Case Report

Gender dysphoria presenting as genital self-mutilation: A case report

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ABSTRACT

Genital self-mutilation is a rare but critical clinical event that commonly reflects severe psychological distress, often linked to psychiatric illness or unresolved gender identity conflict. We describe a 20-year-old biological male who presented after intentionally amputating his penis and testes as part of an unsupervised attempt at self-directed gender transition. The procedure was carried out at home under self-administered local anesthesia, and the patient arrived hemodynamically stable, enabling immediate surgical wound care and stabilization. Subsequent psychiatric assessment confirmed a diagnosis of gender dysphoria with coexisting major depressive disorder, neither of which had been previously treated. This case illustrates the degree of distress that may accompany persistent, unsupported gender incongruence and emphasizes the need for timely mental-health intervention, structured gender-affirming care pathways, and coordinated multidisciplinary management. Improving awareness, reducing stigma, and ensuring accessible medical and psychological support for individuals with gender dysphoria are crucial measures to prevent irreversible self-harm and improve long-term outcomes.

Key words: Case report, Gender dysphoria, Genital self-mutilation, Self-injury, Transgender identity

Gender dysphoria refers to psychological distress arising when an individual's experienced gender does not align with the sex assigned at birth [1]. In untreated or unrecognized cases, this conflict can cause severe anxiety, depression, and occasionally self-destructive acts such as genital self-mutilation (GSM) [2]. GSM is rare but documented in psychiatric and surgical literature, most often linked with psychotic illnesses, severe depression, or profound gender identity conflict [3-5].

This case describes a deliberate genital self-amputation performed by a young adult male with untreated gender dysphoria and major depressive disorder and discusses its clinical and ethical implications [6]. A review of 173 published cases of male GSM found that 15.3% involved individuals with gender dysphoria, and most of them (around 71%) reported difficulty accessing gender-affirming treatment [7]. While the exact rate of such self-injury among non-psychotic people with gender dysphoria is still undetermined, the available evidence suggests that lack of appropriate care can place these individuals at heightened risk of attempting genital self-removal. This case is significant because it represents a planned, non-psychotic act of GSM carried out as an extreme substitute for inaccessible gender-affirming treatment. Most published cases focus on psychosis-related injuries, making gender dysphoria-driven GSM an under-recognized clinical entity. Reporting this case highlights preventable gaps in mental-health and transgender healthcare systems.

Access this article online	
Received - 18 October 2025 Initial Review - 04 November 2025 Accepted - 04 Decemebr 2025	Quick Response code
DOI: 10.32677/ijcr.v11i12.7911	

CASE PRESENTATION

A 20-year-old biological male was brought to the emergency department (ED) after intentionally amputating his penis and testes at home. He stated that the act was planned and carried out as part of his long-standing wish to transition to the female gender. The patient had injected 2% lignocaine locally before performing the amputation himself using a surgical blade. The procedure was done approximately 2 h before arrival, after which he attempted to control the bleeding with gauze and then informed family members. No sedatives, alcohol, or recreational drugs were taken before the incident.

On arrival, he was conscious, oriented, and able to give a clear history. His vital parameters were within normal limits: pulse 94/min, blood pressure 118/74 mmHg, respiratory rate 18/min, temperature 36.9°C, and oxygen saturation 99% on room air. Local examination revealed complete removal of the glans and body of the penis, leaving a 3-cm stump with irregular

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bleeding edges, along with the absence of both testes. The amputated genital parts were not brought with him. No ligature marks, tourniquet injuries, or foreign material were present at the site (Fig. 1).

Routine laboratory evaluation demonstrated hemoglobin 11.8 g/dL, leukocyte count 9200/mm^3, and platelet count 2.7×10^5/mm^3. Renal function and coagulation profile were normal. Endocrine testing showed serum testosterone of 480 ng/dL (reference 300–1000 ng/dL). Chromosomal analysis confirmed a 46, XY karyotype. Toxicology screening was negative for alcohol, opioids, benzodiazepines, or other substances.

Initial management in the ED consisted of intravenous (IV) fluid resuscitation, analgesics, broad-spectrum antibiotics (ceftriaxone 1 g IV), tetanus prophylaxis, thorough saline-povidone wound irrigation, ligation of visible bleeding vessels, insertion of a Foley catheter, and sterile dressing of the wound (Fig. 2). Reimplantation was not feasible due to the unavailability of the severed organs and prolonged warm ischemia time. The patient was, therefore, planned for delayed reconstruction after stabilization.

