Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

WINTER 2023 NEWSLETTER

WORD FROM THE CHAIR

Happy New Year to all of our valued Women's Health Division members! I hope the holidays were restful, warm, and restorative for you and your families.

I am excited to announce that our website will soon be integrated with the main CPA website! Once this transition has been completed, you will be able to access all of your Women's Health Division content directly from CPA account - eliminating the need for a separate Women's Health Division password. This change will improve our ability to keep our website up to date, and streamline communication. I'd like to extend an enormous thank you to your Communications Lead Rendalyn Preun and your Member Representative Marie-Eve Lavoie for their dedication and diligence on this project. I am so excited to see the finished product, estimated to be completed in April 2023.

We have also been hard at work laying the groundwork for another long awaited and requested project - a Women's Health Division name update. The name of our division is something that has long been a topic of conversation among our membership and our volunteers. We are excited to be starting this process, and are eager to keep you involved and up to date on our progress as we work towards finding a name that more accurately represents our membership, and the diverse populations that we serve. Keep your eyes on your e-blasts for continued updates on this exciting project.

Lastly, don't forget to take a look at our Bursary Program for 2023 - applications open mid-February. I love having the opportunity to go through all the bursary applications and see what projects and courses our membership is passionate about. You are such an inspiring group of practitioners.

Stay in touch and stay warm as we move through the coldest days of our year.

Alison Gordon

Chair, Women's Health Division, Canadian Physiotherapy Association
Physiotherapist
(she/her)

IN THIS ISSUE

NOTE FROM THE EDITOR

Dear WHD Members,

Happy 2023 everyone! I hope that this year brings you all the love, health and happiness. I am so looking forward to a new year of learning from and working alongside the wonderful WHD team!

In this issue, we are diving into neurological conditions and the pelvic floor and how we as physiotherapists can help! A special thanks to our newsletter subcommittee members Katie Kelly, Alyssa Brunt, Laura Powers and Kaeleigh Brown for the incredible work, as always!

Happy reading!

Stephanie Boone, PT
WHD Newsletter Editor
(she/her)

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Pelvic Floor Physiotherapist

The CONNECT team and CONNECT clinic are growing! In addition to increasing our facility by almost 1,000 square feet, we're looking to add a pelvic floor physiotherapist to help us be the area's premier centre for women's health physiotherapy.

Led by two pioneering women, CONNECT is a leader in both the health care and fitness field. We take a holistic approach to patient care where like-minded clinicians are supported to create an environment leading to patient success and excellent relationships with the local medical community. This holistic approach is what keeps us growing.

Our #NewMomStrong group fitness series is designed to ease women back into exercise (with baby), while also providing a chance to build a support system. By thinking outside the box and offering other group sessions such as Barbells4Bones, CONNECT has tripled its team in the last three years.

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To learn more about CONNECT and the Owen Sound area please visit our **Careers** page or contact us at **admin@connectrehab.com.** Thinking about relocating? We'd be happy to show you around.

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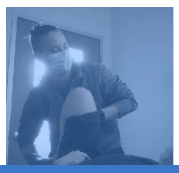


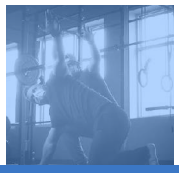


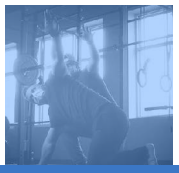


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Instructor: Dr Sinéad Dufour
Dates: Friday, February 17th, March 10th
Time: 12:00 - 4:00 PM EST

Name: Pain Neuroscience Applied to Childbirth: Exploring Theory, Integration and Outcomes
Instructor: Ibukun Afolabi
Dates: Wednesday, March 22nd
Time: 6:30 - 9:30 PM EST

Name: Reframe Endometriosis in Rehabilitation
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Dates: May 26th, June 2nd
Time: 12:00 - 3:00 PM EST

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KT CORNER

By Stéphanie Bernard, PhD, MSc, PT
Postdoctoral Fellow at the University of Alberta

With the spotlight of this Winter Edition being on neurological conditions, here is one recent systematic review investigating the effects of pharmacological and non-pharmacological (including pelvic floor muscle training and transcutaneous electrical nerve stimulation) for overactive neurogenic bladder. This review was published in Open Access; I therefore invite you to read the full-text to gain greater perspective on the modalities and their parameters investigated. Also, the WHD is happy to support the efforts of a research team from Western University: they are investigating physiotherapists experiences in identifying and managing Relative Energy Deficiency (The Female Athlete Triad) in Sport. Please click the link below and contribute to their study!

