

Persistent Genital Arousal Disorder (PGAD) / Genito-Pelvic Dysesthesia (GPD)

Causes, Symptoms, Neurological Factors, Diagnosis, Treatment, Sexual Health Impact and an Integrative Unani Approach

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Introduction

Sometimes a patient comes to me with a sexual-health complaint that is very difficult to explain to family members—and sometimes even difficult to explain to a doctor.

She may say:

“Doctor, I constantly feel unwanted sensations in my genital area, almost as if I am sexually aroused, but mentally I do not want sex.”

Another patient may describe:

“There is continuous throbbing, tingling or pressure around my clitoris. An orgasm may reduce it for a few minutes, but then it comes back.”

Someone else may have burning, buzzing or pulsating sensations that become worse while sitting, driving or lying in bed.

These symptoms can occur in a condition known as **Persistent Genital Arousal Disorder (PGAD)**, increasingly discussed together with the broader term **Genito-Pelvic Dysesthesia (GPD)**.

PGAD/GPD is a genuine and potentially very distressing sensory disorder. The symptoms are **unwanted and intrusive** and are not necessarily associated with sexual desire, sexual thoughts or pleasure.



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The most recent international consensus, published in 2026 following the Fifth International Consultation on Sexual Medicine, describes PGAD/GPD as a sensory hyperactivity condition that can involve unwanted genital arousal and other abnormal sensations in the genito-pelvic region. Current understanding recognizes that symptoms may originate not only from the genital organs themselves but from the pelvic floor, pelvic nerves, sacral nerve roots, spinal cord or brain.

This distinction is extremely important.

A person with PGAD is not simply “overly sexual.” The disorder is not the same as high libido, hypersexuality or excessive sexual desire.

What Is Persistent Genital Arousal Disorder?

Persistent Genital Arousal Disorder refers to **persistent or recurrent, unwanted, intrusive and distressing sensations of genital arousal that occur without corresponding sexual desire.**

Modern terminology increasingly uses **PGAD/GPD—Persistent Genital Arousal Disorder/Genito-Pelvic Dysesthesia**—because many affected people describe sensations that do not actually feel like normal pleasurable arousal.

Instead, they may describe:

- Tingling
- Throbbing
- Pulsating
- Pressure
- Fullness
- Twitching
- Burning
- Buzzing
- Itching
- Genital sensitivity
- A feeling of being continuously “on the verge of orgasm”
- Unwanted contractions
- Pain or discomfort



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The 2021 ISSWSH consensus recommends considering PGAD/GPD when these unwanted and distressing symptoms persist or recur for **at least three months**. Symptoms may involve the clitoris, vulva, vestibule, vagina, urethra, perineum, bladder or rectum.

Recent 2026 international recommendations have expanded the understanding further and recognize PGAD/GPD across genders rather than considering it exclusively a female disorder. Historically, however, most research has involved women.

PGAD Is Not the Same as Sexual Desire

This is perhaps the single most important point for patients and their partners.

Normal sexual arousal generally occurs in association with:

- Sexual interest
- Sexual attraction
- Erotic thoughts
- Desire for sexual activity
- Pleasure

PGAD is different.

The genital sensations may appear:

- During work
- While travelling
- While sitting
- During sleep
- While studying
- During completely nonsexual activities
- Without any sexual thoughts whatsoever

The person may actually **want the sensation to stop**.

Therefore, asking a patient:

“Why don't you simply enjoy it?”

can be deeply inappropriate.



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The sensations may be exhausting, painful, intrusive and emotionally distressing rather than pleasurable. Cleveland Clinic similarly describes PGAD as unwanted genital arousal without corresponding sexual desire and notes that orgasm often fails to provide lasting relief.

Why Is the Term “Genito-Pelvic Dysesthesia” Now Used?

The word **arousal** sometimes creates misunderstanding.

Patients may feel embarrassed because other people interpret the diagnosis as meaning excessive sexual excitement.

However, many patients describe the condition primarily as abnormal **sensory activity**.

The term **dysesthesia** means an unusual, uncomfortable or abnormal sensation.

Therefore, **Genito-Pelvic Dysesthesia (GPD)** can describe sensations such as:

- Burning
- Tingling
- Buzzing
- Electric sensations
- Throbbing
- Pressure
- Pain
- Itching
- Twitching
- Unwanted feelings resembling sexual arousal

The International Society for the Study of Women's Sexual Health adopted PGAD/GPD terminology because it better reflects the broad range of symptoms and reduces the misleading implication that the patient is experiencing ordinary pleasurable sexual arousal.

The 2026 International Consultation on Sexual Medicine has continued this broader PGAD/GPD framework for people of all genders.

Common Symptoms of PGAD/GPD



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Symptoms differ substantially between patients.

A person may experience one or several of the following:

- Persistent clitoral sensation
- Throbbing or pulsation in the vulva
- Genital pressure or fullness
- Unwanted lubrication
- Vaginal contractions
- Feeling continuously close to orgasm
- Recurrent spontaneous orgasms
- Tingling around the vagina or perineum
- Burning or buzzing
- Genital itching without a dermatological cause
- Rectal or perianal sensations
- Urethral sensations
- Urinary urgency
- Pelvic pressure
- Pelvic pain
- Lower-back symptoms
- Sensations extending into the buttocks or legs

Cleveland Clinic notes that episodes can last hours or even days and may involve the clitoris, labia, perineal region or anus.

Some patients experience symptoms continuously, while others have episodes separated by symptom-free periods.

Does Orgasm Relieve PGAD?

Not necessarily.

This is another major difference between PGAD and normal sexual arousal.

