3.2.2.3.2.21 Pergolide compared with other dopaminergics

Serge,

I have been on Pergolide now for about 10 days, and have had a chance to try it about 6 times before sex. The bottom line is that it works, and it works pretty well, as a pro-sexual drug for those with dopamine deficiency or dopamine receptor loss.

Here is my report:

Dose: I dose-escalated up to the point where I was taking 0.5 mg (two pills) 2 to 4 hours before sex, PRN, last week. Since I have been trying it almost every day, and since the half-life of pergolide is about 27 hours, this actually equates to about 1.0 mg of pergolide in the system at any given time. This is about 1/3rd the average dose level that is used for Parkinson's treatment of about 3 mg/day. At this dose level I get some slight dyspepsia, dizziness, and nausea for about an hour to two hours after taking the dose, but the side effects fade after that. It appears that the active drug is quickly metabolized to some long half-life active metabolites, which are reported in the literature – the early dizzy phase must correspond to the unaltered drug in the bloodstream. My experience is that the therapeutic window of all of these dopamine agonists (including cabergoline, apomorphine, bromocriptine, and pergolide) is very narrow – one has to reach the level where nausea is about to begin in order to have any positive effects. Pergolide was no exception.

Effectiveness: After reaching the effective dose level, I found that pergolide definitely restored libido and desire. It gave me back what I call that "warm fuzzy feeling" you want to have when you are starting to have sex, and made it pleasurable. In comparison to Dostinex, it was much more effective in this regard. However, the dose level that I was on for Dostinex, 0.5 mg two times per week, was almost certainly much too low for me, so this comparison probably has no validity until Dostinex has been tried at a similar dosage level (i.e., the level just below that which produces a slight nausea or dizziness).

Side effects: Pergolide was very effective, but I would describe it as not being as “clean” for pro-sexual use as Dostinex (again, compared to the low level dose of Dostinex I was on), and it isn’t as clean as Apomorphine (Uprima). By this I mean that it was not effective until there was noticeable dizziness and nausea. In studying the reported binding coefficients at various receptors, it appears this may be due to pergolide having a much higher affinity for serotonin receptors (all subtypes) than either cabergoline or apomorphine, by a factor of as much as 100 times for some receptors. So while pergolide has a better receptor binding affinity profile for dopamine D1 and D2 receptors than either apomorphine or cabergoline (making it a more effective pro-sexual drug), this is somewhat offset by the side effects at other receptors.

Conclusion: I would say that I am satisfied with pergolide, and am more satisfied than I was with the low level Dostinex dose I have been on for the last 8 months. However, I now think that I should cycle this experiment by trying an equivalent, more effective dose level of Dostinex, consistent with the levels I have found are necessary for me for pergolide and apomorphine (about 3x the levels for most normal people). After this trial I could draw a better comparison between the two drugs.

For now, I plan to stop using Pergolide this weekend, flush it out of my system for a couple of days, then begin using the Amantadine next week, and compare how that works. I have some hope that Amantadine may actually do quite well, since it only stimulates dopamine production and acts as a MAO-B inhibitor, so it has little to no effect on serotonin, adrenergic, or other receptors. Unlike all the dopamine agonists, which have partial to full activity at many other receptor types, Amantadine may be more focused on where it counts and thus more successful. I’ll let you know how it turns out.