

An Impulse Control Disorder Case with Penile Fracture and Trichotillomania

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Abstract: Penile fractures are classically described as presenting with rapid detumescence of an erection associated with blunt trauma. This clinical finding is due to a tear in the tunica albuginea surrounding the corpora cavernosum. In this study, we report and discuss a case of trichotillomania and penile bending impulse resulting in penile fracture, which was operated in the urology clinic. The possible psychological and psychiatric problems underlying the impulsive behavior are discussed, and the value of a psychiatric evaluation is emphasized.

Key Words: Penile fracture, impulse control, trichotillomania

Penis Fraktürü Ve Trikotilomanili Bir Dürtü Kontrol Bozukluğu Olgusu

Özet: Penis kırılmaları klasik olarak ereksiyon halindeki penisin doğrudan travmaya maruz kalması sonucu hızlı detümesans olması olarak tanımlanmaktadır. Klinik bulgular korpus kavernozumun etrafındaki tunika albuginea'nın yırtılmasına bağlı olarak oluşmaktadır. Bu çalışmada, trikotilomani ve penis bükme dürtü bozukluğu olan hastada penil fraktür ile sonuçlanıp üroloji kliniğinde opere edilen bir olguyu sunuyoruz. Penis kırılmasına neden olan dürtüsel davranışa yol açtığı düşünülen altta yatan psikolojik ve psikiyatrik sorunlar tartışılmış olup benzer olgularda psikiyatrik değerlendirmenin önemini vurgulamak amaçlanmıştır.

Anahtar Sözcükler: Penil fraktür, dürtü kontrolü, trikotilomani

Introduction

Penile fracture is defined as a rupture of the corpus cavernosum caused by a direct blunt trauma to the erect penis (1). In the western hemisphere, it usually occurs during sexual intercourse, whereas in Middle East, Mediterranean and Far East countries there have been reports of cases resulting from penile manipulation, masturbation or rolling over in bed (1,2,3). A thorough examination of the literature shows that penile fracture cases generally lack psychiatric evaluation.

Impulsive disorders are classified as intermittent explosive disorder, kleptomania pyromania, pathological gambling, and trichotillomania. Trichotillomania was described as "noticeable pulling out of one's own hair, unable to resist the urge" (4). Sites of hair pulling may include any region of the body where hair grows, including axillary, pubic, and perirectal regions, with the most common sites being the scalp, eyebrows, and eyelashes (5,6). Before they act, there is a sense of increasing tension or arousal, and afterward there is a sense of pleasure and satisfaction.

In this report, the clinical features of a case with trichotillomania and penile bending impulse, which resulted in penile fracture, are presented and discussed together with the relevant literature.

Case Report

A 28-year-old man was admitted to our clinic with a six-month history of painful erection and penile deviation. The symptoms had worsened during the previous two weeks. His detailed past medical history relevant a penile fracture approximately eight

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months before. He had experienced penile erection during urination eight months before, and upon bending the penis with his hand, a snapping sound was heard. Although a rapid swelling followed, no treatment was administered. Biochemical and routine hematologic studies including hormone profile were within normal ranges. Surgical operation was suggested because of fibrosis, penile deviation and painful erection. After successful operation, it was noted that he frequently bent his penis. The patient was consulted to the Psychiatry Department. During the psychiatric evaluation the patient revealed that he frequently played with his penis, bent his erect penis, and pulled out his scalp and thoracic hair, and he also reported sleep disorder and nervousness. His penis bending impulse began some 15 years before. Bending of his erect penis generated a feeling of pleasure and an immediate sense of relief. He could not resist the urge and usually performed it when alone, sometimes 14 or 15 times a day.

He had been pulling out his hair (scalp and thoracic) for the last three years, more often when alone, anxious or driving. The patient had an increasing sense of tension immediately before pulling out the hair, could not resist the urge and felt a sense of pleasure from the act. He also reported biting and pulled out his mustache until two years before. He had never had a satisfactory relationship with his father. He described an indifferent father, who beat his children for any fault. Memories of his childhood beatings were still vivid.

