

Prevalence and Predictors of Sexual Dysfunction in Men and Women with Atrial Fibrillation

n = 230

symptomatic AF

Nicholas D'Elia^{1,2,3}, Mariana Dragas¹, Frank Bevacqua¹, Nathan Better², Romaniya Fernando², Emma Baker², Hariharan Sugumar^{1,2,3}, Louise Segan^{1,2,6}, Liang-Han Ling¹, David Chieng^{1,2}, Kenneth Cho^{1,5,6}, Rose Crowley^{1,5,6}, Jeremy William^{1,3,6}, Sandeep Prabhu^{1,5,6}, Jonathan Kalman^{4,5}, Peter Kistler^{1,2,3,5,6}, Joseph Morton⁴, Aleksandr Voskoboinik^{1,2,3,6}

¹ Heart Centre, Alfred Hospital, Melbourne ² Department of Cardiology, Cabrini Health, Melbourne ³ Department of Medicine, Monash University, Melbourne

⁴ Department of Cardiology, Royal Melbourne Hospital, Melbourne ⁵ Department of Medicine, University of Melbourne, Melbourne ⁶ Cardiac Electrophysiology Lab, Baker Heart & Diabetes Institute, Melbourne

WHY THIS MATTERS

Sexual dysfunction is an under-recognised comorbidity in atrial fibrillation (AF). This study quantified its prevalence, clinical predictors and psychological burden in symptomatic patients.

METHODS

Prospective cross-sectional study across two centres. Adults with symptomatic AF completed validated surveys of sexual function, sexual quality of life and psychological distress. Multivariable regression assessed AF phenotype, comorbidities and cardiovascular pharmacotherapies.

230 patients
64.1 ± 10.7 mean age, years

177 men · 77%
53 women · 23%

VALIDATED MEASURES

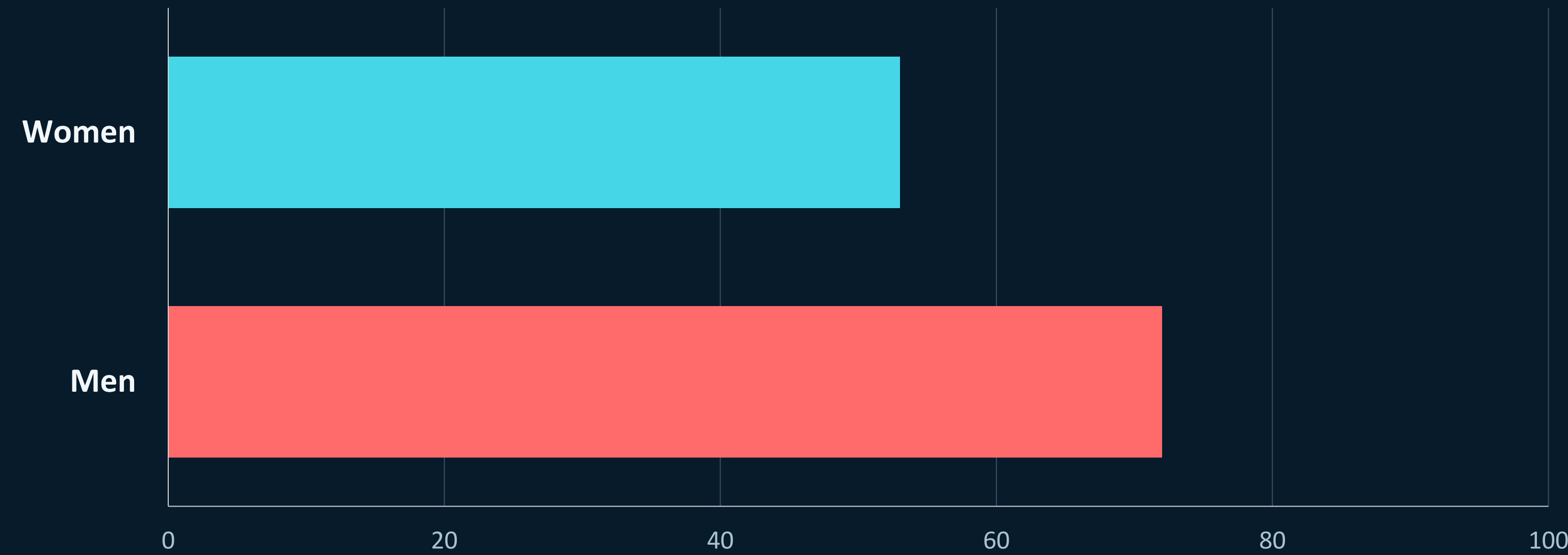
MEN
IIEF · PEDT · SHIM
WOMEN
FSFI · SQOL-Female

ALL PARTICIPANTS
DASS-21 psychological distress

Models evaluated AF phenotype, comorbidities, beta-blockers, antiarrhythmics, calcium-channel blockers, diuretics and RAAS inhibitors.

