Sex and the sexagenarian-plus

A large proportion of older people remain sexually active, but the physiological changes of ageing and the effects of chronic illness contribute to making the incidence of sexual dysfunction in this age group considerable. In this context, **Dr Walter Pierre Bouman** discusses precipitating factors for sexual problems as well as a practical 'how to' guide for approaching assessment and management on a subject many clinicians find awkward.

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Sexual intimacy and sexual activity is an important quality of life issue for everybody. Increasing life expectancy and the ever-growing population of older adults make discussion of sex and sexual health in clinical practice with this age group topical. Particularly as a significant proportion of older people remain sexually active. At the same time, sexual dysfunction finds its highest prevalence among this group due to the effects of ageing and physical illness on sexual response as well as the increased sensitivity to the side effects of medication. Recent advances in the management of sexual dysfunction should be made available to everyone, regardless of age, gender, ethnicity, religion, disability and sexuality. Unfortunately, many clinicians feel uncomfortable and unskilled to discuss sexual issues with their patients, although not acceptable it is perhaps unsurprising given the National Sexual Health Strategy's comment that 'there are a number of important gaps in sexual health training and education, including inadequate, patchy or absent sexual health training in undergraduate medical curricula'[1].

Sexual physiology and ageing

Hormonal changes

In women, the most salient biochemical markers of senescence are the age-related changes in the level of oestrogen and testosterone. The structural integrity of the female genitalia is predominantly maintained by oestrogen. Vaginal dryness and atrophy, dyspareunia and urinary tract symptoms may suggest a lack of oestrogen. In men, testosterone production remains relatively stable until the fifth decade, when usually a gradual decline in testosterone production begins. This is mainly a result of testicular ageing[2]. The decline in circulating testosterone is responsible for a decrease in desire, but not erectile function, although clinically it may be difficult to reliably distinguish between these two.

Sexual response

In both sexes, as one ages, the speed and intensity of the various vasocongestive responses to sexual stimulation tends to be reduced. *Table 1* reflects the main changes in sexual response with age in women and *Table 2* describes these changes in men. While the overall decline of the sexual responses may seem dreary and disheartening, it is important to remember that the way this process develops is extremely gradual, allowing a couple or individual to adjust to a less intense – but not necessarily less enjoyable – form of sexual activity.

Effects of physical illness

One of the most common reasons given by older

Table 1. Sexual response and the effects of ageing in women

Decreased sexual desire
Increased time required to become sexually aroused
Vaginal lubrication response is slower and less marked
Less intense orgasms
Increased need for stimulation to become orgasmic
No change in the ability to have orgasms
Less likely to be multiorgasmic
Resolution following orgasm is more rapid

Based on Bancroft, J. (1989) Human sexuality and its problems. 2nd Edition. Churchill Livingstone, Edinburgh with permission.

Table 2. Sexual response and the effects of ageing in men

Decreased sexual desire
Erection takes longer to develop and may require more direct tactile stimulation
Period of sustaining an erection gets shorter
Nocturnal erections and emissions are less frequent
Less marked scrotal and testicular changes associated with arousal
Production of less pre-ejaculatory mucus
Ejaculation becomes less powerful with fewer contractions and seminal fluid volume is reduced
The point of ejaculatory inevitability becomes more difficult to recognise
Resolution is more rapid
The refractory period is markedly longer

Based on Bancroft, J. (1989) Human sexuality and its problems. 2nd Edition. Churchill Livingstone, Edinburgh with permission.

people for ending sexual activity is the onset of physical illness, which may operate through a number of different mechanisms. Physical illness may generate unfounded anxieties about the risks of sexual activity (as in heart disease or stroke); it may make intercourse difficult, exhausting, or painful (as in respiratory disease, arthritis and infection); or it may impair the responsiveness of the sexual organs (as in diabetes mellitus or peripheral vascular disease). Physical illness may further undermine self-confidence and the feeling of attractiveness (as in operations such as mastectomy or colostomy), and it may have a direct effect in reducing sexual desire (as in depression, chronic renal or hepatic failure, and Parkinson's disease). *Table 3* outlines physical illnesses and surgery associated with sexual dysfunction.

Effects of medication

The majority of older people take medication, and often there is considerable polypharmacy. *Table 4* (*overleaf*) gives an overview of medication associated with sexual dysfunction.

Assessment of sexual problems

Taking a sexual history

The principles of taking a sexual history[3,4] are not altered by the age of the patient and are outlined as follows.

