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Frequency and factors associated with sexual dysfunction in chronic low back pain in Ouagadougou (Burkina Faso).

Fréquence et facteurs associés aux troubles sexuels au cours de la lombalgie commune chronique à Ouagadougou (Burkina Faso).

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ABSTRACT

Aim: To evaluate the frequency and factors associated with sexual disorders during chronic common low back pain in Ouagadougou (Burkina Faso).
Material and methods: We conducted an analytic cross-sectional study from May 10 to September 10, 2019, of adult patients with chronic non-deficient common low back pain. Sexual disorders were screened using the Male Sexual Health Questionnaire (MSHQ) in men, and the Female Sexual Function Index (FSFI) in women. We assessed the frequency of these sexual disorders, and the factors associated with them, among the epidemiological and functional (Owestry disability index) characteristics of the patients.
Results: One hundred and fourteen patients were included in the study. Their mean age was 46.5 +/- 3.5 years and the sex ratio was 0.36. Of these patients, 93 (81.6%) had a sexual disorder, i.e. 21 out of 30 men (70%), and 72 out of 84 women (85.7%). A sedentary lifestyle (p=0.04), smoking (p=0.01) or alcohol consumption (p=0.03), or the presence of a moderate or severe functional disability (p=0.03) significantly influenced the occurrence of sexual disorders in men. A sedentary lifestyle (p=0.04), overweight and obesity (p=0.02), or the presence of a moderate or severe disability (p=0.02) significantly influenced the occurrence of sexual disorders in women.
Conclusions: Sexual dysfunction was common among patients with chronic low back pain in Ouagadougou. Their frequency was 81.6%, and the associated factors were a sedentary lifestyle and the presence of a moderate or severe functional disability, in addition to overweight and obesity in women, and smoking and alcoholism in men.

Key words: *low back pain, sexual disorder, frequency, sub-Saharan Africa*

RESUME

Objectif : Evaluer la fréquence et les facteurs associés aux troubles sexuels au cours de la lombalgie commune chronique à Ouagadougou (Burkina Faso).
Patients et méthodes : Nous avons mené une étude transversale à visée analytique allant du 10 mai au 10 septembre 2019, portant sur des patients adultes ayant une lombalgie commune chronique non déficitaire. Les troubles sexuels ont été dépistés à l'aide du Male Sexual Health Questionnaire (MSHQ) chez l'homme, et du Female Sexual Function Index (FSFI) chez la femme. Nous avons évalué

la fréquence de ces troubles sexuels, et les facteurs qui y étaient associées parmi les caractéristiques épidémio-cliniques, et fonctionnelles (Owestry disability index) des patients.
Résultats : Cent quatorze patients ont été inclus dans l'étude. Leur âge moyen était de 46,5 +/- 3,5 ans et le sex ratio était de 0,36. Parmi ces patients, 93 (81,6%) avaient un trouble sexuel soit 21 hommes sur 30 (70%), et 72 femmes sur 84 (85,7%). Chez les 30 hommes, on observait des troubles sévères ou moyennement sévères de l'érection chez 13 patients (43,4%), et 33,3% à 46,7% des patients étaient très gênés ou extrêmement gênés par leur troubles sexuels. La sédentarité (p=0,04), la consommation de tabac (p=0,01), ou d'alcool (p=0,03), ou la présence d'un handicap fonctionnel modéré ou sévère (p=0,03) influaient significativement la survenue des troubles sexuels chez les hommes. La présence concomitante de ces quatre éléments augmentait le risque de 70% d'avoir un TS (p=0,01). Parmi les 84 femmes, 37 (44%) avaient un troubles sexuel minime, 27 avaient un trouble modéré (32,1%), et 15 avaient un trouble sévère (17,9%). La sédentarité (p=0,04), le surpoids et l'obésité (p=0,02), ou la présence d'un handicap modéré ou sévère (p=0,02) influaient significativement la survenue de troubles sexuels de la femme. La présence concomitante de ces trois éléments augmentait le risque de 50% d'avoir un troubles sexuel (p=0,02).
Conclusion : Les troubles sexuels étaient fréquents chez les patients souffrant de lombalgie commune chronique à Ouagadougou. Leur fréquence était de 81,6% et les facteurs associés étaient la sédentarité et la présence d'un handicap fonctionnel modéré ou sévère ; et ce en plus du surpoids et de l'obésité chez la femme, et du tabagisme et de l'alcoolisme chez l'homme.

