Brooke M. Faught

Sexuality in the aging population: Statement of the problem

By Brooke M. Faught, MSN, WHNP-BC, IF

This column is the first part of a 2-part series.

The aging process can compromise sexual functioning in both women and men. Many older persons deal with this situation by terminating sexual activity—perhaps because they are unaware of various therapeutic approaches that are available. If patients address this problem, they can find themselves enjoying sex as much now as they did in the past. Some patients even report experiencing an *improvement* in sexual functioning. When caring for older patients, then, healthcare providers should recognize sexuality as an important component of their overall health, diagnose sexual dysfunction if it exists, and either treat the condition or refer patients to specialists as needed.

According to a survey conducted by AARP in 2009, among 1,670 individuals aged 45 years or older, 77.4% of women and 67% of men reported having sexual intercourse infrequently: once or twice a month, less than once a month, or not at all. *Table 1* shows this and other similar findings from the AARP survey.[1] Although fairly large proportions of female and male respondents in the survey did not engage in sexual activities very often, 58% reported believing that sex is critical to a good relationship. Therefore, many midlife and older adults may not be experiencing the sex lives they want to have, but they have little recourse. Either they do not broach the topic with their healthcare providers (HCPs) or their HCPs are not as well informed as they might be about identifying sexual dissatisfaction or dysfunction in their patients or managing these situations.[2]

For example, Maes and Louis[3] conducted a study to identify the sexual history-taking practices of 500 U.S. nurse practitioners (NPs) with regard to patients aged 50 years or older. Only 2% of the NPs reported always conducting a sexual history and 23.4% reported never or seldom doing so. The biggest barrier to sexual history taking was lack of time. Other barriers included interruptions, limited communication skills, embarrassment, and feeling that taking such a history in older patients was inappropriate. A study of general practitioners in Great Britain revealed that many of them did not discuss sexual health matters with older patients because they thought that these matters were of "legitimate" interest only to younger patients.[4] From the perspective of midlife or older patients, many of them do not discuss sexual problems with their HCP because they do not feel their problems are serious or sufficiently bothersome.[5] Many older patients, already assumed to be invisible and post-sexual by society, may be even less likely than their younger counterparts to approach their HCPs with sexual problems and concerns—even though research suggests that these patients often hope that their HCPs will approach *them* in this regard.[6]

Sexual dysfunction in older patients

In 1998, sildenafil (Viagra®) hit the market, initiating a sexual revolution. Advertisements for this product—and for two similar prescription products approved in subsequent years—targeted over-50 males, leaving similarly aged women "in the dust." Desire, arousal, and orgasmic dysfunctions in the older female popu-

lation remained without an FDA-approved treatment option. Although history was made in August 2015 when the FDA approved the first-ever medication for hypoactive sexual desire disorder, this medication is indicated only for premenopausal women. With the exception of two medications used to treat dyspareunia related to menopausal changes, conjugated estrogens cream (Premarin® Vaginal Cream) and ospemifene oral tablets (Osphena®), sexual complaints in older women must be addressed with off-label options.[7]

Table 1. Proportion of respondents aged 45+ years who engage in these sexual activities infrequently[1]

	Female (N = 588)	Men (N = 524)
Sexual intercourse	77.4%	67%
Oral sex	88.1%	80%
Anal sex	98.2%	95.7%
Self-stimulation	88.2%	66.3%

Note: "Infrequently" means once or twice a month, less than once a month, or not at all. The remaining respondents in this survey engaged in these activities about once a week, more than once a week, or daily.

