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THE CASE OF RESTLESS GENITAL SYNDROME WITH A COMPLEX COMORBIDITY

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INTRODUCTION

Restless Genital Syndrome (RGS) is characterized by persistent, physiologic, genital excitation in the absence of subjective sexual arousal. Symptoms are intrusive, unwanted, and do not remit after orgasm(s) (Jackowich et al. 2016). There are five diagnostic criteria:

- The physiological responses characteristic of sexual arousal persist for an extended period of time and do not subside completely on their own;
- The genital arousal does not resolve completely despite one or more orgasms;
- The persistent genital arousal is experienced as unbidden, intrusive, and unwanted;
- The persistent genital arousal may be triggered not only by sexual activity but by nonsexual stimuli as well;
- There is at least a moderate or greater feeling of distress associated with the experience (Leiblum et al. 2005).

RGS may coexist with Overactive bladder syndrome, and it was associated with Restless legs syndrome (Waldinger & Schweitzer 2009). Because of the unremitting course of the disorder, patients may become severely depressed (Leiblum et al. 2007). Most frequently found causes are pudendal neuropathy, hormonal changes, Tarlov cyst, and use or abrupt withdrawal from selective serotonin reuptake inhibitors (SSRI’s) Waldinger et al. 2011). Different therapeutic approaches are used for symptoms reduction (Table 1).

Aim is observational description of a patient with RGS.

CASE REPORT

Female patient age of 55, was admitted into the psychiatric department of University hospital because of symptoms of depression with delusions of being poisoned. She had a history of hysterectomy and ovariectomy, thyroidectomy, she had epilepsy (petit mal seizures) since she was 29 years old, and she was treated with antiepileptics. The patient was visiting a psychiatrist in the community mental health center, and was treated with risperidone (4 mg/d) and SSRI. She tried various SSRI's and repeatedly reported unspecific „side effects“ which was the reason she stopped taking the medications. After exacerbation of depression with psychotic symptoms, she was admitted into the psychiatric department. Treatment with olanzapine (10 mg/d) was initiated. During the treatment symptoms of psychosis, but not of depression, gradually diminished. The patient started to complain of unwanted sexual arousal. At first, the patient hesitated to report these symptoms because of the feelings of shame and guilt. Gradually, with the building of a therapeutic alliance, she becomes more willing to talk about her symptoms. She claimed that she is constantly „on the edge of orgasm“. Even minor movements worsen the symptoms. The patient missed the relief after one or more orgasms (spontaneous or through masturbation). Her depression worsened. Her self esteem was very low. She started thinking about suicide. She had ideas of being immoral because of the genital arousal she felt. At first, her symptoms were considered as a cenesthetic hallucinations. The symptoms persisted with the same severity for weeks.

Table 1. Treatment options for the Restless Genital Syndrome

Author, Year	Treatment	Study design	Study population	Results
Ahmad et al. 2018	Ropinirole	Case report	1	Full remission
Elkins et al. 2014	Hypnotherapy	Case report	1	Substantial improvement
Hrynko et al. 2017	Cognitive bihevioral therapy	Case report	1	Moderate effect
Nazik et al. 2014	Botulinum A toxin	Case report	2	Improvement of symptoms
Phylippsohn & Kruger 2012	Duloxetine	Case report	1	Full remission
Philippsohn & Kruger 2012	Pregabalin	Case report	1	Substantial improvement
Sforza et al. 2017	Pramipexole	Case report	1	Reduced intensity of symptoms
Yero et al. 2006	ECT	Case report	2	Full remision
Waldinger et al. 2009	TENS	Case report	2	Substantial improvement

After the group discussion about the patient we set the diagnosis of RGS and started with comprehensive treatment. Medications were changed. The dosage was adjusted to the most effective and the best tolerable (venlafaxine 150 mg/d, quetiapine 300 mg/d, clonazepam 1.5 mg/d). Soon, the patient reported sleep improvement and some reduction in genital arousal. We simultaneously started with hypnotherapy by focusing on relaxation, stress reduction, mindfulness, and calming imagery. After 3 weeks of treatment, her mood level normalized, unwanted genital arousal diminished. The patient was discharged recovered, without symptoms of RGS. She was on regular check-ups. The patient gave written consent for this case report.

DISCUSSION

Our patient has met all of five diagnostic criteria for RGS. We have not found a clear etiological factor. Using or abrupt withdrawing from SSRI medication, can trigger RGS (Eibye & Jensen 2014). Our patient was previously treated with several SSRI's which were rapidly changed one with another. Majority of documented patients were women in the early menopausal age which points to hormonal changes (Waldinger & Schweitzer 2009). Our patient was postmenopausal regarding ovariectomy and was treated for hypothyreosis too. We didn't found any vascular abnormalities in the pelvic region through ultrasound examination. Central neurological causes such as epilepsy also can play a role in etiology. Our patient suffered from epilepsy which was adequately medically treated, and the patient was without seizures. Stress can exacerbate symptoms, while distraction and relaxation lessen the suffering. Our patient benefited from psychotherapy and hypnotherapy. She had learned how to relax, being mindful, how to reduce the stress, and the unpleasant sensations.

CONCLUSION

RGS is a disabling condition with unclear etiology. The symptoms can exacerbate the existing psychiatric condition. Our patient suffered from the complex comorbidity, each of which could cause RGS.

Contribution of individual authors:

Rusmir Softic designed report, managed the patient, and wrote the paper.

Mitra Mirkovic Hajdukov, provided psychometric evaluation of the patient.

Nera Hodzic & Vera Vrbljanac provided literature research.

All the authors read and approved the final manuscript.

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Conflict of interest : None to declare.

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