On psychiatric observation, he appeared worried. His thought flow was normal, and his speech was fluent and comprehensive. Cognitive functions were preserved. He demonstrated no depressive or anxiety disorder according to psychiatric examination, with scores of 4 and 6 on the Hamilton Rating Scale for Depression and Hamilton Anxiety Rating Scale, respectively. He was diagnosed as "impulse-control disorder not elsewhere classified" (trichotillomania and impulse-control disorder not otherwise specified) according to Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnostic criteria. He also had antisocial and obsessive personality features on axis II.

He was put on sertraline 50 mg/day. Homework based on cognitive and behavioral treatment principles was initiated. In the follow-up period a decrease in the number of penis bending impulses as well as in hair pulling was noted.

Discussion

Although the primary causal factor remains unknown, psychodynamic, psychosocial, and biological factors all play an important role in impulse-control disorders (7). In his work with adolescents, August Aichhorn described impulsive behavior as related to weak ego structures associated with psychic trauma produced by childhood deprivation (7). In the literature, some authors considered impulse-control problems to be related to an incomplete sense of self. Authors observed that the self might fragment when patients do not receive the affirming responses that they seek from significant others. As a way of dealing with this fragmentation and regaining a sense of wholeness in the self, individuals may engage in self-destructive impulsive behaviors (7). Our patient's exposure to his father's beatings as well as his unsatisfactory relationship with him might have resulted in this form of impulse-control problem.

The etiology of impulsive disorder is unknown. However, a relation has been found between low cerebrospinal fluid levels of 5-hydroxyindolacetic acid and impulsive aggression. Certain hormones, especially testosterone, have also been associated with violent and aggressive behavior (7). In addition, the association between temporal lobe epilepsy related to head trauma in childhood and impulse control disorder has been reported (7). There was no trauma injury in our patient's history. Impulse-control disorder symptoms may appear in adulthood in patients with attention-deficit/hyperactivity disorder in childhood (7). Our patient's hyperactivity and misconduct in childhood, irregular school attendance, smoking, involvement in fights and stealing money in adolescence, and his antisocial behavior in early adulthood point to a possible hyperactivity disorder in childhood.

The implicated psychosocial factors are improper models for identification, such as parents who had difficulty controlling impulses, exposure to violence in the home, alcohol abuse, promiscuity, and antisocial behavior (6). In our case, violence from the father might have contributed to the development of such an impulse-control problem.

It is known that the phenomenology of trichotillomania and obsessive-compulsive disorder overlap (7); trichotillomania was once considered to be a subtype of obsessive-compulsive disorder (8). The development of trichotillomania in our patient and the comorbid obsessive

personality features also support the argument about obsessive-compulsive spectrum disorders (9,10).

According to DSM-IV criteria, we diagnosed the case as "trichotillomania" for his hair pulling, and "impulse-control disorder not otherwise specified" for his penis bending. In a previous report it was shown that "impulse-control disorders" may be seen in various types, such as pathological internet use, trichotillomania, and psychogenic excoriation (10). Similarly, our patient had difficulty in controlling his impulses of scalp and thoracic hair pulling and penis bending. Moreover, we believe the penis bending might also be associated with self-mutilation, which is also discussed in the context of impulse-control disorders not otherwise specified.

Penile fracture is a relatively rare urological emergency. The fracture occurs to the erect penis when one or both corpora cavernosa are ruptured, usually during erection due to a direct trauma (1). The rupture occurs during sexual intercourse, rolling over in bed and kneading the penis to achieve detumescence. The pathological lesion is a tear of the outer longitudinal layer

of the tunica albuginea of the corpus cavernosum or spongiosum, resulting in hematoma, swelling, and skin discoloration (1). Penile fracture is easily recognizable due to its characteristic history and appearance. The World Health Organization has recommended that all acute injuries to the tunica albuginea should be repaired immediately to avoid erectile dysfunction and penile fibrosis (1). Currently, early surgical repair is considered the most appropriate treatment for penile fractures (11). The long-term results of conservative treatment indicated significant complications, such as curved or painful erection, fibrotic plaque precluding erection, infection and erectile dysfunction, as in our case (11).

A thorough examination of the literature shows that penile fracture cases generally lack psychiatric evaluation. This case might be an interesting example to show a different cause of this urological condition. Psychiatric evaluation of penile fracture cases and investigation of the presence of a possible underlying impulse-control disorder might contribute to the enlightenment of the relationship between these two conditions.

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