

Male genital self-amputation in the Middle East

A simple repair by anterior urethroostomy

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ABSTRACT

Genital self-mutilation, whether partial or complete, is a rare condition, which usually occurs in psychotic patients and occasionally has a religious background. The initial management of complete genital self-mutilation usually involves a formation of perineal urethroostomy or a more complex procedure to form a short penile stump. Here, we present a case of complete genital self-mutilation in a psychotic male who was managed with simple urethral spatulation to form an anterior urethroostomy.

Saudi Med J 2007; Vol. 28 (5): 791-793

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Received 22nd May 2006. Accepted 11th September 2006.

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Genital self-mutilation is a serious, self-harming and rare incident, which is usually found in psychotics, substance abusers and transsexuals.^{1,2} Religious factors, gender-identity crisis, and rarely suicidal attempts have been reported to be plausible underlying causes.³ Genital self-mutilation is likely to be under-reported in the Middle East. Here, we report a case of genital self-mutilation from the Middle East, which occurred without any suicidal overtones. In addition, we report on the technique of simply suturing the urethral remnant to the skin (namely, anterior urethroostomy) without formal perineal urethroostomy as previously reported.

Case Report. A 37-year-old male patient who was a known case of schizophrenia was admitted to the emergency department in October 2005 with severe hemorrhage due to total genital self-amputation. He lives in Dubai away from his family and shares his room with his work colleague. On the day of the accident, his colleague found him, unconscious in the toilet in a pool of blood. On examination, he was found to have an altered sensorium and was hypotensive. The genitalia were amputated and there was approximately 12x10 cm oval sharply incised perineal wound extending from pubic symphysis to approximately 3 cm above the anal orifice. The severed corpora cavernosa were bleeding profusely and large pulsating hematomas were seen bilaterally on the cut cord structures (**Figure 1**). His history included a 5-month admission to a psychiatric hospital 6 years prior to the incident with symptoms and signs suggestive of schizophrenia. He was prescribed with antipsychotic drugs and a course of modified electroconvulsive treatments was also given. Reportedly, he showed substantial improvement on the medication, which he used for the next 6 months and continued to be stable thereafter. Notably, he stopped abusing alcohol and marijuana 3 years prior to the psychiatric consultation and there was no family history of any psychiatric disorders. Four days before this event, he acutely developed sleep disturbance, tiredness, giddiness, perplexity, and tendency to fight with others. There was no history of any major stress prior to the onset of symptoms. He experienced as if a "huge block of black sky is falling down and the world was coming to an end". In addition, he began to perceive a foul smell from his body parts including genitals and arm pits, the living room and from outside the dormitory, which was not perceived by his colleagues. Concurrently, he began to hear disturbing complex hissing noises. Furthermore, he thought that he was "watched and followed by the devil". The devil gave offensive commands to the patient's 'self' to transgress religious codes and values and abuse the almighty God. When the self (*Nafs in Arabic*) resisted these orders, the devil ordered him to go out and have sex with prostitutes and if the patient's 'self' could not perform such orders, he must cut his genitals. He succumbed to this idea on the 4th day and the patient's 'self' declared that it can do without genitals but can never violate the religious notions in particular

abusing the almighty God. He reported no suicidal or death wishes or guilt prior to the genital self-mutilation. On the day of the event, the patient was fully alert and cooperative with nearly normal speech and psychomotor activity. He was attentive with fairly good concentration and no orientation impairment or memory disturbances were found. He had a delusion that he was under the influence of the supernatural, powerful spirits. Both insight and judgment were impaired. No addictive drug withdrawals were noticed. His intelligence quotient was normal on clinical assessment. No cognitive impairment was found on mini mental state examination (score=29). All other investigations including electroencephalogram and laboratory tests were not contributory. After resuscitation, he was shifted to the operation theater, the wound was irrigated and the cut ends of the corpora cavernosa were secured with under-running sutures. A stump approximately 1.5 cm of corpora cavernosa was left behind, ventral to which the corpora spongiosum was identified and catheterized. The cord structures were ligated separately. After a thorough hemostasis, the wound was closed vertically in the midline. The urethral stump and corpus spongiosum were spatulated and sutured to the skin in the upper third of the incision, surrounding a 16F size catheter (**Figure 2**). Post-operatively, on catheter removal, he voided well in the squatting position with a slight terminal spraying of urine. He felt shameful of his act of genital self-mutilation and enquired regarding the possibility of penile reconstruction and therefore, was counselled regarding reconstruction of phallus using a forearm musculo-cutaneous flap at a latter date. Although initially, he had a normal sexual desire, this is expected to decline due to hormone deficiency. Consequently, he will require testosterone supplementation to maintain the various androgen-dependent functions. From a psychiatric perspective, he was treated with olanzapine 20 mg and clonazepam 4 mg on a daily basis and he showed substantial improvement followed by counselling.

