International Journal of Clinical Urology
2025, Vol. 9, No. 1, pp. 85-88
https://doi.org/10.11648/j.ijcu.20250901.24

Case Report

Genital Self-Mutilation in Two Young Men: Case Reports and Literature Review

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Abstract

The aim of this case series was to report the diagnostic and therapeutic characteristics of self-mutilation of the external genitalia received in the urology department of the Yalgado OUEDRAOGO University Hospital in Ouagadougou. Two cases of self-mutilation of the external genitalia were retrospectively studied: one case of total emasculation and one case of laceration of the root of the penis. The parameters studied were age, reason for consultation, history, psychological state, clinical signs and treatment. The two patients were aged 27 and 29. The first was a smoker and drug user and the second a schizophrenic. The clinical signs were marked by total removal of the penis and external genitalia in one patient and a simple laceration in the other. Treatment was surgical and consisted of a urethroplasty and a simple suture. The psychiatric assessment was conducted according to DSM-5 criteria and revealed acute psychotic disorder and paranoid schizophrenia, respectively. The patients underwent multidisciplinary care with close psychiatric monitoring and postoperative urological follow-up. No cases of recurrence of self-harm were observed within six months of treatment. Management of self-injurious lesions remains problematic in developing countries due to the lack of microsurgical equipment.

Keywords

Self-mutilation, External Genitalia, Psychiatric History, Burkina Faso

1. Introduction

Self-mutilation is an intentional injury inflicted by a person on a part of his own body, with no apparent intention of killing himself [1]. In everyday urological practice, this is an uncommon phenomenon. Psychiatric examination most often reveals a state of chronic psychosis, and sometimes a context of drug or alcohol abuse [2, 3]. The lesions are varied, ranging from simple lacerations to complete removal of the penis and/or scrotum [2]. We report two cases of self-mutilation of the external genitalia received at the urology department of the Yalgado OUEDRAOGO university hospital, including one case of total emasculation and one case of laceration of the base of the penis.

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Received: 14 April 2025; **Accepted:** 24 April 2025; **Published:** 29 May 2025

2. Cases Report

Observation 1

D. B., a 27-year-old travelling salesman, smoker of 4 pack-years and user of unspecified narcotics, was brought to the visceral emergency department by the fire department for self-mutilation of the external genitalia. His general condition was World Health Organization (WHO) stage II, and hemodynamics were good.

Psychiatric examination noted carelessness, incoherent speech with delusions of persecution and dissociative symptoms (school disinvestment, pathological travel, morbid rationalism, barrage). Urological examination revealed total emasculation with a soiled wound and bleeding edges classified as American Association for the Surgery of Trauma (AAST) (V) for penile damage + AAST (V) for testicular lesions (Figure 1).

In the operating room, for the surgical technique, we performed surgical debridement (excision of necrotic edges), urethroplasty by urethral eversion fixed to the skin with absorbable 3/0 Vicryl on a 16 Ch silicone urinary catheter left in place for 10 days; ligation of the spermatic cord stumps with 2/0 Vicryl (Figure 2). In the absence of an operating microscope and microsurgical sutures (6/0, 7/0), no attempt at reimplantation was undertaken, illustrating the technical limitations of resource-limited countries. Antibiotic prophylaxis with Ceftriaxone + metronidazole and tetanus sero-vaccination were indicated. A psychiatric evaluation was conducted by a psychiatrist according to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition) criteria. The patient presented with a picture of acute psychotic disorder not otherwise specified, characterized by persecutory delusions, disorganized thinking, incoherent speech, and catatonic behavior. The Positive and Negative Syndrome Scale (PANSS) was not administered due to local unavailability. The patient was then prescribed haloperidol and lepticur following psychiatric advice.

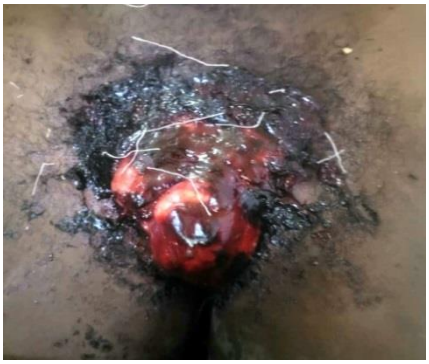

Figure 1. *Total emasculation: removal of testicles and penis.*

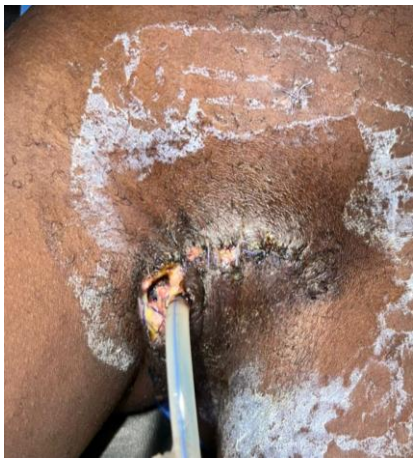

Figure 2. *Wound status at third postoperative day.*

At six months and one year, there was still maintenance of urethral patency with good urination, no urinary tract infection, no recurrence of self-mutilation, and regular intake of neuroleptic treatment (haloperidol). Erectile function was not applicable due to total emasculation. Mental health monitoring is provided on an outpatient basis with the psychiatry department.

