

Diagnostic Challenges in Rare Diseases: Our First Case of Post-Orgasmic Illness Syndrome

Donafologo Daouda Yeo^{1,2*}, Yao Kouamé Evrard^{1,2,3}, Legnima Sekou Michel Tuo^{1,2},
Tawakaltu Bolasade Adebayo^{1,2}, Binaté Abdoul-Rahamane², Touré Ba Karamoko²,
Noel Coulibaly^{1,2}

¹Medical Sciences Training and Research Unit, Abidjan, Department of Specialties and Surgical Specialties, Félix Houphouët Boigny University, Abidjan, Ivory Coast

²Urology Department, Treichville University Hospital, Abidjan, Ivory Coast

³Surgery Department, Abidjan Military Hospital, Abidjan, Ivory Coast

Email: *dofologo@gmail.com

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Abstract

Post-orgasmic illness syndrome is a rare condition with a polymorphic clinical presentation; its diagnosis relies on a constellation of genitourinary and general clinical findings. Diagnosis is based on criteria established by Waldinger in the literature. We report the case of a 42-year old man who had been incorrectly treated for recurrent genital infections for over a year. Clinical and paraclinical investigations led to a diagnosis of post-orgasmic illness syndrome.

Keywords

Post-Orgasmic Illness Syndrome, Ejaculation

1. Introduction

Post-orgasmic illness syndrome (POIS) is a rare but debilitating condition characterized by a polymorphic clinical presentation involving systemic and/or genitourinary symptoms following ejaculation [1]. Its pathophysiological mechanism remains unclear; several hypotheses have been proposed, including autoimmune processes, hormonal imbalances, and autonomic nervous system dysfunction. However, an immuno-allergic mechanism is the most frequently cited hypothesis [2].

As a rare disease, it is often unrecognized by urologists. Some practitioners may mistake it for an acute urinary tract infection due to its pronounced symptomatology, which can include fever accompanied by urinary or genital disturbances. These symptoms may also be associated with systemic and neurosensory signs

that could suggest malaria or a neurological disorder. The aim of this report is to raise awareness among practitioners about this rare condition and to prevent diagnostic errors. Informed patient consent was obtained for the presentation of this clinical case. The manuscript was reviewed and approved by the Medical and Scientific Director and the Ethics Committee of the Treichville University Hospital (CHU).

2. Case Report

The patient was a 42-year-old male presenting with post-coital symptoms consisting of fever (ranging from 38°C to 38.8°C), myalgia, polyarthralgia, and moderate, dull pelvic pain occurring 15 to 20 minutes after ejaculation. These symptoms were sometimes accompanied by cramps, headaches, and physical fatigue. They affected the patient's sexual quality of life and impacted his daily activities for at least 48 hours post-ejaculation, causing anxiety prior to each sexual encounter.

The symptoms resolved spontaneously after 72 hours or within 48 hours following the administration of paracetamol. The patient had previously consulted general practitioners and urologists.

Clinical and paraclinical evaluations suggested chronic prostatitis, according to the report from the physician who initially examined him. He had received unsuccessful treatment with quinolones and anti-inflammatories, sometimes combined with anti-flu medication.

Given the persistence of these increasingly debilitating post-coital symptoms and following several failed therapeutic attempts, the patient presented to our facility for an opinion and management.

His genitourinary history was notable for similar episodes occurring after ejaculation or masturbation over the past year, with no history of urinary disorders prior to the onset of these symptoms. Regarding comorbidities, the patient was neither diabetic nor hypertensive, and retroviral serology was normal.

Physical examination, performed 24 hours post-coitus, revealed a conscious patient with the following vital signs: temperature 38.5°C, pulse 88 beats/minute, and blood pressure 130/80 mmHg.

Urogenital examination showed no tenderness in the lumbar fossae or at the mid- and upper-ureteral points.

Palpation of the hypogastrium revealed a soft abdomen with no masses, though deep palpation elicited mild tenderness. Hernial orifices were clear, and the testes were unremarkable.

Digital rectal examination revealed a prostate of normal size, firm and non-tender, with good anal sphincter tone.

Neurological examination showed the patient to be alert and well-oriented in time and space; reflexes and sensation were preserved, with no genito-sphincteric dysfunction. No further neurological investigations were performed.

Laboratory tests showed: hemoglobin 12 g/dL, white blood cell count 8100/mm³, C-reactive protein 5 mg/L, blood glucose 0.79 g/L, and testosterone 6 ng/mL; urine

culture and semen culture results were normal.

Morphologically, the requested ultrasound estimated the prostate volume at 28 g with no calcifications and a normal post-void residual volume.