CITATION

Bapir R, Bhatti KH, Eliwa A, García-Perdomo HA, Gherabi N, Hennessey D, Magri V, Mourmouris P, Ouattara A, Perletti G, Philipraj J, Stamatiou K, Trinchieri A, Buchholz N. Efficacy of overactive neurogenic bladder treatment: A systematic review of randomized controlled trials. Arch Ital Urol Androl. 2022 Dec 28;94(4):492-506. PMID: 36576454.

LINK

https://doi.org/10.4081/aiua.2022.4.492

BACKGROUND

Overactive bladder (OAB) symptoms of frequency, urgency and urge incontinence are frequently associated with known neurological diseases like multiple sclerosis (MS), spinal cord injury (SCI), Parkinson's disease (PD), stroke. Objective: The aim of our study was to review the efficacy of pharmacological and non-pharmacological treatments for neurogenic overactive bladder.

MATERIALS AND METHODS

We searched two electronic databases (PubMed and EMBASE) for randomized controlled trials focusing on pharmacological and non-pharmacological medical treatments for overactive bladder symptoms associated with neurological diseases published up to 30 April 2022.

RESULTS

A total of 157 articles were retrieved; 94 were selected by title and abstract screening; after removal of 17 duplicates, 77 records were evaluated by full-text examination. Sixty-two studies were finally selected. The articles selected for review focused on the following interventions: anticholinergics (n = 9), mirabegron (n = 5), comparison of different drugs (n = 3), cannabinoids (n = 2), intravesical instillations (n = 3), botulinum toxin (n = 16), transcutaneous tibial nerve stimulation (TTNS) (n = 6), acupuncture (n = 2), transcutaneous electrical nerve stimulation TENS (n = 4), pelvic floor muscle training (PFMT) (n = 10), others (n = 2). Anticholinergics were more effective than placebo in decreasing the number of daily voids in patients with PD (mean difference [MD]- 1.16, 95 % CI - 1.80 to - 0.52, 2 trials, 86 patients, $p < 0.004$), but no significant difference from baseline was found for incontinence episodes and nocturia. Mirabegron was more effective than placebo in increasing the cystometric capacity in patients with MS (mean difference [MD] 89.89 mL, 95 % CI 29.76 to 150.01, 2 trials, 98 patients, $p < 0.003$) but no significant difference was observed for symptom scores and bladder diary parameters. TTNS was more effective than its sham-control in decreasing the number of nocturia episodes (MD -1.40, 95 % CI -2.39 to -0.42, 2 trials, 53 patients, $p < 0.005$) but no significant changes of OAB symptom scores were reported. PFMT was more effective than conservative advice in decreasing the ICIQ symptom score (MD, -1.12, 95 % CI -2.13 to -0.11, 2 trials, 91 patients, $p = 0.03$), although the number of incontinence episodes was not significantly different between groups.

CONCLUSIONS

The results of the meta-analysis demonstrate a moderate efficacy of all considered treatments without proving the superiority of one therapy over the others. Combination treatment using different pharmacological and non-pharmacological therapies could achieve the best clinical efficacy due to the favorable combination of the different mechanisms of action. This could be associated with fewer side effects due to drug dosage reduction. These data are only provisional and should be considered with caution, due to the few studies included in metaanalysis and to the small number of patients.

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ARE YOU A PHYSIOTHERAPIST ACTIVELY PRACTICING IN CANADA?

We are conducting a study evaluating physiotherapists experiences identifying and managing Relative Energy Deficiency (The Female Athlete Triad) in Sport while practicing in Canada. The survey takes approximately 10 minutes to complete. For more information on the study as well as the link to the survey, click here. Your participation is greatly appreciated!

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Principle Investigator: Dr. Jane Thornton

PELVIC FLOOR SIGNS AND SYMPTOMS IN NEUROLOGICAL CONDITIONS

By Katie Kelly (she/her)

In pelvic floor physiotherapy, those who have a keen understanding of neurological symptoms and evaluation can be incredibly adept at screening and rehabilitating underlying neurological problems. Urinary, bowel and sexual function symptoms are classic characteristics of many neurological conditions. Due to the taboo nature of these issues, pelvic floor physiotherapists are often the first practitioners to hear about these red flags. For this reason, it is worthwhile to discuss a (non-exhaustive) review of neurological signs and symptoms that might present as common pelvic floor dysfunctions.

