

Self-inflicted traumatic penile amputation: A case of Klingsor syndrome

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Abstract

Klingsor syndrome, also known as self-inflicted traumatic penile amputation, is a rare condition that often occurs in individuals who suffer from psychiatric disorders, religious preoccupations, substance abuse, and societal neglect or isolation. This condition is a urological emergency that requires immediate and prompt attention. Despite its rarity, the management of Klingsor syndrome is crucial for optimal prognosis and function. Here we present a case of a 52-year-old male, who presented to our hospital after completely amputating his penis at the base using a kitchen knife.

Keywords

Klingsor syndrome; Penile self-amputation; Penile trauma; Reconstructive urology.

Introduction

Klingsor syndrome, also known as self-inflicted traumatic penile amputation, is a rare condition that often occurs in individuals who suffer from psychiatric disorders, religious preoccupations, substance abuse, and societal neglect or isolation. This condition is a urological emergency that requires immediate and prompt attention. Despite its rarity, the management of Klingsor syndrome is crucial for optimal prognosis and function.

Case Report

A 52-year-old male, who was a known case of Schizophrenia presented to our hospital after completely amputating his penis at the base using a kitchen knife. He attributed his action to voices in his head that told him to cut his penis or otherwise face dire consequences. He reported no suicidal intention. He was non-compliant with his medication. He presented approximately 16 hours following the amputation. The amputated penis was flushed down the toilet. At presentation, his vital signs were within normal ranges.

The penile amputation was noted to be peri-pubic, and the scrotal skin was avulsed from its attachment from the root of the penis. There were no other injuries on the 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 anesthesia was administered, and the pubic region was cleaned and draped. A 16-French Foley catheter was inserted to facilitate intra-operative manipulation and post-operative bladder emptying. The skin, Buck's fascia, and the tunica albuginea were debrided. Each of the corpora cavernosum was then closed separately with 2-0 absorbable sutures. The urethra was spatulated and everted to prevent the development of stenosis. The scrotal skin was refashioned and sutured to the urethra circumferentially. 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 postoperative day. The patient reported no other complication and as expected he retained urinary continence. Subsequent perineal urethrostomy will be offered based on the patient's preference.

Discussion

Self-inflicted penile amputation is a rare form of physical self-harm that stems from psychological anomalies. It presents not only as a surgical emergency but also has the potential to worsen the patient's psychological distress and self-care challenges. Research has shown that 87% of patients with self-inflicted penile amputation suffer from undiagnosed psychiatric disorders, with 51% of these individuals having decompensated schizophrenia [6]. Risk factors for this condition include being an elderly single male, having trans-sexual or homosexual tendencies, or feeling guilty for committing sexual offenses [6-8].

The management of Klingsor syndrome requires a multidisciplinary approach involving both a urologist and a psychiatrist. Re-implantation is the gold standard, but it may not always be possible due to significant local ischemia and a prolonged duration post-trauma. A concurrent psychiatric evaluation is crucial to prevent future occurrences and to ensure optimal functional outcomes. In this case, a diagnosis of paranoid schizophrenia was made, and the patient was promptly initiated on medications. Long-term follow-up, psychosocial rehabilitation, and support from family and society are necessary for optimal outcomes.

Penile amputation can be classified as phallicide when the intention was to commit suicide or Klingsor syndrome when the patient did not intend to commit suicide. Other causes of penile amputation include accidental trauma, domestic violence, animal bites, circumcision complications, and malignancy. Anatomically, penile amputation can occur at the peri-pubic, proximal, or glans level [1]. The principles of management following self-penile amputation include saving life, restoring function, and managing the underlying psychiatric condition.

Definitive surgical options include re-plantation, stump-plasty, and total phallic reconstruction [2]. Microscopic re-anastomosis of the venous sinusoids and nerves has been shown to have better outcomes than macroscopic re-plantation [3,4]. Re-plantation requires early presentation, proper preservation of



Figure 1: Pre-operative photo of completely amputated penis with a small penile stump.



Figure 2: Post-operative photo showing a per-urethral catheter in the reconstructed urethra with the scrotal skin refashioned circumferentially around the urethra.

the amputated organ, minimal contamination, and pre-requisite skills and equipment. Complications following re-plantation can include urethral stricture, urethral fistula, skin necrosis, venous congestion, and diminished sexual function [5]. Stump-plasty is a good option for glans amputation, as it spares the corpus cavernosum and only involves the corpus spongiosum, resulting in good sexual function and minimal urinary complications [1]. Total phallic reconstruction is often used for cancer-related amputations or when re-plantation is not possible.

Conclusion

Self-penile amputation is a rare urological and psychiatric emergency requiring a multidisciplinary approach for optimal management. In descending order, the preferred modes of management are microscopic re-plantation, macroscopic re-plantation, stump-plasty, and total phallic reconstruction. The management of the underlying psychiatric condition is essential to complement the urological management and achieve the best outcomes.

References

1. Terayama T, Sakamoto T, Ikeuchi H, Tanaka Y. Self-penile glans amputation: a report of two cases. *Acute Med Surg.* 2017; 4: 101-104.
2. Jezior JR, Brady JD, Schlossberg SM. Management of penile amputation injuries. *World J Surg.* 2001; 25: 1602-1609.
3. Roche NA, Vermeulen BT, Blondeel PN, Stillaert FB. Technical recommendations for penile replantation based on lessons lear-

ned from penile reconstruction. J Reconstr Microsurg. 2012; 28: 247-250.

4. Çelik A, Ulman I, Özcan C, Avanoğlu A, Erdener A, Gökdemir A. Reconstruction of penile shaft amputation: is microvascular re-anastomosis mandatory? BJU Int. 2003; 92: 1-2.

5. Morrison SD, Shakir A, Vyas KS, Remington AC, Mogni B, et al. Penile replantation: a retrospective analysis of outcomes and complications. J Reconstr Microsurg. 2017; 33: 227-232.

6. Kochakarn W. Traumatic amputation of the penis. Braz J Urol. 2000; 26: 385-389.

7. Ozan E, Deveci E, Oral M, Yazici E, Kirpınar I. Male genital self-mutilation as a psychotic solution. Isr J Psychiatry Relat Sci. 2010; 47: 297-303.

8. Bhatt YC, Vyas KA, Srivastava RK, Panse NS. Microneurovascular reimplantation in a case of total penile amputation. Indian J Plast Surg. 2008; 41: 206-210.

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