https://www.youtube.com/watch?v=3gOHvDP_vCs

Linda S. MacConnell PA-C, MPAS, MAEd
Gerry Keenan MMS, PA-C

Bringing Sexy back to the Sexagenarians:
Healthy Sexuality Throughout a Lifetime

https://www.youtube.com/watch?v=UD8tGWIqA-
c

Learning Objectives
At the end of the session the learner will be able to:
• Discuss the physiologic effects of aging in terms of sexuality in males and females
• Explain the effect of aging as applied to sexuality in both males and females
• Describe the benefits of healthy sexuality on aging in both males and females
• Compare the physical effects of aging versus the psychosocial effects of aging on sexuality
• Comfortably discuss the sexual history with older patients
• Plan and educate patients about treatment options.
• “Bringing Sexy Back”: revival or a renaissance of some form of “sexy.”
• "Bringing the sexy": already in a person: carrying a confident, alluring attitude
• May be used by either gender in almost any situation. Analogous to "bringing my game face."
• What DO sexy seniors look like?

Kids DON’T OWN SEX  [just did they invent it]

We still like to Netflix and Chill

US Survey of Sexual Health and Behavior

CENTER FOR SEXUAL HEALTH PROMOTION

Promoting Sexual Health through Research, Education, & Training

Kinsey Institute
Affects of Aging on Sex

- M/F remain sexually active late in life. But:
  - Physiological, psychological, social changes, meds illness-related factors (DM, htn; was asked to mention obesity, et al Cancers)
- Female: < libido (43%) vaginal lubrication difficulties (39%) inability to climax (34%)
  - Desire: most common sexual dysfunction reported by older women(aged 57 to 85) [inhibited sexual desire (77%)]

Aging and Sexuality

- Males: erectile dysfunction: 37% difficulty w/ erections. About 15% take some form of medication for sexual function
- > physical stimulation required to attain /maintain erections, less firm; orgasms less intense.
- Refractory time between erections lengthens; ejaculation is less forceful with smaller amounts of ejaculate (also meds/surgery, retrograde)

Ladies First

- Trust
- Mood swings
- Hot flashes
- Nerve pain
- Money
- Fatigue
- Weight gain
- Skin changes
- Hair changes
- Hair loss
- Fatigue
- Fatigue
- Fatigue
• 71% of women aged 80 to 102 report that they still fantasize or daydream about sex. (Bretschneider MJ, McCoy NL. Sexual interest and behavior in healthy adults aged 80 to 102 years. Archives of Sexual Behavior. 1988;17(2):109–129.

• But many do not have the desire to have sexual activity

Libido and Desire

• Promotes desire and ability (to achieve penetration
• Sensation and fulfilment
• Causes: Low self-esteem, stress/mental health problems, hormone changes, physical factors, such as fatigue or lifestyle habits
• Weight gain in either or both partners

• Resentment
• “Leaving you fantasies”
• They ALL need to be addressed

Rx not the answer: Flibanserin: only to treat premenopausal women with low sexual desire. Unfavorable risks/benefits profile
Decreasing Desire

- Atrophic vag is biggest contributor
- Estrogen deficiency = <blood flow to the vagina/vulva = < vaginal lubrication & function
- Vaginal dryness/dyspareunia via cervical atrophy, decreased elasticity & shortening & narrowing of the vaginal wall. Sex may improve size and shape of the vagina, even w/o estrogen therapy.
- Respond nicely to vaginal estrogen therapy

When treating atrophy ONLY:

- **Vaginal** estrogens commercially available in the United States are conjugated estrogens (cream) and estradiol (cream, tablet, and ring)

Menopause (Final Menstrual P.)

