Sexually transmitted infections and older people

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Aims and intended learning outcomes

This article aims to raise awareness of the probability of sexually transmitted infections (STIs) in the older population and to challenge beliefs around the sexual health needs of the older adult. It also aims to alert nurses and other carers to the dangerous consequences of ignoring the possibility of STIs and not providing adequate health screening or education for people over the age of 60. After working through this article you should be able to:

- Recognise that someone over the age of 60 is as much a sexual being as someone younger.
- Understand that people over the age of 60 are no more immune to STIs than any other age group.
- Describe major STIs that can affect any age group.
- Apply knowledge to practice experiences.
- Discuss the consequences of not providing equality of care around sexual health for older people.
- Know what, when and where to refer on to specialist services.

In brief

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Summary
Sexually transmitted infection (STI) remains a taboo subject when associated with older people. Elizabeth Grigg advises nurses to consider, without prejudice, the possibility of STI in older people.

Keywords
- Elderly health
- Sexual health
- Sexually transmitted infections

Introduction

Older adults are no more immune to STIs than anyone else if they are victims of inadequate sexual health screening and education. Accurate statistics on the incidence of STIs among older people are hard to find. The Public Health Laboratory Service, which publishes STI figures from genitourinary medicine clinics (GUM), provides some data, grouping ‘older people’ as 45 plus. But older people tend not to access GUM or other sexual health services – they are more likely to seek help from their GP.

The prime obstacle in sexual health care for older adults is the fact that they are customarily portrayed as asexual. Thus they might never be screened for an STI even if they present with relevant symptoms. Older people often adopt this asexual label and might never associate physical symptoms with sexual practice (Drench et al 1996).

There are statistics and articles that address HIV and AIDS in the older adult, but there is a dearth of literature about other STIs and the older population (Grigg 1999). However, nurses appear to be aware of syphilis in relation to older people.
Diseases with sexual connotations carry with them not only prejudices linked to a lack of knowledge and understanding but also to influences from the mores of society on sexual indulgence.

In the 16th and 17th centuries, under the influence of Puritans, STIs were feared, and sufferers were isolated and described as ‘loathsome and filthy’ (Morton 1976). In the 18th century, STIs were less feared. Gonorrhoea and syphilis were common but did not appear to be life threatening in their early stages and there was no knowledge of the connection syphilis had to paralysis, heart disease, blindness and insanity. Sexual freedom was tolerated (Morton 1976). In the 19th century, STIs became sinful and degrading and became a penalty for straying from the ‘path of good behaviour’ (Morton 1976). Laws were developed to curb the spread of diseases and isolate victims. In 1864 the British government passed the Contagious Diseases Act which attempted to protect military personnel from ‘venereal disease, including gonorrhoea’ (Morton 1976). Punitive measures were introduced which included the arrest, examination and treatment of ‘loose’ women.

Arguably, we are suffering from this Victorianism. Western society appeared to experience a sexual revolution in the 1960s, with the advent of the contraceptive pill, the availability of penicillin and the acceptance of homosexuality in some countries. However, recent studies show that attitudes towards anything associated with sexuality are more conservative today than they were over a decade ago (Thompson 1990).

STIs are about sex, which in this supposedly liberated and enlightened world is still a ‘dirty’ word. ‘Anything which has sexual overtones stimulates an unholy trinity of inhibition, hypocrisy and prejudice, all of which can, and do, have a detrimental effect on both prevention and care… this combined with ignorance produces a seemingly impenetrable barrier’ (Hancock 1991).

**Gonorrhoea**

Between three and five days after being infected, a man will feel discomfort in the urethra, followed by a thick purulent discharge from the penis. He will experience burning pain on urination. Women will also experience a thick purulent discharge, but this is often difficult to differentiate from vaginal discharges caused by normal pathogens, by *Candida albicans* (thrush) or by trichomoniasis. *Neisseria gonorrhoeae* can cause gonococcal tonsillitis if the bacteria is transmitted orally.

Treatment with antibiotics is successful. If untreated, gonorrhoea can cause a type of arthritis and inflammation of the reproductive organs resulting in pelvic inflammatory disease (PID) or inflammation of the prostate or testicles (Adler 1995). Arthritis, gynaecological and prostrate problems are extremely common among older people, but are rarely allied by people to STIs.

