MALE PSEUDOHERMAPHRODITISM

BY

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With the change in the socio-economic condition of women and advance in education in our country more women seek medical advice for gynaecological problems than ever before. When polygamy was legally possible, women had no alternative to permitting their husbands to remarry when abnormalities of the generative organs prevented consummation of marriage or child bearing. Little attention was paid to the correction of the defects when possible. With the growth of democracy and awakening among women, attempts to vindicate their rights and safeguard their position are made by legislation. One of these is the Prevention of Polygamy Act by the Bombay State. Fresh problems have cropped up, as a second marriage is permissible only after divorce, which is obtained under certain specific conditions. This has resulted in a marked increase in the number of divorce suits making the position of a woman with abnormalities of sexual organs extremely precarious in society. It would be more so in cases of male pseudohermaphrodites who are brought up as women, and not educated sufficiently to earn their own living. Their abnormality is usually discovered after marriage, which in our country is often at an early age. Appearance of male secondary sex characteristics in persons brought up as girls save them from an unhappy marriage and psychological trauma. But all are not so fortunate as the gonads are rudimentary and these individuals remain feminine throughout their adolescence. Their psychological make up is feminine and quite a large number of them have a well developed vulval pouch which makes normal sex life possible. Some of them have gynaecomastia also and have been noted to be happily married in spite of presence of sperms in the urine.

One would consider it strange that the subject is dealt with by a gynaecologist. But my personal experience with several such cases corroborated by Hamblen et al, justifies this step.

As can be expected, these individuals are mistaken for girls and consult gynaecologists for abnormalities of sex organs.

Management of these cases present complicated social and legal problems. When diagnosed in infancy and early childhood the change in

the sex, from that recorded at birth, presents less difficulty as the parents can bring up the child according to the correct sex. In adults, however, the problem is different. The individual finds it difficult to adjust himself to the sudden change in his social status and environment and becomes more or less a social outcast. He is neither physically nor psychologically fitted to be a male nor acceptable to the feminine fold on account of his gonadal sex. Attempts at masculisation are very often unsuccessful and the frustrated individual with an inferiority complex becomes a psychoneurotic and a burden to the family.

The present consensus of opinion is to assess the sex of the individual from the psychic and general physical make-up regardless of the hormonal and histological structure of the gonads. In individuals with a feminine psyche, attempts are made at retaining and enhancing these qualities by measures like castration, construction of artificial vagina and estrinisation.

For detailed discussion on this interesting problem the readers are referred to excellent articles by Hamblen et al and Bhoumik.

With this background, I present the following four case reports: The first three were mere infants who appeared to be girls to all external appearances. Diagnosis of male pseudohermaphroditism was made by careful clinical examination of the external generative organs. The diagnostic features in each case were a rather large clitoris, absence of vulva and cloacal depression and the presence of a well marked median raphe extending from the external urethral meatus to the skin of the perineum. In all cases the parents were advised to bring up the babies as boys and educated adequately so that they may be self supporting in adult life. One of these cases was seen in the out-patient department of the hospital and two in private.

The fourth case was that of an adult and being rather unusual will be described in details:

Mrs. M. S., aged 23 years, was admitted to the hospital for primary amenorrhoea, sterility and dyspareunia. She was married for three years. She was a well developed person with feminine distribution of hair and voice. Breasts were rudimentary and the slight prominence noticed at first proved on closer examination to be due to the underlying pectoralis major muscles. The labia majora were well developed with the gonads at the upper end of each. The presence of an inguinal hernia was suspected on account of a well marked impulse on coughing in the inguinal canal. The clitoris was rather large and on closer examination was diagnosed as a rudimentary penis. She had a well marked cloacal pouch about $1\frac{1}{2}''$ deep. No uterus or cervix was felt through this pouch or on rectal examination. The case was clearly one of male pseudohermaphroditism. A catheter sample of urine did not reveal any sperms.

In view of the findings the patient was advised a divorce as menstrua-

tion and child bearing were out of question. The patient and her husband were, however, not keen on having either function restored if normal married life was painless and possible after operative treatment.

The patient was operated on 9-9-50 under spinal anaesthesia. The right inguinal canal was opened up through a herniotomy incision and the nature of the gonad explored. It was a well developed testis. The pelvic peritoneal cavity was also explored through the same incision. No uterus or tubes or accessory gonads were found. A bilateral orchidectomy was performed after a rather hot discussion with my surgical and gynaecological colleagues.

A vagino-plasty by Wharton's method was performed on 22-10-50 and the patient placed on replacement therapy with estrogens. The vaginal pouch was further dilated by vulcanite vaginal dilators.

With this treatment the breasts increased in size, her dyspareunia, due to the short vaginal pouch and testis, disappeared and normal marital relations were possible.

An estrone pellet of 25 mgms. was implanted in the right thigh on 10-11-51 to obviate the necessity of taking estrogens orally.

Comment.

The above method of dealing with such a case is in agreement with the modern views on the subject of pseudohermaphroditism. The present trend is to consider the sex of the individual according to the psychic and socio-economic status rather than the actual gonads, male or female, and perform operations required for the necessary adjustment in life. Opinions are divided on the necessity of castration. Some workers do not consider it necessary and transplant the gonads to the abdominal cavity if they cause dyspareunia. This prevents violent symptoms of castration like headache, mental depression and flushes. The arguments in favour of castration are (1) estrinisation is easier, (2) the danger of development and unpleasant masculinisation like growth of beard and moustache and change in voice is removed, (3) the chances of occurrence of malignant change in misplaced gonads are reduced.

The symptoms of castration are effectively relieved by substitution therapy with estrogens. Estrone pellets may be implanted for prolonged and continuous effect. The result in this case justifies the adoption of this attitude, especially if the individual desires to retain the sex as recorded at birth.

Summary and Conclusions.

(1) The socio-economic and medico-legal aspects of male pseudohermaphroditism are discussed.

(2) Four cases of pseudohermaphroditism with detailed description of one are presented.

(3) Attempt is made to justify the present trend of relying more on the

psyche of the individual rather than the gonad in deciding the line of treatment in each case. This is contrary to the orthodox view of treating cases according to the histological structure of the gonads irrespective of the general physical development, psyche and socio-economic status of the person concerned.

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References.

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