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Case Report

Penile Self-Amputation and Failed Re-Implantation in a Patient with Schizophrenia

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ABSTRACT

Self-mutilation or self-amputation has been defined as the direct and deliberate self-destruction of a part of an individual's own body without the intention of suicide. Here we report a case of self-amputation of genitalia.

Key words: self-amputation, schizophrenia, genitalia

INTRODUCTION

Self-mutilation or self-amputation has been defined as the direct and deliberate self-destruction of a part of an individual's own body without the intention of suicide.[1] Minor self-mutilation is quite common, does not usually cause significant disability, and may even be a part of recognized cultural practices. In contrast, major self-mutilation (MSM) is quite rare, usually occurs in association with serious mental illness and often results in permanent loss of an organ or its function.[2] The three major forms of MSM are ocular, genital, and limb mutilation.

The published literatures of MSM are either single-case histories or small case series, from which it is very difficult to make valid causal inferences. However, through available literature it is clear that patients exhibiting MSM behaviours are almost always psychotic, and so are three quarters of patients who severely injure their genitals.[3] Self-mutilations of the external genitals in psychiatric patients are also known as Klingsor syndrome.[4] Genital mutilations in psychotic patients may be considered as partial suicides as the disability caused is often permanent or even life threatening.[5] Though literature reports cases of genital self-amputations, no precise data are available on the prevalence among males, such acts are presumably much more frequent than the small number of published cases.

However few feature that may be regarded as risk factors for self-mutilation are:

- Homosexual or transsexual tendencies
- Repudiation of the male genitals

- Absence of a competent male for identification during childhood
- Feeling of guilt for sexual offences
- As a behavioural manifestation in a psychotic episode like schizophrenia.[6]

Various literatures report successful surgical re-implantations as the management of genital amputations;[7] however we currently report a case of failed re-implantation, post penile self-amputation in a patient with schizophrenia.

CASE REPORT

Mr. A, a 29 year old unmarried male, hailing from northern part of India, educated to be an engineer from a Hindu Family of a middle socio-economic status was presented to our tertiary care centre with a 5 year history of illness, diagnosis- Schizophrenia-Paranoid type according to ICD-10.

Premorbid history reveals that Mr. A was well adjusted till the age of 24 (2008) when he was forced to resign from his job following misbehaviour with his boss and a colleague along with unsatisfactory job performance. Post resignation, Mr. A was occupationally free, began to have frequent quarrels with family members. He reportedly became suspicious of family members, refused to have food cooked by others and was socially withdrawn. He was then brought under psychiatric supervision and had his first hospitalization that resulted in the improvement of symptoms. Without further follow-ups, medication was stopped which resulted in his first relapse.

Mr. A lost his father due to heart attack and reportedly showed little or no emotion to this loss. His treatment was thus restarted. In 2010, Mr. A resumed his occupational functioning. He shifted to Bangalore in 2011, to work for a new job. He was able to manage alone and was in touch with the family members. After 2 months of which Mr. A isolated him from the family and he had his third relapse, as he had stopped his medication. The patient was hospitalized in Bangalore and the treatment schedule restarted. Mr. A was reportedly better and hence was taken back to his home and the follow-up was lost.

The patient was admitted at our centre for a two month rehabilitation program after a fourth relapse owing to medication incompliance. He was administered optimal dosages of risperidone and quetiapine. Three weeks post admission, Mr. A was observed by the hospital staff to be aloof, withdrawn and was persisting his family and staff to discharge him. Mr. A cut off his penis (3 inches in length) with the crushed pieces of a twin shaving blade, each cut edge being 3mm in width, in the toilet and carried the organ around the hospital premises saying, “See this dead rat, throw it away!” and had profuse bleeding from perineal region.

Mr. A was attended immediately, first aid was given and the bleeders were ligated. The cut penis was preserved under sterile conditions and Mr. A was shifted to a higher center. Within 4 hours, the penis was re-implanted by a team of urosurgeon and plastic surgeon. However, it is to be noted that Mr. A had not reported the presence of a commanding hallucination to his treating team till the incident of amputation.