**Syphilis**

From two to 12 weeks after initial infection a painless sore will develop at the point of transmission. This is usually on the penis, vulva or anal area, but can occur orally. At this primary stage there can be some swelling of nearby glands. These symptoms will disappear even if untreated. After a few symptomless weeks a widespread pink skin
rash occurs. The spots develop into pimples. Some people will present with warty growths on their mucous membranes. Penicillin will cure the disease at both of these stages but, if these symptoms are ignored and left untreated, the person will eventually die of tertiary syphilis; ulcerating tumours affecting the heart, spinal cord and brain (Adler 1995). Some psychiatric elderly care units still routinely test clients for syphilis rather than for HIV, even though the incidence of syphilis is falling and that of HIV is rising. Some researchers argue that there is strong kinship between syphilis and HIV (Coulter 1996).

The changing emphasis of STIs

Although gonorrhoea is still one of the most common STIs and its incidence is increasing, non-specific genital infection and the genital wart virus will possibly cause more severe, long-lasting effects on most people. Many people have not heard of chlamydia, or do not know about the effects of genital warts. Non-specific urethritis (NSU) caused by chlamydia and genital warts caused by the papilloma virus are increasing at an alarming rate. Increases in medical knowledge, the availability of sophisticated technology and enhanced communication channels have done nothing substantial to control the spread of STIs and to change human behaviour in the area of sexuality and risk.

Genital warts It has been stated that treating genital warts in GUM is ‘the bread and butter of the clinic’. However more than 80 per cent of cases are treated by GPs, dermatologists and gynaecologists. In the UK there are about 90,000 new cases a year (Adler 1995).

Genito-anal warts have been known about for centuries. In 1954 they were recognised as being sexually transmitted and frequently observed in the wives of American soldiers who had served in the Korean war. In 1969 the human papilloma virus (HPV) was found in genital warts but it was not until 1980 that molecular biology techniques determined that there were many different types.

Genital warts are caused by a small DNA virus belonging to the papavirus group, they differ from skin warts histologically and antigenically. However, cross-infection, that is skin to genital infection or vice versa, can occur.

The infectivity of sexually acquired warts is 60 per cent, the incubation period varies from two weeks to eight months. However, 50 per cent of infected people remain asymptomatic. Women are less likely to be aware of warts because it is harder for them to examine their genitalia.

Genital warts can occur wherever sexual contact occurs, but also in areas where there has not been direct sexual contact. Warts flourish in warm, moist conditions, particularly if a discharge or other infections are present. Even when the lesions are not visible they actively produce and shed virus particles that are readily transmissible. Lesions can occur in the urethra where they are an unseen reservoir of disease and papilloma viral DNA has been found in the semen of men afflicted with chronic wart disease (Roberts 1987).

It was suggested several years ago that the upsurge in STIs would predict a commensurate upswing in the number of women who were at risk of developing cancer of the lower genital tract. In 1986 Professor Martin Tattersall described cervical cancer as the female equivalent of AIDS. It is argued by some that cancer itself is an STI. HPV has also been linked to a heritable skin disease and, in 25 per cent of people with this condition, ultimately, to squamous carcinoma of the non-genital skin (Baird 1986). Cervical cancer classically develops slowly, materialising ten to 20 years after the initial insult. But aggressive pre-cancerous growths are emerging that can turn malignant in a matter of months.

Treatment can be arduous and time
Consuming. Initial treatment is usually with locally applied caustic agents applied two or three times a week. Attending for treatment can be socially difficult but it is undesirable for patients to treat themselves as the agents can burn if applied incorrectly. Larger and more resistant lesions might require cautery or surgical excision. Some warts regress spontaneously and some people have recurring episodes of infection without associated sexual contact. Treatment is therefore difficult to assess.

All women attending for treatment should be encouraged to have cytology performed at least every year and all sexually active women, irrespective of their sexual activity status and age, should be encouraged to attend for cervical smears at least every second year. Screening for carcinoma of the cervix is arguably cheaper than treating it. Screening for other diseases should also be a priority in public health.

