Gender-Affirming Self-Orchiectomy in a Nonbinary Patient

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ABSTRACT

Introduction: Self-orchiectomy is a rare occurrence primarily documented in the context of psychosis. We present the case of a nonbinary individual without psychotic symptoms who performed self-orchiectomy to alleviate gender dysphoria.

Case presentation: An adult nonbinary individual who was assigned male sex at birth presented to the emergency department after removing their testicles several hours earlier. Psychiatry was consulted to assess capacity to refuse testicle reattachment. There was no psychosis, substance use, or suicidal ideation. The patient verbalized all necessary criteria for decision-making capacity. Urology performed wound closure, and the patient was discharged.

Discussion: Few similar cases in the existing literature discuss capacity assessment following self-orchiectomy in nonbinary patients.

Conclusions: While our patient recovered, self-surgery is dangerous. This case illustrates that self-orchiectomy is not limited to cases of psychosis or substance use and emphasizes the importance of broad access to gender-affirming care.

INTRODUCTION

Self-orchiectomy, the removal of one's own testicles, is a rare occurrence primarily documented in the context of psychosis or substance intoxication.[1-4] For transgender, nonbinary, or other gender-diverse patients with limited access to gender-affirming health care amid a constantly evolving political landscape, self-orchiectomy may feel like a last resort. We present a unique case of self-orchiectomy in a nonbinary patient without acute psychosis who demonstrated capacity to refuse urologic reattachment of testicles.

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CASE PRESENTATION

A nonbinary individual in their 30s who was assigned male sex at birth presented to the emergency department (ED) after removing their testicles several hours earlier at home. The patient applied lidocaine cream as a topical anesthetic agent, then used a zip tie as a tourniquet and a sterilized kitchen knife to remove the scrotum. They experienced significant bleeding, called emergency services, and were brought to the hospital by ambulance. The discarded scrotum was transported to the hospital separately.

Physical examination was notable for mild tachycardia with otherwise stable vital signs, absent testes, and excision of 90% of scrotal skin. Laboratory investigations, including complete blood cell count and basic metabolic panel, were unremarkable. No urine toxicology was obtained; however, there was no evidence of intoxication. The recommendation from urology was to attempt microsurgical reanastomosis of testes, which the patient declined. Consultation-liaison psychiatry was asked to assess capacity to refuse surgical reattachment of the testicles.

The patient had no significant past medical history. Psychiatric history was significant for gender dysphoria, anxiety, and depression. At the time of presentation, they were not taking any psychotropic medications and reported an extended period of stable mood and minimal anxiety prior to admission. The patient reported identifying as nonbinary for many years. They had researched treatment options to suppress testosterone for the past month because of unwanted masculine features and irritability. They felt surgical bilateral orchiectomy would be cost-prohibitive and did not obtain formal consultation for hormone-blocking medications for fear of being stigmatized by clinicians.

The patient was interviewed in the trauma bay of the ED. Mental status examiantion showed a fully oriented adult patient who was calm and cooperative with evaluation. The patient had euthymic affect, intact attention, and organized and logical thought. There was no evidence of depression, psychosis, or delusion. They were not intoxicated and did not demonstrate any cognitive impairment. They denied depressed mood, suicidal ideation, or self-harming intent. With the patient's permission, their mother was at bedside and corroborated their story. The patient accurately described the sequelae of declining testicle reattachment—specifically, sterility, reduced muscle mass, changed tone of voice, and reduced body hair; these factors were viewed positively by the patient. The patient verbalized necessary criteria for decision-making capacity and consistently chose to forego reanastomosis of their testicles. They also declined fertility preservation via sperm banking. Urology performed wound closure, and the patient was discharged the following day in stable condition. At urology follow-up 3 months later, the patient was noted to be well-healed with stable mood.

DISCUSSION

Also known as Eshmun complex, as originally described by the Greeks, self-orchiectomy has rarely been reported in the literature and almost exclusively in the context of psychosis, substance use, or delusion.[1,3-5] It also has been known as Klingsor syndrome when the motivation for castration is due to religious delusions.[6] Given the potentially stigmatizing nature of this injury, it is thought to be underreported; thus, accurate epidemiological data about self-orchiectomy are unknown.

It has been estimated that up to 87% of cases of genital self-mutilation occur in the setting of psychotic symptoms.[7] First documented in the medical literature in 1901, Stroch described a young adult man who removed his scrotum in attempt to relieve pain due to "lack of success in life" that he considered secondary to his sexual organs.[8] In 1949, Bisset documented a young man who removed both testicles as he believed it would cure his epilepsy.[9] A case report from 1979 includes a man who cut a significant distal portion of his penis "in obedience to the New Testament."[7] Also in 1979, Kalin reported a case of self-surgery by a patient who completed a bilateral orchiectomy (and later attempted adrenal gland denervation) because of the belief he needed to be saved from being "hyper-aggressive."[5] More recently, Isaacs and Kaleka (2023) reported an older man who amputated his penis in the context of schizophrenia (delusions about women arguing over his penis) and methamphetamine use.[3]

At the time of their literature review, Greilsheimer and Groves reported 40 known cases of genital self-mutilation at the time, only 6 of which involved testicle removal.[7] More recently, a systematic review by Veeder and Leo reported 173 cases of male genital self-mutilation from 1900 to December 2015, with 32.4% involving removal of the testicles.[4] They also found that for patients with gender dysphoria, inaccessibility to treatment was noted in 71% of cases.[4]

Some case reports describe attempts at castration secondary to concerns related to sexual identity and libido. One unique case report describes a middle-aged man who hired another person via an online chat room to remove his testicles; the intent was to suppress his sexual drive, to which he attributed many previous tumultuous relationships.[10] In a nonsurgical case, an adult man injected his testicles with food-grade calcium chloride in an attempt to decrease libido.[11] In both cases, neither patient was found to have acute symptoms of psychosis or depression, nor evidence of suicidality.