First and foremost, it is sensible to remind practitioners that a thorough subjective exam is important. Screening for red flags of underlying medical conditions is necessary and our questioning around urinary and bowel changes, altered sexual function, numbness and pain should come with good explanations. Simply asking "do you feel any numbness in your saddle region?" might not be clear, and patients might be too embarrassed to ask for clarification. Most people require direct explanation to understand where the saddle region is, what counts as a urinary or bowel change, and that sexual dysfunction can include loss of erection/orgasm.

Secondly, a full lumbar and hip assessment is essential to determine the source of neurological symptoms. Ruling out upper and lower motor neuron injury, disc and peripheral nerve issues can all start with a proper lower extremity exam. These findings are then further supported by pelvic floor assessment findings.

The pelvic floor exam can extend beyond the typical lumbar spine assessment. Perineal and anal reflexes, sensation, myotomes and dermatomes, and pelvic floor and anal sphincter muscle strength, tone and tenderness, can include the sacral nerve branches in the perineum and offer insight into neurological status. A good understanding of the iliohypogastric, ilioinguinal, genitofemoral, pudendal, cluneal nerves and the sacro and coccygeal plexuses are necessary for the most thorough exam.

PELVIC FLOOR SIGNS AND SYMPTOMS

Neurogenic Bladder: Urinary continence requires normal function of the bladder and urethra, controlled by the central nervous system regulating both the sympathetic and parasympathetic components. Neurogenic bladder can arise with damage to the central, peripheral and autonomic nervous system and can include conditions like stroke, MS, Parkinson's disease, spina bifida, spinal cord injury and advanced diabetes mellitus. Neurogenic bladder can be classified based on the location of nervous system injury (for a great open access review see Dorsher and McIntosh, 2012). Symptoms include, decreased urinary urge, hesitant urinary stream, urinary retention, incomplete voiding, urinary incontinence, dysuria, nocturia, urinary urgency/frequency, urinary tract infections and subsequent renal damage.[1] Neurogenic bladder can co-occur with neurogenic bowel, and altered sensation of the genitals.

Neurogenic Bowel: Similar to neurogenic bladder, neurogenic bowel is the loss of normal bowel function due to damage or disease in the nervous system. Symptoms can present as spastic or flaccid bowel issues. Symptoms include decreased bowel urge, constipation, diarrhea, bowel urgency, stomach pain, fecal and gas incontinence. Neurogenic bowel can co-occur with neurogenic bladder and altered sensation of the genitals and perineal area.

Pelvic Neuralgias: There are a variety of neuropathic pain sources within the pelvis. While pudendal neuralgia often comes to mind, genitofemoral, iliohypogastric, ilioinguinal, posterior femoral cutaneous, and obturator neuralgias are all possible. These nerves have overlapping dermatomes therefore a good understanding of differential diagnosis is important. Like other types of neuropathic pain, they are usually described as burning, shooting or stabbing, and may have radiating symptoms into the genitals, rectum, groin, or low back area. They can be constant or intermittent, and sometimes exacerbated or relieved with certain positions. Urinating, defecating and sexual activity can alter symptoms as well.

Hopefully this article has served as a reminder to maintain good neurological exam skills while working with pelvic floor physiotherapy patients.

