

# Apotemnophilia Masquerading as Medical Morbidity

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**Abstract:** We report a case of apotemnophilia, or “love of amputation,” in a man in his mid-20s. *Apotemnophilia* is defined as self-desired amputation driven by the patient’s erotic fantasy of possessing an amputated limb and overachieving despite being handicapped. The desire of a patient with apotemnophilia for amputation is obsessive, and a history of repeated, unexplained injuries to the same segment of the body is common among these patients. Patients with apotemnophilia secretly harm themselves to necessitate amputation of an injured limb, which creates a diagnostic challenge for the health care provider because of the atypical presentation of self-inflicted medical morbidity caused by apotemnophilia.

**Key Words:** amputation, apotemnophilia, cellulitis

Two case reports of apotemnophilia, or “amputation love,” were first described by Money et al<sup>1</sup> in 1977. Everaerd<sup>2</sup> and Wise and Kalyanam<sup>3</sup> also have reported cases of this extremely rare paraphilia, but few case reports exist in the mainstream medical literature. Furth and Smith<sup>4</sup> recently wrote a book on the subject that outlines the various characteristics of apotemnophilia. The Internet has also contributed to the increasing amount of information available about apotemnophilia that is widely accessible to the general public.<sup>5</sup> This disorder of self-desired amputation is related to the erotic fantasy of undergoing amputation of a limb and subsequently overachieving despite a handicap. Apotemnophilia has been compared with Munchausen syndrome and masochism,<sup>1</sup> but the characteristic findings of this fascinating disease clearly distinguish apotemnophilia as a unique paraphilia. Few psychiatrists have evaluated and treated patients with apotemnophilia, and even fewer primary care providers have knowledge of the disorder. We report the case of a patient in his 20s

with apotemnophilia who presented with several conditions mimicking common medical problems.

## Case Report

The patient was a 24-year-old man who presented to a campus health clinic with a 2-week history of bilateral lower-extremity foot weakness and numbness. He was subsequently referred to the neurology service for further workup of his symptoms. His physical examination was remarkable for 2/5 strength with dorsiflexion and plantarflexion of the feet bilaterally, along with decreased sensation to light touch bilaterally over the lower extremities up to the level of the midcalf. It was also noted that the distal phalanges of the patient’s feet were missing, which the patient reported was secondary to “frostbite” sustained during a mountain-climbing accident in 1999. After cerebrospinal fluid and blood chemistry were found to be normal, the patient underwent nerve conduction studies, which revealed absent sural sensory nerve action potentials bilaterally, increased bilateral F-wave latency along the distal portion of the tibial nerves, and moderate slowing of nerve conduction velocity in the peroneal nerves and tibial nerves bilaterally. His nerve conduction studies were consistent with a diagnosis of Guillain-Barré syndrome (GBS). A 5-day course of outpatient intravenous immunoglobulin was administered, and the patient was instructed to follow up at the clinic if his symptoms progressed.

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## Key Points

- Symmetric, bilateral cellulitis is extremely uncommon.
- Apotemnophilia is a rare cause of significant medical morbidity in atypical patient presentations.
- A history of unexplained, repeated injuries to a given segment of the body should prompt the physician to take a thorough medical history concerning psychiatric disease.

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(Case Report continued from previous page)

One week later, the patient presented to the emergency department with bilateral lower-extremity pain, weakness, and swelling, along with 39.6°C fever and tachycardia. A repeat physical examination demonstrated 0/5 strength with dorsiflexion and plantarflexion of the feet bilaterally, along with bilateral, symmetrical erythema and edema of the lower extremities. Minor excoriations were noted on the patient's ankles, but no noticeable lacerations, ecchymoses, or puncture wounds were found. The patient was diagnosed with bilateral lower-extremity cellulitis as a complication of GBS, and he was admitted to the neurology service for administration of intravenous antibiotics.

