Original Research

SEXUAL DYSFUNCTION IN ALCOHOLICS- EXPERIENCE AT TERTIARY CARE CENTER OF NORTHEREN INDIA

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ABSTRACT

Introduction: The search for sex-enhancing drugs or aphrodisiacs has been a human fascination throughout history and alcohol being the most commonly and universally consumed substance, has been related to sexuality since time immemorial. Although alcohol may contribute to the initiation of sexual activity by subduing inhibitions and relieving anxiety,[1] prolonged and heavy use can lead to alcohol-induced sexual dysfunction.[2] Masters et al,[3] proposed a four-phase human sexual response cycle – excitement, plateau phase, orgasm, and resolution which forms the basis for classifying various domains of sexual dysfunction in the latest Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) as well as ICD-10.The relationship between alcohol and sexual dysfunction depends on a myriad of biopsychosocial factors. These include direct toxic effects of alcohol on the endocrine system, leading to derangements in the hypothalamo–pituitary–adrenal and the hypothalamo–pituitary–gonadal axis and neurotransmitters imbalance (increased GABA and reduced glutamate), psychosocial factors such as anxiety/ depression/ psychotropic medications, unemployment, illiteracy, poor socioeconomic status, and so on. **Aim of study:** To estimate prevalence of sexual dysfunction in Alcoholic Liver disease patients at tertiary care center of Northern India. **Material and Methods:** This study was conducted at Medical Gastroenterology Department at PGIMS, Rohtak**.** It was a prospective study done over two years, from 01.05.2025 to 30.04.2026, during which 200 confirmed alcoholic patients were enquired for any kind of sexual dysfunction. For better understanding 100 patients each of chronic hepatitis (F0-F3 fibrosis) and cirrhosis were enrolled. All 200 alcoholics were males, in 20-50 yrs age group and were sexually active. Patient with past history of sexual dysfunction, anxiety, depression, diabetes mellitus, hypertension, hypothyroidism, hepatitis B, C and HIV which can cause sexual dysfunction were not included in the study. All hepatitis patients were confirmed on daily intake of alcohol, biochemical tests include liver & renal function tests, complete hemogram, thyroid profile, blood sugar, HbA1C, Fibroscan, ultrasonogram and upper gastro-intestinal endoscopy. Fibrosis was graded by Fibroscan readings- <6 Kpa- F0, 6-7 Kpa- F1-F2, 7-12.2 Kpa- F3 and > 12.2 Kpa- F4 or cirrhosis. The written informed consent was taken before enrollment in the study. **Observation and Results:** Our department is seeing alcoholic liver disease (ALD) patients regularly for last 16 years and daily at least 10 ALD patients, including new and old come for consultation. All the biochemical tests, Fibroscan, ultrasonogram abdomen, Endoscopy, ultrasonogram abdomen and treatment are available free of cost which increases regular follow-up and compliance of patients. On prospective analysis of 200 confirmed ALD patients, all were males. Out of total pool of 200 patients, 100 patients each of F0-F3 fibrosis and cirrhosis were enrolled in the study. The sexual dysfunction was seen in 43 % of total ALD patients. Out of these 43 patients, 18 (41.86 %) were in F0-F3 and 25 (58.14 %) were having cirrhosis. Most common kind of sexual dysfunction was erectile impotence (36 patients, 83.72%) followed by and loss of libido (28 patients, 65.11%) and premature ejaculation (5 patients,11.62%). Out of total pool of 43 ALD patients with SD, characteristically, 23 patients (53.48 %) had both erectile impotence and loss of libido. Out of 100 patients of alcoholic cirrhotic patients, sexual dysfunction was seen in 25 patients (58.14 %) and out of them 21 (84 %) had erectile impotence and 3 (12 %) had premature ejaculation and 20 (71.42%) had loss of libido. In group of 100 patients of F0-F3 fibrosis with SD, total 18 patients (41.86 %) had sexual dysfunction. In them, 15 patients (83.33 %) had erectile impotence, 2 (13.33 %) had premature ejaculation and 8 (53.33 %) had loss of libido. **Conclusion:** In alcoholic patients, the main thrust of treating health care professionals goes on hepatic impairment and extra-hepatic manifestations are usually missed. Sexual dysfunction is important arm of extra-hepatic impact of alcohol which is rarely discussed by both doctor, patient and family members, most likely due to inhibition and male ego. Hence whenever treating an alcoholic, sexual history must be evaluated in detail and impact of same should be scientifically assessed and treated accordingly.

