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MALE GENITAL MUTILATION: FOUR EVENTS OF A KIND

J.C. ORAKWE AND N.O. CHUKWUJAMA
Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria

INTRODUCTION

Male genital mutilation may occur by accident, as a result of an attack by an assailant or by self-infliction[1]. Genital self-mutilation is thought to be rare, but the incidence seems to be increasing, as many cases are now reported in the literature. By 1996, 110 cases of genital mutilation had been reported in the English literature[2], and in 2002 the 24th case was reported in the Japanese literature[3]. In Nigeria, very few cases have been seen[4,5]. Reports of genital mutilation from road traffic accidents and other accidents abound in the literature[6,7], while - apart from a few published reports[5,8,7,10] - genital mutilation as a result of attacks by assailants, ritualists or other willful perpetrators is more often read and heard of in the media and rarely published in the medical literature. Male circumcision, which is widespread amongst native Africans and Africans in the diaspora, is a sociocultural ritual. Though regarded as genital mutilation by some[11], we regard it as symbolic and, thus, not as a genital mutilation by willful perpetrators.

We herein present and discuss four cases of male genital mutilation, two of which occurred by self-infliction, while the other two were done by assailants.

CASE REPORTS

Case No. 1

A.M, a 28-year-old university graduate, presented with a cut-off penis at MacBenson Hospital, Onitsha at about 9.00 a.m. on February 25th, 1991. On presentation, he was calm and apparently unremorseful, saying that he had cut off his penis because he did not need it in his new-found life. He claimed that the penis was pulling him towards sinful feelings and that he had to cut it off at about 5.30 a.m. that day with a sharp kitchen knife. The cut-off penile stump was brought along to the hospital wrapped in a piece of cloth.

The patient had a normal childhood with caring parents who saw him through the university till he graduated with a bachelor's degree in chemistry. During his early youth, his sexual experiences consisted only of masturbation for which he felt no guilt. He had his first heterosexual contact when he was 23 years old. He had then graduated and was doing his national service. He had sexual relationships with many women and he described his experiences as satisfactory and without problems. He also indulged in alcohol and cigarette smoking. Soon after completing his national service and taking up a paid appointment, he was converted to a Pentecostal "born-again" Christian religious group. Thereafter, his general attitude changed. He made away with a lot of his friends and dumped alcohol and smoking. He lived, as he said, only with his bible, fasting often and meditating over bible passages. His new perceived fanatical inclination brought him into conflict with his family members and erstwhile friends, such conflict being at times violent.

He was not known to have previously consulted a psychologist or psychiatrist and no known family history of psychiatric illness was admitted. He was single and was working in a privately owned factory that produced beauty products. When the act was committed, he was initially scared by what had happened, but soon after, he had a feeling of relief. .

On examination, the patient was conscious, calm and unremorseful. He was not pale. There was complete amputation of the penis at the level of about the proximal 1/3 of it. The wound was still fresh with minimal bleeding. The bladder was not distended. He had an emergency operation, and wound debridement with urethrocutaneostomy was done using 4/0 vicryl sutures. A 16 Fr. Foley urethral catheter was left in-situ. While the patient was in the ward, the psychiatrist was consulted and after review, schizophrenia was diagnosed and the patient was commenced on treatment and followed up.

The urethral catheter was removed three weeks later, and the patient's surgical follow-up was uneventful until he stopped keeping his appointments 18 months after discharge. The feeling of relief the patient had had at presentation persisted after three months of follow up in our clinic, but by the time he was last seen at about 18 months after discharge, he had begun to regret his action.

Case No. 2:

E. U., a 30-year old man, was admitted to the Accident and Emergency Unit of the Nnamdi Azikiwe University Teaching Hospital, Nnewi, about two hours after his parents had found him in is room in their family house with a cut-off penis. He claimed to have cut it off with a razor blade that was then still in the room, and to have thrown the penile stump into the pit latrine.

