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Issues of Sexuality In the Elderly

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Case 1

A vibrant, robust 75–year-old widower visits his doctor for a routine check-up. As the doctor reviews the patient's pillboxes, he notices a small Tylenol bottle with a large 'V' inscribed on it. The patient explains, "That's for my lady friends in Florida." The perplexed doctor's look evoked further explanation: "My urologist gave me viagra for when I'm in Florida, I have a few lady friends that I visit with." During the summer, the patient lives with his daughter in Rhode Island, which doesn't allow for much privacy. In the winter, he lives alone in his condominium in Florida, giving him plenty of opportunity for sexual intimacy with his lady friends. This healthy and physically active elderly gentleman remains sexually active with the help of medications to treat his mild **erectile dysfunction (ED).**

Case 2

A 94-year-old gentleman has just seen his primary care doctor regarding multiple chronic medical problems - hypertension, coronary artery disease, hypercholesterolemia, osteoporosis, and depression, in addition to coronary artery disease. As the patient is about to leave, he hesitates and asks "What about that blue pill? I have a new lady friend at the assisted living facility and we were thinking about having sex. Can I have that pill for sex?"

Several questions come to mind. He had just informed you that he had had a few bouts of angina with minimal exertion, which resolved with nitroglycerine sublingually, and you had increased his long-acting nitrate. He further informs you that he has not had an erection or erect penis (even during the night) for several years. His coronary artery disease, use of nitrates, and limited functional capacity increase the risk of the medical treatment for ED significantly (increased risk of hypotension and angina), which offers minimal potential benefit (it is unlikely to resulting in a functional erection). You discuss alternatives to erection and orgasm in obtaining sexual intimacy with his new partner.

Myths about Sexuality in the Older Person

As these two cases illustrate, sexuality remains a prominent part of the lives of older persons. Despite evidence to the contrary, many people believe that older adults do not or should not have sexual activity. In fact, if an older person is physically able and has a partner, sexual activity and satisfaction with sex can persist well into the 90s. Sex, physical intimacy, and emotional intimacy are lifelong needs. Often because of physical or functional limitations, sex may be altered to include mutual masturbation, use of mechanical devices, or simply hugging and kissing. Libido and sexual needs decrease with age in both sexes, thus reducing the frequency of sexual experiences; but persons with healthy sex lives as younger adults will be more likely to have healthy sex lives in their golden years. A national study of older persons showed that sexual activity declines from 73% to 26% among persons aged 57-64 and 75-85, respectively.[1] Physiologically, age affects sexual function by prolonging the excitement phase and requiring a longer period of stimulation in order to achieve orgasm in both men and women. The refractory period between orgasms is also longer in both men and women.[2]

Another myth is that sexual problems are just part of normal aging, with no solutions, so why bother talking to your doctor about it? Physicians are trained to address issues of sexuality in an unbiased, empathetic, and non-judgmental manner. Patients should not feel embarrassed to bring these issues up during their regular appointments. Treatments, medications, or other solutions may be available to improve or solve the problem. Many medications contribute to reducing sexual drive or the ability to have an erection; therefore medication changes can sometimes make dramatic improvements. Such medications include antidepressants (selective serotonin receptor antagonists are most important), narcotics, antihypertensives (in men), alpha-receptor blockers (in men causing ED), and diuretics. (Table 1)[2,3] Except for mirtazepine and wellbutrin, most antidepressants have an impact on libido, and this impact should be discussed.

Many physical conditions exacerbate sexual problems. (Table 2) In addition, many psychological or social factors affect sexuality, including poor body image, feeling less sexy or attractive due to body changes or surgery, feeling less feminine/masculine, fear of

Table 1 – Medications and their impact on sexuality in older persons

Medication	Impact
Antihypertensive	Erectile dysfunction, decreased libido
Alpha-blockers	Erectile dysfunction, decreased libido
Narcotics	Erectile dysfunction, decreased libido
Diuretics	Embarrassment with leakage of urine
Alcohol	Erectile dysfunction, decreased ability to reach orgasm
Antipsychotics	Decreased libido and ability to reach an orgasm, priapism
Anticholinergics	Decreased blood flow to penis
Antidepressants:	
SSRI*	Decreased libido, delayed or no orgasm
Tricyclic Antidepressants	Decreased libido and increases erectile dysfunction but less than SSRI
Trazodone	Increased libido, anorgasmia, priapism
Citalopram	Decreased libido but less than SSRI
Venlafaxine	Decreased libido but less than SSRI
Mirtazepine	No sexual side effects
Wellbutrin	No sexual side effects and may have a pro-sexual benefit

*SSRI = Selective Serotonin Receptor Inhibitors

rejection, performance anxiety, and fear of isolation, abandonment, and guilt. These factors interact to negatively impact sexual experiences in older persons. An assessment of sexual disorders should incorporate these possible medical and psychiatric concerns.

