

CHAPTER 31

Sex and Medical Conditions

Pregnancy and childbirth can dramatically affect sex. This is dealt with in some detail in the chapter devoted to pregnancy but the basic rules can be summarised as: follow doctor's orders; make sure you both know what the other thinks and wants; remember that sex is more than vaginal intercourse and be creative in your lovemaking; be romantic; and be patient.

Most women show some sort of cyclic pattern of sexual desire related to the menstrual cycle and it is very useful for a woman to know her cycle and to use it. Premenstrual syndrome affects many women and turns them off sex. However, lovemaking, particularly orgasm, at this time can often make them feel considerably better.

When you have a cold or the flu, the body throttles back desire by reducing circulating levels of circulating sex hormones. If the illness lasts long enough, it even curtails sperm production and ovulation. If, despite this, you still feel like sex, you should at least try to avoid giving it to your partner by avoiding intimate contact during the first three days and by keeping face-to-face contact and wet kissing to a minimum.

Many chronic illnesses and/or their treatments, and some disabilities, can interfere with sexual functioning. If this is the case with you, you should talk to your doctor frankly and openly. If he or she cannot help, you should not hesitate to consult a sex therapist. It is important that you don't react to your illness or disability by withdrawing into yourself; under these circumstances, affection is even more important than usual. So is having a positive attitude. Thinking about sex and masturbating will help you restore your sexual responsiveness.

The bad effect of alcoholism and alcohol abuse on sex has been explored in some detail in previous chapters. In addition, it is obvious that they almost invariably lead to relationship problems which make satisfactory sex even more unlikely.

Hysterectomy, the removal of the womb, can sometimes lead to decided improvement in a woman's sex life, especially if the medical problem that led to the surgery involved painful intercourse, lengthy menstrual periods, or episodes of uterine bleeding or cramping. Also, women who were worried about the possibility of developing cancer of the cervix or womb or were afraid of becoming pregnant may well find their sexual interest and responsiveness improved significantly. However, in some women, the psychological impact of losing what to them is a sexual organ as well as a reproductive one can lead to depression. Some women complain that their orgasms feel different after a hysterectomy. There is some physiological basis for this in that the uterus contracts vigorously during orgasm. Women who previously experienced 'deep orgasm' from contact of the penis with the cervix feel this loss more acutely. Sexual difficulties may be even more acute where the ovaries have also been removed, both because of the emotional impact and because this brings on a menopausal or post-menopausal state, with hot flushes and vaginal dryness and, sometimes, decreased sexual arousal. These problems can be fixed with oestrogen replacement therapy. Overall, experiences of women undergoing hysterectomy and ovary removal are pretty evenly split between those who describe sexual problems after surgery, those who have improved sexual responsiveness and those who notice no difference. If hysterectomy does diminish your sex drive, you should consult your doctor. If he or she doesn't listen and won't explain all treatment options, including oestrogen and testosterone replacement therapy and alternative therapies, see another doctor until you find one who will. If your lack of sex drive persists after treatment, you should see a therapist, particularly if you also suffer from depression. It has been convincingly argued that up to ninety percent of hysterectomies are unnecessary, so make sure your's is necessary before you agree to the operation.

Any form of cancer can be devastating to one's sex life - and to one's partner's. Not only is there a possible effect from the cancer itself but cancer treatments, of whatever kind, frequently cause problems. In men, the most common problem is impotence, which may resolve with time or may be permanent - in which case, non-coital sex is the only alternative. Women frequently

suffer from painful intercourse. Sometimes, trying different positions, using oestrogen replacement therapy and/or plenty of lubrication and/or (in the case of pelvic fibrosis) regular vaginal dilation can help. Again, the solution may be non-coital sex, at least until things have repaired themselves. Kegel exercises can also help but the most important factor is having a warm and supportive partner.

Breast cancer can have a negative effect on sexuality. This is not only because of the trauma associated with any major illness (especially one that may be fatal) and the side effects of treatment, but also because of the fact that the whole or part of a breast is usually removed. Many women feel that they are less sexually attractive because of this and may feel uninclined to be seen naked or to be touched on the breasts - even the uninvolved one. Fortunately, the old radical mastectomy operation in which the whole breast was removed - and, often, much other tissue besides - has largely been replaced by a lumpectomy, where only the tumour itself is removed. Reconstructive breast surgery is also usually quite successful. It is important to be as informed as possible about the operation and its effects before you have it. After the surgery, a sex therapist can help, as can sensate focus. Joining a programme like the American Cancer Society's Reach to Recovery programme, which matches volunteers who have had a breast removed more than a year earlier with women who have just had one, can be very beneficial.

Young women diagnosed with breast cancer have a poorer prognosis than older women. A large study has found that this is the case even if their tumour is classified as 'low-risk'. But the added risk of youth is cancelled out if chemotherapy is given following surgery.

Surgery in prostate cancer results in postoperative erectile failure in 40-100 percent of cases, depending on the exact type of surgery performed. Radiation treatment and oestrogen therapy also produce high rates of sexual dysfunction. Considering that, in at least three-quarters of cases, prostate cancer does not spread and does not cause death, there is considerable debate on the conditions under which treatment should be attempted.

