the patient during admission. The second visit will usually be several weeks later. To create a better access to the subject, the discussion should already be initiated by the cardiologist on hospital discharge. A lack of patient-physician communication appeared to be a larger barrier to improving sexual outcomes for women after MI rather than lack of information about safety. Therefore, apart from providing information on discharge, sexual activity questions must also be included in all cardiac rehabilitation programs. In our centre, resuming sexual activity after a myocardial infarction is indeed one of the subjects in our recently updated cardiac rehabilitation program.

The fact that both patients and their partners have a desire and need to receive information about a safe return to sexual activity after various cardiovascular events was concluded from multiple other studies as well. The AHA/ESC consensus document on sexual counselling provides practical information to further expand the general cardiac rehabilitation program with sexual counselling [12]. If a patient suffers from sexual dysfunction, this may sometimes require a more extensive approach than just providing information during a regular consultation or lowering the dose of the beta-blocker. A dedicated nurse involved in the rehabilitation program may provide more information in multiple consults for both patient and partner. A physiotherapist may help the patient in defining exercise limitations and relate those with sexual activity. The physician and also the pharmacist may help in finding medication alternatives where necessary.

Nicolair and colleagues provided us some insight into a probably very much underexposed subject in the outpatient

cardiology clinic. Part I of their article provides us with the facts of our knowledge, or better to say our lack of it, on (side) effects of cardiovascular drugs on sexual function. It also shows us how infrequently we inform our patients about the side effects of cardiovascular drugs on sexual function and how little opportunity we give our patients to talk about the subject. The authors clearly motivate the need for improvement in cardiologists' knowledge about the sexual (side) effects of cardiovascular drugs. We are very much looking forward to Part II, the educational review on the effects of cardiovascular drugs on sexual function and hope this will fill the gap in our knowledge and will help us to be more proactive in addressing bedroom talks in the consulting room.

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