

Case Report

Genital Self Mutilation in Alcohol Withdrawal State Complicated with Delirium

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ABSTRACT

Genital self mutilation is a rare and a severe form of self-injurious behavior usually described in psychotic disorders, with delusions and hallucinations. It has been ascribed to sexual conflicts, Body image distortions, Internalized aggression, and suicidal intent. This phenomenon has been described in schizophrenia, affective psychosis, alcohol intoxication, and personality disorders. The present case genital self mutilation in a case of alcohol withdrawal state complicated by delirium is reported.

Key words: Alcohol, delirium, genital, self mutilation

INTRODUCTION

Genital Self Mutilation is a rare and a severe form of self-injurious behavior. It is usually described in Psychotic disorders, mostly in schizophrenia as a result of Delusions and Hallucinations.^[1-3] In most cases, penile mutilation is common. Combined amputation of penis and scrotum has also been reported.^[1,4] Risk factors of Genital Self Mutilation include commanding hallucination, Religious delusions,^[3,5] Substance abuse, and social isolation.^[6] Genital Mutilation has been ascribed to sexual conflicts and offences,^[2] Body image preoccupation and distortion,^[7] Expression of internalized aggression and suicidal intent,^[1] and a means to get relieved of urinary symptoms^[4]. This phenomenon has been described in schizophrenia,^[2] Affective Psychosis, Alcohol intoxication,^[7] and personality disorders.

A review of literature suggests that Genital Self Mutilation is usually associated with Psychotic illness. Greilshheimer and Groves in a group of 52 cases of Genital Self Mutilation found 87% to be psychotic and 13% to be non-Psychotic. The Psychotic ranged from those with functional Psychosis to those with brain damage. The Non-Psychotic cases included Personality disorders, Transvestism, and complex religious or cultural beliefs. Aboself *et al.* in a series of 14 patients of self-inflicted genital injuries found 65% to be psychotic and 35% to be non-psychotic. There have been sporadic cases of non-psychotic Genital Self Mutilation in the literature. Various forms of psychopathology have been postulated in such cases. In the present case, Genital self mutilation of scrotum in a 28-year-old male, a case of Delirium, due to withdrawal of alcohol, is being reported and the psychosocial factors are discussed.

CASE REPORT

A 28-year-old male working as a tractor driver was brought to the Emergency surgical ward by his wife with complaints of cutting off at the left side at the base of his scrotum with a kitchen knife.

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His history revealed that patient has been taking arrack for the last 6 years. He started with 200 ml of arrack and slowly increased the amount to 1l over a period of 6 years as he was not getting the desired effect he used to get with 200 ml. On occasions, when he did not have the money or opportunity to drink, he used to experience dysphoric state including severe anxiety, palpitations sweating, restlessness, and tremors of hands. These symptoms used to subside upon taking alcohol.

He also did not have any control over the amount of alcohol he is taking and the money he is spending on it once he started to drink. He also neglected his duties both at work and at home due to this habit, for which he had frequent quarrels with his wife and has also ended up in financial crisis with a big debt. Due to above mentioned problems two days before admission, patient decided to stop drinking alcohol and stopped all of a sudden and he has developed abnormal behavior like talking to self, not feeding self, not recognizing family members, and talking irrelevantly. He started to complain that he is hearing voices of male and female when no one around.

On the morning of the day of admission, patient went to the kitchen and cut his scrotum at the base with a knife on left side. The dimensions 2×3 inches with a depth of 1 inch. After amputation, patient did not talk to anyone and sat all alone. His wife after one hour saw blood stains on floor and on his groins and brought him to casualty. After suturing the wound, the patient was referred to psychiatry op. The Mental status examination of the patient showed that the patient is not co-operative, not oriented to time, place, and person, hence cognitive functions could not done. He was diagnosed as Mental and behavioral disorders due to alcohol withdrawal state, complicated with delirium. The patient was admitted in psychiatry ward, all the investigations done like complete blood picture, liver function tests, blood urea, serum electrolytes, and Computed Tomography (CT) scan brain to rule out any organic cause. They started on tablet Chlordiazepoxide 200 mg in divided doses, tablet Thiamine 150 mg both given orally in divided doses to prevent Korsakoff's psychosis and injection Lorazepam 2 mg IM on sos basis to prevent any agitation. The patient became oriented on the 4th day of admission and then started to complain of pain at injury site for which he was started on Non steroidal Anti Inflammatory Drugs. Mental status examination then done showed that the patient's cognition was normal.

There were no adverse effects like infection of the injury or cutting of the cord or vas deferens and the wound completely healed in a period of 3 weeks. For next ten days, we slowly tapered off the Chlordiazepoxide and

on the 10th day of admission, patient was discharged on tablet Disulfiram. The patient is on regular follow-up now for last 8 months and completely abstinent from alcohol.

DISCUSSION

Some of the unusual features of the present case are as follows:

1. Commonly, amputation of penis and scrotum has been reported but here penis was spared.
2. Severe self injuries have been reported mostly in Schizophrenia and other psychotic episodes but not in Delirium.
3. This case has no apparent sexual or religious connotation.
4. Because of his problems at work and home, there may be a sub-clinical depressive episode in the patient and the act was done as a suicidal attempt.

Various psychopathological models have been proposed for genital self mutilation. These include psychodynamic, biochemical, moral, and delusional models.

Psychoanalytically, self-injurious behavior has been linked to castration and explained as a process of failure to resolve oedipal complex, repressed impulses, self punishment,^[8] Focal suicide, and aggression turned inward model, especially in depression cases.^[9] Liebowitz and Klein^[10] have postulated interpersonal loss preceding self-injurious behavior and linked it to rejection sensitivity.

Biologically, serotonergic depletion^[11,12] preceding genital self mutilation has been linked to lack of impulse control and depression. Schweitzer and Bhargava *et al.*^[3,5] claimed a strong Moral and delusional component. In the present case, delusional component played a major role. This was evident in the present case where he inflicted such a serious injury without seeking help. As has been communicated by Rao and Begam,^[13] we are in agreement that genital self mutilation, like any self-injurious behavior is not a single clinical entity and can occur in any psychiatric condition with corresponding psychopathology. It is suggested that there is no difference in the severity of self-inflicted injury between Psychotic and non-psychotic group of patients,^[14] and sometimes it could be a rational suicidal act.^[15]

Most cases of Genital self mutilation reported in literature have been in Psychotic patients. This may be the result of selective reporting.^[15] Thus, in this case, genital self mutilation was a psychotic solution to a conflict on the individual plane. In summary, Genital self mutilation may be a pathway out of

diverse Psychological disorders or behavior and may be influenced by cultural factors.

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