Prostatectomy is one of the commonest operations performed on men over sixty. Much of this surgery is for benign prostatic hyperplasia, where the prostate is swollen but not cancerous. Transurethral prostatic resection causes impotence in about five percent of patients and urinary incontinence in about four percent. About ninety percent no longer ejaculate to the outside but instead ejaculate into the bladder. Since research showed a higher death rate in the five years following this operation, there has been renewed interest in finding alternatives, including the use of small balloon-like devices to dilate the prostate and the use of laser or microwaves to remove tissue. A drug, Proscar, is also used as an alternative, but this also has its drawbacks, 5-6 percent of users developing a significant drop in their sex drive, about four percent having inhibited ejaculation and 4-5 percent developing erectile failure. Many of these operations could have been avoided if the condition had been diagnosed and treated early enough. Diet and exercise can help reduce the symptoms and eliminate the need for surgery. Men (and their partners) should become informed about the condition and should not avoid lovemaking because they believe their problem will affect sexuality.

Another common problem that particularly affects men is the heart attack. A man suffering angina during sex is not going to enjoy it, and neither is his partner. This problem can be alleviated with drugs but these can occasionally interfere with erections. A much more common problem is the fear (in both partners) that sex will precipitate a heart attack. This is the reason 50-75 percent of people either curtail their sex lives or eliminate intercourse altogether after a heart attack - and it is usually the spouse, not the patient, responsible for the curtailment. This fear is usually unfounded. Anyone who has suffered a heart attack should be guided by his (or her) doctor about activity during recuperation (although only about half of patients receive any advice from their cardiologist about sex during recovery) but, generally speaking, the moderate exertional demands of sex should be no more limiting after a heart attack than after any other event requiring hospitalisation. The great majority of deaths from heart attack occurring during sex are in men having sex with much younger women not their regular partner and when

they were at least partly intoxicated. Only about twenty percent of patients need to limit sex to some extent. Most patients resume sex at about eight weeks after a bypass operation. About half have sex at about the same rate as before, forty percent less often, and ten percent more often. It is advisable to avoid sexual activity for at least an hour after eating, to avoid alcohol, to rest first, to make sure your surroundings are comfortable, to go slow and to let your partner do the work for at least the first few occasions. Taking an angina drug shortly before sex can reduce both the pain and the apprehension but some of these drugs can cause erection problems. If your partner is hard to convince of your fitness, it can be useful if you can arrange for her or him to watch you do an electrocardiographically monitored exercise test. You should consult your doctor if you experience rapid heartbeat and rapid breathing persisting ten minutes or more after intercourse; if you have a feeling of extreme fatigue that lasts to the next day; or if you experience dizziness, light-headedness, irregular heartbeats, blackouts or chest pain during or after sex.

About half of men with diabetes experience erectile dysfunction. However, perhaps in as many as twenty percent, bringing the diabetes under control will resolve the impotence. But if the diabetes is uncontrolled for a long enough period (and this is cumulative), permanent impotence may result from microscopic damage to the nerves controlling erection. Damage to nerves supplying the urinary bladder also causes retrograde ejaculation, though this occurs in only about one percent. Unfortunately, nothing can be done to reverse the nerve damage. Diabetic women can also suffer sexual difficulties due to nerve damage reducing sensory efficiency; they have difficulty achieving orgasm except under a very strong stimulus (e.g. a vibrator). They also tend to suffer reduced vaginal lubrication and chronic vaginal yeast infections.

About half of arthritis sufferers complain that it interferes with their sex lives. This is usually because pain interferes with things, but cortisone treatment and some other anti-inflammatory drugs can also suppress erection. Most arthritis sufferers can still enjoy sex by using painkillers, loosening up with exercises, warming up with a warm bath or shower, staying warm with an electric blanket or other means, experimenting to find the best times and positions and lubricating well. Non-coital sex may deserve a greater emphasis than usual, including plenty of just touching. However, the biggest problem for arthritics regarding sex can sometimes be an overly solicitous partner, who can become so afraid of causing pain as to be almost afraid to touch. Good communication between partners is essential.

Very similar remarks apply to people with back pain and, indeed, chronic pain in any part of the body.

These kinds of problems are even more acute for many people with handicaps. We often tend to see people with disabilities as asexual but their needs for physical intimacy are often greater than those who are not disabled. In some cases, intercourse is just not possible but this does not lessen the need for hugging and holding and warm, tender intimacy - spiced, if possible, with nonintercourse sex. It is the disabled person's responsibility to educate their partners to their sexual needs and how they can be met.

Stress is deadly to sex because it increases the production of hormones that cause muscles to tense, heart rate and respiration to speed up and blood vessels to constrict, squeezing off the blood flow to the extremities and such parts non-essential to personal survival as the penis and other genital organs. Testosterone levels also drop significantly. The stress-induced presence of distracting thoughts also impairs sexual responses. Some things that can lessen the effects of stress on sex include: going back to dating; not leaving sex until last thing at night; using massage; exercise; making a determined effort to change just one thing that is stressing you; get the kids to bed; find some activity in which you can lose yourself.

