

Postorgasmic Illness Syndrome: Two Cases

MARCEL D. WALDINGER

Department of Psychiatry and Neurosexology, Leyenburg Hospital, The Hague, The Netherlands and Department of Psychopharmacology, Rudolf Magnus Institute for Neurosciences, Faculty of Pharmaceutical Sciences, Utrecht University, Utrecht, The Netherlands

DAVE H. SCHWEITZER

Department of Internal Medicine and Endocrinology, Reinier de Graaf Group, Delft-Voorburg, The Netherlands

We describe the symptoms of a postejaculatory syndrome in two men with spontaneous ejaculations. The syndrome consists of severe fatigue, intense warmth, and a flulike state, with generalized myalgia. These symptoms occur rapidly after ejaculation and only disappear after 4 to 7 days. The symptoms are so severe that sexual activity is avoided. The cluster of symptoms is named postorgasmic illness syndrome (POIS). To date, no explanation has been offered for the etiology and pathogenesis of the symptoms, and the prevalence is unknown. Both cases are presented to draw attention to this syndrome for further research regarding etiology, pathogenesis, and treatment.

Orgasm is characterized by a symphony of neurobiological and psychological interactive processes, of which most parts are still unknown. It is possible that subtle changes in these processes are responsible for a number of disorders and discomforts pertaining to sexuality. In addition, there may be biological syndromes, whose symptoms are erroneously ascribed to psychological factors, somatization, or hypochondria. Coincidentally, two patients with similar complaints pertaining to orgasm presented within 1 year of one another. By previously consulted specialists, their symptoms were diagnosed as psychological in nature. They were subsequently seen in a tertiary referral center for neurosexual disorders. Both patients gave written informed consent for publication of their histories in a case-report article.

Address correspondence to Marcel D. Waldinger, MD, PhD, Department of Psychiatry and Neurosexology, Leyenburg Hospital, Leyweg 275, 2545 CH The Hague, The Netherlands. E-mail: post@m-waldinger.demon.nl

CASE 1

A 43-year-old male visited our department without any referral. His medical history was unremarkable, apart from lifelong hyperhydrosis on mild exertion, spontaneous ejaculations, lifelong premature ejaculation, stuttering, and allergy to penicillin. His symptoms consisted of flulike symptoms the onset of which coincided with the moment of ejaculation and included extreme fatigue and exhaustion; feelings of extreme warmth inside the body ("like an exploding fire-ball" in the lower abdominal region), increased perspiration; onesided headache; burning eyes; sore throat; dry mouth; nasal drip; skin erythema; red colored pimples localized at the neck, back, and abdomen; generalized itching but particularly in region of penis and anus; myalgia, particularly in the lower back region and in the toes of the right leg; slight urinary hesitation; frequent inconsistent stools; agitation; slight concentration problems; increased stuttering and aggravation of unrelated coincidental pains (like toothache); food-craving, and increased thirst. These symptoms had appeared since puberty and occurred rapidly within a few minutes after ejaculation (equally intensely, after spontaneous ejaculation, masturbation, and intercourse). The sensations reached a maximum on the second day and lasted up to 4 days. In puberty, the patient experienced the symptoms for the first time after spontaneous ejaculations that were triggered by uncontrollable environmental situations (crowded public places, waiting in a traffic jams). His erectile function and sexual desire were undisturbed. The intravaginal ejaculation latency time (IELT; Waldinger, Hengeveld, & Zwinderman, 1994; Waldinger, Hengeveld, Zwinderman, & Olivier, 1998) was about 20 s. The occurrence of ejaculations interfered with performance at school and work because of his diminished concentration and a tendency to fall asleep. Periodically, he was moody, with feelings of despair, particularly when consulted medical specialists of various disciplines were unable to diagnose his symptoms.

The patient had divorced and remarried; he had been married to his current wife, who was 37 years old, for 2 years. He had no children. In order to cope with daily life, he and his wife planned intercourse so that the week afterward he had no important obligations or meetings. His strategy also included a diminished frequency of intercourse, which led to spontaneous nocturnal ejaculations and subsequent recurrences of symptoms.