References

1. Dorsher, P. T., & McIntosh, P. M. (2012). Neurogenic bladder. Advances in urology, 2012.

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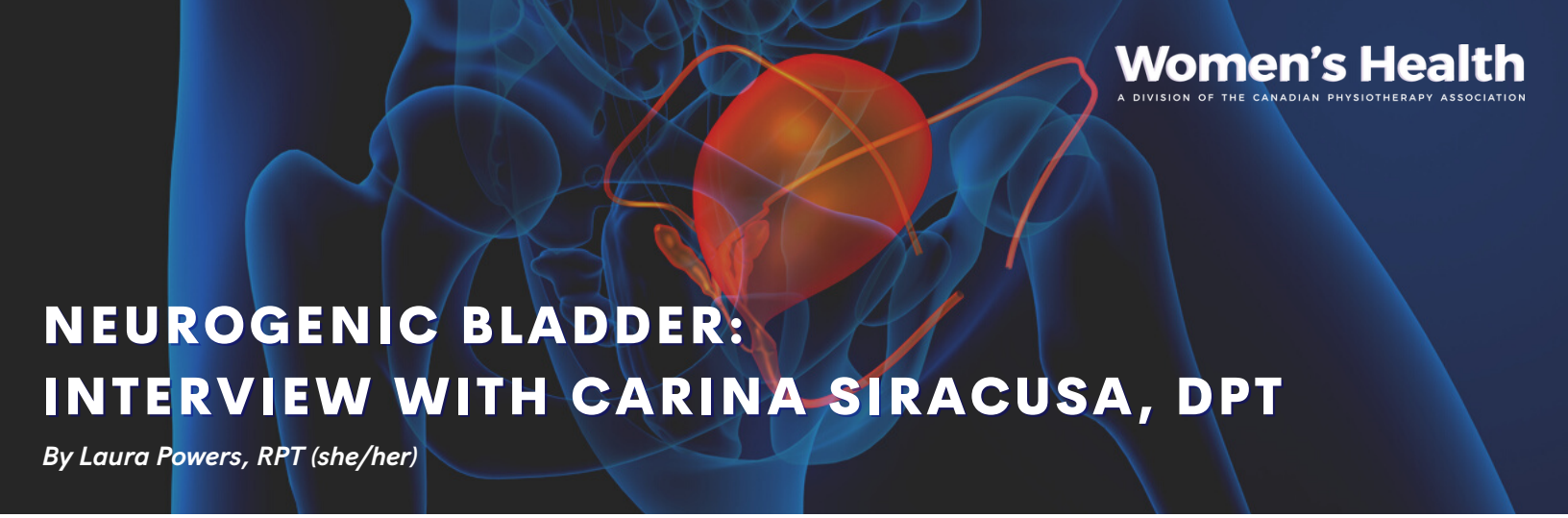


NEUROGENIC BLADDER: INTERVIEW WITH CARINA SIRACUSA, DPT

By Laura Powers, RPT (she/her)

As we dove into this newsletter on pelvic health and the neurogenic bladder it was clear that this is a niche area of pelvic health and an underserved need. So, when I found out about Carina Siracusa, I knew we had to connect and have her for our expert interview. Her passion for this area of physiotherapy was apparent and I so enjoyed our conversation.

CAN YOU TELL ME A LITTLE BIT ABOUT YOURSELF, YOUR PRACTICE, AND HOW YOU CAME TO SPECIALIZE IN PELVIC HEALTH AND NEUROLOGY?

I currently reside in Columbus, Ohio and have been a physical therapist for 18 years. I started in paediatrics in a rural clinic. It was there that I saw a lot of neurological conditions, which started my interest in that area. Two years later I took my first pelvic health course and started applying that knowledge to my paediatric patients as I saw there was a gap in the resources and treatment options. I then started teaching for the Academy of Pelvic Health Physical Therapy (a division of APTA) and created a program that incorporated pelvic health, neurology and paediatrics.

I am currently in transition and will be working clinically part time in a large hospital in the neurology department and also working as a professor at a college in Knoxville, TN. I have also started working with patients post gender affirming surgery.

At my hospital I started a pelvic health specialty in the Neuro line and now every neuro patient gets screened for PF disorders. I am trying to get it out to other hospitals.

CAN YOU PROVIDE SOME INSIGHT ON HOW TO DIFFERENTIATE BETWEEN NEUROLOGICAL FACTORS AND AGE/MSK RELATED CHANGES THAT MAY CONTRIBUTE TO BLADDER AND BOWEL DYSFUNCTION IN A PATIENT WITH A NEUROLOGICAL CONDITION?

When trying to figure it out you have to go back to the neurophysiology of the underlying condition/disease and then sift out their symptoms. For example, with MS, it causes fatigue. So for a lot of patients they started with a weak PF and then MS is making it more weak or fatigued. For treatment you have to keep in mind how many reps you prescribe so you don't cause more fatigue. For PD, that affects dopamine levels in the brain. So our usual urge suppression strategies may not work. Rather you have to optimize what they do have, i.e. timed toileting, bladder irritants etc. And then the rest has to be driven by medication.

