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A Case of Cut Throat and Penis

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Authors' contributions

This work was carried out in collaboration among all authors. Author PAT designed the report and authors PAT, KO and PM wrote the first draft of the manuscript. Authors PAT and PM managed the literature searches. Authors PAT and KQ formed the Otolaryngology team, author KO was the psychiatrist, author PM headed the Urology team and author MN was the general surgeon who all collaborated to manage the patient. All authors read and approved the final manuscript.

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Case Study

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ABSTRACT

Aims: The management of cut throat injuries with genital self-mutilation is very challenging due to the complex anatomy of the neck and the need to attain acceptable cosmetic and functional outcomes of penile reconstruction. This report thus seeks to highlight the importance of a multidisciplinary approach to the management of these cases and to raise awareness of the need for early suspicion and diagnosis of mental diseases especially among young people.
Presentation of Case: We present an 18-year old newly diagnosed paranoid schizophrenic man who presented with cut throat and penis after an attempted suicide and was successfully managed at our facility. The family had not suspected any mental disorder. He had repair of the cut throat

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(involving both trachea and esophagus) after elective tracheostomy, refashioning of the penile stump and psychiatric treatment.

Discussion: Cut throat injuries happen in cases of attempted suicide and among patients with psychiatric problems. Cases of cut throat and genital self-mutilation though rare, have been reported among schizophrenics. Some of such individuals have an impression that destroying their genitals could help them overcome their excessive sexual desires and for others to help them remain righteous. Our patient was diagnosed of schizophrenia after he attempted suicide.

Conclusions: Young people with mental illness must be identified and given appropriate treatment early. Patients presenting with cut throat and penis require a multidisciplinary team approach involving at least an otorhinolaryngologist, a urologist, a general/gastrointestinal surgeon and a psychiatrist for optimum care.

Keywords: Cut throat; penis; suicide; self-mutilation.

ABBREVIATION

NG tube – Nasogastric tube.

1. INTRODUCTION

Cut throat injuries happen in cases of attempted suicide and among patients with psychiatric problems [1]. Cases of cut throat and genital self-mutilation though rare, have been reported among schizophrenics. Some of such individuals have been said to have an impression that destroying their genitals could help them overcome their excessive sexual desires. Some others had severely deprived childhood or had been involved in substance abuse [1,2]. When genital self-mutilation is as a result of religious delusions, it is referred to as Klingsor syndrome. Klingsor was a fictitious character in Wagner's opera who castrated himself to be judged as righteous by the Knights of Grail [3]. The management of these cut throat injuries with genital self-mutilation are very challenging due to the complex anatomy of the neck with the presence of vital structures like the esophagus and trachea and the need to attain acceptable cosmetic and functional outcomes of penile reconstruction.

2. PRESENTATION OF CASE

An 18-year old unemployed young man was referred to our facility eight months ago. A day prior to his presentation at our hospital, his relatives rushed him to the referring hospital with an open neck wound, left wrist wounds and penile amputation. His relatives later found the severed penis after about four hours of injury and wrapped it in a piece of cloth, but it was declared non-viable on arrival at the hospital and disposed off. The patient was then resuscitated and referred to our hospital. His vital signs at presentation were: respiratory rate – 18 cycles/minute, oxygen saturation - 100% on supplemental oxygen via tracheostomy mask over the open neck wound, pulse rate - 88beats/minute, blood pressure - 122/60mmHg. He was admitted and sedated since he was aggressive with thoughts of persecution recurrently. The penile stump was catheterized temporarily (as shown in Fig. 1.) to allow for micturition. The client had no chronic medical or surgical history and no family history of psychological illness. He was accompanied to our hospital by his mother. Haemogram was 6.7g/dL.

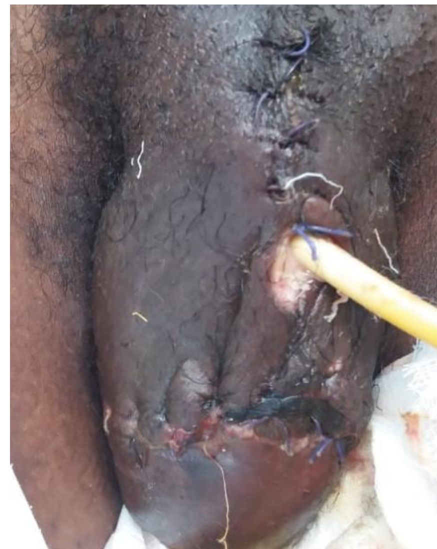

Fig. 1. Catherized penile stump

Our diagnosis was Traumatic Neck Injury with Penile Amputation secondary to Attempted Suicide and Suspected Psychiatry Disorder. Patient was transfused two units of whole blood and neck exploration under general anaesthesia done.

