

## Unanswered Questions during the live event and their answers:

1- If not CLINICALLY beneficial overall shouldn't such non-essential life-style habits be considered as a risk NOT worth taking?

*The risk for the absolute rate of events is miniscule because exposure to sexual activity is of short duration and constitutes a very small percentage of the total time at risk for myocardial ischemia or MI. Sexual activity is the cause of 1% of all acute MIs (source Levin et al, 2012). We believe that as with all activities, patient and partners should be informed about this minimal risk and decide themselves what activities to undertake.*

2 -What are the side-effects of Silendafil & what are its contra-indications + what are the main cardiovascular drug interactions?

*PDE5 inhibitors are generally safe and effective for the treatment of ED in patients with systemic arterial hypertension, stable CAD, and compensated heart failure (source Levine et al, 2012). As mentioned in the webinar, PDE5 inhibitors should not be used in patients receiving nitrate therapy, since these agents cause systemic vasodilation and mild reductions in systolic and diastolic systemic blood pressure).*

3 - Doesn't new-onset erectile dysfunction as a primary symptom warrant investigation for underlying vascular insufficiency?

*As mentioned in the webinar and also is advocated in The Princeton III Consensus Recommendations for the Management of Erectile Dysfunction (Nehra et al, 2012) that all men All men with ED should have their cardiovascular risk assessed.*

4 - In patients with DIABETES would one have a lower threshold for asking about sex dysfunction as part of c-v. Screening?

*As mention in de webinar there are different 'contexts' that can be suitable to use when discussing sexual function. The context of C-v- screening in diabetes would be a good one to add.*

5 - Shouldn't safer forms of physical activity be advised to attain healthier cardio-vascular exercise?

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6 - In women with h/o. D.V.T. (+/- P.E.) aren't some oral contraceptives contraindicated? What are their safer Rx alternatives?

*As described in Levine 2012 et al, Women with CVD should be counseled regarding the safety and advisability of contraceptive methods and pregnancy when appropriate (Class I; Level of Evidence C). We can also refer to: Sable C, Foster E, Uzark K, Bjornsen K, Canobbio MM, Connolly HM, Graham TP, Gurvitz MZ, Kovacs A, Meadows AK, Reid GJ, Reiss JG, Rosenbaum KN, Sagerman PJ, Saidi A, Schonberg R, Shah S, Tong E, Williams RG. Best practices in managing transition to adulthood for adolescents with congenital heart disease: the transition process and medical and psychosocial issues: a scientific statement from the American Heart Association. Circulation. 2011; 123:1454 –1485*

7 - In what congenital cardio-vascular conditions would pregnancy be inadvisable (and how soon should patients be counselled?)

*Issues regarding contraception and pregnancy are particularly important in women with CHD. A study of women with CHD lesions associated with a high risk of pregnancy-related cardiovascular complications showed that 28% were not using adequate birth control methods, 20% were using methods considered contraindicated for their condition, 43% had not been counseled about contraception, and 48% had not been informed of pregnancy-related risks. As described in Levine 2012 et al, We can also refer to: Sable C, Foster E, Uzark K, Bjornsen K, Canobbio MM, Connolly HM, Graham TP, Gurvitz MZ, Kovacs A, Meadows AK, Reid GJ, Reiss JG, Rosenbaum KN, Sagerman PJ, Saidi A, Schonberg R, Shah S, Tong E, Williams RG. Best practices in managing transition to adulthood for adolescents with congenital heart disease: the transition process and medical and psychosocial issues: a scientific statement from the American Heart Association. Circulation. 2011; 123:1454 –1485*

8 - What absolute contraindications preclude sex - and are there any associated sex differences (except for pregnancy risks)?

*Patients with unstable, decompensated, and/or severe symptomatic CVD should defer sexual activity until their condition is stabilized and optimally managed and patients with CVD who experience cardiovascular symptoms precipitated by sexual activity should defer sexual activity until their condition is stabilized and optimally managed (source Levine 2012)*

9 -In tachycardia Hypertensive patients with uncontrolled Atrial Fibrillation what level of B.P. & H.R. makes sex DANGEROUS?

*As far as we know there are no absolute and specific HR and BP values that are described as being dangerous that are especially related sexual activity. Practically one would say that dangerous BP and HR are the same for other activities. IN the AHA statement (Levine et al, 2012) it is written: Sexual activity is reasonable for patients with atrial fibrillation or atrial flutter and well-controlled ventricular rate.*

10 - Couldn't some venereal diseases ^ c.v. risk? So unless depressingly mitigated isn't it better to abstain but exercise safely?

