International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Ramesh B et al. Int J Reprod Contracept Obstet Gynecol. 2024 Dec;13(12):3771-3774
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20243624

Case Report

Clitoral excision for persistent genital arousal disorder in an elderly patient: a surgical approach to long term symptom relief

B. Ramesh[1], Priyanka Das[2]*, Raksha Madhu[2], Shraddha S. G.[2]

[1]Department of Obstetrics and Gynaecology, Altius Hospital, Bangalore, Karnataka, India
[2]Altius Hospital, Bangalore, Karnataka, India

Received: 18 October 2024
Accepted: 12 November 2024

***Correspondence:**
Dr. Priyanka Das,
E-mail: drpriyanka.das@outlook.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

This case report aims to highlight the successful surgical management of persistent genital arousal disorder (PGAD) in an elderly patient, emphasizing the role of clitoral excision as an effective treatment modality. We present the case of an 85-year-old woman who experienced PGAD that severely impacted her quality of life. Despite undergoing various medical and psychological treatments, the patient continued to suffer from debilitating symptoms. Following a comprehensive assessment, clitoral excision was performed as a last-resort surgical intervention. Postoperatively, the patient reported significant symptom relief and improved overall well-being. This case underscores the potential of surgical intervention in managing PGAD, particularly in elderly patients where conservative treatments may be ineffective. Further research is needed to explore the long-term outcomes of such surgical approaches and their implications for clinical practice.

Keywords: PGAD, Clitoral excision, Elderly patient, Surgical intervention, Symptom relief

INTRODUCTION

Persistent genital arousal disorder (PGAD) is a rare yet debilitating condition marked by ongoing and unsolicited sensations of genital arousal, which occur independently of sexual interest or activity. These sensations are persistent and may last for extended periods, severely impacting the quality of life of those affected. PGAD can present across various age groups but is often more prevalent in middle-aged and older women.[1,2] Although the exact prevalence remains undetermined, studies estimate that approximately 1% of women might be affected by this condition.[3,4]

The hallmark symptoms of PGAD include chronic genital vasocongestion, heightened genital and nipple sensitivity, involuntary vaginal lubrication, and sensations of genital tingling, throbbing, or contractions. In some cases, affected individuals may also experience pelvic pain, further exacerbating the physical and emotional toll of the disorder.[5,6] PGAD diagnostic criteria require the presence of these distressing symptoms without any sexual arousal trigger, accompanied by considerable personal and social discomfort.[7] The embarrassment and distress caused by these ongoing symptoms often lead to significant disruption in everyday social and intimate interactions.

The etiology of PGAD is not fully understood but is thought to involve a complex interplay of neurological, psychological, and physiological factors. Pelvic floor dysfunction, hormonal imbalances, and certain neurological conditions have been suggested as contributing factors.[8,9] While a variety of treatments have been explored, including pharmacological and psychological therapies, results have been inconsistent, leaving many patients frustrated and in search of more definitive solutions.[10,11]

In cases where conservative management fails, particularly in elderly patients with coexisting conditions,

surgical intervention may offer an effective alternative. Clitoral excision has been demonstrated to provide complete symptom relief for patients with refractory PGAD.[12] The procedure is relatively straightforward and can be offered after thorough patient counselling and informed consent. This report presents the case of an 85-year-old woman who, after experiencing no improvement from conventional treatments, underwent successful surgical intervention that led to significant relief from PGAD symptoms.

CASE REPORT

An 85-year-old female presented with persistent complaints of pelvic heaviness, genital arousal, and associated discomfort. Initially, the patient hesitated to disclose the nature of her symptoms due to embarrassment and reported only generalized pelvic heaviness, restless leg pain, and symptoms resembling an overactive bladder. Over time, she had been treated with a variety of medications, including conjugated estrogen, cabergoline, alprazolam, vertin, cinnarizine, zolpidem, chlordiazepoxide, escitalopram, clonazepam. Despite these treatments, she experienced no significant relief. After seeking various forms of treatment without success, she presented to us in search of permanent relief from her symptoms.

The patient also had a history of hypertension, for which she was under medical management, and she had undergone several surgeries in the past, including an abdominal hysterectomy, tonsillectomy, hernia repair, bilateral total knee replacement, and cataract surgery. Due to her numerous pre-existing health issues and the additional burden of PGAD, the patient experienced compounded distress, significantly impacting her overall quality of life.

