

Male Genital Self-Mutilation: A Case Report

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Abstract

Background: Male genital self-mutilation (GSM) is a rare condition that mostly occurs with the presence of a psychiatric disorder. The aim of this case report is to discuss an incident of male genital self-mutilation in the absence of discernable psychopathology.

Case Description: A 26-year old single expatriate male who had GSM with suicide intent was admitted to a hospital for urological procedures. The patient did not have an initial overt psychiatric diagnosis. After recovery and discharge from the hospital in a few days, the patient then developed frank psychotic and delusional symptoms. The patient was then started on 2 mg risperidone and 50 mg sertraline and had short-term significant improvements in his thought process and mood symptoms but was later lost to follow-up.

Conclusion: This is an incident of male genital self-mutilation appearing as an early sign of psychosis. The report adds data to the existing literature from the region about this rare condition. These cases require collaborative treatment amongst primary care physicians, mental health professionals and urologists to reduce the possibility of re-presentation and the risk of suicide.

Keywords: Psychotic Disorders; Schizophrenia; Self-mutilation; Self-harm; Male

Abbreviation

GSM: Genital Self-Mutilation

Introduction

Since its first report in 1901, male genital self-mutilation (GSM) is an uncommon phenomenon with a few cases reported globally [1-3]. A recent review, up to 2015, found less than 200 cases (n = 173) of self-inflicted genital harm in the literature [3]. Among these cases, the following psychiatric disorders were common: schizophrenia (49%), substance use (18.5%), personality (15.9%) and gender dysphoric disorders (15.3%) [3]. Even though GSM occurs in all cultures, religions, and racial groups, the vast majority of the incidents reported have occurred in single, young (age 20 - 40) male Caucasians [1].

Within the context of the Middle East region, there are rare reports of male GSM and the reported cases had GSM along with significant psychopathology [4,5]. These GSM cases are different than the ritualistic cultural practices involving male and female genital circumcisions that are practiced in some areas of the Middle East region [6]. This case report describes a rare case of GSM from the region where the patient presented in the absence of any discernible psychopathology [7].

Case Description

In 2014 and in the United Arab Emirates, a 26-year-old single migrant worker was brought in by police to the emergency department of a large multidisciplinary hospital with profuse perineal bleeding. The accompanying police described him trying to amputate his penis using a kitchen knife in front of everyone where he used to work as a porter.

On examination, the patient had severe perineal wound involving his penis. The penis was cut more than half of its girth including urethra and the penile musculature. The organ was still viable (some blood circulation present) however the patient was in a hypovolemic state.

After initial resuscitation, an urgent urologic consultation was sought and the attending urologist performed a lengthy procedure (lasting more than 6 hours) involving penile reconstruction and urethral repair. The patient was put on a suprapubic as well as a Foley's indwelling catheter following the operation to facilitate voiding urine. The patient was given methylnorphine (30 mg three times daily) for fourteen days to prevent morning erections during his convalescence period. The patient showed good physical recovery within a week of the penile reconstruction. His bowel, bladder functions, sleep and appetite returned back to normal.

The patient denied having any perceptual disturbances or pervasive mood changes before the incident. The patient had subjectively felt suicidal and that he "wanted to end it all while teaching others a lesson". He felt remorseful having indulged in the act and created trouble for the family and himself. He further mentioned that this might have been a punishment for his errant ways and straying away from his family values.

The patient did not have any significant past psychiatric history or self-harming behavior although he described abusing opium several years ago while in his home country. He also did not have any forensic history. He was the fourth of nine siblings and there was no family history of mental illnesses present. He had a normal birth and developmental milestones were within normal limits. He was educated up to tenth class and was an average student. He was not quite keen to return to his home country, but he was accepting the fact that he might have to.

After initial psychiatric assessment, the patient was only treated symptomatically as he did not have any overt psychiatric diagnosis. He was discharged from the hospital and was planning to go back to his home country. However, within a few days, he developed frank psychotic and delusional symptoms without any known precipitating features. He was readmitted to the Emergency Department of another general hospital.

On further psychiatric assessment, his brother reported that the patient apparently got very stressed after his resignation from his job a month ago. The patient had worked as a porter, he was not satisfied with his work and had sent his resignation to return to his home country. However, he had a delay in his final payments. He became very ambivalent in the few days before the incident and in fact wanted to cancel his resignation and continue to work without any avail. His brother described him getting very desperate and catching his feet and that of his supervisor at work while pleading for getting his job back. On the particular day of the incident, he had an argument with his supervisor at the workplace and impulsively took a kitchen knife to cut his penis. He could not elaborate or justify the reasons for choosing to mutilate his penis as opposed to any other body parts.

The patient was then started on risperidone (2 mg) twice daily and sertraline (50 mg) daily. He showed significant improvement in his thought process and mood symptoms. However, he was lost to follow up after his second visit since he had travelled to his country.

Discussion

Male GSM was recorded in the Greek mythology when the god Eshmun castrated himself to evade the erotic advances of the goddess Astronae [1]. The influence of religion in male GSM also dates back to the early Roman times where the eponym “Klingsor Syndrome” denoted GSM resulting from religious delusion [8]. The epinome was derived from a character in Parsifal (a German opera) who self-castrated in an attempt to gain entrance into the brotherhood of the Knights of the Holy Grail [8]. It is, however, believed that the etio-pathogenesis, the course, and the prognosis of male GSM resulting from psychotic illness and religious delusions are similar. Thus, in one of the first recorded cases of GSM, it was suggested that the term “Klingsor Syndrome” should encompass both [8].

Three diagnostic groups have been categorized as GSM: transvestites, schizophrenic patients, and those with complicated cultural and religious beliefs [1]. Although the index patient did not belong to any of these categories, the behavior of GSM and self-mutilation has been reported as an early presenting sign of schizophrenia even in the absence of overt psychotic symptoms, as exemplified in this case [9].

Treatment of these patients is challenging and requires collaboration between urologists, psychiatrists and primary care physicians. The ultimate goals of surgical treatment for these injuries include restoration of a functional urethra, preservation of erectile function and testicular androgen production. Superficial lacerations of the scrotum and penis may require no more than simple suturing. In cases of traumatic amputation of the penis, primary anastomosis is preferable if the distal segment is available, in good condition with an ischemia time of less than 16 hours [1]. While the primary aim at presentation remains the timely management of haemorrhage and urological injuries, psychiatric evaluation and treatment has been recommended in all cases to be instituted on day 1 of admission regardless of mode of presentation [1].

The motivational factor responsible for GSM varies. It is estimated that around 1 in 10 of self-mutilators intend suicide [10]. Unfortunately, some of those with GSM will repeat the act [10]. A study of 98 cases with GSM found that 4 died as a result of haemorrhage from the injuries inflicted [10].

Conclusion

This is a rare case of GSM that adds data to the existing literature from the region. These cases require a collaborative treatment amongst primary care physicians, mental health professionals and urologists. Continuous monitoring for future psychotic symptoms would help. Collaborative interventions can work on reducing the possibility of GSM re-presentation and the risk of completed suicide among these sufferers.

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Conflict of Interest

The authors declare no conflict of interest.

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