SURGICAL RECONSTRUCTION OF PENILE STUMP IN A PATIENT WITH KLINGSOR SYNDROME

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SUMMARY
Self-mutilation of genitilia is an extremely rare entity, usually found in psychotic patients. Klingsor syndrome is a condition in which such an act is based upon religious delusions. The extent of genital mutilation can vary from superficial cuts to partial or total amputation of penis to total emasculation. The management of these patients is challenging. The aim of the treatment is restoration of the genital functionality. Microvascular reanastomosis of the phallus is ideal but it is often not possible due to the delay in seeking medical attention, non viability of the excised phallus or lack of surgical expertise. Hence, it is not unusual for these patients to end up with complete loss of the phallus and a perineal urethrostomy.

We describe a patient with Klingsor syndrome who presented to us with near total penile amputation. The excised phallus was not viable and could not be used. The patient was managed with surgical reconstruction of the penile stump which was covered with loco-regional flaps. The case highlights that a functional penile reconstruction is possible in such patients even when microvascular reanastomosis is not feasible. This technique should be attempted before embarking upon perineal urethrostomy.

Key words: Penile injury, Penile reconstruction, Penile amputation

INTRODUCTION
Self-mutilation of genitilia is an extremely rare entity, usually found in psychiatric patients. Klingsor syndrome is a condition in which such an act is based upon religious delusions. The management of these patients is challenging. It is not unusual for these patients to end up with complete loss of a functional phallus and a perineal urethrostomy. We describe a patient with Klingsor syndrome who presented to us with near total penile amputation. The excised phallus was not viable and hence could not be used. The patient was managed with surgical reconstruction of the penile stump.

Case report
A 30-year old unmarried male presented to the emergency with history of self inflicted genital trauma with a shaving blade. The injury was inflicted approximately twenty hours before the presentation. The patient was a known case of schizophrenia but was not taking any medications. On examination, there was a penile stump, little less than 2 cm in length with complete loss of skin up to the level of mons pubis. The scrotum and testis were normal.

He was hypotensive and there was profuse bleed from the severed corporal bodies. The amputated part of the phallus was brought wrapped in a newspaper. Microvascular or macrovascular re-implantation was not an option due to the prolonged time since amputation and improper storage of the amputated phallus. The patient was taken to the operating room. An intravenous injection of a third generation cephalosporin and an aminoglycoside was administered and the wound was cleansed with copious amounts of normal saline and antiseptic solution.

The corporal bodies were closed with vicryl and haemostasis was achieved. The urethra was identified and a 16-Fr catheter was placed in it. As the patient became haemodynamically stable after haemostasis and fluid resuscitation along with transfusion of two units of blood, we contemplated concurrent reparative surgery. Considering the age of the patient it was decided not to go ahead with a perineal urethrostomy. The suspensory ligament of the penis was divided. The stumps of the corpora cavernosa were meticulously dissected off the pubic bone to gain additional length. At the end of the mobilisation, approximately 6 cm of corporal bodies were available (Figure 1 a).

The corpora spongiosum was dissected off the cavernosa for approximately 1 cm. A transverse scrotal flap was elevated in continuity with the dartos layer of the scrotum (Figure 1 b). This flap was sutured to the ventro-lateral surfaces of the corpora cavernosa. The urethra was spatulated and anastomosed with the medial margins of the scrotal flap (Figure 1 c). The medial
margins of the scrotal flaps were then sutured with each other to provide ventral skin coverage. The scrotal flap helped in reduction of the scrotal volume and hence, the scrotum was pushed dorsally. This ensured that there would be no scrotal soiling with urine when the patient voids in standing position. A semicircular flap was mobilised from the right groin of the patient and was used to cover the dorsal part of the penis. This flap was sutured to the corporal bodies and to the dorsal margins of the scrotal flap (Figure 1 d). The donor site was closed primarily (Figure 1 e).

The patient made an uneventful recovery. The antibiotics were stopped on the fifth post-operative day. He was evaluated by the psychiatrist in the post operative period. He attributed his act to a command by God. The name ‘Klingsor’ has been based upon a fictitious character in Richard Wagner’s opera. Klingsor was a magician who castrates himself in order to maintain his chastity and hence, be acceptable in a religious clan.4

These patients are found to be suffering from paranoid schizophrenia along with command hallucinations. The act of genital mutilation is attributed to an order by God.5,6 The extent of genital mutilation can vary from superficial cuts to partial or total amputation of penis to total emasculation.2,4 They present as surgical and urological emergency as the associated haemorrhage can be torrential and life threatening.

The aim of the treatment is restoration of the genital functionality. Microvascular or macrovascular re-anastomosis of the phallus is the ideal treatment and has been shown to have good long-term results but it is often not possible due to the delay in seeking medical attention, non viability of the excised phallus or lack of surgical expertise. It has been seen that the amputated phallus, if properly kept under hypothermic conditions, may survive for up to 16 hours. In the case presented above, the amputation was performed twenty hours prior to presentation and the amputated part was improperly stored, hence re-anastomoses was not an option. Provision of skin cover to the remaining phallus is a major issue.

Split skin grafts have been used but they are not reliable and there is additional morbidity of the donor site. Flaps do not depend upon the recipient site for their blood supply and hence are more reliable. As these patients present in emergency department, phallic reconstruction is not given primary importance and they end up with a total amputation and urethrostomy.2,4

This procedure has a significant bearing of the quality of life of these patients as they are rendered impotent and also that they cannot void while standing.

Our technique is a feasible option, even in emergency setting, as it preserves functional penile length. The patients can void in an erect posture and penile tumescence is maintained. Our technique is applicable only if some amount of phallus remains following amputation. In case of total penile amputation, perineal urethrostomy remains the standard procedure.
CONCLUSION
The case highlights that a functional penile reconstruction is possible in patients with genital mutilation even when microvascular reanastomosis is not feasible. This technique should be attempted before embarking upon perineal urethrostomy.

REFERENCES