

Sexually Transmitted Diseases in the Elderly: What You Need to Know

BY SUSAN LETVAK and DIANNE SCHODER

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Sam, a 65 year old, had recently been admitted to a nursing home. When several lesions appeared on his penis and inner thighs several months after admission, the nursing staff diagnosed the condition as an irritative rash caused by incontinence and the use of incontinence pads. The nurses treated the lesions with a protective skin barrier, but there was no improvement. Only after reviewing medical records and consulting with the physician did they realize the truth: Sam had contracted genital herpes almost 20 years earlier and still suffered outbreaks. In this case proper treatment, infection control, and staff education were delayed because the nursing staff failed to quickly recognize a common sexually transmitted disease (STD).

Most nurses would not be surprised to find themselves caring for a 24-year-old man with genital herpes, syphilis, or AIDS. How many, however, are prepared to recognize and provide counseling and care to an 80 year old with an STD? Would you even consider the possibility of an STD in an elderly patient?

Many nurses might be surprised by the existence of STDs in elderly persons, but the incidence of STDs in this population is significant in terms of newly acquired diseases and residual complications from prior infections.¹ Ageist attitudes cause many people—health care personnel not excepted—to assume that elderly persons are not sexually active or at risk for an STD. Sexual histories on older adults are often incomplete or completely lacking.² Failure to address the possibility of an STD in any patient could lead to lack of treatment and further transmission of the disease. Additionally, counseling on the prevention of STDs is imperative for all sexually active adults, of whatever age.

Sexuality and the Elderly

Human beings are sexual beings throughout their lives. In good health, a person may continue to be sexually active into the seventh, eighth, and even ninth decade.² Some degree of sexual appetite is usually present throughout life.³

Although studies on sexuality in older adults are limited, one national sample reported that the average frequency of sexual activity in older adults is two to four times a month.⁴ Bretschneider and McCoys studied a group of healthy men over 80 years of age. Of this group, 29% were

having intercourse at least weekly, while 38% were not having sex at all. Enjoyment of sexual intercourse was characterized as moderate or great by a full 63% of the respondents.⁵ Older adults are also not necessarily monogamous. The national probability sample mentioned above found that between 2.5% and 3% of older Americans had two or more sexual partners in the previous year.⁴

Society has been slow to recognize the sexual needs and realities of its elderly population, and most adults-

TABLE 1. MAJOR STDs

Disease	Signs & Symptoms	Treatment	Teaching & Prevention
Chlamydia	Men: None or urethritis Women: 2/3 = none 1/3 = mucopurulent discharge; PID	Antibiotics = cure (azithromycin; tetracycline; erythromycin)	STD prevention—partner must also be treated; full course of antibiotic treatment needed
Genital warts (human papillomavirus)	Warts on the genitals, anal region, vagina, cervix, or oropharynx	Cryotherapy & laser = cure; may persist in deep layers of basal epithelium	STD prevention; HPV a major cause of cervical cancer
Gonorrhea	Men: urethritis with discharge Women: none or slight discharge and dysuria-PID	Antibiotics = cure (ceftriaxone; cefixime) ciprofloxacin;	STD prevention
Herpes simplex virus, type II	Vesicular lesions on the genitals, vagina, cervix, anal region, oropharynx;	No cure; treatment with acyclovir may suppress outbreaks and speed healing; frequent recurrence possible	STD prevention; abstain from close contact when known outbreak
HIV	None until progresses to AIDS, then widespread illnesses from immune dysfunction	No cure; treatment with zidovudine (AZT), didanosine, zalcitabine delays onset of AIDS	STD prevention; not transmitted by casual contact
Syphilis	Chancre at entry site	Antibiotics = cure	STD prevention;
Primary (3-8 wks)	Widespread cutaneous eruptions and	(penicillin)	highly infectious
Secondary (6-12 wks after to 1-2 yrs)	systemic symptoms, flu-like, rash	Antibiotics = cure (penicillin)	STD prevention; highly infectious
Latent (2-4 years after infection)	None	Antibiotics = cure (penicillin)	STD prevention; noninfectious after 4 yrs
Late (3-20 yrs after infection)	Cardiovascular and nervous system damage; may be fatal	Irreversible damage	Noninfectious except through spinal fluid

again, including health professionals—have been socialized to not talk about sex. Identifying and intervening in sex-related problems, including diseases, is important for the nurse who cares for patients in this population.

Sexually Transmitted Diseases

STDs are infectious diseases acquired through sexual activity with an infected person. Some STDs, such as hepatitis B and HIV viruses, may also be transmitted by means of blood. Most people, although familiar with syphilis and gonorrhea, do not know that more than 30 etiologic agents that cause STDs may be transmitted by sexual and nonsexual means.¹

When one deals with a sexually inactive elderly patient, one should remember that an STD may be present in a patient who is no longer sexually active. An elderly patient may have contracted HIV from a blood transfusion 10 years ago, or even from another source. In the spring of 1994 CNN TV reviewed a sharp increase in AIDS in the elderly population of Miami not due to blood transfusions. A patient may have a case of tertiary syphilis, the initial infection having occurred decades ago. Because many STDs have no symptoms, the patient may be unaware of his or her infection.

