Case Report

Post-Orgasmic Illness Syndrome: Clinical Presentation, Psychosocial Impact, and Management Challenges Based on Two Case Reports

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Case Report

Post-Orgasmic Illness Syndrome: Clinical Presentation, Psychosocial Impact, and Management Challenges Based on Two Case Reports

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Abstract

Introduction: Post-Orgasmic Illness Syndrome (POIS) is a rare, debilitating condition characterized by a constellation of systemic, allergic, cognitive, and emotional symptoms occurring shortly after orgasm. These symptoms severely impact sexual functioning and quality of life. Despite its profound effects, POIS remains poorly understood, underrecognized, and without a definitive treatment. **Case Presentation:** We report two cases observed in a specialized sexology consultation. The first case concerns a 49-year-old married man presenting with secondary-onset POIS. His symptoms, including muscle rigidity, genital burning, and profound fatigue, consistently emerged after ejaculation, whether during intercourse or masturbation. Extensive investigations revealed no abnormalities. Management included pharmacotherapy (fluvoxamine 50 mg daily and cyclobenzaprine 10 mg daily), psychological support, and sexual counseling. The patient adapted sexual practices, including adopting a lateral coital position to minimize exposure to seminal fluid. Although symptoms persisted after each orgasm, these interventions led to an overall improvement in quality of life. The second case involves an 18-year-old male experiencing primary-onset POIS since puberty. He developed severe fatigue, cognitive dysfunction, low-grade fever sensations, irritability, and abdominal discomfort following ejaculation. Comprehensive evaluations excluded infectious and allergic causes. Notably, the patient required psychiatric hospitalization after a severe behavioral disturbance characterized by agitation and hetero-aggressiveness post-orgasm. Treatment involved antipsychotic and antidepressant therapy, psychological support and psychoeducation. **Conclusion:** These cases highlight the heterogeneous and distressing nature of POIS and its profound impact on sexual health and psychosocial functioning. Multidisciplinary management combining pharmacological, psychological, and sexual interventions may yield partial symptom control and improve patients' quality of life. Increased clinician awareness and further research are urgently needed to advance understanding, diagnosis, and therapeutic strategies for POIS.

Keywords: post-orgasmic illness syndrome; sexual dysfunction; hypersensitivity; cognitive disorders; psychosocial impact; multidisciplinary management

Introduction

Post-Orgasmic Illness Syndrome (POIS) is a rare, distressing, and underdiagnosed disorder first described by Waldinger and Schweitzer in 2002 [1]. It manifests as a constellation of systemic, allergic, cognitive, and emotional symptoms shortly after ejaculation, typically persisting for two to seven days [1]. Symptom clusters commonly include extreme fatigue, feverish sensations, muscle aches, cognitive dysfunction ("brain fog"), nasal congestion, mood disturbances, and flu-like malaise [2].

The true prevalence of POIS is unknown. A systematic review estimated fewer than 1,000 reported cases worldwide, suggesting that POIS is vastly underrecognized [3]. Although initially

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described exclusively in men, isolated cases in women have since been reported, broadening the potential demographic affected [3].

Multiple hypotheses have been proposed regarding the pathophysiology of POIS. These include an IgE-mediated type I hypersensitivity reaction to autologous semen, autoimmune responses targeting seminal plasma proteins, transient neuroendocrine dysregulation involving testosterone or prolactin, and psychogenic components [1–4]. Among these, the allergic hypothesis remains the most studied, supported by positive skin-prick tests in a significant proportion of patients [1–3].

Due to the lack of specific diagnostic tests, clinical history remains the cornerstone of diagnosis [1]. POIS criteria proposed by Waldinger emphasize the reproducibility of symptoms, the temporal relation to ejaculation, symptom persistence, and spontaneous resolution after days [1]. Awareness among clinicians remains low, often leading to years of suffering and misdiagnosis [5].

Given the substantial psychosocial burden associated with POIS, early recognition, validation of symptoms, and compassionate multidisciplinary management are essential.

Case Reports

Case 1

Mr. C, a 49-year-old married male, presented with a five-year history of post-ejaculatory symptoms. His past medical history was notable only for hypertriglyceridemia, managed with dietary modifications; he had no known allergies and no prior psychiatric history. He reported the sudden onset of muscle rigidity, burning sensations in the genital region, and profound fatigue immediately after orgasm. Symptoms occurred consistently following ejaculation, whether during intercourse or masturbation.

Extensive investigations were conducted, including complete blood panels, autoimmune screening, infectious disease testing, neurological evaluations, and psychiatric assessments, all of which yielded unremarkable findings.

As part of a multidisciplinary approach, Mr. C was referred to urology and dermatology consultations. Urological evaluation excluded structural or organic causes, while dermatological assessment, aimed at investigating potential dermatoses associated with the genital burning sensation, found no abnormalities and resulted in discharge after the first appointment.

Management strategies included fluvoxamine (50 mg daily) and cyclobenzaprine (10 mg daily), combined with supportive psychotherapy focusing on anxiety management and symptom acceptance. These interventions resulted in a modest reduction in symptom severity and improved coping mechanisms.