Keywords: Alcoholic Liver Disease**,** Loss of Libido, Erectile Impotence, Premature Ejaculation**,** Orgasm.

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INTRODUCTION

Chronic and persistent alcohol use causes sexual dysfunction leading to marked distress and interpersonal difficulty which itself worsen alcohol abuse. Sexual dysfunction in the alcoholic may be due to the depressant effect of alcohol itself, alcohol-related disease or due to a multitude of psychological forces related to the alcohol use.[1] The spectrum of sexual dysfunction encompasses decreased sexual desire, sexual aversion disorder, erectile impotence, inability to achieve orgasm and premature ejaculation—persistent or recurrent ejaculation with minimal sexual stimulation, before, on or shortly after penetration and before the person wishes it, which causes marked distress.[2] Alcohol abuse is the leading cause of impotence and other disturbances in sexual dysfunction.[3] Episodic erectile failure in alcoholic men is commonly seen when daily intake is more than 12 g and in subjects smoking more than 10 cigarettes/day.[4] Van Thiel and Lester [5] reported that 61% sexual dysfunction in alcoholics, most common being erectile dysfunction followed by reduced sexual desire. Erectile dysfunction and reduced sexual desire were frequently seen to be coexisting. [6-9] Vijayasenan, [10] reported SD in 71% of alcoholic patients admitted for treatment. The disturbances noted were diminished sexual desire (58%), ejaculatory incompetence (22%), erectile impotence (16%) and premature ejaculation (4%). Virtually all aspects of the human sexual response are affected by alcohol especially sexual desire and erection. [11]

Aim of Study - To estimate prevalence of sexual dysfunction in Alcoholic liver disease patients at tertiary care center of Northern India.

MATERIAL AND METHODS

This study was conducted at Medical Gastroenterology Department at PGIMS, Rohtak**.** It was a prospective study done over two years, from 01.05.2025 to 30.04.2026, during which 200 confirmed alcoholic patients were enquired for any kind of sexual dysfunction. For better understanding 100 patients each of chronic hepatitis (F0-F3 fibrosis) and cirrhosis were enrolled. All 200 alcoholics were males, in 20-50 yrs age group and were sexually active. Patient with past history of sexual dysfunction, anxiety, depression, diabetes mellitus, hypertension, hypothyroidism, hepatitis B, C and HIV which can cause sexual dysfunction were not included in the study. All hepatitis patients were confirmed on daily intake of alcohol, biochemical tests include liver & renal function tests, complete hemogram, thyroid profile, blood sugar, HbA1C, Fibroscan, ultrasonogram and upper gastro-intestinal endoscopy. Fibrosis was graded by Fibroscan readings- <6 Kpa- F0, 6-7 Kpa- F1-F2, 7-12.2 Kpa- F3 and > 12.2 Kpa- F4 or cirrhosis. The written informed consent was taken before enrollment in the study.

Observation and Results- Our department is seeing alcoholic liver disease (ALD) patients regularly for last 16 years and daily at least 10 ALD patients, including new and old come for consultation. All the biochemical tests, Fibroscan, ultrasonogram abdomen, Endoscopy, ultrasonogram abdomen and treatment are available free of cost which increases regular follow-up and compliance of patients. On prospective analysis of 200 confirmed ALD patients, all were males. Out of total pool of 200 patients, 100 patients each of F0-F3 fibrosis and cirrhosis were enrolled in the study. The sexual dysfunction was seen in 43 % of total ALD patients. Out of these 43 patients, 18 (41.86 %) were in F0-F3 and 25 (58.14 %) were having cirrhosis. Most common kind of sexual dysfunction was erectile impotence (36 patients, 83.72%) followed by and loss of libido (28 patients, 65.11%) and premature ejaculation (5 patients,11.62%). Out of total pool of 43 ALD patients with SD, characteristically, 23 patients (53.48 %) had both erectile impotence and loss of libido. Out of 100 patients of alcoholic cirrhotic patients, sexual dysfunction was seen in 25 patients (58.14 %) and out of them 21 (84 %) had erectile impotence and 3 (12 %) had premature ejaculation and 20 (71.42%) had loss of libido. In group of 100 patients of F0-F3 fibrosis with SD, total 18 patients (41.86 %) had sexual dysfunction. In them, 15 patients (83.33 %) had erectile impotence, 2 (13.33 %) had premature ejaculation and 8 (53.33 %) had loss of libido.

