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CASE REPORTS

Sleep-Related Abnormal Sexual Behaviors (Sexsomnia) Successfully Treated With a Mandibular Advancement Device: A Case Report

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Sleep-related abnormal sexual behaviors (sexsomnia) are classified as a subtype of non-rapid eye movement sleep parasomnias. There are reported cases of control of sexsomnia with treatment of obstructive sleep apnea (OSA) with continuous positive airway pressure. We present a case of sexsomnia controlled with the treatment of OSA with a mandibular advancement device.

Keywords: mandibular advancement device, parasomnia, sexsomnia

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INTRODUCTION

Sleep-related abnormal sexual behaviors (sexsomnia) are classified as a subtype of non-rapid eye movement (NREM) sleep parasomnias in the International Classification of Sleep Disorders, Third Edition.[1] These sexual behaviors usually present late in the course of a long-standing history of parasomnia, and can also be associated with other sleep disorders such as restless legs syndrome and obstructive sleep apnea (OSA), which can promote arousals from NREM sleep with partial awakening and automatic behavior.[2] There are reported cases of control of sexsomnia with treatment of OSA with continuous positive airway pressure (CPAP).[3,4] We present a case of sexsomnia that was fully controlled with the treatment of OSA with a mandibular advancement device (MAD).

REPORT OF CASE

A 37-year-old male presented with complaints of loud snoring at night for 13 years. His wife reported witnessed apneas. Epworth Sleepiness Scale score was 12 of 24. Examination revealed body mass index 26 kg/m^2, neck girth 16.5 inches, and Mallampati class I designation.

During the first clinic visit, his wife shared that they had had sexual relations during sleep on a nightly basis for many years, though the patient had no recollection of this, even though he had invariably initiated the sexual activity. This appeared to surprise him and he recalled her telling him of this many times, when he would dismiss it in disbelief.

Video polysomnography (vPSG) showed moderately severe sleep apnea with an apnea-hypopnea index (AHI) of 15 events/h and oxygen saturation nadir of 91%. CPAP at 6 cm H_2O pressure was effective in treating OSA. Subsequently, the patient opted for a MAD as an alternative therapy. After 5 months of nightly MAD, he began experiencing pain in his jaw and wanted to switch to CPAP.

The patient had come to realize that he was actually having nocturnal sex outside of awareness for 13 years, when he would protest to his wife about lack of sex in their relationship, and she would dismiss it, saying "you don't remember it." She explained to him that they would have sex in the middle of the night once or twice a week, but within a 6-month period, this frequency began increasing to every night. His snoring was first noted around the time when these episodes began.

He would typically initiate sex between midnight and 2:00 AM after they had fallen asleep by 9:00 PM. Per his wife, the sex during these episodes was "wild," but never violent. He would perform oral sex, though never when sexually active while awake, in spite of his wife's request. After washing himself, he would return to bed and resume sleep, and have no recall of the sexual event. When he would request sex during wakefulness, his wife would refuse, citing their sexual activity the night before. He assumed that she was "making an excuse."

Once he realized that he was sexually active with her without recall, he expressed embarrassment. He then understood her reluctance and was remorseful about his concern that she may have been unfaithful.

The patient's medical history included sleepwalking between the ages of 6 and 13 years. There was no history of psychiatric illness/substance abuse. Medication included only calcium 500 mg q.d. Physical examination was unremarkable.

We hypothesized that arousals related to OSA were the triggers for his sexsomnia, though there was no NREM parasomnia recorded during the vPSG. The patient began use of the MAD after his sleep study, and the sexsomnia ceased immediately. After the occurrence of jaw pain 5 months later, he reverted to nasal CPAP therapy, 6 cm H_2O pressure, and the sexsomnia remained absent over 6 months of follow-up care.

DISCUSSION

This patient demonstrated sexsomnia for 13 years before it was revealed as a problem. It appears to represent a NREM sleep parasomnia, precipitated by OSA, and relieved by CPAP or a MAD. This adds oral appliance therapy to the literature documenting effectiveness of CPAP in such cases of sexsomnia.

In this case, sexsomnia was not the presenting complaint, but an incidental finding that emerged during a clinic visit. This underscores the need to query patients, and their bed partners, about comorbid parasomnias when evaluating OSA. Before the issue was raised, clarified, and treated, there were serious psychosocial ramifications because the patient was dissatisfied with his marital sexual relationship and became doubtful of his wife's fidelity.

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