The patient had grown up with his parents who were of the social middle class. He seemed to be average or below average intellectually, as he attended the secondary school and left after completing the years but failed the final examination. He then opted for apprenticeship in trading. He could not however settle down for the apprenticeship, seeming to be in a hurry. Not long after, he claimed to have mastered the art of trading and thus disengaged from his master to set up his own business. Things did not turn out well for him as he could not establish a stable business. He had thought that his parents would come to his aid and bail him out, especially financially, but that was not forthcoming. He started going astray indulging in alcohol consumption and the smoking of cigarettes and marijuana. He then developed an intense feeling of hatred against his parents, especially his father. He developed serious doubts as to whether his father really was his father because of the perceived wickedness of his father in refusing to help him out of his predicament. He believed that his father had enough funds to do so. Eventually, he believed that since his parents had not displayed any distress at his plight, he had to torture himself, apparently with suicidal intent. There was no history of loss of consciousness.

There was no previous history of deliberate self-harm and he had not been under the care of a psychologist or psychiatrist before. There was no admitted history of psychiatric illness in the family. At the time of the illness, the patient was single and unemployed.

On examination, he was uncooperative and aggressive and talked irrationally. He was conscious, not pale and the vital signs were stable. There was a radical amputation of the penis from the root, with laceration and loss of the adjoining scrotal skin, and fresh bleeding from the site.

An emergency operation was undertaken. The lacerations were sutured with 2/0 nylon suture and a urethrocutaneostomy was fashioned using 4/0 vicryl sutures with a 16 Fr. urethral catheter left in-situ on intermittent drainage. The sutures were removed on the 7th day and the urethral catheter was removed on the 21st day.

Psychiatrists who reviewed him during admission made a diagnosis of Indian Hemp psychosis and commenced him on treatment. As at the time of this report, he was still being seen on follow-up visits by both the urologists and the psychiatrists.

Case No. 3:

R. O., a 42-year old driver/mechanic, presented to the MacBenson Hospital, Onitsha, with a three-day history of injury to his penis. He claimed that he returned home after the day's work to meet his nagging wife who started to pour vituperations on him for coming home late. She accused him of infidelity and extramarital relationship with another lady who also lived in the town. This scenario had become rampant over the preceding three months. He later went to bed after holding back his temper. He was amazed when he was woken up by a sharp pain only to find his wife grabbing his penis and cutting it with a sharp kitchen knife. He struggled free and, after a short brawl with his wife, left for the hospital, where his penile laceration was sutured. On the second postoperative day there was evidence that the wound condition was unsatisfactory, and the patient was referred to our hospital. His assailant wife, though said to be cantankerous, had not previously physically injured her husband, herself, or any other person willfully. She has a stable family background and there is no family history of psychiatric illness. However, she was said not to be a sociable woman

On presentation, the patient was unkempt and anxious-looking with a soggy dressing on the penis. There were sutures on the penis and on removing the sutures, it was discovered that the penis was deeply lacerated at the level of about the distal third, with attachment to the proximal stump maintained by a mesh of tissues in the ventral aspect. The distal stump was obviously unviable. The patient was not catheterized. There was no evidence suggesting self-mutilation. The bruises on his body and the extragenital lacerations were consistent with injury from physical attack using blunt and sharp objects.

Emergency wound debridement with urethrocutaneostomy was done with a 16 Fr. Foley catheter left in situ. The catheter was removed after three weeks. Voiding and the general condition of the patient remained satisfactory until he was last seen eight months after discharge.

His wife, who visited later, admitted committing the act, claiming that she was propelled by the base instinct of jealousy to do so. She refused referral to the psychiatrist for evaluation.

Case No. 4:

G.C., a 38-year old trader, was admitted to the Mac-Benson hospital, Onitsha, with a one-day history of injury to his penis. He was returning from a late night outing when five men he believed were ritualists accosted him. The men pounced on him, overpowered him, held him on the ground and used a sharp object to cut off his penis and ran away. He got home, picked up a few toiletries and went to a private clinic at Nsukka where he received a first-aid treatment before he left in the early hours of the morning to his brother's house at Onitsha. His brother then brought him to our hospital.

On presentation, he looked agitated. The penis was amputated at the level of about the proximal third, and the crudely sutured penile wound was still discharging serosanguinous fluid. There were also bruises of the upper and lower lips and on the thigh, and minor superficial lacerations on the upper third of both thighs.