During the next 2 days in the hospital, the patient continued to spike high fevers as his legs remained erythematous and swollen despite the administration of intravenous antibiotics. After consultation with the general surgery service, it was determined that bilateral incisions and drainage of the lower extremities were indicated to prevent necrotizing fasciitis. At the surgeon's request to take the patient to the operating room, the patient requested bilateral below-the-knee amputations (BKAs) of his lower extremities. An orthopedic surgeon was consulted, and it was determined that amputation was not indicated, so the patient agreed to undergo bilateral incision and drainage of his lower extremities.

Additional history was obtained from the patient's spouse, and she revealed that the patient's distal phalanges of the feet were missing because he had performed self-amputation with a tourniquet in 1999. The patient's spouse further confessed that the patient had had a past "fascination with amputations," and she had previously discovered him placing tourniquets around his lower extremities at

various times. It was concluded that his bilateral neuropathy and cellulitis of the lower extremities were due to self-induced ischemia with tourniquets. The patient was diagnosed with apotemnophilia and transferred to the psychiatric service for further evaluation and treatment.

The patient's medical history was remarkable for previous injuries to the lower extremities. He had a foreign body needle fragment removed from his right knee in 1992 and had sustained a fracture of the third left toe after shooting himself with a pellet gun. In 1995, he had presented to a children's hospital with right lower-extremity cellulitis and compartment syndrome. He had undergone surgical fasciotomy/exploration that revealed no necrosis or evidence of significant infection of the extremity at that time. The patient's medical charts also revealed that his biologic father had paranoid schizophrenia and had committed suicide 2 years earlier.

The patient's stay in the psychiatric ward was brief, consisting of 2 weeks of daily psychotherapy, rehabilitation therapy, and physical therapy. During discussions with the inpatient psychiatric team, he described himself as a world-class athlete and artist and stated that he was extremely intelligent. At the time of his discharge from the psychiatric ward, the patient maintained his desire to undergo bilateral BKAs in the future, stating, "It is likely that my infections will come back." His final wound cultures from incision and drainage grew 3+  $\beta$ -hemolytic *Streptococcus* (not A, B, C, F, or G species), 3+ Gram-positive cocci consistent with oral anaerobes, 3+ mixed skin flora, and 2+ yeast. By the end of the patient's hospitalization, he was walking slowly without discomfort. He was discharged on no medications and instructed to follow up for outpatient counseling.

## Discussion

We think that this report is the first case of a patient with apotemnophilia who presented in his 20s. His psychiatric illness led him to incur significant inpatient medical and surgical hospital costs on several occasions in multiple hospital settings. This hospitalization was the first to bring attention to his true disorder, because none of his previous medical encounters had raised any questions or suspicion of apotemnophilia as a possible cause of his repeated medical consultations.

Consistent with previously mentioned case reports,<sup>1-3,5</sup> our patient was secretive about his attempt to self-amputate his legs. Although his nerve conduction studies were found to be characteristic of early GBS,<sup>6</sup> his lack of reliable physical examination findings, combined with his purposeful omission of a history of self-induced lower-extremity ischemia with a tourniquet, made the diagnosis of apotemnophilia elusive at his initial encounter. Instead, he was given an alternative

diagnosis requiring expensive outpatient pharmacologic therapy that did not help the patient and needlessly increased the already burgeoning costs of his health care. His covert desire for self-amputation also complicated his admission to the hospital from the emergency department: He was improperly admitted to the inpatient neurology ward and not to the general surgery ward, because it was thought that his cellulitis might be a rare complication of GBS. Previous case reports have illustrated that patients with apotemnophilia recognize that others do not validate their desire for self-amputation;<sup>1</sup> thus, maintaining secrecy about the origin of the injured limb may be the only means by which these patients can undergo the sought-after amputation.<sup>1,5</sup> Valuable hospital resources were used unnecessarily before the patient's history of attempted self-amputation was obtained.

