Sexuality Among Women Recipients of a Pancreas and Kidney Transplant

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Significant improvements in health and quality of life generally follow organ transplantation; however, there is evidence that women who have received transplants experience difficulty with sexual function. The specific nature and extent of this difficulty has not been documented. The purpose of this study was to describe sexual functioning and sexual self-esteem among women recipients of a simultaneous pancreas and kidney transplant. Perceived effect of the transplant on sexuality was also explored. Participants completed a questionnaire that measured their sexual functioning (including sexual difficulties), sexual self-esteem, illnesses, medications, and perceived effect of the transplant on sexuality. Data analysis revealed that only 39% of the women would be classified as having normal sexual functioning. The majority reported either some difficulty with sexual function (34%) or sexual dysfunction (27%). About one third of the women reported that transplantation had only positive effects on their sexuality, whereas 28% reported negative effects, and 29% reported no effect.

**Keywords:** sexuality; sexual functioning; transplant; kidney; pancreas; dysfunction

Simultaneous pancreas and kidney transplantation is becoming more common every year (United Network of Organ Sharing, n.d.). Significant improvements in health and quality of life usually follow organ trans-

**Authors’ Note:** The authors acknowledge the Undergraduate Initiative Funds of the University of Wisconsin–Madison and the School of Nursing Honors Program. The first and second authors were the principal investigators for this study and were responsible for the design and conduct of this research. They were also responsible for writing the manuscript. The third and fourth authors were involved in the data analysis and assisted with the manuscript revisions.
plantation; however, there is some evidence that women who have received transplanted organs experience difficulties with sexual functioning (Diemont et al., 2000; Limbos, Chan, & Kesten, 1997; Matas et al., 2002). These difficulties probably arise from a complex interaction of psychological and physiological factors. For example, side effects of immunosuppressants, such as weight gain and hirsutism, may influence women’s feelings about their sexual attractiveness after transplant. Posttransplant complications such as hypertension and depression can require medications that reduce the capacity for orgasm and lubrication and/or impair other aspects of sexual response.

Caring for women who have had organ transplants requires understanding their difficulties with sexual function. In most of the prior research (e.g., Hricik et al., 2001; Matas et al., 2002), only one or two general questions about sexual functioning were asked. Notably absent was a careful delineation of the specific nature and extent of difficulties experienced by these women, which could then be used to guide patient assessment and the design of interventions.

The purpose of this study was to examine sexual functioning among women who have had a simultaneous pancreas and kidney transplant. Emphases were placed on identification of specific difficulties with sexual functioning and women’s perceptions of the effect of the transplant on their sexual lives. Links between sexual functioning and possible explanatory variables, such as medication, length of time since transplant, and sexual self-esteem, were also explored.

**Sexuality Among Women Receiving Organ Transplantation**

Few studies have truly focused on sexuality among recipients of transplants. Diemont and colleagues (2000) compared sexual problems among three groups on renal replacement therapy hemodialysis (HD), peritoneal dialysis (PD), or renal transplant and a control group without known kidney disease. Of the control group, 15% reported a sexual problem, whereas 75% of the HD, 67% of the PD, and 44% of the renal transplant groups reported a sexual problem. Among all three renal replacement therapy groups, the most frequently reported sexual problems were reduced libido and lubrication, orgasm complaints, and pain during intercourse.

Limbos et al. (1997) explored body satisfaction, sexual functioning, and quality of life among women who were either on a waiting list or had received a lung transplant. When compared to women on the waiting list,
transplant recipients reported significantly higher body satisfaction but significantly lower scores for sexual drive. Despite this finding, when asked about their greatest concerns in an open-ended format, 42% of the transplant recipients spontaneously identified concerns related to body satisfaction such as weight gain, facial changes, and hair growth. Of the transplant recipients, 52% scored below the 10th percentile on the Derogatis Sexual Functioning Inventory, a broadly based instrument designed to assess and quantify the nature of sexual functioning.

