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Hypersexuality as a Presenting Feature in Patient of Multiple Sclerosis

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ABSTRACT
Hyper sexuality or the current Compulsive Sexual Behaviour Disorder according to ICD 11 involves a pattern of recurrent, intense, and excessive preoccupation with sexual fantasies, urges and behavior that individuals struggle to control. It has been noted in literature to be associated with several focal brain lesions, though hyper sexuality in Multiple Sclerosis is considered to be rare. We present a case of a young female who presented to us with hyper sexuality as a presenting complaint and was later was suspected to have multiple sclerosis with positive MRI and CSF findings. Though a multitude of psycho tropics were given to curb the hyper sexuality, the prognosis was guarded.

INTRODUCTION

Hypersexuality is a pattern of recurrent, intense and excessive preoccupation with sexual fantasies, urges and behavior that individuals struggle to control[1]. Hyper sexuality has been noted in literature to be associated with several focal brain lesions, especially those that involve loss of integrity of the frontal lobes and diencephalic structures[2]. Neuropsychiatric manifestations are reported in 60% of those with multiple sclerosis[3]. But reports of hyper sexuality in multiple sclerosis are rare[4]. A systematic review done in 2024 to investigate hyper sexuality in neurological disorders did not include MS as a cause for hyper sexuality as the authors were unable to find studies to conclusively show the causal relationship, rather noted that sexual dysfunction is rampant in patients with multiple sclerosis ranging from 50-73% in men and 45-70% in women[5,6]. We present a case of a young female who presented to us with hyper sexuality as a presenting complaint and was later was suspected to have multiple sclerosis with positive MRI and CSF findings.

MATERIALS AND METHODS

Case: A 20yr old female educated up to 12th std, working as a multi-purpose worker in a primary school, unmarried came to the psychiatric department with complaints of increased sexual desire which had intensified since past six months. She would act upon her sexual urges and would run away from her home. She would approach strangers for sexual intercourse and after repeated sexual acts she would feel relieved. She would also approach strangers on social media with sexual demands. Before this, she had been sexually active just once before. She would masturbate but her sexual urges would relieve only on performing sexual acts. She felt guilty of cheating on her boyfriend but was unable to control these urges and felt depressed regarding the same. It further escalated to her feeling suicidal. This was associated with urinary incontinence for 2 months. She also had amenorrhea though was not pregnant. She had an episode of hemiparesis 2 years back which resulted in an unsteady gait and she was prone to falling. Premorbidly, she had been impulsive, stubborn and threatening at times, having a suicide attempt by overdosing 2 years back when her demands were not met. Ward stay also showed patient to be manipulative and attention seeking. Her developmental history showed birth asphyxia and delayed developmental milestones. General physical examination showed hirsutism and patient being overweight. She also had squint in both her eyes since birth. Systemic examination showed patient having a wide gait, increased tone in right lower limb, impaired tandem walking. Mental status examination finding were of depressed affect, suicidal ideas secondary to increased sexual urges. On formal assessment intelligence quotient, she was found to have borderline intelligence. (IQ: 82).

On investigations her serum TSH was greater than 100mIU/ml and patient was started on 100ug of thyroxine for the same. Patient was started on Fluoxetine 20mg for her depressive ideas and was build up to 40mg per day. Tab Lithium 600mg per day was also started in view of suicidal ideas. Tab Aripiprazole up to 20mg per day was prescribed. Tab Thyroxine 100 was started and continued. She was diagnosed with having an overactive bladder and urinary incontinence improved on treatment with mirabegron. She was also diagnosed with pelvic inflammatory disease and improved after antibiotic treatment. She was also diagnosed with Polycystic Ovarian Syndrome and treated with low dose OCP (Cyproterone acetate and ethinyl estradiol tablets). Noting the neurological findings on examination magnetic resonance imaging was done which showed finger like ill-defined T2/FLAIR hyperintensities in pericallosal region, bilateral centrum semiovale, periventricular white matter, in white matter of bilateral frontal, left parietal and occipital lobes showing enhancement on post contrast images which was suggestive of multiple sclerosis. CSF examination was done which showed oligoclonal bands (>10). Neurology opinion was taken after MRI and CSF findings and possibility of Multiple Sclerosis was kept but as the lesions did not seem active so no treatment for MS was done. After treatment with Fluoxetine and Aripiprazole, there was improvement in her mood symptoms. Environmental control helped but the hyper sexuality was fluctuant. Behavioral therapy was started. Family members were also counseled regarding environmental control. During the follow up period of one year, patient had two admissions with complaints of running away from home to establish sexual contact. She also got married but her increased sexual desire and running away from home resulted in marital discord. Lithium had to be stopped due to her having tremors and difficulty in maintaining normal TSH levels. Multiple sclerosis treatment was not initiated as repeat MRI and CSF findings showed no change. On Sexual Compulsivity scale, she scored 32 which implied problems with sexual addiction and thus patient was diagnosed with Compulsive Sexual Behavior Disorder. Trifluoperazine 10 mg was tried but had no response. Fluoxetine was shifted to Fluvoxamine in view of inadequate response and increasedupto 200mg, Topiramate 75mg along with Naltrexone 50mg was given after which patient showed mild improvement in hypersexuality which would increase in periods of stress.

RESULTS AND DISCUSSION

This patient presented with period of heightened sexual desire of an intensity to cause significant distress. Hyper sexuality in multiple sclerosis is more

likely to be transient manifestations of a strategically located plaque which could interrupt pathways that inhibit sexual behavior or cause hyper excitability in pathways favoring sexual activity, for instance in the frontal lobes, where lesions were detected by MRI in our patient also. Another case report showed a male patient of multiple sclerosis who developed profound and abrupt disinhibition and paraphilic behavior during an exacerbation with neuro imaging findings of a marked increase in the number of enhancing lesions in the right sides of the hypothalamus and mesencephalon and extending into the right sides of the red nucleus, substantia nigra and internal capsule[7]. Areport was of a woman with neuropathologically confirmed MS whose aberrant behavior included exhibitionism, incest, scopophilia and zoophilia with extensive lesions involving basal frontal, perithalamic, septal, hypothalamic and temporal regions[8]. Neuropsychiatric signs and symptoms occur frequently in individuals with MS, either as the initial presenting complaint prior to a definitive neurological diagnosis or more commonly with disease progression. Hyper sexuality as a presenting complaint was noted in one case report which cited a male with fetishism and hyper sexuality as chief complaints at the time of presentation[7]. Hypersexual behavior although rare in Multiple Sclerosis but still can be a presenting complaint in some of the patients. All case reports reported in literature regarding presence of hyper sexuality in multiple sclerosis show a poor response to treatment in controlling Behaviour of hyper sexuality.

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- **Consent to Participate:** Written consent taken from patient.
- **Written Consent for Publication:** Consent has been taken from the institute and all authors for publication
- **Availability of Data and Material:** Data can be made available on request.

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