Mots clés : *Lombalgie ; trouble sexuel ; fréquence ; Afrique subsaharienne.*

1. Introduction

Low back pain is the leading cause of consultation in musculoskeletal pathology [1,2]. Depending on the study, the frequency of chronic low back pain (CLBP) varies between 1.2% and 43% [1,2]. It is a disabling pathology, which impairs locomotor function and the psychological state of three-quarters of patients [2]. According to several studies, CLBP has a severe impact on the sex lives of patients and their partners [3-5]. Indeed, the prevalence of sexual dysfunction (SD) during CLBP is estimated at 46% [6,7]. Associated factors include pregnancy, certain sexual positions, advanced age and the presence of a severe disability [5,8-12]. The severity of radiological lesions does not appear to influence the occurrence of sexual disorders [13]. In the Maghreb, the frequency of sexual disorders in low back pain varies between 66% and 82% [5,14,15]. In Sub-Saharan Africa, 27.6% to 67.7% of common chronic low-back pain sufferers have sexual dysfunction [16-18]. Hence the following research question: what is the frequency and factors associated with SD in patients with CLBP in our working context? The aim of our work was therefore to assess the frequency and factors associated with sexual dysfunction in chronic common low back pain, with a view to improving its management.

2. Patients and method

This was a prospectively collected cross-sectional study, with analytical aims, over a four-month period from May 10 to September 10, 2019, focusing on patients with common low back pain. We included two hundred patients (54 men and 146 women) over 18 years of age, seen in a rheumatology consultation for chronic non-deficient common low back pain and who had given written consent. The diagnosis of common low back pain was made on the basis of a clinical and paraclinical examination, after excluding other causes of secondary low back pain such as inflammatory rheumatism, infections, neoplasia, and other weakening osteopathies). We excluded Eighty-six (24 men and 62 women) patients with diabetes mellitus or known cardiovascular or neurodegenerative pathology, those with pre-existing sexual disorders prior to the onset of low back pain, and those who refused to participate in the study. We therefore included 114 people, i.e. 30 men and 84 women (sex ratio 0.36). The mean age of the patients was 46.5 ±3.5 years, with extremes of 20 and 84 years. The investigative method was a questionnaire, with informneoplasiaation collected during a medical consultation carried out by a rheumatologist and assisted by a physician with specialized training in rheumatology.
In terms of the variables studied, the epidemiological and sociodemographic characteristics of the patients were: age, marital status, level of education and profession. The clinical aspects studied were: semiological characteristics of low back pain, pain intensity assessed on a visual analog scale out of 10, history, lifestyle, body mass index (BMI) according to the World Health Organization classification, radiological lesions, and treatments received by patients. The functional impact of low back pain and its impact on patients' quality of life were also assessed using the Owestry Disability Index (ODI) questionnaire [19].
Male sexuality was assessed using the Male Sexual Health Questionnaire (MSHQ), which measures overall male sexuality [20]. This tool comprises 25 questions exploring four domains: erection, ejaculation and orgasm, desire, and the man's satisfaction with his sexuality [20]. For each domain, one question assessed the discomfort associated with the possible existence of a disorder [20]. The MSHQ has enabled us to determine the frequency of a sexual disorder, and its epidemiological characteristics according to the different domains of male sexuality.L'évaluation de la sexualité féminine a été faite en utilisant le « Female Sexual Function Index » (FSFI) [20]. This tool assesses female sexuality as a whole, covering the domains of desire, arousal, lubrication, orgasm, satisfaction and pain. The FSFI enabled us to determine the

frequency of a sexual disorder, and its epidemiological characteristics according to the different domains of female sexuality.
Factors associated with sexual disorders were sought among the patients' epidemiological and functional (ODI) characteristics, using statistical analysis. Data were entered and analyzed using IBM SPSS Stastistics 25 software. The significance level for statistical tests was set at 5%. The chi-square test was used to determine a statistical relationship between two categorical variables. In the event of a link between two categorical variables in the bivariate analysis, a multivariate analysis, in this case logistic regression (binary if two modalities, and multinomial if several modalities) was performed to explain the behavior of the variables. The study protocol was validated by the Health Research and Ethics Committee, and the confidentiality and anonymity of respondents were respected in accordance with Helsinky recommendations.