The intraoperative findings were an open anterior neck wound as shown in Fig. 2. with a deep laceration completely transecting the trachea with air bubbles seen in the wound. The anterior esophageal wall was also perforated. This was a transverse perforation of approximately 1cm as seen on rigid esophagoscopy. The vocal cords were not cut but their mobility could not be assessed since the patient was under general anaesthesia. The esophageal wound was closed and the separated tracheal ends re-apposed with silk 2/0. The strap muscles were also re-apposed, and the subcutaneous tissues closed in layers with Vicryl 2/0. A size 7 plastic cuffed tracheostomy tube was inserted inferior to the injury site through an anterior tracheal wall window and tapes applied. The skin was also closed with nylon and the wound dressed after placement of wound drains. He was then given intravenous fluids, antibiotics and analgesics with nasogastric tube (NG) feeding.

Neck wounds healed well however client remained aggressive and recurrently pulled out his NG tube. Thus, a Stamm's feeding gastrostomy was done by the general surgeons to continue feeding since he needed to be kept nil per os for six weeks to allow the esophageal wound to heal. Parenteral nutrition was not available and was not affordable by the client.

Postoperatively, he continued to inform the staff that attended to him that he wanted to die. The client was thus reviewed by the psychiatrist who obtained a more detailed history. The patient had been apparently well until 3 months prior to presentation at our hospital, when he started believing that close friends, acquaintances and some strangers wanted to harm him, sabotage him or kill him. He also started hearing multiple voices of people he could not see, including the voice a priest he knew. The voices often discussed him in derogatory terms and sometimes gave him commands. 2 months after the onset, the voices started telling him to kill himself so that he would go to heaven. Those voices repeated themselves frequently until he felt pressured to obey them. He thus eventually stabbed himself in the neck and cut his left wrist and penis.

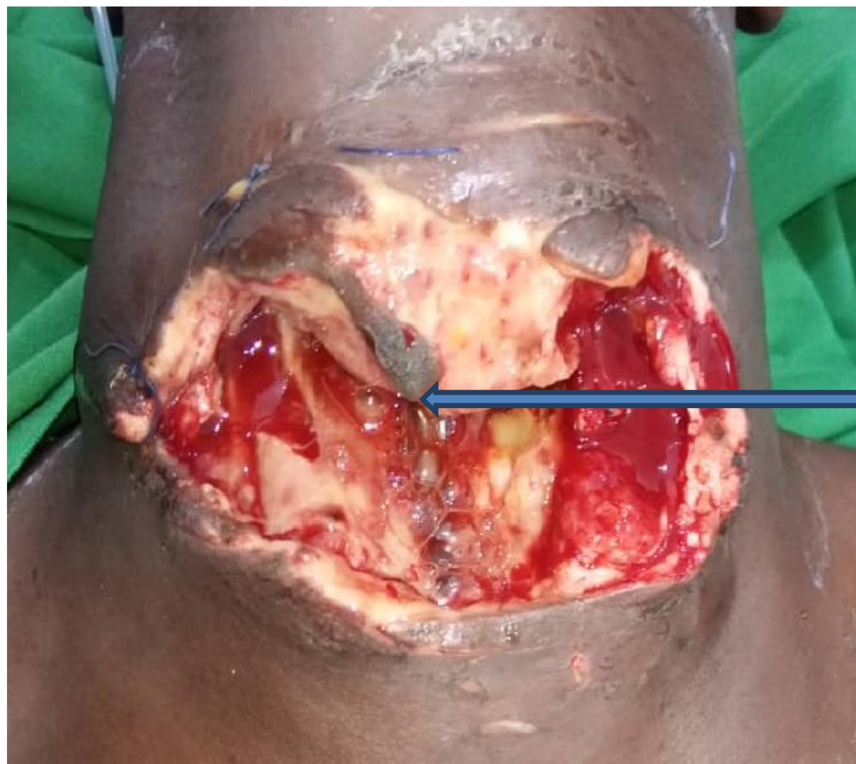

Fig. 2. Open neck wound as seen prior to the wound repair with air bubbles coming out of the trachea (arrowed)

The diagnosis made was paranoid schizophrenia. Treatment with Haloperidol and Olanzapine resolved the delusions that formed the basis of his self-harming behaviour.