Screening for carcinoma of the cervix is arguably cheaper than treating it. Screening for other diseases should also be a priority in public health. Chlamydia trachomatis is the most common curable STI in the UK and early detection and treatment can prevent irreparable damage.

**Chlamydia trachomatis**

Chlamydia trachomatis has been isolated as causing 50 to 70 per cent of non-gonococcal urethritis (NGU) in men. It is symptomless in 25 per cent of cases but, for 75 per cent of men, it causes dysuria and a mucoid discharge from the penis.

Symptoms are usually less marked than with gonococcal urethritis but diagnosis should not be made on purely clinical grounds. Chlamydia trachomatis has been linked to prostatitis. In one study it was detected in 20 out of 45 men with non-bacterial prostatitis.

Furthermore, 48 per cent of their female partners were found to have Chlamydia trachomatis in early morning urine specimens (McMillan and Scott 1991).

It has been muted that chlamydia infection affects at least one in 20 sexually active women and 80 per cent of them will never know they have it. Chlamydia trachomatis might be implicated in 50 per cent of PID. The chlamydia bacterium has a 48-hour life cycle, which presents problems for both testing and therapy – it takes only one invasion to cause salpingitis. Fifteen per cent of women with chlamydial PID fail to respond to treatment and 20 per cent will have at least one recurrence.

The lifestyle and sexual activity of a woman is significant. Chlamydial PID has less severe and obvious symptoms than gonococcal PID and therefore women are less likely to attend for treatment.

Chlamydiae are bacteria but have many of the characteristics of a virus and there are uncertainties about chlamydia which make it intriguing. It can be very difficult to detect. It is vital that couples are treated concurrently, even if one partner is not showing positive. Failure to recognise the sexually transmitted aetiology of the disease can result in repeated infection of the patient and inadequate control of its spread in the community.

Of all the social methods available for limiting the spread of STIs, the most direct and effective is tracing and treating all the sexual contacts of an infected person.

Chlamydia trachomatis has been called the silent disease. Its lack of noticeable symptoms does not help in controlling its growing threat to people’s health. Routine screening for all sexually active men and women must take place. GUM and other sexual health clinics are increasingly carrying this out, but many GP surgeries are not.

However, older people are more likely to seek help from their GP rather than GUM clinics or other sexual health clinics – that is if they seek help, or indeed feel they have cause to. Unless all healthcare providers offer consistent screening, diseases caused by chlamydial infection and the papilloma virus will continue to spread. The older adult is as susceptible to these STIs as any other.
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person. Some would argue that they are more susceptible because of their tendency not to use condoms (Marshall 1997).

**Other infections**

The epidemiology of STIs throughout history has varied but they have never been obliterated. Even though some are less damaging in the long term than others, all STIs should be investigated and treated seriously as they might be a signpost for other more serious conditions. All STIs can occur concurrently with other STIs.

NSU is the ‘diagnosis’ for all those non-gonococcal infections of the urethra (in males) not caused by *Chlamydia trachomatis*. NGU manifests as a urethral discharge (in males) not caused by gonorrhoea.

Accurate microbiological tests are essential to eliminate gonorrhoea and *Chlamydia trachomatis*, as antibiotic treatment differs. Unfortunately 50 per cent of men will be asymptomatic.

Interestingly, 30 per cent of their partners will have *Chlamydia trachomatis*, but 10 per cent of their partners will develop PID although negative to *Chlamydia trachomatis* (Weisburg 1992). NSU can be caused by candidiasis or could be activated by bacterial vaginosis in a partner.

Bacterial vaginosis, or non-specific vaginitis, is induced by an imbalance in the acid in the vagina and can be caused by spermatozoa or bacteria.

Infections such as vaginal candidiasis (caused by fungi), which affects 75 per cent of women; vaginal trichomoniasis (caused by protozoa) and which is implicated in other STIs; and infestations such as pediculosis pubis and scabies can all be transmitted by close contact.

Pediculosis pubis (lice) can also be transmitted by sharing clothes, towels and by ‘bed-hopping’. This can cause particular problems in units where older people with mental health problems are cared for.

