Persistent Genital Arousal Disorder

Key Information for Healthcare Providers

What is PGAD?

Persistent Genital Arousal Disorder (**PGAD**) is defined as persistent or recurrent, unwanted or intrusive, distressing sensations of genital arousal that last for 3 months or more.[1]

Sensations of PGAD are not associated with sexual interest, thoughts, or fantasies and they can occur in various genito-pelvic areas in the absence of observable signs of genital arousal (e.g., vaginal lubrication, genital swelling).[2]

People with PGAD may also experience uncontrollable orgasms or an excessive number of orgasms, which are distressing.[3]

PGAD has been shown to affect up to 4.3% of individuals of all ages, genders, and social locations.[1]

For cis women, one study indicated that onset of PGAD was most common in their mid-30s but PGAD can start at any age and even be present since early childhood.[1]

Symptoms

Some of the symptoms that have been reported include[3]:

- Distressing sensations of persistent genital arousal that do not coincide with feelings of being "turned on"
- Sensations appearing spontaneously or triggered by nonsexual stimuli
- Genito-pelvic pain may be present
- Types of genito-pelvic dysesthesia such as buzzing, burning, twitching, itch, or pain.
- Medical and psychiatric comorbidities
- Negative impact on mental health (e.g., depression, anxiety) sometimes to the point of suicidal ideation
- High levels of distress and shame associated with symptoms
- Negative impact on sexual and relationship wellbeing
- Significant impairment in daily functioning

Individuals with PGAD may engage in frequent solitary and partnered sexual activity to help decrease symptoms; careful differential diagnostics are needed to ensure that they are not being misdiagnosed.[3]

How is PGAD diagnosed?

Initial assessment

A structured clinical history is needed to establish whether the patient meets diagnostic criteria for PGAD[2]:

- Persistent or recurrent unwanted genital arousal sensations
- Not explained by desire, fantasies, or observable signs of arousal
- Symptoms cause distress or impairment
- Duration of 3 months or more

For those who meet the criteria, you should then identify, whenever possible, the **biopsychosocial** triggers of the PGAD symptoms. Particular attention should be given to SSRI or SNRI initiation or withdrawal as potential triggers[2].

Physical examination

The examination may need to be completed over several visits. Begin with a comprehensive assessment of regions presenting genito-pelvic symptoms[2]:

- Penis, scrotum
- Clitoris, vulva, vagina
- Vestibule
- Urethra, bladder

Laboratory tests and imaging

Differentiate PGAD from other conditions (differential diagnosis)[2]:

- **Hormonal:** evaluation of androgen milieu. Check estradiol levels in peri and postmenopausal women. Rule out hyperthyroidism.
- **Imaging:** SEMG or transperineal ultrasound, vascular imaging, consider MRI of the pelvis or lumbosacral spine when indicated

How can PGAD be managed?

Non pharmacological interventions

Although no randomized trials exist, clinicians may consider[2]:

- Cognitive behavioural therapy (**CBT**)
- Mindfulness-based approaches (**MBCT**)
- Pelvic floor physiotherapy

Pharmacological interventions

These are off label and based on expert opinion. Possible options include[2]:

- Anticonvulsants and non opioid inhibitors of neurotransmission
- Benzodiazepine GABA-ergic activators
- Non benzodiazepine GABA-ergic activators
- Opioid inhibitors of neurotransmission
- Dopamine agonists or dopamine lowering medications

Referral Pathways

When to refer[2]:

- Mental health or psychiatry for distress, suicidality, or comorbid mental health conditions
- Sex therapy or mental health providers for sexual or relationship concerns
- Pelvic health physiotherapy for suspected high tone pelvic floor disorders, pudendal nerve irritation, or pain associated with sitting or penetration
- Gynecology, urology, neurology, or pain specialists when regional or neuropathic pathology is suspected
- Endocrinology when hormone abnormalities are identified

1 Jackowich, R. A., & Pukall, C. F. (2020). Prevalence of Persistent Genital Arousal Disorder in 2 North American Samples. The journal of sexual medicine, 17(12), 2408–2416. **https://doi.org/10.1016/j.jsxm.2020.09.004**

2 Goldstein, I., Komisaruk, B. R., Pukall, C. F., Kim, N. N., Goldstein, A. T., Goldstein, S. W., Hartzell-Cushanick, R., Kellogg-Spadt, S., Kim, C. W., Jackowich, R. A., Parish, S. J., Patterson, A., Peters, K. M., & Pfaus, J. G. (2021). International Society for the Study of Women's Sexual Health (ISSWSH) Review of Epidemiology and Pathophysiology, and a Consensus Nomenclature and Process of Care for the Management of Persistent Genital Arousal Disorder/Genito-Pelvic Dysesthesia (PGAD/GPD). The journal of sexual medicine, 18(4), 665–697. **https://doi.org/10.1016/j.jsxm.2021.01.172**

3 Jackowich, R. A., Boyer, S. C., Bienias, S., Chamberlain, S., & Pukall, C. F. (2021). Healthcare Experiences of Individuals With Persistent Genital Arousal Disorder/Genito-Pelvic Dysesthesia. Sexual medicine, 9(3), 100335. **https://doi.org/10.1016/j.esxm.2021.100335**