Grand Rounds Vol 7 pages 9–12
Speciality: Psychiatry, Urology
Article Type: Case Report
DOI: 10.1102/1470-5206.2007.0004

GR

e-med
www.e-med.org.uk

Self-castration: a case report

S. Haleem, S. J. Griffin and G. K. Banerjee

Department of Urology, Ipswich Hospital, Ipswich, Suffolk, IP4 5PD, UK

Corresponding address: Mr S. Haleem, Specialist Registrar, Trauma and Orthopaedic Surgery, Edith Cavell Hospital, Bretton, PE3 9GZ, UK. E-mail: dr_shahnawaz@yahoo.com

Date accepted for publication 21 January 2007

Abstract

We present a case of an apparently well gentleman performing self-castration. On presentation he was in shock. After resuscitation his wound was explored and haemostasis achieved. While such presentations are seen with a background of psychiatric illness, our patient did not suffer from such disorders. This case emphasises the importance of a multi-disciplinary holistic approach for optimum patient care.

Keywords

Genital; self-mutilation; sex reassignment surgery.

Case report

A 62-year-old gentleman was admitted as an emergency after he had performed self-castration using a Stanley knife (Fig. 1). He stated that he had cut off his testicles after an argument with his wife and flushed them down the toilet. He was under the influence of alcohol at the time. He denied suicidal intent and had no past medical history.

On examination, he was peripherally shut down, tachycardic and hypotensive. After fluid resuscitation in the emergency room, he was moved directly to the operating theatre where the wound was explored under general anaesthesia (Fig. 2). The cut ends of the two spermatic cords were identified, transfixed and tied. The wound was well irrigated and closed. No remnant of testicular tissue was found. Intra-operatively, he developed ST depression secondary to haemorrhagic shock. He required a 4 unit blood transfusion peri-operatively. Postoperative recovery was uneventful.

He later admitted wanting to be a girl since the age of ten. He had explored the possibility of gender reassignment 20 years previously at a different hospital, where he was seen in a specialist clinic for gender reassignment but was apparently refused for unknown reasons at this time. He had had three children but had never enjoyed sex. He lived a normal life but would cross dress on weekends, unknown to his family. On this occasion his wife discovered him dressed as a female. This caused an argument and led to his eventually performing self-castration. Psychiatric assessment did not reveal any abnormality with his mental state. He was discharged 2 days later.

Discussion

Genital self-mutilation (GSM) is an under reported event[1]. The first case was reported in 1901 by Stroch[2]. Other reports include transsexuals, patients with suicidal tendencies, and distorted

