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Case Report

Self-Medication of Paraphilic Ideation Contributing to a Pulmonary Embolism: A Case Report

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Introduction

Sexual practices are often an important focus in psychiatric evaluations, and clinicians should be aware of unusual practices that can have adverse medical and/or psychiatric consequences. When patients encounter providers' lacking awareness or exhibiting discomfort discussing such, they may not disclose clinically important information.[1]

Sexuality is a central aspect of being a human, encompassing biologic sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction.[2] Paraphilias are sexual behaviors that deviate significantly from mainstream norms. They become diagnosable disorders when they cause significant distress or impairment to the individual or entail personal harm, or risk of harm, to others.

Initially understood as a component of personality disorders in Diagnostic and Statistical Manual of Mental Disorders II, paraphilic disorders have come to occupy an entirely separate classification in psychiatric literature.[3] Paraphilias are currently defined as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" in Diagnostic and Statistical Manual of Mental Disorders-5.[4] The term autogynephilia was first introduced by Blanchard in 1989, described as a man experiencing paraphilic arousal from the fantasy of being a woman.[5] There are many ways in which autogynephilia may manifest, including wearing female clothing, adopting female physical features, engaging in typically female behaviors socially, and being admired as a woman by another person.[6,7] Autogynephilia is not identical to transvestitism or gender dysphoria; the actual prevalence is 32–46%.[7]

In a disorder that causes significant distress but proves difficult to discuss with medical professionals, it is likely that some affected individuals will seek out alternative treatments to alleviate their symptoms. Here, we describe a patient who obtained medications online without prescription, specifically estrogen supplementation, to alleviate the effects of paraphilic preoccupations. In doing so for a prolonged period, he predisposed himself to a hypercoagulable state that resulted in a pulmonary embolism during psychiatric hospitalization.

Case Presentation

The patient was a 39-year-old man without formal medical or psychiatric history who presented to the emergency department with a chief complaint of auditory and tactile hallucinations. He described the auditory hallucinations as whispers, potentially from demons, that were communicating to him through the walls of his apartment. At times, he noted that they took on more recognizable tones, indicating that 2 of the voices were women who were often critical of him, though he denied the voices were of people he knew. The tactile hallucinations were described as the feeling of cords or whips

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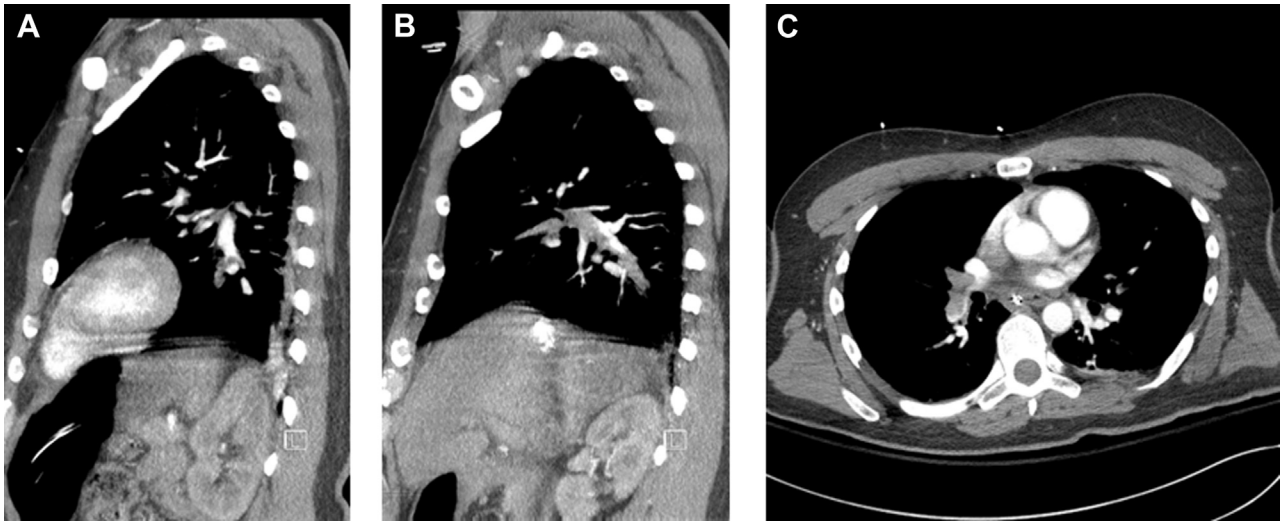
FIGURE 1. **Helical computed tomography imaging obtained demonstrating multiple thrombotic events in pulmonary arteries. Sagittal image A reveals L segmental arterial clotting, while sagittal image B and axial image C reveal extensive occlusion of the distal R main pulmonary artery as well as segmental branches.**