In normal sexual response, orgasm is usually followed by reduction of genital arousal.

In PGAD:



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orgasm may provide no relief, temporary relief, or occasionally worsen symptoms.

A patient may therefore feel compelled to seek repeated orgasms simply to obtain temporary reduction in discomfort.

This can become physically and emotionally exhausting.

The ISSWSH consensus specifically recognizes limited relief, absence of relief or sometimes aggravation following sexual activity or orgasm as a characteristic feature of PGAD/GPD.

This is why repeated masturbation should not automatically be considered a treatment.

Is PGAD the Same as Hypersexuality?

No.

Hypersexuality concerns persistent sexual thoughts, urges or behaviors.

PGAD primarily concerns **unwanted genital sensations**.

A person with PGAD may have no sexual interest at all when the sensations occur.

In fact, many patients gradually develop **sexual avoidance** because genital stimulation has become associated with distress.

This distinction is medically and socially important because patients should not be stigmatized or treated as though their condition reflects inappropriate sexual behavior.

Is PGAD Rare?

PGAD/GPD remains underrecognized, so its true prevalence is uncertain.

Earlier international consensus literature estimated that symptoms compatible with PGAD/GPD may occur in approximately **0.6% to 3% of women**, but prevalence depends greatly on the definitions and populations studied.

The 2026 International Consultation notes evidence indicating that PGAD/GPD can occur in both women and men and may be more common than traditionally assumed.

Many patients probably remain undiagnosed because they:

- Feel embarrassed
- Fear being misunderstood
- Do not know the condition exists



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- Are incorrectly diagnosed with anxiety alone
- Receive repeated treatment for genital infection
- Are reluctant to describe genital sensations

Better medical awareness is therefore essential.

Why Does PGAD/GPD Happen?

There is **no single cause**.

This is one of the most important advances in our understanding of the disorder.

PGAD/GPD is now considered a **biopsychosocial sensory condition** that can originate at different levels of the nervous and pelvic systems.

The 2026 international consensus recommends investigating possible triggers in **five anatomical regions**:

1. **End organ — genital tissues**
2. **Pelvis and perineum**
3. **Cauda equina and sacral nerve roots**
4. **Spinal cord**
5. **Brain**

This five-region approach is extremely useful because it changes the treatment question from:

“Which medicine treats PGAD?”

to:

“Where is this particular patient's abnormal sensory signal being generated or maintained?”

Region 1: The Genital End Organ

Some symptoms may originate primarily within genital structures.

Potential contributing factors can include abnormal sensory nerve activity, local hypersensitivity, hormonal changes or specific genital pathology.

The clitoris is a particularly common location of perceived PGAD symptoms.



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Other possible locations include:

- Vulva
- Vestibule
- Vagina
- Penis in male patients
- Urethral region

The affected person may perceive strong genital sensations even when the tissues look normal.

Specialized sensory examination may occasionally be useful when a local neuropathic process is suspected.

Region 2: Pelvis and Perineum

The pelvis and pelvic floor are extremely important in PGAD.

Possible contributors include:

- Hypertonic pelvic-floor dysfunction
- Pelvic muscle trigger points
- Pudendal neuropathy
- Pudendal nerve entrapment
- Pelvic venous disorders
- Other pelvic nerve irritation

The 2026 international recommendations identify pelvic-floor hypertonicity and pudendal neuropathy as clinically important potential contributors.

Pelvic-Floor Hypertonicity

The pelvic-floor muscles support the pelvic organs and participate in urinary, bowel and sexual function.

When these muscles remain excessively tense, they can compress nerves, generate pain and amplify abnormal genital sensations.

A patient may have:



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- Genital pressure
- Pelvic pain
- Difficulty relaxing the vagina
- Pain during intercourse
- Urinary urgency
- Rectal pressure
- Pain worsened by sitting

Importantly, pelvic-floor tightness may be a **cause, consequence or maintaining factor** in PGAD.

The 2026 consensus strongly recommends pelvic-floor physical therapy when hypertonic pelvic-floor dysfunction is present, particularly using **down-training and relaxation rather than indiscriminate strengthening**.

That distinction matters because repeatedly doing Kegel exercises in someone whose pelvic floor is already overactive can potentially worsen symptoms.

Pudendal Nerve Problems

The pudendal nerve carries sensation from important parts of the genital and perineal region.

Irritation, compression or neuropathy involving this nerve can cause:

- Burning
- Tingling
- Genital hypersensitivity
- Perineal discomfort
- Pain aggravated by sitting
- Abnormal genital sensations

The 2026 consensus describes pudendal neuralgia and pudendal entrapment among possible region-2 triggers. A classic clue is pain that becomes worse while sitting and improves when standing or lying down, although not every patient follows the textbook pattern.

This helps explain why some patients notice that symptoms are particularly severe during long car journeys or prolonged sitting.



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Pelvic Venous Disorders

Vascular factors have also been investigated.

Some patients have pelvic venous congestion or abnormal pelvic venous circulation.

The 2026 consensus discusses pelvic venous disorders as possible contributors in selected individuals and notes an older small study in which pelvic varices occurred more frequently in women with PGAD than expected in the general population.

However, this evidence does **not** mean that pelvic congestion explains most PGAD cases.

Vascular investigation should therefore be targeted rather than performed routinely in every patient.

Region 3: Cauda Equina and Sacral Nerve Roots

One of the most important developments in PGAD research is recognition that symptoms perceived in the genitals can sometimes originate **much higher in the nervous system**.

The **cauda equina** is the bundle of spinal nerve roots at the lower end of the spinal canal.

Sacral nerve roots—particularly those involved in pelvic, pudendal and genital sensation—can become irritated.

