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Male Genital Self-Mutilation with Maggot Infestation in an Intoxicated Individual

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RUNNING HEAD: Genital Self-Mutilation Case Report

Maggot Infestation Following Male Genital Self-Mutilation: A Case Report

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Abstract

We present the case of a 55-year-old homeless male who presented with penoscrotal necrosis and maggot infestation) secondary to genital self-mutilation. The patient gave a history consistent with gender identity disorder and indicated that he had injected lotion and other unknown substances into his penis hoping it would fall off. The patient had no history of psychosis. He sought medical attention only after he was no longer welcome on public transportation due to the odor emanating from this infection. Untreated gender identity disorder with substance abuse in this case led to a drastic behavior with significant consequences.

Key words: Genital Self-Mutilation, Gender Identity Disorder, Myiasis, Homeless, Maggots.

Male Genital Self-Mutilation with Maggot Infestation: A Case Report

Self-harm is a relatively common behavior seen in psychiatric patients and ranges from superficial soft tissue damage to serious injuries sustained following failed suicide. (1) Genital self-mutilation (GSM), however, is quite rare with roughly 125 reported cases in both the urological and behavioral health literatures since 1901. (2,3) Severe cases have included complete auto amputation of the penis and auto castration. (2) Psychosis is thought to be highly associated with GSM, being present in a majority of patients with such behavior. (4,5) Other features common in some cases of male GSM are alcohol intoxication, gender confusion, and guilt following sexual behavior. (6)

Case Presentation:

A 55-year-old homeless man presented to the emergency department complaining of malodorous discharge and pain coming from wounds on his penis. Physical examination revealed two necrotizing abscesses on the dorsal aspect of the penis, each about 1cm in length, along with necrotic tissue of the scrotal skin. Surgical exploration revealed that these two wounds were entrances to a single cavity that was filled with maggots. A burrow was also found leading into the scrotum with accompanying necrotic tunica vaginalis. The maggots were evacuated and necrotic tissue excised. The testes were found to be unaffected. A psychiatric consultation was requested.

Upon initial evaluation, the patient was found to be alert and aware. He explained that he had always felt that he was “supposed to be a woman” and said that he had “gender identity

disorder." He said that he had previously injected lotion and other substances that he could not remember into the base of his penis while severely intoxicated. He stated that he had hoped the result would be his "penis falling off." He reported a history of significant alcohol dependence, but also said he had recently completed a sobriety program and was living at a homeless shelter. He was initially indifferent to the festering infection in his penis. The primary impetus for seeking treatment was reportedly a profoundly foul odor coming from his penis that barred him from riding public transportation. He also admitted that secondary reasons for agreeing to treatment were being in pain and concern about "the bugs." With no other mode of transportation available, he was brought to the hospital by ambulance.

The patient's grooming was appropriate and he presented as oriented in all spheres. He fully cooperated with the clinical interview. His speech was linear and logical; there were no loose associations and was with appropriate rate and rhythm. He said that his mood was "good," although his affect was flat. He denied past treatment for mental illness, but said that he became "depressed" at times about being a man. He denied a history and symptoms of severe depression, as well as having been treated with psychiatric medication or hospitalization for mental health needs. He denied a history of hallucinations, delusions, manic symptoms and suicide attempts. A review of hospital records revealed only a history of hypertension and a dozen visits to the city detoxification facility in the previous 18 months for alcohol withdrawal. The patient reported spending most of his recent time homeless and living off of public assistance and from hand outs. He stated that he had always thought he should have been a woman and reported a history of trouble with the police as a young man after being caught stealing women's underwear.

Following a brief hospital stay, he was discharged without complication. It was felt that he would not benefit from inpatient psychiatric treatment as he regretted the self-mutilation and because behavior had occurred while the patient was intoxicated. He also stated that he had completed a sobriety program since mutilating himself and he felt that the behavior would not recur. He also said that he did not believe that his depressed feelings were "getting in the way" and was not interested in a discussion of whether an antidepressant medication was indicated. Resources for low cost counseling were given to the patient and he was encouraged to return to the hospital if thoughts of self harm returned.

DISCUSSION

This patient's presentation is remarkable in that GSM without co-occurring psychosis is extremely rare. The patient also differs from other GSM cases presented in the literature as his choice of mutilation was not by excising his genitalia, but rather by injecting his penis with lotion and other substances. Such a method is also quite unusual. His motivation for this behavior was clearly driven by revulsion at having a penis, leading to a wish that it would fall off. He showed extreme indifference to the medical complications of his self-injurious behavior, resulting in infection and tolerating, for at least several weeks, the presence of pain, necrotizing tissue and finally maggot infestation.

The patient also reported being intoxicated by alcohol at the time self-mutilation. It has been observed that GSM does occur in patients intoxicated by alcohol at the time of injury, as well as those who suffer from gender confusion. (6) Indeed, the patient explained his highly unusual behavior as being a result of his suffering from gender identity disorder (GID).

GID is thought to be relatively rare and its etiology is not well understood. (7) It is characterized by behaviors associated with strong identification with the other gender and

significant discomfort with or aversion to one's own gender. (8) Some have argued that atypical gender practices are a social construct mediated by cultural norms and a diagnosis simply pathologizes such behavior, while others report a strong link between sexual identity and an interaction of the endocrine and nervous systems. (9,10) Regardless of etiology, those suffering from GID have been identified as having high comorbidity for other Axis I disorders, particularly depression and anxiety. (11)

In an already unusual case, perhaps the most striking feature is the presence of myiasis, or maggot infestation, following GSM. Wound myiasis is common in the homeless population whose soiled clothes and unsanitary living conditions naturally attract flies. (12) Obviously, the presence of necrotizing tissue made an ideal infestation site and account for the maggots in the penis and scrotum. In a multicenter study in 2000, Sherman found that genitourinary myiasis is rare and often misdiagnosed. (12) In this case, the presence of maggots in the penis and scotal sac confirm infestation of the genitals. Follow up analysis of the species of fly larva is not available to us.

Untreated GID and co-occurring alcoholism in a homeless patient led to an extraordinary presentation of genital self-mutilation with penoscrotal myiasis. A confluence of pathologies and circumstances likely led to this presentation, including alcohol intoxication, extreme disgust of the male appendage, self-mutilation, and extreme infection in the presence of homelessness. While not viewed as severe a mental illness as schizophrenia or bipolar mood disorder, GID may be an undertreated disorder in the homeless, leading on occasion to GSM with severe medical complications. This case argues for the need to consider not only psychosis, but GID in the differential diagnosis of genital self-mutilation with severe complications, particularly in those that are homeless with alcohol dependence.

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