3. Results

3.1. Sociodemographic characteristics and frequency of sexual disorders

Two hundred patients (54 men and 146 women) were followed up for chronic non-deficient low back pain during the study period. Eighty-six (24 men and 62 women) patients were excluded from the study due to pre-existing cardiovascular pathology and/or sexual disorders. We therefore included 114 people, i.e. 30 men and 84 women (sex ratio 0.36). The mean age of the patients was 46.5 ±3.5 years, with extremes of 20 and 84 years. Ninety-three (81.6%) patients had a sexual disorder (SD). These included 21 (70%) men and 72 (85.7%) women. There was no statistically significant difference between the mean age of patients with and without sexual dysfunction (p=0.3). According to the socio-professional status of female patients, 36 women (31.6%) were housewives, 26 were shopkeepers or commercial employees (22.8%), nine were teachers (7.9%), five were pupils or students (4.4%), six were farmers (5.3%), 10 were health workers (8.8%), two were drivers (1.7%), and 20 had other miscellaneous occupations (17.5%). There was no statistically significant difference between the socio-professional status of patients with sexual disorders and those without (p=0.2). Concerning the educational level of male patients, 46 (40.4%) were illiterate, 17 (14.9%) had primary education, 36 (31.6%) had secondary education, and 15 (13.1%) had higher education. There was no statistically significant difference between the educational level of patients with and without sexual disorders (p=0.2).

3.2. Clinical features

Isolated low back pain was present in 52 (45.6%) patients, and low back pain in 62 (54.4%); 42 (36.8%) patients had claudicating low back pain. The mean duration of symptoms was 45 months, with extremes of 3 months and 18 years. There was no statistically significant difference between the presence of sciatica or intermittent claudication in patients with and without sexual dysfunction, with p=0.4 and p=0.3 respectively. Mean pain intensity on the visual analog scale (VAS) was 4.82 ±3.25, with extremes of 3 and 9. There was no significant difference in pain intensity between patients with and without sexual dysfunction (p=0.2). In terms of patient history, 39 (34.2%) patients had no previous medical or surgical history, 34 (29.8%) had previously consulted a doctor for a peripheral joint or abarticular pathology, 26 (22.8%) had epigastralgia, 10 (8.8%) had had a previous lumbar trauma, three (2.6%) had a history of lumbar surgery, and two (1.8%) had viral hepatitis B. The presence of a history was not statistically associated with sexual dysfunction (p=0.4).
In terms of female lifestyle, 51 (60.7%) patients were sedentary, five (6%) regularly consumed alcohol, and two (2.4%) smoked. Sedentary lifestyle was statistically associated with sexual dysfunction (p=0.04). In multivariate analysis, binary logistic regression found that a sedentary lifestyle increased the risk of a sexual disorder in women by 30% (p=0.04). As for men, 16 (53.3%) patients were sedentary, 10 (33.3%) regularly consumed alcohol, and eight (26.7%) were regular smokers. Sedentary lifestyle (p=0.04), smoking (p=0.01), or alcohol consumption (p=0.03), or the existence of all three combined (p=0 ,02) were statistically associated with male sexual dysfunction. In multivariate analysis, binary logistic regression found that regular tobacco and alcohol consumption combined with a sedentary lifestyle increased the risk of a male sexual disorder by 60% (p=0.03). Twenty-eight (24.6%) patients had a normal BMI, 56 (49.1%) were overweight and 30 (26.3%) were obese. On bivariate analysis, overweight and obesity were statistically associated with sexual dysfunction (p=0.03). In binary logistic regression, they increased the risk of having a sexual disorder by 20% (p=0.02).

