CASE REPORT

PSYCHIATRIC MANIFESTATIONS OF POST-ORGASMIC ILLNESS SYNDROME: A CASE REPORT

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Post-orgasmic illness syndrome (POIS) is a rare condition, typically characterized by physical symptoms following ejaculation; however, its psychiatric implications remain underreported. We present a case involving episodic cognitive disturbances, social withdrawal, anhedonia, and persistent suicidal ideation occurring after ejaculation. The patient experienced a significant diagnostic delay, resulting in progressive functional decline. Despite multi-drug therapy and immunotherapy, clinical improvement remained limited. This case highlights the limitations of current diagnostic and therapeutic approaches. There is a pressing need for psychiatric integration in POIS management and the development of culturally informed diagnostic frameworks.

Keywords: Sexual Dysfunction; Ejaculation Disorders; Fatigue; Cognitive Dysfunction; Suicidal Ideation.

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INTRODUCTION

Post-orgasmic illness syndrome (POIS) is a rare disorder characterized by the rapid onset of flu-like symptoms and allergic-type mucosal reactions that appear within minutes to hours after ejaculation and typically persist for two to seven days.[1,2] Since its initial identification, approximately 50 cases have been reported; however, its true prevalence is likely underestimated due to limited awareness and reporting.[2–4] Clinically, POIS often presents with symptoms such as severe fatigue, cognitive disturbances, headache, myalgia, nasal congestion, gastrointestinal discomfort, and emotional distress, including irritability and low mood.[2,3] These symptoms significantly impair quality of life, prompting affected individuals to withdraw socially and avoid sexual activities ultimately impacting personal relationships and overall mental health.[1,2] Chronic anxiety related to symptom recurrence can lead to more severe psychological consequences, including suicidal ideation. [2–4]

The pathophysiology of POIS remains unclear, though the most widely supported hypothesis involves an autoimmune or allergic reaction triggered by autologous semen exposure.[2,3] Alternative hypotheses suggest neuroendocrine dysregulation or opioid receptor-mediated withdrawal symptoms, although these theories currently lack reliable supporting evidence.[3,4] Importantly, despite considerable psychiatric morbidity including anxiety, depression, and suicidal behavior[1], the psychiatric implications of POIS remain understudied.[3] Existing literature primarily focuses on relieving physical symptoms through the use of antihistamines, non-steroidal anti-inflammatory drugs (NSAIDs), antidepressants, and controlled semen desensitization protocols.[1] The absence of dedicated psychiatric evaluation and treatment in previously reported cases highlights a significant clinical gap.

We present a case report emphasizing the severe psychiatric morbidity associated with POIS, including suicidal ideation and consideration of irreversible medical interventions such as chemical and surgical castration. To our knowledge, this report represents the first detailed account of psychiatric symptoms associated with POIS from Pakistan.

CASE PRESENTATION

A 32-year-old single male presented with episodic somatic and psychiatric symptoms following ejaculation, first noted at age 18. Each episode began within minutes of ejaculation, whether through masturbation or nocturnal emission and lasted 1-2 weeks before resolving spontaneously.

During episodes, he experienced severe frontal headache with periorbital pressure, generalised fatigue, dry mouth, increased thirst and gastrointestinal discomfort. He described muscle stiffness, weakness and subjective limb heaviness with difficulty initiating movement. Cognitive symptoms included slowed thinking, poor concentration, short-term memory lapses and impaired comprehension of spoken and written language. Speech articulation became difficult with word-finding pauses and reduced fluency. Affective features comprised low mood, anhedonia, social withdrawal and irritability

with reduced frustration tolerance. Psychomotor slowing and loss of motivation were marked; appetite increased during symptomatic periods.

