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GF Strong Rehabilitation Centre

OBJECTIVES

1. Why should HCPs address the area of sexual health with this patient population?
2. Explore the impact of KD on one's sexuality
3. Management options available to address sexual health concerns for those with KD

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Est. 1975 by Dr. George Szasz

Order of Canada

Queen's Golden Jubilee medal

Queen's Diamond Jubilee medal

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Sexual Health Rehab Team 2019

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Why ask about sex?

Sex is part of a full & healthy life

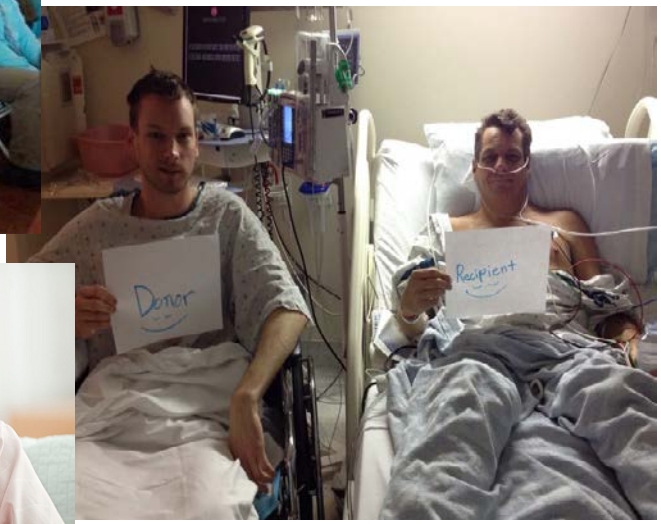
Dysfunctions are common & distressing

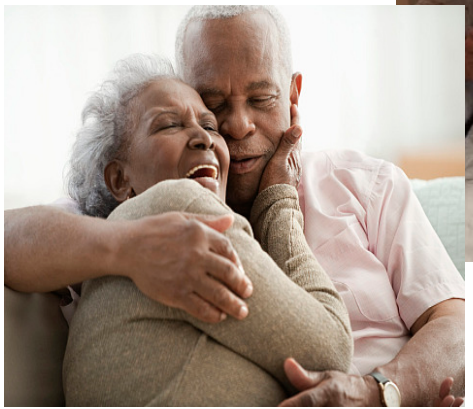
May expose other issues

May influence other illnesses

A major aspect of health that effects people at all ages and stages of their lives

Includes self & partnered activity





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Why Don’t HCP’s Bring it up?

- It is too personal
- I might offend the client
- I don’t know what to say
- The client would bring it up if it was an issue
- I don’t know how to ask the questions…
- They are too young…or too old…
- I don’t think it is part of my role
- If I bring it up I will have to know the answers…

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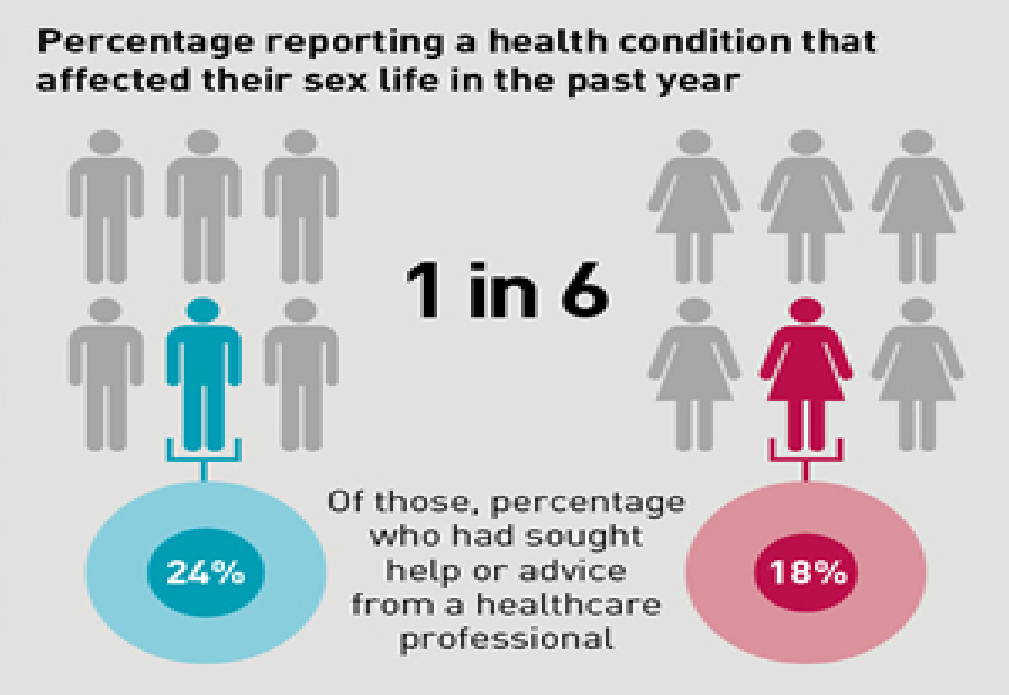
How common are sexual health concerns?