3.3. Radiological and therapeutic features

Osteoarthritis of the lumbar spine was observed in 89 (78%) patients, disc disease in 79 (69.3%) patients, and isthmic lysis with listhesis in eight (7%) patients. There was no statistically significant association between radiological lesions and sexual dysfunction (p=0.3). All patients (100%) were treated with analgesics and postural hygiene measures. Other treatments included non-steroidal anti-inflammatories (79 patients; 69.3%), muscle relaxants (22 patients; 19.3%), anti-neuropathic treatment (15 patients; 13.2%), oral cortisone (nine patients; 7.9%) and cortisone infiltration (13 patients; 11.4%). There was no statistically significant association between treatment and sexual dysfunction (p=0.2).

3.4. Patient characteristics according to functional ability (ODI)

According to the mean total ODI (Owestry disability index) score, disability was moderate in patients without sexual dysfunction (mean ODI score 23.1 ± 1.2, i.e. 26.2% ± 2.4), and severe in patients with sexual dysfunction (mean ODI score 26.8 ± 1.4, i.e. 53.6% ± 2.4). This difference was statistically significant (p=0.02). Table 1 shows the distribution of the 114 patients according to ODI domains. The degree of functional disability was statistically associated with sexual disorders (p=0.03). On binary logistic regression, the presence of a moderate or severe disability increased the risk of having a sexual disorder by 40% (p=0.02). In women, an overweight or obese, sedentary patient with a moderate or severe disability was 50% more likely to have a sexual disorder (p=0.02). In men, regular smoking, alcohol consumption and a sedentary lifestyle were statistically associated with moderate or severe disability (p=0.02). The concomitant presence of these four elements increased the risk of having a sexual disorder in men by 70% (p=0.02). Table 2 shows the distribution of the 114 patients according to degree of disability on the ODI score.

Table 1: Distribution of the 114 patients according to ODI (Owestry disability index) domains

	No sexual disorder (N=21)		**With sexual disorder (N=93)**		***probability***
	Mean	**Standard deviation**	**Mean**	**Standard deviation**	
Intensity of pain	2.5	1.7	2.7	1.3	0.5
Personal care	1.9	0.6	1.9	1.2	0.2
Handling loads	3.9	0.9	3.6	1.4	0.4
Walking	2.8	1.4	2.6	1.1	0.1
Sitting	1.2	0.6	1.9	0.9	0.3
Standing	2.1	1.5	2.8	1.7	0.2
Sleep	2.2	1.2	2.7	1.3	0.1
Sexual life	1.2	0.7	3.5	1.3	0.03
Social life	2.8	1.7	2.6	1.9	0.2
Travelling	2.5	1.5	2.5	1.7	0.4
Overall total score /50	23.1	1.2	26.8	1.4	0.02
Result in percentage	46.2%	2.4	53.6%	2.8	0.02

Table 2: Distribution of 114 patients according to degree of disability using the ODI (Owestry disability index) score

	No sexual disorder (n=21 et N=114)		**With sexual disorder (n=93 et N=114)**		***probability***
	Number (n)	**%**	**Number (n)**	**%**	
No disability	2	2.4	8	9.5	0.02
Slight disability	4	4.7	10	11.9	
Moderate disability	3	3.6	33	39.3	
Severe disability	3	3.6	21	25	
Complete disability	0	0	0	0	

3.5. Male sexual health characteristics according to the Male Sexual Health Questionnaire (MSHQ)

Among the 30 male patients, 21 (70%) had sexual disorders according to the Male Sexual Health Questionnaire (MSHQ). Table 3 shows the characteristics of erection, ejaculation and patients' satisfaction with their sexuality. Sexual desire was low or absent in 10 (33.4%) patients. Table 4 shows the characteristics of patients' sexual desire. Sexual activity was low or absent in 13 patients (43.4%). Table 5 shows the characteristics of sexual activity (masturbation, intercourse, oral fondling or any other kind of sexual activity).

