**Case report**

**Genital self-mutilation, the second tentative was dramatic.**

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**Abstract**

Genital self-mutilation was a urological emergency rarely encountered in practice. It constitutes a drama by its manner of occurrence and its clinical presentation. In case of heavy bleeding, a state of hemorrhagic shock may set in and require resuscitation. The mainstay of treatment is emergency surgery and psychiatric advice. This follow-up must be regular and assess an intention of recurrence.

**Key words**: external genitalia, penis, penis, amputation, mutilation, urethrostomy, schizophrenia.

**INTRODUCTION**

Self-injury is defined as the act of inflicting bodily harm to oneself without suicidal intent (1). Genital self-mutilation is one of the rarer and more complex forms, both psychopathologically and symbolically (2). It constitutes a serious urological emergency (3). The prognosis is marked by the repercussions on the psycho-social level, then those on the urinary and sexual functions of the organ (4). The authors report a new observation of self-mutilation in a schizophrenic patient with a history of attempted testicular amputation.

**CASE REPORT**

Mr I. Y., 29 years old, followed for schizophrenia for 2 years on neuroleptics with poor compliance and an attempt to amputate his testicles a week earlier is brought to the emergency room by his family following the self-amputation of his penis in the toilet about 9 hours before his. On admission, the clinical examination found an agitated patient in hemorrhagic shock with a severed penis at its base and active bleeding and a scrotal wound in the process of healing (Figure 1). Hemostatic measurements were taken in the emergency room spontaneously at resuscitation measures and psychiatric advice. After stabilization, he was referred to the operating room. Under spinal anesthesia, after abundant washing with betadine saline, a perfect control of the hemostasis of the stump was ensured with identification of the urethra and the corpus cavernosum. A bladder catheterization was easy with a foley catheter 18 (Figure2). The final gesture consisted of a urethrostomy, placement of a drain and suturing of the different planes (Figure 3). The postoperative follow-up was simple. The patient is regularly followed up in psychiatry.

**DISCUSSION**

Genital self-mutilation was a urological emergency rarely encountered in practice. It constitutes a drama by its manner of occurrence and its clinical presentation. In case of heavy bleeding, a state of hemorrhagic shock may set in and require resuscitation. The mainstay of treatment is emergency surgery and psychiatric advice. This follow-up must be regular and assess an intention of recurrence. Beyond the functional prognosis (micturition and sexual), there is a problem of body image.

Penile amputation has been classified into three groups: self-mutilation, criminal amputation and traumatic accident (5). Self-mutilation, an unusual situation in daily urological practice, is a rare phenomenon. It occurs in the majority of cases in a psychotic setting, but can be secondary to drug or alcohol abuse. Treatment and management varies according to the severity of the lesions, the time required for consultation and the mental state of the patient (6).

The man has an ambivalent relationship with his body. As an object of care, revered, the body can also be the site of mutilating practices. Men have always marked their bodies in ritual practices (7). Self-mutilation would be reported in mythology, ethnology and some religious and contemporary rituals (2). The first self-castration in history is reported by Lucien of Samosate who relates the legendary story of Combatus. He is a young Syrian of great beauty who, having received from his king the important mission to accompany Queen Stratonice on her journey to Hierapolis in Phrygia. He decided to emasculate himself before the departure and to lock his genitals in a box which he entrusted to the king. This sacrifice enabled him to confound his slanderers on his return and was worth to him to be filled with honors by the king (8).

The incidence of this disease is not well known, the majority of cases do not seem to be reported by the patient or the family (9). Blacket et al identified three particular groups at risk for genital self-harm: schizophrenics, transvestites and men with religious or cultural conflicts (10).

The current standard of treatment for this infrequent injury is replanting with approximation of the urethra, corpus cavernosum and microsurgical anastomosis of the dorsal vein, arteries and nerves. This technique is considered to reduce immediate and long-term postoperative complications (11). Certain conditions are necessary to replant the amputated penis and predict the success of the surgery: state of viability of the organ, state of the graft bed or stump of the penis at the time of injury. The amputated part must be wrapped in gauze soaked in saline solution and placed in a sterile bag (12). If re-implantation is not possible, hemostasis with skin ureterostomy is performed (13).

In our context, given the contexts in which the procedure occurred and the time of presentation, we were unable to attempt reimplantation. Our attitude was first of all to stabilize the patient and transport him to the operating room with perfect control of hemostasis, regularization of the stump and urethrostomy.

**CONCLUSION**

Self-mutilation of the penis is a rare situation in urological practice. It frequently occurs in schizophrenia. The management is multidisciplinary and may involve the resuscitator, the urologist and the psychiatrist. The surgical attitude in emergency depends on the severity of the lesions and the time of consultation. It must be done with the intention of preserving the functions of the penis as much as possible.

**DECLARATIONS**

**Contributions of the authors**

All the authors contributed substantially to the design and production of this article.

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**Conflicts of Interest**

All the authors have declared that there is no conflict of interest.

**Ethical Approval and Consent to Participate**

Not applicable.

**Consent to publication**

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Figure 1: Traumatic section of the penis with a healing wound at the bursae level.



**Figure 2:** Intraoperative appearance: correct hemostasis, identification of the urethra and corpus cavernosum with catheter intubation of the urethra

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**Figure 3**: aspect at the end of the operation