NATSAL, 2013



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Possible Causes for Sexual Difficulties

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Sexual concerns for those with KD

Men

Erectile dysfunction
Decrease libido
Delayed orgasm
Delayed ejaculation

Women

Vaginal dryness and pain
Decreased arousal and desire
Delayed orgasm
Dysmenorrhea

Both sexes may have fertility concerns

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Etiology of Sexual Dysfunctions with KD

- Uremic toxins
- Anemia
- Cardiovascular disease
- Sex hormone imbalance
- Hyperparathyroidism
- Hyperprolactinemia
- Autonomic neuropathy
- Medication side effects
- Comorbid illness (DM, HTN, malnutrition)
- Psychological issues: depression, anxiety, poor self-esteem, social withdrawal, marital discord, body image issues, fear of disability and death

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Sexual Rehabilitation Framework

George Szasz 1980

Sexual Area	Consequences	Comments
Sexual Drive/interest		
Sexual Functioning abilities		
Fertility & Contraception		
Factors re the condition		
Motor & sensory influences		
Bladder & bowel influences		
Sexual Self-view and Self-esteem		
Partnership Issues		

What does the Framework do?

- *Regardless of level of expertise*, for any condition, you can envision what sexual concerns there may be and then prioritize with the client
- *Depending on your level of expertise and interest*, you can focus on an aspect of the sexual concern
- Preempt, Prepare, Provide possibilities: then identify multidisciplinary referrals

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Sexual Areas in Persons with KD

1. **Sexual drive or sexual interest**
2. **Sexual functioning**
3. Bowel and bladder issues
4. **Motor and sensory influences**
5. **Factors specific to the condition**
6. **Partnership/Intimacy issues**
7. Fertility/contraception
8. **Sexual self–view and self-esteem**

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Sexual Drive/Interest

Complex interaction of:

1. *biological urge*
(driven by testosterone, mood and chemical brain factors)

2. motivational factors
(what the sexual payoff is perceived to be)