A large multisite study, the Transplant Learning Center (TLC), has been the source of two reports regarding predictors of quality of life among renal transplant recipients. In this study, participants answered one broad question on adverse effects of transplant related to sexual function and several questions regarding adverse effects on physical appearance. Although the data are limited, they hint at a major link between sexuality and quality of life.

In the first report (Hricik et al., 2001), 61% of respondents (both men and women) reported adverse effects related to loss of interest or ability to perform or respond sexually, and more than half identified adverse effects related to physical appearance, such as changes in body shape and unusual hair growth. Furthermore, multiple regression models revealed that these adverse effects on sexuality and physical appearance were significant predictors of decreased quality of life. The second report from the TLC (Matas et al., 2002) involved a longitudinal analysis of quality of life in which recipients were followed for an average of 1 year. The percentages of patients reporting adverse effects on sexuality and physical appearance were remarkably stable during the 1-year period. Again, regression modeling showed that adverse effects on sexuality and physical appearance were predictors of decreased quality of life.

Significant gender effects were evident in the regression models using the TLC data (Hricik et al., 2001; Matas et al., 2002). The direction of the effects indicates that male recipients have a higher quality of life than do female recipients. Precise reasons for this finding are not clear because gender differences were not explored specifically in either study.

Raiz, Davies, and Ferguson (2003) explored three problems with sexual functioning including lack of interest in sex, lack of enjoyment of sex, and difficulty becoming sexually aroused in a large quality of life study of kidney transplant recipients. About 30% of the sample reported a moderate to severe problem with interest in sex, 30% reported a moderate to severe problem with enjoyment of sex, and 34% reported a moderate to severe problem becoming sexually aroused.

Though limited in number and scope, the available data suggest that women who have had organ transplants encounter problems with sexual
functioning. At least one study demonstrated that these problems are remark-
ably stable, that is, they do not resolve over time when persons have had
experience with the transplanted organ and attendant medications. Possible
sources of these difficulties with sexual functioning are considered next.

**Sources of Difficulty**

**With Sexual Functioning**

Difficulty with sexual functioning is probably the result of a complex
interaction among physiological and psychological variables. Two variables
that may affect sexual functioning are preexisting diseases and side effects of
medications.

Many women receiving transplants have experienced diabetes and/or
chronic renal failure for a number of years. Both of these conditions may
influence sexuality. In one study, 47% of women with diabetes reported sex-
ual problems including inhibited sexual arousal, inhibited desire, and
dyspareunia (Newman & Bertelson, 1986). As previously noted, more than
two thirds of women with chronic renal failure or on dialysis reported a sex-
ual problem (Diemont et al., 2000).

In addition to experiencing the effect of preexisting diseases, transplant
recipients must follow a strict drug regimen that can influence perceptions of
sexual attractiveness. For example, most recipients take corticosteroids. The
side effects of this class of drugs include weight gain, hirsutism, fluid reten-
tion, increased appetite, and a classical buffalo hump with a cushingoid face
(Deglin & Vallerand, 1999). In addition, calcinurin inhibitors such as
cyclosporine are frequently prescribed—these are associated with excessive
hair growth and acne. There is evidence of significant distress related to side
effects of medications among transplant recipients. Persons who received a
lung transplant reported distress because of hair growth, swelling, and unde-
sirable changes in body appearance (Lanuza, McCabe, Norton-Rosko,
Corliss, & Garrity, 1999). In a study of stressors of transplant recipients,
Fallon, Gould, and Wainwright (1997) found that alterations in body image
(e.g., weight gain) were among the most reported stressors. These stressors
were highest among people who had their transplant for 1 to 5 years (as com-
pared to new recipients and those with transplants of more than 5 years).

Because they often develop posttransplant hypertension, many persons
must take antihypertensive medications in addition to immunosuppressants.
There is some evidence that antihypertensive medications affect orgasmic
ability in women (Hodge, Harward, West, Krongaard-DeMong, & Kowal-
Neeley, 1991). Many women experience depression after transplant and
require antidepressants such as Zoloft, Prozac, and Paxil. These selective serotonin reuptake inhibitors (SSRIs) result in increased serotonergic activity, which is believed to cause difficulty with orgasm. Healthy women have reported a decrease in sexual desire and orgasmic dysfunction while taking SSRIs such as Zoloft (Croft et al., 1999).