SEXUAL DYSFUNCTION WAS HIGHLY PREVALENT

Participants meeting validated thresholds



MEN

72% affected
Mean IIEF 41.4 ± 20.4
Deficits across all measured subdomains

WOMEN

53% affected
Mean FSFI 13.9 ± 11.0
SQOL-Female 38.7 ± 18.2

PSYCHOLOGICAL BURDEN

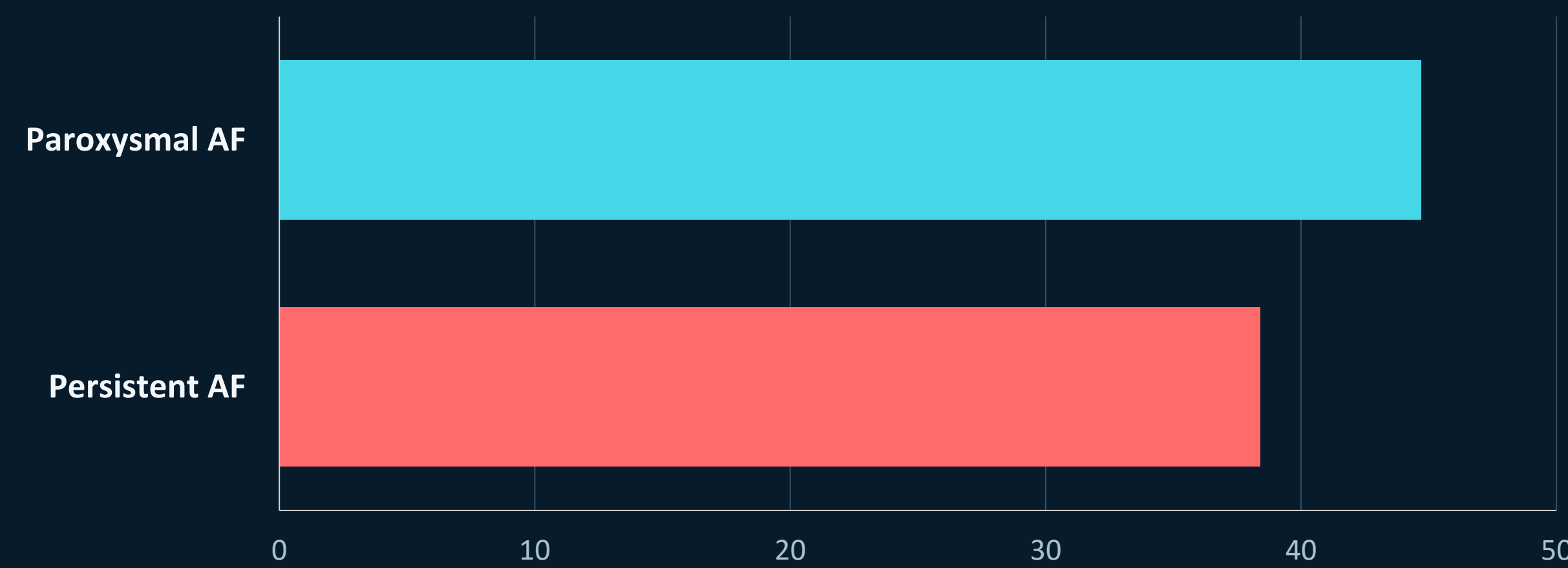
32.7 ± 26.6 mean DASS-21 across the entire cohort

Psychological distress was elevated alongside the high burden of sexual dysfunction, reinforcing the need for integrated assessment rather than symptom-by-symptom care.

Sexual function did not differ by AF phenotype in women
p = 0.949

PERSISTENT AF PREDICTED WORSE MALE FUNCTION

IIEF: persistent 38.4 ± 19.5 | paroxysmal 44.7 ± 20.5



p = 0.043

Persistent AF was also associated with worse intercourse satisfaction (p=0.024) and higher premature ejaculation scores: PEDT 7.3±5.8 vs 5.1±5.0 (p=0.031).

MEDICATION SIGNAL: NONE DETECTED

Beta-blockers · antiarrhythmics

Calcium-channel blockers · diuretics

RAAS inhibitors

No pharmacotherapy class was associated with sexual dysfunction or psychometric scores in either sex.
all p > 0.05

CLINICAL IMPLICATION

ASK about sexual health

SCREEN for psychological distress

INTEGRATE both into comprehensive AF care

TAKE-HOME

Sexual dysfunction and psychological distress are common in symptomatic AF. Persistent arrhythmia tracks with progressive male impairment—cardiovascular pharmacotherapy does not.

Routine sexual and psychological assessment should be integrated into AF care.