Minimal debridement, suturing of lacerations and urethrocutaneostomy were done with a 16 Fr. Foley catheter left in situ. The catheter was removed after three weeks and voiding was still satisfactory at his last follow-up visit at three months from discharge.

Information received later from his wife who visited the hospital revealed that the patient had been a philanderer and adulterer. She claimed that her husband's ordeal was from the aggrieved relatives of the absentee husband of a woman with whom her husband had a sexual relationship. The knowledge of their relationship had permeated the neighborhood and her husband had been repeatedly warned to desist from his nocturnal visits to the woman. It was on one of such visits that her husband suffered his injuries at hands of the aggrieved relatives of the woman.

DISCUSSION

With the identification of a rising incidence of genital self-mutilation by Eke in 2000[2], it seems a plausible presumption that such acts are much more frequent than the small number of published cases would suggest. This is more so for genital mutilation by assailants and thus makes our two cases of genital mutilation by assailants noteworthy. In our socio-cultural environment, the genitals are sacrosanct and regarded with awe. Matters of the genitals are handled in a reclusive and secretive manner. Thus, pathologies involving the genitals may only be known when they become unbearably troublesome, and even then under a veil of secrecy. There is no doubt that the fear of embarrassing publicity is a curtailing factor to reporting cases of this nature. Minor genital mutilations seldom receive medical treatment and are often concealed by the patient. Anonymous cases of genital mutilations are often reported in the media, but one wonders if such reports are not most times sensational.

Three groups of men identified as being at risk for genital self-mutilation are psychotics, character-disordered individuals including transsexuals, and those under social influences (a group that includes schizophrenics with religious delusions)[12], and the frequent diagnoses are schizophrenia, affective psychosis and alcohol intoxication[13]. Our cases 1 and 2 were found to be schizophrenics and case 1 seems to fit into the Klingsor syndrome[14]. He must have committed the self-mutilation in a state of psychosis with religious delusions. This explanation is supported by the patient's deep religious feelings, and this case can be seen as a classical example of atone-

ment for a committed act and prevention of further commission of the act, by sacrificing the "guilty" organ. The patient himself betrayed the underlying train of thought by saying that his penis was pulling him towards sinful feelings, and often quoting the biblical passage Mathew Chapter 5, verses 29-30 to justify his action.

In the second case, a feeling of guilt for perceived failure in his business raised fantasies of genital mutilation. The patient's desire of self-punishment was directed against his parents whom he perceived as the source of his feeling of guilt. Importance has been attributed to the concept of guilt in the psychodynamics of any kind of self-harm.[15]

Genital mutilations by wives have been reported before. These include the sensationalized case of John Bobbitt who suffered genital mutilation by his wife Lorena[8], and 100 penile amputations performed by wives on their philandering husbands in Thailand[9]. The motives of these assailants remain conjectural. It is believed by some people that amputation of the phallus is fatal[16], and traditionally, it is regarded as such in our environment. We suspect that our patient 2 had the intention to commit suicide, as suggested by his failure to raise any alarm after the act. The perpetrator in our case 3, the patient's wife, denied any intention to kill him and insisted that she was merely acting on a base instinct of jealousy. In case 4, only the unidentified assailants would know their motives.

The traditional management of patients with self-inflicted injuries consists of surgical treatment of the physical lesion, followed by psychiatric referral. Van Moffaert[17] found that the integration of a psychiatric strategy into the surgical management is more effective than the sequential provision of surgical and psychiatric treatments. For our patients with genital self-mutilation, we applied this mode of treatment with success. However, the assailant wife in case 3 refused psychiatric referral, even though we believe strongly that to have contemplated and executed such an act within our cultural environment, there was likely to be a psychopathological underlay.

It is now standard practice in many centres to do microsurgical re-implantation of the amputated penis, even after prolonged warm ischemia[18]. In our cases, we resorted to urethrocutaneostomy because the presentations were very late and the facilities and expertise for microsurgery were not for microsurgery were not available. We have found this satisfactory to us and to our patients in the circumstances.

We still believe that cases of genital mutilation are under-reported, especially in our environment.

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