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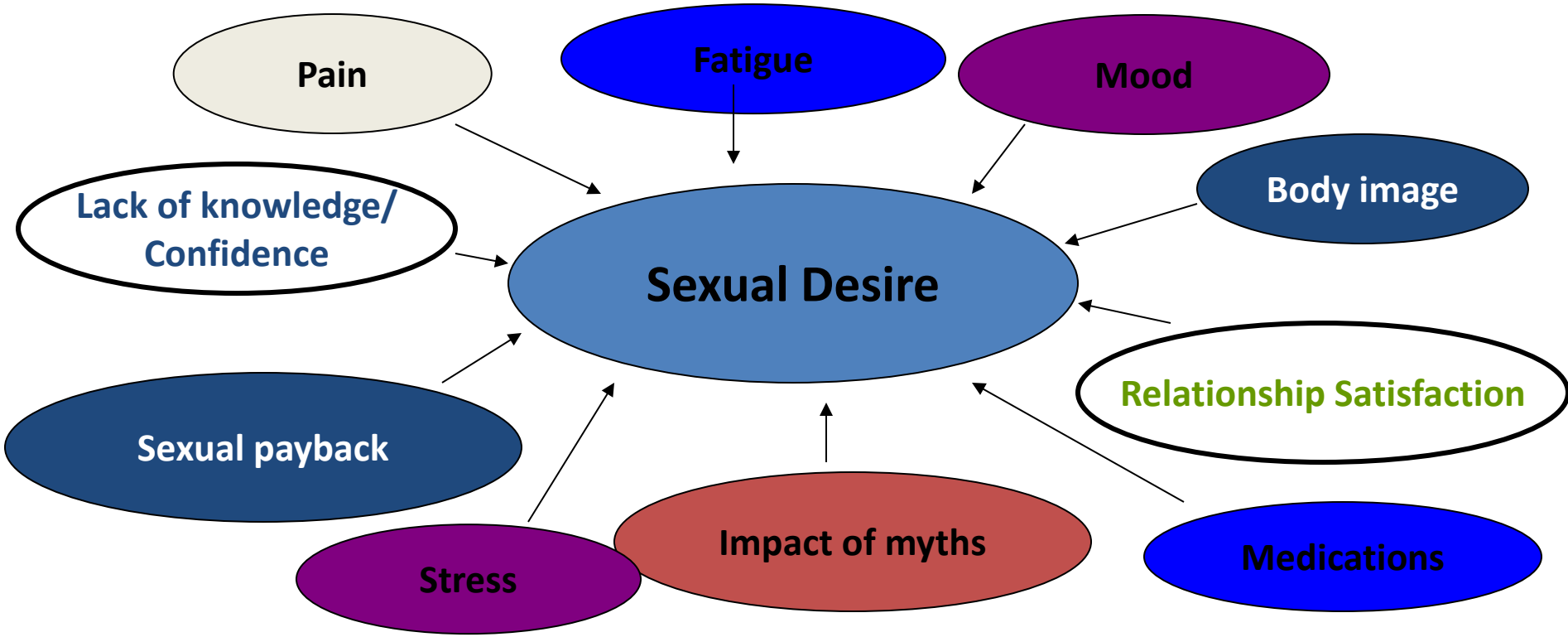
Factors that influence Sexual Desire



Mindfulness

What can you do about….?
Sexual Response

- Erection enhancement options
- Water soluble lubrication
- Extend foreplay to increase arousal
- Minimize distractions/pain/fatigue
- Increase stimulation/vibrators
- Use audio and visual erotic material
- Try to focus on intimacy as the goal

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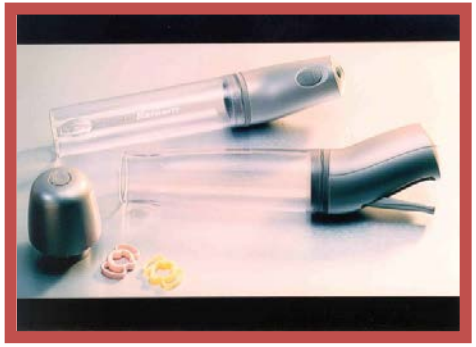
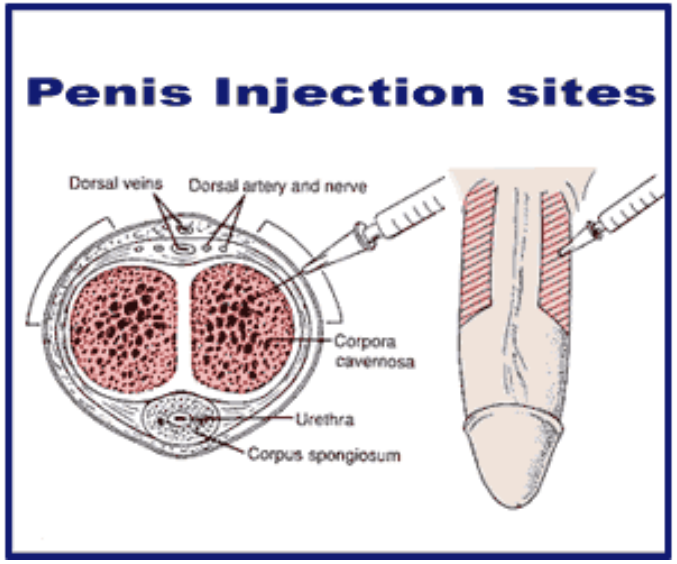
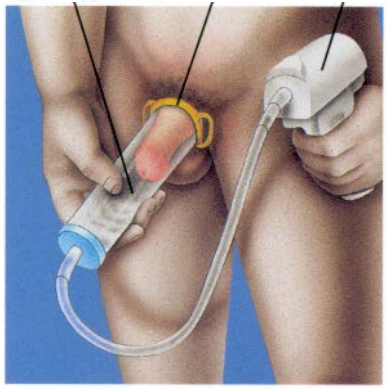
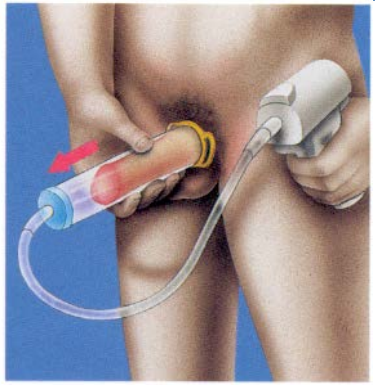
Erection Enhancement Options