Potential causes include:

- Tarlov cysts
- Lumbar or sacral disc disease
- Annular tears
- Disc herniation
- Spinal stenosis
- Spondylolisthesis
- Facet cysts
- Other causes of sacral radiculopathy

The 2026 international consensus specifically includes these spinal and sacral mechanisms in PGAD/GPD assessment.



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Tarlov Cysts and PGAD

Tarlov cysts are fluid-filled nerve-root cysts, frequently found around the sacral spinal nerves.

Many Tarlov cysts are incidental and cause no symptoms.

However, in a subgroup of appropriately selected PGAD/GPD patients, sacral Tarlov cysts may irritate nerve fibers involved in genital sensation.

Research has described PGAD/GPD associated with Tarlov-cyst-related sacral radiculopathy, and specialist surgical treatment has been investigated in carefully selected patients.

An extremely important caution is:

Finding a Tarlov cyst on MRI does not automatically prove that the cyst is causing PGAD.

Many healthy people have incidental spinal abnormalities.

The complete neurological pattern must fit.

Lumbar Disc Disease and PGAD

Lumbar and lumbosacral disc pathology may sometimes irritate nerve roots that ultimately carry sensory information from the genital region.

The 2026 international consensus lists annular tears, disc herniation, spinal stenosis, spondylolisthesis and facet cysts among potential region-3 abnormalities capable of irritating sacral pathways.

Therefore, when PGAD occurs together with:

- Lower-back pain
- Sciatica
- Buttock sensations
- Genital numbness
- Tingling in the legs
- Altered bladder function

a neurological or spinal assessment may become especially important.



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Region 4: Spinal Cord

Abnormal sensory activity higher within the spinal cord has also been considered as a potential contributor.

The nervous pathways carrying genital sensation travel through the spinal cord to the brain.

Therefore, spinal pathology can theoretically alter these signals.

The 2026 consensus discusses cervical and thoracic spinal pathology as potential region-4 mechanisms, although direct clinical evidence remains substantially more limited than for several other regions.

Imaging should be selected according to neurological symptoms rather than performing extensive spinal scanning in every patient.

Region 5: Brain and Central Nervous System

Ultimately, every genital sensation is interpreted by the brain.

Potential central contributors include:

- Changes in sensory processing
- Anxiety and hypervigilance
- Depression
- Trauma-related processes
- Medication effects
- Rare neurological brain disorders
- Seizure-related conditions in exceptional cases

The 2026 International Consultation describes rare organic brain causes including seizures, traumatic brain injury, vascular abnormalities and space-occupying lesions.

However, these are not common explanations for every PGAD patient.

Medication-Related PGAD

Medication history deserves particular attention.

PGAD/GPD has been reported after:

- Starting certain serotonergic antidepressants
- Taking certain centrally acting drugs
- Changing medication doses
- Discontinuing SSRIs
- Discontinuing SNRIs
- Exposure to some other neuroactive medications

The relationship is complicated.

A 2024 pharmacotherapy review found only weak evidence for drug treatment overall and reported that serotonergic medicines can sometimes **improve PGAD symptoms but can also trigger or worsen them**, particularly during treatment changes or discontinuation.

The 2026 consensus likewise recognizes exposure to or withdrawal from SSRIs and SNRIs among important medication-related triggers.

This creates an unusual clinical situation in which the same broad drug class may help one patient and worsen another.

For that reason:

Patients should never abruptly discontinue antidepressants because they suspect PGAD.

Medication changes need to be coordinated with the prescribing clinician.

Hormonal Changes

Hormonal changes may contribute in selected people.

Symptoms have been reported around:

- Menopause
- Perimenopause
- Pregnancy
- Hormonal medication changes

Cleveland Clinic includes hormonal changes among possible PGAD-associated factors.

However, PGAD should not automatically be considered a hormonal disorder.



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Hormonal factors may be important in one patient while another patient's symptoms are primarily neurological or pelvic-floor related.

Conditions Associated With PGAD

PGAD/GPD has been reported alongside conditions including:

- Hypertonic pelvic-floor dysfunction
- Pudendal neuropathy
- Tarlov cysts
- Chronic pelvic pain
- Endometriosis
- Restless legs syndrome
- Irritable bowel syndrome
- Fibromyalgia
- Vulvar or vaginal pain disorders
- Lumbosacral disc disease

Cleveland Clinic also lists several of these conditions among factors reported in patients with PGAD.

An association does not necessarily prove that one condition caused the other.

Why Can Sitting or Driving Trigger PGAD?

Many patients notice worsening while:

- Sitting at a desk
- Driving
- Cycling
- Travelling
- Wearing pressure-producing clothing

There are several possible explanations.

Sitting changes pressure on the:

- Pudendal nerve



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- Pelvic floor
- Perineum
- Pelvic blood vessels
- Lower spine

The original ISSWSH consensus specifically notes sitting and driving among situations capable of aggravating symptoms.

If positional changes strongly influence symptoms, clinicians should consider pelvic and neurological causes rather than assuming the condition is purely psychological.

PGAD and a Full Bladder

Some patients report worsening genital sensations when the bladder is full.

This may reflect shared pelvic and sacral nerve pathways.

Genital, urinary and rectal sensations are not neurologically isolated from one another.

This explains why PGAD can coexist with:

- Urinary urgency
- Bladder pressure
- Pelvic discomfort

and why evaluation should consider the entire genito-pelvic region.

Psychological Factors: Important, but PGAD Is Not “Just Psychological”

A common and harmful misunderstanding is telling a patient:

“This is only anxiety.”