Issues Related to Men

Erectile function is the most important factor in a healthy sexual life in older men. Many chronic diseases contribute to the development of ED, especially chronic, uncontrolled hypertension and diabetes. Obesity, smoking, hypercholesterolemia, heart disease, and lack of physical activity are other risk factors for ED. Surgical treatment for prostate cancer is often a cause of untreatable and irreversible ED. There are mechanical and pharmacological treatment options for ED. Intracavernous injections of alprostadil, a prostaglandin E1 derivative, are one possibility, but often rejected due to the need to insert a needle into the penis. Yohimbe, a natural herbal regimen, has been shown to improve ED, but is NOT recommended due to risks of acute renal failure, seizures, and death. Newer agents, phosphodiesterase V inhibitors, such as, sildenafil, tadalafil, and vardenafil, act peripherally on the penile vascular system to allow improved tumescence and provide significant benefit in the treatment of ED. To take these medications, patients must have some degree of functional and physical endurance, and cannot be on long-acting nitrates. Diabetics are at increased risk for non-arterial ischemic optic neuropathy and visual deficits[2,3]

Issues Related to Women

Vaginal dryness and dyspareunia (pain with sexual intercourse) are the most important factors in reducing the sexual desire and frequency in women. Menopause also results in a marked decrease in libido, which does not always recover, especially now that few women take hormone replacement therapy. Vaginal lubricants can be an easy effective strategy for reducing vaginal dryness and pain with intercourse. Other risk factors for sexual dysfunction for older women include being unmarried, divorced or widowed; lack of a physically capable partner; past sexual problems; and lower educational level. As women outlive their husbands, lack of a physically capable partner is becoming more frequent a problem, and women report significantly less sexual activity than men at all age groups.[1]

Many medical conditions also contribute to a reduced desire for sex, including urinary incontinence, osteoarthritis (due to pain with intercourse), and changes in body mass and shape.[4] Up to 50% of breast cancer patients report significant sexual problems due to alteration of self-image and self-confidence.[5] A study assessing the sexual healthcare needs of older women reported that they had concerns similar to younger women, but were less likely to discuss these concerns. They were, however, willing to address their concerns if brought up by a physician - an important message to primary care physicians.[6] Phosphodiesterase inhibitors have not been shown to be of benefit except as an antidote to the sexual side effects of selective serotonin reuptake inhibitors.[3]

Table 2: Medical conditions affecting sexuality in older persons

Medical Condition	Impact
Osteoarthritis or other	Pain with intercourse joint problems
Stroke	Poor coordination and contractures
Parkinson's Disease	Poor coordination
Surgery for breast cancer	Self image and confidence
Surgery for prostate cancer	Causes incontinence and impotence
Pelvic surgeries	Causes incontinence or impotence
Incontinence (urinary or fecal)	Embarrassment
Chronic foley catheter	Inhibits intimacy and obstruction
Chronic pain syndromes	Inhibits libido
Depression	Decreases libido
Vision and hearing loss	Reduces the stimuli for sexual excitement
Heart and lung disease	Reduces the ability to perform during intercourse
Diabetes mellitus	Causes ED and reduces orgasm

Conclusion

Other issues include sexuality among nursing home residents, especially those with dementia; another difficult issue is sexual activity between unmarried couples in the nursing home. In addition, sexually inappropriate behavior and sexual disinhibition in persons with dementia should not be confused with the normal sexual needs of a older adults.

In summary, sexuality remains an important part of quality of life in older persons. However, due to physical and functional limitations, sexual activity may be adapted to incorporate more intimacy and a wider sexual repertoire to include erotic literature, sexual lubricants, and self-stimulation. Physicians should be open to discussing these issues with their elderly patients, and be open to initiating such conversations, being sensitive to the comfort level of the patient.

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