- Perimenopause: 4 yrs b4 FMP hormones fluc.
  - 80% w/ hot flashes; 20 to 30 will see u for tx.
  - Waning sexual desire
- Estrogenic effects: hot flashes, vagina thin, & dry (only part of the body getting thinner) < bothersome, lipid and bone ^s
- Lot is going on: Career, kids, parents issues, fatigue, physical changes:
  - Weight gain, fine lines and wrinkles, gray hairs
Hot Flashes

Clitoris needs

• Stimulation: less engorged.
• Vaginal dryness and atrophy (mostly estrogenic), & compounded by age-related diminished blood flow to the vagina.
• Lubrication is decreased. Vaginal pH rises, allowing colonization by enteric microflora.
• Solutions for the Lady Parts:
  • Goal of menopausal hormone therapy (MHT) is to relieve symptoms, especially hot flashes
  • Exceptions:
    – hx of breast cancer
    – coronary heart disease (CHD)
    – venous thromboembolic event or stroke
    – active liver disease
    – or those at high risk for these complications

• Estrogen therapy: mood lability/depression, vaginal atrophy, and sleep disturbances (when related to hot flashes)
• Healthy symptomatic women (50s) must be told that the absolute risk of complications of taking MHT for five years is very low (see exceptions)
• For peri/postmenopausal women in their 50/40s w/ moderate-to-severe vasomotor symptoms, short-term HT is tx of choice

• Transdermal 17-beta estradiol for most women starting MHT
• Types and routes of estrogen are equally effective for hot flashes; transdermal preparations are associated with a lower risk of venous thromboembolism (VTE) and stroke.
• The duration of higher dose vaginal therapy or systemic estrogen therapy should be guided by the risks and benefits of therapy.
• W/ uterus, progestin therapy must be added to prevent endometrial hyperplasia and carcinoma.
  – Micronized progesterone = first-line; effective for hyperplasia, metabolically neutral, probably doesn’t > the risk of breast cancer or CHD; data limited
• W/o systemic estrogen, contraindications to estrogen, or stopped MHT and symptoms recur, try SSRIs or gabapentin

• Time of treatment needed for improvement differs for patients, and should be individualized based on the pts’ symptoms.
  – Vaginal estrogen therapy may be used indefinitely; Low risk of adverse effects, but clinical trials have not lasted > one year
• No recommendation of HT to prevent chronic diseases: osteoporosis, CHD, or dementia. +/- Osteoporosis

Moving away from Eponyms
Andropause

- Age-related < libido in men = <T and ^ in receptor site sens. to androgens
- > 50 hormone prod. gradually <s.
- First sign = increasing FSH (causes spermatogenesis) & LH (causes T) = Aging testes making less T
- Although <levels of T = <libido, sex drive may not ^ with T replacement

Andropause “late-onset hypogonadism”

- Only somewhat like menopause: POSSIBLE clinical consequences NOT well established
- Total T = small decrease w/ age + Binding globulin (SHBG) increases gradually = less Free T. Some studies show free T falls 2.8 %/yr
- Spermatogenesis = Not much change
- POSSIBLE connection <T and syx.
  Aging/hypogonadism and menopause similar:
• **Bone mineral density and fractures:** BMD & risk of fractures increases. BMD of the femur and the < spine < age 20 to age 90. Men hypogonadal show < BMD. > 65 years, nonvertebral fractures increased w/ lower bioavailable estradiol or high sex hormone-binding concentration (SHBG) not w/ only a low bioavailable T. Risk was greatest in men with low bioavailable estradiol, T and high SHBG.

• **Muscle and fat mass:** Muscle mass declines. Fat mass increases. Hypogonadal men have less muscle mass and more fat mass. T tx in men with hypogonadism tends to reverse these changes.

• **Muscle strength:** 60 to 79 years muscle strength < aged 20 to 39. Few studies compare muscle strength in hypogonadal men to that in others.

• **Anemia:** High in older men. 14 of 99 men w/ lowest T were anemic compared with only 3 of 100 w/ highest T. Also common in severe hypogonadism and corrected w/ T replacement.

• **Mood:** “Grumpy old men” Low serum free T associated with depressive symptoms, even after correction for possible confounders; men w/ lowest free T = depressed symptoms more often. In hypogonadal men, raising the serum T improves mood.
• **Cognitive function:** Decreased serum T associated w/ decreased neuropsychological function. 407 (50 to 91yo) men classified as hypogonadal by serum free T index (calculated by dividing serum T by SHBG) had much lower scores on measures of verbal and visual memory and visuospatial performance and ++ rate of decline in visual memory.

• **Metabolic cardiovascular parameters:** Studies have shown low serum T has been associated with development of central obesity, higher insulin concentrations, the metabolic syndrome, diabetes, high sensitivity C-reactive protein, and increased mortality.