On clinical examination, the patient's abdomen was unremarkable. A gynecological examination revealed vulvovaginal atrophy, likely related to genitourinary syndrome of menopause (GSM), but no other significant abnormalities were detected. Given the patient's symptoms and the absence of other clear causes, a suspected diagnosis of PGAD was made. The patient denied other sensory disturbances such as paraesthesia or dysesthesia, and she did not report genitopelvic, leg, or lower back pain. However, her medical history included urinary symptoms such as incomplete bladder evacuation and a reduced stream, along with restless legs.

To exclude any organic pathology, a transabdominal and pelvic ultrasound was performed, which showed no significant findings. Hormonal blood analyses were also within normal limits, and her urinalysis was unremarkable. After a thorough explanation of this rare condition and its treatment options, the patient consented to proceed with clitoral excision.

A cystoscopy and thorough dilatation of the urethra were performed, to relieve her genitourinary symptoms, followed by clitoral excision under Spinal anaesthesia (stepwise pictorial presentation).

The surgery was uneventful, and the patient reported immediate relief from her symptoms postoperatively, discharged the very next day. On follow up she shared, she experienced mild postoperative pain, this was managed effectively with pain relief medications and subsided over time. She was advised to use Estriol cream locally for 3months.

The patient’s recovery was smooth, and she remained symptom-free during follow-up visits, highlighting the effectiveness of clitoral excision in managing PGAD in this case.

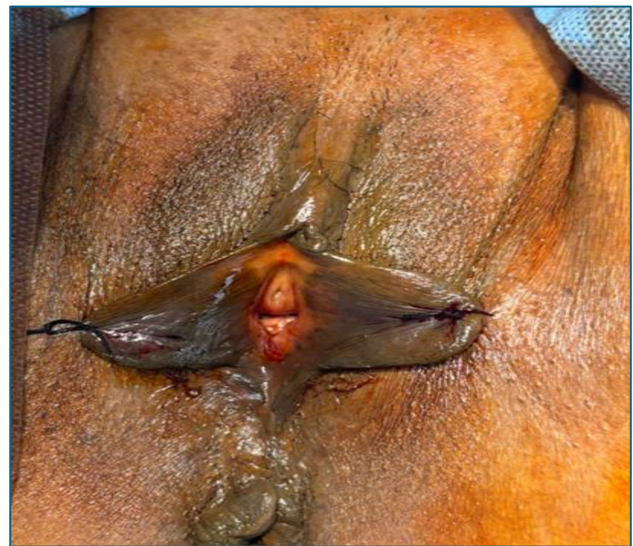

Figure 1: Vulvovaginal atrophy.

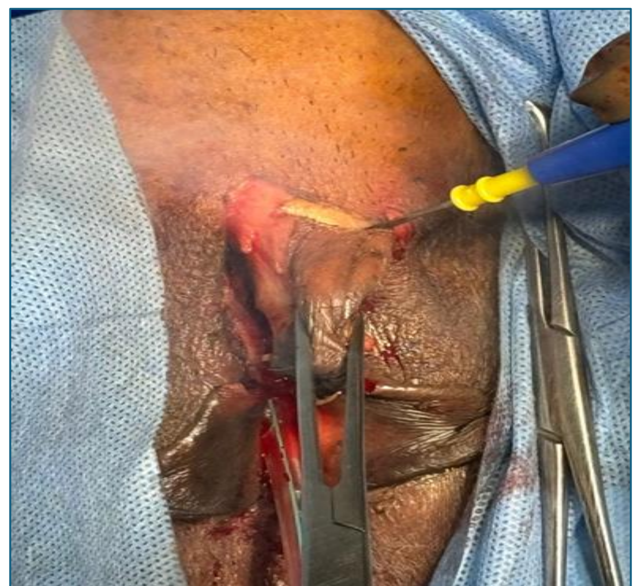

Figure 2: Incision over the clitoris.