That is not an adequate explanation.

Current PGAD/GPD models recognize neurological, muscular, vascular, hormonal, pharmacological and psychological contributors.

At the same time, psychological factors can significantly affect the severity of symptoms.

Imagine experiencing unexplained genital sensations continuously for months.

A patient may begin monitoring every sensation.



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She becomes anxious.

She thinks:

“What if this never stops?”

Attention becomes increasingly focused on the genitals.

The sensation feels even stronger.

Anxiety rises further.

A vicious cycle can develop.

Research reviewed in the 2026 consensus associates catastrophizing, hypervigilance, fear and avoidance with greater symptom severity and worse functioning.

Treating those factors does not mean denying an underlying neurological problem.

Both can be treated simultaneously.

PGAD and Sexual Trauma

Some studies have reported higher levels of previous sexual trauma among groups of patients with PGAD/GPD.

However, trauma is **not required** for PGAD to occur, and clinicians should never assume trauma simply because someone develops PGAD.

The 2026 consensus recommends trauma-informed psychological support where clinically relevant while maintaining a comprehensive neurological and medical assessment.

Patients should be allowed to discuss—or not discuss—personal experiences at an appropriate pace.

Mental-Health Effects of PGAD

PGAD can severely affect quality of life.

Patients may experience:

- Anxiety
- Depression
- Shame
- Difficulty concentrating



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- Social withdrawal
- Sleep disturbance
- Relationship problems
- Reduced ability to work
- Sexual avoidance
- Feelings of hopelessness

The 2024 scoping review of PGAD treatments found recurring patient reports of shame, social isolation, poor sleep, reduced quality of life and suicidal ideation.

The 2026 international consensus also emphasizes the significant psychological burden and the importance of psychological treatment alongside medical evaluation.

If persistent symptoms lead to thoughts of self-harm or suicide, urgent mental-health or emergency support is needed.

How PGAD Can Affect Sexual Relationships

PGAD may create confusing relationship difficulties.

A partner may think:

“If her body feels aroused, why doesn't she want sex?”

But physical genital sensation does not equal desire.

The patient may already be exhausted from unwanted sensations and may actually want less genital stimulation.

Sexual activity can become associated with:

- Anxiety
- Symptom monitoring
- Pressure
- Frustration
- Shame
- Fear of worsening symptoms

Some people eventually avoid intimacy altogether.



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Couple or sex therapy can help both partners separate **unwanted sensory symptoms from attraction, affection and desire.**

Does PGAD Cause Infertility?

PGAD is **not itself a recognized direct biological cause of infertility.**

It does not automatically mean that:

- Ovulation is abnormal
- Fallopian tubes are blocked
- Ovarian reserve is reduced
- Sperm production is impaired

However, PGAD can indirectly affect reproductive life.

A person may avoid intercourse because stimulation aggravates symptoms.

Medication changes may also be relevant in someone planning pregnancy.

In addition, underlying conditions responsible for PGAD—such as endometriosis or certain pelvic disorders—may independently influence fertility.

Therefore, when PGAD occurs in a couple trying to conceive, sexual-health evaluation and fertility evaluation should be coordinated rather than assuming one explains the other.

How Is PGAD Diagnosed?

There is no single blood test or scan that proves PGAD.

Diagnosis begins with a **detailed history.**

The clinician first establishes whether symptoms genuinely match PGAD/GPD.

Then the objective is to identify where the abnormal sensory input may originate.

The 2026 International Consultation strongly recommends a systematic five-region diagnostic approach covering the genital end organ, pelvis/perineum, cauda equina, spinal cord and brain.

Questions I Consider Important

When I evaluate this kind of complaint, I want to understand:



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When did symptoms begin?

Did they start suddenly or gradually?

Where exactly are the sensations located?

Are they pleasurable or distressing?

Are sexual thoughts present?

Do symptoms disappear after orgasm?

Does sitting worsen them?

Does walking improve them?

Does a full bladder trigger symptoms?

Is there pelvic pain?

Is there lower-back pain?

Is there sciatica?

Are there sensations in the buttocks, legs or feet?

Are urinary symptoms present?

Does intercourse aggravate the condition?

Did symptoms begin after starting or stopping medication?

Is menopause or another hormonal change relevant?

Has there been spinal trauma, childbirth trauma or pelvic surgery?

Is the pelvic floor tender or excessively tight?

How badly are symptoms affecting sleep, work, relationships and emotional health?

These questions can be more important than ordering a large group of tests without a clinical hypothesis.

Physical Examination

Examination should be individualized and performed with consent.

Depending on the patient, it may include:

- External genital examination
- Assessment for vulvar disease



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- Clitoral examination
- Pelvic-floor assessment
- Sensory examination
- Pudendal nerve examination
- Basic neurological examination
- Lower-back examination
- Assessment of reflexes where appropriate

The 2026 consensus particularly emphasizes evaluating the local genital and pelvic regions first because they are accessible and are where symptoms are usually perceived.

Pelvic-Floor Examination

If clinically appropriate and consented to, pelvic-floor assessment can determine whether muscles are:

- Excessively tight
- Painful
- Difficult to relax
- Weak
- Poorly coordinated
- Reproducing the PGAD sensations

The 2026 international consensus describes transvaginal or transrectal palpation as useful for evaluating pelvic-floor tone, relaxation, trigger points and symptom reproduction.

Neurological Investigation

When symptoms suggest nerve-root involvement, neurological investigation becomes important.

