Masturbation: Can it be urticarogenic?

Sir,

Physical urticaria is a known disturbing and challenging entity for both the patient and the clinician. Physical urticaria is a subgroup of chronic urticaria in which wheals can be repeatedly induced by different physical stimuli. We report here an unusual precipitating factor-masturbation, as a cause for physical urticaria.

A 30 year-old, married male reported to the OPD of the Department of Skin and VD with a history of recurrent itching, redness and swelling on the penis 1-5 minutes after masturbation for the last three months. These lesions persisted for 4-6 hours after which they gradually disappeared of their own accord within 24 hours. These symptoms did not, however, occur after vaginal intercourse with his wife, with or without condoms, in the three years of his married life. He was not using any cream or oil on his penis or his hand. There was no history of any other manipulations such as oral or anal sex, application of local physical stimulants or chemical irritants during masturbation. However, finding masturbation to be more satisfying than normal vaginal intercourse, the patient continued to masturbate only to develop these complaints. There was no history of generalized urticaria, dermographism, pins and needles sensation or any other systemic complaints. The patient did not give any history of frictional or pressure urticaria such as after scrubbing with a towel, or any lesions over other pressure sites. The patient was a vegetarian, non-smoker and teetotaler. Examination did not reveal any evidence of dermographism all over the body or the penis after scratching. The patient did not take any medications for these symptoms before coming to us.

Routine investigations-hemogram, total eosinophil count, vacuolated eosinophil count, urine and stool microscopy, liver function test and chest radiograph were normal. The patient was prescribed oral hydroxyzine 10 mg TDS and prednisolone 20 mg OD for five days. The patient got some relief from his symptoms within 2-3 hours of treatment and did not develop urticaria even after masturbation. The patient was asymptomatic until seven days after stopping the treatment but it recurred thereafter so he was advised not to masturbate.

In our view, the urticaria probably arises due to unusual and unnatural friction and pressure during masturbation as compared to natural vaginal intercourse. The case in consideration did not have any history of any other type of physical urticaria; physical examination and other investigations did not reveal any abnormality to be the cause for these symptoms.

In their studies, Yadav et al. and Pasricha describe pressure as an important etiological factor leading to urticaria but masturbation has not been listed among the causes of physical pressure urticaria. This unusual cause prompted us to publish this case of uticarial rash appearing after
masturbation over the penis.

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**REFERENCES**


**Sir,**

Cysticercosis is the most common parasitic infestation of the central nervous system, muscle and subcutaneous tissue,[1] caused by tissue-invading larval forms of the pork tapeworm, *Taenia solium.*[2] The ova of the pork tapeworm are spread via the fecal-oral route. The ingested ova develop into larvae (cysticerci) and lodge in soft tissues, especially the skin, muscle, and the brain. Cysticerci are fluid-filled oval cysts, approximately 1–2 cm in diameter, with an internal scolex. The eggs are found in human feces because humans are the only definitive hosts. The most commonly affected age group is that of 5–9 years and there is no gender predilection. Central nervous system involvement is seen in 60–90% of patients with cysticercosis while 50–70% have epilepsy. However, association of neural and subcutaneous cysticercosis is not common.

A five year-old female child presented with low-grade fever since the past five months and multiple swellings all over the body since two months. She also had pica since two months. There were no other complaints. There was no history of known contact with tuberculosis patients, or of measles or whooping cough in the past.

On examination, the patient was found to be febrile (100°F) and pale. Multiple rounded, firm, non-tender subcutaneous nodules of varying size (0.5–1 cm) were present on the scalp, back, abdomen and limbs [Figure 1]. Two submucosal nodules were present on the left buccal mucosa. Systemic examination was within normal limits; fundus was normal.

In the Pediatric ward, the patient was given oral antimalarials and antipyretics for fever. On the 4th day, she developed three episodes of seizures—the first episode was an unprovoked, left-sided seizure lasting for two minutes. She developed two more episodes of generalized, tonic-clonic seizure after 30 minutes. Parenteral phenytoin was started and maintained; there was no postictal neurological deficit.

Her hemogram was unremarkable except for a raised absolute eosinophil count (405/mm³) and raised erythrocyte sedimentation rate (105 mm at one hour). The Mantoux test was negative and the antistreptolysin titre, C-reactive protein, antinuclear antibody and rheumatoid factor were all insignificant or absent. Serum cholesterol levels, renal and liver function tests were all normal. Urine and stool examinations were normal and a perianal swab revealed no...