AND MOST IMPORTANTLY:

• **Sexual function:** frequency of orgasm, intercourse or sexual satisfaction, is less in older men than in young men (despite the fact that men are way out-numbered)
  – Men with hypogonadism due to known disease = decline in sexual function and improve w/ T
  – 3369 men ages 40 to 79*, serum testosterone concentration less than 320 ng/dL had poor morning erection, low sexual desire, and erectile dysfunction.

*European Male Aging Study (EMAS)
Treatment of Andropause

- **Testosterone**
  - Impact of testosterone replacement in older men is unclear
    - small sample size, asymptomatic men w/ low-nl T levels, various T regimens
  - Should T be administered to older men?
    - absent pituitary or testicular disease, T therapy only for
      men with low serum T > one occasion and symptoms of T <
    - Must discuss the risks and benefits of testosterone therapy before recommending this.
    - Target serum T should be < for younger men, for example, 300 to 400 ng/dL vs 500 to 600 ng/dL to minimize potential risk
      - Does testosterone tx reverse decline in function,
      - Does testosterone tx increase testosterone-dependent diseases (like prostate Ca)

- **Prostate Ca**: No clear long studies, but looks good: > PSA, but still WNL, P bx showed no signif change in T in the tissue
- **BPH**: No evidence
- **Sleep apnea**: some studies show increase, others don’t
- **Erthrocytosis**: + correlation
- **Lipids**: Not much effect
- **C/V risk**: Conflicting

Bottom Line on T

- Decreasing T effects energy, sexual function, muscle mass and function, erythropoiesis, and bone. Some decline in T is related to the development of obesity and other comorbidities such as diabetes mellitus; evaluation and management of these comorbidities is therefore essential
- See references for further info on T
- I am a female and I LOVE MY T!!!
Menopause & Andropause

- More < in interest & desire than men
- < vaginal lubrication & tissue thinning = ouch; desire returns w/ rx
- Also < T, but some women experience > T and that => desire/SD
- Some < in interest and desire< women
- Increases in FSH and LH signals < production of T
- DHEA?
- Sexual activity statistics vary WIDELY

Special Medical Considerations

- And solutions
- Hearts and the E_ECTION Fraction

ED- Erectile Dysfunction

- A circulation issue
- Arginine Amino Acid
- Phosphodiesterase inhibitor
- Increase the nitric oxide
- Viagra, Levita
- Etc:
Strong Heart

- Testosterone- CHF treatment in China
- Mind Body medicine – Yoga, relaxation techniques massage mindfulness guided imagery
- Non-pharmacy: stress management

Lots of us believe that sexual interest decreases with age…Which couple do you think your patients would like to feel like?

Sex check –up..

- Wellness score-
  Bio Impedance cholesterol, waist body fat lean body mass intracellular water
- 8 weeks
- 3000
Sexy Statistics

- A 2007 sample of 3,005 U.S. adults ages 57 to 85 (men and women) found that sexual activity varied by age:
- 73% of Americans aged 57 to 64 reported being sexual active
- 53% of those aged 65 to 74 reported being sexual active
- 26% of those aged 75 to 85 reported being sexual active

• https://www.youtube.com/watch?v=a_Jad7hB54E
The Sexual History

- Sexual activity incl. desire & assessing older patients’ sexual health often avoided
- Who is more uncomfortable
- “Are you sexually active?” “No, I just lie there!”

Taking a Sexual History

- Lose the image of walking into your parents bedroom
- Consider: Patient concerns and intimidation
- So….. What do you talk about? Especially with pts your parents and GRANDPARENTS age!

- Sex drive, desire and ability
- Any pain? ANY PAIN
- “Remember Linda,” said my clinical year mentor*, “dyspareunia is better than no pareunia at all.” *Which is the only questionable item he ever told me—he was otherwise a GREAT man and one of the ‘founding fathers” of our profession
• Safe sex: When we were kids, what were condoms for?
  – Condom usage is low among adults >50, with approximately 2/3 reporting they did not use a condom during their last sexual encounter
  – STIs EVERYWHERE. Not just trailer parks; nursing homes

The Sexual History

PA Role
• Be approachable – set the stage
• Know your limits
  – Your own limitations in attending or preparing the patient
• Have referral sources ready
• What the patient is really asking for?
  – What is their level of sexual understanding and awareness with regard to their question