Possible clues include:

- Low-back pain
- Tailbone pain



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- Sciatica
- Genital numbness
- Burning in the legs
- Buttock sensations
- Symptoms strongly affected by spinal position
- Previous spinal injury
- Altered bladder or bowel function

Depending on findings, clinicians may consider:

- Lumbosacral MRI
- Sacral MRI
- Neurological examination
- Specialized neurogenital sensory testing
- Referral to neurology or spine specialists

The 2026 consensus recommends imaging and neurological testing according to the suspected region rather than using one identical investigation for every patient.

When Brain Imaging May Be Considered

Brain imaging is **not routinely required in every patient with PGAD**.

It may become relevant in rare cases if there are additional symptoms suggesting:

- Seizures
- Brain injury
- Major neurological abnormality
- Space-occupying lesion
- Vascular neurological disease

The 2026 consensus mentions MRI and electroencephalography for appropriately selected region-5 neurological presentations.

Conditions That Can Be Confused With PGAD

A proper diagnosis may need to distinguish PGAD/GPD from:



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- Normal sexual arousal
- Hypersexuality
- Vulvodynia
- Vestibulodynia
- Pudendal neuralgia
- Pelvic-floor dysfunction
- Urinary tract disorders
- Vaginal or vulvar infection
- Genitourinary syndrome of menopause
- Clitoral or penile priapism
- Restless genital syndrome
- Neurological paresthesia
- Anxiety-related genital hyperawareness
- Certain medication withdrawal syndromes

Correct terminology matters because the treatments are different.

Treatment of PGAD/GPD

There is currently **no single universally effective treatment**.

This needs to be stated clearly.

A 2024 scoping review found only 46 relevant publications after systematic screening, with case reports forming much of the evidence base. The authors concluded that standardized evidence-based treatment remains limited.

Similarly, a 2024 pharmacotherapy review found no completed randomized drug trials specifically establishing a standard medication for PGAD/GPD and described the evidence for pharmacological therapy as weak.

The strongest modern approach is therefore:

identify likely triggers and treat them within a multidisciplinary biopsychosocial plan.

This is also the central recommendation of the 2026 International Consultation.



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Pelvic-Floor Physical Therapy

When a hypertonic pelvic floor is identified, pelvic-floor physiotherapy is particularly important.

The 2026 international recommendations strongly support pelvic-floor physical therapy as a first-line approach for hypertonic pelvic-floor dysfunction associated with PGAD/GPD.

Treatment may include:

- Pelvic-floor down-training
- Manual therapy
- Muscle relaxation
- Biofeedback
- Diaphragmatic breathing
- Coordination exercises
- Posture and movement assessment
- Hip and pelvic-girdle rehabilitation
- Trigger modification

The goal is often **relaxation and normalization**, not simply strengthening.

Psychological Treatment

Psychological care should not be considered a last resort.

Current international recommendations advise using psychological and medical treatments **in parallel** because PGAD can produce substantial distress regardless of its biological trigger.

Approaches may include:

- Cognitive behavioral therapy
- Mindfulness-based interventions
- Relaxation
- Distress-tolerance techniques



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- Treatment of anxiety or depression
- Trauma-informed therapy when appropriate
- Sex therapy
- Couples therapy

The 2026 consensus notes encouraging case-level evidence but also states that psychological therapy has not yet been adequately studied as a stand-alone PGAD treatment in large trials.

So psychological treatment is valuable, but it should not be used to dismiss the possibility of a nerve, pelvic-floor, vascular or spinal cause.

Medication Review

Medication history may be one of the most important parts of treatment.

If symptoms appeared shortly after:

- An antidepressant was started,
- An antidepressant dose changed,
- An SSRI or SNRI was stopped,
- Another central nervous system drug was changed,

the relationship deserves investigation.

But abrupt discontinuation can worsen psychiatric illness and may itself worsen neurological symptoms.

Medication changes should therefore be coordinated with the responsible physician.

Medicines Used for PGAD

Various medications have been reported in the literature, including selected:

- Antidepressants
- Anticonvulsant/neuropathic-pain medicines
- Dopaminergic drugs
- Other centrally acting medicines

However, evidence remains weak.



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The 2024 pharmacotherapy review found limited case-based evidence for agents including SSRIs, SNRIs and anticonvulsants such as pregabalin and gabapentin, while also warning that serotonergic medications may themselves trigger or worsen PGAD in some patients.

Therefore, I do not believe it is appropriate to publish one drug as **“the medicine for PGAD.”**

Treatment has to follow the underlying mechanism.

Botox and Pelvic-Floor Procedures

Botulinum toxin has been used in selected cases involving hypertonic pelvic-floor dysfunction.

However, evidence specific to PGAD remains limited.

The 2024 scoping review found pelvic-floor Botox to be among the more frequently reported procedures, but the literature was dominated by small studies and case reports.

The 2026 consensus places more invasive pelvic-floor interventions after appropriate physical-therapy approaches rather than treating them as universal first-line therapy.

Pudendal Nerve Treatment

When examination and history strongly suggest pudendal neuropathy, treatment may involve:

- Pelvic-floor rehabilitation
- Modification of sitting and pressure
- Pain-management strategies
- Diagnostic nerve blocks in selected cases
- Specialist nerve procedures

Pudendal decompression surgery is reserved for carefully selected patients with appropriately demonstrated pathology.

It is not an appropriate treatment simply because genital symptoms exist.

Tarlov Cyst or Spine Surgery

Spinal surgery deserves particular caution.

Research has reported symptom improvement after surgery in carefully selected patients whose PGAD/GPD appeared to originate from Tarlov-cyst-associated or disc-related sacral radiculopathy.

But this should never be interpreted as:

“PGAD + Tarlov cyst = surgery.”

Selection requires a much more detailed neurological correlation.