Table 1- Showing sexual dysfunction distribution in total pool of ALD Patients

Total ALD Patients	Males	Females	Sexual Dysfunction Present	Sexual Dysfunction Absent
200	200 (100%)	0 (0%)	(86 Patients, 43 %)	(114 Pt, 57 %)

Table 2- Showing prevalence of sexual dysfunction in various groups of ALD Patients

Total ALD Patients	F0-F3 Fibrosis	F4 (Cirrhosis)
200	100	100
Sexual Dysfunction Present	18 (18%)	25 (25 %)

Sexual Dysfunction Absent	82 (82%)	75 (75 %)

Table 3- Showing types of sexual dysfunction in various groups of ALD Patients

Total ALD Patients with Sexual Dysfunction	**F0-F3 Fibrosis**	**F4 (Cirrhosis)**
43	18	25
Erectile Impotence	15 (83.33%)	21 (84%)
Premature Ejaculation	2 (13.33%)	3 (12%)
Loss of Libido	8 (53.33%)	20 (71.42%)

DISCUSSION

SD is defined as disturbances in sexual desire and the psychophysiological alterations that characterize the sexual response cycle, significantly contributing to interpersonal conflict and unhappiness. The association between sexual dysfunction and consumption of alcohol is complex and almost all aspects of sexual response by a human being are significantly influenced due to alcohol consumption. It can have a negative impact on all aspects of human sexual response, there is a decline in the desire for sex, further, sexual performance is characterized as premature ejaculation and lack of erection, along with overall dissatisfaction **[12]**. Due to consumption of alcohol, alteration of HPG axis function, neuro-toxic effects and many more **[13]**. Even though there have been several international studies, but there is a significant dearth of Indian studies that have focused on linking sexual dysfunction and consumption of alcohol. Bijil Simon et al **[14]** and Vijayasenan **[15] r**espectively found that 72% and 71% alcoholics had occurrence of one type of disorder due to high consumption of alcohol. B.Yadav etal showed that seventy-seven percent of alcoholic had complaints of sexual dysfunction in one or more domains, with reduced sexual pleasure (71.8%) as the most common followed by low sexual desire (in terms of frequency) in 61.5% and erectile dysfunction in 43.6%. The severity of the sexual dysfunction was found to be directly proportional to the severity of alcohol dependence with almost 100 percent of the patients with severe alcohol dependence having sexual dysfunction in all the domains **[16]**. The prevalence of alcohol-induced sexual dysfunction in the available literature is variable and reasons can be due to ignorance, under-reporting fearing humiliation or insignificance exhibited by the clinicians. An epidemiological study by Rao et al **[17]** showed that 63.8% of alcoholic males suffered sexual disorders. In a review of 19 studies by Grover et al **[18]**, sexual dysfunction in alcohol-dependent males was reported to be ranging from 40 to 95.2%, the most common being erectile dysfunction followed by premature ejaculation (PE). Our study is also in alignment with above reported studies and approximately 43% of patients developed sexual dysfunction. As expected, sexual dysfunction was seen more commonly in cirrhotic group which is in accordance with other previous studies which also highlight that as fibrosis advances, then prevalence of sexual dysfunction increases. In our study group, most common sexual dysfunction noted was erectile dysfunction followed by loss of libido and premature ejaculation. The important thing is that spectrum of sexual dysfunction was same in both the non-cirrhotic and cirrhotic groups. We also started them on treatment with sildenafil citrate and around half of patients showed improvement with the same.

CONCLUSION

In alcoholic patients, the main thrust of treating health care professionals goes on hepatic impairment and extra-hepatic manifestations are usually missed. Sexual dysfunction is important arm of extra-hepatic impact of alcohol which is rarely discussed by both doctor, patient and family members, most likely due to inhibition and male ego. Hence whenever treating an alcoholic, sexual history must be evaluated in detail and impact of same should be scientifically assessed and treated accordingly.

Conflict of Interest- The authors have no conflicts of interest to declare. No financial support was taken for the same.

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