**Transplantation and Sexual Self-Esteem**

The combination of changes in physical appearance with arousal or orgasmic difficulties may have a major effect on sexual self-esteem among women who have received transplants. High sexual self-esteem allows one to be comfortable seeking pleasure, asking another to help satisfy sexual needs, and determining what is sexually pleasing. Conversely, low sexual self-esteem leads to guilt, shame, and anxiety about sexual activity (Buzwell & Rosenthal, 1996). Buzwell and Rosenthal (1996) suggested that women can be classified as sexually unassured or sexually competent. Sexually unassured individuals have low sexual self-esteem and perceive their bodies as underdeveloped and/or unappealing. They feel sexually unattractive, uncomfortable about their sexual performance, and unhappy about their sexual conduct. On the other hand, sexually competent individuals have high sexual self-esteem, feel confident of their sexual appeal and body, and are comfortable with their sexual conduct. Sexual self-esteem obviously plays a very important role in sexual functioning. For a variety of reasons already discussed, women who have received transplants may experience a loss of sexual self-esteem, a factor that is essential to maintaining positive sexuality.

**Research Questions**

In sum, existing research indicates that women who receive a simultaneous pancreas and kidney transplant may have difficulties with sexual functioning. The specific nature, extent, and correlates of these difficulties have not been documented. In this study, the following research questions were addressed.

Among women who have had a pancreas or renal transplant, what is the reported level of sexual functioning? What is the reported level of sexual self-esteem? What is the relationship between sexual functioning and sexual self-esteem? Does sexual functioning differ by illness-related variables including years since transplant (≤ 5 years or > 5 years), type of medication, preexisting chronic illness, or preexisting diabetic neuropathy? What are the perceived consequences of the transplant for sexuality?
Design

A descriptive, correlational design was employed.

Sample

Respondents in this study were women who had received a simultaneous pancreas and kidney transplant at a large midwestern hospital in the past 15 years. Women between the ages of 18 and 50 who had both a functional kidney and pancreas allograft for at least 6 months were eligible for the study. The reason for excluding women who were older than 50 years of age was to try to control for effects of menopause on sexual function. (Of the respondents, 82% were not menopausal, and 18% had experienced partial or full cessation of menses.) A total of 150 questionnaires were sent, and 65 individuals returned questionnaires for a response rate of 43%.

The majority of respondents (53.8%) were between the ages of 41 and 50. Of the women, 55.0% worked outside of the home, and most (62.5%) were married; 84.0% had a regular sexual partner, and 81.5% reported that they were sexually active. Frequency of sexual relations varied from rarely to once a day or more.

Of the women, 54% had their transplanted organs for 5 years or less. They took an average of nine medications. All of the women who listed their current medications \((n = 61)\) were taking daily doses of prednisone and at least one other immunosuppressant medication. The most frequently reported additional medications were cyclosporine (62%), mycophenolate mofetil (64%), tacrolimus (36%), and atenolol (30%). Past and present illnesses included hypertension and Type 1 diabetes. Of the women, 58% reported having current diabetic neuropathies.

Method

After a human subjects committee approved the study, potential participants were identified by using the transplant database at a major midwestern university hospital. The database contains medical and contact information for every person who has had a pancreas or renal transplant at that hospital. All of these individuals had agreed to be contacted for research. To protect patient confidentiality, an individual employed by the transplant department obtained a list of names and addresses of potential participants. This list was only accessible to the first author and was destroyed after questionnaires were sent. Each potential participant was sent an informational letter about
the study along with a packet containing three questionnaires and a postage-
paid return envelope. Because the questionnaire contained items pertaining
to sexuality, it was important for responses to be anonymous. To ensure ano-
nymity, participants were instructed not to identify themselves in any way.
Because of the sensitive nature of the questions and a desire to avoid any
appearance of pressure to respond, no reminders were sent.