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Vaginal dryness & Dyspareunia

Water based lubricants

Vaginal moisturizers

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Vibratory Devices

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Male Self-Stimulation Aids

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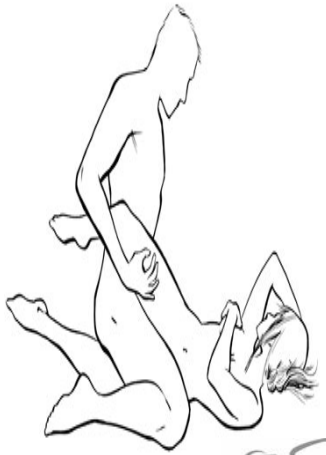
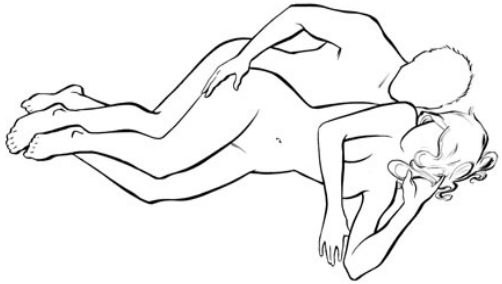
Mobility/Sensory changes: Alternate Sexual Positions and Aids



LOVE BUMPER STORE

TILT



IntimateRider

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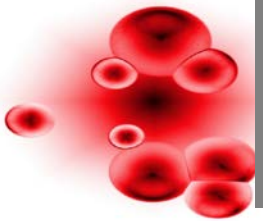
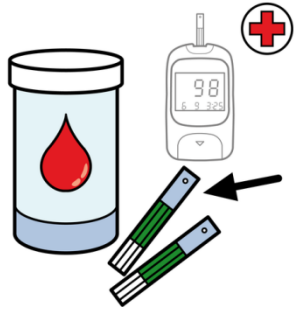
Factors related to the condition





