SSRIs and Sexual Dysfunction

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SSRIs and related antidepressants are great drugs for the treatment of depression, anxiety, premenstrual disorders, and other conditions. However, sexual dysfunction is very common and affects 30% to 70% of patients,[1] or 36% to 43% of patients depending on the particular medications and the study protocol.[2] Men are somewhat more likely than women to have difficulty, especially with the desire phase of sexual function. However, it is clear that patients of both sexes may have either phase-specific or global sexual dysfunction while taking antidepressants.

The pharmacological difficulty is in addition to any prior impairment in sexual functioning. Depression, in particular, is well known for interfering with sexual desire and performance. Approximately 40% of men and 50% of women with major depression report low libido and problems with sexual arousal in questionnaires investigating sexual activity in the month before diagnosis and treatment.[3]

Therapeutic Strategies
There are many options for dealing with patients taking an SSRI (or other type of antidepressant) in whom sexual dysfunction develops. The fact that there are so many possible interventions may indicate that no one approach is all that successful. Also, what works for one patient may not be appropriate or work for someone else.

Strategy 1: Choosing/switching to a more benign drug. A well-done Spanish prospective study followed more than 1000 patients with previously normal sexual function who started taking an antidepressant.[4] The treating psychiatrists, all trained in the use of a detailed sexual dysfunction questionnaire, filled out the form for each patient visit before the patient started taking an antidepressant and through the entire course of treatment. The investigators found that different antidepressants were associated with differing rates of sexual dysfunction. The antidepressants citalopram, paroxetine, and venlafaxine were associated with the highest rates of sexual dysfunction (about 70%); sertraline, fluvoxamine, and fluoxetine were next (about 60%). Mirtazapine, nefazodone, and moclobemide (a reversible inhibitor of monoamine oxidase A available in Europe and other places, but not in the United States) were far less likely to cause a problem (all less than 25%, with moclobemide at 3.9%). Other studies have shown that bupropion is associated with fewer sexual adverse effects than an SSRI.[5] Because of its dopamine-promoting properties, it may actually enhance sexual response. There are also some data indicating that both escitalopram and duloxetine may be associated with fewer sexual adverse effects than other agents.[6]

If one remembers these statistical differences between antidepressants in the likelihood of causing sexual dysfunction, initially choosing a more benign agent may make sense for someone at risk. This kind of information is also pertinent when thinking about switching the patient to an alternative antidepressant after the emergence of sexual difficulty.
Strategy 2: Using bupropion or another agent adjunctively. Bupropion is my preferred adjunctive treatment. It is a dopamine enhancer and thus is likely involved with various brain centers associated with the experience of pleasure and mitigating emotional distress. It is not surprising that adding bupropion to an SSRI often results in an enhanced antidepressant response accompanied by a lessening of any sexual difficulty. Unfortunately, one has to approach the adjunctive use of bupropion a bit gingerly, since there is some interaction between bupropion and some of the SSRIs and serotonin-norepinephrine reuptake inhibitors (SNRIs) as a result of cytochrome P-450 effects. Also, the usual dosage of 150 mg/d may not work, and one may have to gradually increase the dosage of sustained- or extended-release bupropion up to 300 mg/d. Other dopaminergic compounds are also sometimes useful to counter antidepressant sexual adverse effects, especially amantadine or buspirone (acting indirectly on the dopamine system).

Strategy 3: Adding a phosphodiesterase inhibitor. In many ways, this is a great strategy. Phosphodiesterase inhibitors do not interfere with antidepressants and are quite effective. These drugs can often counter most of the sexual adverse effects of SSRIs/SNRIs. Sildenafil, which is the best-studied, not only improves erectile problems associated with antidepressant treatment but also is effective in improving libido and helping achieve orgasm. The major problem with this strategy is cost. Phosphodiesterase inhibitors in general are subject to strict quantity limits in most drug plans, if they are covered at all. Furthermore, using these drugs for managing a medication adverse effect is usually explicitly excluded. I understand the cited rationale for such exclusion (ie, not masking a problem with second drug), but patients end up having to pay out-of-pocket for sexual difficulties related to their depression/anxiety and its treatment.

Strategy 4: Waiting it out. In my own practice, I remind my patients that sexual dysfunction from an antidepressant is limited to the time that they take the drug. When patients stop taking the medication, sexual adverse effects diminish fairly rapidly. Patients almost always return to their usual level of sexual functioning. So while there may be a drug-related adverse effect, no damage is done to sexual organs or, for that matter, the brain. If it is a first-time depression, perhaps just waiting out the symptom makes sense. The symptom will either go away as the person continues to take the medication (this occurs in about 10% of patients), or it will go away after the medication is stopped in 6 to 12 months.

References:

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