Table 3 : Characteristics of erection. Ejaculation and satisfaction in 30 male patients.

		Number	Percentage
Erectile dysfunction Score (0-15)	14-15: Normal	9	30
	11-13: minimal	3	10
	8-10: Moderate	5	16.6
	5-7: Moderately severe	6	20
	0-4 : Severe	7	23.4
Erectile dysfunction (1-5 points)	5 : Not at all bothered	9	30
	4 : A little bothered	2	6.6
	3 Moderately annoyed	5	16.7
	2 Very annoyed	6	20
	1 Extremely embarrassed	8	26.7
Ejaculation disorder (0-35 points)	32-35 : Normal	9	30
	29-31: minimal	4	13.3
	22-28: moderate	6	20
	15-21: Moderately severe	4	13.3
	0-14: Severe	7	23.4
Ejaculation Difficulty (1-5 points)	5 : Not at all bothered	9	30
	4 : A little bothered	3	10
	3 Moderately annoyed	7	23.3
	2 Very annoyed	6	20
	1 Extremely annoyed	5	16.7
Sexual satisfaction (0-30 points)	30 : Extremely satisfied	9	30
	24-29 : Moderately satisfied	3	10
	13-24 : Neither satisfied nor dissatisfied	5	16.7
	7-12: Moderately dissatisfied	7	23.3
	0-6 : Extremely dissatisfied	6	20

Table 4 : characteristics of sexual desire and urge in 30 male patients.

		Number	Percentage
Frequency of sexual desire	5 : All the time	9	30
	4 Most of the time	4	13.3
	3 About half the time	7	23.4
	2 Less than half the time	4	13.3
	1 Never	6	20
Strength of sexual desire	1 Never	9	30
	5 Very strong	7	23.4
	4 Strong	4	13.3
	3 Moderate	4	13.3
	2 Weak	6	20
Discomfort with the sexual urge or desire	1 Very weak or absent	9	30
	5 : Not at all bothered	3	10
	4 A little bothered	7	23.3
	3 Moderately annoyed	6	20
	2 Very annoyed	5	16.7
Change in desire compared with last month.	1 Extremely annoyed	9	30
	5 No change or increased	3	10
	4 Slightly reduced	5	16.7
	3 Moderately reduced	7	23.3
	2 Much reduced	6	20

Tableau 5 : characteristics of sexual activity in the 30 male patients (masturbation. sexual intercourse. oral fondling or any other kind of sexual activity).

		Number	Percentage
Frequency of sexual activity	5 = Every day or almost every day	9	30
	4 = More than 6 times	3	10
	3 = 4 to 6 times	5	16.7
	2 = 1 to 3 times	7	23.3
	1 = 0 times	6	20
Discomfort with sexual activity	5 : Not at all embarrassed	9	30
	4 A little embarrassed	3	10
	3 Moderately annoyed	7	23.3
	2 Very annoyed	6	20
	1 Extremely annoyed	5	16.7
Modification of sexual activity	5 No change or increased	9	30
	4 Slightly reduced	3	10
	3 Moderately reduced	5	16.7
	2 Much reduced	7	23.3
	1 No activity	6	20

3.6. Characteristics of female sexuality according to the Female Sexual Function Index (FSFI)

Of the 84 female patients, 72 (85.7%) had sexual disorders according to the Female Sexual Function Index (FSFI). Table 6 shows the degree of sexual dysfunction in the 84 female patients, according to areas of female sexuality.

Table 6 : Distribution of the degree of sexual disorder according to the areas of female sexuality in the 84 patients.

