OPEN ACCESS

Saudi Journal of Medical and Pharmaceutical Sciences
Abbreviated Key Title: Saudi J Med Pharm Sci
ISSN 2413-4929 (Print) | ISSN 2413-4910 (Online)
Scholars Middle East Publishers, Dubai, United Arab Emirates
Journal homepage: https://saudijournals.com

Case Report **Psychiatry**

Penile Strangulation in a Schizophrenic Patient: A Case Study

Serigne Souaïbou Ba[1]*, Djiby Dieng[2], Cheikh Diop[3], Elhadj Daouda Diop[4], Malick Ngom[5]

[1]Department of Psychiatry, Fann Universitary Hospital at Dakar
[2]Department of Urology, Regional Health Center at Kaffrine
[3]Department of Urology, Regional Health Center at Thies
[4]Department of Public Health, Iba Der Thiam University
[5]Department of General Medicine, Abdou Aziz Sy Dabakh Hospital

DOI: https://doi.org/10.36348/sjmps.2025.v11i08.011 | **Received:** 15.06.2025 | **Accepted:** 19.08.2025 | **Published:** 23.08.2025

***Corresponding author:** Serigne Souaïbou Ba
Department of Psychiatry, Fann Universitary Hospital at Dakar

Abstract

Penile strangulation is a rare event that requires emergency treatment. Metal rings are most commonly used on the penis for autoerotic or aggressive purposes or to enhance sexual performance. We report a case of a 19-year-old male patient undergoing psychiatric treatment at the Dalal Xél health center in Fatick, who was admitted to the emergency department of Kaffrine Regional Hospital (in Senegal), for penile strangulation by a metal ring. The ring had been placed at the root of the penis three days earlier. The patient had no urinary disorders. Treatment consisted of removing the ring and providing psychiatric care. However, to prevent urinary and sexual complications, treatment must be provided early. Through this observation and data from the literature, the authors report the subtlety of the management of this pathological situation, highlighting the psychotic context which favors this type of self-aggressive behavior.

Keywords: penis, self-harm, metal rings, psychosis, emergencies, Kaffrine.

1- INTRODUCTION

Penile strangulation by a ring is a rare event, easily diagnosed, the prognosis of which depends on the early treatment [1].

This condition is often seen in patients who are seeking to enhance their sexual performance [2].

Among patients with psychotic disorders, sexuality is rarely discussed during their follow-ups. In their impulsiveness and delusional background, they can have dangerous attitudes such as mutilation and strangulation of the external genitalia [3-5].

This is described under the name Klingsor syndrome [6].

In this paper, we report a case observed in the urology andrology department of the Kaffrine regional hospital center in Senegal. The aim is to describe the circumstances of its occurence, as well as the clinical and therapeutic aspects.

2- CASE PRESENTATION

Mr X.X, aged 19, single with no children, has been receiving psychiatric care at the Dalal Xel mental health centre in Fatick for six years with undetermined treatment. He was admitted to the emergency department with a ring strangulating his penis. The clinical picture had been evolving for three days prior to admission. We had no information about the regularity of his follow-up or his compliance with his psychiatric treatment. His mental state was not assessed by a psychiatrist on that day. However, the patient appeared emotionally cold, and was dressed appropriately. He did not speak incoherently, was unresponsive to questions and appeared indifferent to those around him. The patient reported having mishandled a ring on his penis for autoerotic reasons. He felt the need to do so for relief and was accustomed to this act, according to him. The physical examination revealed that he was in good general health, with no bladder distension and oedema of the distal two-thirds of the penis below the constricting ring (Image 1). The rest of the examination was unremarkable. The haemostasis assessment was satisfactory.