Instruments

Three different questionnaires were utilized in this study. The first ques-
tionnaire was the Arizona Sexual Experiences Scale (ASEX). The ASEX is a
gender-specific, five-item, self-report measure in which women rate their
sexual drive, arousal ability, vaginal lubrication, ease of orgasm, and orgasm
satisfaction on a 6-point scale from 1 (high level of functioning or satisfac-
tion) to 6 (absence of functioning). Thus, lower scores indicate better func-
tioning. The ASEX was designed to be self- or clinician administered, and it
is for use in heterosexual or homosexual populations regardless of availabil-
ity of a sexual partner. Individuals are considered to have a sexual dysfunc-
tion if they have a total ASEX score of 19 or greater or any one item with a
score of 5 or greater or any three items with scores of 4 or greater. In one
study, ASEX scores were highly correlated with the presence of clinician-
diagnosed sexual dysfunction (McGahuey et al., 2000). In a second study
comparing patients taking SSRIs to a normal control group, the ASEX demon-
strated excellent internal consistency (α = .91) and test-retest reliability
(patients, r = .80; controls, r = .89; Piazza et al., 1997). In the present study,
internal consistency for the transplant group was .82.

The second questionnaire, the Sexual Self-Esteem Scale, measures self-
estee in the sexual domain (Buzwell & Rosenthal, 1996). It consists of a
total of 20 items; each item is rated from 1 (strongly disagree) to 4 (strongly
agree). A score for the entire scale and each of four subscales is computed by
obtaining a mean of relevant items. The sexual behavior subscale (seven
items) measures enjoyment of one’s overall sexual activity. The sexual
attractiveness subscale (five items) assesses respondents’ feelings of their
sexual appeal and desirability. The sexual conduct subscale (five items)
focuses on feelings of the adequacy of behavior in sexual situations and with
a partner. The body perception subscale (three items) measures the respon-
dent’s contentment with his or her body and feelings of his or her body as
“mature.” For the overall scale and all subscales, higher mean scores indicate
higher levels of sexual self-esteem. In this sample, internal consistency for
the overall scale was .88. Three of the subscales (sexual behavior, sexual
attractiveness, and sexual conduct) had good reliability, and the fourth (body perception) had lower reliability (\( \alpha = .76, .73, .82, .56 \), respectively). The lower alpha for the body perception subscale may be because of the small number of items (Mishel, 1989).

The third questionnaire contained demographic items and questions to measure illness-related variables. Women were asked to list years of functioning organs, current medications, chronic illnesses, and/or diabetic neuropathy. At the very end of this questionnaire, there was an open-ended question asking women to describe the effect of transplant on their sexuality and sexual functioning. The open-ended question was, “Do you believe that your pancreas or renal transplant has affected your ability to perform sexually or your interest in sex? Please explain the effects if any that the transplant has had on this aspect of your life.”

Data Analysis

Content analysis was used to analyze responses to the open-ended question. This procedure had a number of steps. In the first step, one rater wrote each response on an index card, examined all responses, and sorted the cards into categories that shared a common theme. In the second step, the categories were named, and definitions were developed for each category. In the third step, cards were sorted into the named categories by a second rater. Definitions of some categories were then refined, and the cards were resorted by each rater independently. Using percentage agreement, interrater reliability was 92% after the second sorting. Discrepancies between raters were then resolved through discussion.