Domain		**Degree of sexual disorder (N=84)**			
	Average score Global	**4.6-6 No trouble**	**3.1-4.5 minor disorder**	**1.6-3 moderate disorder**	**0-1.5 severe disorder**
		Number (%)	**Number (%)**	**Number (%)**	**Number (%)**
Desire	2.4± 1.7	12 (14.3)	32 (38.1)	23 (27.4)	17 (20.2)
Excitement	2.4± 1.2	12 (14.3)	35 (41.7)	20 (23.8)	17 (20.2)
Lubrication	2.2± 1.5	12 (14.3)	40 (47.6)	17 (20.2)	15 (17.9)
Orgasm	2.3± 1.8	12 (14.3)	37 (44)	18 (21.5)	17 (20.2)
Satisfaction	2.1 ± 1.6	12 (14.3)	45 (53.6)	17 (20.2)	10 (11.9)
Pain	2.4± 1.9	12 (14.3)	30 (35.7)	27 (32.1)	15 (17.9)
Overall average	2.3± 1.6	12 (14.3)	37 (44)	20 (23.8)	15 (17.9)

4. Discussion

Sexual disorders were very common in patients with chronic low back pain in Ouagadougou. They significantly affected all areas of sexual life, namely desire, arousal, lubrication, orgasm, pain and overall sexual satisfaction. These disorders were severe in a large proportion of people, and created significant discomfort in these patients. Factors associated with sexual dysfunction in men included a sedentary lifestyle, smoking, alcohol consumption and the presence of a moderate or severe functional disability. In women, the factors associated with sexual dysfunction were a sedentary lifestyle, overweight or obesity, and the presence of a moderate or severe functional disability. However, any interpretation of the results of our study must take into account the limitations of our methodology. Indeed, the questionnaire was administered face-to-face, which, given the sensitivity of the subject, may have led to an underestimation of positive responses. In addition, most of the items call for subjective responses, calling into question accuracy and precision. Despite these limitations, the various tools used have been validated for use. The sociodemographic, clinical and radiological characteristics of patients included in our study were similar to other African series [2,16-18]. In our series, sexual disorders were frequent in patients followed up in rheumatology for low back pain and/or common lomboradiculalgia. They affected almost nine out of 10 people, i.e. three quarters of men and more than four out of five women. These data appear to be above the global prevalence, but are superposable with other African studies [5-7,14-18]. The investigative methods and scores used to screen for sexual dysfunction differ from one study to another [5,14-20]. Indeed, the frequency of sexual dysfunction in low back pain varies from 66% to 82% in the Maghreb [5,14,15] and from 27.6 to 67.7% in Sub-Saharan Africa [5, 14-18]. According to some studies, patients with low back pain are six times more likely to suffer from sexual dysfunction [16-18]. The risk of sexual dysfunction in men compared to women depends on the study [5,17-18]. Men are significantly more affected than women in the Maghreb, but this seems contrary to data from Sub-Saharan Africa and Europe [5,6,17,18]. Indeed, according to the literature, men's sexual desire is naturally more developed and expressed than that of women [21]. What's more, male culture and psychology, which favor competence over emotion, may influence men to be less forthcoming about their sexual problems [22]. These sexual disorders significantly affected all areas of the patients' sexual lives in our study, and those concerned felt a very high level of discomfort in relation to these dysfunctions. This discomfort is justified by the lowered self-esteem [22], but also because these disorders have a negative impact on the partner's sex life [4]. In men, one to two-thirds of patients had fairly severe problems with erection, ejaculation and orgasm, desire or craving. Many had virtually no sexual activity, and two out of five were totally dissatisfied with their overall sex life. In women, between a third and a half of patients had moderate or severe disorders of desire, arousal, lubrication, orgasm, satisfaction, or experienced pain during intercourse. All these areas of male and female sexuality were also significantly affected in most studies [5,6,7,14-18]. In the literature, certain factors could be associated with sexual disorders in low back pain, such as pregnancy, certain positions during the sexual act, advanced age and the presence of a severe disability [5,8-12]. However, as observed in our study, radiological lesions do not appear to influence the occurrence of sexual disorders [13]. In our study, the factors associated with sexual disorders were sedentary lifestyle and the presence of moderate or severe functional disability. Smoking and alcohol consumption were also observed in men, and overweight or obesity in women. Most of these factors are cardiovascular risk factors and/or part of a metabolic syndrome. These factors can lead to arteriopathy responsible for peripheral hypoperfusion, resulting in erectile dysfunction, with its corollary of ejaculation and orgasm disorders in men. This highly anxiety-provoking situation may lead to reduced desire, which, combined with erectile dysfunction, may explain the drop in sexual activity, and ultimately to sexual dissatisfaction and reduced self-esteem [22,23]. In women, metabolic syndrome may be responsible for hormonal disturbances, leading to reduced desire, arousal, lubrication and orgasm, as well as reduced sexual activity and sexual dissatisfaction [24]. Functional disability, unanimously recognized as a risk factor in most studies [5,8-12,14-18], can lead to a drop in self-esteem, due to the inability to perform basic activities of daily living [22,23]. Functional disability can also be responsible for a drop in desire, and therefore sexual activity, as it is closely linked to pain. The adoption of certain positions during the sexual act, alternative movement patterns, the use of lumbar support, depending on specific intolerances, combined with the active collaboration of the partner, could alleviate pain and improve the sexual quality of life of low-back pain sufferers [8,10]. Similarly, back massage prior to sexual intercourse could reduce the risk of experiencing low-back pain attacks during intercourse by 81% [18].

