-

Sex

Sex

It is commonly believed that too much excitement can lead to a heart attack and it is therefore not surprising that many couples (up to 40%) abandon sex after one of them has had an MI, heart surgery or other heart trouble. The Heart Manual has a section on sex with information on resuming sex after a heart attack or revascularisation. It generally encourages patients to resume sexual activity when both partners feel willing after heart attack or angioplasty and at least six weeks after a bypass.

Some cardiac medication such as hypertensive agents, diuretics and beta-blockers may have side effects which can interfere with sexual performance, although more recent analysis has revealed that often there is indeed another underlying cause. such as depression, smoking and low levels of fitness. (Byrne, Doherty, Murphy, McGee, and Jaarsma, 2013). Patients mentioning problems with erections and who are on these medications should be referred to their general practitioner to see if a change of prescription can help. If long-standing sexual problems are mentioned then referral to a sexual dysfunction clinic or clinical psychologist would be recommended.

Sexual difficulty such as erectile dysfunction is a risk factor for cardiovascular disease of the same size as smoking. However, after a cardiac event, fear of a heart attack may be another cause of sexual problems. Sexual activity can trigger a myocardial infarction, but the risks are fairly low. In a systematic review and meta-analysis of studies on triggers of acute cardiac events, during the period of actual sexual activity, the relative risk (RR) of MI has been found to be 2.70 (the hazard period, 2hrs before the MI compared to the control period, the period when the MI did not occur). However, the absolute increase in risk of an MI is not large. This is because the length of exposure to sexual activity is very short (Dahabreh and Paulus 2011). In the SHEEP study, the risk of reinfarction within one year was found to be 10.5% for those people surviving the first 28 days after the infarction. The increased absolute risk to those people if they engage in sexual activity once a week would be 0.24%, therefore the increase in absolute risk is very small. This small increase could be further reduced if the patients engaged in regular physical exercise (Moller et al. 2001). A review of the research in this area has shown that these rates are more applicable to men; the risks for women are lower than for men (Niederseer et al. 2012).

 © The Heart Manual and NHS Lothian 2016

Post MI, men tend to have concerns over performance whereas women may have concerns over lack of arousal or desire. Sexual activity may be considered as any other physical activity in terms of strenuousness. A comparison study of physical stress during sexual intercourse and treadmill testing found that heart rate and blood pressure is approximately 75% of maximum treadmill testing. Most participants perceived their level of exertion to be moderate and substantially less than the treadmill demands (Palmeri et al. 2007).

Often the exertion levels have been compared to climbing two flights of stairs; however much of the evidence is based on young to middle-aged individuals, therefore this might not be generalised to those who are older and less fit. It is wise then to take into account the individual’s capacity for physical activity (Steinke, Jaarsma, Barnason et al 2013). Please see chapter on Physical Activity and Exercise for more information on this topic.

A paced approach is recommended after an MI or surgery. There are increased risks associated with an unfamiliar or much younger partner in an unfamiliar environment. Excessive eating and alcohol consumption may also increase the risks. The greater the number of other risk factors, the greater the risk of sexual activity triggering an MI. Again each individual patient may need to have tailored advice.

Although cardiac nurses feel responsible and are not anxious discussing patients' sexual concerns, these issues are not often discussed in daily practice, in the main for concerns about embarrassing the patient (Levine et al 2012). Patients often do want to discuss but health professionals don’t consider themselves the right person for the job? Cardiac rehab nurses are in the prime position to help address these issues (Byrne et al 2013).

Professionals who carry out sex therapy are used to talking about sex, and after a few minutes embarrassment the great majority of patients are able to do so as well. The facilitator could adopt the same bold approach with the same results. Signs of embarrassment on the part of the patient may be vagueness, not directly tackling the subject, blushing and fidgeting. By appearing non-judgemental and unembarrassed the facilitator can help the patient discuss the issue.

The great majority of patients will not find a simple question offensive, such as ‘Has this affected your love life? A ‘yes’ should be followed by a question such as

‘How do you feel about that? Some patients will volunteer the nature of the problem, with others you will need to ask ‘Is it because you don’t feel well enough yet or because you are having problems when making love?’ It is important to explore the patient’s view of the situation and not to make assumptions of their expectations of sexual activity based on their age, religion or sex. It is also important to realise that for many couples the cardiac problems may have come as a welcome excuse for giving up what has become a non-pleasurable activity.

Jaarsma et al (2010a) have collated a selection of different styles and approaches to start the assessment of sexual problems in cardiac patients, namely the gradual approach, the matter-of-fact approach, a context approach, the sensitive approach and policy approach.