But you also need to know their history before the diagnosis, i.e. did they leak before? I often say, "the pelvis had a life before the neurological insult." From that consider what can we help and also not help! When do we have to shift our focus? Are we accommodating or "fixing"? Usually we can still accommodate. Regardless, I do educate on the basic lifestyle strategies: drinking water, fiber, positioning on the toilet etc.

Here is a summary of the main neurological conditions, the symptoms associated and typical treatment approaches:

PARKINSON'S

- Most common issues: bladder urgency (due to loss of dopamine, can not be helped with PFPT).
- Most common treatment: education on bladder irritants and timed voiding.

MS

- Most common issues: bladder urgency and leakage due to muscle fatigue at the end of the day.
- Most common treatment: education, reduction of hold contractions, energy conservation.

STROKE

- Most common issues: bladder urgency (can be treated depending on what part of the brain was affected), bladder leakage, constipation.
- Most common treatment: Typical pelvic floor treatment unless stroke was the in the Pons - then medication only.

SPINAL CORD INJURY

- Most common issues: constipation and neurogenic bladder.
- Most common treatment: working with team for catheter schedule and constipation care.

DO YOU HAVE ANY SUGGESTIONS FOR PRACTITIONERS THAT MAY HAVE PATIENTS WITH UNDERLYING NEUROLOGICAL CONDITIONS ON HOW THEY SHOULD APPROACH THEIR ASSESSMENT AND TREATMENT? ARE THERE ANY SPECIAL TESTS, REPORTS, OR RED FLAGS THEY SHOULD BE AWARE OF?

When assessing and treating a patient with a known diagnosis, I often try to refer to urology and get urodynamic testing if they haven't already. Sometimes we need to see more specifically what is happening with the bladder. It can also be a segue for patients that may not have a diagnosis and help to identify an underlying issue.

My main focus for the assessment is the subjective history taking: when did it start, previous history, fluid/food intake, mobility around the house, needed assistance, routine around the house, and bladder and bowel routine. An internal exam is prohibited with a neuro diagnosis if there is any dementia or cognitive issues, if you think they need to see a urologist, and/or when it is a really severe neurogenic bladder. In that last case prescribing kegels could impede their function, so you want to know from urology what's happening first.

If you do a pelvic exam it is the same as what you would do in a regular pelvic exam. Except you really want to assess side to side, especially with patients who have had a stroke/CVA and then correlate those findings with their mobility.

With reports, you may want to see doctors' notes and with CVA patients you will want to look at a CT report for where the impairment is. If it is in the Pons then that will affect the bladder.

A LOT OF THE RESEARCH FOR PATIENTS WITH MS OR PD TALKS ABOUT PELVIC HEALTH DYSFUNCTION IN REGARDS TO URGENCY AND INCONTINENCE BUT, DO YOU HAVE ANY THOUGHTS ON HOW THESE CONDITIONS ALSO IMPACT PROLAPSE? SPECIFICALLY, THE EFFECT OF RIGIDITY AND/OR MUSCLE WEAKNESS.

Sadly, there is NO research on POP and neurological conditions. Clinically, I definitely do see it though. For these patients, I would still focus on pressure management, areas of weakness, and how prolonged sitting may be influencing symptoms, i.e. sitting in a bad wheelchair. They are also not great candidates for surgery due to their neurological condition so you may want to educate on a pessary.

> "I often say, "the pelvis had a life before the neurological insult." From that consider what can we help and also not help! When do we have to shift our focus? Are we accommodating or "fixing"? Usually we can still accommodate."

ARE THERE ANY EDUCATIONAL RESOURCES (BOOKS, COURSES) OR CURRENT RESEARCH PAPERS ON THIS TOPIC THAT YOU WOULD RECOMMEND TO OUR READERS?

I do teach a course through PHS and am planning on teaching that course this year. We are just finalizing dates. I like a podcast I spoke on called The MSing Link and I also provide the International Continence Society as a resource. They have some good information.

WHAT ARE YOUR SOCIAL MEDIA HANDLES?

My Instagram is @carinadpt and my Twitter is @Carina_DPT.

ANY OTHER WORDS OF WISDOM TO PASS ON IN REGARDS TO WORKING WITH THIS POPULATION OF PATIENTS?