5. Conclusion

Sexual dysfunction was common among patients with chronic low back pain in Ouagadougou. Their frequency was 81.6%, and the associated factors were a sedentary lifestyle and the presence of a moderate or severe functional disability, in addition to overweight and obesity in women, and smoking and alcoholism in men. Because of the sensitivity of the subject, patients rarely raise it in consultation. It's up to rheumatologists to think about it. The management of chronic common low-back pain must be holistic, “bio-psycho-social”, taking into account systematic screening and appropriate management of sexual disorders.

Conflict of interest: The authors declare that they have no ties of interest.

Références

1. Konstantinou K, Dunn KM. Sciatica: Review of epidemiological studies and prevalence estimates. Spine 2008; 33:2464-72. DOI:10.1097/BRS.0b013e318183a4a2
2. Tiaho Y, Tiendrébéogo WSJ, Sougué C, Kaboré F, Savadogo JE, Gandema S, and al. Kinesiophobia: frequency, associated factors and impact on the life quality of participants with chronic low back pain in sub-saharan africa. Wiad Lek. 2021;74(12):3240-4. DOI: 10.36740/WLek202112120
3. Ferrari S, Vanti C, Giagio S, Anesi M, Youssef S, Bortolami A, Cedraschi C, Pillastrini P. Low back pain and sexual disability from the patient's perspective: a qualitative study. Disabil Rehabil. 2022;44(10):2011-2019.
4. Akbari F, Dehghani M, Mohammadi S, Goubert L, Sanderman R, Hagedoorn M. Why do Patients Engage in Pain Behaviors? A Qualitative Study Examining the Perspective of Patients and Partners. Clin J Pain. 2020;36(10):750-756. doi: 10.1097/AJP.0000000000000868.
5. Bahouq H, Fadoua A, Hanan R, Ihsane H, Najia HH. Profile of sexuality in Moroccan chronic low back pain patients. BMC Musculoskelet Disord. 2013;14(63) :1-6. doi: 10.1186/1471-2474-14-63.
6. Maigne JY, Chatellier G. Assessment of sexual activity in patients with back pain compared with patients with neck pain. Clin Orthop Relat Res. 2001;(385):82-7. doi:10.1097/00003086-200104000-00014 .
7. Turk DC, Fillingim RB, Ohrbach R, and Patel KV. Assessment of psychosocial and functional impact of chronic pain. The Journal of Pain 2016;17(9):T21-T49. https://doi.org/10.1016/j.jpain.2016.02.006
8. Sidorkewicz N, McGill SM. Male spine motion during coitus: implications for the low back pain patient. Spine (Phila Pa 1976). 2014;39(20):1633-9. doi: 10.1097/BRS.0000000000000518.
9. Mogren I. Perceived health, sick leave, psychosocial situation, and sexual life in women with low-back pain and pelvic pain during pregnancy. Acta Obstet Gynecol Scand. 2006;85(6):647-56. doi: 10.1080/00016340600607297.
10. Sidorkewicz N, McGill SM. Documenting female spine motion during coitus with a commentary on the implications for the low back pain patient. Eur Spine J. 2015;24(3):513-20. doi: 10.1007/s00586-014-3626-y.
