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Occult Problem in Paraplegia - A case report

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Presented herewith is a case of Traumatic Paraplegia in which the neurological status was not agreeing with the functional outcome achieved. The investigations into the causation of the condition revealed an occult problem: sexuality issues.

Introduction

In any spinal cord injury rehabilitation setup paraplegics present with many a problems to be taken care of. Sexuality and concerns about it are some of those issues that are often ignored or left for future. This attitude is not conforming to the holistic rehabilitation program, where comprehensive rehabilitation is the goal. It has been observed that if talked into this aspect, 70% do talk freely.1 One such case is reported here where myth and beliefs related to sexuality was the causative factor for paraplegia and hindered the ultimate rehabilitation. Holistic rehabilitation approach to details of clinical history, problems leading to the occurrence of anatomical diagnosis and the remedial measures by the physiatrist led team is highlighted in this report.

Case Report

A 35 years old male presented with fracture L1 vertebra with bilateral fracture calcaneum with incomplete paraplegia of two years duration, following fall from a height, treated conservatively elsewhere. Motor system examination revealed reduced muscle tone, power in the hip extensors and abductors were in the range of 2+, knee 3 and ankle in the range of 2+ with associated stiffness of the ankle movements. He could not get up from sitting to standing by himself, but was able to walk with crutches if made to stand. Stress incontinence of the bladder was present. The patient was worried about achieving normality of lower limbs. He was in a dilemma about whether further investigations and possible surgery could cure him. He looked depressed and was hardly communicative. The relatives of the patient were ready to do anything including getting surgery done in a centre abroad. The patient was engaged and the family wanted to know if he could get married under the present condition. Initial advice to the patient consisted of working up the lower extremity muscles, to mobilize the stiff joints, achieving independence in activities of daily living to achieve better physical independence. Advice about decision for marriage was deferred initially for a period of about two months. In the six weeks period, the patient worked hard, muscle power improved to 3 to 3+ in lower limbs, improved his gait with crutches, was able to get up independently but with difficulty, did not report erections though signs of presence of semen in the urine were present. He was sent to sexual guidance clinic in psychiatry but was lost for follow up for about 3-4 months after that.

He came back about six months later with the same physical status as he had left us after about 6 weeks of intervention in our department. At that moment, he was scheduled for surgery in a private hospital where he was given the hope of recovery after surgery. He wanted to know if he should go

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ahead for surgery over there or not. At this stage he was counseled against surgery and told that it may not help him achieve full cure as he was thinking and besides there was no indication for surgery at the end of two and a half years. The patient did not proceed to the private hospital for surgery and decided to continue treatment in our department. The patient was depressed further though he had the will to work hard. He was more anxious about his marriage because the pressure from the girl's side was mounting up to get married early. While asked about his treatment in sexual guidance clinic, he was very reserved and did not want to go back there. Efforts to build up further physical reconditioning was not fruitful to get rid of crutches after further two months though muscle power improved by about one in all the muscle groups making it about grade 4.

Sexual counseling session conducted by us in the department of PMR with the patient revealed old habit of masturbation and depression due to feeling of guilt for having indulged in masturbation, which that patient thought could have caused weakness in his sexual abilities. The proposal for marriage arranged by parents aggravated the fear and depression as he felt that habit of masturbation could mar his sex life after marriage. In such a depression he attempted suicide by jumping from the roof of a building leading to paraplegia.

The working diagnoses reached after sexual counseling session (S.C.S.) with the patient were that the myth about masturbation lead to fear of inability to perform after marriage leading to killing of sexual desire leading to suicidal attempt and paraplegia, but recovery from paraplegia was masked by the conversion reaction. Plan of management after S.C.S. was to continue repeated counseling only for his sexual problems while continuing strengthening of lower extremities and gait training. Patient was kept in total confidence though the actual diagnosis reached was not revealed to the patient. He was asked to work on and report any psychological erections. After repeated boosting of morale, clarifying the unfounded basis for myths related to masturbation and sexual performance and counseling, the patient reported weak erections. He could not masturbate but no advice on masturbation was stressed, therefore, status about ejaculation was not known. Keeping in view the moral code, he was not advised to have a try at the pre-marital sex with the fiancee. The pressure about marriage was further mounting on him. With these guidelines in mind, the patient was asked to go ahead for the marriage with the advice to report after marriage for further counseling with the partner for problem sorting.

Soon after the above decision, the patient started showing dramatic recovery and could walk with only one stick instead of two crutches, in a period of two weeks.

The patient along with the partner reported the day after the marriage. He came walking independently without any walking aid with near normal gait pattern. During the counseling session understanding about the condition of the patient to the partner was stressed. The patient was instilled with confidence to go ahead and try sex play including intercourse. The spouse was guided on the techniques to maintain arousal in the patient. During the early post marriage period patient reported semi-erections and pre-mature ejaculation and inability to penetrate, on which the patient was further counseled to take this as a usual yardstick in most marriages or sexual relations. Two weeks after marriage following repeated efforts, coitus was achieved and the patient had a co-ordinated ejaculation. In the following two menstrual cycles and active sex life, pregnancy was achieved. At the time of writing this report, they are the proud parents of a six years old daughter. The patient runs a shop, has mild stiffness of ankles and no apparent physical weakness.

