CASE REPORT

Persistent genital arousal disorder: a clinical challenge

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SUMMARY

A 54-year-old woman presented to a community-based psychiatric clinic with unique problem of persistent genital arousal disorder. All relevant investigations were normal. Treatment with psychotropic medication and psychotherapy did not help. The patient though reported improvement in mood. The patient has been followed up since 2011 and visits the clinic every 3 months without much improvement in the disorder. Hence, this case has become a clinical challenge in terms of treatment.

BACKGROUND

This case is important in terms of treatment. Despite biological, psychological and social treatment in an aggressive manner, the case remained resistant. This write-up may invite suggestions based on experiences by readers. This would possibly help in treating the patient.

CASE PRESENTATION

A patient, aged 54, was seen in a community-based out-patient psychiatric clinic in 2011 following referral from her family physician. The major concerns expressed in the referral letter were issues with anxiety and obsessive-compulsive disorder. Upon interview, the patient reported anxiety symptoms in social situations and remaining 'on edge' for a couple of hours in a typical day. She reported preoccupation with obsessional thoughts with a theme of 'doubt' and reported multiple checking rituals in a day. She did not report any depressive features, 'highs' or psychotic features. She also reported 'genital arousal' multiple times during the week leading to sensation of pain in the lower abdomen. She described such arousal even before she started taking medication (Citalopram). She was taking citalopram 20 mg/day, zopiclone 7.5 mg at bedtime, clonazepam 0.5 mg twice a day with some good effect on anxiety but not on genital arousal. She was previously seen by a psychiatrist who did not wish to continue with follow-up. No family history of mental illness was noted. In the personal history, she reported an incident of sexual abuse that she now does not dwell upon. The patient did acknowledge that sexual abuse as a child was quite traumatic for her but the patient did not want to discuss that issue. She had a high school education and worked in a shopping mall. Her marriage lasted for many years and ended up in divorce but the patient got married again and is happy. She has a son 31 years of age. There was no history of alcohol or drug abuse. The patient did not report any medical problem. She was undergoing menopause. No drug allergies were reported. There

were no social or legal issues of significance. On Mental Status Examination: she was found to be very cooperative and adequate report was developed. Her mood was assessed to be anxious, speech was normal in rate, rhythm and volume. Thoughts were preoccupied with 'obsessions of doubt'. No evidence of perceptual anomaly. There were no safety concerns. Cognitive functions were in normal range. Insight and judgement were preserved. Her primary multi-axial diagnosis:

1. Generalised anxiety disorder versus obsessive compulsive disorder and comorbid genital arousal syndrome
2. Deferred
3. Undergoing menopause
4. Non-specific stress with mild intensity
5. 70–80

The patient was more concerned about her genital arousal problem but was happy with current medications and dosages. She did not want review of medication on first consultation. The patient continued her out-patient follow-up and complied with medications. A year later, she started focusing more on genital arousal problem and remained quite apprehensive about it. She also saw a neurologist who did not recommend any medication but advised her to continue with current medications and avail counselling services. She reported increasing frequency of this problem since and has refused to avail counselling services.

INVESTIGATIONS

All blood work investigations, ultrasound and CT scan of uterus remained non-significant. The patient was seen and examined by a gynaecologist. No significant findings were reported as a result of that consultation.

DIFFERENTIAL DIAGNOSIS

- Obsessive compulsive disorder
- Psychosomatic disorder
- Non-specific genital organic disorder

TREATMENT

- Citalopram 20 mg/day
- Clonazepam 0.5 mg twice a day
- Zopiclone 7.5 mg for sleep at night

The patient did not allow review of the medication as she believed that nothing much will help her. She reported side effects in the past when an attempt to increase the dose of Citalopram was made. She was tried on a number of different psychotropics in the past with no effect. She was not comfortable considering electroconvulsive treatment (ECT).

To cite: Gadit A. *BMJ Case Rep* Published online: [please include Day Month Year] doi:10.1136/bcr-2013-009098

OUTCOME AND FOLLOW-UP

No improvement in persistent genital arousal disorder. The patient attends outpatient clinic once every 3 months.

DISCUSSION

By definition, persistent genital arousal disorder (PGAD) is a potentially debilitating disorder of unwanted genital sensation and arousal that is generally spontaneous and unrelenting. This is not preceded by sexual stimulation. It has a prevalence of 1% and is common in age group 35–54 years and associated with overactive bladder and restless legs.¹ The patient in this case report falls in this age group but did not report overactive bladder or restless legs. Study mentions that PGAD is often associated with depression, anxiety, panic attacks and obsessive compulsive disorder.² The woman in question who came for consultation reported depression and anxiety. It is found to be associated with pelvic varices and sensory neuropathy of the pudendal nerve.³ An observation was made that use of and withdrawal from pharmacological agents contribute to the development of PGAD.⁴ Atrial natriuretic peptide causes profound vasodilatation and vascular leakage that is related to persistent sexual arousal.⁵ Possible organic aetiology is indicated with genitosensory analyser test.⁶ Investigation with the use of Doppler ultrasound had demonstrated multiple pelvic varices in some cases.⁷ A number of treatments have been suggested in different studies. Psychological treatment, clonazepam and transcutaneous electrical nerve stimulation were described.¹ Cognitive behavioural therapy including mindfulness meditation and acceptance therapy is also suggested.⁸ Use of oestrogen, lubricants and vibrators are suggested in order to address this problem.⁹ ECT has resulted in improvement in cases with concomitant depression.¹⁰ There appears to be no specific therapy for PGAD.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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Learning points

- ▶ A thorough sexual and gynaecological history is important.
- ▶ Investigation for detecting organic pathology with the use of MRI and/or Doppler ultrasound is helpful.
- ▶ Electroconvulsive treatment may be an option for treating this condition.

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