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Headache associated with sexual activity: analysis of gender differences and diagnostic barriers

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Introduction
Headache Associated with Sexual Activity (HASA) is a rare disorder occurring in approximately 0.37% of patients evaluated at tertiary headache centers. Unlike most primary headaches, which predominantly affect women, HASA demonstrates clear male predominance, with a male-to-female ratio ranging from 2.9:1 to 3:1. Recent studies show that men are diagnosed with HASA more frequently than women (1.54% vs. 0.61% in sex-specific analyses). However, it remains uncertain whether this difference reflects higher prevalence in men or underdiagnosis in women due to cultural, social, and physician–patient communication barriers. In Brazil, cultural aspects related to female sexuality may further amplify these barriers.

Objective
To analyze gender differences in the prevalence and diagnosis of Headache Associated with Sexual Activity, identify potential barriers to diagnosis in women, and discuss Brazilian cultural factors that may influence the reporting of this condition.

Methods
A narrative literature review was conducted using the PubMed/MEDLINE databases, focusing on epidemiological studies and case series published between 1988 and 2025. Demographic data, sex ratio, clinical characteristics, and factors potentially influencing differential diagnosis between men and women were analyzed. A critical analysis of possible reporting biases and cultural barriers specific to the Brazilian context was also performed.

Results
A recent meta-analysis involving 40,702 individuals demonstrated a prevalence of HASA of 0.37% in tertiary centers, with significant male predominance (ratio 2.9–3:1). Sex-specific analysis revealed that 1.54% of men versus 0.61% of women presented with HASA. However, an Asian study found a balanced proportion (50% women), suggesting the influence of regional cultural factors. The mean age of onset is similar between sexes (37–40 years), as are clinical characteristics, pain location, and comorbidities. Patients frequently report difficulty discussing the condition with physicians, often resulting in limitation of sexual activity due to embarrassment. Studies indicate that therapeutic counseling plays an essential role in management, in addition to pharmacological treatment. In the Brazilian context, cultural taboos related to female sexuality, lower perceived sexual autonomy among women, and possible gender bias in medical evaluation may contribute to underreporting in women.

Conclusion
The male predominance observed in HASA may reflect not only a true biological difference but also underdiagnosis in women resulting from cultural and communication barriers. Brazilian cultural aspects related to female sexuality may further intensify these barriers. Strategies to improve physician–patient communication, reduce stigma, and facilitate symptom reporting by women are essential for accurate diagnosis. Brazilian epidemiological studies are needed to characterize the true profile of this condition in the national population and to identify gender disparities in diagnosis.

Keywords:
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Sexual activity
Gender differences
Diagnostic barriers

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