Sexual interest/arousal disorders

A telephone survey of 1,491 U.S. adults aged 40-80 years showed that a lack of sexual interest (33.2%) and lubrication difficulties (21.5%) were the most common female sexual problems and early ejaculation (26.2%) and erectile difficulties (22.5%) were the most common male sexual problems.[5] Fewer than 25% of these adults with a sexual problem had sought help for their problem from an HCP. A study of 3,005 female and male interviewees aged 57-85 years showed that as women got older, a larger proportion became unable to achieve orgasm.[8] *Table 2* shows the prevalence of sexual problems in the preceding year among sexually active female participants in this study.[8]

Genito-pelvic pain/penetration disorder

According to the aforementioned telephone survey, 12.7% of women aged 40-80 years reported pain with sex.[5] Causes of dyspareunia in older women can include vulvovaginal atrophy (VVA), disuse atrophy, pelvic floor dysfunction, vaginal anatomic changes related to surgery such as vaginal hysterectomy, and vulvovaginal skin conditions and infections.[7]

Menopause is accompanied by a significant drop in circulating estrogen levels, which adversely affects the maturation of vaginal epithelial cells, resulting in VVA.[9] Subsequently, a shift in the vaginal ecosystem occurs, allowing overgrowth of pathogenic organisms.[10] Nearly half of all postmenopausal women experience VVA symptoms, including burning with urination, dyspareunia, bleeding with intercourse, vaginal discharge, and vulvovaginal soreness, itching, and burning—all of which warrant regular screening in this population.[9-13] Genital pain often results in avoidance of sexual encounters and/or involuntary tensing of pelvic floor muscles in response to anticipated pain. As a result, disuse atrophy and high-tone pelvic floor dysfunction are commonly seen in postmenopausal women.[7]

Sexually transmitted infections

Most sexually active individuals contract a sexually transmitted infection (STI) at some point in their lives.[14] Midlife and older individuals who are engaging in sex are not immune. However, HCPs may be less likely to inquire about or test for STIs in older individuals, who may also be hesitant to discuss STI symptoms with their HCP. The most common risky behaviors in persons aged 50 or older include sexual contact with MSM (men who have sex with men), intravenous drug use, and receipt of blood products,[6] although *all sexually active individuals are at risk for STIs*. Undiagnosed and untreated STIs can have long-term sequelae such as chronic pain, cancer, heart damage, blindness, and, in severe cases, death.

A British study showed that, over a 7-year period, the number of STI cases more than doubled in persons aged 45 years or older.[15] Rates of chlamydia, genital herpes, genital warts, gonorrhea, and syphilis all increased. Genital warts and genital herpes were identified as the most common STIs, and persons aged 55-59 years were the most likely to be affected. In the U.S.,

Table 2. Prevalence of sexual problems in preceding year among older women[8]

Age (y)	Lacked interest in sex	Unable to achieve orgasm	Experienced pain during sex	Sex not pleasurable	Anxious about performance	Trouble lubricating
57-64	45.4 (37.9-52.9)	35.0 (28.9-41.2)	18.2 (13.8-22.7)	23.4 (17.6-29.2)	10.7 (6.5-14.9)	36.1 (29.7-42.6)
65-74	37.6 (28.3-46.9)	33.4 (25.4-41.3)	18.9 (11.0-26.8)	22.4 (15.3-29.4)	12.7 (6.4-19.1)	43.7 (35.3-52.1)
75-85	49.3 (36.8-61.9)	38.2 (23.7-52.8)	11.8 (4.3-19.4)	24.9 (14.8-35.0)	9.9 (1.7-18.2)	43.6 (27.8-59.3)

Note: Statistics provided in this table are the prevalence and the 95% confidence interval.

trichomoniasis is most prevalent in women older than 40 years, whereas chlamydia and gonorrhea have the lowest prevalence in this age category.[16]

Conclusion

Statistics show that most people of any age are, or want to be, sexually active. HCPs should never assume that a given person, based on her or his age, appearance, or presence of a disability, does not engage in sexual activity or does not wish to do so. Regardless of a person's age, HCPs should take a sexual history during healthcare encounters, and they should offer counseling, treatment, or referrals in appropriate cases of sexual dysfunction or disease.

Brooke M. Faught is a nurse practitioner and the Clinical Director of the Women's Institute for Sexual Health (WISH), A Division of Urology Associates, in Nashville, Tennessee. The author states that she serves as a speaker and advisory board member for Shionogi and Actavis and as an advisory board member for Valeant.

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