

newsletter

Eldercare Programme

38th Edition | February 2023

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SEXUAL DYSFUNCTION IN OLD AGE

This newsletter is for your general information and is not a substitute for medical advice. You should contact your doctor with any questions about your health, treatment or care.

Little may be known about the **sexual habits** of the elderly because many may ridicule the subject or find it to be taboo. Research has shown that factors like biological and physiological changes and social factors associated with ageing, contribute to **sexual dysfunction in old age**.

Physiological changes in ageing **MEN**

- Sexual organ degeneration
- Diminished testosterone level
- Delay in attaining erection
- Erection of poor quality
- Longer delay in achieving and maintaining a full penile erection
- Decline in intensity of orgasm
- Decreased hormone levels are associated with reduced desire

Physiological changes in ageing **WOMEN**

- Changes are secondary to declining secretion of oestrogen (female sex hormones) after menopause
- Loss of elasticity in breast tissue and loss of breast dimensions
- Cervix and uterus shrink in size
- Walls of the vaginal canal weaken and vaginal length and width decrease
- Decrease in vaginal lubrication

Social attitudes and beliefs that consider sexual behaviour as inappropriate, unacceptable or abnormal in old age contribute to sexual dysfunction. Older people tend to accept decline in physical attributes, sexual potency and attractiveness. These changes result in them adopting negative attitudes towards their sexuality. Other factors preventing a regular sex life are disturbed relationship, physical fatigue, illness, psychological problems and economic worries.

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Classification of sexual dysfunction

Sexual desire disorders or decreased sex drive: This is characterised by a lack of interest in sexual activity due to decrease in the production of normal oestrogen in women or testosterone in men and women, ageing, fatigue, medications such as the selective serotonin re-uptake inhibitors (SSRIs) used for treatment of psychiatric conditions, such as depression and anxiety.

Sexual arousal disorders: These may be due to medical conditions like decreased blood flow or lack of vaginal lubrication, chronic conditions as well as the nature of the relationship between the partners.

Erectile dysfunction: This is characterised by the inability to develop or maintain an erection of the penis mostly caused by diabetes mellitus, resulting in decrease in the blood flow to the tissue in the penis, which may be medically reversible in some cases. It is also caused by the damaged nerves of the pelvic walls and can be damaged in prostate and bowel surgeries.

Orgasm disorders: This is characterised by persistent delays or absence of orgasm following a normal sexual excitement phase. It can have physical, psychological, or pharmacological origins.

Sexual pain disorders: This affects women mostly and may be caused by insufficient lubrication (vaginal dryness). Poor lubrication may result from insufficient excitement and stimulation, or from hormonal changes caused by menopause.

Management of sexual dysfunction

Assessment of a sexual dysfunction requires careful history-taking from the client with a corroborative history from the spouse/partner. Treatment options include the following:

Patient education: This is an important part of the management of sexual dysfunctions.

Psychosexual counselling: There is usually an underlying cause which needs to be addressed and be combined with pharmacological treatment.

Lifestyle changes: Quit smoking, regular exercises and eating healthy.

Physical examination: To screen for any medical risk factors or co-morbidities (chronic conditions) associated with sexual dysfunction and an assessment of cardiovascular, neurological and genital systems is important.

Recommended laboratory testing: These include fasting glucose, cholesterol, lipids, hormonal profile and thyroid function.

Drug management: Includes oral agents, intra-urethral (introduced into the urethra) drugs, topical creams, intra-corporal (into the body) injection therapy and mechanical devices.

Specialist consultation and referral: Where necessary, especially when there are co-morbidities, patients should be referred for specialised consultation to a gynaecologist, psychiatrist, psychologist etc., whichever is appropriate.

NOTE!

Specialist consultations and procedures are subject to pre-authorisation by the Society's designated agent or hospital designated service provider (DSP).

Source

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