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MALE GENITAL MUTILATION: ABOUT 3 OBSERVATIONS

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SUMMARY

Male genital mutilation is a rare but serious phenomenon that occurs most often on a psychotic ground. It can be the source of major complications. We report three cases of genital mutilation in patients with schizophrenia.

KEYWORDS: Penis; Self-section; Psychosis.

INTRODUCTION

Self-injury is an intentional injury that a subject inflicts on a part of his body with no apparent intention to kill himself. Acts of self-harm of the external genitals are infrequent. These are potentially serious traumas involve sexual, aesthetic and urinary prognosis. Their surgical management has benefited from microsurgery which gives excellent results in terms of sexual, urinary and aesthetic.[1]

OBSERVATION 1

A.T 25 years old was brought to the surgical emergency department of the Ibn Rochd University Hospital by his family for auto amputation of his external genitalia. The patient had cut his penis and testicles with a knife 20 hours before. The amputated penis was kept in a plastic box (figure 1). During the interrogation, a psychiatric history of schizophrenia, diagnosed five years earlier, was discovered. Treatment was based on neuroleptics with poor treatment adherence. Clinical examination revealed a complete section of the penis and testes (figure 2). The patient was stable hemodynamically. After spinal anesthesia, we performed a large cleansing with serum and betadine, then haemostasis of the cavernous body and spermatic cord and then a meatoplasty on a urinary catheter. The patient received seroprevention, antibiotic and analgesic and psychiatric care. Ablation of the urinary catheter was performed on the 15th postoperative day and the patient had resumed satisfactory urination, after a regular follow-up of 2 months, and then was lost to follow-up.

Figure 1: Amputated penis was in a plastic box.

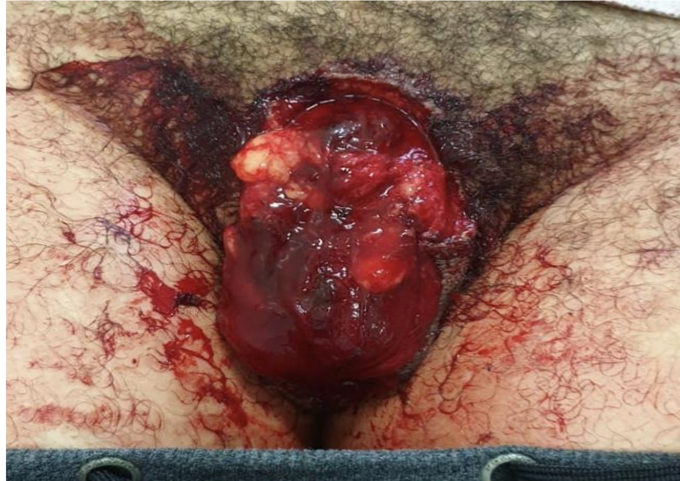

Figure 2: Complete section of the penis and testes.

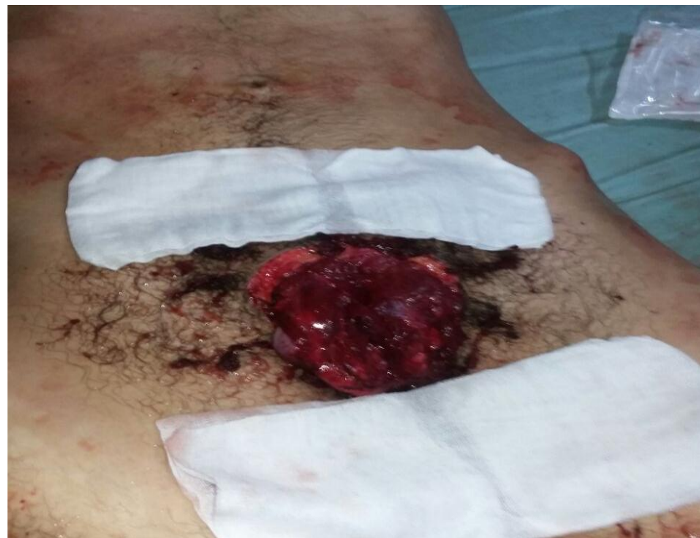

Figure 3: Complete section of the penis, the testicles are intact.