Findings

Responses to the ASEX were examined to determine the level of sexual functioning of the sample. Means for each item on the ASEX are reported next. The lowest mean score at 2.33 (\( SD = 1.21 \)) was reported for orgasm satisfaction, indicating that the women were most satisfied with this aspect of their sexual function. The mean rating for arousal ability was 2.85 (\( SD = 1.11 \)), whereas ability to orgasm received a mean rating of 3.10 (\( SD = 1.22 \)). The mean rating for sex drive was 3.16 (\( SD = 1.19 \)), and vaginal lubrication had the highest mean at 3.25 (\( SD = 1.08 \)), indicating that women were least satisfied with this aspect of their sexual function. Using the traditional method of scoring the ASEX, 27% of the women would be classified as having sexual dysfunction.
One problem with the traditional method of scoring the ASEX is that it does not allow women to be classified as having some difficulty with sexual function. They are considered either as dysfunctional or normal. We felt it was important to examine a middle group of women who reported some sexual difficulty but were clearly not dysfunctional. Therefore, the sample was divided into three groups: normal sexual functioning, some difficulty with sexual functioning, and sexual dysfunction. A participant who answered each individual item with a 3 or less (somewhat easy or better) was considered to have normal function. Approximately 39% \( (n = 24) \) of the women were classified as having normal sexual functioning. A participant who answered with a score of 4 or higher (somewhat difficult) in at least one of the five areas but did not meet the criteria for a sexual dysfunction was considered to have some difficulty with sexual functioning. Using this method, approximately 34% \( (n = 21) \) of the women would be classified as having some difficulty with sexual functioning. Finally, as previously noted, 27% \( (n = 17) \) of the women were classified as having a sexual dysfunction.

The overall sexual self-esteem scale score and subscale scores were then examined for the entire sample. The mean for the overall scale was 3.11 \( (SD = 0.47) \), suggesting that women tended to agree with the statements in the scale and reported a fairly high level of sexual self-esteem. The mean scores for the subscales were also fairly high and quite similar. Sexual attractiveness was rated lowest, with a mean of 2.98 \( (SD = 0.55) \), followed by the body perception subscale with a mean of 3.02 \( (SD = 0.59) \). The mean for the sexual behavior subscale was 3.16 \( (SD = 0.47) \), whereas the mean for sexual conduct was a bit higher at 3.24 \( (SD = 0.60) \).

To determine the relationship between sexual functioning and sexual self-esteem, correlations among the ASEX scale and the overall sexual self-esteem scale and its subscales were examined. The ASEX score was negatively correlated with the overall sexual self-esteem scale, \( r = -.43 \) \( (p < .01) \), the sexual conduct subscale, \( r = -.41 \) \( (p < .01) \), the body perception subscale, \( r = -.39 \) \( (p < .01) \), and the sexual behavior subscale, \( r = -.47 \) \( (p < .01) \).

Sexual self-esteem scores were then compared for women in each of the three sexual functioning groups. Mean scores on the overall scale and subscales for each of the groups are listed in Table 1. Analysis of variance revealed that the three groups differed significantly on the overall scale, \( F(2, 59) = 3.77, p < .05 \), and the sexual behavior, \( F(2, 59) = 4.99, p < .01 \), and the sexual attractiveness subscales, \( F(2, 59) = 3.58, p < .05 \). Using Fischer least significant difference, post hoc analyses were performed to locate the sources of group differences. Women in the normal sexual functioning group had significantly higher scores on the overall scale and on the sexual behavior subscale than did women with a sexual dysfunction or sexual difficulties.
In addition, women in the normal sexual functioning group had significantly higher scores on the sexual attractiveness subscale than did women in the group with sexual difficulties.

A relationship between illness-related variables and sexual function was not found. Women who had their transplant for 5 years or less did not differ in sexual functioning from those whose transplants had been completed more than 5 years prior, \( \chi^2(2, n = 62) = .49, p = .78 \). Because all of the women were taking prednisone and at least one other immunosuppressant and had at least one chronic illness (diabetes), it was not possible to examine whether these two illness-related variables differed by sexual functioning group. In addition, because of the small sample size, it was not possible to examine whether taking antihypertensives or SSRIs had an effect on sexual functioning because the data did not meet the assumptions for chi-square analysis. Presence of diabetic neuropathy did not differ by group, \( \chi^2(2, n = 61) = 1.22, p = .54 \).

