

Sexual function in older adults with thoracolumbar-pelvic instrumentation

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Surgeons investigated sexual function in 62 patients, 50 years and older, who had received extensive spinal–pelvic instrumentation for spinal deformity at the University of Virginia Health Center. Based on their results, the surgeons found that it is very possible for older people to achieve satisfactory sexual function despite having extensive spinal–pelvic instrumentation. Details of this study are disclosed in "Sexual function in older adults following thoracolumbar to pelvic instrumentation for spinal deformity. Clinical article," by Dr. D. Kojo Hamilton and colleagues, published today online, ahead of print, in the *Journal of Neurosurgery: Spine*.

Spinal instrumentation is a metal (or nonmetal) device or complex of devices—screws, hooks, rods, wires, cables, plates, and/or "spinal cage"—that is attached to [vertebrae](#) to correct deformity and instability of the spine and allow fusion between vertebrae. It is used in patients with spinal disorders caused by [congenital defects](#), illness (such as cancer), trauma, or advanced age. The human spine generally contains thirty-three vertebrae, twenty-four of which are movable. The surgeon may place instrumentation at only one vertebral level or along several levels to reposition and stabilize the spine.

Weakness or deformity of the spine is a fairly common sign of aging. The authors cite another study that reported that the prevalence of spinal deformity in the elderly could be as high as 68 percent. As the baby-boomer population inexorably moves toward "elderly" status, more and more [surgeries](#) will have to be performed to correct spinal deformity and

improve older persons' quality of life. An important aspect of health-related quality of life, sexual function, has been largely overlooked in [older adults](#) with spinal instrumentation. The authors of this paper set out to examine whether and how spinal instrumentation affects these patients' sexual function.

The authors focused on 54 patients (37 women and 17 men, ages 50 to 83 years) who had received spinal instrumentation during surgery to treat scoliosis (abnormal curvature of the spine from side to side), kyphosis (excessive [humpback] curvature of the thoracic spine), or kyphoscoliosis (mixture of scoliosis and kyphosis). Spinal instrumentation in these patients extended for six to 18 vertebral levels (mean nine levels) and affected the thoracic and lumbar portions of the spine as well as the pelvis. The patients reported on their health-related quality of life by filling out questionnaires on general health issues (12-Item Short-Form Health Survey), physical disability (Oswestry Disability Index), and sexual function (14-Item Changes in Sexual Function Questionnaire).

Thirteen of the 54 patients reported no sexual dysfunction. Among the 41 patients who reported some level of sexual dysfunction, eight patients (15 percent) described the dysfunction as mild, 10 patients (19 percent) as moderate, and 23 patients (42 percent) as severe. Of the 23 patients with severe sexual dysfunction, nine had no available sexual partner and 11 had additional medical disorders and concomitant physical disabilities that prevented them from experiencing satisfactory sexual function.

When the authors examined the relationship between sexual dysfunction and the severity of disabilities facing the patients, they found that "patients with minimal or moderate disability tended to have no or mild sexual dysfunction." An examination of the relationship between sexual dysfunction and patient age (separating patients in their 50s, 60s, and 70s) showed no significant correlations.

In their discussion of the findings, the authors reiterate that severe sexual dysfunction was experienced by a substantial percentage of patients (42 percent), but in large part it appeared to be attributable to the lack of a sexual partner (through death or illness of the partner) or a disabling medical comorbidity. The percentage of older adults with thoracolumbar–pelvic instrumentation who reported no or only mild [sexual dysfunction](#) was also high (nearly 40 percent), and this reflected the ability of minimally disabled older people to have satisfactory sexual function.

One finding of this study seemed to surprise the authors. Only one patient complained of symptoms due to iliac bolts. Published reports by other surgeons suggest a higher percentage of patients with discomfort due to these bolts. The authors believe that the difference between their findings and those of other studies rests on operative technique. In this group of patients, iliac bolts were placed below the surface of the iliac spine of the pelvis; in other reported patient groups, the bolts may not have been recessed below the surface of the bone.

The authors point out the limitations of their study (retrospective nature, heterogeneous patient population, lack of preoperative determination of [sexual function](#)) and mention that the report should be viewed as preliminary because a prospective controlled investigation is in the planning stages. Despite its limitations, the importance of this study lies in the positive message it has for older [patients](#) with extensive thoracolumbar–pelvic instrumentation. Dr. D. Kojo Hamilton, first author of the report, states, "After extensive spine reconstructive surgery for degenerative [spinal deformity](#), sexual activity and satisfaction are achievable in healthy older adults with available partners."

More information: Hamilton DK, Smith JS, Nguyen T, Arlet V, Kasliwal MK, Shaffrey CI. Sexual function in older adults following thoracolumbar to pelvic instrumentation for spinal deformity. Clinical

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