ABSTRACT

Background: Persistent genital arousal disorder (PGAD) is an understudied condition characterized by unwanted physiologic genital arousal in the absence of subjective sexual arousal. Markos and Dinsmore (Int J STD AIDS 2013;24:852–858) theorized that PGAD shares a number of similarities with vulvodynia (unexplained chronic vulvar pain [CVP]), including symptom characteristics and comorbidities.

Aim: To compare medical histories, symptom characteristics, pain characteristics, and daily functioning among women with persistent genital pain (PGA) (n = 42), painful PGA (n = 37), and CVP (n = 42) symptoms.

Methods: An online cross-sectional survey was conducted from October 2015 through April 2016.

Outcomes: Self-report measures of symptoms, diagnosed medical conditions, pain characteristics (McGill Pain Questionnaire), catastrophizing (Pain Catastrophizing Scale), and daily functioning (Functional Status Questionnaire) were collected.

Results: All 3 groups reported similar medical diagnoses and high frequencies of other chronic pelvic pain conditions. Women in all 3 groups reported comparable ages at symptom onset and timing of symptom expression (ie, constant vs intermittent). Women in the 2 PGA groups reported significantly greater feelings of helplessness than women in the CVP group. Women in the painful PGA and CVP groups endorsed significantly more sensory terms to describe their symptoms compared with women in the PGA group, whereas women in the painful PGA group reported significantly more affective terms to describe their symptoms compared with women in the CVP group. Women in the 2 PGA groups reported that their symptoms interfered significantly with most areas of daily functioning.

Clinical Implications: Given the similarities between PGA and CVP symptoms, women with PGA may benefit from similar assessment, treatment, and research approaches.

Strengths and Limitations: Limitations of the present study include its sole use of self-report measures; the presence of PGA or CVP symptoms was not confirmed by clinical assessment. However, the anonymous design of the online survey could have resulted in a larger and more diverse sample.

Conclusion: The results of this study provide some initial support for the conceptualization of persistent genital arousal as a subtype of genital paresthesias/discomfort. These results also further highlight the negative impact that PGA symptoms have on many domains of daily living and the need for further research on this distressing condition.


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Key Words: Persistent Genital Arousal; Chronic Vulvar Pain; Genital Discomfort; Symptom Characteristics; Catastrophizing; Survey

INTRODUCTION

Persistent genital arousal disorder (PGAD) is characterized by unwanted, intrusive physiologic sexual arousal (vasocongestion, genital-nipple sensitivity) in the absence of subjective arousal.1,2 The symptoms last for hours or days or are constant and do not
remit with any behavior (such as masturbation to orgasm or multiple orgasms) or over-the-counter remedies. PGAD is often very distressing, and women report a substantial impact on psychosocial well-being as a result of the disorder. Information on the etiology and treatment of PGAD is generally piecemeal, but some have suggested initial conceptual frameworks for this condition. For example, Markos and Dinsmore7 upon reviewing the literature on PGAD and vulvodynia (unexplained chronic vulvar pain [CVP]), found that the 2 conditions share similar features: symptom presentations, unknown etiologies, lack of biological indicators, common comorbidities, and similar treatment response to overlapping therapeutic modalities. They also noted that the sensation of being on the verge of orgasm is unique to PGAD. This characteristic of PGAD, they acknowledged, could lead some to consider PGAD a sexual dysfunction rather than a genital pain/discomfort condition. However, based on the number of similarities, they proposed that PGAD would be best considered a subtype of vulvodynia. They argued that this classification would result in better access to treatments for women with PGAD, and that combining bodies of research could help to identify potential etiologies or underlying mechanisms involved in the development of both conditions.

Others also have noted pain characteristics in women with PGAD. Leiblum et al8 found in an online survey of 103 women with PGAD (then referred to as persistent sexual arousal syndrome) that 35.4% of women described their PGAD symptoms as painful. More recently, Pink et al9 interviewed 15 women at a chronic non-cancer pain clinic with PGAD symptoms and found that almost half (46.7%, n = 7) reported allodynia (pain in response to non-painful stimulus) associated with their symptoms, 33.3% (n = 5) reported hyperalgesia (heightened pain sensitivity), and 20% (n = 3) reported burning sensations. Waldinger et al10 conducted thorough medical investigations and in-depth interviews with 23 women with restless genital syndrome (an alternative name proposed for PGAD). In their sample, 83% of women reported an intolerance of tight clothing and underwear, indicating the presence of allosthenia and hyperalgesia. 2 additional online surveys found that women with PGAD reported increased pain with penetration.11,12 The 1st found that women who met all 5 criteria of PGAD (n = 206) reported significantly greater self-reported pain with penetration (on the Female Sexual Function Index) than women who endorsed some, but not all, criteria (n = 176). The 2nd study compared an online sample of women with PGAD (n = 172) with previously published Female Sexual Function Index scores of healthy controls (n = 131) and found that women with PGAD reported significantly greater pain with penetration.12

Although the experience of pain is a commonly reported feature of PGAD, no studies have directly compared this group of women with a CVP sample. The majority of research on PGAD reviewed by Markos and Dinsmore7 was in the form of case studies. Similarities between persistent genital arousal (PGA) symptoms (defined broadly as genital arousal that occurs for an extended period, such as hours to days) and CVP symptoms would lend support to a more pain- or discomfort-based classification of PGA. In addition, very few studies have explicitly recognized the presentation of pain in women with symptoms of PGA. As such, we include a 3rd group—those with combined symptoms of PGA and CVP—in this study.

RESEARCH GOALS AND QUESTIONS

The present study is an exploratory comparison of 3 groups of women: those with PGA, those with painful PGA, and those with CVP symptoms. The overarching question framing this study was, do women with these different symptom profiles present with similar medical histories, symptom characteristics, and self-reported daily functioning? Although it was expected that women in the PGA, painful PGA, and CVP groups would not differ on several variables (ie, number of diagnosed medical conditions, symptom characteristics, symptom descriptions, and daily functioning), it was hypothesized that women in the PGA group would report a different constellation of symptom characteristics (ie, more arousal and orgasm sensations), whereas the painful PGA and CVP would report more painful symptoms.

METHODS

Participants

Inclusion criteria for this study consisted of (i) female sex, (ii) age at least 18 years, and (iii) fluency in English. Women were included in the PGA symptom group if they endorsed the question, “Do you currently experience persistent feelings of arousal in your genitals?” Persistent arousal was defined as “physical arousal (such as genital swelling, genital sensitivity, lubrication, nipple sensitivity and/or nipple swelling) that occurs for an extended period of time (such as hours or days).” Women were included in the CVP group if they endorsed the question, “Do you currently experience vulvar pain that has lasted for a duration of 3 months or longer?” Vulvar pain was defined as “pain in the pubic area, labia majora, labia minora, urethra, and/or the vulvar vestibule.” Women in the painful PGA symptom group endorsed the 2 questions. A flowchart of participants is presented in Figure 1. Participants in the present study were part of a larger investigation of symptom characteristics and psychosocial functioning in women with PGA (for other results, see3,14).

Procedures

Queen’s University research ethics board provided ethical approval for this study. Recruitment was undertaken from October 2015 to April 2016. Sample size was based on the number of participants recruited during that timeframe. Participants were recruited using social media, listservs, online support groups, and letters to health care providers and researchers who treat or study individuals with PGA or CVP. Multiple recruitment sources were sought in an effort to lessen participant bias; however, the study was limited to English-speaking participants.
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