

Persistent Genital Arousal Disorder: A case series and review of current literature

S. Drummond¹, K. Ekevall², M. Cruickshank³, I. Hay¹

1. Department of Dermatology, Royal Alexandra Hospital, Paisley. 2. Department of Obstetrics and Gynaecology, Forth Valley Royal Infirmary.
3. Department of Obstetrics and Gynaecology, Aberdeen Royal Infirmary

INTRODUCTION

Since first described by Leiblum¹ in 2001, persistent genital arousal disorder (PGAD) remains a poorly understood condition. It is characterised by spontaneous and unwanted genital sexual arousal which is not diminished by orgasm. The symptoms are intrusive and distressing and can persist for up to several days per episode, conferring a significant impact on quality of life^{2,3}. PGAD is reported almost exclusively in women. We present 3 cases of PGAD presenting to Gynaecology.

CASE 1

A 34 year-old woman was referred having presented to her GP aged 26 with vulval pain which felt akin to arousal but was distressing and unpleasant. This was exacerbated by sexual intercourse. Her symptoms had been present intermittently since childhood. Physical examination was normal, as was pelvic ultrasound and MRI. Citalopram was ineffective and Amitriptyline caused intolerable side effects. A course of physiotherapy was not helpful. Clomipramine provided some benefit. Pudendal nerve block and steroid injections are planned.

CASE 2

A 73 year-old woman was referred with a 2 year history of persistent genital arousal with no increase in libido. Her history includes total abdominal hysterectomy and bilateral salpingo-oophorectomy. Her GP had commenced Gabapentin and Spironolactone with no improvement in symptoms. Pelvic MRI was normal. Topical 5% Lidocaine ointment and 1% Dermacool lotion had no benefit. Nortriptyline has recently been commenced.

CASE 3

A 26 year-old woman presented with a 6 month history of episodic vulval discomfort and clitoral swelling exacerbated by orgasm. Her history includes anti-phospholipid syndrome and anxiety. Physical examination was normal. She was also seen by Psychiatry and tried different anti-depressants and anxiolytics as well as a course of CBT with little benefit. She underwent a pudendal nerve block with improvement restricted to a few weeks.

DISCUSSION

The pathophysiology of PGAD remains poorly defined but is thought to be complex and multi-factorial. Reported aetiologies include pharmacological causes such as libido enhancing medications or abrupt discontinuation of libido inhibiting medications. Sacral dorsal root Tarlov cysts, lumbosacral disc herniation, pelvic congestion syndrome and pelvic floor hypertonicity have all been suggested as potential causes.^{2,3}

As demonstrated by our case series, management of PGAD is challenging with often a disappointing response to treatment. This reflects the literature on PGAD which lacks robust evidence to guide management. Suggested symptomatic management includes gradual tapering of causative medications, physiotherapy, tricyclic anti-depressants and anti-convulsants as used in neuropathic pain.^{2,3}

CONCLUSION

We present this case series to raise awareness about this debilitating condition. Further work is required to better understand PGAD. We welcome cases from other centres to gather a larger cohort of patients to ascertain the prevalence of PGAD in the UK and collate experience of managing patients with PGAD. (Correspondence: sarah.drummond@ggc.scot.nhs.uk)

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