



Trauma and reconstruction

Self-penile amputation: A case of Klingsor Syndrome

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ABSTRACT

Klingsor Syndrome is an infrequent Surgical and Psychiatric emergency. We present such a case of self-penile amputation with delayed presentation precluding re-plantation. A 48 year-old man on follow-up for Schizophrenia presented 16 hours after peripubic self-penile amputation. Patient was managed by stump-plasty with an option for subsequent perineal urethrostomy. Anatomically, there are three levels of penile amputation: peripubic like in our case, proximal shaft and glans. Surgical options are re-plantation, stump-plasty and total penile reconstruction. Complications following re-plantation include urethral stricture, urethral fistula, and diminished sexual function. Concomitant Psychiatric care is paramount.

Introduction

Self-inflicted penile amputation is an uncommon form of physical self-harm resulting from psychological anomaly. The condition not only presents a surgical emergency but also has the potential to cause subsequent challenges in self-care and sexual function thereby exacerbating the psychological distress of the patient. We present a case of self peripubic penile amputation with delayed presentation precluding re-plantation.

Case report

A 48 year-old male on follow-up for Schizophrenia presented to our hospital after completely amputating his penis at the base using a kitchen knife. He attributed his action to perennial problems with the spouse, most of which surrounded his reproductive organs. He reported no suicidal intention. He was non-compliant with his medication. He presented approximately 16 hours following the amputation. The amputated penis was brought too but had not been preserved. At presentation his vital signs were within normal ranges. The penile amputation was noted to be peri-pubic. There were no other injuries on secondary survey.

The delayed presentation and lack of preservation of the amputated penis prompted the decision to opt out of re-implantation and to proceed with stump fashioning.

In theatre, with the patient supine, general anaesthesia was administered and the pubic region cleaned and draped. A 16 French Foley

catheter was inserted to facilitate intra-operative manipulation and post-operative bladder emptying. The skin, the Buck's fascia and the tunica albuginea were debrided. Each of the corpora carvenosum was then closed separately with 2-0 absorbable suture. The urethra was spatulated and everted to avert development of stenosis. Hemostasis was achieved and the minimal remaining penile skin approximated with 3-0 absorbable suture. Sterile dressing was then applied.

The patient subsequently underwent 7 days of in-hospital stump care. Management by the Psychiatry team was also re-established. Following discharge, the patient was followed-up at the Urology and Psychiatry Clinics. The stump was healing well by the 20th post-operative day. The patient reported no other complication and as expected he retained urinary continence. Subsequent perineal urethrostomy will be offered based on patient's preference.

Discussion

Self-penile amputation is a rare form of self-harm. It is classified as either phallic when the intention was to commit suicide or Klingsor syndrome when the patient was not intent on committing suicide. Other causes of penile amputation include accidental trauma, domestic violence, animal bites, as a complication of circumcision and malignancy. Anatomically, penile amputation can be peri-pubic like in our case, proximal part of the penis or at the level of the glans.¹

The principles of management following self-penile amputation are saving life, restoration of function and management of the underlying Psychiatric condition. Following advanced trauma life support (ATLS)

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protocol to save life, the options for definitive surgical management are re-plantation, stump-plasty and total phallic reconstruction.² Re-plantation offers the best results with a majority having restoration of micturition function and sexual function. Microscopic re-anastomosis of the venous sinusoids and nerves has been shown to have better outcome than macroscopic re-plantation.^{3,4} Requisite for re-plantation is early presentation, proper preservation of the amputated organ, minimal contamination and availability of pre-requisite skill and equipment. In addition, stabilisation of the predisposing Psychiatric condition is paramount to minimise chances of repeat occurrence. Complications following re-plantation include urethral stricture, urethral fistula, skin necrosis, venous congestion and diminished sexual function.⁵ For glans amputation only, there is documented good sexual function and minimal urinary complications following stump-plasty.¹ This is because glans amputation spares the corpus carvenosum and involves the corpus spongiosum only. Total phallic reconstruction is often used for cancer-related amputations and in instances where re-plantation is not possible, as it was in our case above.

Conclusion

Self-penile amputation is an uncommon Urological and Psychiatric

emergency. The preferred modes of management in descending order are microscopic re-plantation, macroscopic replantation, stump-plasty and total phallic reconstruction. Management of the underlying Psychiatric condition should complement the Urological management.

Ethical considerations

Informed consent for this case report including the medical image was obtained from the patient.

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