# Interventional Management of Refractory Pelvic Pain with Persistent Genital Arousal Disorder

**Sharon M. Mathew, BA, MS-4[1] · Tanvee Singh, MD, MPH[2]**

1UQ Ochsner Clinical School, New Orleans, Louisiana, USA 2Department of Anesthesiology, Columbia University Irving Medical Center, New York, NY, USA

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## INTRODUCTION

**Persistent genital arousal disorder (PGAD) is**
**A RARE, DEBILITATING CONDITION OF GENITAL AROUSAL INDEPENDENT OF STIMULATION.**

Emerging evidence frames it as a pain disorder involving autonomic dysregulation and central sensitization rather than a psychosexual condition. Pudendal neuropathy is implicated, but sympathetic pain in PGAD is understudied and evidence-based algorithms are lacking.

### LEARNING OBJECTIVES

1. Recognize PGAD as a pain disorder with somatic and sympathetic components.
1. Use pain phenotyping and distribution to consider sequential pudendal and/or ganglion impar blockade.

## CASE PRESENTATION

| | |
|---|---|
| **67 y** G4P2 woman | **35 y** history of PGAD |
| **18 mo** exacerbation | **<15 min** sitting tolerance |

**Persistent genital arousal with clitoral and perineal pain, impairing daily function, travel, intimacy and clothing tolerance.**

**Prior treatments**

| | |
|---|---|
| Multimodal pharmacotherapy | No meaningful relief |
| Prolonged bed rest | No meaningful relief |
| Pelvic floor physical therapy | No meaningful relief |
| Acupuncture | No meaningful relief |
| Biofeedback | Worsened symptoms |

*No patient identifiers are included.*
*The case was exempt from IRB review, and the patient provided written informed consent for publication and dissemination.*

## SEQUENTIAL BLOCKADE

**PHENOTYPE**
**Persistent arousal, clitoral–perineal pain and severe sitting intolerance → pudendal involvement**

**BLOCK 1 · BILATERAL PUDENDAL NERVE**
Fluoro-guided; 2 mL 0.25% bupivacaine + 5 mg dexamethasone

**RESPONSE**
**~50% improvement in pain and function × 4 weeks**

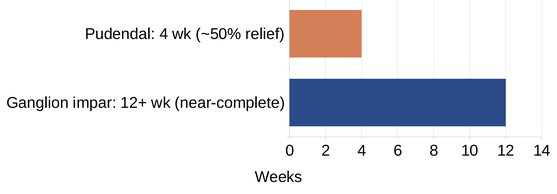
**PHENOTYPE**
**Recurrence with persistent midline perineal pain → nociplastic → sympathetically maintained component**

**BLOCK 2 · GANGLION IMPAR**
Fluoro-guided; 2.5 mL 0.25% bupivacaine + 5 mg dexamethasone

**RESPONSE**
**Pain resolution, relief of persistent arousal, restored sitting tolerance and function; negligible pain at 12 weeks**

***"The patient described this as the first sustained relief in more than three decades."***

**Duration of relief after each block**




## NEURAL TARGETS

| | Pudendal nerve | Ganglion impar |
|---|---|---|
| Fiber type | Somatic (sensory and motor) | Sympathetic + visceral |
| Location | S2–S4 roots; passes through the pudendal (Alcock's) canal | Terminal fusion of paired sympathetic chains, anterior to sacrococcygeal junction |
| Territory | Clitoris, perineum, labia, anal sphincter | Distal perineum, vulva, distal rectum, anus, distal urethra |
| Suggestive phenotype | Clitoral–perineal pain worse with sitting | Midline, poorly localized pain |
| Response in this case | ~50%, lasting 4 weeks | Near-complete, sustained at 12 weeks |

## PGAD: REGIONS OF ORIGIN

***ISSWSH consensus framework[3]***

1. **End organ** Genital and clitoral tissues
2. **Pelvis and perineum nerves** **TARGETED HERE**
3. **Cauda equina** Sacral nerve roots
4. **Spinal cord** Spinal pathways
5. **Brain** Central processing

## ? WHEN TO CONSIDER EACH BLOCK

Clitoral–perineal pain with sitting intolerance → **Pudendal nerve block**

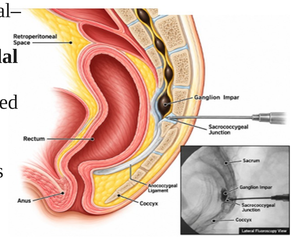
Partial or short-lived relief with residual midline pain; nociplastic pain → **Ganglion impar block**

## DISCUSSION

**Reframing PGAD.** The ISSWSH consensus classifies PGAD/genito-pelvic dysesthesia by region of origin, from end organ and pelvic nerves to spinal cord and brain.[3]

**Delayed care.** Stigma drives non-disclosure and years of delay; this patient lived with the diagnosis for 35 years.

**Somatic and Sympathetic component.** Clitoral–perineal pain and sitting intolerance suggested pudendal involvement. **Pudendal blockade is reported in PGAD[5]** Residual neuropathic midline pain suggested sympathetically maintained pain. The ganglion of impar carries sympathetic and visceral afferents from distal pelvis, and its blockade gave sustained near complete relief.




## CLINICAL PEARLS

- **Map pain phenotype and distribution before choosing a target**
- **Re-phenotype after partial or short-lived relief**
- **PGAD is a chronic pain conversation with interventional relief, not just a psychosexual one**

## CONCLUSION

PGAD is a rare debilitating, often overlooked condition associated with perineal pain. There may be a sympathetic component to PGAD. Addressing this with sympathetic blocks using ganglion impar blockade may mitigate pain and PGAD related distress.

### REFERENCES

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