



Self-Mutilation of the External Genitalia in Psychiatric Patients in Souro Sanou University Teaching Hospital: Two Cases Report and Literature Review

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Abstract: Over a period of three years, two cases of self-amputation of the external genitalia were recorded and managed in our urology division in Souro Sanou University Teaching Hospital. These were male patients and aged 18 years and 32 years respectively. They were irregularly followed up for psychiatric disorders. One was suffering from schizophrenia, the other from paranoid schizophrenia. The first patient self-mutilated with complete sectioning of the penis with a kitchen knife, while the second patient self-mutilated with partial amputation of the penis with exposure of the corpus cavernosa and the left testicle. Managed as an emergency from the onset, the reimplantation of the penile stump could not be carried out due to the lack of an efficient technical expertise with the availability of microsurgery. Hemostasis and refashioning of the amputation stump were performed with definitive urethrostomy for one and penile reconstruction on urethral catheter and directed healing for the other. Postoperatively the two patients were able to urinate through the urethrostomy but the cosmetic appearance of the external genitalia was unsatisfactory. Although rare, self-mutilations are dramatic and serious accidents that can be life-threatening and functionally disabling for patients. Their management must be multidisciplinary, involving urological surgeons, intensive care physicians, emergency physicians and psychiatrists with the treatment of the underlying psychiatric disorder.

Keywords: Self-Injury, External Genitalia, Psychiatric, Emergency

1. Introduction

Self-harm or self-destructive behaviour is the term used to define any deliberate destruction or alteration of body tissue in the absence of conscious suicidal intent [1]. Penile self-amputation is a rare entity of male genital trauma that occurs mainly in schizophrenic patients [2, 3]. Its management always requires surgical intervention through penile reimplantation if possible or refashioning of the stump followed by management of the causative events. We report two cases of dramatic penile

self-amputation in psychiatric patients, in whom we were unable to perform reimplantation due to lack of surgical equipment and adequate technical expertise.

2. Cases Report

Observation 1

Patient S B, male, 18 years old, single, with

schizophrenic disorders and who had not been seen by his psychiatrist for three years, was brought to the emergency department for self-mutilation of the external genitalia. The patient refused to communicate, and questioning of his entourage revealed that the patient had his penis amputated with a kitchen knife during an episode of delusions and hallucinations developed over several days. The examination of the patient noted a preserved general state, non-agitated and mute patient who refused to communicate. The locoregional examination noted a haemorrhagic wound of the external genitalia with complete sectioning of the penis at its base, exposing the erectile bodies and the urethra (Figure 1). The amputated stump was found and brought in by the parents (Figure 2). In view of the patient's psychiatric history, the diagnosis of self-harm on psychiatric grounds was made. The patient was admitted urgently and sent to the operating theatre for appropriate management. After conditioning, the patient went through a preoperative workup, tetanus antitoxin and tetanus vaccine were administered. Intraoperative exploration revealed a haemorrhagic wound with complete penile section at its base, exposing the erectile bodies and penile urethra. As we did not have adequate material for penile reimplantation, we proceeded to refashion the stump with haemostasis of the erectile bodies and a skin covering the plasty and at the end scrotal urethrostomy on a CH 18 urethral catheter (Figure 3). The catheter was removed two weeks later and the postoperative course was uncomplicated. The patient received a psychiatric consultation during his hospitalization and was put on neuroleptic treatment. He was discharged from hospital one week later and referred to the psychiatric ward for further psychiatric care and follow-up. At the 3rd month postoperative check-up, the patient was able to urinate through the urethrostomy but the cosmetic appearance of the external genitalia was unsatisfactory. (Figure 4).



Figure 1. Penile amputation.



Figure 2. Catheterised stump.



Figure 3. Urethrostomy of the stump.



Figure 4. Appearance one month later.



Figure 5. Self-mutilation with amputation of glans, penile skin and left testicle.



Figure 6. Postoperative appearance after stump regularization and urethrostomy.

Observation 2

Patient O D, 32 years old, farmer, single and being managed in the psychiatric department for about three years for paranoid schizophrenia, for which he was under neuroleptic treatment but had been in therapeutic break for three months. Patient OD was evacuated urgently from a remote medical center to the

