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Sexual health and the older adult

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Background

Sexual health is an integral component of holistic health across the lifespan. Despite this, nurse practitioners (NP) often omit sexual health histories from their examination of older adults.[1] While the aging adult may be seen as nonsexual, one study found that 73% of participants aged 57–64 were sexually active. Additionally, 53% of the 64–75 age group and 26% of the 75–85 age group were having sex.[1,2] Increased divorce rates, widowed status, erectile dysfunction medication use, and Internet dating place older adults at risk of sexually transmitted infections (STIs) and HIV.[1,3] The Centers for Disease Control and Prevention (CDC)[4] reported that from 2012–2016 there was a significant increase in the incidence of chlamydia (6084–11,093), gonorrhea (3874–9737), and syphilis (737–1697) among the 55 and older age group. While human papillomavirus (HPV) is the most common STI in the United States (US), it is not a nationally notifiable condition.[4] Overall prevalence of HPV was 42.5% among US adults aged 18–59, with subtypes 16 and 18 accounting for 66% of cervical cancers and approximately 25–50% of low and high-grade dysplasias, respectively.[4] The CDC[2] also reports people aged 50 and older account for 17% of new HIV diagnoses. Similar to the infection rates among younger people, the subgroup of older adults with the highest infection rates is gay and bisexual men (49%). However, the heterosexual population is also at increased risk (44%) with heterosexual women accounting for 24%.[2]

HIV risk factors for older adults are the same as in the general population, yet society has the misconception that older adults do not engage in high-risk behaviors, are not at risk for infection, or are no longer sexually active due to their age. Research has found that older adults remain sexually active well into their 80′s; yet, they may lack knowledge about HIV transmission.[5] This gap in knowledge highlights the need for providers to seize the opportunity to include education regarding sexual health, sexual hygiene, and information about STI and HIV transmission during primary care visits and focused visits related to gynecological and genitourinary complaints. Individuals who have been in long-term monogamous relationships who are recently divorced or widowed may not consider using condoms due to misinformation or lack of information about STI transmission rates among older adults. Likewise, women who have gone through menopause do not have the risk of pregnancy; therefore, they may be less likely to use a condom.[5] Despite visiting their providers more frequently, older people are less likely to initiate a discussion related to their sexual behaviors, and NPs are less inclined to ask their older patients about sexual health because they may not view them as participating in risky behaviors.[6–8] However, given the high rates of HIV and STI transmission among this population, patients could benefit from the inclusion of sexual health as a routine part of these visits.

HIV symptoms often mimic other common biological changes or age-related symptoms that occur during the normal aging process[9]; therefore, older adults could be less likely to seek care early in the disease process and more likely to have late-stage infection at the time of diagnosis.[2] This leads to delayed initiation of treatment and could result in higher morbidity and more progressive immune system damage. While studies have suggested that providers cite lack of knowledge, discomfort with the issue, and time as barriers to discussing sexual health with patients,[1,7,10] NPs should play an active role in assisting older adults in maintaining a healthy overall quality of life, which includes their sexual health. NPs should take the initiative to initiate those difficult conversations, conveying HIV prevention information, and properly screen their older patients for HIV.

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Recommendations

Current CDC guidelines recommend that providers conduct a sexual health history on anyone who could be sexually active. Providers must be confident and capable of completing a thorough sexual health history. The first step is to develop a comfort level with the topic of sexual health in general and specifically for the geriatric population. Including the sexual history as a part of each new patient's social history, with each annual physical exam, or both is an efficient way to include this topic in the visit. Additionally, patients experiencing a life transition such as divorce or newly dating should also be screened. The CDC's guide to conducting a sexual health history advises providers to assess the five "P's" of sexual health[11]: partners, practices, protection from STIs, prior history of STIs, and prevention of pregnancy. For older adults, since pregnancy prevention is no longer of concern, providers should focus on the first four. Placing patients at ease during the conversation can be accomplished by normalizing the conversation and letting the patient know that sexual health and sexual activity are a part of holistic health. Providers can advise patients that the questions are standard and asked of all patients as part of the sexual history component of a regular medical exam. Patients will become accustomed to being asked and even be more comfortable initiating the conversation in future office visits.

An example of an introductory question could be "Are you sexually active?" The NP should allow the patient time and security to answer. If the patient is sexually active, the provider should then ascertain with whom. It is important to not make assumptions about the patient's sexual orientation or practices. Follow up questions could include "Are your sex partners men, women or both?" It is also necessary to evaluate risk by asking how many sex partners the patient has had in a lifetime and throughout the last 12 months. Patients should be asked if they are currently in a committed relationship with one person. If a patient has had multiple sexual partners in the past year or is not in a monogamous relationship, asking about sex practices is beneficial to educating on risk reduction, determining necessary testing, and identifying anatomical sites from which to collect specimens.[11] The NP should ask the patient what kinds of sexual contact they have had (vaginal, anal, oral). They should also ask what protective measures, if any, they have taken to prevent STIs. Patients in monogamous relationships greater than 12 months may not need risk reduction counseling. In other cases, NPs need to explore the patient's condom use with each encounter and assess their perceived risk of contracting an STI.

Prior history of STIs may increase a patient's current risk. The NP should ask patients if they have ever been diagnosed or treated for an STI or if they have had any recurring symptoms. The CDC recommends HIV screening at least once for everyone between the ages of 13–64 as part of routine health care and yearly testing for patients with specific risk.[11] The NP should inquire if the patient has been tested for HIV in the past and if they would like to be tested at the current office visit. The NP should also ask the patient if their partner has been tested for and is aware of their STI/HIV status. If the patient is unaware, counseling of the importance of knowing the partner's status is inidcated. Finally, the NP should complete the sexual history by asking open ended questions to stimulate additional dialogue. For example, the NP could ask patients if they had additional concerns or questions or anything else to share about their sexual health.

In addition to collecting an adequate health history, the NP should be aware of screening recommendations for the geriatric population. The CDC[12] recommends screening for gonorrhea and chlamydia annually for older women with risk factors such as new or multiple sex partners or a sex partner with an STI. HIV screening is recommended for anyone aged 13–64 at least once as part of routine health care and more frequently for those with risk factors.[12] The United States Preventive Services Task Force (2012)[13] recommends women aged 30–65 be screened for cervical cancer every three years by cytology alone or every five years with a combination of cytology and HPV testing. Guidelines recommend that even if a woman over 65 reports a new sexual partner, after initial cessation of screening, further screening should not be conducted.[13]

Summary

Older adults, NPs, and the community need to be aware of the prevalence of STIs and HIV in persons over age 50. An awareness that sexual desires, emotions, and practices do not disappear as one gets older is important in the NP's ability to deliver appropriate care that can aid in preventing STIs and HIV. A secure environment, cultivation of a rapport, and eliminating personal biases of the provider are all necessary aspects of obtaining the information needed to guide the educational and treatment process. NPs have the task of familiarizing themselves with the risk factors that this population face in regards to maintaining their sexual health. It is essential that the NP initiate and guide the conversation to gain the information needed. A valuable part of the physical examination should be to inquire about sexual preferences and practices, which would allow the NP to identify areas of concern and direct the intervention and education. As the elderly population increases, future recommendations for NPs who treat this population are to dismiss their preconceived notions and conduct comprehensive sexual health histories, while adequately assessing risk, screening appropriately, and providing age-appropriate education. Implementing these measures will enhance comfort for both the patient and NP in addressing a difficult topic, which may play a significant role in reducing newly acquired infections and delayed diagnosis.

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