

Genital Self-Mutilation Patient without Diagnosed Psychiatric Disorder: A Multidisciplinary Approach

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Abstract: Testicular self-mutilation is an unusual type of urologic trauma in the emergency room. Frequently related with psychiatric disorders and drug abuse, it demands careful management during the initial assessment and follow-up. We present a unique case of self-mutilation in a patient with no reported psychiatric disorders.

Keywords: Genital, Self-Mutilation, Hypogonadism, Urologic Trauma

Introduction

Genital self-mutilation is an uncommon phenomenon of self-injurious behavior, with testicular lesions being the most common (61%) (Anand et al., 2015). Cases of self-mutilation range from simple lacerations of the external genitalia to complete amputation of the penis and testes (Lok et al., 2014). Rarely presented in the urologic literature, genital self-mutilation is usually associated with psychotic disorders, sexual conflict, body image distortion, internalized aggression, suicidal intent, and personality disorders (Charan and Reddy, 2011). We present a testicular self-mutilation case in a patient with no evidence of prior psychiatric disorders.

Case Report

A 56-year-old man was brought to the emergency department by his ex-wife complaining of self-inflicted amputation of both testicles with a kitchen knife. The physical examination revealed an open scrotal wound with active bleeding and absence of both testicles. The patient was conscious, alert, in painful distress but hemodynamically stable. He was admitted to the surgical ward.

A physical examination confirmed bilateral testicular amputation, with a large laceration of the skin and active bleeding from the spermatic vessels. Ligation of both spermatic chords was performed, non-viable tissue was debrided and hemostasis was established. The scrotal wound was repaired in layers and a Penrose drain was inserted. He was prescribed adequate analgesia, antibiotics and tetanus prophylaxis.

The patient was seen and evaluated by the psychiatry team on Day 2 of admission. When questioned about the reasons for his act, he said that he had argued with his ex-wife and in order to stop having erections and sexual desire decided to amputate both testicles. The psychiatrists reported that the patient was not cooperative, but oriented in respect to time, place and people, and denied any depressive symptoms, suicidal tendencies or previous psychiatric treatment. He was diagnosed as having a major depressive disorder and unspecified psychosis. The interview was difficult because the patient did not cooperate and so the psychiatric staff did not prescribe any medication and requested an interview with the patient's family for proper diagnosis and therapeutic planning.

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The patient was discharged two days after admission and the urology staff prescribed long-term testosterone replacement therapy (testosterone undecanoate every three months) for hypogonadism. The patient did not attend the psychiatric follow-up and had no symptoms of hypogonadism at the urology follow-up attendance.

Discussion

Self-mutilation is uncommon in the daily practice of urologists. Observed in several psychiatric disorders, self-mutilation is defined as deliberate harm to one's own body without conscious intention of dying (Greilshheimer and Groves, 1979). Generally self-castration is only seen in patients with psychotic disorders, especially in schizophrenic individuals (Myers and Nguyen, 2001) but it has also been described in the medical literature associated to drug abuse such as cannabis (Ahsaini et al., 2011) and methamphetamine addiction (Anand et al., 2015) and even linked to alcohol withdrawal complicated by delirium (Charan and Reddy, 2011).

Men who intentionally perform genital self-mutilation are usually psychotic at the time of the act and have a number of motives relating to conflicts about the male role and guilty feelings associated with sexual conflict (Mago, 2011).

This case is unique because it brings two different discussions within the urological literature to the limelight, self-inflicted hypogonadism and genital self-mutilation as the first manifestation of a psychiatric disorder.

A review of 53 cases showed that a significant number of cases involve individuals who were not psychotic at the time of the act, but rather have character disorders and bad feelings towards themselves or towards women (Mago, 2011). These findings corroborate the history of the current case as the patient told the psychiatry staff that his motivation for performing this act was an argument with his ex-wife.

At admission, the first objective of treatment was to stabilize the hemostasis. As the spermatic cord was not retracted, scrotal access was a safe surgical approach.

After the initial assessment and surgical repair of the scrotal wound which consisted in the restoration of the anatomy and hemostasis (Figures 1 and 2), a

further concern was brought into discussion by the urology team, that of hypogonadism.

Testosterone replacement therapy was the treatment of choice due to its cost-effectiveness and convenient dose interval. Owing to the cardiovascular and osteoporotic risks, hormone replacement in these cases must be established immediately (Kumar et al., 2010).

In the context of a multidisciplinary approach, it is imperative to have the patient properly assessed by psychiatry staff to prevent possible future self-mutilation attempts and bring peace of mind to relatives. That being said, the patient had a psychiatric evaluation during his hospital stay and was correctly managed to avoid any further incidents; identifying the risk of repeating this act and recognizing any suicidal intent is essential.

Self-mutilation behavior is being increasingly observed (Ahsaini et al., 2011) and is quite challenging to treat due to the numerous etiologies and complications. The management of urological injuries, a detailed psychiatric evaluation and treatment of hypogonadism should be carried out to ensure the best prognosis for this kind of patient.

Conflict of interest: none

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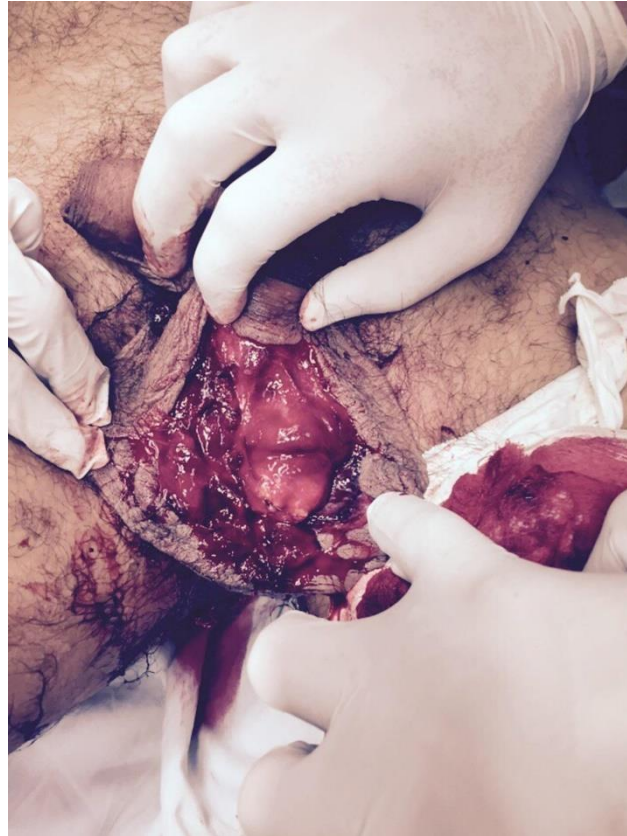


Figure 1. Extensive scrotal laceration seen during the initial assessment in the emergency ward



Figure 2. Ligation of both spermatic chords