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Case Report

# Persistent genital arousal disorder in a male: a case report and analysis of the cause

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A 54-year-old male presented to the psychosexual clinic with symptoms suggestive of persistent genital arousal disorder of 2years duration. Physical examination and investigations ruled out any underlying urological or neurological causes. He was treated with Diazepam and Pregabalin and his symptoms reduced in intensity.

**Introduction:**

Persistent genital arousal disorder (PGAD), also known as persistent sexual arousal syndrome (PSAS) or restless genital syndrome (ReGS), is recently recognised as a sexual health problem in western countries although it is not been considered as a physical or psychiatric disorder by DSM IV or ICD 10. PGAD is associated with constant, spontaneous and intrusive feelings of genital arousal in the absence of conscious sexual thoughts or stimuli.

The working definition of PGAD[1],[2] is as follows:

1) Persistent physical arousal in the genital area
2) in the absence of conscious thoughts of sexual desire or interests
3) associated with spontaneous orgasm or feelings that orgasm is imminent and
4) the symptoms not diminished by orgasm.

It may be present throughout the person's life (primary PGAD) or develop at any age (secondary PGAD). It is associated with varying degrees of distress in the patients. This new disorder has been reported in women by numerous clinicians in the last decade. However, so far, there is only one report of two males suffering with ReGS in the literature.[3] We report a case of PGAD in a male and aim to analyse the cause.

**Case Report**

A 54-year-old male was referred to the psychosexual clinic by an urologist with 2 years history of constant feelings of physical arousal in the genital area as if he was about to ejaculate. These feelings were associated with pain which was relieved to an extent after ejaculation. These symptoms started suddenly for the first time when he was browsing the internet and accidentally ended up in pornographic websites. But later on, the symptoms were constant without any sexual stimuli and he got some relief from attaining climax.

He described that the physical arousal in the genital area increased in intensity to a point he had to ejaculate to have some relief. He felt this "as if wanting to have climax all the time". Post- ejaculation, he felt anxious, tired and nauseated for sometime, during which the symptoms intensified again that he needed climax. Initially this cycle repeated every 2-3 days but later on the frequency increased to 2-3 times a day. He achieved climax both by masturbation and sexual intercourse. He felt these ejaculations were unpleasant and not enjoyable. He felt frenzied if he couldn't ejaculate and the post orgasmic feelings were severe if he avoided orgasm for a day or two. He described regular ejaculations led to less severe "come downs" but left him constantly drained.

His medical history included vasectomy four years ago with minor complication of painful scrotum which subsided fully with pain killers. He also had few urinary tract infections (UTI) in the past which were treated with antibiotics. He was initially seen by urologist who carried out physical examination which was noted to be normal. Then investigations including CT-KUB, CT- Abdomen, Urogram, Transrectal Ultrasound of prostate and seminal vesicles, Flexible Cystoscopy were done and no abnormalities noted. He also had MRI- Brain which was normal. He had no symptoms of hyperactive bladder and no varicocele was noted.

When he was seen in the psychosexual clinic, he was noted to be very anxious and expressed guilty feelings around the incident of watching pornography which initiated the onset of symptoms. There were no depressive or psychotic symptoms. Prior to attending this clinic he was prescribed duloxetine 30mgs by the urologist, which he took only for few weeks. He stopped it as there was no symptom relief. He was started on diazepam and pregabalin. The dose was increased to 2mgs qds of diazepam and 50mgs qds of pregabalin. His symptoms diminished gradually and now he remains mildly symptomatic although feeling "more in control". He was also referred to psychologist and had an assessment. As he was not

psychologically minded and unable to engage in sessions, he stopped attending.

**Discussion**

The clinical features in this man were consistent with the definition of PGAD. He had physical arousal symptoms, which were not related to sexual desire or thoughts and was causing severe distress to him. The symptoms were relieved by ejaculation to a certain extent. He was treated with diazepam and pregabalin which reduced the intensity of the symptoms.

There is an emerging literature on the pathophysiology, possible aetiological factors and the management options of PGAD. There are various associations reported including psychological[4,5] and organic[6-9] pathologies with some convincing evidence.

In this case, he suffered few UTI and a minor complication of painful scrotum following vasectomy, few years before the onset of PGAD. However he had a full urological and neurological work-up recently which didn't show any underlying organic cause for his current symptoms. He suffered no previous depressive or anxiety disorder. Hence his current symptoms may be induced by anxiety which is further worsened by the fact that he became focussed on the genital arousal and attaining climax to relieve the pain. When he was prescribed diazepam and pregabalin, his anxiety eased and his physical symptoms diminished in intensity. However the possibility of an organic cause cannot be ruled out completely as he previously suffered sensory neuropathic pain following vasectomy. Further pregabalin is useful for both generalised anxiety and neuropathic pain. Therefore we conclude that his symptoms may be a result of interaction between physical and psychological factors. This suggests that PGAD could be a psychosomatic condition, which was already proposed as a cause for PGAD in women by Goldmeier and Leiblum.[4]

Similar to the causes for PGAD, there is few treatment modalities reported in the literature. These include treatment of the underlying organic causes if any found, electro-convulsive therapy (ECT) if co-morbid with mood symptoms,[10]transcutaneous electrical nerve stimulation (TENS),[3] cognitive behavioural therapy[11] and medications like varenicline.[2]We used anti-anxiety medications (diazepam and pregabalin) and achieved adequate symptom relief. This also supports the idea that PGAD could be a psychosomatic condition related to the peripheral nerves of the genito-urinary system.

This case is reported to confirm that PGAD also occurs in males, which is quite different from priapism and it could be a psychosomatic condition. More research is needed into the pathophysiology of PGAD and its management.

**Competing Interests**
None declared
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