At the end of our patient's hospitalization in the psychiatric ward and after his lengthy stay in the neurological, sur-

gical, and medicine inpatient wards, the patient revealed his wish to have bilateral BKAs. His reluctance to undergo bilateral incisions and drainage instead of the desired BKAs for cellulitis was the first significant clue leading to the diagnosis of apotemnophilia. The patient's medical history of repeated lower-extremity morbidity and his family history of psychiatric disease also were characteristic of patients with apotemnophilia,<sup>1</sup> and the symmetric, distal phalangectomies of his feet were indicative of psychiatric illness presenting as medical morbidity. Patients with apotemnophilia fantasize about accomplishing great feats despite having a handicapping amputation,<sup>1</sup> and the patient's claim of being a world-class artist may have stemmed from such a preconceived fantasy. He could have continued painting if his attempt to undergo BKAs had been successful. Therefore, his motivation to undergo lower-extremity rather than upper-extremity bilateral amputations was most likely due to his fantasy of remaining a superior artist and excelling in painting despite of having no feet or legs.

Money et al's<sup>1</sup> original case reports of two individuals with apotemnophilia describe individuals who were much older than our patient, and subsequent case reports have described individuals in their late 40s<sup>3</sup> and 60s.<sup>2</sup> The accessibility and availability of information about apotemnophilia on the Internet may be a factor in the relatively early age of presentation of this patient compared with patients discussed in previous case reports. Money et al<sup>1</sup> remarked that apotemnophilia was first brought to public attention in the September and October issues of *Penthouse* magazine in 1972. Fewer than a dozen case reports of apotemnophilia currently exist in the literature. The scant literature available on apotemnophilia is currently too small to draw conclusions about the true prevalence of this rare disorder.

There are reportedly several Internet sites that provide access to amputee pornography and information about so-called amputee devotees, or *acrotomophiles*<sup>7</sup> (ie, amputee partners), and "wannabes," or people with apotemnophilia, as well as listservs and other web-based discussion sites dedi-

cated to apotemnophilia. Although our patient did not specifically mention any web-based resources, he reported frequent nonspecific use of the Internet. The patient's wife also confessed that her husband subscribed to various magazines about lower-extremity prosthetics, although he denied having any subscriptions to medical journals or magazines related to amputation.

## Conclusions

Symmetric, bilateral cellulitis and distal phalangectomies of the feet are extremely uncommon, and atypical presentations of medical diseases combined with a medical history of repeated, unexplained injuries to a given segment of the body should prompt the clinician to take a more thorough medical history concerning psychiatric disease. Early recognition and diagnosis of apotemnophilia may prevent unnecessary serious injuries requiring costly hospitalizations for patients with apotemnophilia. Apotemnophilia is a rare potential cause of significant morbidity in atypical patient presentations.

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## References

1. Money J, Jobaris R, Furth G. Apotemnophilia: Two cases of self-demand amputation as a paraphilia. *J Sex Res* 1977;13:115-125.
2. Everaerd W. A case of apotemnophilia: A handicap as sexual preference. *Am J Psychother* 1983;37:285-293.
3. Wise TN, Kalyanam RC. Amputee fetishism and genital mutilation: Case report and literature review. *J Sex Marital Ther* 2000;26:339-344.
4. Furth GM, Smith R. *Apotemnophilia: Information, Questions, Answers, and Recommendations about Self-demand Amputation*. Bloomington, IN, 1stBooks Library, 2000.
5. Elliott C. A new way to be mad. *Atl Mon* 2000;286(6):72-84.
6. Bansal R, Kalita J, Misra UK. Pattern of sensory conduction in Guillain-Barré syndrome. *Electromyogr Clin Neurophysiol* 2001;41:433-437.
7. Money J. Paraphilias: Phenomenology and classification. *Am J Psychother* 1984;38:164-179.

Problems loom large when men don't.

—Robert J. Bidinotto