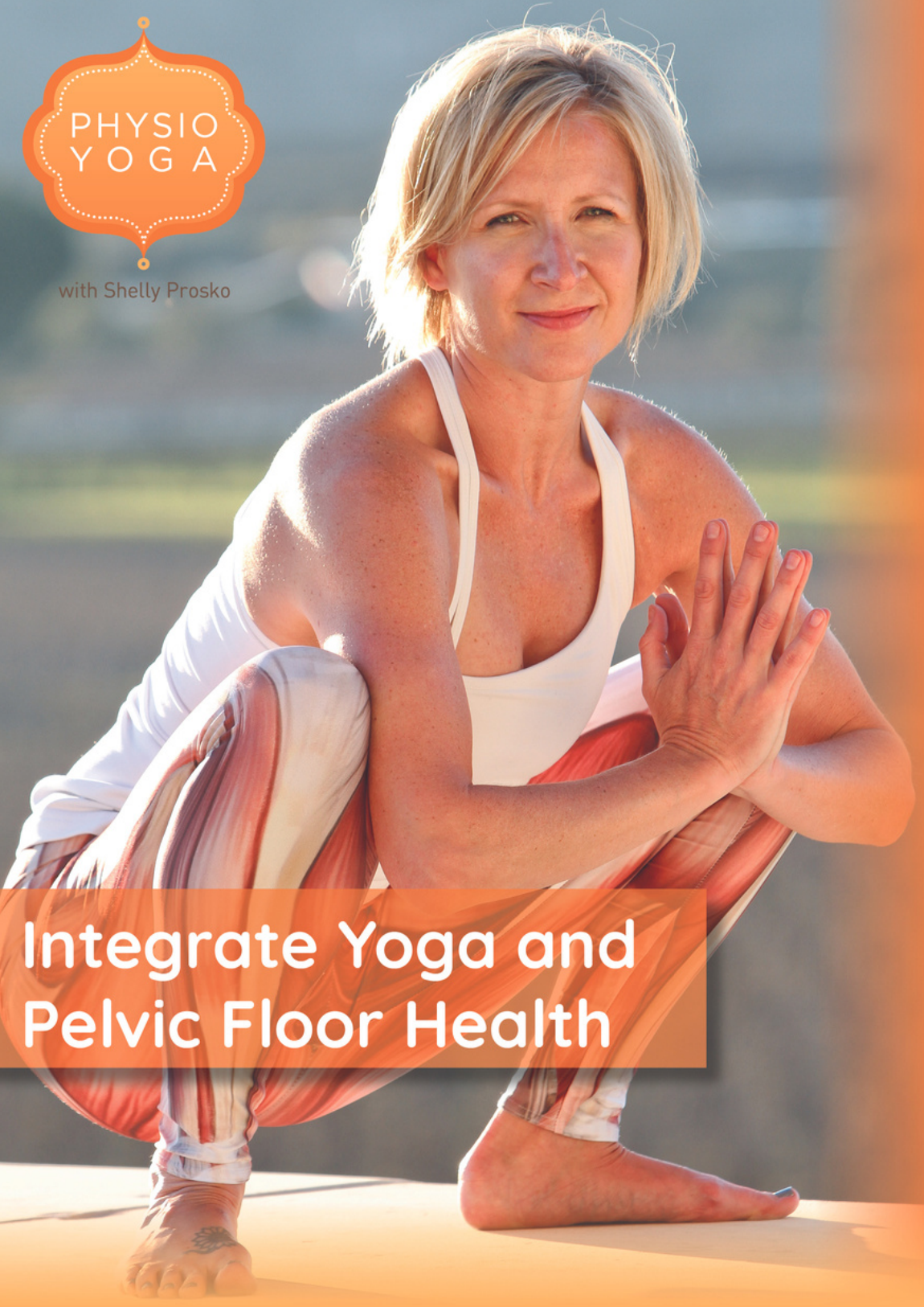
Don't shy away from treating this population, but know it's not quite the same as treating a "typical" MSK patient.

If you are starting to see your treatment is not working then go back to your neurophysiology education and look at what it does to their CNS. That can guide your approach. Recognize that this population does still need us!

Thank you again to Carina! The WHD members truly appreciate your time and knowledge.