Lice and scabies have been known about for some time and treatment is successful. Most people have heard of herpes. Seventy five per cent of people are infected with herpes simplex viruses and the incidence is increasing. Type 2 causes genital or anal ulceration. Some people do not know that they are infected and may never present with an ulcer, but they can still be infectious. Other people will develop extremely painful ulcerations. Antiviral treatment is usually effective in the primary stages but not so if the ulcers recur. Herpes can have a detrimental influence on some people’s quality of life but it is not life-threatening in adults. However herpes sores might be a symptom of other diseases such as HIV or they could be confused with a syphilitic chancre.

Some of the hepatitis viruses can also be transmitted by intimate contact. Hepatitis B and C are serious and hepatitis C is increasing among people who do not practise risk reduction and harm minimisation when using intravenous drugs. Hepatitis C has been linked to HIV (Pratt 1995).

**HIV and AIDS** Issues around HIV and AIDS are considerable and have been well documented (Pratt 1995). There are more than 1,000 British people over the age of 50 who have been diagnosed with HIV. Eleven per cent of people with AIDS are within this age group and the incidence is on the increase (Marshall 1997, Powell 1995).

It is estimated that there are around 10,000 older people in Britain who have HIV without knowing it. Acutely or chronically ill older people could indeed have AIDS but, unless they have an HIV test, this will not be diagnosed.

For example, dementia as a result of AIDS is often misdiagnosed by those who are not familiar with the differences in the presenting symptoms as Parkinson’s disease or the early stages of Alzheimer’s (Tordoff 1996). Some studies suggest that in 25 per cent of older people with HIV, dementia is the only symptom that they will experience (Marshall 1997).

**Other manifestations in older people**

TIME OUT 6

Reflect on your practice with older people who had a dementing condition. Write down the symptoms with which they presented and details of their social and medical backgrounds. Could any of these older people have had undiagnosed AIDS? What makes you think so? Reflect honestly on how much you really knew about the person’s lifestyle.
There is an increased number of older people presenting with HIV encephalopathy and, for many older people with AIDS, neurological symptoms are the first signs that they will have.

It is vital that nurses who work with older people are aware of this as they frequently assess cognitive function in the older person.

*Pneumocystis carinii pneumonia* (PCP) has been mistaken for chronic obstructive airways disorder and congestive cardiac failure. Bacterial infections, skin problems and respiratory complications may well be regarded as a ‘normal’ process of ageing but could well be HIV-related disease.

These signals in a younger person would probably alert both the patient and health workers to a possible STI (including HIV) and a sexual history would then be taken. In an older person this is usually not the case. Because of stereotyping and ignorance and because of the older person’s perception of themselves as asexual, having an STI might not be considered.

**Sexual older people**

Studies have shown that an adult’s sexual expression is not age dependent (Marshall 1997), but older people are commonly more reluctant to discuss sexual issues. In addition, older men grew up in an era where men having sex with men was illegal. They have learnt to be covert and may feel very vulnerable discussing their homosexual behaviour. Older adults are often totally unaware that they are at risk of HIV, yet an older woman can contract the virus more easily than a younger one because of a thinner vaginal wall and decreased vaginal lubrication. Older people, for obvious reasons, tend not to use contraception, including barrier methods.

Age can influence the progression of HIV, and HIV-related disease appears to be more aggressive in older people, possibly because their immune systems are less robust. Early diagnosis is vital. Prophylactic treatment is now very effective.

The new triple combination therapy treatment for HIV is having a profound impact on the progression of the disease in any age group, provided it is commenced early. How this will affect the future of the disease and those infected is not known, but the incidence of HIV and other STIs continues to elicit panic, fear and prejudice in the same way that syphilis did in the 16th century.

**The future**

Despite our so-called ‘permissive society’ anything which has sexual implications is still looked on by many with intolerance. Nonetheless all people, whatever their age, are sexual beings and will express their sexuality in whatever way they choose.

The incidence and variety of STIs is on the increase. Of greatest concern to western society are those diseases which are not well understood but are intensifying sufficiently to have a huge impact on the health of populations in the future. Not only will this have cost implications within healthcare provision and services, but the consequences of these infections could have devastating effects on an individual’s quality of life.

**REFERENCES**


