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Case Report

Partners sexual dysfunctions as problems in gynecological praxis - a case of men libido disorder associated with rare endocrine disruption (Addison's disease)

G. Jarząbek-Bielecka[1], M. Mizgier[2], W. Kędzia[1]

[1]Department of Gynecology, Faculty of Perinatology and Gynecology, Section of Adolescence Gynecology and Sexuology, Poznań University of Medical Sciences, Poznań

[2]Department of Morphological and Health Sciences, Dietetic Division, Poznan University of Physical Education, Faculty of Physical Culture in Gorzów, Gorzów (Poland)

Summary

The authors present a case that clearly shows how the essential the element of gynecological anamnesis is the issue of sexual life and partner problems.The first author is a gynecologist and sexologist. A 58-year-old woman came to the Gynecological Clinic for regular annual gynecological control; when asked about the issues of sexual intercourse, she said that for reasons of partnership, husband's malaise and loss of libido in him, there was no intercourse, although they have had a good marriage for years and wanted to remain together. A sexological consultation for her husband was recommended. This patient aged 58 years reported to the Sexology Clinic because of a substantial feeling of libido loss. He had skin hyperpigmentation, persistent fatigue, lack of appetite, and nausea. After examination was diagnosed, primary adrenal insufficiency was confirmed. The endocrynological treatment of the underlying disease improved sexual function as well. It improved sexual relationship between the patient and his wife.

Key words: Gynecology; Sexology; Endocrinology.

Introduction

Addison's disease is a rare problem [1-5]. It affects about 0.04% of adults. It usually manifests itself in the third to fourth decades of life, more often in women than in men [6-8]. With regards to the patient in question, it was revealed at the age of 58. The most common symptoms of this disease, otherwise known as hypocortisolism, include permanent weakness, including libido weakness, muscle fatigue, weight loss, and lack of appetite. Clinical manifestations of Addison's disease appear when ~ 90% of the adrenal cortex is destroyed [1-5]. One of important elements of gynecological anamnesis is the issue of sexual life and partner problems. The first author is a gynecologist and sexologist.

Case Report

A 58-year-old woman came to the Gynecological Clinic for regular annual gynecological control; when asked about the issues of sexual intercourse, she said that for reasons of partnership, husband's malaise and loss of libido in him, there was no intercourse, although they have had a good marriage for years and wanted to remain together. A sexological consultation for her husband was recommended. The patient reported to the Sexology Clinic because of a substantial feeling of libido loss. He had skin hyperpigmentation ,persistent fatigue, lack of appetite, and nausea. Current weight of this patient was 74 kg (6 kg weight loss per year) and height: 171 cm. An additional symptom found in the patient was excessive pigmentation of the body. It should be added that the patient has been suffering from psoriasis since early childhood. RR 90/60; Endocrine counselling was recommended; and laboratory, hormonal, electrolyte, and metabolic tests were performed. Slightly lowered sodium level was found, i.e. 130 mmol/l, along with slightly elevated level of potassium: 5.51 mmol/l; M/uL, elevated ACTH 364.7 pg/ml, and N 7.2-63.3. Other results of hormone tests were within normal limits; imaging tests of thyroid gland, abdominal cavity and RTG of thyroid gland were normal; primary adrenal insufficiency was diagnosed. Hydrocortisone 20 mg three times daily 1-1/2-1/2, cortineff 1.5 tablets, and parenteral vitamin B12 were prescribed. In stressful situations, an increased dose of hydrocortisone was recommended – max. 80 grams/day; in case of vomiting or diarrhoea, intramuscular administration of 50 mg hydrocortisonum hemisuccinatum, every 8-12 hours, was recommended. A polyglandular autoimmune syndrome (primary adrenal insufficiency - Addison's disease and Addison-Biermer anaemia) were diagnosed. The patient was under strict endocrine control. The general condition of the patient gradually improved over time, skin pigmentation normalised, and appetite and libido also improved. The problem which was recognised in the patient is a specific type of endocrine disorder that also results in sexual dysfunction.

