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INVITED COMMENTARY

Sexual health after myocardial infarction: from an overlooked stigma to a professional advocacy action

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This invited commentary refers to 'Sexual life experiences after myocardial infarction: a systematic review and synthesis of qualitative studies', by E. Arıkan and G. Yavaş https://doi.org/10.1093/eurjcn/zvae101.

Introduction

Myocardial infarction (MI) may have adverse effects not only on cardiovascular and body functions, but also on emotional status, even touching sexual health, fundamental to general well-being.[1] After a cardiac event, patients often encounter substantial challenges in resuming sexual activity, due to several factors for both biological genders.[2] Erectile dysfunction frequently precedes and accompanies coronary artery disease in male subjects, as both conditions share a common vascular pathogenesis.[3] Myocardial infarction also has a negative impact on females especially on the frequency and satisfaction of sexual activity and leads to sexual dysfunction also linked to hormonal status in the pre- or post-menopausal period, and psychologic factors.[4] Both sexes may experience increased anxiety about the safety of sexual intercourse after MI, which can be alleviated by appropriate counselling.[5] Steinke *et al.*[6] conducted a cross-sectional study in 2015, with 211 cardiac patients, to examine the role of psychological factors, comorbidity, and medications in cardiac patients and their association with changes in sexual activity. These authors identified that various cardiac medications, such as diuretics, renin–angiotensin–aldosterone antagonists, calcium channel blockers, and beta-blockers, adversely affect sexual functions. Comorbidities such as diabetes mellitus, chronic sexual infections, or benign prostatic hyperplasia can further contribute to sexual dysfunction.

Arikan and Yavaş[7] should be congratulated for their exhaustive report on the perspectives of post-MI patients on sexual health experiences and related challenges in the *European Journal of Cardiovascular Nursing*. Their focus on this relevant and overlooked topic paves the way for prospective studies on the sexual health concerns of cardiac patients and their partners, as well as the challenge of healthcare professionals in providing sexual counselling. The issue is persistent around the world, emphasizing the need for further research and training of healthcare professionals to improve the sexual health, recognized as fundamental for quality of life of cardiac patients. The existing gap in the continuum of patient care can also be attributed to the lack of dedicated guidelines that can be applied in real scenarios.

Changes, barriers, needs, and solutions

The review by Arikan and Yavaş included 12 studies that highlighted 4 main themes, which could be represented as a 'Lack of Education Domino Effect' (*Figure 1*), triggered by the subjective abrupt perception of the state of the disease, as well as by the lack of personal resources to deal with these changes, also in their sexual lives. This perception dramatically changes the patient's approach to sexual activity, being associated with fear, anxiety, depressive reactions, or with disease-attributable sexual dysfunction and medications factors.

These elements, all read together, define a still unmet need for information and education about sexual life after MI, currently not adequately addressed by medical doctors and health professionals during hospitalization. The authors' findings are consistent with previous knowledge in the literature; for example, in another recent review of the literature, Inayat *et al.*[8] identified that advanced age, fears of having another MI and uncertainties regarding the resumption of sexual activity, lack of sexual

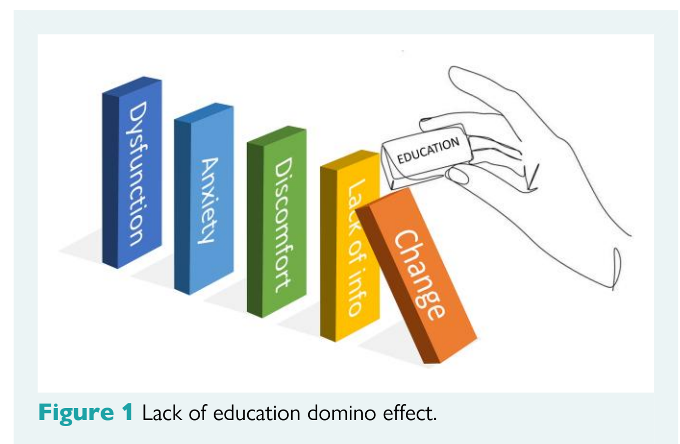

Figure 1 Lack of education domino effect.

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health education and counselling, and ineffective sexual health communication between partners were the key determinants of sexual health and quality of life among patients with cardiovascular surgeries.

Reinforcing the notion that these issues do not vary by latitude, although they can be exacerbated by social and cultural habits or gender issues, while knowledge of the differential impact on heterosexual or not subjects is still lacking.[6,9,10] The universality of the issue highlighted by the authors confirms the urgency of a solution to the problem, also supported by another recent study, underscoring the lack of interventional trials that could effectively impact clinical practice.[11]

There are several reasons why healthcare professionals may avoid addressing the topic of resuming sexual activity after MI, beyond the scarcity of an empathic attitude. Primarily, embarrassment can arise from discussing topics perceived as too intimate and personal to the patient, indicating a lack of adequate training to handle such sensitive topics. Additionally, it is essential to identify both for doctors and nurses the respective, complementary roles in dealing with the matter, the modality to handle a personalized counselling, the necessary skills, and the timing for this discussion (e.g. at hospital discharge, during rehabilitation, and at follow-up appointments). These uncertainties appear to contribute to a situation where, up to date, no one takes responsibility for addressing the problem at any stage of the care pathway.

Secondly, it is important to consider the different perceptions of the importance of resuming sexual activity for the patient or the healthcare professional. For the latter, this topic often takes a backseat and is not prioritized in patient guidance, unlike recommendations on lifestyle or medication adherence. It is evident that sexual health consultation is not currently part of the standard of care pathway for people experiencing MI. However, within a patient-centred approach and a focus on quality of life, beyond mere longevity, sexual health is a matter that can no longer be overlooked or dismissed. Most importantly, it must be addressed by competent professionals who possess the knowledge necessary to engage with the topic, considering cultural and gender-specific factors.

The article by Arikan and Yavaş is a call to action, highlighting the need for the integration of sexual health as a therapeutic target in all cardiovascular patients, moving forward the indications of scientific societies.[12] We hope that in the near future trials or implementation studies will evaluate the effectiveness of the most appropriate interventions, such as counselling, education, and individual or couples' consultations, with the goal of a holistic, personalized approach of care, to heal not only the diseased heart, but even the lone soul of the patient. These interventions should be designed with the consideration of various orientations and, therefore, involve the expertise of specialists, such as sexologists, who can be involved in the care pathway.

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Author contributions

Angela Durante, (Conceptualization [lead], Writing—original draft [lead], Writing—review & editing [lead]), Shahzad Inayat (Conceptualization [equal], Writing—original draft [equal], Writing—review & editing [equal]), and Michele Emdin, professor (Conceptualization [equal], Writing—original draft [equal], Writing—review & editing [equal]).

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Data availability

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