Spinal findings can be incidental.

Surgery belongs in specialist centers after adequate evaluation.

Vascular Treatment

If a clinically meaningful pelvic venous disorder is identified, vascular or interventional treatment may occasionally be considered.

Again, this is appropriate only for a specific subgroup.

PGAD should not lead automatically to pelvic vascular procedures.

What Patients Can Do While Awaiting Assessment

Some practical strategies can reduce symptoms in selected patients.

These may include:

- Identifying and recording triggers
- Taking breaks from prolonged sitting
- Avoiding unnecessary perineal pressure
- Using a comfortable sitting position
- Gentle walking if it reduces symptoms
- Diaphragmatic breathing
- Relaxation exercises
- Following pelvic-floor guidance from a qualified therapist
- Maintaining adequate sleep
- Managing constipation



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- Avoiding repeated genital checking
- Discussing medication changes with the prescribing clinician

The ISSWSH consensus describes movement modification, walking, breathing, relaxation and selected self-management strategies as potentially useful when pelvic-floor dysfunction is present.

These measures are supportive, not substitutes for diagnosis.

Should a Patient Keep Trying to Reach Orgasm for Relief?

Not necessarily.

Some patients report brief improvement after orgasm, while others experience no relief or worsening.

If repeated orgasm becomes an exhausting attempt to suppress symptoms, it can itself reduce quality of life.

The aim of treatment should be to correct or control the abnormal sensory process rather than obligating the patient to repeatedly stimulate the genitals.

PGAD and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine** and working in sexual and reproductive health, I believe one traditional principle is particularly relevant to a complex disorder like PGAD:

Izala-i-Sabab — Identification and removal or correction of the causative factor

Official CCRUM material describes **Izala-i-Sabab** as a fundamental principle in Unani treatment: the causative factors involved in a disease process are identified and addressed as part of management.

This principle fits particularly well with modern PGAD/GPD care.

PGAD is not one disease mechanism.

The cause may lie in:

- The genital tissues
- Pelvic floor
- Pudendal nerve
- Pelvic circulation



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- Sacral nerve roots
- Spine
- Medication effects
- Central sensory processing

Therefore, giving every patient the same sexual tonic or herbal preparation would not be a rational application of Unani medicine.

The Main Unani Therapeutic Framework

The Central Council for Research in Unani Medicine describes four major therapeutic approaches:

- **Ilaj-bil-Ghiza — Dietotherapy**
- **Ilaj-bil-Tadbir — Regimental therapy**
- **Ilaj-bil-Dawa — Pharmacotherapy**
- **Ilaj-bil-Yad — Procedural or surgical treatment where appropriate**

Unani medicine also traditionally evaluates the patient's **Mizaj or constitution**, general health, lifestyle and mental and physical state.

The Ministry of AYUSH describes Unani health maintenance around six essential factors—including diet, physical activity and rest, sleep and wakefulness, and psychological activity and rest—and emphasizes the relationship between mental and physical health.

These principles can support an integrative approach to PGAD—but they need to be applied cautiously because direct scientific evidence for Unani treatment of PGAD is presently extremely limited.

Ilaj-bil-Ghiza — Dietary and General Health Support

There is **no scientifically established “PGAD diet.”**

Diet cannot remove a Tarlov cyst, decompress a pudendal nerve or reverse every neurological sensory disorder.

However, individualized nutrition can still support:

- General health
- Metabolic health



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- Bowel regularity
- Energy
- Healthy weight
- Sleep quality
- Overall neurological and pelvic health

Constipation deserves particular attention because straining and pelvic-floor tension can aggravate some pelvic symptoms.

I therefore consider dietary care supportive rather than curative.

Ilaj-bil-Tadbir — Regimental and Lifestyle Care

The broader lifestyle-oriented principles of Unani medicine may be especially useful as supportive management.

An individualized plan can consider:

- Sleep
- Physical activity
- Rest
- Stress
- Bowel function
- General pelvic health
- Mental well-being
- Sexual-health counselling

However, certain traditional procedures should **not automatically be applied directly to the genital or pelvic region** merely because symptoms are located there.

PGAD may involve hypersensitive nerves.

Aggressive massage, irritating local substances or unnecessary stimulation may worsen symptoms.

Ilaj-bil-Dawa — Unani Pharmacotherapy



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Unani medicine includes many herbal and compound preparations used traditionally for neurological, psychological, reproductive and sexual-health complaints.

Nevertheless, scientific honesty is essential.

I could not identify high-quality randomized clinical trials establishing a specific Unani medicine as an effective treatment for PGAD/GPD.

The modern PGAD literature itself remains limited even for conventional pharmacotherapy: a 2024 review found only weak evidence for available medicines and no established pharmacological standard.

Therefore, Unani pharmacotherapy should be presented as **individualized supportive treatment**, not as a proven cure.

Any herbal treatment should also be reviewed for:

- Quality
- Appropriate dose
- Drug interactions
- Pregnancy considerations
- Neurological conditions
- Psychiatric medicines
- Liver and kidney health

How Unani Medicine May Be Useful

The useful contribution of an integrative Unani approach may include helping address factors such as:

- Poor sleep
- Chronic stress
- Lifestyle imbalance
- Constipation
- General health
- Diet
- Anxiety associated with persistent symptoms
- Overall sexual-health counselling



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For a patient whose symptoms are being maintained partly by pelvic tension, stress and disrupted sleep, these areas can be clinically meaningful.

But if MRI demonstrates clinically significant sacral nerve-root pathology, lifestyle treatment should not delay neurological assessment.

Similarly, if symptoms began during antidepressant withdrawal, the relevant prescribing clinician should be involved.

