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RESEARCH

Quality of life and sexual satisfaction in women suffering from endometriosis: An Italian preliminary study



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KEYWORDS

Endometriosis;
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Summary Endometriosis is a chronic gynaecological disease that affects women during the reproductive age, and may compromise their quality of life (QoL) and sexual satisfaction. Few data are available on women affected by pelvic endometriosis in the absence of deep infiltrating endometriosis.

Aim of the study. – To evaluate QoL and sexual satisfaction in a group of Italian women affected by pelvic endometriosis identifying specific sociodemographic variables that could impact on the individual perception of the disease.

Method. – A survey was conducted on 150 women with pelvic endometriosis, recruited at the University hospital of Rome. The control group included 150 healthy women matched for age and relational status. A sociodemographic questionnaire, the Italian versions of the WHOQOL-Bref and McCoy Female Sexuality Questionnaire (MFSQ) and the Visual Analogue Scale were administered to participants.

Results. – Our data show that the experimental group obtained a lower score than the control group in the questionnaire total scores and, specifically, in the physical, psychological and social relationships domains (WHOQOL) and in the sexuality domain (MFSQ). A positive and significant correlation was observed between relational status and the MFSQ total score. No significant correlation emerged between pain intensity and sociodemographic variables, total scores and subscales of the MFSQ and WHOQOL-BREF.

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Discussion and conclusion. – Our results showed that the disease has a negative impact on many areas of the overall functioning and sexuality quality of life of women. Nevertheless, the existence of mediatory variables emerged, emphasising how the presence of a partner could be considered a protective value in the experience of pain, therefore stressing the need to adopt a bio-psychosocial perspective to study and fully understand the disease.

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Introduction

Endometriosis is an estrogen-dependent chronic condition affecting 5–10% of reproductive-age women (Eskenazi and Warner, 1997), in whom endometrial glands and stromata are present outside the uterus, usually in the abdominal cavity and surrounding areas (Denny and Mann, 2007a, 2007b; Eriksen et al., 2008; Rogers et al., 2009; Montanari et al., 2013). The real incidence of the disease is unknown, however it is estimated to affect 176 million women worldwide (about 3 million in Italy) (Meuleman et al., 2009; Rogers et al., 2009; Adamson and Pasta, 2010).

Endometriosis has a multifactorial aetiology which includes: genetic predisposition, immune system abnormalities, anatomical and environmental factors (Busacca et al., 2006; Minici et al., 2007; Galandrini et al., 2008; García Manero et al., 2009; Porpora et al., 2009; Kajihara et al., 2011; Ballester et al., 2012; Vichi et al., 2012; Begum and Chowdhury, 2013). The American society for reproductive medicine classification identifies four stages of endometriosis (I-minimal, II-mild, III-moderate, and IV-severe) depending on the location, extent, and depth of endometrial implants, presence and severity of adhesions, presence and size of ovarian endometriomas (ASRM, 1997). The diagnosis is based on individual history, symptoms and signs, gynaecological examination and imaging techniques such as: pelvic, transvaginal and abdominal ultrasonography and magnetic resonance. The gold standard is the histological confirmation of implants visualized during laparoscopy (ESHRE, 2013). Unfortunately, there is an average diagnostic delay of 7 years (Nnoaham et al., 2011). An Italian survey conducted by the Endometriosis Association, published by *Senato della Repubblica Italiana* (2006) and involving about 7000 women, showed a diagnostic delay of 9.3 years from the first onset of symptoms (*Senato della Repubblica Italiana*, 2006). The diagnostic delay worsens the negative effect of the disease on the physical, emotional, and social well-being of patients and their ability to work (Denny, 2004; Jones et al., 2004; Denny and Mann, 2007a, 2007b; Fourquet et al., 2010, 2011).

Pelvic pain represents the major clinical problem of the disease, manifesting as dysmenorrhea, dyspareunia, chronic pelvic pain and, less frequently, dysuria and dyschezia (Montanari et al., 2013). These symptoms usually have adverse effects on women's working abilities and psychosocial functioning. The presence and intensity of pain symptoms are not significantly related to the stage of the disease (ASRM, 1997; Porpora et al., 1999; ESHRE, 2013)

whereas deep infiltrating endometriosis (DIE), defined as the presence of endometriosis that penetrates for more than 5 mm under the peritoneal surface and frequently located in the rectovaginal septum, is significantly associated with the presence and intensity of pain (Porpora et al., 1999; Chapron et al., 2003).

Some studies have shown that general quality of life (QoL) and sexual satisfaction are seriously compromised in women with endometriosis (Colwell et al., 1998; Chapron et al., 2003; Kennedy et al., 2005; Denny and Mann, 2007a, 2007b; Ferrero et al., 2007; Mabrouk et al., 2012; Montanari et al., 2013). The QoL is defined as the individual's perception of itself in its own cultural system of values in relation to own goals, expectations, standards and concerns. This depends on physical health, psychological state, level of independence, social relationships, and relationship with salient environmental features (WHOQOL Group, 1994). Indeed, sexual satisfaction refers to the subjective perception in relation to multiple aspects of sex life: realization of erotic desires, satisfaction of passion, feeling loved, frequency of sexual activity, meeting of expectations, and satisfaction in general with relationship (Ortiz and Ortiz, 2003; Castellanos-Torres et al., 2013). Both these domains are considered two core aspects of human health (WHO, 2006; Schwartz and Young, 2009; WHO, 2010; Tripoli et al., 2011; Castellanos-Torres et al., 2013; Peloquin et al., 2013). Moreover, some studies stress how endometriosis also affects negatively the perception of health, the ability to work and daily life, and can be associated with mood and anxiety disorders (Denny and Mann, 2007a, 2007b; Sepulcri and doAmaral, 2009; Fourquet et al., 2010, 2011; Nnoaham et al., 2011; Tripoli et al., 2011; Montanari et al., 2013; Cavaggioni et al., 2014; Fritzer et al., 2014).

These aspects highlight how endometriosis could have a significant negative socioeconomic impact. The World Endometriosis Research Foundation (WERF) EndoCost study showed how the costs arising from women with endometriosis treated in referral centres are substantial. The result is a physical, psychological and economic burden that is at least comparable to the burden associated with other chronic diseases, such as diabetes mellitus. The European Society of Human Reproduction and Embryology (ESHRE) estimated that total annual cost of endometriosis-related symptoms for Europe is between 0.8 million and 12.5 billion euros. In Italy, data from the Ministry of Health show that about 54 million euros were spent in 2002 for hospital admissions due to endometriosis (*Senato della Repubblica Italiana*, 2006; ESHRE, 2013). Despite the impact of endometriosis on

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