choking him or tightening around his chest or genitalia. He also worried about being spied on in his home. He expressed significant distrust of the medical system without demonstrable reasoning. He reported suffering from depression for more than 20 years, attributing this to having grown up in an abusive household. He denied any significant substance misuse, and this was consistent with laboratory findings at the time of presentation.

He was voluntarily admitted to address his paranoia and hallucinations. On medication reconciliation, he revealed that he had been taking estradiol 2 mg daily and dutasteride 0.5mg daily that he purchased from overseas markets online, purportedly taking these for approximately 12 years without interruption or physician management, to curb a "pornography addiction." The dosages were what he had read about online as being efficacious in suppressing testosterone effects in men. These medications were not continued while he was admitted.

After admission to the inpatient psychiatry service, risperidone 0.5 mg twice daily was started for his reported hallucinations, paranoia, and perseverative thought patterns. His mood on the unit was generally depressed, and he largely remained reclusive in his room, with few interactions with other patients.

Five days after his initial presentation, during which he had been noted to ambulate frequently throughout the unit, he was walking on the unit after midnight complaining of insomnia. He also reported some mild peripheral stiffness that was attributed to extrapyramidal effects from the risperidone. Staff attempted to assist him back to bed when he collapsed to the floor, being diaphoretic and appearing hypoxic. Initial vitals were blood pressure 74/55, pulse oxidation 84% on room air, heart rate 143, and rapidly worsening. A code blue was initiated, and he was intubated in situ before transferring to the intensive care unit. Computed tomography scan (Figure 1) demonstrated pulmonary emboli obstructing his distal right main pulmonary artery as well as segmental arteries of the left upper and lower lobe in addition to prominent right heart strain. He subsequently underwent catheterization and received thrombolytics to encourage clot dissolution. His intensive care unit course was relatively uncomplicated, and he was successfully extubated without issue.

In subsequent psychiatric consultative visits on the medicine service, he disclosed that he was a self-diagnosed autogynephiliac and that for 15 years, he had been engrossed with the erotic fantasy of being a woman in a sexual relationship. He maintained an identity as a heterosexual male and reported having relationships with women. However, he stated that he never had the desire for sexual intercourse with any of his partners even before his use of estradiol and dutasteride. He struggled with urges to watch and use what he described as "transsexual pornography" during the early years of this, often engaging in masturbation up to 5 to 7

times daily, until he perceived it to be interfering with his ability to function. Approximately 12 years before presentation, consulting online sources, he determined that the best method to curb his desires was to self-medicate with dutasteride, to counteract his testosterone, and estradiol, to decrease libido and suppress sexual function. He was able to procure these medications from overseas online markets without a prescription. He denied any prior adverse effects from them and felt that they had been working for his intended purposes.

He was ultimately discharged in stable condition with risperidone 1 mg at bedtime and referrals for psychiatric and psychotherapeutic treatments. On the day of discharge, he reported his auditory and tactile hallucinations had decreased, and he felt no residual stiffness or rigidity. The diagnosis made was of an unspecified psychotic disorder; however, there were notable elements present of cluster A traits. There was no mention in his discharge paperwork of his paraphilic ideation. He was counseled extensively on the risks of purchasing medications online without physician guidance and the risks should he use estradiol in the future. Unfortunately, he was lost to follow-up after the hospitalization.