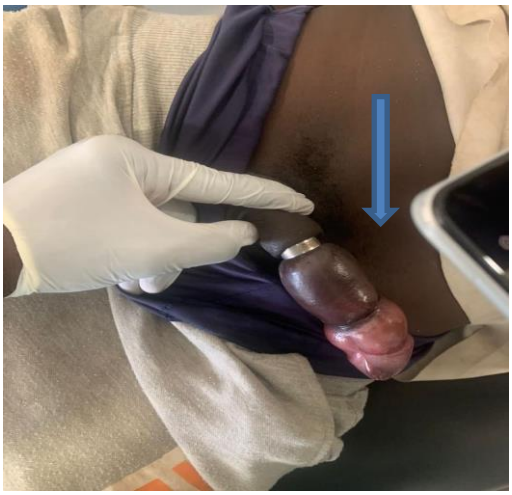

Image 1: Oedema of the distal two-thirds of the penis below the constriction ring

The procedure involved removing the metal ring in the operating theatre under local anaesthetic. The ring was removed by soaking the strangulated area with red betadine and then inserting two Kelly forceps on either side of the ring to avoid skin damage. A Harrington cutting forceps was used to cut the ring (Image 2).

Image 2: Harrington cutting pliers

After removal of the ring and re-circumcision due to excess foreskin, gradual decongestion of the penis was achieved immediately. Ulcerations around the site of ring constriction were noted. Treatment was administered, and the aftermath was marked by an isolated episode of acute urinary retention on day 1, requiring transurethral bladder drainage (Image 3).

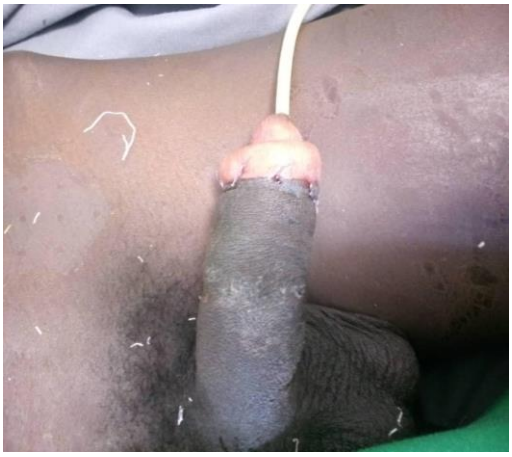

Image 3: Appearance of the penis after removal of the metal ring and insertion of a transurethral urinary catheter

The catheter was removed on day 2. The patient responded well to antibiotic therapy and local care. No psychiatric treatment was administered to him. The patient did not receive psychiatric consultation during

his stay, and his condition did not require emergency transfer to a mental health center. On his release, he was referred for further psychological care.

3- DISCUSSION

- **Urological aspects of penile strangulation:**

Penile strangulation manifests early on as oedema, making it impossible for the patient to remove the ring themselves within the first few hours. This is due to the rapid interruption of venous and lymphatic circulation in the skin. The subsequent course will depend on the severity of the obstruction. For tight rings, ischaemia and then necrosis set in early. This is observed in young patients who seek to maintain a prolonged erection by using tight rings that compress the entire penis [7, 2].

For loose rings, which cause damage to the skin and subcutaneous tissue, there is no ischaemia of the penis. Lymphoedema develops secondarily and progressively worsens in the penile skin, giving it a cardboard-like appearance in the long term and, later, an elephantiasis-like appearance [8].

The time between the onset of the incident and the start of treatment is decisive for the short-, medium- and long-term prognosis. Treatment must be urgent. However, Prunet et al. noted that the patient's psychological state influences the time taken to seek medical advice. It is widely accepted that psychological disturbances can lead to anosognosia of medical urgency. Our patient was seen at the early stage of penile lymphoedema. The time to consultation was 72 hours, which would have limited the risk of complications such as skin necrosis, a section of the spongy body, with an upstream urethral fistula [9, 10].

The first step in treatment is to remove the compressive material, often under local anaesthetic. The technique used depends on the hardness and shape of the ring. For thin, narrow rings, cutting is generally easy and can be done using cutting forceps. However, this procedure is difficult for hard, thick and/or wide rings that cannot be grasped by cutting forceps [7].