*In this webinar we did not discuss the relationship between getting a heart disease and sexual activity. In the view of general safe sex behavior we would advocate the general public to practice safe sex to prevent any disease. But we do not advocate refraining from sexual activity for everyone to prevent 'bad things' to happen.*

11 - In patients with Hypercoagulable conditions > any circumstances when contraceptive risks would outweigh pregnancy risks?

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12 - Sex activity costs physically 3-5 MET but is associated with a variable psychologic involvement that may induce a dangerous heart response as heart rate blood pressure and so on. What you thing about?

*We indeed agree that sexual actiivtiy does not always cost 3-5 MET and for some people it might cause additional stress and stain on the heart. Individual counssneling and tailored advice is needed As Steinke et al, 2013 wirte in their statement: to reduce the psychological sequelae associated with CVD, sexual counseling can be useful for most patients and their partners.*

13 - After uncomplicated AMI it is better to back to sexuall activy as soon as possiple?

*The current guidelines advice: Sexual activity is reasonable 1 or more weeks after uncomplicated MI if the patient is without cardiac symptoms during mild to moderate physical activity(Levine, 2013).*

14 - In heart failure patients..What sexual activity are they allowed to..Eg METS

*Sexual activity is reasonable for patients with compensated and/or mild (NYHA class I or II) heart failure and sexual activity is not advised for patients with decompensated or advanced (NYHA class III or IV) heart failure until their condition is stabilized and optimally managed (Levine et al., 2012). Depending on the physical condition in other activities, sexaul activity can be planned and generally advised to 'start low and go slow'.*

15 - Colleagues in China expressed surprise that sexual activity was covered as a topic. How do we manage this? is this a widespread view?

*As we mentioned in the webinar, sexual activity is a topic that is not always easy to take up, but the topic is increasingly addressed in educational activities (including this webinar) and slowly the awareness to discuss this subject with patients is increasing.*

16 - Do you find that medications adverse effects have a significant impact on patient sexual function?

*As discussed in the webinar there is still no 'hard' evidence that cardiac medication have side effects on sexual function, however, some are described to have effects on sexual functions. However, as Steinke et al (2013) write: it is important to discuss this with patients, since some patients do report these and with regard to to report any side effects of medications related to sexual activity and to inform the patient to not stop taking the medication if a side effect is experienced; as long as cardiac risk is not altered, it can be beneficial to change medication dosage or drug type to minimize impact on sexual function.*

17 - When we can prescribe lavitra for long time treatment?

*The active component of Levitra/Lavitra is Vardenafil and the current guidelines (Levine et al, 2012) : PDE5 inhibitors are generally safe and effective for the treatment of ED in patients with systemic arterial hypertension, stable CAD, and compensated heart failure. As mentioned in the webinar, PDE5 inhibitors should not be used in patients receiving nitrate therapy, since these agents cause systemic vasodilation and mild reductions in systolic and diastolic systemic blood pressure).*

18 - When is the right time to start the discussion about the sexual life with the patients?

*This was discussed in the webinar and we would also recommend to have a closer look at the document by Steinke et al (2013) that actually has summarized the thoughts about this. They also write that from 1 study it was found patients stated that they would prefer to receive general information about the effect of the cardiac event on sexuality when hospitalized; however, some patients preferred more specific information, such as the ideal setting for sexual activity, to be provided later, after hospital discharge.*

19 - How when and who should deliver sexual counselling? Some research reveals that patients expect providers to initiate this. Even if it is offered however there is low uptake reported in the literature at least in the AMI group. How to address this?

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20 - Do you think that sexual activity decreases the risk of further CV event and is sex activity associated with cognition?

*As Levine (2012) describes: The relative risk of MI does not appear to be higher in subjects with a history of MI than in those without prior known CAD.*

21 - Are there any guidelines on this area?

*We would like to recommend 3 papers that we referred to in our Webinar: 1. Steinke EE et al. A Scientific Statement from the American Heart Association. Circulation 2012;125:1058-1072 and 2. Levine GN A Scientific Statement from the American Heart Association. Circulation 2012;125:1058-1072 and 3. Nehra et al: The Princeton III Consensus Recommendations for the Management of Erectile Dysfunction and Cardiovascular Disease Mayo Clin Proc. 2012;87(8):766-778.*

22 - Should patients in primary care being diagnosed with ED automatically be screened for CV risk factors?

*As mentioned in the webinar and also is advocated in The Princeton III Consensus Recommendations for the Management of Erectile Dysfunction (Nehra et al, 2012) that all men All men with ED should have their cardiovascular risk assessed.*

23 - What is the cut off for low BP for these treatments?

