Sexually transmitted infections among geriatric population

Sir,

We read with interest the recent publication by Relhan *et al*. entitled "Sexually transmitted infections in the elderly: A 6-year retrospective study in a tertiary care hospital in New Delhi."[1]

The authors present data pertaining to a largely ignored group in epidemiological studies on sexually transmitted infections (STIs). However, before we laud the publication, it is important to critically assess whether the data is indeed representative of the scenario of STIs in the elderly.

The inclusion criteria of the study were all patients over 60 years of age referred to STI clinic, regardless whether the final evaluation demonstrated an STI or not. So how do we logically label every genital complaint as an STI? Several of the presenting complaints were rather nonspecific to warrant inclusion in a cohort of STI patients. For example, genital itching was the presenting or associated complaint in 20 patients. Possible etiologies of genital pruritus are numerous. In the absence of associated genital lesions, or presence of a causative sexually transmissible organism, it is most likely that STIs were the etiology in only a small fraction of patients. Similarly, one patient each with fluid-filled lesions (site not mentioned), burning micturition, rash over palms and soles, inguinal swelling had VDRL positivity (dilution not given), final diagnosis has not been mentioned, although none of the patients were eventually diagnosed as secondary syphilis. Cervical and urethral discharge contributing to vaginal discharge and without finding any pathogen is unusual. Cervical discharge in a woman aged 60 years or more in the absence of an infectious cause is a matter of concern and cannot be left at that. Similarly, the basis for confirmation of diagnosis of late latent syphilis and pelvic inflammatory diseases has not been elucidated.

This misclassification bias in data collection becomes more apparent when final diagnoses are considered. Several patients had genital infections which are better described as dysbiosis[2-4] rather than STIs, namely, 24 patients with candidal balanoposthitis, 8 patients with vulvovaginal candidiasis, and 21 patients with bacterial vaginosis. While these infections are more common in sexually active individuals, other factors such as uncontrolled diabetes mellitus, recent antibiotic use, hygiene practices, immunosuppression, and smoking may also predispose an individual to develop these dysbioses. Further, 9 patients with uncertain diagnosis, 8 patients with scabies, and 2 patients with genital ulcers of uncertain etiology could have had diseases which were not necessarily sexually transmitted. Hence, more than half of the study population may not even have had STIs. Hence, the major limitation of this study is overestimation of the prevalence of STIs among the elderly.

As the duration of diseases has not been recorded, it is impossible to state with any certainty when the infection was acquired. STIs presenting now as late latent syphilis and genital herpes may have been acquired years ago. The assessment of risk factors such as condom use, type of sexual exposure, number of partners, and nature of contact that form a part of routine history taking in every STI case should have been included. Without the availability of such information, the use of condoms in couples in a monogamous relationship can only be expected/recommended in special situations and not as a routine. The study is a mix of syndromic diagnosis and also some investigations - leaving out cultures and also one important organism - *Chlamydia trachomatis*.

Finally, the conclusion that the elderly population should be considered a "high-risk group" seems unsubstantiated and perhaps stems from the unclear definition of STIs and resulting overestimation of prevalence of STIs in this age group.

The reported doubling of the number of patients from 2013 to 2018 cannot be interpreted to exactly mean the STIs only, because of the faulty definition of STIs followed by the authors. To label, every genital symptom as a result of STI is not only wrong but very traumatizing and also stigmatizing. Although there is some evidence of increase in the prevalence of STIs in older adults, they remain rare in comparison to younger populations, and routine screening for STIs in elderly is not warranted.[5]

Further large-scale studies, preferably at the community level with a thorough assessment of sexual behaviors, strict inclusion criteria, and etiological rather than syndromic diagnosis will be useful in the estimation of true prevalence of STIs in the geriatric population.

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Conflicts of interest
There are no conflicts of interest.

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