Hypersexuality and SSRI use: Presentation of 2 cases

Monica Pevida[1], Alberto Dominguez-Bali[1] , Sarah Mourtada[2] , Yanicka Shepherd[2]

Abstract

Fluoxetine, sertraline, and paroxetine have been associated with the production of hypersexuality. These antidepressants belong to the selective serotonin reuptake inhibitors(SSRI). Sexual dysfunction related with the use of these kinds of medications have been found between 30-80% of these patients, producing decrease of the sexual function, however very few reports have been published regarding hypersexuality and the use of SSRIS. We present two cases of hypersexuality in perimenopausal women that were diagnosed, evaluated, and prescribed treatment for what seems to be a recently described sexual dysfunction caused by the specific combination of bupropion with sertraline or fluoxetine for psychiatric conditions.

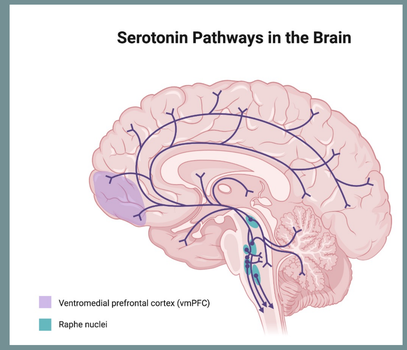
Aim & Methodology

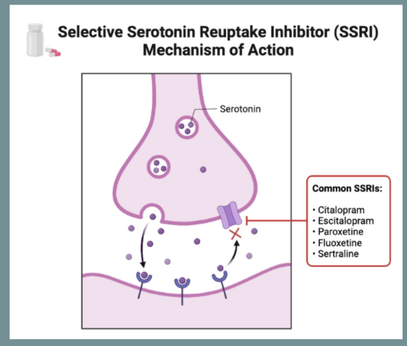
To present two cases of hypersexuality with the use of SSRIs that we have diagnosed, evaluated and treated in our center with good control of their sexual dysfunction

Two patients came to our office knowing we provide sex therapy. Both patients were managed by discontinuing the SSRI and preceding with use of bupropion. In the first case, the hypersexuality behavior decreased frankly between 2 to 4 weeks. The patient remained with increased sexual drive for more than a month afterwards. However, under the management of her psychiatrist and the sexual therapy, the problem resolved after 10 weeks. In the second case, the response was faster. In four weeks, the patient had recuperated and her sexual activity went to normal limits. In both cases, couple therapy and sex therapy improved the relationship and controlled the depression

Results

In these two cases, the treatment given, being equal to those described in the medical literature that has been scantly published until now, was effective. Discontinuing the SSRI that was initially installed and adding sexual therapy to the existing psychiatric therapy achieved the desired therapeutic goal.





Conclusion

Despite the favorable effect of bupropion on sexual functioning, no sexual stimulation has been described when we use bupropion monotherapy. Hypersexuality in these two patients could be the result of the addition of sertraline or fluoxetine as an independent side effect of each one of these medications or could be the synergistic action of these SSRIs plus bupropion.

The mechanism of SSRIs in the sexual dysfunction is not clear, but serotonin receptors 5HT2 and 5HT3, neurotransmitters such as dopamine, and prolactin has been involved. Curiously SSRIS including fluoxetine and paroxetine have been involved in the appearance of hypersexuality. A dose-dependent hypersexuality has been described with fluoxetine, present with high doses and disappearing with low doses or suspension of the medication.

Sertraline is not only a serotoninergic agent, but also acts on norepinephrine and dopamine receptors. Sertraline and fluoxetine increase extracellular levels of dopamine in the the nucleus accumbens and stratum in rats. This could explain the hypersexuality as an independent dose dependent side effect of the SSRIs, especially when SSRI is combined with bupropion.