Women’s perceptions of the consequences of their transplant on sexuality and sexual functioning were both positive and negative. Table 2 lists the positive and negative consequences identified. Of the women, 32% listed only positive effects of the transplant, and 28% listed only negative effects of the transplant. One woman had a mixed response, listing both positive and negative effects. Finally, 28.8% of the sample said that the transplant had no effect on their sexual lives, 6.4% did not respond to the question, and 4.8% were not

Table 1

<table>
<thead>
<tr>
<th>Name of Scale or Subscale</th>
<th>Women With Normal Sexual Functioning(^a)</th>
<th>Women With Some Difficulty in Sexual Functioning(^b)</th>
<th>Women With Sexual Dysfunction(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual conduct</td>
<td>3.40 0.57</td>
<td>3.22 0.59</td>
<td>3.06 0.67</td>
</tr>
<tr>
<td>Sexual behavior(^d)</td>
<td>3.40 0.40</td>
<td>3.11 0.37</td>
<td>2.99 0.56</td>
</tr>
<tr>
<td>Body perception</td>
<td>3.24 0.58</td>
<td>2.95 0.51</td>
<td>2.90 0.55</td>
</tr>
<tr>
<td>Sexual attractiveness(^e)</td>
<td>3.21 0.55</td>
<td>2.79 0.45</td>
<td>2.96 0.57</td>
</tr>
<tr>
<td>Overall sexual self-esteem(^d)</td>
<td>3.33 0.44</td>
<td>3.03 0.38</td>
<td>2.99 0.53</td>
</tr>
</tbody>
</table>

a. \( n = 24 \).
b. \( n = 21 \).
c. \( n = 17 \).
d. Indicates a significant difference between normal and the other two groups at \( p \leq .05 \).
e. Indicates a significant difference between normal and the sexual difficulty group at \( p \leq .05 \).
Table 2
Perceived Consequences of Transplant on Sexuality and Sexual Functioning

<table>
<thead>
<tr>
<th>Positive consequences</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved physical health leading to more energy, feeling better overall, and better quality of life.</td>
<td>42.3</td>
<td>11</td>
</tr>
<tr>
<td>More sex drive, better lubrication and arousal, increase in orgasmic strength.</td>
<td>38.5</td>
<td>10</td>
</tr>
<tr>
<td>Enhanced self-image or self-confidence.</td>
<td>13.4</td>
<td>4</td>
</tr>
<tr>
<td>Improved general psychological health leading to more interest in sex.</td>
<td>3.8</td>
<td>1</td>
</tr>
<tr>
<td>Negative consequences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of pregnancy or urinary tract infections, STDs, or other infections.</td>
<td>44.4</td>
<td>12</td>
</tr>
<tr>
<td>Decreased sexual functioning (e.g., lubrication) or interest in sex.</td>
<td>25.9</td>
<td>7</td>
</tr>
<tr>
<td>Body image—Scarring, side effects of medications.</td>
<td>22.2</td>
<td>6</td>
</tr>
<tr>
<td>Decreased energy or tiring easily.</td>
<td>7.4</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: A total of 26 positive responses and 27 negative responses were listed. Respondents could give more than one response.

For too long, sexuality has been largely ignored among women who have had simultaneous pancreas and kidney transplants. Providing comprehensive care to these patients requires specific exploration of sexual functioning, esteem, and consequences of transplantation. Important issues that must be addressed by nurses caring for these women are suggested by data in this study.

Among the women who reported positive consequences, 42% of responses related to improvements in physical health that enhanced their energy level and overall quality of life, and 39% related to enhanced capacity for sexual response. Among the women who reported negative consequences, 44% of responses concerned fear of infections or pregnancy, and 26% of responses concerned diminished interest in sex or a decrease in sexual functioning. Other consequences were negative body image and decreased energy.

Discussion

For too long, sexuality has been largely ignored among women who have had simultaneous pancreas and kidney transplants. Providing comprehensive care to these patients requires specific exploration of sexual functioning, esteem, and consequences of transplantation. Important issues that must be addressed by nurses caring for these women are suggested by data in this study.