*As far as we know the guidelines do not provide specific cut off values.*

24 - Suppose that you already addressed the sexual problem that your patient has experiencing after having and MI 1 year ago and he/she tell you than feels tired and cannot run anymore but the cardiac images did not show any significant structural heart problem could you consider to order an exercise test with his cardiologist before to recommend him/her start having a normal sexual activity?

*We believe such a patient should be referred to a cardiologist and additional testing is recommended*



25 - If a patient is under Pulmonary Hypertension treatment with sildenafil or tadalafil but still have sexual problems how could we help to it?

*We suggest to refer this patient. As Mehra 2012 and the Princeton panel suggest: the panel encourages a collaborative approach to the management of men's sexual function and cardiovascular risk, incorporating general, urologic, endocrine, and cardiologic expertise.*

26 - The first discussion should take place before discharge from the hospital and with the patient's partner present?

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27 - Every sexual counselling must to have question: use nitrates with PDE5 inh.(sildenafil tadalafil...)=DANGER!! Please for your opinion-it's very important for practice!

PDE5 inh.with nitrates-I redid question for dangers in this combination.

*PDE5 inhibitors are generally safe and effective for the treatment of ED in patients with systemic arterial hypertension, stable CAD, and compensated heart failure (source Levine et al, 2012). As mentioned in the webinar, PDE5 inhibitors should not be used in patients receiving nitrate therapy, since these agents cause systemic vasodilation and mild reductions in systolic and diastolic systemic blood pressure).*

28 - HR BP METS-pleas for CLASS/LEVEL in guidelines? And for nebivolol-what is class/level (guidelines)?

*The evidence level in the guidelines is recognized as low and most statements have a Class III; Level of Evidence C.*

*The guidelines (Levine et al 2012) suggest: In male patients with clearly established -blocker– induced sexual dysfunction, nebivolol (which has nitric oxide–mediated vasodilating properties and a lower incidence of ED than other -blockers) may be considered provided the -blocker is not being administered specifically for survival improvement for the patient with systolic heart failure or after MI.*

29 - When can you resume sexual activity after MI?

*The current guidelines advice: Sexual activity is reasonable 1 or more weeks after uncomplicated MI if the patient is without cardiac symptoms during mild to moderate physical activity (Levine, 2013).*

30 - Please name some of the contemporary psychotherapeutic techniques most relevant to cardiac patients with erectile dysfunction.

*A Cochrane review conducted in 2007 to evaluation the effectiveness of psychosocial interventions for erectile dysfunction concluded that there is some evidence that group psychotherapy may improve erectile function. Treatment response varied between patient subgroups, but focused sex-group therapy showed greater efficacy than control group (no treatment). No differences in effectiveness were found between psychosocial interventions versus local injection and vacuum devices. See the full review at:*  
<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004825.pub2/full>

31 - Will aerobic exercise improve sexual satisfaction?

*Cardiac rehabilitation can improve the exercise capacity of patients who received transplants, enabling them to achieve improvements in physical activity, which may also enhance sexual functioning (Steinke et al, 2013).*

32 - Will yoga helpful to address this issue?

*There is little empirical research exploring the relationship between yoga and sexual dysfunction. However, you may be interested to read the following article which suggests that this may be a useful avenue for future research: Lori A. Brotto , Lisa Mehak , Cassandra Kit (2009) Yoga and Sexual Functioning: A Review. Journal of Sex & Marital Therapy, Vol. 35, Iss. 5, 2009*

33 - What about patient with cardiac devices e.g. defibrillators?

*Levine et al 2013 write: Sexual activity is reasonable for patients with an ICD implanted for primary prevention . Sexual activity is reasonable for patients with an ICD used for secondary prevention in whom moderate physical activity (>3–5 METS) does not precipitate ventricular tachycardia or fibrillation and who do not receive frequent multiple appropriate shocks. Sexual activity should be deferred in patients with an ICD who have received multiple shocks until the causative arrhythmia is stabilized and optimally controlled. Strategies are available for healthcare specialists to use in counseling ICD patients and their partners,61,64 and an excellent “Cardiology Patient Page” (<http://circ.ahajournals.org/content/122/13/e465.long>) addresses the concerns of patients and partners*

34 - Could we please get the references for the 2 articles you referred to?

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35 - To what level of physical activity could we address sex? What limitation in sex activity should we advise for patients?

*As discussed in the webinar we advise to have a tailored approach and discuss openly with a patient and partner what will be safe and feasible for the patient in his/her situation.*