A psychiatric consultation was obtained within the first 12 h of admission. The patient reported a 3-year history of marked distress related to gender incongruence, along with symptoms of low mood, loss of interest, social withdrawal, and passive suicidal ideation. He had never sought psychiatric help or undergone hormone therapy. Mental status examination showed a sad affect, intact reality testing, and no hallucinations or delusions. He was diagnosed with gender dysphoria and comorbid major depressive disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria. There was no family history of psychiatric illness, self-harm, or endocrine disorders. He had no significant medical or surgical history and was not taking any regular medications.

During the hospital stay, the patient remained hemodynamically stable, and his wound showed healthy granulation by day 3. Psychiatric management was initiated with supportive psychotherapeutic sessions and a selective serotonin reuptake inhibitor for depressive symptoms. After clinical stabilization, a structured discharge plan was made, including outpatient psychiatric follow-up, gender-affirming counseling, endocrinology evaluation for future hormone therapy, and referral to urology and plastic surgery teams for staged genital reconstruction once psychological readiness criteria are fulfilled as per the World Professional Association for Transgender Health (WPATH) Standards of Care (Version 8).

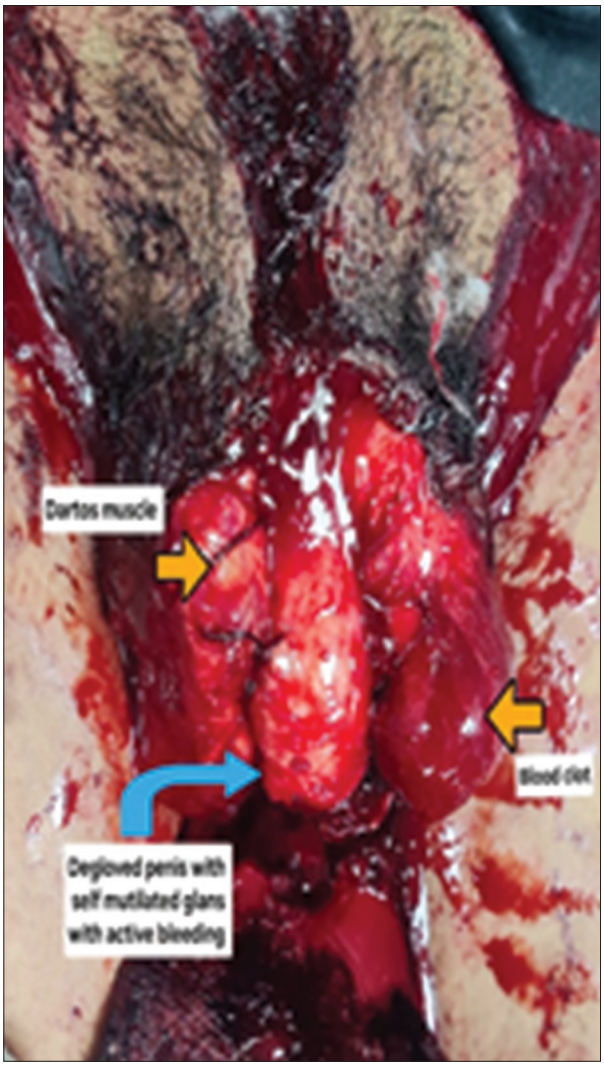

Figure 1: Self-mutilated genitalia with adherent blood clots and multiple active bleeding points

DISCUSSION

GSM is an uncommon but clinically important presentation requiring simultaneous surgical, psychiatric, ethical, and rehabilitative consideration. Earlier