Psychiatric Course: A mental status examination (MSE) conducted post-surgery revealed that Mr. A was dull, withdrawn and had blunt affect. He later on reported to have cut off his penis on the instructions of a commanding hallucination: “Get rid of this dead rat!” Mr. A revealed no delusions of religious nature or somatic content.

The global assessment of functioning (GAF) score was found to be 28, indicating severe disability. Mr. A was extremely guarded and did not reveal much about the intensity or frequency of the hallucination.

Mr. A's treatment schedule was re-structured and doses of medication were up-titrated.

Surgical Course: Mr. A underwent several surgical procedures. The urethra and the cavernosal bodies were reanastomosed as shown in figure 1. The dorsal penile artery was exposed, followed by the extraction of a coagulum. A microsurgical end-to-end anastomosis was performed. After 11 days the skin was sloughing off, thus debridement was done and later on considered for mesh graft. He was put on adequate doses of higher antibiotics and anticoagulants.

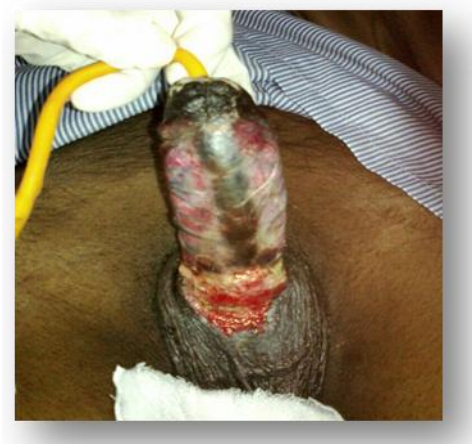

Figure 1: Reimplanted genitalia.

However, attempt at the microsurgical re-implantation of the amputated penis failed and consequently the shaft was salvaged but the glans was lost due to necrosis, in spite of best possible surgical care and intervention.

DISCUSSION

Klingsor Syndrome is generally reported in schizophrenia as an act of auto castration in response to biblical delusions.[8,9] Few reported cases of genital self-amputation seem to have mythological, religious, historical and cultural undertones while the severity of injury is determined by the extent of psychopathology.[10,11]

In this particular case, active psychopathology that remained dormant had resulted in auto-aggressive actions that were directed by a commanding voice saying "get rid of this dead rat". This is a rare presentation that imposed significant diagnostic and management challenges to psychiatry and to plastic surgery. In spite of timely intervention, the re-implantation was unsuccessful as the length of the organ cut off was closer to mons pubis.

As a physical consequence, the patient now does not have a penis as the reconstructed organ shaft was lost due to necrosis and the urethra was reconstructed. Though the MSE revealed a commanding auditory hallucination, it was reported only after self amputation. Mr. A had no suicidal ideations, no pervasive sadness, helplessness, hopelessness and worthlessness or any other symptoms meeting the criteria for depression.

CONCLUSION

Complete genital self amputation is a rare, yet severe form of self-injurious behaviour usually described in personality disorders and psychotic disorders. It has been ascribed to sexual conflicts, body image distortion, internalized aggression and suicidal intent. To our knowledge this is not one of the first reported cases of Genital Self-amputation. Cases reporting the death of patients post MSM due to haemorrhage have been reported.[12-15]

The case reported is however unique in the terms that the active psychopathology was masked by general apathetic nature of the patient and challenges faced by the treating team in successfully re-implanting the amputated organ. Early intervention was preposterous as the treating team had no hint of active psychopathology.

A general awareness of genital self amputations should be promulgated among Mental Health Practitioners so that it can be

prevented and treated effectively. The careful assessment, medication compliance clubbed with optimal attention per patient will facilitate early recognition of warning signs that may be important to prevent such dreadful acts.

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