

Shilajit-associated orgasmic thunderclap headache: A probable case of reversible cerebral vasoconstriction syndrome managed with nerve blocks

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ABSTRACT

A 46-year-old man with no prior history of headache presented with explosive orgasmic headaches that began six days after initiating the Ayurvedic supplement Shilajit. The headaches were of sudden onset and maximal intensity (10/10), interrupted ejaculation, and subsequently recurred with mild Valsalva-like exertion. Neuroimaging, including CT, CTA, and MRI, was negative for intracranial hemorrhage or evidence of cerebral vasoconstriction. Lumbar puncture findings excluded subarachnoid hemorrhage. Given the patient's low-normal blood pressure (110/70 mmHg), calcium channel blockers were not initiated.

He underwent a transnasal sphenopalatine ganglion block in combination with bilateral greater occipital, lesser occipital, and supraorbital nerve blocks. This resulted in immediate resolution of his headache, and he resumed sexual activity without recurrence of symptoms within 48 hours.

To our knowledge, this is the first reported case of a probable reversible cerebral vasoconstriction syndrome (RCVS)-like presentation associated with Shilajit use. Combined autonomic and sensory nerve blocks provided rapid and sustained headache relief when standard vasodilator therapy was contraindicated.

Keywords: Reversible cerebral vasoconstriction syndrome, thunderclap headache, Shilajit, nerve block, sphenopalatine ganglion, sexual activity

INTRODUCTION

Thunderclap headache triggered by sexual activity presents a diagnostic challenge, as it may represent either a primary headache associated with sexual activity (PHASA) or a manifestation of secondary causes such as reversible cerebral vasoconstriction syndrome (RCVS) or subarachnoid hemorrhage.^{1,2} RCVS is characterized by recurrent severe headaches and reversible multifocal cerebral vasoconstriction and is often associated with exposure to vasoactive substances.³ Although sphenopalatine

ganglion (SPG) and pericranial nerve blocks are established treatments for migraine, their role in the management of thunderclap headache triggered by sexual activity remains poorly described.⁴ We report the first known case of orgasmic thunderclap headache associated with Shilajit use and managed with regional nerve blocks.

CASE PRESENTATION

A 46-year-old man with obesity and no prior history of headaches presented with headaches triggered by sexual climax. Symptoms began six days after initiating daily Shilajit supplementation. The first episode occurred during sexual intercourse and was characterized by a sudden-onset, bilateral frontal headache that reached maximal intensity (10/10) at orgasm. He

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described the sensation as though his “head would burst,” causing him to stop sexual activity. He rolled off his partner and remained in a crouched position due to the severity of the pain. There were no associated focal neurologic deficits, nausea, or vomiting. The headache partially improved with ibuprofen but worsened the following day during mild exertion (while removing a lid from a food container), prompting presentation to the emergency department. A non-contrast head CT was unremarkable, and he was discharged.

A persistent mild baseline headache (3/10 intensity) subsequently developed. On day nine, a second episode of an identical orgasm-triggered headache occurred, again preventing ejaculation and prompting hospital admission. Repeat neuroimaging, including non-contrast head CT, CT angiography, and brain MRI, revealed no evidence of intracranial hemorrhage, aneurysm, vascular malformation, or vasoconstriction. Lumbar puncture revealed findings consistent with a traumatic tap, with the red blood cell count (RBC) decreasing from 112,738/ μ L in tube 1 to 244/ μ L in tube 3, effectively excluding subarachnoid hemorrhage.

Blood pressure remained in the low-normal range (approximately 110/70 mmHg), limiting the use of calcium channel blockers. Based on the explosive, climax-interrupting headaches, recurrence with mild exertion, and temporal association with initiation of Shilajit supplementation, a probable reversible cerebral vasoconstriction syndrome (RCVS)-like syndrome was diagnosed.

On day 10, the patient underwent a transnasal sphenopalatine ganglion (SPG) block in combination with bilateral greater occipital, lesser occipital, and supraorbital nerve blocks. His baseline headache resolved immediately following the procedure. Shilajit was discontinued. Within 48 hours, he resumed sexual activity without recurrence of thunderclap headache and was able to achieve normal orgasm. He remained asymptomatic at follow-up.

DISCUSSION

This case illustrates the diagnostic challenge of distinguishing primary from secondary orgasmic

headache.¹ The pain's thunderclap onset and occurrence at climax suggested an underlying vascular etiology rather than a benign primary headache disorder. Recurrence of symptoms with even mild Valsalva-related exertion further supported a diagnosis of reversible cerebral vasoconstriction syndrome (RCVS) over primary headache associated with sexual activity (PHASA).¹ Although initial neuroimaging was unremarkable, angiographic abnormalities in RCVS may be delayed in appearance or confined to distal vessels.³ Therefore, the clinical context—including the trigger, thunderclap presentation, and recurrence with exertion—remains essential for accurate diagnosis.

Shilajit, a nutraceutical containing fulvic acid and minerals, has been purported to increase testosterone levels and may enhance sympathetic activity. This case expands the growing list of nutraceuticals associated with reversible cerebral vasoconstriction syndrome (RCVS).³ Previously reported agents include Hydroxycut⁵ and eucalyptus vapor.⁶

First-line treatment for RCVS typically involves calcium channel blockade,³ but its use was precluded by the patient's low-normal blood pressure. The sphenopalatine ganglion (SPG) plays an important role in regulating cerebral vascular tone through parasympathetic pathways.⁴ Blockade of the SPG, along with pericranial nerve blocks, may stabilize neurovascular dysfunction. The rapid clinical improvement observed in this case suggests nerve blocks may represent a potential therapeutic alternative for hemodynamically sensitive patients; however, larger studies are needed.

CONCLUSION

Shilajit may represent a novel trigger for probable reversible cerebral vasoconstriction syndrome (RCVS) presenting as an orgasmic thunderclap headache. In our case, combined sphenopalatine ganglion (SPG) and pericranial nerve blocks provided effective symptom control when standard vasodilators were contraindicated because of low-normal blood pressure. Clinicians evaluating patients with thunderclap headache should specifically inquire about the use of

supplements and nutraceuticals as potential precipitating factors.

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