- Understand the barriers to taking a sexual history, which include:
  - lack of knowledge other than one's own

Table 3. Physical illnesses and surgery associated with sexual dysfunction

Cardiovascular	Angina pectoris; myocardial infarction, hypertension; insufficiency (atherosclerosi); vascular surgery (aorto-iliac/aorto-femoral bypass)
Endocrine	Primary hypogonadism; hypogonadotrophic hypogonadism; hyperprolactinaemia; thyroid disorders; Addison's diseas; Cushing's syndrome; postsurgical: gonadectomy
Metabolic	Diabetes mellitus; chronic renal insufficiency; chronic hepatic insufficiency
Neurological: Central	Temporal lobe pathology; multiple sclerosis; Parkinson's disease; amyotrophic lateral sclerosis; cerebrovascular lesions (stroke); Sleep disorders (apnea); Alzheimer's disease; tumours and traumatic lesions (brain and spinal cord)
Peripheral degenerative	Diabetic neuropathy; alcoholic neuropathy
Peripheral postsurgical	Transurethal surgeries; radical prostatectomy; abdominoperineal resection; bilateral lumbar sympathectomy
Anatomical	Peyronies' disease; postsurgical (mastectomy, hysterectomy, genital tumours)
Other systemic conditions	Chronic obstructive pulmonary disease; arthritis; obesity

Based on Schiavi, R.C. (1999). Aging and male sexuality. Cambridge University Press, Cambridge with permission.

Table 4: Commonly prescribed classes of medication associated with sexual dysfunction

Anticholinergics	Antipsychotics
Anticonvulsants	Antispasmodics
Antidepressants	Benzodiazepines
Antiemetics	Diuretics
Antihypertensives	Statins

experience. Sole reliance on one's own sexual background and experience is problematic as a clinical point of reference and may encourage a judgemental point of view regarding patients' sexual problems;

> fear of the effects generated by taking a sexual history. Taking a sexual history invites and encourages an intimacy that can feel simultaneously embarrassing, exciting, anxiety provoking and disturbing. However, if the doctor's attitude is matter of fact, then the patient will relax and become matter of fact;

> choice of sexual vocabulary. Should we use vernacular terms or only medical terms? Both can cause problems in getting an accurate history, but clinicians must use careful judgement in deciding which terminology to use. 'Let me know if you're not sure what I am asking?' or 'Use your own words and I'll tell you if I don't understand' are helpful interventions;

> ageism has infiltrated so deeply into the belief system of our society that many older patients, as well as clinicians, view older people as too old for sex.

◆ Ensure the patient is seated comfortably in a private clinic room free from interruption.

◆ Assure the patient of complete confidentiality very early in the assessment, especially if personal secrets are disclosed.

◆ Use open and non-threatening questions, which allow the patient to describe their sexual functioning. 'What is the role of sexuality in your life right now?' and 'Are you experiencing any sexual problems or concerns?' are useful openings. These can be followed by closed, more specific questions to establish exact details. Judgmental questions, such as 'Don't you think you're past that sort of thing now?' should be avoided.

◆ Take a comprehensive medical history. Many sexual problems have an organic aetiology, although the interaction with psychological, social and relationship factors should be considered.

◆ Ask about medication and recreational drugs. Many medications, as well as alcohol and nicotine intake, can affect sexual function. Illicit drugs tend to have a deleterious long-term effect.

◆ Take a thorough psycho-social history, including the history from childhood, quality of relationships in the family, role of religion, family attitudes regarding sexuality and gender, the sources of sexual information, close friendships and relationships, and especially a history of the current relationship.

Further assessment of sexual problems

When a sexual problem is diagnosed, further assessment should include a physical examination and blood investigations, which generally comprise full blood count, liver function, thyroid function, fasting blood glucose, cholesterol, prolactin, testosterone and sex hormone binding globulin. Other specific tests may be appropriate (eg, FSH, LH, free testosterone). Interviewing the partner is vital and its importance should be explained to the patient. When the assessment is completed, a careful explanation is given to the couple concerning the nature of the problem – the likely reasons why it arose, the factors that may be perpetuating it and the various treatment options available. It should be presented in a manner that does not lay blame on either partner, leaving room for positive steps to be taken. Even where nothing else is possible, there is usually scope for helping communication and understanding between the partners. Finally, the couple should be encouraged to ask questions, through which the doctor can assure himself they have understood what has been said.

Sexual problems and ageing

In many respects, the complaints differ little from younger people who seek help for their sexual or relationship problems, which may have emotional or physical origins – or both. Fear of poor performance, lack of or diminished sexual desire, difficulty becoming sexually aroused either physically or psychologically, difficulty maintaining an erection, difficulty achieving orgasm, and pain or discomfort with sexual intercourse as well as a lack of opportunities for sexual encounters are the most common complaints older people present with[5]. Sexual dysfunction may also arise simply from a lack of information about normal age-related changes in sexual physiology. Despite prevailing preconceptions, many older people are willing to address their sexual difficulties. If sex was a source of pleasure and gratification during

Key points

> A significant proportion of older people remain sexually active well into advanced age.