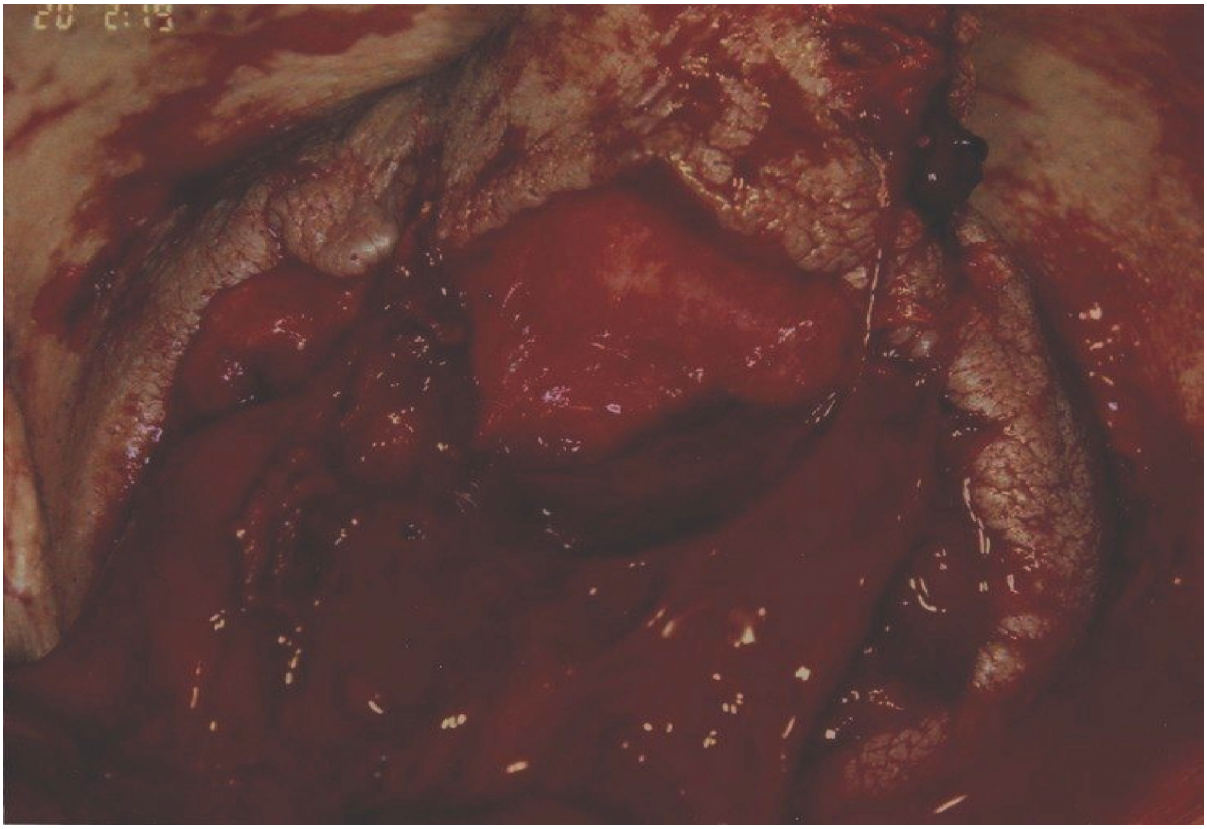

Fig. 1. Pre-operative view of the open wound containing a blood clot with loss of scrotal skin and testicles.