Discussion

Symptoms often develop after infections, traumas, and stressful situations. These factors were not found in the pa-

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tient's history. Other characteristic symptoms include darkening of the skin. According to the literature, symptoms include fatigue, anorexia, weight loss, nausea, vomiting, abdominal pain, muscle cramps, orthostatic hypotension, craving for salty food, electrolyte abnormalities (hyponatremia, hyperkalemia with accompanying metabolic acidosis), and hyperpigmentation of skin and mucous membrane caused by overproduction of pro-opiomelanocortin, precursor for adrenocorticotropic (ACTH) and melanocyte-stimulating hormone (MSH) [1, 3] The only possible treatment for this disease is regular substitution of coronary hormones: glucocorticosteroids, mineralocorticoids, and optionally adrenal corticosteroids. However, the administration of exogenous steroids is never physiological, and patients have shorter life expectancy and worse quality of life [1, 2, 4-7]. Even taking into account the recently introduced modified-release hydrocortisone preparations (HC), which allows to better follow the natural daily rhythm of cortisol secretion, there is always the issue of individual dosage selection. The causes of primary adrenal insufficiency are other autoimmune diseases, tuberculosis, cancer, and some infectious diseases. HLA B8 and DR3 serotypes may be responsible for the onset of the disease [2, 6-8]. In the analysed patient, an autoimmune form of primary adrenal insufficiency was diagnosed. However, this disease can have, as it has already been mentioned, various etiologies, e.g. related to infectious agents (in tuberculosis, cytomegalies, mycosis) or rare metabolic diseases (amyloidosis, hemochromatosis), cancer etiology or it can be genetically determined. Today, however, the most common cause is autoimmune destruction of the adrenal cortex [1-8]. The patient also had psoriasis, which is also considered to be an autoimmune disease [9]. However, no data on the association of psoriasis with primary adrenal insufficiency were found in the literature.

Sexual dysfunction in Addison's autoimmune disease is associated with deficiency of glucocorticoids and mineralocorticoids [6-8]. There are studies aimed at assessing sexuality and related psychological problems in men with Addison's disease before and after the replacement therapy with mineralocorticoids glycocorticoids. It has been shown that cortisol and aldosterone deficiency appear to play an important role in the development of sexual dysfunction, including erectile dysfunction, despite the fact that the mechanism of this action is not fully understood [7, 8]. The patient in question had lowered libido before therapy was initiated, but did not complain about erectile dysfunction. Other authors report that men with Addison's disease who are properly treated should not experience any major sexual dysfunction. The authors describe the impairment of these functions in few men at the time of diagnosis of Addison's disease, before treatment is begun, but then the patients experience generalised weakness; sexual dysfunction is a component of their general well-being. However, as the authors stated after two months following the initiation of replacement therapy with cortisol and mineral corticosteroids, patients recover and reacquire their drive in all areas – including the sexual. The described case is confirmed by data from the literature. Once therapy is begun, the effects are usually spectacular: two to three days and the patient experiences an improved quality of life. It should be stressed that untreated hypocortisolism is not only a threat to sexual health and health in general, but also to life. The endocrinological treatment of the underlying disease improved sexual function as well. It also improved sexual relationship between the patient and his wife [1-8].

Conclusion

The present case indicates that rare endocrine disorders should also be considered when diagnosing libido disorders. This case clearly shows how the essential element of gynecological anamnesis is the issue of sexual life and partner problems.

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Corresponding Author:
M. MIZGIER, PhD
Department of Morphological and Health Sciences
Dietetic Division, Poznan University of Physical Education
Faculty of Physical Culture in Gorzów Wlkp
Estkowskiego 13, 66-400 Gorzów Wlkp. (Poland)
e-mail: m.mizgier@awf-gorzow.edu.pl