> Changes in sexual response and hormones with ageing, physical illness, surgery and medication potentially affect sexual function.

> Clinicians should address sexuality and sexual health with older people. There is no place for ageism in this respect.

> Most older people are open and willing to discuss sexual problems with their doctor.

>In essence, sexual problems in older people differ little from their younger counterparts.

> There is a wide variety of psychological and physical treatment options available for sexual dysfunction

adulthood, it will probably continue to be an important source of life satisfaction.

Management

Education

Most authors on sexuality and ageing, from Masters and Johnson onwards, have emphasised the necessity of disseminating accurate information about normal sexual physiology and about the acceptability of sexual feelings and behaviour in later life, so as to dispel harmful attitudes and myths. The publication of books[6,7,8] and magazines easily accessible to the general public, and programmes on radio and television are important vehicles for this process. The education of health and social care professionals is also vital.

Prevention

The sexual difficulties that can occur following illness, surgery or treatment, might be alleviated or prevented if clinicians discussed with their patients beforehand any sexual implications of their condition or treatment. Among women referred for gynaecological cancers, at least a third over the age of 70 who had radical surgery were still sexually active; this emphasises the importance of preoperative counselling regarding sexuality[9]. In another study, in only 30 per cent of men undergoing prostatectomy was there a record of preoperative counselling concerning the possibility of retrograde ejaculation postoperatively. Moreover, men over 70 were significantly less likely to have been advised on the sexual consequences of their operation[10]. Counselling after stroke regarding potential sexual difficulties is also important[11]. Finally, older people require education about safe sex practices. Many older adults, who resume dating in later life, are unaware about sexually transmitted infections, including HIV/AIDS.

Common sexual problems

Many sexual difficulties, especially those arising in untroubled relationships and related to physical illness, can be helped by relatively simple advice. It is important to have an open and frank discussion about how certain medical conditions can affect sexual functioning and what precautions the couple may need to take. Topics may include:

> when to resume intercourse after a myocardial infarction or stroke;

> identifying different positions and different

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timing for analgesic medication for intercourse when arthritis or pain is a problem; and

> how long to wait before resuming sexual activity after surgery.

It should be pointed out that weakness may hinder usual sexual activity and 'going slow' may be the operative approach. Solid examples, such as 'if you can walk a flight of stairs without shortness of breath, you can resume intercourse' may help[12].

Following the loss of a partner, many older people may find themselves facing sexual activity with a new partner, which can be a very stressful prospect. Advice on open communication and sexual education, particularly about practising safe sex, is paramount. If intercourse is no longer a possibility, masturbation should be discussed as another source of sexual activity. However, masturbation may not be perceived as an appropriate or comfortable option for everyone. Addressing the subject and giving permission may be all that is needed to restart engaging in sexual activity. If medication is implicated in causing sexual dysfunction, the possibility of a change in dosage or changing to a different type of medication could be considered. Dyspareunia due to vaginal dryness and atrophy may need advice on lubricants and prescription of low-dose vaginal oestrogens.

Erectile dysfunction is the most common sexual complaint in older men. The oral phosphodiesterase type-5 inhibitors have revolutionised treatment of erectile dysfunction. In addition, modification of risk factors, including diabetes mellitus, hypertension, cardiovascular disease, depression, prostatic hypertrophy, smoking, medication, a sedentary lifestyle, drug and alcohol misuse, is an essential part of first-line treatment for erectile dysfunction. Other treatment options are generally provided by specialist services following rigorous assessment procedures. They include intracavernosal injection involving self-administration of vasodilator medication, intraurethral vasodilators by application of a microsuppository into the distal urethra, androgen replacement, psychosexual counselling, vacuum constrictor devices and penile prosthesis implantation.

Specialist services

Where psychological and relationship issues contributing to a sexual problem are too time-consuming or complex to deal with, help may be sought from Relate (www.relate.org.uk), or from psychosexual clinics provided through local secondary services. The British Association of Sexual and Relationship Therapy (www.basrt.org.uk) holds a list of all accredited psychosexual therapists and also approve training programmes for psychosexual therapy. Where physical issues contributing to a sexual problem are beyond the expertise of primary care, specialist advice may be obtained from a variety of specialities, which include andrology, genito-urinary medicine, gynaecology, sexual medicine and urology[13].

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