Integrative medicine is strongest when each component is used for the problem it can reasonably address.

The Saira Health Care Approach to PGAD/GPD

At **Saira Health Care**, I believe PGAD requires a particularly respectful and systematic approach because patients are frequently misunderstood before reaching appropriate care.

When someone tells me:

“Doctor, I constantly feel genital arousal but I am not sexually excited,”

my first objective is not to judge the symptom or assume psychological disease.

I want to identify the nature of the sensation and ask:

Where could this signal be coming from?

My Clinical Framework

First: Confirm the Pattern

Does the patient actually have persistent or recurrent unwanted genito-pelvic sensations?

Are they distressing?

Are they unrelated to desire?

How long have they existed?

Second: Map the Symptoms

Are symptoms primarily:

- Clitoral?
- Vulvar?



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- Vaginal?
- Urethral?
- Perineal?
- Bladder-related?
- Rectal?
- Associated with the back or legs?

Third: Search for Triggers

Is the symptom affected by:

- Sitting?
- Walking?
- Driving?
- Sexual activity?
- Orgasm?
- Bladder filling?
- Stress?
- Menstrual or hormonal changes?
- Medication changes?

Fourth: Examine the Pelvic Floor

An overactive pelvic floor can maintain significant sensory symptoms.

Fifth: Review Neurological Clues

Lower-back pain, sciatica or neurological symptoms may change the diagnostic pathway.

Sixth: Review Medication History

This includes not only current medication but recently discontinued medication.

Seventh: Assess Emotional Impact

Depression, shame, insomnia and relationship distress deserve treatment whether they are causes, consequences or both.

Eighth: Build a Cause-Oriented Treatment Plan

This may combine:



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- Patient education
- Pelvic-floor physiotherapy
- Sexual counselling
- Psychological support
- Medication review
- Neurological evaluation
- Specialist pelvic assessment
- Appropriate imaging
- Individualized Unani supportive care
- Referral to gynecology, urology, neurology, pain medicine or spine specialists where indicated

This type of multidisciplinary, cause-directed approach is closely aligned with the latest 2026 international PGAD/GPD recommendations.

The Contribution of Saira Health Care in Sexual Disorders and Infertility

Sexual-health conditions cannot always be understood by looking only at reproductive organs.

A patient may have:

- A neurological disorder presenting as genital sensation,
- A pelvic-floor problem presenting as sexual dysfunction,
- Medication withdrawal presenting as dysesthesia,
- A sexual disorder producing severe anxiety,
- Or infertility coexisting with an unrelated sexual-health condition.

At **Saira Health Care**, the aim of focused practice in sexual disorders and infertility is to help differentiate these overlapping conditions rather than treating every complaint as “sexual weakness.”

Saira Health Care's current published professional material identifies **Dr. Nizamuddin Qasmi** as Founder and Chief Physician with a focused practice in sexual disorders and infertility and lists the professional education and training used in this article.



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For a disorder such as PGAD/GPD, responsible care particularly requires knowing when the patient's needs extend beyond a sexual-health clinic and require pelvic-floor physiotherapy, gynecology, neurology, psychiatry/psychology, pain medicine or specialist spine assessment.

When Should You See a Doctor?

Professional assessment is appropriate when:

- Genital arousal sensations repeatedly occur without desire.
- Symptoms persist for months.
- Orgasm does not resolve the sensation.
- Sitting or driving severely worsens symptoms.
- Genital sensations are associated with back or leg symptoms.
- Sleep is being disturbed.
- The condition interferes with work.
- Sexual relationships are being affected.
- Symptoms began after a medication change.
- Symptoms are producing severe anxiety or depression.

Because PGAD remains poorly recognized, bringing a clear symptom history to the consultation can be extremely helpful.

When Urgent Medical Assessment Is Needed

Certain symptoms deserve urgent evaluation rather than routine follow-up.

Seek urgent medical care if abnormal genital sensations occur with:

- New severe leg weakness
- Sudden loss of bladder control
- Sudden loss of bowel control
- Significant numbness around the genital or saddle area
- Severe acute spinal symptoms

These may indicate significant neurological compression.

Similarly, if distress from PGAD leads to **thoughts of self-harm or suicide**, urgent mental-health or emergency support is required. Severe psychological distress and suicidal ideation are well documented complications of PGAD/GPD.

Common Mistakes I Encourage Patients to Avoid

Patients can lose considerable time because PGAD is unfamiliar.

Important mistakes include:

- Assuming PGAD means excessive sexual desire.
- Repeatedly trying to achieve orgasm as the only treatment.
- Feeling ashamed and hiding symptoms.
- Accepting that the problem is “only anxiety” without appropriate assessment.
- Assuming every spinal cyst is automatically responsible.
- Undergoing invasive procedures without adequate diagnostic correlation.
- Abruptly stopping antidepressants.
- Performing repeated Kegel exercises despite an overactive pelvic floor.
- Applying irritating oils or herbal preparations directly to sensitive genital tissues.
- Assuming one medicine can treat every type of PGAD.

The more complex a disorder is, the more important accurate diagnosis becomes.

Frequently Asked Questions About PGAD

Is PGAD the same as being sexually excited all the time?

No. PGAD involves unwanted genital sensory activity that may occur without sexual desire, fantasy or pleasure.

Is PGAD a psychological disease?

Not simply. Modern understanding recognizes neurological, pelvic-floor, spinal, vascular, hormonal, medication-related and psychological contributors.

Can PGAD affect men?

Yes. Although historically researched mainly in women, the 2026 International Consultation recognizes PGAD/GPD across genders.