university hospital for self-mutilation of the external genitalia, which had occurred the previous day (18 hours after the self-mutilation). Questioning of the patient's entourage allowed us to understand the circumstances of the incident. The patient was suddenly aggressive, grabbed a knife and seriously injured a young child before self-mutilating his external genitalia. The clinical examination revealed a patient in average general condition, clinically anaemic, fully conscious but confused with incoherent speech against a background of delusions. Examination of the external genitalia revealed a large haemorrhagic wound of the external genitalia with total absence of the penis sheath, loss of 2/3 of the scrotum and the left testicle, total amputation of the glans penis with exposure of the urethra and the erectile bodies. The right hemi-schrotum and testicle were intact (Figure 5). The rest of the examination was normal. The diagnosis of self-mutilation with partial castration was made. After performing a minimal emergency workup, we performed a repair preceded by debridement of the skin lesions, erectile bodies followed by a urethrostomy over a urethral catheter (Figure 6). The patient was transfused with two units of cross-matched red blood cells intraoperatively. He was also treated with analgesics, antibiotic coverage and tetanus vaccine and antitoxin. Daily dressings were performed and the recovery was favourable with removal of the urinary catheter after 15 days and resumption of spontaneous and normal urination. As the loss of penile skin was significant, a subsequent penile covering plasty was planned. Following the operation, a psychiatric evaluation was requested and the diagnosis of acute paranoid schizophrenia in a patient who had defaulted his treatment was diagnosed by the treating psychiatrist. A medication based on haloperidol (Haldol) and tropatépine (Lepticur) was instituted. With the favourable outcome of the surgical wound and a good healing, the patient was discharged to ambulatory care with follow-up visits to psychiatry and urology divisions. The patient was lost to follow-up and did not attend his 3rd month check-up.

3. Discussion

Self-injury of the external genitalia is rare in routine clinical practice and only a few isolated or anecdotal observations have been reported in the literature [4, 5]. It is a surgical emergency in the majority of cases because it is a functional and sexual threat to the organs involved. Waterhouse et al. reported only three penile amputations in a review of 10,660 trauma admissions [6]. Self-injury involves the scrotum, its contents and the penis. The type of injury varies from simple skin laceration to removal of the testicles and penis. The most common type of injury is removal of the testicle, followed by laceration of the scrotal or penile skin and finally sectioning of the penis [7]. Known as Klingsor's syndrome, which is used in the literature as a synonym for male genital self-mutilation, the first case was reported in 1901 involving a case of self-castration [8]. The number of cases reported in the literature and in different articles rarely exceeds 3. It is a frequent pathology in patients with a psychiatric record, as was the case in our two observations, where schizophrenia was incriminated.

In our two observations, the patients all had an irregular psychiatric history, in therapeutic rupture. These same findings were made by Moufid et al in Morocco and Bart et al in France [3, 9] in their respective series. The psychotic aetiology is found in 28.5% of cases by Greilscheimer et al in a series of 52 cases of self-harm [10]. Recurrent self-amputation of the penis has also been reported by Kaboré et al, highlighting the recurrent nature of this dramatic accident if the patient is not properly treated for the underlying psychiatric pathology [11]. Alcoholism would be a contributing factor, as reported by Odzébé et al in Brazzaville, or patients under the influence of psychoactive substances, as reported by Ghar et al in a systematic review [12, 13]. Other authors have described amputation of the penis or glans penis as an accident of ritual circumcision, a common practice in most West African countries [14]. Some authors have also reported cases of heteromutilation of the genitals during fights or marital conflicts [7, 13]. In a recent study, schizophrenia was identified as the main cause of self-inflicted genital injury, accounting for almost half of the patients who inflicted severe genital injury [5]. From the review of observations on this phenomenon, the act of sexual mutilation in patients with schizophrenia or other psychotic disorders appears to be a direct and plausible consequence of acute psychotic states. In contrast, a study by Greilscheimer et al relativises this hypothesis and notes that the majority of men who underwent genital mutilation were not psychotic, but rather had personality disorders, sexual conflicts with aggressive elements or transsexuality [10]. Penile self-amputation is in itself a dramatic condition and has been found to be a predictor of suicidal events [4, 15]. In most cases, patients with known or unconfirmed schizophrenia who underwent self-amputation and then went to the emergency room with the amputated stump benefited from penile reimplantation. Microsurgery has become the standard approach to surgical treatment [16]. However, good results have been reported without microsurgery [17]. Unfortunately, in our two patients, penile reimplantation surgery was not possible for various reasons. Although in one of our patients, the amputated stump was found and brought back by the patient's relatives, the 18-hours delay no longer allowed such surgery. Also, the lack of a technical expertise without the possibility of microsurgery or microvascular surgery made any attempt for penile reimplantation uncertain. These conditions led us to favour the refashioning of amputation stumps with urethrostomy and haemostasis of the erectile bodies. The postoperative follow-up in our two patients was favourable with micturition allowing bladder emptying through the urethrostomy but with the impossibility of sexual intercourse in the case of complete amputation. The long-term prognosis may also be marked by stenosis of the urethrostomy but also recurrence of the accident, hence the need for multidisciplinary follow-up with continued psychiatric monitoring. The first patient continues to be followed up in urology division and in psychiatry division however the second patient has been lost to follow-up for a year and it is feared that a recurrence of the accident may occur.

4. Conclusion

Self-mutilation of the external genitalia is rare and serious and often occurs in the context of an underlying psychiatric pathology in a depressed patient. Possibilities of re-implantation exist with microsurgery if the patient is seen early, but in developing countries in general, the functional prognosis remains compromised because the techniques of microvascular surgery are not easily accessible in emergency. Management must be multidisciplinary, involving urological surgeons, psychiatrists and support from the victim's family.

Conflicts of Interest

The authors declare no conflict of interest.

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