PHYSIO YOGA

with Shelly Prosko



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THERAPEUTIC INTERVENTIONS FOR NEUROLOGICAL CONDITIONS

By Alyssa Brunt (she/her)

The pelvic floor is a network of muscles, tissues, and nerves that stabilize the pelvis and support the pelvic organs, influence sexuality and pleasure, and maintain bowel and bladder control. Because nerves contribute to proper functioning of the pelvic floor, some neurological conditions that affect the brain and nerves (MS, PD, ALS, SCI, Stroke, CP, CES, CVA etc) can cause lower urinary tract symptoms (LUTS), sexual dysfunction, and issues surrounding bladder activity and bowel regulation.[1-6,7,9,12]

LUTS and sexual dysfunction are commonly reported in patients with neurological conditions.[1-6,7,9] Bladder complications can include neurogenic detrusor overactivity (NDO), detrusor sphincter dyssynergia, weakness or spasticity of the pelvic floor muscles (PFM), OAB, incontinence and more. Sexual dysfunction can include reduce libido, inability to orgasm, muscle spasms, erectile dysfunction, and reduced lubrication.

Unfortunately, very few health practitioners screen for incontinence and sexual dysfunction in patients with neurological conditions. When considering therapeutic interventions, practitioners should use an ongoing, biopsychosocial approach within a multidisciplinary healthcare team. Treatment should be individualized and reflect the patient's neurological condition, symptoms, disease course, comorbidities, physical status and medications.[1]

PELVIC FLOOR PHYSICAL THERAPY

Pelvic floor physical therapy (PFPT) including pelvic floor strengthening, manual therapy, biofeedback, pelvic floor relaxation exercises, modalities and education has been shown to be effective in treating patients with neurological conditions (all). As the PFM help maintain continence and sexual function, it is important that they are strengthened like any other muscle in the body.

Pelvic floor muscle training (PFMT) has shown to be effective in treating patients with neurological conditions.[1-8] In a recent systematic review examining pelvic floor rehabilitation in patients with multiple sclerosis (MS), PFMT was associated with improvements in LUTS severity, quality of life (QoL), level of anxiety and depression, and sexual dysfunction.[2]

Additionally, women with MS treated with PFMT reported less storage and voiding symptoms as compared to control groups, reduced number of used pads and nocturia events, improvements in muscle power, endurance, resistance, and fast contractions of PFM, reduced anxiety and depression, and increased arousal, lubrication and satisfaction.[2]

In relapse-remitting MS, PFMT was found to not only decrease LUTS by increasing maximum bladder volume but also to improve sexual function, QoL and depression.[3]

PFMT combined with biofeedback may provide greater outcomes in patients with neurological conditions.[2-4] Women with MS treated with both PFMT and intravaginal NMES reported significantly greater improvement in tone, flexibility, ability to relax the PFM, and OAB-V8 scores compared to those without.[2,4] Women with MS treated with PFMT and electrotherapy demonstrated greater improvements of OAB symptoms, perineal musculature contraction, and QoL compared with patients treated with PFMT without electrotherapy.[2]

In female stroke patients, PFMT was shown to reduce urinary incontinence after 6 weeks versus control patients.[5] In individuals with incomplete SCI, 6 weeks of PFMT significantly improved PFM strength and endurance and reduced NDO but had minimal effect on continence.[6]

Although PFMT shows promising findings for LUTS and sexual function, there is no specific protocol for treating pelvic floor dysfunction in neurological conditions so more research is needed.[2-6]

Patient may also benefit from other treatment techniques, outside of PFMT including manual therapy, pelvic floor

relaxation exercises, behavioural training and education.[7] Women with MS and bladder issues reported improvements in QoL and reduced disability after completing a 6-week multifaceted, individualized bladder rehabilitation program, at follow up and 12 months later.[7,8] Additionally, behavioural therapy including PFMT, bladder training, fluid and constipation management, and bladder diary self-monitoring was shown to reduce urinary symptoms and improve QoL in individuals with Parkinson's disease.[8]

> **Unfortunately, very few health practitioners screen for incontinence and sexual dysfunction in patients with neurological conditions. When considering therapeutic interventions, practitioners should use an ongoing, biopsychosocial approach within a multidisciplinary healthcare team.**

MEDICATIONS & SURGICAL PROCEDURES

Antimuscarinic medications have been used to help bladder storage problems and intradetrusor injections of botulinum toxin type A have been shown to be effective in managing NDO.[10,11] As physical therapists, it is important for us to be aware of medications as some can help urinary incontinence and sexual dysfunction and some may produce these symptoms as a side effect.