After four weeks of admission, the urologists re-fashioned the penile stump after debriding off necrotic tissues. The penile stump was formalized by closing the corpora and spatulating the urethral neomeatus. The penile repair was only going to allow micturition but not sexual intercourse.

Flexible nasolaryngoscopy done after six weeks on admission showed paralyses of both vocal cords. Barium swallow also showed an intact pharynx. The tracheostomy tube was thus maintained, and oral feeding resumed.

He recovered well and continues to depend on the tracheostomy tube due to the paralyzed vocal cords. He urinates through the penile stump but cannot have sexual intercourse because of the loss of the penile shaft and continues care by the surgical teams and the psychiatrist.

3. DISCUSSION

Suicide is a common cause of death among psychiatric patients. Suicidal cut throat is rare. People who may not be suffering from a major mental illness may also inflict suicidal cut throat on themselves in the face of socio-economic challenges. These injuries are increasing around the world due to alcohol and drug addiction, poverty, unemployment and increased road traffic accidents. Males tended to have these injuries more often in an Indian study [4]. Early suspicion, diagnosis and treatment of mental diseases especially among young people is key.

The treatment of cut throat injuries must be based on careful history and examination. Various tests like contrast studies, esophagoscopy, angiography etc. may be done [5]. Our patient had neck exploration and repair of the neck wounds.

The management of these injuries requires close collaboration between the otolaryngologist, anesthetist and the psychiatrist. The anesthetist ensuring a secured airway, the otolaryngologist repairing the neck injuries and the psychiatrist providing mental healthcare both prior to and after the surgical repair [6]. The neck wound must be closed layer by layer to reduce the risk of fistula formation [4]. This patient also required a feeding gastrostomy since he had to be kept nil per os for six weeks until adequate healing of the esophageal wall was achieved. Most cases of cut throat are managed under general anaesthesia with a few being repaired under local anaesthesia and sedation [4]. In cases of cut throat, early intervention is important since these patients could die from aspiration of blood from the neck wounds and from acute upper airway obstruction [7]. There is also a risk of hemorrhagic shock resulting from severe bleeding from a severed vessel.

The most appropriate management of penile amputation is reimplantation using microsurgical techniques. This involves reconstruction of the urethra and reanastomoses of the corporeal bodies with microsurgical repair of dorsal penile vessels and nerves. If microsurgical techniques are unavailable, macroscopic anastomosis of the urethra and corporeal bodies can be performed to achieve satisfactory erectile function. However, successful reimplantation is only possible after 16 hours of cold ischemia time or 6 hours of warm ischemia [8].

In this case, reimplantation was not possible as the patient arrived at our hospital after 24 hours of the injury and the distal penile stump had been discarded at the referring health facility.

In all cases of penile amputation, the severed portion should be identified, cleaned, preserved and quickly sent to hospital with the patient. The severed penis should be rinsed in saline solution, wrapped in saline-soaked gauze, and kept sealed in a sterile plastic bag. The bag should then be placed in an outer bag with ice. This is important as hypothermic injury to the severed segment can occur if it is in direct contact with ice for long periods. [9]

In this case, although the patient's relatives managed to send the amputated segment to the referring hospital early, it was poorly preserved and thus was not found viable enough for reimplantation.

The psychological input in the management of these patients is important as they tend to relapse into a worse state if not closely monitored and adequate psychiatric treatment given. Family support was also crucial in achieving a successful recovery in this case.

4. CONCLUSION

Young people with mental illness must be identified and given appropriate treatment early to avoid such incidents. Patients with cut throat and penis require a multidisciplinary team approach involving at least an otorhinolaryngologist, a urologist, a general/ gastrointestinal surgeon and a psychiatrist for optimum care. Early presentation and repair of the neck injury with well-preserved severed penis improves the chances of a favorable outcome.

CONSENT

Informed consent was obtained from this patient for the publication of this article.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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