The older adult is also at risk for a newly acquired STD. Postmenopausal vaginal wall thinning may leave the elderly woman at greater risk for STDs than when she was young. The decline in estrogen levels renders the vaginal mucosa more susceptible to abrasion during intercourse, and this allows organisms a greater number of sites for entry.⁶ In addition, for both men and women the immune system declines with advancing age.⁷ The condom, considered the only contraceptive device prophylactic against STDs, is unlikely to be used by older couples, who are past their reproductive years.⁸ Many older adults have been in long-term monogamous relationships and may be unaware of the risks when entering into a new sexual relationship.

In addition, there is the possibility of sexual abuse of the elderly. Sexual abuse may occur with both hospitalized patients or nursing home residents, as well as elders residing in the community. The media frequently reports incidences of rape and sexual abuse in the elderly population.

Nurses' Responsibility

Nurses must be familiar with the most common STDs. This includes being able to recognize major signs and symptoms, identifying the route of transmission, knowing the appropriate treatment, and being able to provide appropriate prevention education and counseling. The more common STDs with which the nurse should be familiar are chlamydia, genital warts (human papillomavirus), gonorrhea, herpes, HIV, and syphilis (Table 1).

To recognize an STD in an elderly patient, one must first take an accurate sexual history. If an STD is present, education on treatment and prevention of further transmission is necessary. Additionally, the nurse has the responsibility for providing counseling regarding the prevention of STDs.

Confronting Sexuality

To accurately obtain the sexual history, a nurse must first become comfortable with discussing sexual issues. This may be done only if the nurse increases her awareness of her own behavior,

thoughts, and feelings in regards to sexual issues.⁹ An examination of one's own attitude and feelings regarding sexuality begins the process of feeling comfortable with discussing sexuality with others. Discussing sexual issues with peers or with a clinical specialist may also assist the nurse.

A nurse may also enhance her comfort with the subject through self-study and reflection.¹⁰ This may be done through reading new literature on women's sexuality. The books *The New Our Bodies Ourselves* and *Women's Experience of Sex* both consider women's sexuality within various contexts of women's lives.¹¹⁻¹²

Workshops on human sexuality may also help nurses gain comfort with the subject. Because not all nursing staff have been trained in school or at work to assess sexual history (or even to discuss sexual issues), workshops or courses may help nurses be more comfortable, as well as learn more, about sexuality.

The Sexual History

While the sexual history needs to be a part of the complete nursing history, an increase in HIV infection as well as other STDs among elders emphasizes the importance of obtaining the sexual history. The taking of a sexual history may be a difficult task with any patient, and even more so with elders, who may not feel comfortable talking about their past and present sexual practices. To make matters more difficult, the communication skills necessary to understand safe sex practices may be less well developed among the elderly than younger adults.

While interviewing the elderly client, the nurse should remember that sexual behavior may involve body parts other than the genitalia. Counseling should be based on the assumption that everyone may have engaged in every type of sexual activity.

The nursing history is usually done on the day of the client's admission to the hospital or nursing home, or during the first clinic visit. The nurse must be especially attentive to developing a trusting relationship. By introducing herself, by being attentive to cues from the client, by eliciting the assessment in a quiet area that ensures privacy, and by demonstrating an attitude of caring, the nurse can help build a trusting relationship.

Once the nurse begins the sexual history section of the assessment, the purpose of the history must be explained. The nurse should also acknowledge that some questions may be personal or otherwise sensitive. The sexual history should not be the last part of the health history, as some experts say that waiting until the end of the interview indicates to the patient that the nurse is uncomfortable with the subject matter.¹³

While asking questions in a caring, nonthreatening, nonjudgmental manner, the nurse should make eye contact with the patient. The patients should be allowed ample time to think and respond. (A patient's hesitation in answering a question may not be a case of embarrassment but a delayed recall of past events.) It is generally

BOX 1. SEXUAL HEALTH HISTORY: MALE AND FEMALE

- 1. Are you currently sexually active?
- 2. Are you currently active with more than one partner?
- 3. What kinds of protection do you and your partner use during sexual activity?
- 4. How has your illness and/or medications affected your sexual activity?
- 5. Do you have questions or concerns about your sexual activity?
- 6. Have you ever had a sexually transmitted disease, or knowingly been exposed to somebody with a sexually transmitted disease?
- 7. Have you ever had, or do you now have, discharge, rashes or sores in the genital area?
- 8. Is there anything you would like to discuss concerning sexual issues?

*Please put a check in the box next to any question you are unsure of how to answer, or in which you would like to discuss further with your nurse or physician.