11. Moradi Z, Shahali S, Ahmadi F, Montazeri A. Correlates of sexual function in women with acute lumbar disc herniation in Iran: a cross-sectional study. Sci Rep. 2024;14(1):6430. doi: 10.1038/s41598-024-57274-w.
12. Costa M, Marshman LA. Sex life and the Oswestry Disability Index. Spine J. 2015;15(6):1225-32.
13. Babińska A, Wawrzynek W, Czech E, et al. No association between MRI changes in the lumbar spine and intensity of pain, quality of life, depressive and anxiety symptoms in patients with low back pain. Neurologia i Neurochirurgia Polska. 2019;53(1):74-82. DOI: 10.5603/pjnns.a2018.0006. PMID: 30614517.
14. Rouached L, Messaoud MB, Mourad DK, Cherni N, Bouden S, Tekaya AB, and al. Qu'en est-il des troubles sexuels chez les patients lombalgiques chroniques? Revue du Rhumatisme 2023, 90(1)A301. doi.org/10.1016/j.rhum.2023.10.463
15. Fazaa A, Saad A, Miladi S, Makhlouf Y, Boussaa H, Abdelghani KB, and al. Évaluation de l'activité sexuelle chez les femmes tunisiennes ayant une lombalgie chronique. Revue du Rhumatisme 2023 ;90(1) : A298. DOI: 10.1016/j.rhum.2023.10.463
16. Fianyo E., Kakpovi K., Koffi-Tessio V, Tagbor K, Houzou P, Djanda M, et al. Qualite de vie du personnel hospitalier lombalgique à Lome (Togo). ESJ. 2020 ;16(3). DOI: https://doi.org/10.19044/esj.2020.v16n3p254
17. Kamissoko AB, Barry A, Gbadamassi AA, Nato CB, Traoré M. Impact des lombalgies sur les activités de la vie quotidienne et sur la sexualité : étude cas-témoin de 638 patients au CHU Ignace Deen de Conakry (Guinée). Rhum Afr Franc. 2023;6(1):11-6. DOI : https://doi.org/10.62455/raf.v6i1.56
18. Zomalhèto Z, Possi S, Dossou-Yovo H, Hodjigue F. Facteurs associés à l'altération de la qualité de vie sexuelle chez les lombalgiques chroniques à Cotonou. ESJ. 2021 ; 17(34),126. 10. DOI: https://doi.org/10.19044/esj.2021.v17n34p126
19. Tonosu J, Takeshita K, Hara N, Matsudaira K, Kato S, Masuda K and al. The normative score and the cut-off value of the Oswestry Disability Index (ODI). European Spine Journal, 2012 ;21 :1596-1602. doi: 10.1007/s00586-012-2173-7.
20. Giuliano F. Questionnaires in sexual medicine. Prog. Urol. 2013;23(9) :811-21. http://dx.doi.org/10.1016/j.purol.2013.01.006
21. Johannes CB, and Avis NE. Gender differences in sexual activity among mid-aged adults in Massachusetts. Maturitas, 1997 ;26(3) :175-184. doi: 10.1016/s0378-5122(97)01102-x.
22. Lafrenaye-Dugas AJ, and Courtois F. Lombalgie chronique et difficultés sexuelles: évaluation, éducation et intervention. Sexologies 2019 ;28(1) :1-13. Doi : 10.1016/j.sexol.2018.09.004
23. Hachfi H, Haddada I, Braham M, Jomaa O, Kessomtini W, and Younes M. Impact des lombalgies chroniques sur la qualité de vie sexuelle. Revue du Rhumatisme 2022;89:A215-A216. https://doi.org/10.1016/j.rhum.2022.10.330
24. Bentley-Lewis R, Koruda K and Seely E. The metabolic syndrome in women. Nat Rev Endocrinol 2007 ;3 :696–704. https://doi.org/10.1038/ncpendmet0616.