Discussion

The behavior of him described—taking matters into his own hands to clandestinely treat distressing symptoms without the guidance of a medical professional—likely occurs unrecognized in patients with paraphilic disorders who fear being stigmatized. There is an important distinction worth noting that he, and not a clinician, diagnosed himself with autogynephilia and researched a potential "treatment." The term autogynephilia, in recent literature, has been described as archaic and discriminatory against male-to-female transsexuals, making it unlikely to have been applied by a mental health professional.[8,9] Significant to him, when his paraphilic ideation was disclosed, no formal diagnosis was made at that time, and efforts were made to normalize his desires. His referrals for psychotherapy and psychiatric follow-up were efforts to better elucidate any true psychiatric symptoms and further his ability to cope with the thoughts and behaviors distressing him.

When patients do seek medication assistance for paraphilias, the literature best supports a combination of cognitive behavioral therapy and medication as leading to the greatest rates of remission.[10] Psychotherapy supporting patient self-acceptance may also be beneficial depending on the paraphilic disorder. First-line medication options for nonviolent patients include selective serotonin reuptake inhibitors to help decrease libido and sexual arousal. In patients who are sexual offenders or violent, treatment may include both serotonergic and antiandrogenic drugs. Progesterone compounds are recommended before use of estrogens or luteinizing hormone–releasing hormone agonists. The most used include cyproterone acetate as an oral preparation and medroxyprogesterone acetate as an intramuscular injection.[10]

Estrogens are considered second- or third-line treatments owing to the risk of thrombogenesis. In a study looking at hormone replacement therapy with either ethinylestradiol in women or diethylstilbestrol in men with prostate cancer, 30% of the women and 47% of the men were found to produce immunoreactive antibodies in a radioimmunoassay.[11] For participants who did have a thromboembolic event, even greater percentages were found to have antibodies (90% in women and 74% in men).

Luteinizing hormone–releasing hormone agonists are also typically reserved for violent offenders with paraphilias, as they reduce testosterone levels to lower than castration values.[10] However, medications such as leuprolide are highly effective at reducing patients' sexual arousal and fantasies. MRI studies have shown that patients on luteinizing hormone–releasing hormone agonists display decreased activation in brain areas that are associated with the emotional appraisal of sexual stimuli, including the amygdala, insula, cingulate cortex, and hypothalamus.[12]

Another important component of this case is the ease with which patients can access various medications and compounds from unregulated sources. Unlike medications from legitimate pharmacies, those bought over the Internet can have nearly untraceable supply chains, making it extremely difficult to provide effective oversight to ensure product quality.[13] In addition, online "rogue" pharmacies often provide little-to-no protection against sales to younger people, as many of these sites do not require prescriptions or identifying medical information.[14,15] Fittler et al[16] monitored 136 Internet pharmacies for 4 years and found that only 9 (6.6%) requested prior medical prescriptions before purchase of medications and 38.2% did not require any medical information from patients. Moreover, when they examined the actual medications, they noted that 92.6% of product information was displayed

inadequately and 76.5% of the patient information leaflets were incomplete, leaving their purchasers at significant risk of adverse effects.

Not only was he distrusting of seeking help from a medical professional for his paraphilia but he also put his health at risk by buying unregulated medicines from overseas pharmacies that did not ask for his medical history, provide proper information about medication risks, or meet proper regulatory standards. The combination led to a catastrophic outcome that, had he not already been hospitalized, would have likely been fatal.

Conclusions

While many patients with paraphilic preferences find suitable outlets to satisfy their attraction, some are truly distressed by their thoughts and behaviors and will seek out methods of alleviation such as medications or psychotherapy. Our case calls attention to a potential danger of patient self-procurement of medications to suppress male sexuality specifically in the setting of a self-diagnosed paraphilic disorder. Fortunately, he was hospitalized at the time he spontaneously developed pulmonary emboli. This case highlights the importance of detailed histories, including sexual histories. Furthermore, when uncommon findings are present, subsequent clinical follow-up and questioning are merited in addition to, when appropriate, efforts being made to destigmatize behaviors and thoughts.

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