It is encouraging to note the relatively high levels of sexual self-esteem in this sample. Using the classification derived by Buzwell and Rosenthal...
In (1996), these women would be considered sexually competent. Individuals in this category feel confident of their sexual appeal and body and are comfortable in sexual situations. On the other hand, fully one fourth of the women could be diagnosed as having a sexual dysfunction, and an additional 34% reported some sexual difficulty. Finally, there is a clear link between sexual self-esteem and sexual functioning. The ASEX score was correlated significantly with the overall score on sexual self-esteem and with three of four subscales. When the three sexual function groups were compared, women classified as having normal sexual functioning had significantly higher scores on the overall scale and on the sexual behavior subscale than did the other groups.

Responses to the open-ended question added an important dimension to this study. A significant portion of the women identified only positive consequences of the transplant on their sexual functioning. These consequences included improved physical health, which gave them more energy and better quality of life, an increase in sexual functioning including sex drive, better lubrication and arousal, and an increase in orgasmic strength. Some women reported that the transplant enhanced their self-image; one considered her scar a “badge of courage.” Others stated that after some initial adjustment, the transplant improved their sex life.

Of the women, 28% listed only negative consequences of transplant, including fear of infection and pregnancy, a decrease in sexual functioning including desire, lubrication, and lack of energy, and a decreased body image because of surgery scar or medication side effects. Some women stated that they were afraid to have sex because every incident resulted in a urinary tract infection. In addition to listing negative consequences, some women expressed disappointment over lack of information given to them regarding their medications and sexuality. For example, women stated that they were not given adequate information regarding medication side effects. Still others wished that someone would address the issue of sexuality with them. This result is not unique to our study. Hart et al. (1997) explored sexual concerns among organ transplant recipients. One of the variables examined was desire for and receipt of instruction regarding sexuality and fertility issues. In all, 67% of the sample indicated that they had never received information or instruction about possible sexual changes related to transplant. Of these individuals, 66% wished that they had been given this information. Of the individuals who did receive instruction, 85% found it useful.

It is important for clinicians to address the issue of sexual functioning with all women who have received a pancreas and renal transplant. Problems in sexual functioning are treatable once properly diagnosed; however, clini-
cians often overlook these problems (Phillips, 2000). Assessment of sexual functioning should be a regular aspect of clinical care. Such assessment could involve simply administering the ASEX to all women who have received a transplant. This questionnaire is brief and easily administered and contains specific areas of troublesome functioning. Thus, it is ideal for use in clinical settings.

Using the ASEX responses as a guide, treatment can be targeted at specific symptoms. For example, a problem with vaginal lubrication can be addressed by suggesting the use of over-the-counter lubricants such as KY Jelly and Astroglide. Discussions must be detailed so that patients know how much lubricant may be needed and how to apply it. Difficulties with orgasm may be related to use of SSRI antidepressants. If the clinician believes that the problem is being caused by a medication, changing to a different antidepressant can be discussed. Offering specific, fairly simple solutions to sexual problems may make a major difference in the lives of transplant patients.

Some sexual problems will be complex and difficult to address. For example, impaired immune system functioning can lead to susceptibility to infection and a realistic fear of sexual activity. It may be possible to reduce the dose of immunosuppressants and/or provide prophylactic medication to prevent infection. If patients feel free to discuss their sexual problems and fears with clinicians, strategies to overcome these issues can be attempted.

Psychological issues related to sexuality also merit attention from clinicians. For example, the data from this study clearly indicate that sexual self-esteem is linked to sexual functioning. Often, clinicians are afraid to pursue psychological issues because of fear that they will be unable to handle them adequately. A caring discussion about perceptions of self may be truly helpful to women. If the problem is serious and sustained, referral to a support group or counselor is indicated and should be initiated by the clinician.

There were some limitations to this study. The first is that a convenience sample was used. All participants were recruited from the same transplant center. Another limitation is a relatively low response rate of 43%. Although this sample size seems small by comparison to other studies, it is not uncommon for research with transplant recipients (Toorians et al., 1997). One possible explanation could be that many of the women were not comfortable participating in the study because of the sensitivity of the subject addressed, and no reminders were sent in an attempt to protect confidentiality of the patient. Despite these limitations, this study provides important information about potential sexual problems that women may experience after receiving a simultaneous pancreas and kidney transplant and some areas in which assessment and intervention are needed.
References


