CASE REPORTS

Self-Castration by a Transsexual Woman: Financial and Psychological Costs: A Case Report

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ABSTRACT

Introduction. The out-of-pocket cost for an elective orchiectomy, which is often not covered by health insurance, is a significant barrier to male-to-female transsexuals ready to proceed with their physical transition. This and other barriers (lack of access to a surgeon willing to perform the operation, waiting times, and underlying psychological and psychiatric conditions) lead a subset of transsexual women to attempt self-castration. Little information has been published on the financial costs and implications of self-castration to both patients and health care systems.

Aim. We compare the financial and psychological costs of elective surgical orchiectomy vs. self-castration in the case of a transsexual woman in her 40s.

Methods. We interviewed the patient and her providers and obtained financial information from local reimbursement and billing specialists.

Results. After experiencing minor hemorrhage following the self-castration, our patient presented to the emergency department and underwent a bilateral inguinal exploration, ligation and removal of bilateral spermatic cords, and complicated scrotal exploration, debridement, and closure. She was admitted to the psychiatric service for a hospital stay of three days. The total bill was US $14,923, which would compare with US $4,000 for an elective outpatient orchiectomy in the patient's geographical area.

Conclusions. From a financial standpoint, an elective orchiectomy could have cost the health care system significantly less than a hospital admission with its associated additional costs. From a patient safety standpoint, elective orchiectomy is preferable to self-castration which carries significant risks such as hemorrhage, disfigurement, infection, urinary fistulae, and nerve damage. Healthcare providers of transsexual women should carefully explore patient attitudes toward self-castration and work toward improving access to elective orchiectomy to reduce the number of self-castrations and costs to the overall health care system. Further research on the financial implications of self-castration from different health care systems and from a series of patients is needed. **St. Peter M, Trinidad A, and Irwig MS. Self-castration by a transsexual woman: Financial and psychological costs: A case report. J Sex Med 2012;9:1216–1219.**

Key Words. Self-Castration; Transsexual; Orchiectomy; Cost; Sex Reassignment Surgery; Economics

Introduction

Male-to-female transsexuals suffer from intense gender dysphoria, usually beginning in childhood. The management of transsexual patients ideally involves a stepwise process which first includes mental health professionals who identify those who meet the criteria for gender identity disorder. Transsexual women typically begin hormonal therapy after successful completion of the "real life test" or in concert with it [1]. Sex reassignment surgery, which is not undertaken by all patients, may include orchiectomy, penectomy, vaginoplasty, breast augmentation, and/or facial feminization.

Elective outpatient orchiectomy is often out of reach for many patients, primarily due to cost but

also due to waiting times, local laws prohibiting such surgeries, and cultural disapproval of transsexualism in certain countries [2,3]. In some locations, patients may lack access to a surgeon willing to perform the operation out of fear of destroying normal tissue, legal consequences, or undesirable publicity [4]. In the United Sates, elective orchiectomy is often not covered by healthcare insurance plans and patients would be responsible for all costs, which are typically in the thousands of dollars. Medical and surgical costs vary widely by country, and some patients travel internationally to have surgery performed for a significantly lower price than in their home country. Nonetheless, the above barriers to surgery have prompted some transsexual women to resort to self-castration [2,3,5,6]. Self-castration rarely results in death, but significant risks are present, which include hemorrhage, disfigurement, infection, urinary fistulae, and nerve damage [2,3]. Many patients who perform or attempt to perform self-castration subsequently seek care at a hospital emergency department, often for bleeding.

The medical literature reveals three major subtypes of patients who have performed self-castration and/or genital self-mutilation: transsexuals, schizophrenics, and eunuchs. In a review of 109 reported cases in the literature, 48 individuals had schizophrenia and only 10 had transsexualism [7]. Nevertheless, the distinction between these two groups is not that clear as significant overlap does exist. In this case series, 42% of those with schizophrenia had a "disturbance with their sexual identity." The criteria used to define schizophrenia can also contribute to the overlap between this diagnosis and transsexualism. For example, one published case describes a patient without episodes of frank psychosis whose "projective tests suggested schizophrenic features with misinterpretations, overgeneralizations and bizarre ideas" [5]. Physical eunuchs represent quite a diverse population in that their self-identified gender was neither male nor female in 24% of a population who completed an online questionnaire [8]. This population is also interesting from a sexual orientation standpoint as 29% were heterosexual, 32% were homosexual, 27% were bisexual, and 12% were asexual/other.

Case Report

An unemployed transsexual woman in her 40s presented to the Emergency Department 2 hours after performing self-castration. Prior to performing this procedure, the patient had researched relevant male anatomy and "banding" on Internet Web sites. Although she read about constricting the blood supply to the scrotum to promote dry necrosis, she wished to avoid the odor of dead tissue. The night prior to presentation, the patient used rubbing alcohol to "sterilize" a set of elastic hair ties which she placed around the scrotum. She also self-medicated with benzodiazepines. After approximately 7 hours of "banding," she used a pair of pink garden shears, specifically purchased for this purpose, to excise part of the scrotum and both testes. She chose to make the incision as distal as possible to preserve tissue for future vaginoplasty. She promptly flushed the testes and excised tissue down the toilet to prevent reattachment. Shortly thereafter, the hair ties slipped off and pulsatile bleeding ensued. Attempts to stop the bleeding were unsuccessful, prompting the patient to travel by public transportation to the Emergency Department. Upon arrival, she was hemodynamically stable with a blood pressure of 114/82, a heart rate of 96 and a hematocrit of 31%. She was promptly taken to the operating room for bilateral inguinal exploration to control the bleeding of the testicular arteries. The wound was explored, and a large hematoma was evacuated. The cavity was irrigated, and the wound closed with minimal debridement necessary.

The patient was admitted to the psychiatric service for a 3-day hospitalization to clarify her psychiatric conditions, to assure safety, and to modify her endocrine treatment. The total cost was US $14,923. The fee breakdown was US $6,210 for room charges, US $5,574 for the surgeon, US $1,320 for the anesthesiologist, and US $1,819 for pharmacy medications, lab tests, and various consults. The patient's health insurance was Medicaid, a plan that covers low-income residents in the United States and varies by state. Consequently, she was not responsible for the hospital bill.

In terms of her psychiatric history, at the time of the admission, the patient was being followed at a local mental health center by a psychiatrist and a social worker who performs case management services. She carried the diagnoses of complex posttraumatic stress disorder, gender identity disorder, major depression, and social anxiety disorder. She met some, but not all, criteria for borderline personality disorder. She was taking estradiol 8 mg daily, spironolactone, selegeline 9 mg daily,