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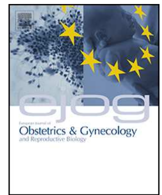
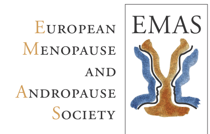


Review article

Joint Opinion Paper- "Ageing and sexual health" by the European Board & College of Obstetrics and Gynaecology (EBCOG) and the European Menopause and Andropause Society (EMAS)



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Introduction

Life expectancy has increased remarkably in recent years. In 2013 in the European Union, life expectancy at birth was 83.3 years for women and 77.8 years for men [1]. Worldwide, the number of postmenopausal women is estimated to reach 1.1 billion in 2025 [2]. Overall life expectancy at age 60 is approximately another 25 years. Therefore a statement on ageing and sexual health is timely because older people remain sexually active for longer than in the past.

Several studies show that people report sexual activity into the 9th decade and the number is increasing. Thus a Swedish study of 1407 70-year-olds found that in the time periods 1971–1972 and 2000–2001, sexual activity among men increased from 47% to 66%, and in women from 12% to 34%. [3] Similar findings have been found in the UK National Surveys of Sexual Attitudes and Lifestyles (Natsal): the last one being undertaken between 2010 and 2012 and involved people up to 74 years. [4]

Sexual activity in the Swedish study was related to positive attitude toward sexuality, sexual debut before age 20, having avery happy relationship, having a physically and mentally healthy partner, self-reported good global health, interviewer-rated good mental health, being married/cohabiting, satisfaction with sleep, and drinking alcohol more than three times a week. Having an older partner, diabetes mellitus, coronary heart disease, higher physical health-sum score, and depression were related to less sexual activity. A US study found that almost 60% of women over the age of 60 who are in committed relationships are sexually active, while 13% of

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women who do not have a steady romantic partner are also sexually active [5].

The English Longitudinal Study of Ageing (ELSA) with 6201 participants aged 50 to >90 (56% women), looked at associations with age, health, and partnership factors [6]. They found that levels of sexual activity decline with increasing age, although a sizeable minority of men and women remain sexually active until the eighth and ninth decades of life. Poorer health was associated with lower levels of sexual activity and a higher prevalence of problems with sexual functioning, particularly among men. Difficulties most frequently reported by sexually active women related to becoming sexually aroused (32%) and achieving orgasm (27%), while for men it was erectile function (39%). Sexual health concerns most commonly reported by women related to their level of sexual desire (11%) and frequency of sexual activities (8%). Among men it was level of sexual desire (15%) and erectile difficulties (14%).

Reduced sexual activity does not necessarily correspond with sexual distress or dissatisfaction because sexual activity especially intercourse may lose its importance and "attractiveness" in older people especially if they are dealing with chronic health conditions [7]. For health care professionals (HCPs), this means that they should assess the individual needs not only of the woman but of the couple. The HCP should personalise consultations and advice dealing with age and sexuality [8]. It is very often not a question of quantity but a question of quality.

Effects of hormonal changes and the sexual health of the partner

Postmenopausal oestrogen deficiency and resulting vulvovaginal atrophy (VVA) lead to significant changes in sexual health [9,10]. Up to 50% of women will develop urogenital signs and symptoms at some time in their postmenopausal life. The negative impact of vaginal atrophy on a woman's general and sexual quality of life and on that of the couple cannot be underestimated. The European arm of the CLOSER (Clarifying Vaginal Atrophy's Impact on Sex and Relationships) survey including over 5000 women and men, found that 'worry that vaginal discomfort would never go away' was expressed by 28% and 38% of women in Northern and Southern Europe respectively; and 21% and 27% were worried that vaginal discomfort would ruin their future sex life.

Another endocrine factor having an impact on female sexual function is the decline in androgen production by the ovaries and/or the adrenals, which starts already in the mid 30s. Although there is debate, it is important to understand that androgen deficiency can affect sexual function both after surgical and natural menopause [11].

Sexual health of partners in both hetero and homosexual relationships must not be overlooked as it is an important contributory factor. For example age-related sexual dysfunction in men (erectile dysfunction, premature ejaculation) may lead to sexual dissatisfaction and loss of desire and interest in sexual activity in their female partners [11].

It is therefore important that HCPs communicate with both partners to be able to come to an overall assessment.

Management

Management is summarised in the following review published in 2015 [10]. Oestrogen, either topical or systemic, is an effective treatment for women with moderate to severe symptoms of vaginal atrophy and both can be used together. The literature supports the efficacy of lower doses to minimise adverse effects. Tibolone is a synthetic steroid that has oestrogenic effects on the vagina but not on the endometrium. This drug has been associated with significant improvements in sexual function in postmenopausal women. Ospemifene is a selective oestrogen receptor modulator. Approved in the USA and Europe, oral ospemifene provides a new option for women with urogenital symptoms. In Europe, it is indicated for the treatment of moderate to severe symptomatic VVA in postmenopausal women who are not candidates for local vaginal oestrogen therapy.