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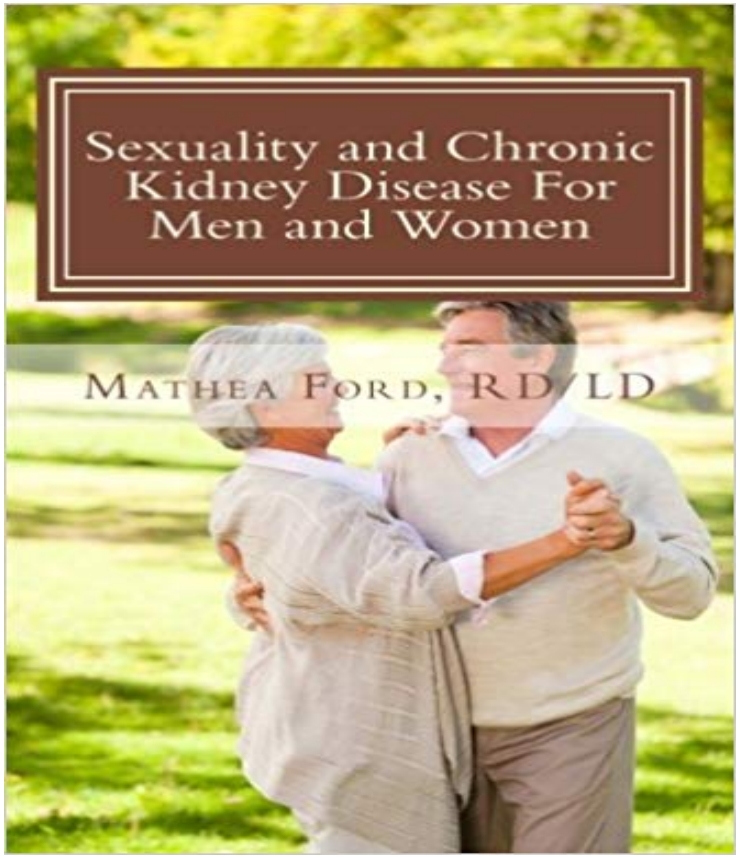
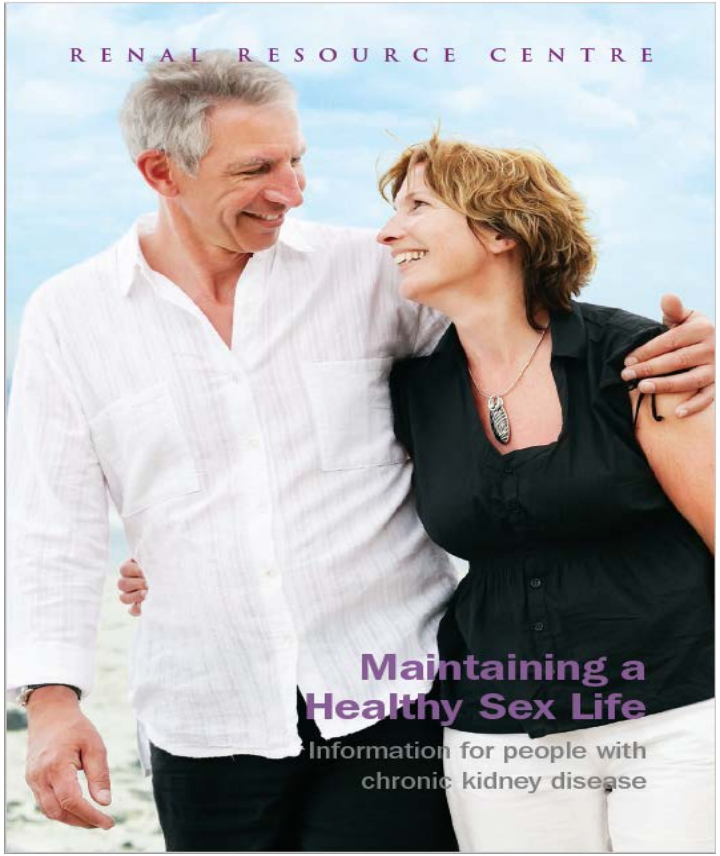
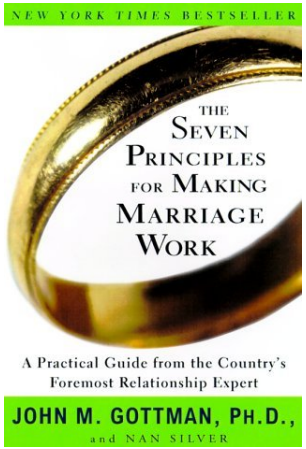
Partnership/Intimacy issues







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Strategies To Enhance Intimacy

- Make time for intimacy
- Communication
- Remain open to trying new things
- Be positive about experiences….

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Sexual Self-View

- Communication with partner/close friend
- Support groups
- Individual counselling
- Eliminate negative self-talk
- Personal grooming…when you look good, you feel good!

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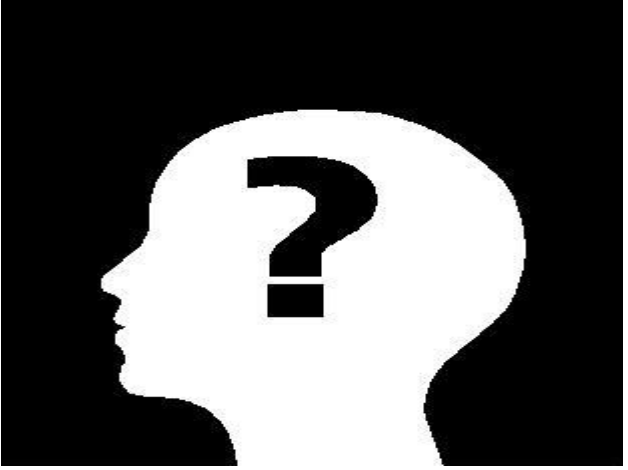

How do you know the importance of any client's sexuality until you ask?