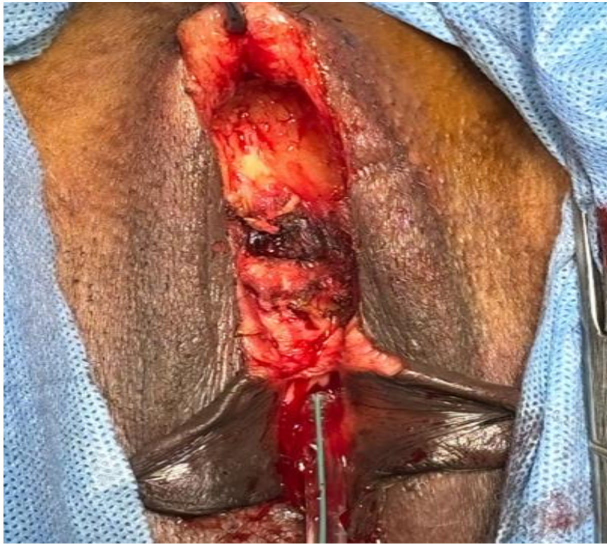

Figure 3: Complete excision of the clitoris.

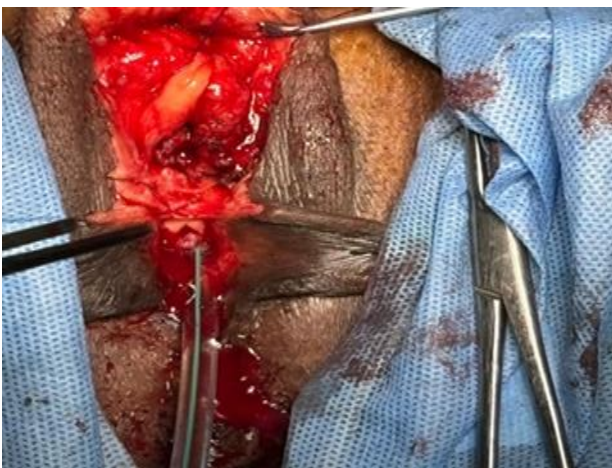

Figure 4: Hemostasis achieved, closure in layers with vicryl 2-0.

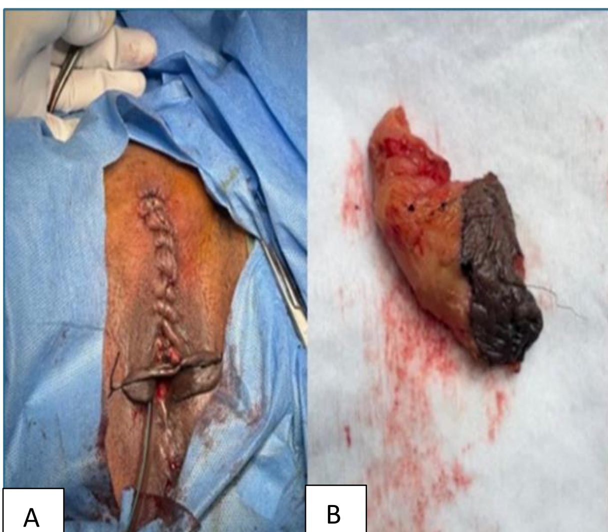

Figure 5 (A and B): Final closure look and clitoris specimen.

DISCUSSION

PGAD remains an enigmatic and distressing condition for both patients and clinicians due to its unclear pathophysiology and challenging management. Despite extensive research, there are no standardized guidelines for diagnosis or treatment, which places significant importance on published literature to guide therapeutic decisions. For patients like ours, surgical intervention can become a valuable treatment avenue after exhausting conservative management options.[1,2]

In the case we present, an 85-year-old woman with a long history of unexplained pelvic heaviness and symptoms of genital arousal underwent clitoral excision following the failure of multiple pharmacological interventions. This surgical approach, while rarely discussed in the literature, has shown promise for patients experiencing severe, refractory symptoms, especially those that have not responded to medications or psychological therapy.[3,4]

Several case studies have described how clitoral excision can provide immediate symptom relief. For example, Kuehner et al reported that the surgical removal of the clitoral glans alleviated distressing arousal sensations in their cohort of patients, supporting the potential of surgical intervention when other treatment modalities fail.[5] Our patient experienced a similar outcome, with postoperative relief of all PGAD symptoms, highlighting the effectiveness of this approach in well-selected cases.

