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Male genital injuries caused by ritual attacks in Nigeria: Problems of management

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Abstract
Reports of genital injury and loss from attacks allegedly perpetrated for ritual purposes are often reported in the media and discussed in social circles in Nigeria, but such reports are rare in the medical literature. We report three cases of genital injuries caused by attacks, allegedly for ritual purposes, so as to document the occurrence of such injuries and to stimulate interest in their prevention and medical management. The patterns of presentation and the problems of management in Nigeria are discussed.

Introduction

The Nigerian media frequently present anonymous reports of genital loss or injury resulting from violent attacks by alleged ritualists. Such cases are also mentioned frequently in social circles and in casual discussions. In contrast, such reports are rarely seen in the medical literature. It is not known if this is because the victims do not present to hospitals, or because the media reports are fabricated. Most cases mentioned in social discussions are based on speculation and anecdotes.

Reporting such cases in our environment will help to document their occurrence and may help to develop strategies for public information and medical management. Herein we report the presentation and management of three such cases in Nigeria.

Case 1

A 12-year-old boy was brought to the emergency room in a semi-conscious state with injuries he had sustained earlier that day. The history was that two relatives of the patient had visited his family house in the early morning while his parents were away. They were well known to the patient as they had visited his parents on many occasions previously. The visitors asked him to accompany them to

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the forest to find some local herbs recommended for the treatment of his mother's stomach upset, and he accepted the invitation.

While in the bush, these relatives forced him to the ground and tied ropes around his neck. He lost consciousness, and when he woke up he found himself in severe pain and lying in a pool of blood with his external genitalia gone. Passers-by heard his groaning and found him covered with branches and leaves, apparently presumed dead by his attackers. He was taken to his parents' house, from where he was brought to hospital.

On examination he was in hypovolaemic shock due to severe blood loss. There were fresh abrasions around his neck and upper abdomen. The penis, scrotum, testes and the entire perineal skin short of the anal orifice had been removed *en bloc* by clean and precise excision (Fig. 1).

After resuscitation with intravenous fluid and blood transfusion, the wound was explored in theatre. The superficial perineal muscles, including the ischiocavernosi, superficial transverse perineal muscles and bulbospongiosus were exposed. The penile structures, including the urethra, were transected at the level of the bulb. The periosteum over the symphysis pubis as well as the structures in the femoral triangle, were exposed. Haemostasis was secured and fasciocutaneous flaps were raised from the thighs and anterior abdominal wall to approximate the wound edges. A 16F urethral catheter was passed. The remaining raw surfaces were dressed daily with eusol.

In the following weeks, further flaps were raised to close the defect and a perineal urethrostomy was fashioned. The urethral catheter was changed every 3 weeks and was removed when the wound had completely healed. The urinary stream was satisfactory until one year after the event, when the patient returned with chronic urinary retention due to stenosis of the urethrostomy. After the urethrostomy was re-fashioned, the patient remained symptom-free.

In the course of the patient's management, the opinion of the Catholic Church leaders, who are the proprietors of the hospital, and that of the family of the patient was sought on the possibility of a sex conversion and change of environment on discharge. Both groups were vehemently opposed to a sex conversion. We were informed that the police had succeeded in arresting one of the assailants, who confessed that a rich businessman had hired them to execute the act. They were promised the sum of one and a half million naira (about ten thousand US dollars) to deliver a complete set of male genital organs. We did not take any steps to confirm this allegation.

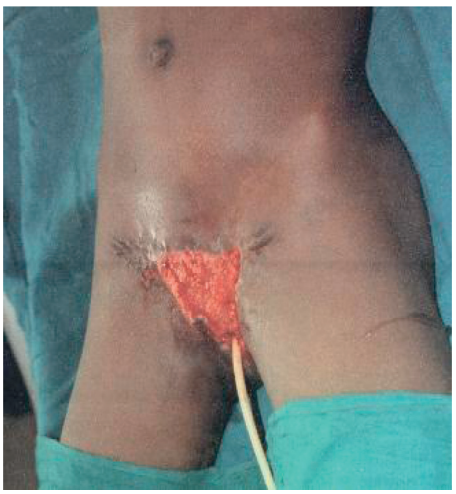

Fig. 1 Case 1 at presentation after initial debridement, mobilizing of a fasciocutaneous flap to reduce the wound gap, and urethral catheterization.

Case 2

A 28-year-old male trader was brought to hospital in the early hours of the morning. He was said to have been attacked by unknown assailants the preceding night and had apparently been wounded in the genitalia. His family members had taken the man, who was said to be psychotic, to a spiritual healing home where he was restrained with hand and leg cuffs and isolated in a room while receiving 'spiritual' treatment. On the day of the incident all members of the spiritual group had gone to 'night vigil' Christian worship in the chapel. Three unidentified men were alleged to have entered the room of the patient, gagged him, cut off his testicles and departed. It was only the next morning that the patient was discovered, still gagged, with his clothing bloodstained due to a scrotal wound. There was nothing to suggest self-mutilation as the patient was in handcuffs.