The gradual approach involves asking about more general sexual concerns before proceeding to more sensitive issues. The matter-of-fact approach uses other people’s experiences or research evidence to prompt discussion; for example, saying something like, ‘Many people have concerns about starting sexual activity again after an MI, what concerns do you have?’ thus normalising having the concerns. The context approach would involve raising the topic within the wider topic of exercise or medication (e.g. side effects such as impotence). The sensitivity approach would directly address the issue of difficulty or potential embarrassment by saying something like, ‘some people find talking about sex difficult, however we recognise that it may be an important element in your life, is it alright to talk about this topic?’ Finally the policy approach would be to state that it is routine to ask all patients on our programme about sexual activity and the effects of treatment. Discussion and feedback on Jaarsma et al’s (2010b) paper during Heart Manual training sessions with health professionals who are experienced with working with cardiac patients, highlighted the fact that all these approaches can be and indeed *are* used interchangeably or in combination depending on the patient and their situation. Or discussions also highlighted that cultural context is very important. The information in the Heart Manual allows the patient to read the information on sex with privacy. We are aware that there may be cultural differences in attitudes to dialogue concerning sexual issues. For example the open discussions recommended in European and American guidelines may not be easily applicable in Middle and Far Eastern countries. In some areas patients may not be willing to discuss sexual difficulties with a health professional of the opposite sex. We therefore need to be mindful of these

 © The Heart Manual and NHS Lothian 2016

sensitivities according to the cultural context. Written information therefore may be more welcome where such sensitivities exist.

The skills needed in motivational interviewing such as listening, empathy and a non-judgemental approach are useful when discussing sexual issues (see Motivational Interviewing section). The main 'take home' message is that although not uncommon, there is plenty that can be done to address sexual problems, with the right help. Having established that there is a problem and that the patient wants to do something about it, you should refer the problem to the most appropriate person – a cardiologist/general practitioner for medication change or a sex therapist, psychologist, or other consultant. Please see contacts on sexual health in 'Useful Organisations' (Appendix 1).

References

Dahabreh, I.J. and Paulus, J.K. 2011. Association of episodic physical and sexual activity with triggering of acute cardiac events: systematic review and meta-analysis. *Journal of the American Medical Association*, 305(12) pp. 1225-1233.

Byrne, M., Doherty, S., Murphy, A.W., McGee, H.M. and Jaarsma, T., 2013. The CHARMS Study: cardiac patients' experiences of sexual problems following cardiac rehabilitation. *European Journal of Cardiovascular Nursing*, p.1474515113477273.

Jaarsma, T., Steinke, E.E. and Gianotten, W.L. 2010a. Sexual problems in cardiac patients: how to assess, when to refer. *Journal of Cardiovascular Nursing*, 25(2) pp. 159-164.

Jaarsma, T., Stromberg, A., Fridlund, B., De Geest, S., Martensson, J., Moons, P., Norekval, T.M., Smith, K., Steinke, E., Thompson, D.R. and Unite Research Group. 2010b. Sexual counselling of cardiac patients: nurses' perceptions of practice

responsibility and confidence. *European Journal of Cardiovascular Nursing*, 9(1) pp. 24-29.

Steinke, E.E., Jaarsma, T., Baranson, S.A., Byrne, M., Doherty, S., Dougherty, C.M., Fridlund, B., Kautz, D.D., Martensson, J., Mosack, V., Moser, D.K. on ehalf of the Council on Cardiovascular and Stroke Nursing of the American Heart Association and the ESC Council on Cardiovascular Nursing and Allied Professions (CCNAP). 2013. Sexual Counselling for Individuals With Cardiovascular Disease and Their Partners. *European Heart Journal* 34 (41) 3217-35.

Levine, G.N., Steinke, E., Bakaeen, F.G., Bozhurt, B., Chetlin, M.D., Conti, J.B., Foster, E., Jaarsma, T., Kloner, R.A., Lange, R.A., Lindau, S.T., Maron, B.J., Moser, D.K., Ohman, E.M., Seftel, A.D., Stewart, W.J., American Heart Association Council on Clinical Cardiology., Council on Cardiovascular Nursing., Council on Cardiovascular Surgery and Anesthesia and Council on Quality of Care and Outcomes Research. 2012. Sexual activity and cardiovascular disease: a scientific statement from the American Heart Association. *Circulation*, 125(8) pp. 1058-1072.

Moller, J., Ahlbom, A., Hulting, J., Diderichsen, F., De Faire, U., Reuterwall, C. and Hallgvist, J. 2001. Sexual activity as a trigger of myocardial infarction. A case-crossover analysis in the Stockholm Heart Epidemiology Programme (SHEEP). *Heart*, 86(4) pp. 387-390.

Niederseer, D., Moller, J. and Niebauer, J. 2012. Increased rates of myocardial infarction and death in men after sexual activity. *International Journal of Cardiology*, 156(2) pp. 234-235.

Palmeri, S.T., Kostis, J.B., Casazza, L., Sleeper, L.A., Lu, M., Nezgoda, J. and Rosen, R.S. 2007. Heart rate and blood pressure response in adult men and women during exercise and sexual activity. *American Journal of Cardiology*, 100(12) pp. 1795-1801.

 © The Heart Manual and NHS Lothian 2016