The need for surgery in PGAD cases, particularly in postmenopausal women, is compounded by the chronic nature of their symptoms and the psychological toll they endure. Our patient had significant embarrassment, compounded by her inability to articulate her symptoms clearly, as noted in other literature. PGAD can severely impact a woman's mental health, social functioning, and quality of life.[6,7] Therefore, the decision to proceed with clitoral excision was made after careful consideration, informed by the available literature and extensive patient consent.

The precise role of surgical intervention in PGAD is still being explored. While some authors advocate for clitoral excision in select patients, others emphasize the importance of thorough patient evaluation, including neurological and psychological assessments, prior to opting for surgery. A comprehensive review by Leal et al emphasized the need for more rigorous long-term studies to establish the efficacy and safety of this procedure.[8]

This case adds to the growing body of evidence supporting the use of surgical interventions such as clitoral excision in the management of severe PGAD. Given the rarity of the condition and the limited treatment options available, surgery may offer a path to symptom resolution and improved quality of life for patients suffering from this debilitating disorder. However, further research is

necessary to standardize treatment protocols and identify the most appropriate candidates for surgery.[9,10]

CONCLUSION

PGAD presents a significant challenge for both patients and healthcare providers due to its complex and multifactorial nature. Despite limited understanding of its etiology, this case highlights the potential of surgical intervention-specifically clitoral excision-as an effective treatment option for patients with refractory symptoms. For our patient, the procedure offered substantial relief after conservative therapies failed, underscoring the importance of individualized treatment strategies. While the use of clitoral excision in PGAD remains underexplored, the growing body of evidence supports its viability in select cases, particularly when non-invasive treatments provide limited success. Further research is needed to better define optimal candidates for surgery and refine post-operative care, but this case demonstrates that, in appropriate circumstances, surgical treatment can restore quality of life and alleviate the severe psychological burden associated with PGAD.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Kümpers FMLM, Sinke C, Schippert C, Kollewe K, Körner S, Raab P, et al. Clinical characterisation of women with persistent genital arousal disorder: the iPGAD-study. Sex Med Rev. 2021;9(3):411-23
2. Stanton A. Persistent Genital Arousal Disorder: a Biopsychosocial Framework. Curr Sex Health Rep. 2020;12:127-35.
3. Singh D et al. Persistent Genital Arousal Disorder in an Elderly Female: A Case Report and Review of Literature. Int J Reprod Contracept Obstet Gynecol. 2021;10(4):1676-9.
4. Sarabando R, Sousa N, Borges AC, Nogueira-Silva C. Persistent Genital Arousal Disorder: A Review. Int J Reprod Contracept Obstet Gynecol. 2021;10(4):1691-4.
5. Shankar A, et al. Persistent genital arousal disorder: A review. Indian J Psychiatry. 2015;57(3):283-5.
6. Sood A, et al. Persistent genital arousal disorder: A case series. Indian J Psychiatry. 2017;59(4):482-4.
7. Sarabando R, Natacha S, Ana CB, Cristina Nogueira-Silva. Persistent Genital Arousal Disorder: A Review. Int J Reprod Contracept Obstet Gynecol. 2021;10(4):1691-4.
8. Kuehner C, et al. The Role of Surgery in the Management of Persistent Genital Arousal Disorder. J Sex Med. 2020;17(9):1785-93.
9. Leal M, et al. Surgical treatment of persistent genital arousal disorder: A systematic review. Sex Med Rev. 2023;11(2):300-6.
10. Chivers ML, et al. The role of sexual arousal in the experience of persistent genital arousal disorder: A qualitative analysis. Arch Sex Behav. 2015;44(5):1293-303.
11. Berenson AB, et al. The impact of pelvic floor dysfunction on quality of life in women: A systematic review. Int Urogynecol J. 2018;29(1):49-60.
12. Salonia A, Alberto B, Federico D, Giuseppe Z, Patrizo R, Francesco M. Women's sexual dysfunction: a review of the "surgical landscape. Eur Urol. 2006;50(1):44-52.

Cite this article as: Ramesh B, Das P, Madhu R, Shraddha SG. Clitoral excision for persistent genital arousal disorder in an elderly patient: a surgical approach to long term symptom relief. Int J Reprod Contracept Obstet Gynecol 2024;13:3771-4.