In these cases, it is recommended to drain the stagnant blood in the penis by incision or puncture of the glans, followed by compression of the penis with a silk thread over which the ring is gradually slid [9, 11, 12].

In our patient, removal was not difficult and was performed under local anaesthesia using Harrington cutting forceps. The second stage involves debridement of the ischaemic and necrotic edges of the wound, followed by a thorough examination of the urethra to check for fistulas, particularly in the presence of deep ulceration. A suprapubic catheter must be inserted if there is a urethral fistula or urinary retention [1, 13].

Penile amputation is necessary in cases of penile necrosis. It is performed one to eight days after removal of the ring, in order to allow for possible recovery [2, 7].

In our patient, there was no evidence of urinary retention or urethral fistula.

Snoy *et al.,* in their management of penile incarceration, warned of the risk of aggravating skin lesions through the heat generated by a drill or electric saw, recommending that protection be placed between the metal body and the penis sheath and that the procedure be performed with a continuous flow of cold liquid irrigation [14].

- **Genital self-harm and psychotic disorders**

The incidence of this condition is poorly understood. Cases may not be reported by those around the patients due to negligence, a breakdown in social contact, or the loss of sight of wandering schizophrenics [15].

Our patient was younger (aged 19 years) compared to what is described in the literature: 35 years for Eric'study (Congo) and 60 years for Cordero's study in the United States [6, 16].

The brief psychiatric examination of our patient can be explained by the absence of a psychiatrist within the reception structure. A more in-depth psychiatric interview would have revealed an underlying delusional outbreak or a disorganization syndrome [17].

The association between genital self-mutilation and schizophrenia is well established. According to Greilsheimer and Groves, 83% of cases of self-mutilation involved individuals suffering from psychotic disorders [18].

These behaviors are not pathognomonic of any particular condition, even though most cases in the literature are described in the context of a delusional episode (most often mystical). They could also be the prerogative of depressive disorders, personality disorders, mental retardation

Some authors would consider it as a desire for sexual satisfaction experienced, as reported by our patient [2, 10, 19, 20].

A review of the literature highlights other factors that may have contributed to his acting out: young adult male, ambivalent relationship with body image, lack of a supportive social network (as we can observe in today's society), difficulty in maintaining a stable heterosexual relationship, history of self-harm or previous dependence on psychoactive substances [21-24].

From a psychoanalytic perspective, self-harm is considered a defence mechanism against massive archaic anxiety in psychotics [25].

An act targeting the sexual organ is quite significant. It is the organ of 'pleasure' and procreation, ensuring the subject's place as a man, belonging to his community. He targeted the organ that allowed him to belong to society as a man: this would be a 'resignation from the community' [26].

Optimal care for this type of patient requires adequate psychiatric treatment and follow-up, which was the case for ours, who was referred to the nearest mental health center. Psychological support focused on sexual therapy is also essential [11].

4-CONCLUSION

Penile strangulation is most often diagnosed in psychotic patients. It is a urological emergency and the prognosis depends on the delay in treatment. The importance of understanding such behaviour is reflected in its destructive and surprising nature, given the absence of specific warning signs. It raises questions about the suffering of these patients and has an important symbolic dimension. It is therefore essential to avoid ignoring sexuality in the doctor-patient relationship, particularly in psychotic patients. A multidisciplinary approach is necessary, addressing the individual in terms of their physical, identity, psychological and sociocultural dimensions.

