Preejaculatory illness syndrome: Two cases of a rare psychosomatic disorder

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INTRODUCTION

Human ejaculation is the emission of semen to the exterior. It is a coordinated mechanism of male sexual organs: Prostate, seminal vesicles, urethra, and pelvic floor muscle.¹ It happens in the orgasmic phase of the human sexual response cycle. Although organic ejaculatory problems such as premature ejaculation, inhibited ejaculation, anejaculation, retrograde ejaculation, and anorgasmia were reported,² we have not found reported cases of preejaculatory illness syndrome (PEIS).³

Psychosomatic ejaculatory disorders may happen before, during, or after ejaculation. Postorgasmic illness syndrome (POIS) has been reported as patients may have severe fatigue, intense warmth, and a flulike state, with generalized myalgia.³

To describe one of the psychosomatic abnormalities that may happen before or during ejaculation disorders, we present two cases of PEIS.

CASE REPORT

Case one
A 35-year-old patient presented with episodes of palpitation, sweating, fainting, loss of muscle tone, and sense of impending death. The sensation of impending death, and muscle atonia with subsequent failure to ejaculate. Depression, anxiety disorders, and family histories of psychiatric problems were noticed as risk factors. Medical conditions that may lead to panic attack type symptoms were eliminated before the final diagnosis. After the failure of empirical medications, symptoms became controlled with fluoxetine. Patients reported a recurrence of the symptoms on trying to stop the prescribed medication. On the last follow-up, they still take fluoxetine on a regular base with satisfactory sexual life.

Key Words: Human ejaculation, male sexual dysfunctions, preejaculation disorders
death. This would occur just before ejaculation during sexual intercourse resulting in his inability to ejaculate.

His history included reactive depression and anxiety disorder as well as family history of anxiety and panic disorder.

As per patient’s history, he is married with a monogamous relationship with his wife with five siblings. The patient did not have such symptoms prior to his psychiatric problems.

Clonazepam 0.5 mg was prescribed empirically for a couple of months with no improvement that was substituted by fluoxetine 20 mg OD and propranolol 10 mg.

After 2 weeks, the patient reported significant improvement. On follow-up, the symptoms disappeared, and the ability to ejaculate was restored. Propranolol was stopped as the patient developed diabetes mellitus to avoid masking of the hypoglycemic symptoms. He has maintained on fluoxetine 20 mg daily that restored the preejaculation loss of muscle tone and treated the associated anxiety.

Case two
A 30-year-old recently married patient reported similar symptoms as case one during sexual intercourse in his first marriage.

He had a history of a recently sustained car accident with serious head injury and brain hemorrhage. After surgery, injury to the optic and olfactory nerves ended with a loss of smell sensation and blindness. The patient has had depression from the associated multiple disabilities and breakdown of his finances that was treated with psychotherapy and selective serotonin reuptake inhibitors (SSRIs) as citalopram.

After he had treated and recovered from depression, he got married. The patient admitted failure to ejaculate was restored since marriage, decided to ask for medical advice and disclosed his problem after 10 times of unsuccessful attempts of sexual intercourse.

Due to the previous diagnosis, the patient was started on a treatment of fluoxetine 20 mg OD. There was a significant improvement after 2 weeks. When the patient stopped the medication for few weeks, he reported the recurrence of the symptoms. Fluoxetine was prescribed for a second time with restoring of the symptoms.

Comment
A midline search did not reveal any reported cases of PEIS. It is a group of psychosomatic symptoms that include episodes of palpitation, sweating, fainting, loss of muscle tone, and sense of impending death. The syndrome occurs during sexual intercourse with subsequent inability to ejaculate.

As first described by William Masters and Virginia Johnson, the human sexual response consists of four discrete phases; excitement, plateau, orgasm, and resolution phase. PEIS can be considered a disorder at the end of the plateau and the beginning of orgasm phases.[4]

In men, orgasm is triggered by a subjective sense of ejaculation followed by forceful emission of semen. Orgasm lasts for 3–15 s and is associated with changes in the genital organs that include rhythmic contraction of pelvic floor muscle with a slight clouding of consciousness. Exogenous changes include general cardiovascular (tachycardia and elevated blood pressure) and respiratory changes as well as increase skeletal muscle tone (characteristic spastic contractions of the feet).[5]

Temporary loss of muscle tone at a critical point of impending ejaculation has a devastating effect on the psychological equilibrium of males leading to anxiety and depression in addition to primary and secondary symptoms.

As medical conditions that may lead to panic attack type symptoms as anemia, mitral valve prolapse, hyperthyroidism, etc., may give similar symptoms, our work up first was ruled out.

The clinical picture of PEIS is similar to cataplexy, which is a sudden, short-lived loss of muscle tone, and paralysis of voluntary muscles induced by strong emotions. As there are no reported cases of PEIS, we tried SSRI (fluoxetine) as a primary treatment of cataplexy and sleep paralysis.

If we would consider PEIS part of depression or anxiety disorders, we do not have an explanation why all SSRIs - that were prescribed-improved all symptoms of depression except the inability to ejaculate which is the core symptoms of the PEIS syndrome. Fluoxetine is among SSRIs “it is known to work on muscle tone” which was able to improve PEIS symptoms and restored the muscle tone.

Compared to POIS, the etiology seems to be different, because Waldinger and Schweitzer[3] hypothesized that males with POIS develop an immunogenic reactivity to their own semen. This was supported by the positive skin tests with diluted autologous seminal fluid and by successful hyposensitivity therapy in men with POIS.

Our report is lacking the data regarding the situation of patient’s female partners. Although we asked our patient, their wives did not attend. It seems to be an embarrassing situation for patients in our community.

The full explanation of this syndrome (PEIS) is unclear in the view of rarity of the disease and maybe different compared to POIS. However, the two cases shared past history of depression, family history of panic disorder, and anxiety. We aimed to alert
physicians and urologists to this group of symptoms for future reporting and a possible explanation.

CONCLUSION

PEIS is a rare psychosomatic disorder. Patients may have symptoms of sympathetic over activity, muscle atonia, and sensation of impending death. Depression, anxiety disorders, and family histories of psychiatric problems were noticed as risk factors. Although this condition is embarrassing, it is equally serious. Both patients were prescribed fluoxetine 20 mg OD resulting in the successful restoration of their sexual activity.

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There are no conflicts of interest.

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