An unusual case of polyembolokoilamania: Urethral avulsion from foreign object use during sexual gratification

Michael S. Floyd Jr, MCh FRCS (Urol), Andrew D. Baird, FRCS (Urol)

Department of Urology, Aintree University Hospital, Liverpool, United Kingdom

CUAJ Letters is an open forum to discuss papers published in CUAJ. Letters are published at the discretion of the editors, and are subject to abridgement and editing for style and content. Letters can be sent to the Editor at journal@cua.org.

Cite as: *Can Urol Assoc J* 2016;10(9-10):357-8. http://dx.doi.org/10.5489/cuaj.4003

We read with interest the recent unusual case of genitourinary trauma reported by Chan et al.[1] A very rare case of urethral avulsion resulting from autoinsertion of a plastic tube for sexual gratification (polyembolokoilamania) is presented and the subsequent surgical management — an emergency urethroplasty — is described. The authors are to be commended for avoiding a perineal urethrostomy and for performing a urethral realignment in an emergency situation. Although the followup reported is limited to eight weeks postinjury, it is reassuring to see that erectile activity has been preserved without significant chordee. It is stated that no voiding complaints have been reported by the patient, but it is not mentioned if the patient has resumed intercourse postoperatively or if ejaculation is affected in any way.

The authors allude to the many etiologies of self-embedding behaviour, with particular reference to the genitourinary tract, and highlight polyembolokoilamania as a predominant one. Specific to certain patient groups, it should be acknowledged that repeated urethral foreign body insertion can be a form of manipulative behaviour, as it requires transfer to an acute healthcare provider.[2] It has also been reported in the psychiatric literature that the practice can be mimicked by other patients in institutions.[3] In 2013, we reported an emergency surgical intervention rate of 9% in the acutely hospitalized, incarcerated patients and demonstrated higher rates of urethral foreign body insertion;[4] however, all cases were managed with endoscopic retrieval.

The authors discuss that the exact prevalence of self-inflicted injuries following foreign body insertion is unknown and mention that delayed presentation is common and further discuss the symptoms and complications. It should be mentioned that self-embedding behaviour may also cause injury to the patient's partner. The well-documented practice of "genital beading," performed in order to enhance the sexual response of partners,[5] may cause inadvertent vaginal lacerations, as well as acute and delayed problems in the male.[6,7]

Finally, the authors emphasize the importance of a candid history being offered by the patient, as well as appropriate radiology and cystoscopic evaluation. This is an important point. Eke has demonstrated that cultural attitudes may hinder patients from divulging the exact nature of a sexual related injury and, consequently, treatment may not be sought until the complications become intolerable.[8] Although expertise in such cases is limited to a few, it is important to note that injudicious attempts at removing genitourethral foreign bodies can potentially compound the initial injuries. The role of the radiologist should not be underestimated, as prompt and appropriate radiological investigations aid in determining the exact location, orientation, and radiolucency of the foreign body[9] and, in select cases, may also assist in foreign body removal.[10]

Competing interests: The authors declare no competing financial or personal interests.

References

1. Chan G, Mamut A, Tatzel S, et al. An unusual case of polyembolokoilamania: Urethral avulsion from foreign object use during sexual gratification. *Can Urol Assoc J* 2016;10(5-6):E181-3. http://dx.doi.org/10.5489/cuaj.3778
2. Mastromichalis M, Sackman D, Tycast JF, et al. Urethral foreign body insertion for secondary gain in the incarcerated population. *Can J Urol* 2011;18:5916-7.
3. Rada RT, James W. Urethral insertion of foreign bodies. A report of contagious self-mutilation in a maximum-security hospital. *Arch Gen Psychiatry* 1982;39:423-9. http://dx.doi.org/10.1001/archpsyc.1982.04290040033005
4. Floyd Jr MS, Mistry R, Williamson EPMW, et al. Urology on the inside: Managing the needs of the incarcerated. *J Clin Urol* 2013;6:100-5. http://dx.doi.org/10.1177/2051415812472677
5. Nguyen DP, Desai BK, Falgiani M. Visual diagnosis: Pearling: A case study. *Int J Emerg Med* 2011;4:74. http://dx.doi.org/10.1186/1865-1380-4-74
6. Floyd Jr MS, Cotter D, Corcoran MO. Penile bead implantation. *British J Sex Med* 2007;30:16-7.
7. Marzouk E. Implantation of beads into the penile skin and its complications. *Scand J Urol Nephrol* 1990;24:167-9. http://dx.doi.org/10.3109/00365599009180852
8. Eke N. Urological complications of coitus. *BJU Int* 2002;89:273-7. http://dx.doi.org/10.1046/j.1464-4096.2001.01458.x

9. Yacobi Y, Tsivian A, Sidi AA. Emergent and surgical interventions for injuries associated with eroticism: A review. *J Trauma* 2007;62:1522-30. http://dx.doi.org/10.1097/TA.0b013e3180341f8f
10. Young AS, Shiels WE 2nd, Murakami JW, et al. Self-embedding behaviour: Radiologic management of self-inserted soft-tissue foreign bodies. *Radiology* 2010;257:233-9. http://dx.doi.org/10.1148/radiol.10091566

Correspondence: Mr. Michael S. Floyd Jr, Department of Urology, Aintree University Hospital, Liverpool United Kingdom; michaelfloyd@nhs.net

Author reply

Blayne Welk, MD, FRCSC, MSc

Department of Surgery and Epidemiology and Biostatistics, St. Joseph's Health Care, London, ON, Canada

Cite as: *Can Urol Assoc J* 2016;10(9-10):357-8. http://dx.doi.org/10.5489/cuaj.4174

I am happy to offer an update on our previously submitted case report.[1]

As suggested by Floyd (Jr) and Baird, further details on erectile function are indeed an important part of judging the functional outcomes of our operative management. At eight months post-injury, the patient has mild to moderate erectile dysfunction (IIEF-5 score of 12), which he describes as slightly worse than prior to the injury. His ejaculatory function is unchanged and he has not attempted sexual activity with a partner. He has an aversion to medications and has refused any form of therapy for his erections. In terms of his voiding, he continues to deny any lower urinary tract symptoms; a followup retrograde urethrogram continues to show slight narrowing at the penoscrotal junction, his urethra accommodates a 16 French bougie, and his post-void residual is low (34 mL).

Competing interests: The author declares no competing financial or personal interests.

Reference

1. Chan G, Mamut A, Tatzel S, et al. An unusual case of polyembolokoilamania: Urethral avulsion from foreign object use during sexual gratification. *Can Urol Assoc J* 2016;10(5-6):E181-3. http://dx.doi.org/10.5489/cuaj.3778

Correspondence: Dr. Blayne Welk, Department of Surgery and Epidemiology and Biostatistics, St Joseph's Health Care, London, ON, Canada; bkwelk@gmail.com