Maturitas 83 (2016) 27–32

Contents lists available at ScienceDirect

Maturitas

journal homepage: www.elsevier.com/locate/maturitas

Review article

Sexual health and relationships after age 60

Mary Jane Minkin*

Department of Obstetrics, Gynecology, and Reproductive Sciences, Yale University School of Medicine, United States

ARTICLE INFO

Article history:
Received 30 September 2015
Accepted 5 October 2015

Keywords:
Sexual health
Survivorship
Gynecological cancer
Prostate cancer
Erectile dysfunction
Interventions

ABSTRACT

A commonly used phrase describing aging is "60 is the new 40". Although in many aspects of life this may be correct, in discussing sexual health, challenges to maintaining excellent sexual health become more common around age 60. Biological aging challenges physical sexual activity and responsiveness. We commence by briefly surveying the extensive coverage of 'normal' physiological aging. We primarily focus on issues that arise in distinct disease and or pathophysiological states, including gynecological and breast cancer, as well as those associated with partners of men who are either prostate cancer survivors or who have taken therapy for erectile dysfunction (ED). Regrettably, there is a very modest literature on sexual health and associated possible interventions in older patients in these cohorts. We discuss a variety of interventions and approaches, including those that we have developed and applied in a clinic at our host university, which have generally produced successful outcomes. The extended focus to sexual relationship dynamics in partners of men with either prostate cancer or ED in particular is virtually unexplored, yet is especially timely given the large numbers of women who encounter this situation. Finally, we briefly discuss cross-cultural distinctions in older couples' expectations, which exhibit remarkable variation.

Contents

1. Introduction

The appearance of the paper "A Study of Sexuality and Health among Older Adults in the United States" in 2007 was greeted by much press enthusiasm and a sense of surprise among many health care providers. By providing data on over 3000 adults, ages 57–85, the authors reported on the sexual activity, behaviors and problems

* Fax: +1 203 453 8969.
E-mail address: maryjane.minkin@yale.edu

http://dx.doi.org/10.1016/j.maturitas.2015.10.004
0378-5122/

in this somewhat older cohort. 73% of the 57–64 year old, 53% of the 65–74 year old, and 26% of the 75–85 year old were sexually active, and half of the respondents reported at least one bothersome sexual problem [1]. In a much more recent report, published in 2015, almost 60% of women over the age of 60 who are in committed relationships are sexually active, while 13% of women who do not have a steady romantic partner are also sexually active [2]. As life expectancy at age 60 is approximately another 25 years, this data is extremely relevant.

Fortunately, the majority of women and men over the age of 60 are basically healthy. The ubiquitous impact of declining sex hormone levels already has been extensively discussed in the literature for both genders for many years, and accordingly, herein we do not recapitulate a long list of well-known findings on this topic. Instead, we start our review by briefly summarizing and highlighting the subset of findings that we consider particularly essential to a study of sexual satisfaction, and in the process, identifying many of the primary references to (normal) 'Physiological Aging'.

Unfortunately, older adults also have a higher prevalence of many types of cancers and other chronic diseases, which can have a significant impact on sexual health. The most common cancers diagnosed in women in the United States (breast cancer, at 232,000 in 2014) and men (prostate cancer, at 233,000 in 2014) [3], both directly impact the sexual health of our patients. Prostate cancer is the second most common cancer diagnosed world wide (after breast cancer)-in 2008, 889,102 cases were diagnosed [4]. Equally important is to emphasize the high percentages of survivors: there were less than 30,000 prostate cancer deaths, and 40,000 breast cancer deaths in the United States in 2014 [5]. Among the 5.9 million women who are cancer survivors, the majority have breast or gynecological cancer [6].

Many studies of survivorship emphasize the importance of sexual well being to quality of life. The vast majority of articles on sexuality focus in on either breast or gynecological cancer survivors, or in a distinct literature, prostate cancer survivors. Below, we take a broader view across several axes. We discuss both the male and female cancers together, and notably, the relationship aspects that ideally should actively involve both partners, independent of the genesis of the insult. This focus on sexuality in (older) survivors and their partners forms the central corpus of this review. Necessarily, these considerations encompass significant cross-disciplinary treatment.