3 Step Method:

1. Many people with____ have questions or concerns about the sexual part of their life.
2. Have you thought about this at all?
3. Would you like to talk to me (or someone) about your concerns?

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Summary

Patients' rights

- **to know how treatment will affect them.**
- **to know how to manage changes.**

Break the silence

- **with your patients.**
- **encourage them to do the same at home.**

Key messages

- **Offer management options before sexual health concerns become an issue.**
- **Sexual pleasure is always possible.**
- **Keep the focus on intimacy.**
- **Be flexible and open to new ways of being sexual.**

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Thank you!

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Community Resources

Sexual Health Rehabilitation Service

GF Strong Rehab Centre 604-737-6233
http://www.vch.ca/Locations-Services/result?res_id=871
Blusson Spinal Cord Centre 604-875-4992
http://www.vch.ca/Locations-Services/result?res_id=869

BC Centre for Sexual Medicine

604-875-4705
http://www.vch.ca/Locations-Services/result?res_id=353

Multidisciplinary Vulvodynia Program

604-875-5022 press #3

BC Psychology Referral Service

604-730-0522

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7. van Ek G F., Krouwel E, Nicolai M P., et al *Discussing Sexual Dysfunction with Chronic Kidney Disease Patients: Practice Patterns in the Office of the Nephrologist* J Sex Med 2015; 12: 2350-2363

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Pregnancy in patients with kidney disease – risks and rewards

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THE UNIVERSITY OF BRITISH COLUMBIA

Objectives

- Review the principles of pre-pregnancy counselling for patients with CKD
  - What do patients want to know?
- Discuss what is known about pregnancy outcomes in women with CKD and post transplantation

Case – Mrs. WB

- 32 year old G_0 who is 2 years post kidney transplant. Her renal disease was IgA nephropathy
- Her creatinine is 110 (eGFR 45 mL/min), her urine ACR is 4 mmol/L
- She wants to get pregnant

How will my kidney disease affect the pregnancy?

Will I have a healthy baby?

Are the medications that I need to take safe?

How will the pregnancy affect my kidney disease?

Will it make my kidneys fail faster?

Will it hurt my transplant?

When is the best time to get pregnant for me?

What do I need to do to prepare?

Is there anything that can reduce my risk?

Women with CKD are at increase risk for adverse maternal and fetal events

Pregnancy in CKD has been associated with loss of maternal renal function

Creatinine	Chance of worsening CKD?	Will it stay lower after delivery?	
< 125	Up to 10%	Possibly	
125-180	40%	50%	
> 180	70%	Almost always	23% progress to ESKD within 6 months of delivery

Jones DC et al. N Engl J Med 1996;335:226-232

Quantifying risks of adverse pregnancy outcomes

Creatinine	Successful obstetric outcome (%)	Preterm (%)	Small for gestational age (%)	Preeclampsia (%)
< 125	96	30	25	22
125-180	90	60	40	40
> 180	78	> 95	65	60

Other counselling points to consider

Pregnancy and CKD— optimizing outcomes

Low-dose Aspirin

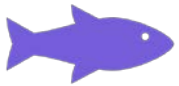
ASA 81mg/d if increased risk of preeclampsia (so anyone with CKD, Proteinuria, HTN)

Start at 12 weeks, continue to 36wks or delivery

Calcium supplementation

Evidence strongest if dietary intake low

If intake <1000mg/d, increase to 1000-2500mg/day with diet or supplementation



Not routinely recommended

Vitamin C, Vitamin E, Fish oil, etc.