Conflict of Interest: the authors declare no conflict of interest

REFERENCES

1. Gonzalez-Satue C, Riera-Canals L, Fontdevila J, et al. : Penile and urethral lesion caused by metallic ring. Reconstruction with radial free flap. Actas Urol Esp. 2001; 25 (10): 746-749.
2. Osman M, Al Kadi H, Al Hafi R. Gangrene of the penis due to strangulation by a metallic ring. Scand J Urol Nephrol. 1996; 30(1):77-8.
3. Ichaoui H, Sallami S, Samet A, et al. Strangulation of the penis by a metallic ring: Prevention is better than cure. Case Rep Urol. 2018; 1725-752.
4. Jain S, Gupta A, Singh T, et al. Penile strangulation by a hard plastic bottle: a case report. Indian J Surg. 2004; 66:173–175.
5. Ostman M, Bjorkman A C. Schizophrenia and relationships : The effect of mental illness on sexuality. Clin Schizophr Relat Psychoses. 2013; 7: 20–4.
6. Mbuya E M, Ouaké H, Agounkpe M, et al. Klingsor Syndrome : An Observation in a Patient with Schizophrenia. Open J Urol. 2004; 14: 346-351.
7. Moufid K, Joual A, Debbagh A, et al. L'automutilation génitale: à propos de 3 cas. Prog Urol. 2004; 14(4): 540-3.
8. Tanabe N, Muya M, Isonokami M, et al. Lymphedema due to chronic penile strangulation: a case report. J Dermatol. 1996; 23: 648-651.
9. Noh J, Kang T.W, Heo T, et al. Penile strangulation treated with the modified string method. Urology. 2004; 64 : 591.
10. Prunet D, Bouchot O. Les traumatismes du pénis. Prog Urol. 1996; 6:987-93.
11. Mclaughlin T, Coyner W. Removal of a strangulating metal bearing from the penis. J Urol. 1989; 141 : 617.
12. Vahasarjav J, Hellstrom P A, Serlo W, et al. Treatment of penile incarceration by the string method: 2 case reports. J Urol. 1993; 149 : 372-373.
13. Perabo F G, Steiner G, Albers P, et al. Treatment of penile strangulation caused by constricting devices. Urology. 2002; 59(1): 137.
14. Snoy F J, Wagner S A, Woodside J R, et al. Management of penile incarceration. Urology. 1984; 24 :18-20.
15. Outarahout M, Sekkat F Z. Automutilation de la verge ou le suicide de genre. Trois cas de schizophrènes. Informat Psychiatr. 2014; 90(3) : 207-11.
16. Cordero R, Mohit A, Lubin J, et al. Schizophrénie associée au syndrome de Klingsor : un cas unique. J Med Case Rep. 2021; 2 : 1-2.
17. American psychiatric association. DSM-5 : manuel diagnostique et statistique des troubles mentaux (5e éd.). Elsevier Masson, 2015.
18. Greilsheimer H, Groves J E. Male genital self-mutilation. Arch gen Psychiatry. 1979; 36(4): 441-446.
19. Eke N. Genital self-mutilation: there is no method in this madness. B J U Int. 2000 Feb; 85(3): 295-8.
20. Hendershot E, Stutson A C, Adair T W. A case of extreme sexual self-mutilation. J Forensic Sci. 2010; 55 : 245-7.
21. Kamoun-Siala M, Bellaaj-Lachtar F, Dammak M, et al. De la dysérection à l'automutilation génitale (à propos d'un cas). Ann Med Psychol. 2005; 588-594.
22. Nakaya M. On background factors of male genital selfmutilation. Psychopathology. 1996; 29 : 242-8.
23. Romily C S, Isaac M T. Male genital self-mutilation. Br J Hosp Med. 1996; 55 : 427-31.
24. Siddiquee R A, Deshpande S. A case of genital selfmutilation in a patient with psychosis. German J Psychiatry. 2007; 10: 25-8.
25. Scaramozzino S. Pour une approche psychiatrique de l'automutilation : implications

nosographiques. Champ Psy. 2004; 36(4): 25-38.

26. Aboseif S, Gomez R, McAninch J W. Genital selfmutilation. J Urol. 1993; 150: 1143-6.