Indeed, the survivorship quality of life academic literature is scattered across multiple strata, including medicine, psychology, sociology and even anthropology. We will also briefly consider cultural aspects; ideal treatment must relate to cultural norms and expectations, and as discussed below, these can vary remarkably from the canon put forth in the United States and much of western Europe.

We aim to address the big picture relationship dynamic, not just an organ system or even one individual. Not surprisingly, given the heterogeneity of the cancer survivorship cohorts, there are very few studies of the efficacy of a particular protocol to "restore" sexual relationships towards a "normative baseline", as it is difficult to establish what such a baseline should be? Many survivors want to resume their lives as completely as possible and desperately seek treatment and counsel as how best to approach the resumption of normalcy.

The sheer number of patients requesting medical help has expanded greatly over the past 15 years, due to the volume of procedures and to their ostensible success rates, with life expectancies almost that of the age matched population. This has led to the recent emergence and formation of several clinics to treat the multifaceted aspects of recovery of sexual well being, one of which I have founded at our institution, described briefly below. We emphasize that such clinics are only approaching a mature infancy, and will continue to develop as providers continue to attend to their patients' needs.

2. Physiologic aging

The Study of Midlife Development in the United States was intended to examine the prevalence of sexual activity by age; it also was designed to look at sexual satisfaction. The most significant predictor of sexual activity was, as suggested by many previous studies, a partner (married or cohabitating). Also significant were higher prior sexual satisfaction, lack of depression, younger age, and lower body mass index. Absence of dyspareunia was important to sexual satisfaction, but age and menopausal status were not related to sexual satisfaction [2]. Good communication was associated with higher sexual satisfaction. In a review of "Sexual function in elderly women," Ambler et al. encourage practitioners to "dismiss taboo and incorrect thoughts on sexual function, and spark better management for patients, allowing them to live more enjoyable lives," [7].

It is interesting to note that menopause itself does not necessarily correlate with a decline in sexual satisfaction. Multiple studies, such as the REVIVE study, have shown that vulvovaginal atrophy (VVA) interferes with overall healthy sexual functioning [8]. The CLOSER study showed that VVA related painful sex negatively affected relationships for both the woman and her male partner [9]. Trials of the drug ospemifene have shown that the medication does improve dyspareunia [10] and women treated with ospemifene do show improvements in their FSFI scores (Female Sexual Function Index) [11]. Any evaluation of a menopausal woman requires an evaluation for VVA [12].

Unfortunately, given the modest extent of menopause education in American obstetrics and gynecology residency programs, we can anticipate an ongoing deficiency of treatment of couples' sexual health, at least in the United States. Currently, only 20% of residents are being educated with a formal menopausal medicine learning curriculum [13]. Furthermore, world wide there has been a marked decline in the use of systemic hormonal therapy since the publication of the Women's Health Initiative findings in 2002. As pointed out in surveys as recently published as this year [14], we are failing to treat menopausal symptoms appropriately. Despite appeals from the North American Menopause Society to the FDA to remove the black box warning from low dose vaginal estrogen therapy [15], no actions have yet been taken, and clinicians must help symptomatic women to disentangle safety profiles of totally different products [16].

3. Our special needs patients

3.1. Gynecologic and breast cancer survivors

It is only recently that the needs of breast and gynecological cancer survivors have been regularly addressed. Indeed, in 2015, the authors of "a manifesto on the preservation of sexual function in women and girls with cancer" emphasized that to this day, "female patients who are treated for cancer receive insufficient counseling, support, or treatment to preserve or regain sexual function after cancer treatment," despite the fact that even most menopausal oncology patients who have a partner "are sexually active in the year before treatment" [17]. In a survey of women, mean age 55, attending a gynecological oncology clinic for routine followup in 2008, 7% had sought advice or medical help for problems related to sexuality, while over 40% were interested in receiving care to address sexual issues [6].

A committee of multidisciplinary specialists reported in 2010 that "Cancer and its management have a significant impact on