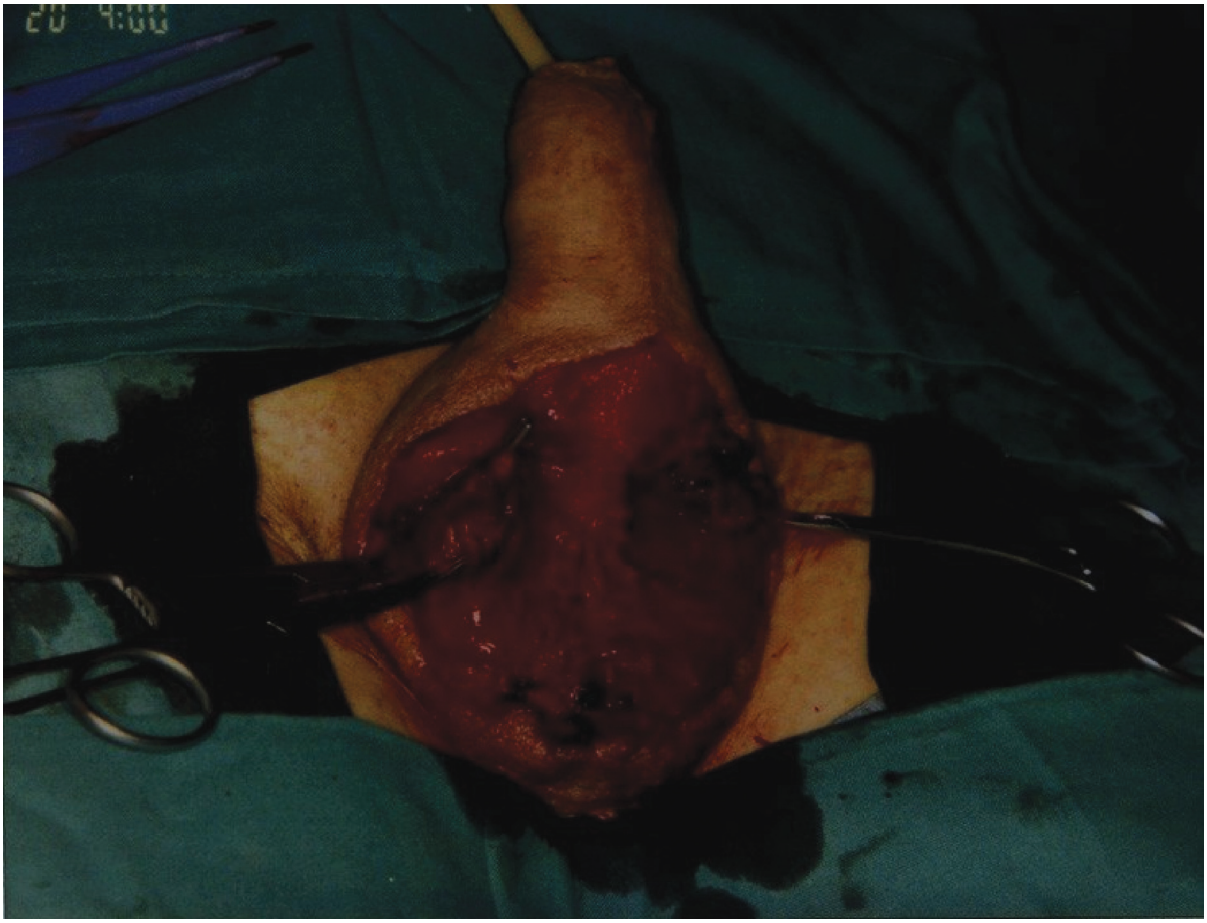

Fig. 2. Peri-operative view after haemostasis was achieved with clipping of the spermatic cords.

religious beliefs, with concurrent substance abuse also playing an important role[3]. GSM has recently been performed in an attempt to become a hijra (eunuch of the Indian subcontinent)[4], because of dissatisfaction with the wait for sex reassignment surgery(SRS)[5].

Transsexualism is a relatively rare condition of atypical gender development in which there is a psychological perception of self as masculine or feminine which is incongruent with one's phenotype. This term was replaced by the term gender identity disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition™ (DSM IV, 1994). GSM in the case of transsexuals is an amateur attempt at sex change, usually with co-existent substance abuse. Previous reports have indicated that such patients, in order to achieve gender reassignment, resort to genital self-mutilation especially when unaware of the availability of professional help[6]. Russell *et al.*[7] state that genital mutilation with a 'rational' basis occurs by auto-castration, with penile mutilation usually seen in a psychotic state and in a more haphazard manner.

A study by Aboseif *et al.*[8] reveals that 61% of episodes involved one or both testicles and repeat mutilation has been widely reported in up to 31% of attempts with a history of alcohol and/or drug abuse in 55% of patients. It is accepted that the majority of self-mutilators are psychotic at the time of the attempt[9]. Our patient was living a normal life and his interest in dressing up as a woman was not known even to his family. This episode was induced with excess alcohol consumption followed by discovery by his wife, which led to an argument. It is understood that had he not been discovered he may have continued living the same way.