The patient discovered that a single bout of jogging at approximately 7 km/h for 40–50 minutes would elevate his symptoms until the next episode. In 2020 and 2022, he underwent Bilateral Meniscectomies for recurrent meniscal injuries, followed by a right Anterior Cruciate Ligament (ACL) tear, which prevented him from maintaining his exercise routine. Thereafter, an increase in both the frequency and severity of his symptoms was observed. Over the subsequent two years, he developed chronic suicidal ideation with thoughts of self-harm. He became preoccupied with eliminating ejaculation and researched both chemical and surgical castration as definitive solutions. He expressed a deliberate intent to pursue these interventions.

The patient consulted multiple specialists including Psychiatrists, Neurologists, and Urologists but no clear diagnosis until recently. He is currently being treated with Duloxetine 30 mg once daily, Hydroxyzine 25 mg twice daily, Pregabalin 75 mg at night, Fexofenadine 180 mg twice daily, Silodosin 4 mg at night, weekly Human Chorionic Gonadotropin (HCG) injections (1500 IU) and subcutaneous immunotherapy with autologous semen. Despite this treatment, he continues to experience recurrent episodes with minimal relief.

DISCUSSION

While post-orgasmic illness syndrome (POIS) has primarily been described in terms of its somatic and immunological symptoms, the deliberating psychiatric and psychosocial consequences remain under-explored.[1,4] Existing literature has mainly concentrated on flu-like symptoms, fatigue, and proposed immunological aetiologies, often overlooking detailed characterisation of affective disturbance, cognitive slowing and emotional reactivity.[1,3] It has previously been documented in clinical observations, with some patients describing prolonged depressive states and anxiety that persist between episodes led to significant impairment in daily functioning.[5] A recent case series found that psychiatric co-morbidities primarily depression, anxiety and increased social isolation were present in most patients, and in several instances, these included sustained suicidal ideation following symptomatic episodes.[6] In the case discussed here, psychiatric morbidity accompanying POIS episodes, particularly depressive symptoms, social withdrawal, suicidal ideation and the patient's desperate consideration of surgical and chemical castration as a means to control symptoms were prominent and disabling, posing an equal, if not greater burden than the physical symptoms.[6,7]

Therapeutic reports have suggested that improvement in psychological distress may accompany resolution of physical complaints, but findings remain preliminary. In isolated clinical cases, the use of Omalizumab has been linked to concurrent improvement in post-ejaculatory somatic symptoms and co-occurring anxiety, while Flibanserin has shown benefit in alleviating mood disturbance and fatigue in selected individuals.[7,8] Although these treatments were not used in this case, their reported effects support the rationale for addressing both physical and psychological aspects of POIS within a combined treatment approach.

In South Asian populations, diagnostic confusion with culture-bound syndromes such as Dhat Syndrome can further delay appropriate intervention. Dhat syndrome is commonly characterised by fatigue, somatic symptoms, and psychological distress attributed to perceived semen loss.[9] Its overlap with POIS in terms of symptom attribution and cultural interpretation may lead to misdiagnosis, inappropriate labelling, or treatment focused narrowly on sexual dysfunction. [9] However, POIS is an idiosyncratic condition, with significant inter-individual variability in symptom presentation, response to treatment, and longitudinal trajectory. These variations call for clinical approaches that move beyond a fixed diagnostic or treatment model and instead accommodate the unique needs of each patient. [10]

The case strongly indicates the necessity of detailed, individualised mental health evaluation as an integral component of POIS management. Clinicians must be cautious of diagnostic overshadowing, particularly in cultural contexts where semen-loss anxiety is prominent.[9] There is a clear need to broaden current approaches to POIS assessment and management.[11] In addition to urological and immunological input, psychiatric evaluation should be included early in the care pathway, with attention to suicidality, functional impairment, and patient beliefs.[12] Culturally informed psycho-education can also play a role in reducing shame, correcting misconceptions and improving engagement. Given the current paucity of literature documenting psychiatric management in POIS, further research is needed to document mental health outcomes systematically while developing evidence-based, individualised care models.[11,12]

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