Editöre mektup / *Letter to editor*

Paroxetine as an option for persistent genital arousal disorder (Süregen genital uyarılma bozukluğunda br seçenek olarak paroksetin)

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To the Editors,

Persistent genital arousal disorder (PGAD) is a relatively new diagnosis in psychiatry. This disorder is frequently reported in females. Goldmeier et al. defined six criteria for PGAD: 1. Sexual arousal persists for an extended period, 2. Physiological arousals don't resolve with ordinary orgasm, 3. Arousals are unrelated to sexual desire, 4. Arousals are triggered by non-sexual stimuli, 5. Unwanted experience of symptoms, and 6. Symptoms cause distress.[1] According to previous literature, anxiety and sexual stimuli could be related to each other, so PGAD could be comorbid with anxiety disorders like obsessive compulsive disorder (OCD).[2] Here we demonstrate a case of PGAD comorbid with OCD, where the patient benefited from paroxetine in terms of both disorders.

CASE

Thirty-six year-old married, heterosexual female was admitted to our clinic with complaints of feeling dirty, washing her hands repeatedly through the day, cleaning her home repeatedly, and being unable to touch people or objects. She stated that these symptoms started 2 years ago and had become intensified for 6 months. She also stated that she was having spontaneous orgasms without any stimulus, and these orgasms had been lasting all day for the past 3 years. Neutral stimuli like voices or moving cars were arousing her, she was distressed during these episodes, and described them as 'unwanted' orgasms. Her functionality decreased in all aspects of life and she was anxious. Patient was diagnosed with PGAD and OCD. She had never used medication for these conditions prior to our examination. She consulted with a gynecologist and an internist, but they didn't find an organic cause. Paroxetine, 20 mg/day initiated. One week later PGAD had diminished mildly. After a month of paroxetine 20 mg/day, PGAD had been relieved markedly but there was no change in the OCD. Six weeks after increasing paroxetine to a 60 mg/d, OCD symptoms were relieved by half. Nine months after her initial application, she was clinically stable for both PGAD and OCD.

DISCUSSION

As a relatively new diagnosis in psychiatry, there is little known about how to manage PGAD. At first, defining an etiological factor and its management is recommended. While the etiology is unknown, behavioral strategies, pharmacological treatments, and somatic therapies (electroconvulsive therapy) exist for management.[1]

As far as we know, this is the first case presenting comorbid OCD with PGAD. Yıldırım noted that Muslim patients with PGAD may take repetitive baths (ghusl) after orgasms and may be misdiagnosed as OCD.[3] However, in our case the patient demonstrated handwashing compulsions independent of her orgasms, which is typical for OCD. SSRIs are related to sexual side effects like decreased libido and delayed or decreased ejaculation, so in this context they could be beneficial to relieve PGAD.[4] Paroxetine delayed ejaculation and orgasm in males with premature ejaculation. This side effect of paroxetine is probably related to the blockage of $5HT_{1A}$ and the activation of $5HT_{2C}$.[5] So we chose paroxetine for this patient to reduce the severity and number of her spontaneous orgasms, and as expected, the patient benefited from paroxetine.

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