



The emerging trend of self-circumcision and the need to define cause: Case report of a 21 year-old male



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ARTICLE INFO

Article history:

Received 21 March 2016

Received in revised form 11 June 2016

Accepted 11 June 2016

Available online 29 June 2016

Keywords:

Self-circumcision

Causes

Complications

Disease burden

ABSTRACT

INTRODUCTION: Male circumcision is traditionally carried out by ascribed practitioners, so self-circumcision is very rare. It is intriguing why the victims should not seek available modern health care. This article highlights another case of self-circumcision, the related causes, complications and their management. The gradual increase in numbers is contributing to the surgical disease burden.

CASE PRESENTATION: A 21 year old male circumcised himself using a razor-blade 13 days prior to presentation at the hospital. He attributes this to reluctance to have him circumcised. He sustained extensive penile skin denudation of 7 cm in length, severe bleeding and pain. He lives close to traditionally-circumcising communities and was once chided by peers for being uncircumcised. He had no evidence of psychosis. He did not use any medications during the procedure. He was managed with analgesics, antibiotics and surgical reconstruction. He was discharged on the second post-operative day and subsequently recovered fully.

DISCUSSION: Such patients face a variety of complications, both the immediate and long term. Some are fatal especially those with systemic effects including haemorrhagic shock and septicemia associated with gangrene. Timely referral to specialist surgeons is critical, as well as thorough review and control of the causes prompting this practice.

CONCLUSION: Cases of self-circumcision continue to emerge. There is need to report all cases, explore and manage the possible causes. The stigma uncircumcised males face among circumcised peers may be an important cause. Public health education and improved access to voluntary medical male circumcision services may help to prevent this practice.

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1. Introduction

Male circumcision is an age-old practice [1,2]. Initially the practice was done crudely in traditional settings [2]. However, with modernisation it has largely shifted to modern clinical settings, even in Africa where resources are limited. Only a few strongly cultural communities continue to circumcise outside the health facilities [1,2]. Notably too, the procedure has always been carried out by ascribed practitioners [2] from traditional ones to the modern medical surgeon, but not the individual on themselves. Few cases of male self-circumcision have been reported [3–6]. Most of these used devices marketed on the internet or sold over-the-counters, some medically approved and others not [3,4,6–8].

Reports where basic tools like knives and razor-blades are used for self-circumcision, are even fewer [5]. This category of patients may have been exposed to images or information on how to carry out the procedure.

Circumcisions done outside the clinical setting generally develop more complications than those in the clinical setting [1,9], and self-circumcision in particular is associated with even more complications, including the adverse forms [3,5]. Investigation is imperative into why cases of self-circumcision should arise amidst increased health awareness and improved access to modern clinical services [1,2], which include voluntary medical male circumcision [9]. It is equally perplexing that it happens within a traditionally-circumcising community.

Management includes resuscitation and corrective local surgical procedures tailored to the specific complications [8–10]. Possible psychological or psychiatric causes must be assessed for and managed accordingly if present [11,12]. This article aims to highlight another case of self-circumcision, involving a young male who was seen at Kuajok state hospital in South Sudan. It points out the

Abbreviations: cm, centimetres; no, number.

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related complications, and how they were managed, and further explores the reasons behind this behaviour. This case specifically contributes to the record of device-free self-circumcisions.

2. Case presentation

A 21 year old male presented to our hospital thirteen days following self-circumcision at home (Figs. 1–2). He complained mainly of severe pain over the penile wound, causing difficulty in walking. He reported minimal bleeding at presentation and was passing urine normally. He reports he used a new razor-blade bought from a shop. He pulled forward the foreskin, secured it with a rubber band and a steel wire, and then cut once through the entire foreskin between the wire and rubber-band. He bled severely and sustained a large wound as the remaining penile skin retracted (Figs. 1–2). He poured over a warm salt solution and tied a cloth around the penis to control the bleeding. Later he took some painkillers from a nearby drugshop, however due to worsening discomfort the mother eventually brought him to hospital (Figs. 1–2).

He further narrates that this act was prompted by his father's reluctance to take him for circumcision, something he had demanded for over 4 years. On that day, he says the father instead

accused him of deliberately avoiding circumcision, so he did it to prove him wrong. The patient's pre-occupation with circumcision started about 4 years ago while swimming in a river when his play-mates chided him and his brothers for being uncircumcised. He also expressed some feelings on the religious importance of circumcision. The patient said he had never observed the procedure before though he has looked at recently circumcised males. He has also never had access to any literature, images or verbal description of the procedure. The procedure was carried out in clear sensorium. He didn't use any pain-killing or psycho-active agents before or during the procedure. There was no report of previous abnormal behaviour or family history of psychiatric illness. He has a younger brother who self-circumcised after a girl rejected him for being uncircumcised. He still lives with both parents. He finished secondary school one year ago and is waiting to join university. He is presently a community youth leader.

On examination, he was a kempt young male in good general condition. All systems were clinically normal. Mental health assessment revealed episodic verbal diarrhea, an increased sense of self-importance and hyperactivity. He had good memory and judgment. There was no evidence of psychosis. Locally, he had 7 cm length of circumferentially denuded anterior penile shaft with the remaining skin retracted proximally. The raw area had healthy granulation tissue and healing skin edges, with minimal bleeding, serous exudate and a traumatised/excised frenulum. There was no oedema or sepsis (Figs. 1–2).

He was admitted and the wound dressed with topical antibiotics. Physiological investigations including, haemoglobin levels, blood count and urinalysis were normal. Wound swab was deferred since the wound was not infected. Parenteral analgesics and antibiotics were administered. Later he was counseled, consented, catheterised and prepared for theatre. Surgical reconstruction was done under spinal anaesthesia; The proximal penile skin was undermined, freed, and advanced – guided by the urethral catheter to identify and preserve the urethra. It was sutured to the distal skin edge around the corona using vicryl no. 2/0 interrupted suture. Haemostasis was achieved and the suture line protected with 3% tetracycline ointment gauze dressing. He was discharged on the second post-operative day. Subsequent reviews revealed progressive recovery (Fig. 3). The patient was encouraged to return for long term follow up, to assess for possible long term complications and repeat mental health assessments.



Fig. 1. 13days post self-circumcision.



Fig. 2. 13days post self-circumcision.



Fig. 3. 3days post reconstruction.

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