On examination, the patient was calm and cooperative and was conscious of the preceding events. There were fresh incisional wounds over the right and left antero-inferior aspects of the scrotum. The patient was haemodynamically stable. Exploration in theatre confirmed that the testicles had been completely excised, apparently with a very sharp instrument, because the wound edges were smooth. There was no significant bleeding from the spermatic cords. The penis and the urethra were intact. The cords were ligated with polyglactin sutures and the wounds were closed. The skin sutures were removed on the seventh postoperative day. Wound healing and the patient's general condition were satisfactory, and he was discharged from hospital.

The patient's relatives were advised to take him to a psychiatrist for evaluation. The relatives and the proprietor of the spiritual healing home refused to report the incident to the police. Instead, they promised to carry out their own 'spiritual investigation' to expose the culprits. When the patient was last seen at follow up two weeks after discharge, he had not been to a psychiatrist and the matter had not been reported to the police.

Case 3

An 18-year-old student presented with wounds on the genitalia and the left thigh. He had gone with friends to a village to take his senior school certificate examination. They stayed in a primary school building in the village. He went out in the evening to go shopping and met a group of four young men who offered to take him to a shop. They then took him along a bush path, where they pounced on him and pinned him to the ground. One of them brought out a sharp-edged metal object, grabbed his genitals and started cutting. He shouted repeatedly and managed to free himself from their hold and fight back. Apparently frightened by his shouting and resistance, the young men ran away.

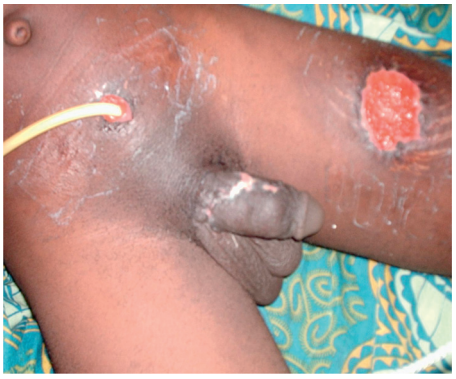

Fig. 2 Case 3 one week after at presentation showing the suprapubic cystostomy, granulating wound in the thigh, and healing penile wound.

He continued shouting until two other men came to his aid. They escorted him to a clinic in town where the wounds on his penis and left thigh were sutured. Attempts at urethral catheterization failed and urinary retention was initially relieved by repeated suprapubic aspiration and later by insertion of a needle cystostomy. His parents were informed the next day, arrived five days later and brought him to our hospital.

On examination, the patient was unkempt and looked depressed. There was a skin avulsion wound on the anterior aspect of the upper third of the left thigh. The avulsed tissue had been sutured back, but appeared necrotic. There was a sutured septic-looking wound extending from the peno-scrotal junction, curving up the right lateral aspect to the dorsum of the proximal third of the penis. Urine drained from the ventro-lateral aspect of the wound, suggesting a urethral injury.

After resuscitation of the patient, a formal suprapubic cystostomy was performed. The sutures were removed from the wound on the left thigh and the wound was debrided and dressed. Antibiotic treatment was commenced.

The patient made satisfactory progress and was discharged 24 days after admission. When he was seen in the clinic a month later his condition was satisfactory. However, before his second appointment a month later, he died in a road traffic accident while travelling to his hometown (Fig. 2).

Discussion

In Nigeria very few cases of male genital mutilation by assailants have been reported in the medical literature [1,2]. In contrast, reports on accidental and self-inflicted genital injuries in Nigeria and worldwide abound in the literature [3–6].

In the Nigerian sociocultural environment and especially in the Igbo culture in which the authors practice, the genitals are sacrosanct and are dealt with in a secretive manner [2]. Public opinion and media reports suggest that mutilations of the female breast and the male external genitalia are associated with the desire for financial gain. Since the reproductive organs multiply and sustain the human race, the apparent belief is that they are effective when harnessed by the 'medicine man' to achieve financial prosperity.

It is also believed that genital mutilation will cause the death of the victim, thus preventing identification of the assailant. In the Igbo cultural environment of Southeast Nigeria it is believed that amputation of the phallus is fatal [7]. The victim in Case 1 was apparently assumed dead after the attack. The genitals and breasts are not common organs for transplantation and the suggestion that these organs are harvested for sale abroad for transplantation is unfounded.

Genital mutilation or loss presents a formidable management problem in our environment. Psychosociocultural problems may interfere with early presentation to the hospital. There is a paucity of centres with sufficient personnel and facilities for appropriate care. This may result in inappropriate management at ill-equipped peripheral healthcare facilities, as in Case 3. The endemic poverty may make the services unaffordable even where they are available.

Patients with genital loss from trauma invariably wish to have their organs replaced. However, the genitals are often not available or suitable for re-anastomosis. Whereas it is now standard practice in many centres in the developed world to perform microsurgical re-anastomosis of an amputated penis, such treatment is unavailable in many third-world countries like Nigeria [8]. The only management option is perineal urethrostomy [2].

In Case 1, the vehement opposition of the patient's relatives and church leaders to the suggestion of sex conversion reflects the general attitude towards such 'unnatural events'. Because of the traditional belief in reincarnation, sex conversion is a taboo in our environment.

Conclusion

Our cases highlight the presentation and management problems of genital injuries caused by attacks for ritual purposes in Nigeria. Reporting such cases in our environment may establish the incidence and help to develop a local strategy for public information and medical management.

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