Following clinical and paraclinical investigations, we suspected post-orgasmic illness syndrome (POIS) after ruling out urogenital and systemic infections—as there were no clinical or laboratory signs of infection—and excluding neurological pathology based on the clinical examination.

Regarding therapeutic management, we initiated symptomatic treatment: the patient was prescribed a course of corticosteroids (prednisone 40 mg tablets for 7 days) combined with a muscle relaxant (thiocolchicoside 16 mg daily, in two divided doses) and advised to take 72 hours of medical leave.

Upon re-evaluation, we observed a regression of certain symptoms within 24 hours, such as fever (37.8°C), hypogastric pain, and myalgia; however, physical asthenia, polyarthralgia, cramps, and headaches persisted.

Five days after starting treatment, the symptoms had significantly subsided, both urogenitally and systemically. The patient reported no adverse drug reactions. Anxiety regarding sexual intercourse persisted, so we recommended a psychological consultation for comprehensive care.

3. Discussion

Post-orgasmic illness syndrome (POIS) is a condition reportedly first described in 2002, with an incompletely understood etiopathogenesis. Several theories have been proposed, converging on an immuno-allergic hypothesis [1].

Diagnosis is based on five criteria defined by Waldinger, derived from a series of 45 cases described in the literature. First, the patient must exhibit at least one of the following symptoms: flu-like sensations or extreme fatigue, muscle weakness, fever or chills, mood disturbances, irritability, memory issues, difficulty concentrating, incoherent speech, or nasal and/or ocular itching. Second, symptoms must appear immediately—within hours—following ejaculation. Third, these symptoms must occur always or almost always (in more than 90% of cases) after ejaculation. Fourth, the symptoms must last between 2 and 7 days. Fifth, they must resolve spontaneously [1]-[3]. Regarding diagnosis, a study published by Strashny evaluated these established criteria using self-reported data. Among 127 patients suffering from the condition, only 20% reported having been diagnosed by a healthcare professional; these patients met Waldinger's criteria. However, 44% did not meet criterion 3, as symptoms did not always occur in the context of ejaculation. Consequently, Strashny proposed modifying criterion 3 to require occurrence in at least one instance of ejaculation rather than every instance [4].

In this case study, our patient exhibited these criteria—specifically, post-ejaculatory genitourinary symptoms, flu-like illness, and asthenia. This led to reduced sexual activity or even abstinence to avoid symptoms, a pattern also described in the study by Shegeta [3], ultimately leaving the patient with psychological aftereffects.

The condition's rarity and the variability of symptoms make diagnosis challeng-

ing, particularly given that we encountered this for the first time in our hospital practice, often alongside normal paraclinical test results.

Therefore, a highly methodical patient interview is required, focusing on the chronology of symptoms to avoid missing the diagnosis.

This symptomatic variability and the diagnostic criteria were described in a case series by Bignami involving three patients with post-orgasmic illness syndrome, all of whom met the diagnostic criteria [5].

As described in the literature, management is symptomatic, except in cases of allergy, where desensitization may be used [6]. The immuno-allergic hypothesis is supported by the case of a woman who experienced allergic reactions after exposure to her partner's semen, as well as by the partial efficacy of semen desensitization in her case [7]. A similar reaction was observed in two patients in another study [6]. Treatment is therefore tailored to the specific symptoms presented by the patient; the use of non-steroidal anti-inflammatory drugs (NSAIDs) has been described in the literature [8].

In the study conducted in Australia, the use of omalizumab led to a significant improvement in clinical symptoms, enabling increased sexual activity and the resolution of post-orgasmic symptoms. The patient reported no adverse reactions to omalizumab [9].

In our case, a corticosteroid combined with a muscle relaxant and rest resulted in a faster symptomatic response. This suggests a potential therapeutic option for such patients, or an avenue for further research into these agents for managing this condition.

4. Conclusion

Post-orgasmic illness syndrome is a rare condition that is unfamiliar to many physicians, which likely explains its underdiagnosis. Practitioners need to be made aware of the condition, as cases are increasingly encountered in clinical practice. Its etiology remains poorly understood, and treatment is primarily symptomatic following desensitization. It is a debilitating condition requiring comprehensive, multidisciplinary management that includes psychologists.

Author Contributions

DONAFOLOGO DAOUDA YEO: Editor-in-chief, reviewed the literature.

YAO KOUAME EVRARD: statistical analyst.

LEGNIMA SEKOU MICHEL TUO: statistical analyst.

TAWAKALTU BOLASSADE ADEBAYO: reviewed the literature.

BINATE ABDOUL-RAHAMANE: data collection.

TOURE BA KARAMOKO: data collection.

Noel COULIBALY: co-editor.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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