Sexual disinterest among spondyloarthritis patients. Comparison between psoriatic arthritis and axial spondyloarthritis using a sexuality-specific question from the ASAS Health Index

Sirs,

Sexual dysfunction (SD) is frequent in spondyloarthritis (SpA) but little attention is paid to it in clinical practice (1-3). The Assessment of SpondyloArthritis international Society-Health Index (ASAS-HI) is a disease impact instrument that includes a specific question (item #7) referring to the loss of interest in sex (4). We aimed to evaluate the frequency and disease factors associated with a positive response to this item in axial SpA and psoriatic arthritis (PsA).

We conducted a *post-hoc* comparative analysis of two studies in which we verified the construct validity properties of ASAS HI in patients with axial SpA and PsA. The methodological details, main results, and ethical considerations, applicable to both studies, have been published elsewhere (5, 6). This analysis included 111 consecutive patients with axial SpA [median age 42 years (IQR: 36–50), 74 men: 37 women, median duration of disease 5 years (IQR: 4–10)] and 90 consecutive patients with PsA [median age 53 (IQR: 45–65), 52 men: 38 women, median duration of arthritis 7 years (IQR: 3–14), median psoriasis duration of 16 years (IQR: 10–29)].

Mean ASAS-HI was 5.8±4.4 in PsA and 5.4±3.8 in axial SpA. Of the 90 patients with PsA, 8 declined to answer item #7, while of the 111 with axial SpA, all answered this statement. Taking this into account, 33 of 82 patients (40.2%) with PsA answered affirmatively to item #7, while 29 of 111 (26.1%) of axial SpA also answered affirmatively to this item, p<0.05 (Fig. 1). Compared to axial SpA, PsA patients were significantly older (55.3±14.3 yrs *vs.* 43.3±10.6 yrs, $p<0.001$), were receiving fewer biological therapies at the inclusion visit (44.4% *vs.* 55.9%, $p<0.05$); however, a substantially higher proportion of them were in remission / low activity upon study entry (73% *vs.* 48.6%, $p<0.001$). In PsA, subjects with Disease Activity index for Psoriatic Arthritis (DAPSA) values higher than 14 (that is, DAPSA categories of moderate-high activity) were independently associated with a positive response to item #7 (OR 14.9, 95%CI: 3.6–80.6, $p<0.001$). In axial SpA, patients with active disease both by the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) (OR 6.2, 95%CI: 1.8–24.1, $p=0.005$) and Ankylosing Spondylitis Disease Activity Score-C-Reactive Protein (ASDAS-CRP) (OR 5.9, 95%CI: 1.7–24.7, $p=0.007$) were also independently associated to an item #7 positive response. After correcting for age, sex, comorbidities, treatment, and duration of illness, PsA (OR 3.6, 95%CI: 1.6–8.3, $p=0.004$) and a higher disease activity (OR 9.1, 95%CI: 4.2–20, $p<0.001$) were found independently associated to an item #7 positive response.

This *post-hoc* comparative study between two of the main SpA showed that patients