The patient
Consider:
• 1. Emotional aspects
• 2. The medical – acute and chronic
• 3. The Physical “age” issues

Taking a Sexual History

• If uncomfortable discussing sex issues MUST make referrals to clinicians with proper training and confidence to evaluate & treat sexual issues (including desire problems) in an increasing patient population
• You must check your mores and personal morality at the door (Sex outside marriage, same sex relations, the acts themselves...)
• How would you feel? Gerry/Linda
Where the rubber hits the road

Like fine Wine...
(Sex may improve with age)

- Increased self-awareness and confidence
- More free time, relaxation and fewer distractions (kids interrupting)
- May feel better about the aging body
- The need for intimacy is lifelong

Barriers to sex 60+

- Physical/Emotional/Medical
- Embarrassment:
  - Aging body appearance
  - Performance issues (Spiral and cat-chasing tail)
- Illness or loss of a partner
- “Temporary Issues” can become permanent
- Communication
- Life circumstances. Money
- But - “Love will find a way......”
**Benefits of Healthy Sexuality**

- Demands and (rewards) of career and parenting may have decreased; more time and need for intimacy...
  - Sex and physical connection may fill the gap
- Improves physical and mental health
  - Physical exercise, endorphin release, anxiety reduction
  - Closeness of the deepest interpersonal relationship
- Escape from stress/reality

**Great Sex for a Lifetime**

- Active sex life seems to guard seniors against poor health in later life
- Sexual activity has + effects on older adults' physical health (important to resume a sexual relationship after an illness or traumatic event)
- Positive attitudes about sexuality and having a communicative partner may help one to resume sexual interaction

**Turns out, if it’s good for you it’s good for sex; you’ll recognize:**

- Lifestyle
  - Food Plan
  - Sleep
  - Exercise (yoga increases flexibility)
  - Emotions
- Address Underlying Medical Problems
Bringing Sexy Back

- COMMUNICATION
- 5 factors that encourage sexuality/increased sex drive in older patients:
  1. Positive attitude towards sexuality
  2. Active sex life in younger/middle years
  3. Good health, recuperating
  4. Interested and interesting partner
  5. Willingness to experiment sexually

“LAY ADVICE” : who can argue?
- Schedule sex: on the calendar; in your phone.
- Kiss ... sweetly, passionately, frequently, slowly, contentedly, hungrily, lightly, sloppily and kiss some more (Bonding and foreplay)
- Select your high energy time (remember morning erections)
- Silky Lubricant or...coconut oil (yummy taste organic > refined)
- Toys –Stimulate
- Laugh...laughter is bonding and flirtatious
- Do it anyway...even when you “don’t feel like it”

The LAY press: Know what your patients see and read

http://www.huffingtonpost.com/2012/11/16/sex-over-60-tips_n_2128938.html
In conclusion:
Sexuality in older years is not too different than at any age:
• Not a question of age, but desire
• Breaking down stereotypes (one is never too old)
• Open communication (isn’t that basic to sexuality at any age)

• Encourage NOT dwelling on how things are different
• Confidence and honesty are sexy and appealing
• Individual choices
• Self-discovery
• Enjoy!
• Bioidentical hormones
• Low-dose paroxetine (7.5 mg), which is usually used for the treatment of depression and other psychiatric indications at higher doses, is the only approved nonhormonal treatment for vasomotor symptoms (not w/ tamoxifen)

• Afternoon delight
References

Referrals

- Urology and urogynecology:
- Physical therapy:
- Psychology:
  - Sexual Therapists
  

Treatment

- Androderm Patch
- Testoderm Patch
- Creams
- Pellets
- Sublingual tablets
- Expensive Pharmaceuticals
### Synthetic Testosterone - Conventional
- Danzol
- Ozandrolone
- *Propionate - DO NOT USE* (Liver, cancer)
- *entahate - DO NOT USE*

### Natural Testosterone Bioidentical Hormone Replacement (BHRT)
- Same as testicular produced
- Compounded by Pharmacists = 1/5th as expensive
- Weekly injection
- Subcutaneous pellet
- Buccal troche
- Transdermal cream/gels
- 20-100mg a day