While non-hormonal vaginal lubricants and moisturisers do not reverse the atrophic vaginal changes they improve coital comfort and maintain vaginal secretions. A combination of vaginal moisturising agents used on a regular basis and lubricants during intercourse can alleviate symptoms of vaginal dryness. Lubricants are typically used episodically to correspond to sexual activity. Moisturisers are typically used on a regular basis, rather than episodically associated with sexual activity.

Recent short-term studies have suggested that laser therapy may improve VVA symptoms but long term studies are required.

Sexually transmitted infections

Older people may consider themselves to be immune to sexually transmitted infections (STIs) and therefore not use condoms. However anybody who has a new sexual partner is at risk of a STI, whatever their age. Not surprisingly STIs in older people are increasing [12,13]. Therefore counselling regarding STIs should be an integral part of any consultation with a HCP. This is of particular importance given the backdrop of the emergence of multi-drug resistant gonorrhoea.

Current service provision

Sexual problems may be undertreated as HCPs and women may find it difficult to broach the subject due to embarrassment. Furthermore service provision and delivery varies between countries. For example, the European REVIVE internet survey found that around 95% of participants reported visiting a HCP for their gynaecological care in all countries, except in the UK where only 68% reported seeing a HCP [14]. With the exception of the UK, gynaecologists/obstetricians were overwhelmingly the primary HCP professional that the participants visited for their gynaecological care (Spain 78%, 91% Italy, 92% Germany, 9% UK). In contrast with other countries, the 68% of UK women who saw a HCP for gynaecological care were often directed to a general practitioner (41%) or a nurse (24%). The majority of participants in Italy, Germany and Spain spoke to their HCP about within 6 months of developing VVA symptomatology, whereas in the UK participants tended to wait for a longer period of time before asking their HCP (especially for symptoms like pain with intercourse and dryness). Furthermore, Italian and Spanish participants were more likely to be receiving treatment than their German and British counterparts. The situation becomes more complex for older people in long term care. A recent study found that a light-hearted or non-physical connection between residents is deemed acceptable, but the moment it becomes a sexual relationship then decision making becomes more complicated [15]. Staff were inclined to turn to managers for advice and to consider separating residents.

Advice for health care planners

Although the general belief that older people should not have sex has never been true, it is becoming even less valid now that the baby boomers are reaching their 60 s and 70s. So now is the time to break down barriers so that older people and health providers can deal with sexual problems without embarrassment or judgemental attitudes. The European Board and College of Obstetrics & Gynaecology (EBCOG) launched its *Standards of Care for*

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Table 1
Standards of Care for the provision of Sexual Health Services for the Ageing Population.

Patient Focus
1. Information should be widely available in different languages, according to the population being served, about the availability of services in the Primary and Secondary Care setting
2. Couples should receive up-to-date information about the natural course of sexually transmitted pelvic infections and age related sexual difficulties and the treatment options available
3. Counselling should take into account and respect the life style of the couple
4. Psychological, sexual and partner related aspects should be addressed
5. Both men and women should have the opportunity to address sexual health problems, i.e., screening for sexually transmitted infections and sexual dysfunction issues etc

Accessibility
6.There should be open and free access to the sexual health services in the community setting provided by properly trained HCPs

Environment
7. Primary and Secondary care settings should all provide discrete, confidential, patient/couple centred and non-judgemental care
8. All HCPs providing sexual health services should operate within a multidisciplinary environment with access to specialists such as; Gynaecologists, Urologists, Sexologists, Psychiatrists, genito-urinary Medicine specialists, internal medicine etc.

Process
9. There should be well defined care pathways in place to ensure appropriate initial assessment, support and specialised management
10. All services should have up-to-date diagnostic and treatment protocols in place derived from the best available scientific evidence
11. Couples/individuals with suspected pelvic inflammatory disease should be risk assessed and managed
12. For those with chronic sexual dysfunction problems and those not responding to initial treatment, multidisciplinary consultation should be considered.

Staffing
13. All HCPs providing these services in both Primary and Secondary care setting should be trained and competent in all issues related to sexuality and infection risks in the target population
14. All HCPs should be fully trained in communication skills, cultural/gender awareness, equality and diversity

Gynaecological Services in 2014(*free to download from:* www.ebcog.eu)[16]. The document provides advice as regards the provision of couple focused sexual and reproductive services, and they can be adapted for developing community based sexual health services for the ageing population.

The key principles for the provision of such a service are laid out in Table 1:

Contributors

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Conflict of interest

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Provenance and peer review

This paper was not peer reviewed.

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