Few similar reports in the existing literature are in the setting of gender dysphoria, estimated to represent 15.3% of total cases.[4] McGovern documents an adult transgender woman who performed self-castration while awaiting gender-affirming surgery and cautions that if wait times for gender-affirming surgery lengthen or care becomes less accessible, the incidence of genital self-mutilation may increase.[12]

In our case, the patient was a nonbinary individual who performed a self-orchiectomy at home to remove masculinizing effects of testosterone and alleviate gender dysphoria. Consultation-liaison psychiatry was asked to determine whether the patient had capacity to refuse urological reattachment of their testicles. Their actions were not suicidal or self-harming in nature. In contrast with much of the existing literature, the patient was not psychotic, delusional, or under the influence of substances.

Few documented similar cases remark on capacity assessment in the setting of self-orchiectomy. In one case, the patient was asked to sign a statement before consenting to an operation to close the wound, describing this was intended to "prove legal cover in the event of any subsequent action after the patient had realized his deformity."[9] This patient was later described as "indeed rather proud of himself."[9] Greilsheimer and Groves posit that individuals "adamantly opposed to surgical repair" will likely dispose of the organs, while ambivalent individuals may bring the organs to the hospital.[7] They recommend that any individual who brings the severed genital organ should have surgical reattachment attempted. They also note that psychiatric consultants should prepare for negative countertransference from other team members, especially in the case of self-castration, as "he has intentionally inflicted on himself that wound Freud tells us neurotic men fear above all else and some neurotic women feel they have sustained."[7] In describing a case of a self-castration in a transgender adult woman, McGovern asserts that "people who perform self-castration usually oppose surgical repair of their genitals."[12]

The four criteria of decision-making capacity include (1) understanding of the condition including all potential risks, benefits, and alternatives; (2) ability to appreciate all relevant information and apply it to their own situation; (3) clear reasoning process; and (4) expression of a clear and consistent choice.[13] Our patient

demonstrated an understanding of their condition, including the possible effects of declining testicle reattachment and a subsequent acute drop in testosterone; in fact, they viewed potential sequelae as desirable and reported no interest in ever parenting biological children. They demonstrated appreciation of all information and a clear reasoning process, which was supported by their mother during the interview. While the patient did transport the severed testicles to the hospital, they expressed a clear and consistent choice to refuse the procedure to reattach them. We determined that they had capacity to make this decision; indeed, it was our assessment that reattaching the testicles would be more likely to cause psychological harm to this patient.

Finally, one might also consider the "four topics" or "four quadrants" ethical framework proposed by Jonsen et al, which builds on the four principles of bioethics: respect for autonomy, beneficence, nonmaleficence, and justice.[14] The first topic, medical indications, requires assessment of diagnosis, proposed treatment, and expected outcome, as well as consideration of beneficence and nonmaleficence. In this case, from a psychological standpoint, it was decided that upholding the patient's choice to remove their primary source of testosterone was both promoting their well-being and avoiding any further harm. Further, in comparison with attempted reanastamosis of the testicles, wound washout and closure was a much simpler and less invasive procedure, presenting fewer objective surgical risks. The second topic of patient preference, guided by the ethical principle of respect for autonomy, has already been discussed, as the patient was deemed to have decision-making capacity and communicated clear preference. Quality of life, the third topic, involves consideration of both respect for autonomy and beneficence in assessing how proposed treatment might impact quality of life for the patient. In our case, the patient was readily able to describe how their quality of life would be improved secondary to removal of their testicles, namely in ways that reduced their gender dysphoria and aligned with nonbinary gender identity (eg, changes in tone of voice, muscle mass, body hair). The fourth topic, contextual features, includes any psychosocial aspects that may affect patient care, such as family and relationship dynamics, economic or legal issues, or religious affiliations. Our patient described good social support in their mother and friends, no significant financial or legal issues, and gainful employment. However, the broader sociopolitical context is also relevant.

In June 2023, the Human Rights Campaign declared a state of emergency for lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) individuals in the United States, citing multiple restrictive legislative changes.[15] These developments have contributed to an increasingly volatile and unpredictable landscape for gender-affirming care. For some patients, barriers to accessing medically supervised treatment may lead to extreme measures such as self-orchiectomy.

CONCLUSIONS

This case contributes to the limited literature on self-orchiectomy in nonbinary patients and underscores the need for careful psychiatric evaluation in the context of gender dysphoria. Unlike most reported cases, our patient was not psychotic, delusional, intoxicated, or otherwise impaired. Their decision-making was intact, and their motivations reflected longstanding gender dysphoria and barriers to gender-affirming care.

Although the patient recovered without complication, self-surgery is dangerous and carries significant risk. Clinicians—particularly psychiatrists and emergency care providers—should be prepared to evaluate patients presenting with self-injury related to gender dysphoria. This case illustrates that self-oriectomy is not limited to cases of psychosis or substance use and underscores the importance of broad access to gender-affirming care.

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