Sex, drugs and the medical role: A case report of a man prescribed Alprazolam following stroke

Natalie Hamam[1,2]

1. The University of Sydney, Health Sciences

2. Family Planning Victoria, Box Hill, Melbourne, Australia

CASE REPORT

Please cite this paper as: Hamam, N. Sex, drugs and the medical role: A case report of a man prescribed Alprazolam following stroke. AMJ 2011, 4, 11, 608-609
http://doi.org/10.21767/AMJ.2011.1045

Corresponding Author:
Natalie Hamam
Family Planning Victoria
PO Box 1377
Box Hill, Victoria 3128
Australia
Email: nhamam@fpv.org.au

Abstract

It is well-known that sexual dysfunction can result from many classes of drugs including sedatives, anti-hypertensives and anti-depressants. Untreated sexual dysfunction can lead to patient distress.

A 64-year-old man with a history of a left cerebrovascular accident participated in a qualitative research study on sex after stroke. He had been experiencing sexual dysfunction for four years.

Discussions with the patient were difficult due to his expressive dysphasia. The researcher asked him to re-visit his general practitioner (GP) who reviewed his medications and changed the prescribed sleeping tablet. Sexual function returned within a week. This case report highlights the contribution of medication to sexual dysfunction and the need for doctors to initiate conversations about sexual concerns.

Key Words

Sexual dysfunction, doctor-patient communication, stroke, sleeping tablets, expressive dysphasia.

Background

Many doctors acknowledge that talking with patients about their sexual concerns is important but it often remains difficult to address.[1] There are many reasons for this including lack of knowledge, lack of time and embarrassment.[1,2] While it is assumed that patients will raise their concern if it is important, frequently this does not occur. [3] Additional barriers such as expressive dysphasia can make it even less likely that patients would initiate a discussion about sexual function. Some doctors and practice nurses report thinking that discussing sexual concerns will be highly problematic and complex and not fit in with the constraints of time in primary care.[3] Sexual dysfunctions including erectile dysfunction, changes in desire, inhibited ejaculation and anorgasmia are well-recognised side effects from hypnotics and anti-depressants, including Alprazolam, a benzodiazepine. Experiencing sexual dysfunction can be distressing for patients,[4] particularly when they are unaware of the cause and are unable to express their concern.

Case details

A 64-year-old man with a history of a left cerebrovascular accident five years earlier presented with erectile dysfunction to his local disability support organisation. He volunteered to be part of a qualitative study investigating sex after stroke that was advertised by the organisation. His residual disabilities included right-sided muscle weakness and expressive dysphasia. He walked with a cane and required some assistance with self-care. The patient was divorced and lived alone.

An interview was conducted by the author/researcher with the patient and his support worker who knew his communication style well. The patient communicated with single word speech, actions, and responses to direct yes/no questions. Care was taken to check and re-check the meaning of his responses. Through the interview process the patient described a number of symptoms: erections were not spontaneous and not as firm as before; arousal was slow; reaching ejaculation could take 20 minutes or

more; and ejaculation and/or orgasm could not always be achieved. The researcher suggested consulting his GP to review his medications. The support worker wrote a letter to the GP explaining the patient's concerns. The GP changed his medication from Alprazolam to Fluvoxamine.

The patient participated in a follow-up interview one month later and reported that his sexual dysfunction had resolved within a week of changing his medication and that he felt much happier. He reported his erections were now spontaneous, firm, and reaching orgasm now took 1–2 minutes. Significantly, the patient expressed anger that he had incorrectly believed his sexual problems were due to his stroke and had thus not previously raised his concerns with his doctor. A full list of the patient's medications at the time he consulted his GP is included at the end of this report.

Discussion

Whilst sexual dysfunction as a result of medication is not uncommon, this case highlights: 1) how simple a sexual problem can be to resolve; and 2) how important it is for the doctor or other health professional to routinely raise the topic of sexual function with patients. The patient's age, disability, sexual orientation, gender or social situation should not be used to determine whether or not the topic of sex is suitable for discussion as this could mean some patients' concerns are overlooked. Prescribing drugs with a known impact on sexual function allows the topic of sexuality to be raised in a straightforward manner within the medical role. Adopting a universal approach to asking about sexual concerns is important, as patients do not always raise their concerns due to embarrassment, communication difficulties and other reasons.

Table 1. Patients' medication list at time of consult

Medication	Dose	Frequency
Coloxyl with senna	50mg/8mg	Once daily when needed
Rosuvastatin calcium (Crestor)	20mg	1 tab morning
Folic acid (Megafol 5)	5mg	1 tab morning
Metformin Generic Health	500mg	Twice/day after food
Paracetamol and codeine phosphate (Panadeine Forte)	500mg/30mg	2 tabs at night when needed
Perindopril (Perindo)	2mg	1 tab morning
Clopidogrel bisulfate (Plavix)	75mg	1 tab morning
Alprazolam	0.5mg	2 tabs evening before bed

References

1. Haboubi NHJ, Lincoln N. Views of health professionals on discussing sexual issues with patients. Disabil Rehabil. 2003 Mar;25(6):291-6.
2. McLaughlin J, Cregan A. Sexuality in stroke care: A neglected quality of life issue in stroke rehabilitation? A pilot study. Sex Disabil. 2005 Win;23(4):213-26.
3. Gott M, Galena E, Hinchliff S, Elford H. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. Family Practice 2004; 21: 528-536.
4. Bocchio M, Pelliccione F, Mihalca R, Ciociola F, Necozione S, Rossi A, Francavilla F, Francavilla S. Treatment of erectile dysfunction reduces psychological distress. Int J Androl. 2009 Feb;32(1):74-80.

ACKNOWLEDGEMENTS

Dr Spring Cooper Robbins and Prof Susan Sawyer for their editorial comments and guidance on this case report.

PEER REVIEW

Not commissioned. Externally peer reviewed.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

FUNDING

Project grant from the National Stroke Foundation of Australia.

PATIENT CONSENT

The author, Natalie Hamam, declares that:

1. They have obtained written, informed consent for the publication of the details relating to the patient in this report.
2. All possible steps have been taken to safeguard the identity of the patient.
3. This submission is compliant with the requirements of local research ethics committees.