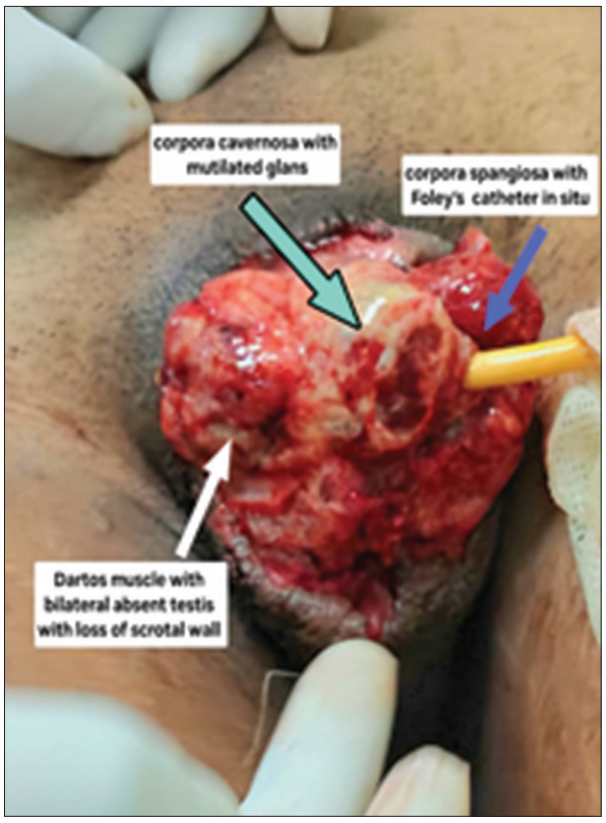

Figure 2: External genitalia after hemostasis with a Foley's catheter *in situ*

literature predominantly linked GSM to schizophrenia, psychotic commands, and religious delusions; however, an increasing proportion of cases are now reported in individuals with untreated gender dysphoria rather than active psychosis [3,4]. These cases are typically characterized by a planned and anatomically deliberate approach, in contrast to the disorganized or violent injury patterns associated with psychotic self-harm [5]. The present case reflects this pattern, as the patient demonstrated preserved orientation, purposeful use of local anesthesia, and explicit gender-affirming intent before the act.

Gender dysphoria is defined in DSM-5-TR as distress caused by incongruence between assigned sex and experienced gender [1]. When left untreated, this conflict may manifest as depression, social withdrawal, self-neglect, or self-directed surgical attempts at anatomical modification [6]. A systematic review of 173 GSM cases showed that 15.3% occurred in individuals with gender dysphoria, and the majority of these patients reported inability to access professional gender-affirming care before injury [7]. This reinforces the view that GSM may represent a preventable endpoint of prolonged distress rather than impulsive self-harm.

From a surgical standpoint, GSM is a urological emergency requiring rapid hemorrhage control, infection prophylaxis, and urinary diversion [8]. Successful reimplantation is feasible only when the amputated organ is preserved in cold ischemia and repaired within a 6-h window [9]. When reconstruction is delayed, as in this case, management shifts toward staged procedures such as perineal urethrostomy, neovaginoplasty, or scrotal reconstruction, depending on the patient's future affirmed gender [10]. Long-term functional and cosmetic outcomes depend not only on surgical technique but also on psychological readiness, endocrine support, and post-operative compliance.

Psychiatric assessment remains essential in every GSM case to distinguish between psychosis-driven mutilation and deliberate gender-affirming behavior. The absence of delusions, intact reality testing, and the presence of structured long-term gender incongruence in this patient are consistent with non-psychotic GSM [4]. Studies show that access to hormone therapy, counseling, and peer-validated gender identity support reduces self-harm attempts and suicidal ideation in transgender individuals by more than 50% [11]. Thus, psychiatric intervention is not merely diagnostic but preventive.

Ethical considerations in such cases involve balancing patient autonomy with safety. Although the act was self-inflicted, care must prioritize dignity, confidentiality, and respect for gender identity. Indian legislation under the Mental Healthcare Act (2017) guarantees non-discriminatory mental-health access irrespective of gender identity, obligating institutions to provide supportive rather than punitive care [12]. The WPATH Standards of Care (Version 8) emphasize that genital surgery should follow structured mental-health evaluation, informed consent, and documented readiness – not self-performed anatomical alteration [13].

CONCLUSION

This case highlights the extreme manifestation of untreated gender dysphoria culminating in GSM. It emphasizes the need for early recognition, psychiatric counseling, and multidisciplinary collaboration. Accessible, stigma-free gender-affirming services are essential to prevent such catastrophic outcomes.

PATIENT CONSENT

The patient provided written informed consent for the use of clinical details and accompanying information in this publication. All identifying data have been omitted to maintain anonymity.

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Funding: Nil; Conflicts of interest: Nil.

How to cite this article: Kumar A, Singh SK, Saha A, Kumar V, Dwivedi C. Gender dysphoria presenting as genital self-mutilation: A case report. Indian J Case Reports. 2025;11(12):678-680.