BOX 2. RECOMMENDATIONS FROM THE CDC FOR THE USE OF CONDOMS

1. Only latex condoms should be used. "Natural skin" condoms have pores that are large enough for HIV and other infections to pass through.
2. Condoms must be used during vaginal, oral, or rectal sex.
3. Condoms should contain, or be used in conjunction with, 5% nonoxynol 9, which has been shown to kill HIV and other infectious diseases.
4. The expiration date should be checked. Do not use out dated condoms.
5. Store condoms in a cool, dry place.
6. Have condoms available at all times and discard after each use.
7. The condom should be placed on an erect penis. As the condom is rolled onto the penis, the tip of the condom should be held to squeeze out the air, leaving space for the ejaculate. The entire penis, to the hair, must be covered.
8. Only water-soluble lubricants, such as K-Y jelly or nonoxynol-9, should be used. Oil-based lubricants, such as Vaseline, cause disintegration of the condom.
9. After ejaculation, the condom should be removed while the penis is still erect.
10. Unlubricated condoms should be used during oral sex. Nonoxynol-9 may be placed inside the condom before oral sex but should not be on the outside.

From US Department of Health and Human Services, Public Health Services. Condoms for the prevention of sexually transmitted diseases. MMWR 1988;37(9):133-7.

BOX 3. RECOMMENDATIONS FOR SAFE SEX

1. Know your partner.
2. Limit the number of sexual partners.
3. Avoid the exchange of body fluids.
4. Use condoms and spermicidal ointment or foam for all sexual activity.
5. Practice good hygiene: Wash the genital area before and after sex.
6. See your physician yearly for medical check-ups.

best to proceed from topics that are easy for the patient to discuss to more difficult topics. The nurse can begin the topic in a general manner, such as, "As a nurse, I am concerned about all aspects of your health. In discussing your past medical history, we have neglected an important area in our lives—our sexual needs."

Open-ended questions facilitate the client's comfort during the sexual history interview and also call on the client to answer with responses other than yes or no. It is also helpful to imply universality in questioning, for example, "Many people have questions about..." The use of open-ended questions is also more likely to provide the most information about sexual habits and practices. For example, "What are your experiences with heterosexual and homosexual activities?"

A sexual history form may be used in your work setting. If nurses use such a form, they must evaluate the patient's ability to accurately complete the form. Pay attention to sensory factors and cognitive abilities as well. The form should be reviewed thoroughly with the patient, highlighting any suspect areas. This can be done by simply checking a provided box, by either the patient or the nurse. After reviewing the form, the nurse can then approach the patient on the area of concern (Box 1).

The sexual history, whether orally taken or written by the patient, should include information about sexual partners, physical signs or symptoms that may be present, and problems or satisfaction with sex life. It should also include the use of protection and precautions against STDs, including HIV. A thorough psychosocial history may also give the nurse clues as to the presence of risk factors for STDs that warrant further investigation.

The Reluctant Patient

It is important for the nurse to remember that obtaining a complete sexual history may not be possible for all elderly patients. In fact, obtaining a complete medical history alone is sometimes difficult. A nurse in a longterm care setting may wish to continue this part of the history at a later date when a more trusting relationship has been established. In the acute care or outpatient setting, however, the nurse must remind the patient of the importance of the sexual history as part of his or her complete medical history. The use of pamphlets or even video material will allow the patient to review the information in private. If the patient is still unwilling to complete the sexual history, the nurse should still provide the proper prevention education and remind the patient that he or she may wish to continue the discussion at a later time.

Prevention of STDs

An excellent time for providing patient education on STD prevention is during the sexual history. It is the nurse's responsibility to provide patient education on the prevention of STDs. Patients must be told that celibacy or the maintenance of a strictly monogamous relationship is the only guarantee against acquiring an STD. Patients should be told that when they have sex, they expose themselves to the infections of everyone with whom their partner has ever had sex. Safe sex practices, including the use of a latex condom and limiting the number of sexual partners, must be discussed with all patients.

Safe sex practices include all activities that do not involve the exchange of bodily fluids, such as cuddling, massage, and mutual masturbation. Encourage open communication between partners. When your patients are comfortable discussing sexual issues with you, they may be able to communicate more openly with potential sexual partners.

The patient should be told that the presence of any rash, blister, sore, or discharge should be viewed with care. The use of a condom provides the most effective mechanical barrier method to infection. A spermicidal agent, such as nonoxynol 9, and concurrent use of a condom will further reduce the risk of disease.¹⁴ The elderly patient should be provided verbal and written instructions on condom use (Box 2). It is important for the nurse to review proper use of condoms with the patient, as it cannot be assumed that the patient will read the instructions provided. Many patients cannot read, and many elders with impaired vision will have difficulty reading the small print of instruction pamphlets. Even patients who can read may not fully comprehend the instructions. One study found that the readability levels of condom instructions required an average of 10th grade schooling.¹⁵ An additional handout on safe sexual practices could also be given out (Box 3).

Sexual relationships can still be enjoyed as long as safe sex practices are maintained. The nurse may need counseling and other assistance in becoming comfortable discussing sexual issues with elderly clients as well as in recognizing signs and symptoms of the common STDs and developing appropriate prevention strategies.

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