The above-mentioned symptoms were confirmed by his female partner. Both partners judged their overall relationship as harmonious. However, their diminished sexual activities were disturbing to both of them. Our physical examination took place 2 days after intercourse. On this occasion, the patient was nervous and agitated and experienced concomitant profuse perspiration. His stuttering was increased. There were no genital abnormalities, and masculinity was intact. Laboratory investigation was generally normal.

Endocrine investigation revealed eugonadism: total testosterone 14.8 nmo1/1 (ref 8.3–34.0 nmo1/1), SHBG 20 nmo1/1 (ref 20–55 nmo1/1), LH 3.2 U/1 (ref: 1.5–12.0), FSH 4.6 U/1 (ref: 2.0–8.0), PSA 0.4 µg/1 (ref < 4.0 µg/1).

CASE 2

A 52-year-old male was referred by a psychiatrist. His medical history revealed primary hyperhidrosis on exertion and right-sided seminoma testis at the age of 25, for which a hemicastration was performed, followed by radiotherapy. At the age of 45, he developed, quite suddenly, spontaneous ejaculations, which were triggered mostly by stress and mechanical stimuli (car driving) and never associated with sexual arousal. Approximately 15 min after his voluntary and involuntary ejaculations, a cascade of flulike symptoms occurred: extreme fatigue and exhaustion; a very warm burning sensation in the lower left belly (“like an exploding ball”) radiating to the anus; perspiration; one-sided headache; burning eyes; sore throat; dry mouth; skin erythema and itching pimples, mainly at the penis; generalized myalgia, particularly in the lower back region, radiating to his left leg and ankle; slight urinary hesitation; frequently occurring changes of stool consistencies; agitated feelings; slight concentration problems and the urge to eat and to drink cold soft drinks. His symptoms occurred equally intensely after spontaneous ejaculations, masturbation, and intercourse, reached a maximum on the second day, diminished after 3 days, and disappeared only after 1 week. Sexual desire and erectile function were normal. Ejaculation itself was not painful. Morning erections remained intact.

Patient had been married for 25 years, and his wife was currently 48 years old. The couple had 2 children. Their sexual relationship had always been very satisfying until he experienced the onset of spontaneous ejaculations at the age of 45. The couple agreed to refrain from sexual activities in order to avoid the symptoms, which led to spontaneous ejaculations and subsequent recurrences of symptoms. The referring psychiatrist treated the patient with paroxetine 20 mg/day for a depressive reaction after his unemployment without any concomitant effect on his spontaneous ejaculations.

On physical examination, he presented as overweight (body-mass index 31 kg/m²), with scant beard growth, loss of pubic and axillary hair, bilateral gynecomastia, and abdominal obesity. The consistency of the remaining testicle was weak, and the volume was 8 ml.

Laboratory investigation was normal, apart from features of primary testicular insufficiency; total testosterone 8 nmo1/1 (ref. 8.3–34 nmo1/1), free testosterone 30 pmo1/1 (ref.: 45–108 pmo1/1), dehydroxytestosterone 0.62 nmo1/1 (ref: 0.90–3.70 nmo1/1), LH 5.7 U/1 (ref: 1.5–12.0), FSH 25.8 U/1 (ref: 2.0–8.0), prolactine 210 mU/1 (ref: 75–275 mU/1).

DISCUSSION

The common features of both men included a rapid onset of flulike symptoms after ejaculation that became most intense on the second day and lasted to 4–7 days. The intensity of the complaints led the patient to avoid masturbation and intercourse. Both men suffered from exhaustion, flulike symptoms (very warm feelings, perspiration, headache, burning eyes, sore throat, general myalgia), erythema of the skin (itching, pimples), urinary hesitation, changed stools, mental disturbances (concentration problems and agitation). Remarkably, both men suffered from spontaneous and premature ejaculation (patient 1, lifelong; patient 2, acquired), and both had lifelong hyperhidrosis on exertion. Sexual desire, arousal, and erectile function were normal. Ejaculation itself was not painful. Both couples decided to diminish their sexual activities, although with different coping strategies.