Discussion and Conclusions

Studies pertaining to the sexuality of the disabled from this part of the world are almost nonexistent.[2] The disabled themselves have a negative self-concept and a low self-esteem and this affects their attitudes towards sexuality and their sexual behavior. Health care professionals tend to neglect this issue perhaps due to their insensitivity to the sexual needs for the disabled or a lack of understanding and expertise in this area. Attitudes and misconceptions of the public need to be corrected. Sexual rehabilitation needs to be incorporated as part of holistic medical rehabilitation program.[2] Stiens[3] emphasized interdisciplinary person-centered rehabilitation, and success of the individual in chosen life roles and proposed a module to update SCI issues reviewed in past syllabi.

Every worry of the patient needs to be honoured while working in rehabilitation. While ascertaining the cause of paraplegia, each and every aspect of the etiology needs to be thought about. Unfortunately, patients as well as the doctors and other care givers do not like to discuss the sexual issues at the first instance. White et al,4 in a series of 79 spinal cord injured (SCI) men reported that with respect to eleven other areas of life, sex life ranked the lowest in terms of satisfaction and fifth in terms of importance. Of the sample, 67% reported having had a physical relationship (not necessarily including intercourse) in the past 12 months. From among seven topics related to sexuality, the three in which there was greatest interest were methods and techniques to achieve sexual satisfaction, helping a partner cope emotionally with limitations on sexual activity and ability to have children. Alexander[5] noted that many physicians and allied health care workers responded to patients' sexual concerns with dismissal or reassurance at the exclusion of emotional aspect of sexuality. In another community based study by Ide et al [6] 102 subjects indicated that the provision of information regarding sexuality should remain a high priority for health care providers.

Siosteen et al[7] in a study on 73 SCI subjects found more than half of the subjects (57%) rated their sexual relations after injury as satisfying or at least rather satisfying. The study further suggested that sexual information and counseling should be integrated in the total care of the SCI patient to reduce the negative effects on sexuality, caused by the injury. Similarly Evans et al [8] suggested a multidisciplinary sex education program with specific recommendations for content, which should be included in the information-giving counseling process.

In a study on 49 partners of SCI, Kreuter et al [9] reported, 61% appreciated the quality of their sexual relationship and most partners (84%) considered their relationship overall to be satisfying. Half of the couples engaged in sex, with or without intercourse, once a week or more. Fifty-five per cent of the partners reported being content with the frequency of their sexual interaction while one third would have wished more frequent activity. Almost half of the partners (45%) considered their current sex life to be as good as or even better than their previous sex life.

Considering the above case, if the diagnosis of paraplegia (cauda-equina syndrome) was made as only traumatic paraplegia without going into the reasons why the patient fell, understanding of the problems of the patient would not have been very clear. Here, an attempt to suicide leading to fall from height prompted further investigation into the reasons for the attempt. The reason for the suicide lead to our understanding of the basic problem related to sexual behaviour of the patient prior to attainment of disability. The problems being faced by the patient due to myths about his sexual affairs lead him to a conversion reaction despite his attaining adequate recovery physically, but still that was not apparent clinically due to this

being masked. Gunther[13] reported that (1) Socially universal sources: the demands posed by patients' regression; patients' misplaced aggression; patients' thwarting of staff's (narcissistic) professionalism; the threat of obligatory identification; staff disgust at patient's body damage. (2) Individualized sources: individual residues of caregivers' own developmental experience (conscious and unconscious) with issues such as dependency, aggression, sexuality, self-esteem and autonomy. Solutions involve understanding and mastering the distinction. Miller[10] found SCI patients had many fears and misapprehension about there Sexual functioning. Common beliefs include: (a) disabled men cannot sexually satisfy able-bodied women; and (b) cord-injured persons cannot have sexual intercourse. Such misapprehensions can be helped by the counselor's willingness to discuss sexual issues openly. Clients need a clear and accurate picture of the facts, as well as encouragement and support to help them rediscover their sexuality. Spinal cord injury does not mean sexual incapacity. Given a knowing and patient partner, most clients can enjoy a satisfying sex life. Hence S.C.S. forms an essential component of any SCI rehabilitation program. However, before such an interaction can comfortably take place, the counselor may gain from an opportunity to examine his or her own attitudes toward human sexuality and gather more information about the sexuality of physically disabled adults.[11] Anderson et al [12] presented a framework to show how different types of physical disability affect sexual function. Addressing to the patient's problems related to the underlying cause lead to the reversal of the conversion reaction and the patient could surface the optimum level of functional and clinical recovery. This could only be achieved due to problem oriented goal planning and not leaving sexual matters about the patient to others or leaving them unattended. Sexual satisfaction and feelings of self-esteem play an important role in the ability to adapt to an acquired physical disability. Sexual counseling for the disabled differs little from that for the able-bodied. However, the same principles apply. It is appropriate to remind not only the counselor but also the disabled that (1) loss of sensation does not mean loss of feelings, (2) loss of potency does not mean loss of ability, (3) loss of urinary continence does not mean loss of penile competence, and (4) loss of genitalia does not mean loss of sexuality.

We come to the conclusion that sexual perversions or sexual behaviour of the patients can be a cause of paraplegia (by conversion reaction), or can complicate the paraplegia. Sexuality issues may complicate and delay the progress of the patient even in the physical status and rehabilitation is incomplete until sexuality issues are settled.

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