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GENITAL SELF AMPUTATION FOR URINARY SYMPTOM RELIEF OR SUICIDE?

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ABSTRACT

Complete combined amputation of penis and scrotum has been rarely reported.A case of an elderly male with complete genital mutilation is presented with the complexities of the phenomena.He was suffering from severe depressive episode and had experienced multiple events related to urinary system. His vulnerability to self injurious behaviour had been established by past suicide attempt.Gross impairment of judgement and depressive cognitions were instrumental in precipitating such behaviour.Related literatures are discussed.

Key Works: Genital self mutilation, depression, urinary symptoms,suicide

Genital self-mutilation is an uncommon phenomenon. Extents of injuries vary from simple laceration to amputation (Aboseif et al,1993). However most cases represent an isolated penile mutilation. Complete combined amputation of penis and scrotum has been rarely reported (Becker & Hartmann,1997). We describe a case of complete self-amputation of genitalia with the complexities of the phenomenon.

CASE REPORT

A 56-year-old Hindu married,male working as an government officer was suffering from recurrent depressive disorder from the age 39 and was experiencing yet another depressive episode. He was prescribed imipramine 75 mg per day along with other medicines for sedation. Within 3 days he has obstructive urinary symptoms . Imipramine was replaced by fluoxetine.Clinical examination and investigation revealed grade one benign hypertrophy of prostrate,high residual urine of around 200 ml without back pressure effect.There was no urethral stricture. He experienced incontinence of urine occasionally. Around a week after, he was admitted in the emergency surgical ward with his scrotum,penis completely amputated. He had cut off his genitals along with skin and superficial tissue of a portion of lower abdominal wall immediately above penis through several strokes using a shaving blade. He was conscious and described the act as a way to get rid of his urinary problem of incontinence and consequent social embarrassment. He denied this being a suicide attempt even though he had death wishes and suicidal ideas. He did it in his secluded drawing room where the chance of being discovered was less. He did not seek help. He did not complain of pain. He was seen unperturbed. He showed no regret. There was no obsessions or guilt feeling regarding sex. His judgement was severely impaired. He expressed hopelessness. He was feeling helpless and considered himself worthless. He was much worried about the incontinence and particularly worried about social embarrassment. He had no imperative hallucinations,religious delusions or any other psychotic features. He had significant worsening of mood in morning, decreased sleep,decreased appetite,loss of

weight and decreased sexual interest. The degree of depression was considered severe. There was no indication of delirium or post-ictal confusional state.

The patient had attempted suicide by jumping into the well in one of his previous episodes. Besides this he never had any self injurious behaviour. His right testis was removed because of a complication during inguinal hernia operation at the age of 29 years. His sexual desire and activities were described as satisfactory. There was no sexual dysfunction beside the lack of desire during depressive episodes. He had no extramarital sexual relationship. The frequency of sexual intercourse was once or twice a month in the last one year. The last time he had sexual intercourse was before the onset of the ongoing depression around two months back.

There was no substance abuse, impulse control disorder or any personality disorder. No other comorbid psychiatric disorders were present. The patient had no history of seizure disorder. There was no family history of suicide, self-injurious behaviour or any psychiatric illness.

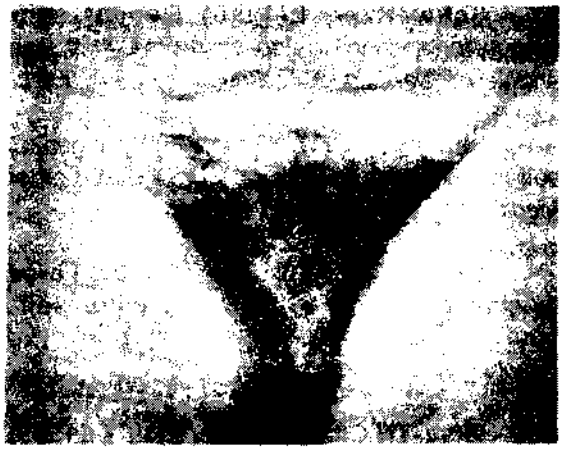

Fig.1-Perineum after reconstruction: a portion of scrotal skin on left side is seen

The organs could not be reptanted because of altered state of the severed organs. After healing of the wound the urination was occurring in a poor stream through the stenosed meatus at the residual penile stump which was embedded in the skin. There were about two inches of perineal skin of the scrotum in the left side. After recovering from the depressive episode two months later patient was repentant about the act. He expressed that he should not have acted in that manner by an idea within the spur of a moment.