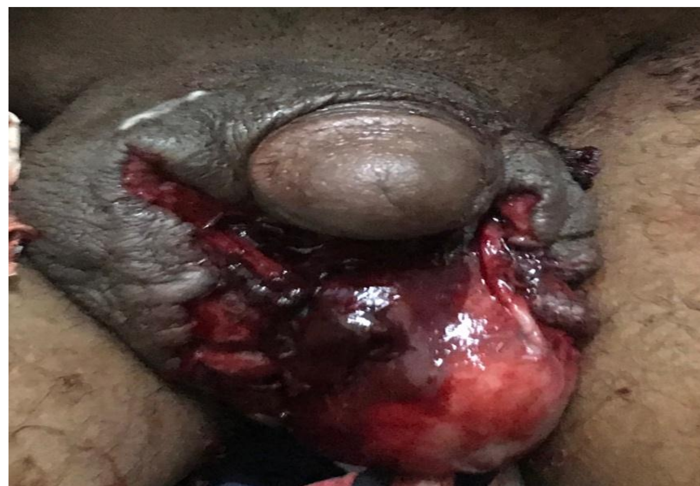

Figure 4: Self genital mutilation by a white weapon.

OBSERVATION 2

C.Y, 30 years old, was referred to urological emergencies for self-management of the penis with a knife. The clinical picture evolved since 18 hours. The patient followed for 12 years in psychiatry for schizophrenia. At admission, the patient was hemodynamically stable but agitated. On examination, there was a complete section of the penis and the

testicles were intact (Figure 3). We performed a cleansing with serum and betadine, and then we performed hemostasis of cavernous body then a meatoplasty on a urinary catheter followed by a psychiatric care.6 hours after the patient committed suicide by razor strike at the neck.

OBSERVATION 3

G.M, 18 years old, is taken to the emergency room by his family for self-mutilation of the external genitalia by a white weapon .Clinical examination revealed a 7 cm wound of the scrotum extending to the base of the penis with externalization of the testis (Figure 4) .The patient was followed for schizophrenia for 2 years but without treatment compliance. Therapeutically, he benefited from parage and suturing the wound after taking seroprevention and antibiotic therapy followed by psychiatric care.

DISCUSSION

Self-harm is a deliberate destruction of a part of the body, without any conscious intent to commit suicide. Penis amputation is a rare and serious phenomenon.[2] Genital mutilators are divided into three groups: psychotics (schizophrenics), transvestites and patients with religious complex or cultural beliefs. Schizophrenia is the most frequently implicated psychiatric disorder.[3] Reilsheimer and Groves,[4] on a series of 53 cases of self-amputation of the penis, revealed that 83% of patients were psychotic and 13% were transsexual or had character disorders. The most common male genital mutilation is the removal of the testicle (unilateral or bilateral), followed by laceration of the scrotal or penis skin and finally the section of the penis. Only 10% of genital mutilation is radical.[5] This is the case of two of our patients. Most patients see the same day of the procedure, but delayed management may sometimes be long or may be revealed by a complication such as hemorrhagic shock or a urine retention.[6] The proper surgical management of penile amputations involves not only the regularization and hemostasis of the stump to save the life of the victim but especially the "repositioning". Therapeutic management is at the same time a good level of development of the technical platform but also the experience of the urologist or the surgeon in this field. Functional results depend on the speed of care. a maximum delay of 6 hours should not be exceeded for reimplantation, but thanks to advances in microsurgery, successful reimplantation after 16 hours of ischemia.[7] If reimplantation is not possible, homostasis and urethrostomy should be performed. This is the case of our two patients who consulted 20 hours after the incident. The existence of psychosis poses the problem of reconstructive surgery in case of bodily injury. Young and Feinsilver.[8] proposes that the surgical procedure be reconstructed, being supervised by psychiatric care so that it is simply recidivated, or that it is useless to carry out a reimplantation of the penis if the patient is not stable at the psychiatric level.[1]

CONCLUSION

Genital self-amputations are rare phenomena frequently occurring in the field of chronic psychosis (schizophrenia). The care must be concerted between the surgeon and the psychiatrist to optimize the chances of success of the penile reimplantation that has benefited from the progress of the microsurgery.

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