Treatment with antihistamines and prednison, taken prior and after intercourse, was based on the assumption of a possible urticarial reaction but did not result in any relief of symptoms. Treatment with Benzodiazepines and SSRIs (paroxetine and citalopram) was partly successful in the improvement of the mental state but did not result in any disappearance of the somatic features. Both men were not particularly susceptible to viral infections, such as influenza. In fact, their general health had always been excellent. For example, patient 1 had walked the Nijmeegse Vierdaagse, a yearly 4-day walk of 40 km/day, in the Netherlands. He remarked that one ejaculation made him more tired and ill than walking that many kilometers.

Both men requested medication to diminish their ejaculation frequency. We decided, therefore, to titrate a very low dose of flutamide, an androgen receptor antagonist, using the gonadotrophins (LH and FSH) as parameters. To avoid hypogonadism, we titrated flutamide up to a maximum of a three-fold increase of early morning LH concentrations. This strategy resulted in a substantial decrease of spontaneous ejaculations and intercourse events, although sexual desire remained at acceptable levels. Despite these clear effects, the intensity of somatic and mental symptoms after ejaculation were not affected. On the basis of their experiences, both men voluntarily decided to continue flutamide on a daily basis, thereby accepting a mild diminishing of their libido. Endocrine followup revealed a threefold increase of LH during the treatment period of 3 years.

Emphasizing the severity of clinical features, we propose to call this cluster of symptoms post-orgasmic illness syndrome (POIS). POIS typically is a postsexual disorder, suggesting that a factor associated with ejaculation or orgasm serves as a trigger for the induction of a cascade of biological reactions. A few studies in males and females have shown that during and after orgasm prolactine and oxytocin concentrations are increased (Carmichael, Warburton, Dixen, & Davidson, 1994; Exton et al., 2000). To our best knowledge, there are no reports in the literature that suggest that these hormones

are related to flulike symptoms. However, oxytocine has been suggested to negatively interfere with cognition (Geenen et al., 1988). We assume that a still-undiscovered factor or mechanism associated with ejaculation or orgasm triggers a cascade of immunological reactions that culminate in the previously described flulike symptoms.

Indeed, flulike syndromes have been described as side effects of the medical use of cytokines (Vial and Descotes, 1995a, 1995b). Involvement of an immediate-type immune response, clinically represented by urticaria, can be excluded by the unresponsiveness of symptoms to antihistamines.

The prevalence of POIS is unknown. We describe these two cases to draw attention to this syndrome and encourage colleagues and investigators to contact us regarding similar case findings. Further research is necessary to unravel the biological background of this post sexual disorder.

REFERENCES

- Carmichael, M. S., Warburton, V. L., Dixen, J., & Davidson, J. M. (1994). Relationships among cardiovascular, muscular, and oxytocin responses during human sexual activity. *Archives of Sexual Behavior*, 23, 59–79.
- Exton, N. G., Truong, T. C., Exton, M. S., Wingenfeld, S. A., Leygraf, N., Saller, B., Hartmann, U., & Schedlowski, M. (2000). Neuroendocrine response to film-induced sexual arousal in men and women. *Psychoneuroendocrinology*, 25, 187–199.
- Geenen, V., Adam, F., Baro, V., Mantanus, H., Ansseau, M., Timsit-Berthier, M., & Legros, J. J. (1988). Inhibitory influence of oxytocin infusion on contingent negative variation and some memory tasks in normal men. *Psychoneuroendocrinology*, 13, 367–375.
- Vial, T., & Descotes, J. (1995a). Clinical toxicity of cytokines used as haemopoietic growth factors. *Drug Safety*, 13, 371–406.
- Vial, T., & Descotes, J. (1995b). Immune-mediated side-effects of cytokines in humans. *Toxicology*, 105, 31–57.
- Waldinger, M. D., Hengeveld, M. W., & Zwinderman, A. H. (1994). Paroxetine treatment of premature ejaculation: A double-blind, randomized, placebo-controlled study. *American Journal of Psychiatry*, 151, 1377–1379.
- Waldinger, M. D., Hengeveld, M. W., Zwinderman, A. H., & Olivier, B. (1998). An empirical operationalization study of DSM-IV diagnostic criteria for premature ejaculation. *International Journal of Psychiatry in Clinical Practice*, 2, 287–293.

Copyright of Journal of Sex & Marital Therapy is the property of Brunner / Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

Copyright of Journal of Sex & Marital Therapy is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.