**Letter to the Editor**

**Genital theft: Cotard syndrome or depersonalization? A Case Report**

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Dear Sir,

Genital theft or denial of genital ownership is a rare clinical event (except in Africa). Only a single case is reported in the global literature from New Zealand. 1 We present the second case of ‘genital theft’ from West Bengal, India. This is a fascinating case who complained that a friend had stolen his genital organs in the background of depression and cannabis use.

**Case:** Mr DN, a 53-year-old Bengali, Hindu, single male, presented himself to a rural hospital emergency with abdominal acute pain and distension, feeling of a hard moving mass inside the lower abdomen. During the examination, he disclosed that his penis and scrotum were stolen by a friend, two weeks ago, and currently he has no genital organs. No definite organicity was found about his abdominal complaint, and symptomatic management relieved his distension, and he was referred and was admitted to the Institute of Psychiatry, Kolkata.

On examination, there was no gross physical abnormality, no neurological deficit found, normal gait and communication was a bit anxious. He complained of low mood for the last five months after being laid off in a local Jute mill. His affect was of a dulled emotional tone (apathy). He also complained of extreme physical and mental slowing and lost motivation to carry out day-to-day activities. He also expressed his extreme concern for his lost genitals. He disclosed that he smoked cannabis for a last five months on weekend evenings with one of his known person (F). One evening F palpated his genitals (the reason is unknown), and after that, in that evening, he discovered that F had stolen the body parts. After this event, that so-called friend stopped calling him. He was convinced that F was the ‘culprit’ though he had no clues for this theft. He repeatedly requested us to summon F and order him to return his genitals (Penis and scrotum).

All laboratory tests were regular, except a urine drug test was positive for cannabis on admission. Neurology referral was uneventful, with standard CT head, without any deficit in tone, power, reflexes or any abnormal movements. The mood was low for the last five months, and the Hamilton Depression rating scale score was 27. He denied any suicidal thoughts or intent. His MMSE was 24/30. No formal thought disorder or delusional thought content is evident except his firm solitary belief that his genitals have been stolen by his friend. However, he could not provide any suitable motive behind this alleged theft. He had no fear of death from this genital loss but was feeling shameful and apprehensive about the probability of ridicule by the people of his locality. He denied any heterosexual or homosexual relations and remained single by his own choice.

Regular supportive psychotherapy and assurances of recovering the lost genitals facilitated a good rapport. He was put on tab amoxapine 50 mg daily for three days and then increased to 50 mg morning and 100 mg afternoon along with tab clonazepam 0.50 mg at bedtime. Given his repeated request to recover his lost genitals from his fried, a psychodrama type of session 2 was planned on the third week of his admission. His alleged friend was called and he participated in a psychodrama therapy session where he acknowledged the theft and acted as he was returning the theft genitals. The clinical team staged the fixing of the genitals with his consent in this psychodrama session.

**Discussion:** The diagnosis and differential diagnosis of this case poses some critical conceptual difficulties. At least three main clinical issues seem essential here. Firstly, Cotard syndrome, secondly a dissociative disorder like depersonalization/derealization and lastly, asomatognosia. Sporadic cases of ‘genital theft’ are extremely rare in the literature. Some authors regarded the penile dissolution in Koro as a delusional perception and tried to explain the phenomenology in the light of Cotard syndrome. Bandinelli et al., 3 reported a case of 58 yr old single man with complaint of chronic Koro-like symptoms (KLS) and suggested nihilistic or hypochondriacal delusions are associated with depersonalization experiences. They believe the feature of KLS is sharing annihilation delusion, which may be called a variant of Cotard’s delusion. Connors and Waldau 1 reported one case of 36 yr old man who complained that his penis had been stolen and replaced with someone else’s, at the background of a history of schizoaffective disorder and longstanding body dysmorphic disorder, with positive urine test for cannabis.

Cotard syndrome is a constellation of false nihilistic beliefs that often surface in self-negation. Patients with psychotic depression often show Cotard syndrome as an internalized attribution style or accompanied depersonalization. 4 In the present case, if his firm conviction of genital theft and consequent persecutory accusation of his fiend is considered as a part of psychotic delusion, then there is a probability that the symptom of genital loss (theft) may be explained as a part psychotic depression. Psychotic depression is reported with Cotard symptom.5 Berrios and Luque 6 in their review of 100 cases of Cotard syndrome found that 89% of subjects reported depression, and the most common nihilistic delusions were concerning the body (86%) and existence (69%). .

Depersonalization/ Derealization Disorderis a form of dissociative disorder characterized by periods of feeling disconnected or detached from one's body and thoughts (depersonalization). Usually it is an episodic feeling state and often associated with epilepsy, brain diseases, certain personality disorders, and substance abuse. Cannabis is notably associated with depersonalization, 7 which may later become chronic in nature. 8 The weekly cannabis smoking for nearly last five months in this case may be a potentialcontributorfor genital depersonalization.

The two other clinical conditions in the differential diagnosis are essential. The first one is delusional hypochondriasis and depression. Major depression might have mood-congruent psychotic symptoms like somatic delusion, e.g., dysmorphophobia. 9 Asomatognosiais the other issue of consideration, which means “lack of recognition of the body, which is a pathological somaesthetic experience that the parts of the body are “missing, are stolen or have decayed.” 10 Moreover, the denial of boy part (s) is not associated with identifying a person responsible for the loss (or theft). There is no evidence of any focal brain lesion in the present case.

**Conclusion**

The cases with subjective perceptual genital symptoms need a very careful clinical analysis. Depression, psychosis, Cotard syndrome, depersonalization-derealization, asomatognosia, and even body-dysmorphic disorders (penile dysmorphophobia) 11 are the potential clinical issues to be differentiated for proper diagnosis and treatment. We attempted a modified psychodrama therapy approach along with antidepressant and anti-anxiety medications with success. His positive response (regaining of genital organs) with staged drama resembles somewhat similar responses in conversion disorder (limb paralysis), but we have no easy answer to how all these worked for him. His belief and trust that the lost genitals can also be recovered played a vital role in this dramatic treatment approach and his recovery. He once said that he heard from his old grandmother that in the village side witches or ‘night ghosts’ (Nishi) steals penises and often return the stolen objects if they are appropriated through traditional rituals. We believe that this rural cultural background of the subject was conducive for this psychodrama therapy approach.

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**Ethical Declaration:** The authors are thankful to the patient for giving informed consent for his case's unanimous presentation. It was obtained by respecting his right to privacy and taken in a manner consistent with the guidelines of the World Health Organization and the declaration of Helsinki. Ethical Committee of IPGME&R approved this presentation.

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# Appendix

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