While our patient was indeed living a normal life it seems apparent that he never came to terms with not being able to proceed with his desire for SRS. This is evidenced by the fact that he never enjoyed sex and regularly cross-dressed. There was subjective distress at being male and earlier attempts to obtain reassignment surgery were turned down for reasons not known at this time. This indicates that he was a transsexual, bearing in mind that his post-operative psychiatric assessment did not reveal any mental illness. It is possible that he may have had psychological problems prior to or following the problems he faced being a transsexual. However, the absence of an acute or mental illness shows that his coping mechanisms were allowing him to function reasonably well. The presence of a mental illness would have manifested as a psychosis or severe depression with psychotic symptoms, manifestations of which would have arisen much earlier and been reported by family members. While homosexuality and transvestism are alternatives, the patient in question had a strong desire for gender reassignment and felt disgust in having a male body. Other reports have also found that some transsexuals who had attempted GSM were not considered psychotic at the time of their psychiatric assessment[6] and that auto-castration was simply a method of facilitating the process of achieving their primary objective of SRS[10].

The treatment of GID begins with a possible diagnosis of transgender issues which should be raised when any patient presents with any degree of genital self-mutilation[7]. Treatment in many centres follows the Standards of Care of the Harry Benjamin International Gender Dysphoria Association. This is a professional organization developed to bring definition and consistency to treatment of patients with GID. Treatment may last several years and includes psychological/psychiatric evaluations, completion of the 'real life' test, administration of hormone therapy to create desired secondary sex characteristics, and finally SRS[11]. Psychotherapy has proved useful in helping to adapt to the new situation or in dealing with issues not addressed before treatment[12]. A recent study showed that transsexuals who underwent SRS showed improvement, while those who did not undergo SRS showed a more dysfunctional psychological profile[13].

Our patient has been referred to the psychiatric team and it is envisaged that he will be offered further assessment of his gender dysphoria, psychological support in coping with the consequences of his actions (the cross dressing as well as the self-mutilation) not only for himself but also for his family. The psychiatric input will focus on preparing him to lead his life as a female. This will reflect society's expectations and his ability to deal with the resulting consequences. The family may pass through a period of grief and may need supportive psychotherapy. At the time of writing this report there were no indications for psychotropic medications.

Teaching point

A holistic view of care is needed between urologists and psychiatrists to prevent further harm to an already fragile state of mind. Community care with a sympathetic approach in the recognition of this presentation may be the most important aspect of treatment. All such presentations should then be referred to a centre treating patients with transgender issues.

References

1. Catalano G, Morejon M, Alberts VA, Catalano MC. Report of a case of male genital self mutilation and a review of the literature with special emphasis on the effects of the media. J Sex Marital Ther 1996; 22: 35–46.
2. Stroch D. Self castration. Letter to the Editor. JAMA 1901; 36: 270.
3. Romilly CS, Isaac MT. Male genital self-mutilation. Br J Hosp Med 1996; 55: 427–31.
4. Master V, Santucci R. An American hijra; a report of a case of genital self-mutilation to become India's ''third sex''. Urology 2003; 62: 1121.
5. Murphy D, Murphy M, Grainger R. Self-castration. Ir J Med Sci 2001; 170: 195.
6. Krieger MJ, McAninch JW, Weimer SR. Self-performed bilateral orchiectomy in transsexuals. J Clin Psychiatry 1982; 43: 292–3.
7. Russell DB, McGovern G, Harte FB. Genital self-mutilation by radio-frequency in a male-to-female transsexual. Sexual Health 2005; 2: 203–4.
8. Aboseif S, Gomez R, McAninch JW. Genital self-mutilation. J Urol 1993; 150: 1143–46.
9. Greilsheimer H, Groves JE. Male genital self-mutilation. Arch Gen Psychiatry 1979; 36: 441.
10. Baltieri DA, de Andrade AG. Transsexual genital self-mutilation. Am J Forensic Med Pathol 2005; 26: 268–70.
11. Cole CM, Emory LE, Huang T, Meyer 3rd WJ. Treatment of gender dysphoria (transsexualism). Tex Med 1994; 90: 68–72.
12. Cohen-Kettenis PT, Gooren LJ. Transsexualism: a review of etiology, diagnosis and treatment. J Psychosom Res 1999; 46: 315–33.
13. Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. J Am Acad Child Adolesc Psychiatry 2001; 40: 472–81.