Common renal diagnosis – Lupus nephritis

- Quiescent disease for at least 6 months before attempting conception
- Kidney flares most common post-partum vs in pregnancy
- Continue hydroxychloroquine to reduce risk of flares +/- preeclampsia

Common renal diagnosis – Diabetic Nephropathy

- Best if tight glycemic control for at least 6 months pre-pregnancy
- Patients with diabetic kidney disease are at risk of progression with or without pregnancy
- Stop ACE/ARB in most patients prior to pregnancy and in all patients during pregnancy
- Pre-existing proteinuria increases significantly during pregnancy (avg. 7 fold increase) and usually returns to baseline by 12 weeks post-partum

Pregnancy in patients on dialysis

- Fertility significantly diminished
  - Pregnancy rare but still possible
- Intensive dialysis has been shown to improve
  - Chances of conceiving
  - Maternal and fetal outcomes
- Amount of dialysis required depends on residual renal function
  - Better outcomes with increased frequency and length of dialysis
  - Aim for as close to normal physiology as possible
  - Goal of 36 hours per week in studies

Pregnancy in patients on dialysis

- Control blood pressure
- Estimate volume removal/dry weight a moving target!
- Manage anemia with increasing doses of ESA
- Attention to ensuring adequate nutrition/protein intake, folate, vitamin, zinc supplements
- Fetal monitoring during/post hemodialysis once viability reached
- If conceive on PD, general recommendation is to stay on PD

Pregnancy post renal transplantation

- Kidney transplant improves reproductive function
  - Fertility generally returns a few months after renal transplantation
- Preconception counselling, family planning and contraception important components of care

Pregnancy post renal transplantation

- Advised to wait 1-2 years post transplantation
  - Individualized to the patient
- Kidney function stable and optimized
- No episodes of rejection in the previous year
- No concurrent fetotoxic infections, such as cytomegalovirus (CMV)
  - Preferable to wait 6-12 months since resolution of disease before conception
- On no teratogenic or fetotoxic medications
- Immunosuppressive regimen is stable at maintenance levels

Pregnancy post renal transplantation

- Live birth rate and miscarriage rate similar to general population
- No effect on graft function or rejection if baseline GFR “normal”
- Increased risk of:
  - Preeclampsia (27% vs 3.8%)
  - Gestational diabetes (8% vs 3.9%)
- Preterm delivery (46% vs 12.5%)
  - Average gestation 35.6 wks
  - Average weight 2420 gms

Pregnancy post renal transplantation

- Immunosuppressive regimen needs to be modified preconception
  - Azathioprine, tacrolimus/cyclosporine +/- prednisone
  - Change at least 3 months before conception
- Tacrolimus doses often need to be increased substantially
  - Whole blood tac levels in pregnancy may not accurately reflect free levels
- Breastfeeding is encouraged for most women post delivery

Medications in pregnancy

Drug	Adverse Effects During Pregnancy
Safe	
Hydroxychloroquine	No known risk for teratogenicity; withdrawal may cause flare
Glucocorticoids	Risk for gestational diabetes; risk for cleft lip and palate; risk for premature rupture of membranes
Azathioprine	No known risk for teratogenicity
Cyclosporine	Increased risk for cholestasis
Tacrolimus	Risk for gestational diabetes and hypertension
Hazardous	
Cyclophosphamide	Fetal malformations, higher rates of pregnancy loss
Mycophenolate mofetil	Teratogenic (lip, palate, ear abnormalities), higher rates of pregnancy loss
Unknown	
Rituximab	Transient fetal B-cell depletion

Case – Mrs. WB

- 32 year old G_0 who is 2 years post kidney transplant. Her renal disease was IgA nephropathy
- Her creatinine is 110 (eGFR 45 mL/min, her urine ACR is 4 mmol/L
- She wants to get pregnant

Case – Mrs. WB

- ACE-I discontinued prior to pregnancy, prepreg uACR was 60 mmol/L
- Immunosuppressive medications changed to pregnancy safe regimen
- Started ASA 81mg po daily at 12 weeks
- Creat 90 umol/L in T2 and 118 umol/L prior to delivery
- uACR 120 mmol/L at 37 weeks but no other signs preeclampsia
- SVD at 38 weeks
- Creatinine increased transiently to 130 and then improved to baseline over 6 months
- She is currently 6 years post-partum, Cr 125, ACR 10

Summary

- Patients with pre-existing kidney disease can and do have successful pregnancies
- No kidney disease is trivial in pregnancy
- Discuss family planning goals with all women of childbearing age and **in the context of their anticipated renal trajectory**
  - Both renal function/fertility declines over time!
- Patients should be evaluated by an obstetrician and a nephrologist with experience caring for pregnant patients with CKD to evaluate their risks particular to their disease processes and kidney function

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