Mr. C maintained regular weekly sexual intercourse with his wife, implementing specific adaptations to mitigate symptom onset. The couple adopted a lateral coital position during intercourse to minimize exposure of Mr. C's body to seminal fluid. Although he continued to experience post-orgasmic symptoms, the combination of positional adaptations, pharmacological treatment, and psychotherapy contributed to a significant improvement in his overall quality of life.

Case 2

Mr. A, an 18-year-old single male, presented with a long-standing history of debilitating symptoms consistently triggered by ejaculation. He reported that, beginning in early adolescence, orgasm would be followed by profound fatigue, cognitive cloudiness, irritability, and abdominal discomfort.

His past medical history was significant for psychiatric follow-up in Child and Adolescent Psychiatry since the age of 12, due to persistent suicidal ideation. At the age of 14, he required inpatient psychiatric hospitalization following ongoing verbalizations of suicidal intent and repeated episodes of self-injurious behavior throughout his adolescence.

A comprehensive diagnostic evaluation was conducted, including infectious, autoimmune, neurological, and psychiatric assessments, all of which were unremarkable. He also underwent a

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multidisciplinary urological evaluation, which excluded any structural or organic etiology contributing to his post-orgasmic symptomatology.

Mr. A reported having consistently avoided romantic relationships and had never engaged in sexual intercourse, primarily due to the distress and fear associated with his symptoms following ejaculation.

Despite stable outpatient psychiatric management, Mr. A experienced a severe exacerbation of behavioral disturbance following an orgasmic episode, characterized by marked psychomotor agitation and hetero-aggressive behavior, which prompted acute psychiatric hospitalization for reassessment. Following stabilization, he was discharged on antidepressant and antipsychotic therapy — specifically, sertraline 100 mg once daily and quetiapine 50 mg (extended-release formulation), two pills administered at bedtime — and was engaged in psychological support focused on anxiety management, emotional regulation, and psychoeducation regarding his condition.

During subsequent outpatient follow-up, Mr. A reported partial symptomatic improvement; however, persistent post-ejaculatory symptoms continued to pose significant challenges to his quality of life, emotional well-being, and social development.

Discussion

The clinical presentations of Mr. C and Mr. A exemplify the heterogeneous and debilitating nature of POIS [1]. Both cases meet the diagnostic criteria proposed by Waldinger et al [1], particularly the reproducibility of symptoms after ejaculation, the temporal relationship, and the spontaneous resolution after.

The pathogenesis of POIS remains elusive. The most widely supported theory posits a type I hypersensitivity reaction, possibly triggered by seminal plasma proteins crossing into systemic circulation [1–3]. Skin-prick testing with autologous semen yields positive results in approximately 88% of tested patients [3], providing indirect evidence for this mechanism.

Alternatively, autoimmune processes have been suggested, with the body mistakenly attacking its own semen-related antigens [4]. Neuroendocrine dysregulation involving fluctuations in testosterone, prolactin, or cortisol levels has also been proposed [4]. Moreover, some researchers suggest that psychogenic factors, including conditioned anxiety responses related to sexual activity, may exacerbate symptom expression [4,5].

Therapeutic interventions remain empirical. Antihistamines have been beneficial for some patients [2], presumably mitigating the allergic response. Non-steroidal anti-inflammatory drugs (NSAIDs) help address systemic inflammatory symptoms [2]. Selective serotonin reuptake inhibitors (SSRIs) may assist by delaying ejaculation and reducing anxiety [5]. Immunotherapy using autologous semen has shown promise in small studies [3]. Emerging biologic therapies, such as omalizumab (an anti-IgE monoclonal antibody), offer exciting future avenues but require further research[7].

The psychosocial burden of POIS cannot be overstated. Patients often experience profound social isolation, avoidance of intimacy, fear of symptom provocation, and secondary depression or anxiety [5]. In Mr. A's case, POIS significantly impaired his social development during late adolescence, highlighting the urgent need for psychological support alongside medical management.

Early diagnosis is crucial to prevent years of unnecessary suffering and healthcare utilization [1–3]. A multidisciplinary approach involving urology, immunology, psychiatry, and sexual medicine offers the best prospect for comprehensive care [5].

Conclusion

Post-Orgasmic Illness Syndrome is a rare but profoundly distressing condition that significantly impairs patients' physical, emotional, and social well-being [1–5]. Despite increasing recognition in

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recent years, POIS remains underdiagnosed, and many patients continue to suffer in silence. Greater clinician awareness is paramount to ensure timely diagnosis and the provision of symptomatic relief.

Future research must focus on elucidating the precise immunological and neuroendocrine mechanisms underlying POIS [1–5]. Controlled clinical trials evaluating antihistamines, immunotherapies, and biologic agents are urgently needed [5–7]. Additionally, psychological interventions tailored to the unique anxieties and challenges faced by POIS patients should be integrated into standard management protocols [5].

Until definitive treatments are established, a compassionate, individualized, and multidisciplinary approach remains the cornerstone of effective care.

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