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23 – Sexuality in the Elderly

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As a result of longer life expectancy the proportion of people over 60 years is growing. The OMS estimates between years 2000 and 2050, the number of people aged 60 and over is expected to be doubled. Therefore ageing must be a challenge for primary care physicians, and health must be optimized, including the sexuality field.

According to Pérez and Arcia, 75% of elderly were interested in sex and expressed sexual desire, while 69.6% perform sexual activity. Similar data in USA showed that in a large population-based survey of sexual activity, among older adults in the United States, 67% of men and 40% of women aged 65 to 74 years reported sexual activity with the same partner in the previous 12 months.

Sexuality may impact quality of life and health of older women and men. Consequently, clinicians have to ask them about sexuality and sexual dysfunction.

Age Related Changes in Sexuality

Women:

Urogenital system is affected by ageing and the menopausal and postmenopausal state. Oestrogen deficiency is associated with vaginal dryness, reduced secretions from sebaceous glands, decrease in vaginal elasticity and result in vulvovaginal atrophy and dyspareunia, pelvic organ prolapse and pelvic floor weakening, decreased clitoral erection and sensitivity. Accompanying changes in sexual function include declines in: libido, sexual responsiveness, comfort level, sexual frequency and genito-pelvic pain.

Men:

Changes related with age in men are not as evident as in women. However they can have changes such as a decreased testosterone production and a decreased sexual function.

Sexual desire could decrease or keep stable, erectile dysfunction could be presented, this is less reliable and durable, delayed ejaculation, decreased amounts of seminal fluid and the refractory period between orgasms can increase by hours to days and can produce anxiety about performance.

Sexual Dysfunction in late life

Causes are multifactorial, involving combinations of factors. Including general physical health, psychological causes and male or female sexual dysfunction problems.

Potential contribution factors:

Physical effects of medical illness

Any medical illness that impairs the blood supply or nervous innervation of genital tissue can potentially serve as a primary cause of sexual dysfunction. Examples include diabetic neuropathy, which can impair sexual arousal, and peripheral vascular disease. Chronic, uncontrolled hypertension, obesity, smoking, hypercholesterolaemia, heart disease, and lack of physical activity are other risk factors.

Secondary sexual dysfunction may result from fatigue, pain, physical disability, or some other effect of a medical illness.

Medications:

Many medications contribute to reducing sexual drive in both sexes or the ability to have an erection, including antidepressants (selective serotonin receptor antagonists are most important), narcotics, antihypertensives (alpha-receptor blockers, beta blockers and diuretics), anti-androgens, are the most common.

Co-morbid psychiatric illness:

Often co-morbid with psychiatric illness, particularly mood and anxiety disorders in which loss of libido is a frequent symptom.

Losses and other stressful events:

Sexual dysfunction in older adults is often precipitated by a major psychosocial stress, such as the loss of a job or loved one, medical crisis or prolonged illness, or hospitalization.

Sexual disorders in men and women

The most prevalent sexual problems among women were low desire (43%), difficulty with vaginal lubrication (39%), and inability to climax (34%). Among men, the most prevalent sexual problems were erectile difficulties (37%).

Evaluation

Sexual history taking should be done in patients in any life cycle to anticipate guidance regarding sexuality when they become elderly. The clinician must be able to ask direct questions using common language, and to listen carefully and patiently, keeping in mind that older people will have many of the same sexual concerns as younger people. A complete medical and psychiatric history should include:

- A mental status examination to identify symptoms of anxiety or depression
- A physical examination with focus on urological or gynaecological function done by a specialist
- Select laboratory studies, including testosterone and prolactin levels if a metabolic or hormonal aetiology is suspected

Primary care physicians must emphasize in the interview about:

- In men, about the beginning problem, frequency, quality and durability of erection. To evaluate this can be used the scale of erectile function (IIFE5). Sexual history should be directed to discriminate whether the condition is sexual or psychological. It is also important to find out about the environment of the patient, the couple prior sexual life, use of drugs and the perception of the patient about sexuality.

- In women ask about sexual problems such as vaginal dryness , declines in libido , genito pelvic pain .

Treatment

Changing lifestyles:

- Withdraw medications that may be affecting.
- Modify risk factors for cardiovascular disease. Maintain body mass index below 30.
- Quit smoking
- Adequate control of co-morbidities such as diabetes, hypertension and dyslipidaemia

- Psychotherapy for sexual dysfunction

Pharmacological approach

- 5 phosphodiesterase inhibitors, Sildenafil, Tadalafil or Vardenafil
- Lubricant Gel
- Testosterone IM
- Conjugated oestrogens intra vagina

Take Home Message

- As family physicians we should ask our elderly patients about their sexuality.
- Physiological and psychological changes that occur with menopause are associated with decline in sexual function.
- Men have a decline in testosterone production, which can contribute to sexual dysfunction.
- Many factors can contribute to sexual dysfunction in elderly patients; these factors include: physical effects of illness, medications, co-morbid psychiatric disorders, and psychosocial stressors like losing a partner or other close relationship.

Original Abstract

<http://www.woncaeurope.org/content/op-275-sexuality-elderly>

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