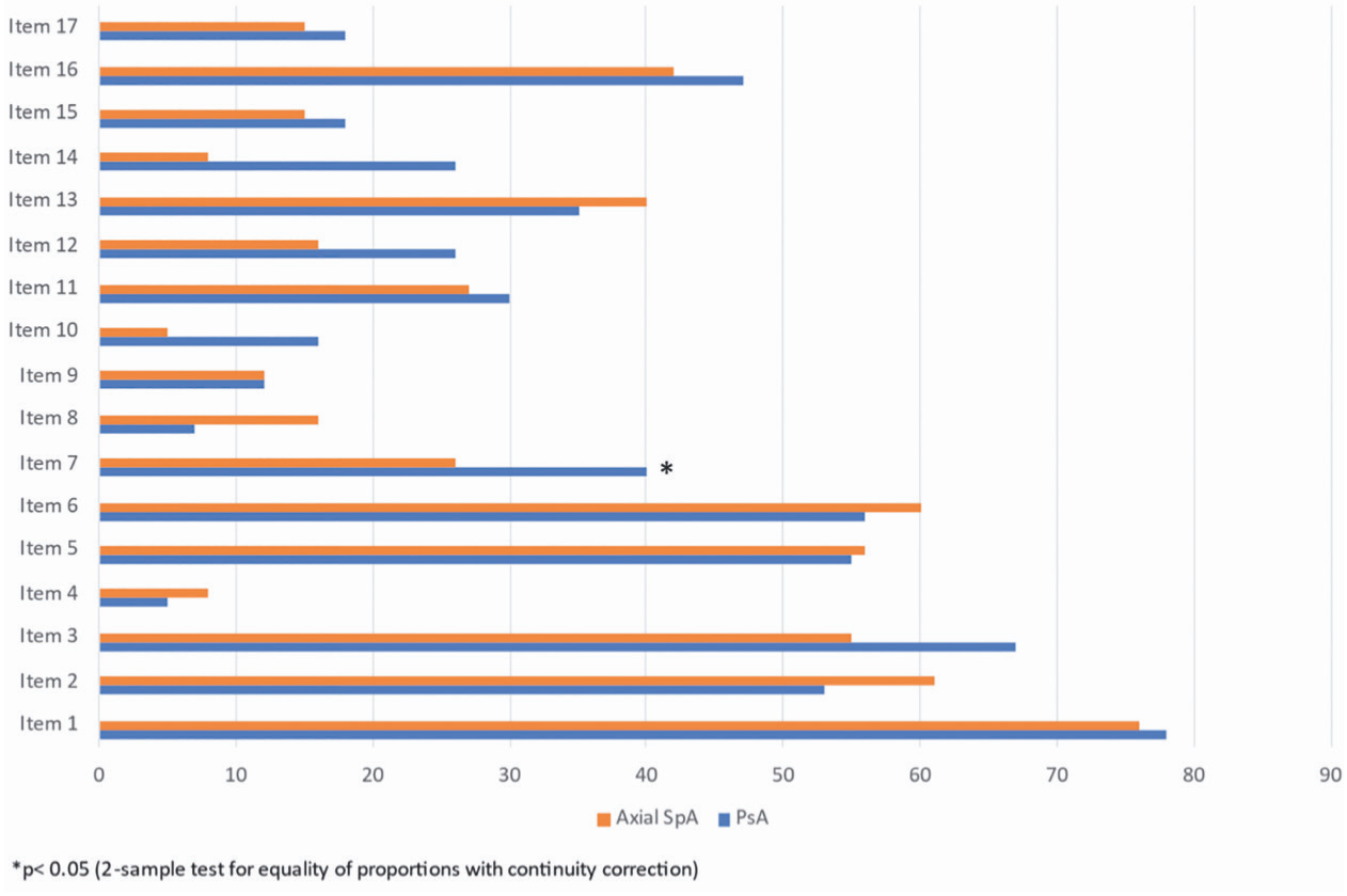

Fig. 1. Comparative distribution of the ASAS health index items in both study populations.
Item 1: Pain sometimes disrupts my normal activities; Item 2: I find it hard to stand for long; Item 3: I have problems running; Item 4: I have problems using toilet facilities; Item 5: I am often exhausted; Item 6: I am less motivated to do anything that requires physical effort; Item 7: I have lost interest in sex; Item 8: I have difficulty operating the pedals in my car; Item 9: I am finding it hard to make contact with people; Item 10: I am not able to walk outdoors on flat ground; Item 11: I find it hard to concentrate; Item 12: I am restricted in travelling because of my mobility; Item 13: I often get frustrated; Item 14: I find it difficult to wash my hair; Item 15: I have experienced financial changes because of my rheumatic disease; Item 16: I sleep badly at night; Item 17: I cannot overcome my difficulties.
PsA: psoriatic arthritis, SpA: spondyloarthritis.

with PsA experience a greater impact of the disease on their sexual life. We also found that alterations in this sphere of quality of life are associated with the activity of both processes.

The prevalence of SD in rheumatic diseases ranges from 36% to 70% and tends to increase with the duration of the disease (1-3). Among other causes, physical or emotional problems, arthritis-related pain, some hormonal alterations, some treatments, and lack of understanding with the partner, can contribute to less active and often less satisfying sex life (1-3).

Sexuality is an integral part of the individual. Despite the data that we have previously presented, alterations in sexuality constitute an issue that is hardly addressed in usual doctor-patient interaction, and patients with rheumatic diseases do not escape this consideration (7, 8).

Our results support the use of ASAS HI as an adequate screening tool to detect sexuality alterations in SpA patients, and therefore, as an aid for redirecting therapeutic options to patients' needs.

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