Persistent Genital Arousal Disorder – A Case Study

Introduction

Persistent genital arousal disorder (PGAD), also referred to as persistent sexual arousal disorder (PSAS) and restless genital syndrome (RGS), was first described in 2001 (2). Although descriptions of possible PGAD have been found dating back to 200 AD (2). The diagnosis is not clearly defined however five criteria have been proposed:

1. Symptoms of physiologic sexual arousal (genital fullness or swelling) and tautness without nipple gallop or swelling) that persist for hours or days and do not subside completely on their own.
2. These symptoms do not resolve with ordinary remake experience and might require multiple orgasms over hours or days to remit (for some women, this might include spontaneous and intense orgasms). Different from deliberate orgasms resulting from sexual activity.
3. Symptoms of arousal are experienced as unrelated to any subjective sense of sexual desire.
4. The persistent genital arousal can be triggered not only by a sexual activity but also by non-sexual stimuli or by no apparent stimuli.
5. Arousal symptoms feel unbidden, intrusive, unwanted, and unwanted, and the symptoms cause at least a moderate degree of distress.

Aetiology

As a large number of pathways are involved in sexual function, the aetiology of PGAD is likely to be numerous and subgroups may be plausible (3). Assessments in most cases are normal. Possible causes to be explored with a person presenting with PGAD are:

- Neurological
- Psychological
- Hormonal
- Medical
- Other
- Benign}

Case Presentation

Thelma*, a 64-year-old woman diagnosed with multiple sclerosis (MS) in 2001, telephoned for advice. She described a feeling of constant sexual arousal is talked to between her thighs and vagina. The sensations commenced at 7 years of age, to start with a "couple of nights", a work and was initially pleasant the "just didn't reach climax", although it did interrupt sleep. The sensation then progressed to become more constant and she "can't stand it", it is not suppressed to happen at my age". Thomas met all the criteria for PGAD, although she didn't have physical signs of arousal as described in criteria 1, the sensation would fit as a physiological symptom. This prompted further investigation, and one key feature was a medical history of MS.

Co-morbidities: asthma, prolonged QT syndrome, depression, lumbar disc entrapment of pudendal nerve overactive bladder, neuropathy or restless leg syndrome (RLS) and restless leg syndrome. Multiple sclerosis 22(6) NP10/hyphen.ucNP11  Presentation to 2nd MENACTRIMS Congress 2016

Thelma’s symptoms became more constant and severe with a prolonged QT syndrome. Her symptoms lessened post disclosure although this was not sustained. Interestingly her symptoms knew post disclosures although this was not sustained. Thelma’s symptoms were secondary to a spinal lesion affecting the neural pathways of the spinal cord, including the frontal lobes, thalamus, and basal ganglia. She had difficulty walking and a lateral burning discomfort in both legs. Her symptoms were secondary to a spinal lesion affecting the neural pathways of the spinal cord, including the frontal lobes, thalamus, and basal ganglia. She had difficulty walking and a lateral burning discomfort in both legs. Thelma's symptoms were secondary to a spinal lesion affecting the neural pathways of the spinal cord, including the frontal lobes, thalamus, and basal ganglia. She had difficulty walking and a lateral burning discomfort in both legs. Thelma*** was a 64-year-old woman diagnosed with multiple sclerosis in 2001. She was later diagnosed with MS and was under-recognised. Although alluded to as a potential cause for PGAD in literature, Due to the pathology of MS PGAD is a potential symptom which is undoubtedly under-recognised. Although alluded to as a potential cause for PGAD in literature, I presented this case at the 2017 Multiple Sclerosis Nurses Association (MSN) conference four MS nurses have told me of patients that appear to have PGAD.

Conclusion

As nurses, we are in the prime position to identify this disorder in our patient population. This has certainly changed my MS nursing practice, I now include more in-depth discussion about sexual function particularly around genital sensation in all assessments.

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