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Can orgasm stop PGAD?

Sometimes temporarily, but frequently it does not provide lasting relief, and symptoms can sometimes worsen.

Can sitting make PGAD worse?

Yes. Sitting and driving are recognized triggers in some patients, particularly when pelvic-floor or pudendal-nerve factors are involved.

Can antidepressants cause PGAD?

PGAD has been reported both during serotonergic medication use and after SSRI/SNRI changes or withdrawal. However, these medicines can also help some patients, so they should never be stopped without medical supervision.

Are Tarlov cysts associated with PGAD?

They can be relevant in a subgroup of patients when they irritate sacral nerve roots, but finding a cyst on MRI does not automatically prove causation.

Can a slipped disc cause genital sensations?

Certain lumbosacral disc abnormalities may irritate sacral nerve pathways involved in genital sensation and are recognized as possible region-3 PGAD/GPD triggers.

Can pelvic-floor physiotherapy help?

Yes, particularly when a hypertonic or overactive pelvic floor is present. The latest international consensus strongly recommends pelvic-floor physical therapy as first-line management for this component.

Are Kegel exercises always helpful?

No. If the pelvic floor is already excessively tight, the treatment may need to emphasize relaxation and down-training rather than strengthening.

Is there one proven medicine for PGAD?

No. Current pharmacological evidence remains weak, and no universally accepted drug treatment exists.

Can PGAD cause infertility?

PGAD is not itself a direct established biological cause of infertility, but it may affect intercourse and sexual relationships, and associated conditions may independently influence fertility.

Can Unani medicine treat PGAD?



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Unani medicine can contribute an individualized supportive framework involving **Izala-i-Sabab, diet, lifestyle, sleep, stress management and appropriately selected pharmacotherapy**, but direct high-quality clinical evidence for a specific Unani cure for PGAD is currently lacking. A neurological, pelvic or medication-related cause should not be missed or left untreated.

A Message to My Patients

When a patient tells me:

“Doctor, I feel embarrassed even explaining these symptoms,”

I want the first message to be clear:

There is no reason for a healthcare professional to judge you for having an involuntary sensory symptom.

When another patient says:

“Everyone assumes I must want sex because my genital area constantly feels aroused,”

I explain that **physical sensation and sexual desire are not the same thing.**

And when a patient tells me:

“The reports from my genital examination are normal, but the feeling will not stop,”

I remember that the source of the sensory signal may be outside the genitals—in the pelvic floor, pudendal nerve, sacral nerve roots, spinal pathways or central nervous system.

This is exactly why PGAD requires careful clinical reasoning.

My goal is not simply to suppress a symptom temporarily.

The goal is to understand the possible source, reduce the distress, restore day-to-day function, protect sexual and relationship health and refer for specialist treatment whenever the findings require it.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility



Professional Education & Training

BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Saira Health Care's current published professional profile lists these qualifications and training and describes Dr. Nizamuddin Qasmi's clinical focus in sexual disorders and infertility.

At **Saira Health Care**, the approach to sexual-health disorders emphasizes confidential assessment, patient education, differentiation of neurological, physical, psychological and relationship factors, responsible integration of Unani principles and timely referral to appropriate specialists when required.

Conclusion

Persistent Genital Arousal Disorder/Genito-Pelvic Dysesthesia is a real, complex sensory disorder—not simply excessive sexual desire.

Current international understanding has changed substantially.

The latest **2026 International Consultation on Sexual Medicine** recommends viewing PGAD/GPD as a condition capable of arising from five interconnected levels: the genital end organ, pelvis/perineum, cauda equina and sacral nerve roots, spinal cord, and brain. It also recognizes the condition in people of all genders.

This model explains why treatment is not one-size-fits-all.

One patient may primarily need pelvic-floor rehabilitation.

Another may need medication review.

Another may require neurological investigation for sacral radiculopathy.

Another may need treatment of pudendal neuropathy.

Some need psychological support for the enormous distress produced by the condition.

And many require several approaches simultaneously.



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Current research remains limited. A 2024 scoping review found that much of the treatment literature still consists of case reports, while a separate pharmacotherapy review concluded that evidence for medications remains weak.

From an **integrative Unani perspective**, the traditional principles of identifying causative factors, considering the whole person, regulating diet and lifestyle, and appropriately selecting supportive treatment can complement modern management. Official CCRUM guidance describes **Izala-i-Sabab, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and Ilaj-bil-Dawa** among the established conceptual components of Unani treatment.

However, there is currently no strong clinical evidence showing that a specific Unani medicine alone can cure PGAD/GPD. Responsible treatment should therefore integrate appropriate Unani supportive principles **without delaying pelvic-floor, neurological, gynecological, psychological or spinal evaluation when these are indicated**.

At **Saira Health Care**, I believe the most valuable first step is often helping the patient understand:

The sensation is involuntary. It is not a reflection of character, desire or morality. And because different biological mechanisms can produce the same symptom, careful diagnosis is the foundation of appropriate treatment.

For more information:

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Book an appointment:

<https://www.sairahealthcare.com/Appointment.aspx>

Saira Health Care Pharmacy:

<https://pharmacy.sairahealthcare.com/>

Medical Disclaimer: This article is intended for general medical education and patient awareness. It does not replace an individualized sexual-health, gynecological, neurological or mental-health evaluation. PGAD/GPD may arise from several different mechanisms, and treatment that is appropriate for one person may be ineffective or harmful for another. Prescription medicines—particularly antidepressants—should not be started, stopped or changed without the prescribing clinician. Unani medicines and herbal products should also be selected under qualified supervision and reviewed for interactions with existing medicines.



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