Surgical procedures including implanting artificial urinary sphincters, urethral tape and sling surgery, and sacral neuromodulation are also recommended for individuals with neurogenic stress incontinence.[10,11] A recent study in examining sacral neuromodulation in patients with PD who had OAB/urgency incontinence demonstrated a significant improvement in urinary symptoms following permanent implants, with 68% of patients able to discontinue OAB medications.[12]

MENTAL & SEXUAL HEALTH COUNSELLING

There is a large overlap with neurological conditions and depression and anxiety.[2,5,6,13]

Referring patients to mental and sexual health therapists encompasses a biopsychosocial treatment approach that may improve outcomes in physical and mental health. As mentioned before, PFPT has been shown to improve QoL and reduce feelings of depression and anxiety, however patients can further benefit by speaking with mental and sexual health therapists.

Sex therapist may also provide benefit to individuals experiencing sexual dysfunction as couples and individuals can learn to feel safe, communicate better, and enjoy sex more.

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PERSONS WITH NEUROLOGICAL CONDITIONS AND SEXUAL HEALTH: WHAT ARE THEIR NEEDS AND WHAT IS THE ROLE OF CLINICIANS?

By Kaeleigh Brown, PT, PhD Student (she/her)

Sexual function requires complex interactions between various body structures, functions, and the environment.[1] The central and peripheral nervous systems play an integral role in sexuality and sexual function.[1] Important structures include both the sympathetic and parasympathetic systems, limbic system, thoracic, sacral, and lumbar levels of the spinal cord, and the hypothalamo-pituitary axis.[1,2] At times, sexual function can be altered – for example, by psychological, hormonal, social, or physical changes. Individuals living with a neurological condition often experience changes in sexual function, although clinicians may not ask about it during their assessments.[2] Symptoms can include pain, reduced engorgement, hypoarousal, hyperarousal, and loss of libido.[1,2,3]

To help understand the various factors influencing the sexual health of individuals with neurological diseases, researchers[4] have proposed a model of sexual dysfunction. Three categories: primary, secondary, or tertiary are used to describe the factors responsible for sexual dysfunction. When sexual function is directly affected by the neurological condition it is categorized as primary. Secondary dysfunction is related to changes unrelated to the sexual response. Finally, psychosocial factors are lumped under tertiary dysfunction.

Both primary and secondary sexual dysfunction are related to the disease process. Changes such as altered sensation to the genitals or lesions to brain centres responsible for climax, are categorized under primary dysfunction.[3] Secondary sexual dysfunction covers several contributing factors. Medications used to treat other symptoms of the neurological conditions (e.g., psychoactive medications, opiates, muscle relaxants[1] may inadvertently impact an individual's sexual function.[3] Impairments related to mobility (e.g., spasticity, rigidity) may make engaging in sexual activities difficult or painful.[3] Brain level changes may impair the ability to communicate about sexual health (with partners and health care providers), create disinhibited behaviour (hypersexuality), or result in cognitive changes.[1]

Psychosocial factors under tertiary sexual dysfunction can include beliefs, and factors related to the unaffected partner. Attitudes and beliefs held by societies can impact individuals' ability to engage in romantic relationships,[3] access sexual health information,[4] and receive appropriate medical care.[3,5]

It has been suggested that persons with disabilities can be perceived as asexual,[3,5] which is inaccurate. This perception may be adopted by the affected individual, their partners, and/or healthcare team.[3,5] Within the changing dynamic of a relationship, partners may have a direct influence on sexual function. For example, the sexual nature of a partnership may be altered in response to the evolution of roles and responsibilities required to meet the needs of the person with the neurological condition.[1]

Since sexual dysfunction is complex, a multidisciplinary approach may be required.[3] Screening for sexual dysfunction is recommended, including the use of outcome measures (e.g., Arizona Sexual Experience Scale).[3] Recognizing the relationship between sexual dysfunction, medical conditions (such as heart disease) and psychological conditions (such as depression), a thorough health history is also recommended.[1,3] Much of the literature describes treatment for erectile dysfunction, with a brief mention of female sexual dysfunction.[1,3] Medication can be prescribed to address the physiological changes from the neurological conditions (e.g., spasticity).[1,3] Other treatments can include education about positioning, other modes of intimacy, counselling, and treating incontinence.[1]

Sexual health is an important component of quality of life.[6] Although discussing sexual function and sexuality with clients may be uncomfortable, health care providers are strongly encouraged to ask about it.[3]

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