

CASE SERIES**PRESENTATION OF CHILDREN WITH MASTURBATION****Syed Sajid Hussain Shah¹, Bibi Aalia², Shahzad Najeeb³**Paediatric Nephrology, Institute of Kidney Diseases, Peshawar, ² Department of Paediatrics, Lady Reading Hospital, Peshawar, Department of Paediatrics, Ayub Medical College, Abbottabad

Childhood masturbations (CM) is stimulation of genital by pre-adolescent children with accompanying symptoms including sweating, tachycardia, blushing, muscle contraction and increase rate of breathing. We are presenting case series of three patients, who presented with history of vague symptoms and ultimately diagnosed and managed as case of CM. A 2 years old girl presented with history of to and fro movements. A 3 years old girl presented with history of rubbing of inner thighs and 3 years old boy presented with history of holding and rubbing genitalia with forward bending and symptoms of increase breathing, flushing and sweating. Video recording was available with two patients, which helped in making final diagnosis. Parents were counselled and patients referred for behavioural therapy.

Conclusion: In young child CM should be considered in differential diagnosis whenever history is not fully suggestive of seizures.

Keywords: Childhood; Masturbation; Self-stimulation; Behaviour

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INTRODUCTION

Masturbation is stimulation of genitalia both in males and females.¹ It is considered as normal behaviour as in literature it is reported that 50–60% females and 90–94% males masturbate any time in life.^{2–4} Regarding the aetiology of this behaviour, there is not sufficient information. In one of study done in Iran the prevalence of childhood masturbation is 6% in boys and 8.8% in girls under 12 years of age.⁵

Childhood masturbations (CM) is defined as “the fact that pre-adolescent children to stimulate in any way their genitals and observation during this course of the accompanying symptoms such as sweating, blushing and frequent breathing”.⁶ In 1909, Still GF recognized and gave the concept of childhood masturbation.⁷ Regarding CM, the Diagnostic and Statistical Manual of Mental Disorders (DSM) does not have some definite diagnostic criteria. Though in DSM-5 definition of CM is given as “body focused repetitive behaviour disorder” under subtitle “Other defined and undefined obsessive compulsive and related disorders” under title “Obsessive compulsive and related disorders”, yet it does not reflect the true definition.⁸ CM patients presentation mimics with other disorders and is often mistaken for abdominal pain, dyskinesia, epilepsy and paroxysmal dystonia⁹ and most of times exact diagnosis is missed.

We are presenting case series of three patients who presented with various features and ultimately diagnosis of childhood masturbation was made on basis of clinical features and exclusion of

other diagnosis. Parents’ consent was taken for inclusion of case in this case series.

CASE 1

A 2 years old female child brought to paediatric OPD by parents. There was history of body movements along with rubbing of perineum while sitting in bed or when mom is carrying the child for last 4 months. There was also history of increase breathing and flushing of face and sweating during the process. Patient was seen by local doctors as one of doctor described that child was having worm infestation, that’s why child was behaving in this manner. Clinical examination was unremarkable. Ultrasound abdomen and urine DR did not reveal any abnormality. Mother was counselled to make video which revealed child having gratification and diagnosis of CM was made. Parents were counselled about the diagnosis and patient referred for behavioural therapy.

CASE 2

A 3 years old female child brought to paediatric OPD with history of rubbing inner part of thighs while sitting and there was associated flushing of face, sweating and increase respiration. This behaviour of child was on going for last 3 months. Parents only consulted once and the doctor prescribed anti-scabies treatment but condition did not improve. Patient was finally diagnosed as case of CM. Parents were counselled about the diagnosis and behavioural therapy started.

CASE 3

A 3 years old boy presented with history of pain abdomen on off for last nine months. According to the parents’ child use to hold the genitalia and kept it

rubbing and then bends forward with facial flushing, sweating and increase respiration. Patients perceived this to be due to pain abdomen and visited various doctors. Laboratory investigations including complete blood count, renal function tests, serum ALT, AST, Amylase, urine DR were normal. Ultrasound abdomen done multiple times and revealed nothing. Patient was given multiple antibiotics, antispasmodic medicine, anthelmintic syrup, antacids and analgesics but no effect not the condition. Parents even got the video of child while having the same episode. When patient was being examined, the child was having the same episode and there was stimulation of genitalia and penile erection was there. Patient was ultimately diagnosed as case of CM and parents were counselled about the diagnosis and further management.

DISCUSSION

Children with behavioural issues and problems are prone to develop more serious issues if not properly diagnosed and managed.¹⁰ Masturbation is normal part of human development but is not discussed openly due as its challenging for parents and society. Most of parents are naïve to prevalence of sexual behaviours in early childhood and may perceive CM as pain in perineum or seizure disorder. So, detail and through history is one of the important steps. Video recording of the event has its own importance.¹¹ In our patients, details history was taken and examination done. Video recording of two patients was also available for making proper diagnosis. Gerges MAM *et al*¹² in their study found that mother's knowledge about preschool and school going children was not good. In health care setting, there should be provision of counselling services about the diagnosis and management of childhood behavioural issues.¹³ All of the three patients included in this case series were visiting doctors but definite diagnosis could not be done. This lead not only to persistence of CM behaviour in children but also kept parents in trouble. In one of study by Askari M *et al*⁵ the prevalence of CM in boys was 6% and girls was 8.8% and mean age was 4±3.31 years. While in our case series, patient's age was 2 to 3 years. Martin J *et al*¹⁴ study finding suggests that preschool children mothers' knowledge and attitude can be improved with definite sex education program and this will also help in teaching of children about sex education and behaviour. Ağır M *et al*⁶ studied CM relationship with parental attitude and found that there was direct relationship between CM and authoritarian parental attitude.

CM should be part of differential diagnosis whenever young children present with vague history of paroxysmal event and fit like activity.¹⁴ Parents counselling and video recording of the event not only prevent the child from unnecessary investigations but also helpful in diagnosis and management.

CONCLUSION

In young child CM should be considered in differential diagnosis whenever history is not fully suggestive of seizures.

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