DISCUSSION

Self-multilation has been defined as an individual's intentionally damaging a part of his or her own body apparently without a conscious intent to die. Various risk factors have been identified in the previous case reports of genital self-mutilation. Guilt feeling associated with sexual conflicts (Nakaya, 1996) or sexual offences (Martin & Gattaz, 1991) have been reported in most studies. Disturbance of sexual identity (Nakaya, 1996), conflict over masturbation (Shimizu & Mizuta, 1995), homosexual or transsexual tendencies, repudiation of male genitals, absence of a competent male for identification in childhood (Martin & Gattaz, 1991), forced early sexual activity, profound ambivalence towards adult sexuality have been described (Krasucki et al., 1995). Religious psychotic experiences (Nakaya, 1996; Schweitzer, 1990), schizophrenia (Martin, & Gattaz, 1991; Feldman, 1988), affective psychoses, alcohol intoxication (Martin & Gattaz, 1991), personality disorders (Krasucki et al., 1995; Wise et al., 1989), especially borderline personality disorder (Feldman, 1988) have been associated with genital self-mutilation.

Genital self-mutilation have been observed as a possible method of suicide attempt (Becker & Hartmann, 1997; Conacher et al., 1991; Yang & Bollard, 1993; Schweitzer, 1990). Body image preoccupation (Krasucki et al., 1995) and distoration (Wise et al., 1989) have also been reported as the associated conditions in genital self-mutilation.

The index case was undergoing depression and had death wishes and suicidal ideas. However, according to him he intended to amputate his genitals to get rid of urinary problems of incontinence secondary to benign hypertrophy of prostate. The facts that the act was potentially

lethal and he himself did not seek help may indicate suicidal intention. Nonetheless the impairment in his judgement was significant. There was no sexual conflicts, dysfunction,guilt,or personality disorder as previously reported. There were no obsessions regarding sex or religious psychotic features. Rituals like circumcision are not observed in his religion. He described that while he was engaged in amputating he did not think of suicide. He understood that the act was potentially lethal.However with a past history of suicide attempt and current suicidal idea it is difficult to imagine such a deliberate injurious act of probable grave consequences without the intent to die.

The patient had experienced multiple events related to genito-urinary system like orchidectomy at an early age,benign hypertrophy of prostrate, obstructive urinary symptoms precipitated by imipramine and recent invasive investigations of urinary system. His vulnerability towards self harm had been established by past suicidal attempt and suicidal ideas in the current depressive episode. In the above background and with grossly impaired judgement, the urinary symptoms could possibly have precipitated the cognition to amputate the genitals to get rid of the symptoms and have lead to the subsequent behaviour.

REFERENCES

Aboseilf, S.,Gomez, R.& McAninch J.W.(1993). Genital self-mutilation *The Journal of Urolology*,150(4), 1143-6.

Becker, H. & Hartmann U(1997) Genital self-injury behaviour- phenomenologic and differential diagnosis considerations from the psychiatric viewpoint. *Fortschritte-der-Neurologie-psychiatric*; 65(2),71-8.

Becker, M.,Hofner, K., Lassner, F., Pallua, N. & Berger, A.(1997) Replantation of the complete external genitals. *Plastic and Reconstructive Surgery*;99(4),1165-8.

Conancher, G.N.,Villeneuve, D.,& Kane G.(1991) Penile self-mutilation presenting as rational attempted suicide. *Canadian Journal of Psychiatry*, 36(9), 682-5.

Feldman, M.D.(1988) More on female genital self-mutilation. *Psychosomatics*,29(1),141.

Krasucki, C.,Kemp, R. & David, A. (1995) A case study of female genital self-mutilation in schizophrenia.*British Journal of Medical Psychology*; 68(pt.2), 179-86.

Martin, T. &Gattaz, W.F.(1991) Psychiatric aspects of male genital sellf-mutilation. *Psychopathology*, 24(3).170-8.

Nakaya, M.(1996) On background factors of male genital self-mutilation. *Psychopathology*, 29(4),242-8.

Schweitzer, I.(1990) Genital self-amputation and the Klingsor syndrome. *Australian and New Zealand Journal of Psychiatry*; 24(4),566-9.

Shimizu, A.,Mizuta, I.(1995) Male genital self mutilation: A case report. *British Journal of Medical Psychology*,68(pt.2),187-9.

Yang, J.G. & Bullard, M.J.(1993) Failed suicide or successful male genital self-amputation? *American Journal of Psychiatry*;150(2),350-1.

Wise TN,Dietrich AM,segall E:(1989) Female genital self-mutilation: Case reports and literature review. *Journal of Sex and Marital Therapy*;15(4),269-74.

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