Discussion. Although Strock¹ reported the first case of genital self-mutilation in 1901, this act is well known for a long time among individuals and groups with different racial, cultural, and religious backgrounds. For example, group genital mutilation is a custom of a sect of Australian Aborigines, in which the blood is drunk by the infirm, who believes that it restores health.⁴ In addition, self-castrated priests were common in early Rome, but this form of religion-based castration was replaced by celibacy in some religions.⁵ Furthermore, some patients have been reported to justify their unusual act of self-mutilation by citing passages in the Holy Bible,⁶ and Klingsor syndrome is the term used to indicate religious



Figure 1 - The sharply incised wound following genital-self amputation, with clamps on the corpora cavernosa and cord structures. The catheter is inserted in the remnant urethral stump.



Figure 2 - The post-operative scar and the site of the anterior urethrostomy.

delusions leading to genital self-mutilation.⁷ However, reviewing the English literature revealed that up to date there is no case of genital self-mutilation reported from the Middle East. Whether this is due to under-reporting or to the fact that this act is strongly condemned by the Islamic principles, and hence it is a truly rare incident in this area, is difficult to ascertain from this case report. In favor of the first is the fact that the majority of these cases were reported in psychotic patients especially those with schizophrenia and drug abusers,⁸ and as psychotic diseases are well known to affect patients with different backgrounds including those from the Middle East, it is likely that complete genital self-mutilation is under-reported. However, some cases of genital self-mutilation may occur in non-psychotic transsexual patients, in a desperate act to adjust the body to their gender identity or in an autoerotic act, which is condemned in the Islamic societies and may indicate that the incidence of this condition in the Middle East may be lower than other societies with different cultural backgrounds.⁹ The current case represents one of the severest forms of genital self-mutilation in which the patient totally

amputated his penis and scrotum. This form, which is sometimes called 'lock, stock and barrel' mutilation, occurs in 10% of cases of genital self-mutilation, the extents of injuries being similar in psychotics and others.⁹ Similar to most patients with this condition, our patient showed no interest in his amputated parts and flushed them down the toilet;⁵ however, like few of these patients he sought help to reconstruct his genitalia. In simple cases of genital self-mutilation with superficial injuries, hemostasis and simple suturing are all that are required. However, in the more severe form, the goals of surgery in the male patient include restoration of an anatomical and functional phallus including urethral reconstruction, preservation of erectile function and testicular androgen activity if possible. In the current case, re-implantation of the genitalia was not possible as the patient flushed away his amputated genitalia, although re-implantation of the penis, glans or testes by microvascular techniques has shown to give excellent results.¹⁰ In cases similar to our patient, formal perineal urethrostomy and fashioning of a short penile stump have been previously described to result in an acceptable outcome.¹¹ The new technique reported in the current case, which includes simple spatulation and formation of urethrostomy in a more anterior position in comparison to the formal urethrostomy serves a quick and easier alternative and has good functional results. The anterior location of the urethrostomy allows a forward direction of the stream even in the squatting position and renders future penile reconstruction much easier, especially in view of the fact that some of these patients seek penile reconstruction.

In conclusion, herein we present a case of genital self-mutilation from the Middle East where the Islamic culture particularly condemns such an act. Milder forms of emasculation may be under-reported. In addition,

simple suturing of the severed end of the urethra to the skin instead of the formal perineal urethrostomy appears to have good outcome and has the advantage of making further reconstruction feasible.

Acknowledgment. *The authors would like to acknowledge Dr. Khaled Al Qaiwani and Dr. Ahmad Ezzat for their clinical input into the case.*

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