Observation 2

I. S., 29-year-old patient in psychiatric care for schizophrenia on Haloperidol, drug user with history of abdominal self-mutilation one year ago received for genital self-mutilation. On examination, his general condition was WHO stage I, and his hemodynamic status was good.

Psychiatric examination noted incoherent speech with dissociative symptoms. Urological examination revealed a 5 cm arciform laceration at the base of the penis on the dorsal surface (Figure 3).

In the operating room, after extensive washing with SSI, exploration revealed a laceration involving Buck's fascia, the albuginea of the corpora cavernosa and a section of the superficial dorsal vein of the penis. The corpus spongiosum and urethra were intact classified as AAST (II). (Figure 4). We performed a layer-by-layer suture: Albuginea repaired with Vicryl 3/0, Buck's fascia and skin plane closed successively with separated stitches with Vicryl 4/0 and 2/0. No active bleeding at the end of the procedure. We administered antibiotic prophylaxis with Ceftriaxone + metronidazole and tetanus sero-vaccination. The patient was then transferred to psychiatry for further management. After psychiatric evaluation, the patient, already being treated for paranoid schizophrenia according to DSM-5 under haloperidol with poor compliance, presented elements of relapse: auditory hallucinations, withdrawal, emotional dissociation.

Figure 3. *Arciform laceration on the dorsal surface of the penis.*

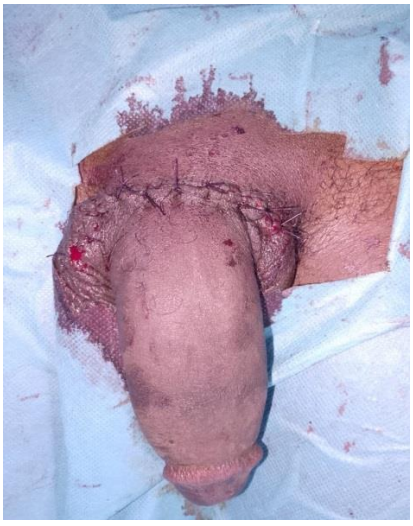

Figure 4. *Closing after trimming and thorough washing with ISS.*

At one year, there was complete healing without urethral stricture or fistula. There was persistence of negative symptoms of schizophrenia but good adherence to treatment, no recurrence of self-mutilation to date; erectile function preserved according to the patient, without objective exploration (absence of complaint).

3. Discussion

Genital self-mutilation is a uro-psychiatric emergency whose incidence is poorly known in Burkina Faso due to under-notification and the absence of studies on the subject. Many cases of behavioral or psychiatric disorders are in fact treated at the indigent hospital in our context. According to the literature, this is a rare condition [2, 4, 5]. In Morocco, 08 cases were reported over 10 years at the Hassan II University Hospital, Fez [6].

Genital self-mutilation is not pathognomonic of any particular disorder. It is observed in a wide variety of morbid states [2], with a preponderance of psychotic conditions [4-6]. A review of the literature by Veeder T. et al. found that schizophrenia spectrum disorders were the predominant causes (49%), followed by substance abuse (18.5%), personality disorders (15.9%) and gender dysphoria (15.3%) [7]. The contributing factors can be multiple and complex, and are often interconnected. This was the case with our two patients, all of whom were psychotic and also had addictions to psychoactive substances.

For lesion assessment, surgical exploration in the operating theatre is always advisable. Lesions may include laceration or amputation of the penis, strangulation of the penis with possible penis necrosis, scrotal and testicular laceration or amputation [3, 6, 8-11].

Intraoperative surgical procedures depend on the lesion assessment, and the management of these lesions has benefited from advances in microsurgery. In the literature, superficial lacerations require simple suturing [12].

In cases of scrotal and/or testicular amputation, surgical exploration of the lesions in the operating room is always indicated, with evacuation of hematoma, hemostasis by ligation of the remaining spermatic cord stumps, trimming and skin covering [2].

In cases of deep laceration or amputation of the penis with an available and viable amputated stump, microscopic reimplantation with anastomosis of the dorsal neurovascular structures is the treatment of choice. Ideally, patients should be transferred to centers with expertise in microvascular techniques [13]. In cases where the amputated segment is lost or non-viable, some authors have performed microsurgical free-flap phalloplasty with satisfactory results [13, 14].

In our setting, with a sober technical set-up due to the absence of microsurgical equipment (magnifying glasses, fine sutures, microsurgical box), we were unable to carry out a reimplantation in our first patient. Makeshift reimplantation without magnifying glasses is the prerogative of developing countries [1, 5, 11].

Therapeutic management of external genital self-mutilation requires concomitant psychiatric evaluation. It is a psychiatric emergency due to the risk of recurrence, suicide or significant psychological trauma [5, 11].

4. Conclusion

Genital Self-Mutilation lesions are varied, and their management has benefited from the contribution of microsurgery in developed countries. It remains problematic in developing countries due to the lack of microsurgical equipment. Psychiatric care is necessary in all cases to consolidate the results of surgery.

Abbreviations

WHO	World Health Organization
AAST	American Association for the Surgery of Trauma
DSM	Diagnostic and Statistical Manual of Mental Disorders

PANSS Positive and Negative Syndrome Scale

Author Contributions

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Funding

This research has not received any fund or grant.

Conflicts of Interest

The authors declare no conflicts of interest.

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