These days, with many couples working long hours and with numerous outside activities as well as home responsibilities, fatigue may well be the most common reason for lack of quantity and quality in a couple's sex life. Forty-two percent of Australian men feel their job has a negative effect on their sex life. If this is the case, perhaps the first thing you should consider is dropping some activities if possible. Otherwise, you should plan some time for sex. This doesn't

have to be when you go to bed, but it helps if you can at least synchronise bedtimes. If you can't, make an effort to arrange some time when you can be together alone - even if that means both checking into a hotel for the night. However, if you can't blame your tiredness on hard work and lack of sleep, you should visit your doctor and have the problem thoroughly examined. There are a number of medical problems that can cause chronic fatigue - anaemia, drug side effects, infections of various kinds, and many others - including the still controversial 'chronic fatigue syndrome'. This latter (ill-defined) condition is likely to eventually prove to have a range of causes. The best-proven treatments are exercise and cognitive behavioural therapy. Prolonged rest probably doesn't help and may make things worse.

The majority of depressed persons experience a marked reduction in their sex drives (even to men having fewer nighttime erections) but overt sexual dysfunction occurs in less than a third of cases. The most common sexual difficulty in males is inhibited ejaculation, while inhibited orgasm is most common in women. The capacity for enjoying sexual fantasies is often lost. Unfortunately, virtually all the antidepressant drugs can affect sexual functioning adversely in both males and females, although this problem occurs in only a small minority of patients. For this reason, you may do better with a good psychologist or sex therapist than with a psychiatrist - combined with plenty of exercise. Talking to partner and friends, improving your diet, and showing and seeking affection can all help. Rather than waiting to feel sexual, initiate some form of lovemaking and you may well find yourself feeling the desire to continue. If you don't, just continue showing affection and enjoying the intimacy.

On the other hand, during a bout of mania (which typically lasts for weeks or months), hypersexuality is common in both males and females, who may (usually quite uncharacteristically) have sex with numerous partners, including with total strangers. Lithium calms the mania and also the hypersexuality (by decreasing testosterone levels in the blood; in males, this causes erectile problems and decreased sexual desire).

Anorexic females typically show little or no interest in sex; in fact, they often appear frightened of sex. Most anorectic females avoid dating, do not masturbate and have no desire to give up their much-coveted virginity. Adolescents with anorexia nervosa are often shy and withdrawn and appear childlike in their social interactions. In some cases, a history of sexual abuse or assault precedes the development of anorexia. Even among married adult anorexics, avoidance of sex is common and sexual dysfunctions such as inability to reach orgasm or vaginismus are frequently seen. It is possible that it is the very fear of sex that triggers the anorexia. The anorexic female actually makes her body regress sexually by severely restricting her food intake. She can postpone the onset of puberty or make her menstrual periods stop and her breasts shrink by losing a lot of weight, thus suppressing the production of luteinising hormone, follicle-stimulating hormone and oestrogen. A similar thing happens in male anorexics, where testosterone levels are kept low and the development of such secondary sex characteristics as facial hair and lowering of the voice is delayed.

On the other hand, many bulimics are sexually normal though, overall, bulimics do tend to have a relatively high rate of sexual dysfunction and inhibited sexual desire.

Lots of people who suffer from anxiety disorders have sexual problems. Unfortunately, most of the drugs used for treating anxiety can also adversely affect one's sex life. The exception is buspirone (Buspar), which actually boosts sexual desire in many patients. Such non-drug therapies as biofeedback, meditation, progressive muscle relaxation and guided imagery can also help relieve anxiety without interfering with sexual function.

The old 'not tonight, dear, I've got a headache' line is thought of as the classic excuse and sometimes it is but certainly a headache is a definite sexual turn-off. However, most headaches respond well to appropriate medication and, if you regularly get them, you should consult your doctor. Sex can also give you a headache - especially if you are a man; they are four times as frequent in men as in women. Some of these are caused by tension in the neck muscles during sex and can often be relieved and prevented by learning muscle relaxation techniques (a good

physiotherapist can help). Vascular headaches are caused by the increase in blood pressure occurring during sex and can cause a sudden, explosive pain at orgasm. They can be relieved by propranolol or anti-migraine preparations. Postural headaches are the opposite side of the coin and are caused by low blood pressure to the brain during sex in seated or standing positions, which can also cause fainting. Sex also increases the potential for drugs to cause headaches by raising or lowering blood pressure. These include alcohol (especially histamine-containing red wine), cocaine, marijuana, nitrates and nitrites, and some prescription drugs. Most of these headaches are pretty harmless and go fairly rapidly after the cessation of sexual activity, but if they happen to you regularly or are particularly severe, you should consult your doctor.

Keeping yourself as healthy as possible will certainly improve your sexuality. Make sure your diet is right and you take sufficient exercise (however, consult your doctor before going on a diet regimen or exercise programme). Start with moderate exercise you can easily build into your day, involve your partner and don't take any excuses - from yourself or your partner.