### Testosterone Gel
- 25-50mg/day with hormone blocker
- Add 25 to 50mg CHRYsin (estradiol level)
- Test/Chrysin (50/25 is standard dose)
- RECHECK 3 months – HISTORY-are you better?
- Cannot use serum (inacturate)-travels through lymphatics
- Saliva Test only to monitor Topical agents
Bio Identical pellets

• Arizona: SottoPelle founded by Dr. Gino Tutera
• Menopause and Andropause solutions
  200mg sottopelle (35.00)
  Testopel FDA – 85.00 (1000mg Q3 months)

Injectable

NOT bioidentical- cypionate, deconate
Urologist- 50mg BID (SUN WED) YO YO effect
Vial- 100mg/ml and 200 mg/ml
Weekly injections- 200mg IM

Supplements-Healthy Testosterone

• “Active Man” vitamins.
• Tomatoes
• www.RegenNow.com
• Anwanwellness.com
• ANAWAN regenerative Ctr.
Donovan W. Christie, MD:
https://www.youtube.com/watch?v=hxIDNko06A0
### Sexy Stats: “Sexual Behaviors, Condom Use, and Sexual Health of Americans Over 50: Implications for Sexual Health Promotion for Older Adults.”

<table>
<thead>
<tr>
<th>Percentage reporting sexual activity within the past year</th>
<th>Men’s 50+</th>
<th>Women’s 50+</th>
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</thead>
<tbody>
<tr>
<td>Masturbation: Not in past year</td>
<td>36.5</td>
<td>53.3</td>
</tr>
<tr>
<td>A few times per year</td>
<td>25.8</td>
<td>34.3</td>
</tr>
<tr>
<td>A few times per month</td>
<td>20.0</td>
<td>10.7</td>
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<tr>
<td>2 or 3 times per week</td>
<td>13.2</td>
<td>1.3</td>
</tr>
<tr>
<td>4 or more times per week</td>
<td>4.5</td>
<td>0.5</td>
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<tr>
<td>Gave oral sex: None</td>
<td>62.9</td>
<td>74.2</td>
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<tr>
<td>Within the past year</td>
<td>37.1</td>
<td>25.8</td>
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<tr>
<td>Received oral sex: None</td>
<td>60.7</td>
<td>74.4</td>
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<tr>
<td>Within the past year</td>
<td>39.3</td>
<td>25.6</td>
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<tr>
<td>Penile-vaginal intercourse: Not in past year</td>
<td>46.4</td>
<td>58.0</td>
</tr>
<tr>
<td>A few times per year</td>
<td>17.8</td>
<td>13.5</td>
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<tr>
<td>A few times per month</td>
<td>24.6</td>
<td>20.3</td>
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<tr>
<td>2 or 3 times per week</td>
<td>10.2</td>
<td>6.8</td>
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<tr>
<td>4 or more times per week</td>
<td>0.9</td>
<td>1.4</td>
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<tr>
<td>Anal intercourse: None</td>
<td>92.3</td>
<td>95.9</td>
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<tr>
<td>Within the past year</td>
<td>7.7</td>
<td>4.1</td>
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### National Survey of Sexual Health and Behavior

#### Percentage of Men Reporting Use of Erectile Medication During Their Last Sexual Encounter

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Overall (50-80+)</td>
<td>16.9</td>
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<tr>
<td>50-59</td>
<td>7.7</td>
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<tr>
<td>60-69</td>
<td>30.1</td>
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<tr>
<td>70-79</td>
<td>22.7</td>
</tr>
<tr>
<td>80+</td>
<td>18.8</td>
</tr>
</tbody>
</table>
• National Survey of Sexual Health and Behavior (NSSHB), from the Center for Sexual Health Promotion at Indiana University’s School of Health, Physical Education and Recreation

• One of the most comprehensive sex studies in two decades; includes sexual experiences and condom-use behaviors of 5,865 adolescents and adults ages 14 to 94.


• In participants aged 18-59, age was related to greater difficulty with erections and lubrication.

• Among ages 18-59, older age for men is associated with lower likelihood of his own orgasm; for women it is associated with a higher likelihood of her own orgasm

• Women >50 less sex 5% per year of age for penile-vaginal intercourse; 7% per year of age receiving or giving oral sex